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1 Swine flu outbreak – important message from your LMC
The national flu line launched last month. Patients can either phone on 0800 15 13 100 or use the flu line website (http://www.direct.gov.uk/pandemicflu).

The situation regarding the A (H1N1) outbreak continues to evolve on a daily basis. Please remember to check your inbox and our website (http://www.lmc.org.uk/news/news-detail.aspx?dsid=4908) daily for the latest information and guidance. You can also keep us updated with your concerns by contacting our exclusive email address: flu@lmc.org.uk.

Please note that the flu@lmc.org.uk email address is not an emergency helpline. However, please be assured that all queries/local intelligence are read. They are also fed back to NHS London on your behalf which helps us to raise the reality that you are facing with those organisations leading on flu.

If you do not receive an email response from the flu account, this is because we are prioritising the queries that we can deal with.

We have been working hard to ensure that key swine flu messages are reported by the media. In the last few weeks our GPs, LMC Chairs, Medical Directors and CEOs have been interviewed or quoted by the following media: BBC TV news, BBC London news, Radio 5 live, Channel 5 news, Sky news, the Telegraph, the Evening Standard and 15 local papers.

We will continue to support you by promoting the hard work that you are doing during this difficult time and by providing patients with clear advice on how to deal with this virus.

2 Urgent – GMC licence to practise – action required now!
The GMC will introduce its licence to practise on 16 November 2009. From this date any doctor wishing to practise medicine in the UK will, by law, need to be both registered and hold a licence to practise.

A licence to practise is the first step towards the introduction of revalidation which will start at some time in 2011.

All doctors need to decide whether they wish to be licensed by 14 August 2009. You will need to inform the GMC if you would like to be classed as one of the following:

- Registration with a licence to practise (£410 per annum)
- Remain registered without a licence to practise (£145 per annum)
- No longer registered

If you have not already done so, you must contact the GMC with your decision on 0161 923 6277 or visit the GMC licensing website at www.gmc-uk.org/licensinghelp.
3 Extra GP sessions and medico-legal cover
Some of you have raised a query about whether you need to take out additional cover because of extra sessions that you are now doing around extended hours.

Our research has shown that there are two levels of cover: GP Principal and GP Salaried/Locum.

The MPS defines ‘full time’ as 11+ sessions; ‘maximum part time’ is 7 – 10 sessions inclusive. Both are aggregated over the whole year. We assume that other defence organisations use similar criteria.

So, for instance, if a doctor is doing eight 8 regular clinical sessions a week, together with a Saturday morning 1in 6 and one evening a month, they would probably be covered on the ‘maximum part time’ subscription.

There is no ‘one size fits all’ here and if you have any concerns about your level of cover, our advice would be for each individual to check with their defence organisation’s membership department.

4 Child protection issues
The report of the Care Quality Commission Review of the involvement and action taken by health bodies in relation to the Baby P case (http://www.cqc.org.uk/_db/_documents/Baby_P.pdf) was published in May 2009.

If you have not already read this document then we recommend that you do so. The BMA has published a Child Protection Toolkit which can also be accessed via our website (http://www.lmc.org.uk/news/news-detail.aspx?dsid=5197). We would also recommend that at least one copy of this toolkit is made available in your practice and drawn to the attention of all members of your team. It is of great importance that all GPs and practice staff are adequately trained and therefore we urge constituents to access the toolkit and ensure that they meet all necessary requirements.

In particular, please note the following in the Care Quality Commission’s report:

- **Page 13 (fifth full paragraph)** – Note that a GP was suspended as a result of the Baby P case.

- **Page 14 (see box)** – Note that the PCT should have a designated doctor and nurse. We are asking the PCT to clarify who these people are and to disseminate this information to all practices.

- **Page 18 (Safeguarding training)** – Note the requirements for level 1 training and be prepared to provide evidence that staff have been trained and comply with the three bullet points.

- **Page 25** – Note the six bullet points setting out the current themes.

- **Page 26 (second paragraph, final sentence)** – Note the implications of this sentence. Note the advice that practices would be wise to ensure that when referring a patient to social services, a follow up phone call is made to check that the referral has been received. Steps should be put in place to ensure that practices have been informed of the outcome of the referral.

- **Page 38** – Please note all of the recommendations that are made.

5 Londonwide practice based commissioning (PBC) update
As promised last month we are now in a position to give a pan London update on the current views held on the progression of PBC to date.

Recently, three lines of exploration have taken place. The first by Dr David Colin-Thome, the National PBC Lead, carried out a PBC assessment via his team by visiting PCTs and using a questionnaire to local PBC leaders. At the same time, Londonwide LMCs did a quick information gathering exercise to see what messages it could gain, and to enable it to...
‘cross-check’ the information gained by the national team.

Our Joint Chief Executives shared information at a recent meeting with Dr Colin-Thome. The results and the messages gained had been remarkably similar and we were able to put forward some simple potential solutions which we felt would improve the development of PBC in the forthcoming year.

The final piece of research has been carried out by the King’s Fund entitled ‘PBC two years on - Moving forward and making a difference?’ (http://www.kingsfund.org.uk/research/publications/pbc_two_years_on.html). Many of the points made in this report also reflected those gained and presented by Londonwide LMCs. The King’s Fund gained its information through a survey that was carried out in March of this year. There were 321 responses and whilst the King’s Fund recognises that it is not a representative sample, it does accept that the comments provide a valuable insight into the views of those most closely involved with PBC. The view’s represent those of not only GPs but of a broader range of professionals including PCT managers, practice managers, commissioners etc. The majority of respondents represented clusters with more than ten practices covering a patient population greater than 50,000.

We strongly advise everyone to read this document as it contains many messages. We feel that the key messages are:

1. **Financial** – In 2007, financial limitations were cited as one of the top criteria delaying the implementation and activation of PBC. Given the current forecast of financial climate it is likely that PBC will again be faced with this dilemma which will pose a significant challenge to its further development.

2. **Clinical engagement** – Lack of engagement of clinicians by PCTs at local level remains a significant barrier. Clinical engagement is frequently referred to in the Department of Health’s (DH’s) ‘World Class Commissioning’ (http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm) as are initiatives such as poly systems and GP led health centres, but all these advancements will not take place if PCTs don’t get the GPs on board.

3. **Directives** – The operational details need to be addressed at a local level and prescriptive national guidance is not going to be forthcoming.

4. **Conclusion** – The King’s Fund ends its report by saying: “Whatever form PBC takes, as the NHS moves into a period of restricted financial resources where critical investment and disinvestment decisions will have to be made, it will become increasingly important for the PCT and clusters/practices to work closely alongside each other in an increasingly expert co-commissioning partnership....” and how should this be brought about.... by real clinical engagement anchored by clear locally developed visions, structures and agreements and lines of accountability.

We couldn’t agree more.

And finally, another piece of recent research may be of interest to readers. A final report on the project of the National Primary Care Research and Development Centre entitled ‘Practice-based Commissioning: theory, implementation and outcome’ (http://www.npcrdc.ac.uk/Publications/6765_PB_C_Briefing_Paper_WEB.pdf) provides a good insight with a perspective taken alongside policy. The full report can also be downloaded from the Centre’s website (http://www.npcrdc.ac.uk/Publications/FINAL%20PBC%20REPORT%202009%20WEB.pdf%20-%20Adobe%20Reader.pdf).

6 **LMC statutory levy**
Londonwide LMCs and individual LMCs across London work tirelessly to secure the future of general practice, ensuring that GPs and practice teams receive the information, support and
advice that they need in these unprecedented challenging times.

The Darzi review and the threat of polyclinics, commercialisation, GP-led health centres, QOF prevalence changes and increased scrutiny of practices by PCTs, are some of the many issues that we have been addressing. Londonwide LMCs has issued a number of tools to support GPs and practice teams, including our successful ‘Keep My NHS GP Local’ campaign, our ‘Self Assessment Toolkit’, our first major conference. ‘Securing the Future of General Practice in London’ and the launch of our Learning Education and Development programme (Londonwide LEAD). Our current major focus is on providing support and information about swine flu to GPs and practice teams.

We are well aware of the considerable financial pressures on practices as costs rise much faster than any increase in resources, and the Board of Londonwide LMCs has made every effort to limit increases in our expenditure. Nevertheless, we have had to employ extra staff to cope with the additional work and it has been necessary to increase the Statutory Levy for 2009/10 by 5.3p to 52.1p per patient per annum. As far as we can see, there will be no above-inflation increases next year.

We hope that you feel that you are getting value for money, and we shall continue to provide you with the best possible level of service.

7 Expanding Practice Allowance (EPA)


In response the DH has told us that the EPA model enables PCTs to provide practices with a grant. This is used to increase practice infrastructure – usually additional staff – in anticipation of increased list sizes. It is one way of overcoming the time delay between additional patients actually registering with the practice and increased capitation-based payments. EPAs are granted at a PCT’s discretion.

EPA payments are not therefore GMS contractual payments with specific entitlements attached to them. They are not SFE (Statement of Financial Entitlement) or enhanced service payments. They draw their legitimacy from the general provisions of section 96 of the NHS Act 2006.

They are time limited, exceptional tailored measures (not necessarily limited to a one-off grant) designed to help with the problems that a practice might face when it looks at the options and risks of expanding.

There is currently no national scheme or specific national guidance relating to EPAs. If a practice faces capacity problems then an EPA might be the answer if it prevents the need for list closure etc.

PCTs would have to identify factors before offering assistance to the practice. Discretion lies entirely with the PCT in question.

The DH is currently considering how the concept of EPAs can be made to work for practices and patients. More information should be available later in the year.