NORFOLK LOCAL MEDICAL COMMITTEE

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February 2007

FLU DES

The LMC is delighted that Norfolk PCT has reinstated the National DES for flu and minor surgery. I hope that lessons will be learned from this sorry saga. We are part of a National Health Service and we have National Terms and Conditions which must be honoured. The DES item of service and prescribing fees are all part of the nationally agreed pricing. Introducing threats about excessive prescribing is totally inappropriate. I hope that we will be able to return to an environment of trust between management and general practice and engage in meaningful discussion. We have enough other challenges and need to concentrate on delivering good patient care. It is clear that the profession needs to remain united against bullying tactics.

I would like to thank everyone for the support they have given the LMC. We would all prefer the local NHS not to be in financial deficit; however the answer is not to ask t local practices to subsidise the NHS out of their own incomes.

The LMC is keeping a close eye on activity in neighbouring PCTs. I think we will all be scrutinising future proposals carefully and will say no when necessary. We must also be aware of policy directions from the DOH. There are other bright ideas within our Region which I would not wish to see locally. We need to work closely with the GPC, with the LMCs in the EoE Region and with our own constituents within Norfolk and Great Yarmouth & Waveney. We need the PCTs to be on the same side so that we may develop appropriately resourced services for our patients. The present climate is bad for morale, recruitment /retention and patients. Proper patient care is our first priority - that is why we are trusted by our patients. Ian Hume.

Dentists and Antibiotic Prophylaxis

The LMC office has been passed a couple of queries about this; at a recent meeting with the LDC Secretary we were able to discuss them.

If a dentist is in full possession of a patient's medical history then he or she should be able to make a clinical decision, based on up-to-date guidance - for example in the BNF - on whether a patient needs antibiotic prophylaxis or not. The dentist should not attempt to transfer the responsibility for this decision by querying the matter with the GP.

On the other hand, if there remains doubt about the medical history after the dentist has obtained all the information s/he can from the patient, then its clearly in the patient's best interest for the doctor and dentist to liaise so that the dentist has the right information upon which to base his decision.

Nick Stolls, Norfolk LDC Secretary, felt that this should be via direct communication between a dentist and a doctor, by whatever method of communication they prefer. If the patient's notes lack the information required in order to make a decision, the doctor or the dentist may need to contact a specialist for advice and this could appropriately be left to the dentist although, of course, it would be perfectly in order for the GP to pursue the enquiries as he or she may need the same information for future reference. Many thanks to the practices who raised these issues.

Target reductions in expenditure on drugs that are available over the counter (OTC)

The LMC was shocked to see a letter from Neil McKay, Chief Executive of the Strategic Health Authority, on this subject. In essence it proposed that drugs that are available over the counter should not be prescribed by GPs.

Even if the GP believes that the drug is required for the clinical benefit of his or her patient, the patient is to be asked to purchase it over the counter rather than receive a prescription. The LMC understands that the Norfolk PEC did not agree with the content but that the local PCTs may still try to implement the letter as policy. You are reminded that your Terms of Service do not allow you to do this even if you believe it to be appropriate. Hereunder I refer to the GMS Regulations, although similar statements are included in the PMS Regulations.

Paragraph 15.3 states: *services are to be provided for registered patients and temporary residents who are, or believe themselves to be, (a) ill with conditions from which recovery is general expected, (b) terminally ill or (c) suffering from chronic disease. Schedule 6, Regulation 26, Paragraph 39 (i) states that .... a prescriber shall order any drugs, medicines or appliances which are needed for the treatment of any patient who is receiving treatment under the contract by issuing to that patient a prescription form or a repeatable prescription form and such a prescription form or repeatable prescription shall not be used in any other circumstances.*

Of course there is nothing to prevent GPs handing over the prescription while saying it may be available over the counter for less than the prescription charge. But you should note that the policy suggested by the EoE SHA would force patients who do not pay prescription charges to pay for drugs necessary for their clinical care. This is wholly outwith the Regulations and would require national debate and changes in the rules. Be very wary of acquiescing if you are asked to do this.

NORFOLK PCT LOCUM POLICY

As those who read their 2003 New Contract documentation carefully will remember, PCTs have a duty to: "develop and seek to agree with the LMC a policy for locum cover and payment arrangements." This relates to payments from the PCT-administered budget for locum costs for maternity, paternity, adoptive leave, sickness leave, to cover for suspended doctors or for the prolonged study leave scheme.

I am a fan of the new contract, but a duty to "develop and seek to agree" is clearly not a duty to do what the LMC says, it is only a duty to listen to what the LMC has to say.

The "rules" of the scheme are in the SFE and, as far as I am concerned, if there are battles to be fought, that is the battle ground. The PCT policy, on the other hand, is the ***PCT's*** protocol to try to implement the SFE through the most cost-effective (internal) process and an opportunity for the PCT to put some spin on those parts of the SFE where there is room for interpretation.

I met Rob Colebrook, NPCT Clinical Director, on the 6th Feb; this followed lengthy correspondence with his predecessors on the locum policy – both specific cases and general issues. We agreed some changes; I satisfied myself that the policy was internally consistent and not wholly at odds with the SFE.

Considering that the LMC "side" was not negotiating from a position of strength, I was reasonably happy with the resulting policy. The internal PCT process should be straightforward and practices should hear within 14 days. I imagine the PCT hopes there will be very few appeals but I suspect there will be more - and now the LMC is a member of the local panel, which was not the case with the previous policy.

Waveney Election to the LMC

We are very pleased to announce that there were four nominations to the four places on the LMC for the Waveney Area of the GtY&W Constituency, to serve from 1st April 2007 - 31st March 2009. They are:

Dr Annette Abbott (Halesworth)
Dr Tim Morton (Beccles)
Dr Manjeet Seehra (Lowestoft)
Dr Sagar Valmiki (Lowestoft)

The LMC was also pleased to co-opt Dr Jennifer Butler (a salaried GP with the Bungay Practice) to the vacancy on the LMC-wide Salaried and Self Employed Constituency.

As you know, the PCT can not have a blanket policy always to pay less than the maximum; this follows a judgement by the ICG. The maternity leave "banding" in the Norfolk PCT policy may be open to the same charge; I was not able to convince Dr Colebrook of this, so it is in there still, until and unless someone successfully appeals to the ICG. Similarly, I am not happy with the implications of question 9) on the draft proforma – which is that sensible practices with locum insurance may be ***less likely*** to obtain funding from the PCT than those that have not. Again, my negotiating skills were insufficient to get that removed from what is, after all, ***the PCT's*** policy. For that to be removed, therefore, the PCT would need to lose a case taken to the Implementation Co-ordination Group (ICG).

I have not yet seen a "final" version of the policy but, assuming it says what I think it does, you should still bear in mind what I have written above if you are told the LMC has "agreed" it. As far as I am concerned this means that the LMC has been allowed input and some changes have been made and the PCT has a right to issue and use it. Practices, of course, have a right to list all extenuating services - making the best possible case they can, also to use proportions of "full parity share" for partners and, when appropriate, to appeal against PCT decisions knowing that an LMC representative - who will be familiar with the SFE - will be on the panel. The LMC can refer cases to the central ICG.

The above applies to GMS practices; I am not in a position to know whether PMS practices have the same clauses in their contracts.

Finally, there is an issue about timing. I understand that some practices are being told that this policy is retrospective and that applications already received and approved will be reviewed. This is a different issue. The LMC would never agree that agreements should be flaunted which had been freely entered into between practices and either the former PCTs or the (then) responsible officer of the Norfolk PCT.

A maternity leave case last year reached a compromise settlement when one of the PCTs attempted to change the rules but the practice was able to prove that it had had an agreement in advance. I would hope the same would happen again if a practice found itself in a similar situation. If the PCT is more intransigent than its predecessors then an appeal is likely to be appropriate. Simon Lockett

NORFOLK PCT TURNAROUND PLAN

The LMC has been advised by the PCT that several of the more alarming proposals in the 21st November 2006 Turnaround Plan have been dropped. These include:

Limit Practice Overhead Funding: apparently Norfolk has been doing it in accordance with the Premises Directions, so no further work is necessary

Rationalisation and re-tendering of GP Surgeries: "it is not the intention to imply a threat to any of the practices currently in operation across Norfolk. It is more to remind the PCT of the opportunities ... as and when contracts come up for recommissioning (eg a practice asking to relinquish a branch surgery, retirement of a single-hander ……)".

GP List Size Review/VAT element of PMS contracts: ".... these two initiatives have been dropped".

Defer Rental Uplifts: the PCT is "clear that this is not acceptable and no action will be taken".

We had assumed that the PCT would want to tell practices this good news, but a month after we received the letter there is no sign of it. Perhaps the PCT has not yet owned up to the SHA that it has had the temerity to drop some possible money saving ideas.

CHARGING PATIENTS

The LMC office recently circulated some new BMA Guidance for GPs on Charges for NHS patients. It is very clear from some of the responses we have received that some of you think part of what is in there is silly and needs to be changed, or the guidance may even be incorrect. The former may well be true, but I do not think the latter is.

The main point at issue is whether procedures that are not commissioned locally can be provided, for a fee, by practices for their own patients. An example might be the removal of asymptomatic, unsuspicious moles that a patient wished to get shot of.

The BMA guidance is very clear and comes from the position that everything we can charge for is clearly listed in the GMS (and, I assume, PMS) contract. Therefore, charging for anything else risks action against the GP and/or practice - up to and including the GMC and NHS counter fraud service.

Since I have been associated with it, the LMC has felt that the guidance it gives should be that which keeps practices well away from trouble, not which encourages practices to sail closer to the wind. I simply have no idea how you do a risk assessment for uncharted waters, to continue the nautical theme. But practices can read the guidance with their contracts and make their own decisions. GPs throughout the country will watch the test case with interest.

A motion to the LMC Conference pointing out that GPs have skills and facilities to provide things patients want, and are happy to pay for, but which the NHS is not providing, might succeed. The LMC will consider whether to submit such a motion. SRL.

VAT on Medical Services "to show to your accountant"?

HM Revenue and Customs has formally announced that implementation of the VAT ruling on medical services (the Dr D"Ambrumenil judgment) will take effect from 01.05.07., subject to House of Commons approval. The BMA recently published guidance http//www.bma.org.uk/ap.nsf/Content/VATon medicalservices

Therefore, medical practitioners registered on a statutory professional register whose taxable income (including VAT) exceeds the VAT registration threshold (currently £61,000*) will need to register for VAT. Similarly medical practitioners who are already VAT registered, for example as a result of dispensing changes which took effect on 1 April 2006, will also need to ensure that they account for VAT on any affected services from 1 May 2007. There will be no compulsory back-dating of VAT registration before the implementation date.

It is vital that practices refer to the BMA guidance in its entirety, or to their own professional financial adviser. A Q&A sheet which addresses, amongst other things, issues such as Access to Health Records, Medical Reports etc can be found at http://www.bma.org.uk/ap.nsf/Content/VATon medicalservicesFAQs

*Apologies that our January guidance had a typo (££61,000) which might have led some of you to think there was a digit missing.

Issue of Med 3 and Med 5 Forms

We are grateful to Wessex LMCs for allowing us to reproduce its guidance following a recent report that a GP was suspended by the GMC for not seeing a patient when signing a Med 3.

It appears that when a Med 3 has been issued after an initial consultation many GPs will issue subsequent repeat certificates based upon a telephone consultation to avoid "wasting" an appointment slot just for this purpose.

However, the issuing of these medical certificates is strictly regulated by law and the official rules are quite clear on the matter. They are set out in the Dept of Work & Pensions "A Guide for Registered Medical Practitioners" at www.dwp.gov.uk/medical/guides_detailed.asp# IB204

The Social Security (Medical Evidence) Regulations 1976, as amended, set out the format and rules for completion of medical statements of incapacity. Providers of NHS primary medical services are required to issue certificates on the prescribed forms and in accordance with these Regulations. The rules state quite specifically in relation to Med 3s:

"You must examine the patient on the day, or the day before, you issue this statement (Note: Although a certificate can be issued to a patient's representative, this does not override the necessity of seeing the patient on the day, or the day before, a Med 3 or Med 4 is issued).

In situations where it is not sensible to arrange a face to face consultation, the GP should issue a Med 5 if the advice to stay off work is based upon a previous examination, just as when a decision is based on another doctor's report (eg from a secondary care report). The rules for using a Med 5 are also set out clearly in the DWP guidance.

Looking to the Future: development of hospital services in the East of England

This SHA document has some interesting comparisons in it. One that caught our eye was Table 2: Standardised Outpatient Rates per 1,000 weighted population 2006/07. Norfolk PCT is bottom of the table with 633 with Gt Yarmouth & Waveney at 773. The average for the East of England was 776, and for England as a whole 780. The highest PCT in the table is Cambridgeshire at 941.

Not being a Public Health physician I may be talking rubbish, but we find it is hard to deduce from these figures that local GPs over-refer and should do more hospital follow-ups!

WN Prescribing Incentive Scheme 2006/07

The office has received reports that the PCT is unilaterally trying to change the parameters of the former West Norfolk Prescribing Scheme 2006/07 which practices signed up to in good

faith. We understand that the statins target wasto prescribe 70% as preferred statins in the last 6 months of the year or have a 20% improvement on the 2005/06 rate in the last 6 months. This has been changed to a requirement to achieve an 80% rate in March 2007 - with no other requirement. This rather suggests that the PCT can not be trusted to honour agreements - not the most sensible of messages for it to be sending when it is asking practices to sign up to enhanced services and practice based commissioning.

UROLOGY GUIDELINES

Reactions to the recently distributed guidance (for practices in Norfolk PCT) have been "mixed". Some GPs are delighted to have clear guidelines that appear to be evidence based, others, however, believe these to be incorrect or to contradict other pathways.

When they were circulated it was far from clear whether it was as a "draft for comment" or as a fait accompli. The LMC at its February meeting was advised that it was the former, though GPs have contacted the office saying their comments have not been taken on board. Most worrying is a rumour that the Norfolk and Norwich has been told that referrals outside the guidelines will not be funded - making it likely that such referrals will be refused.

You are reminded that it is your responsibility to refer patients when you believe it is clinically indicated. A defence based on local urology guidelines may not hold much water, especially if those guidelines are wrong.

MRSA & NNUH

Practices continue to seek the advice of the LMC office for this pathway in the light of the rather vague and difficult to find instructions. The NNUH appears willing only to pay £10 per patient, even though the LMC understands that agreement was reached at one stage for £10 per swabbing - ie there would be additional payment if a patient required re-swabbing.

To claim, a quarterly invoice should be forwarded to the MRSA Screening Programme Co-ordinator c/o Infection Control, West Annexe 2, NNUH.

The good news is that, since the scheme began, 987 orthopaedic and 115 thoracic surgery, patients have been screened, but none has had it done by primary care. Thus, I am afraid, it does not seem a terribly sensible use of anyone's time to try to restart negotiations as the impact on our practices appears to be minimal. Of course, if the information we have received from Dr Richards is wrong and your nurses are swabbing away like mad and you are finding it hard to claim, please do get in touch and we will take up the cudgels.

By the way, if you are asked by another hospital to swab a patient (assuming you are willing to do the work - and you don't have to if you don't want to) we suggest that you explain that the NNUH offers payment and that you expect the same from the requesting trust.

CPD payment of £750 to GP trainers: 2006/07

The Department of Health has confirmed that, following the recommendation by the last Doctors' and Dentists' Review Body (DDRB), GP trainers should receive a £750 CPD payment in 2006/07 (as they did in 2005/06). However, we understand that GP Trainers have, to date, not received this money, despite calls from the GPC for this to be paid as soon as possible.

The Health Department has so far refused to say when the payment will be made and has noted that it is for SHAs to decide how they manage this and to what timetable they make the payments. This is unacceptable and has been drawn to the attention of the DDRB.

If you are a Trainer please let the office know if you have received your money. We are diarying this forward for a couple of weeks and if we have heard nothing by say 14th March we will assume that no Norfolk or Gt Yarmouth & Waveney Trainers have had their money and will take this up direct with the SHA.

OPPORTUNITY TO TEACH UNDERGRADUATE MEDICAL STUDENTS

In September 2007 the University of East Anglia School of Medicine, Health Policy & Practice will enter its 6th year, having successfully graduated our first cohort of new doctors!

One of the greatest strengths these new doctors will take into the next stage of their careers is the extremely valuable experience they have gained in primary care. From the very beginning of each student's training with UEA, they are immersed in general practice and have the opportunity to meet patients in community settings. This is a strong shift of focus from more traditional medical schools which were classically based in a hospital environment. We are very proud of this aspect of our medical degree and we want to make sure we can continue providing this level of experience now and in the future.

If you think you have what it takes to be part of training our future doctors, please get in touch with us for further details. We have opportunities at all stages of the course, so you can teach around which ever area interests you most. The commitment you give varies with different course units, but typically you would take students for 18-24 days each year.

Please don't be put off by common barriers such as inexperience, as we provide full support to any new GP who joins our group of committed and valued tutors. We also want to hear from practice managers who are keen to get their practice into teaching.

We consistently get feedback from GPs who currently work with us who say that this is now one of the best parts of their jobs and that it is a great way of refreshing and maintaining their knowledge.

If you would like to discuss the possibility with GPs who lead practice-based teaching, or would like more details on the teaching or remuneration package please contact us using the details below.

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PENSIONS ..... Advice from the GPC

..... Dividend income pensionable in the NHS pension scheme As more GP practices were become limited companies, the DoH has decided, with effect from April 2006 that any NHS profits that are 'drawn down' as dividends would be pensionable (previously they were not). There seems to have been a bit of a communication breakdown as the Pensions Agency was only informed of this by the Department of Health recently. This decision may have far-reaching implications for GPs who may have wished to change the status of their practice to a limited company but who have not done so because of the presumed non-pensionability of their dividends. The GPC is still awaiting the precise details and facts of the situation and will issue guidance for the profession once these are known. The Pensions Agency has said it will highlight the message when the 2006/07 technical newsletter is issued.

..... HMRC guidance on recording employers' pension contributions on self-assessment tax returns The HMRC would like all GPs and their accountants to be aware of the following when filling out their self-assessment tax returns.

The HMRC's view of the correct accounting and tax treatment of GP contributions is that returns should be submitted stating gross income, including employers' pension contributions. The 14% employers' contribution should also be stated separately so that it can be claimed against tax. Doing tax returns in this way will ensure uniformity across the country but will make no difference to GPs' tax burden if they were previously recording their income net of the employers contributions. In instances where another method has already been used for the 05-06 accounts, HMRC would ask that the self-assessment forms are resubmitted in the correct format. Further guidance can be found on the HMRC's website at:

www.hmrc.gov.uk/pensionschemes/esca9.htm#2

..... Pension Agency Delays GPs who have retired have reported delays in the Pension Agency recalculating their pension following the confirmation of the final dynamising factor of 12.9% for 2003/04.

The Pensions Agency has confirmed that interest will be calculated and paid in line with Regulation T8 that outlines the provisions for payment of interest on late payments of benefits.

We have received assurances from the Pensions Agency that, in order to increase operational efficiencies, work has already started on designing enhancements to the automated practitioner processing systems. They are now looking to further enhance these for the specific purpose of processing the practitioner sub awards backlog as quickly as possible, including incorporating the appropriate interest payment automatically calculated from when the member's benefits first became due. This is in recognition of the delay and loss of timely payment. It is their intention to take some weeks out now to design and develop such a system that will enable them to complete the exercise sooner.

GP RETURNERS

The GPC revised guidance for GP Returners now includes advice on the impact of the Minimum Wage Regulations and the Model Salaried GP contract. It also gives advise to GPs who wish to return in a situation where no new central funding is available for the Scheme: Guidance available at:

www.bma.org.uk/ap.nsf/Contnet/gpreturners

Apologies for the lateness of this flyer - the office has been a bit preoccupied recently! SP