

NORFOLK LOCAL MEDICAL COMMITTEE

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Principals' Edition

NEWSLETTER JUNE 2003

A NEW GMS CONTRACT

Dear Colleague

By now you will all know the result of the ballot. A 70% turnout with 79.4% in favour and 20.6% against. If we were going to have a "Yes" vote then this is the kind of result we needed; an overwhelming endorsement of the new contract. Despite what you read in the GP press I believe this is excellent for Norfolk.

Obviously there are still concerns over some aspects of the deal and we will be liaising with the GPC to ensure that all these issues are adequately addressed during the implementation phase of the new contract. We will also be in discussion with all PCTs in Norfolk to ensure that practices are kept informed of developments and will be working closely with the trusts to ensure enhanced services and out-of-hours opt-out are implemented rapidly. We also need clarification about issues such as allocation of patients, seniority and pension provision and transparency of policy for IT development; we expect central guidance imminently.

The NHS Confederation and the BMA have agreed minimum specifications and priorities for directed enhanced services which all PCTs will be legally required to commission. It is vital that in discussions with your PCT any agreements are in writing. GPs are providers of "first choice" for many of these services but you must be aware that if you say "no" the PCT can commission the work elsewhere and to win it back you may have to bid alongside other providers as and when contracts expire.

I suspect that most practices will want to implement change as quickly as possible and that PCTs may well have difficulty in matching people's expectations.

We will not forget PMS practices who will also gain from the new deal and await details of the Minister's promise that the financial arrangements "*will be fair*" for those practices which wish to return to GMS.

It is immensely exciting that we will all have the opportunity, at least, to get real investment in our practices and see better working conditions for all doctors and their staff. I have little doubt that Norfolk GPs will deliver high quality care and receive their just rewards.

Ian Hume
Chairman

The Disability Discrimination Act and DV Valuations

The DDA comes fully into force in October 2004. You do, however, need to assess your practice now so that you do not fall foul of the law.

The Act requires you to make physical adjustments to your premises to enable disabled people to use the surgery. This includes both patients and staff. The fact that you do not have any disabled staff at present is irrelevant - you may do one day.

You have a duty to take reasonable steps to modify your premises or find alternative ways of providing a service by, for example, relocating it to accessible ground floor accommodation. These facilities include meeting the needs of the deaf and the visually impaired by, for example, fitting an induction loop.

The GPC has published detailed guidance which is available from the GPC website or the LMC office.

You need to make an assessment of your premises and decide if it is feasible to make any alterations or alternative provision of services. Even if no alteration is possible you still need to have made an assessment. The only test will come if someone takes you to court for discrimination. You need to be able to demonstrate that you have acted reasonably and persuade a court of this.

Clearly some of you will need this like a hole in the head at the moment but if you have done nothing yet you need to take action to assess your premises.

The other aspect of compliance with the DDA is the effect it has upon the value of your property. When the District Valuer values your surgery if it does not comply with the DDA then, on the open market, its value will inevitably be less than a similar fully compliant building!

Changes to Child Health Surveillance

The NHS Regulations very clearly state that the monitoring and recording of children's development by or on behalf of the GP will be at such intervals/occasions as is agreed with the Health Authority (for which now read PCT). However, whilst much of this work can be delegated to HVs it

remains the GP's responsibility. Dr Richard Reading, Community Paediatrician at the NNUH, has written to HVs (we believe only in the "central cluster" of PCTs) advising that the 18/12 and 3.5 year checks are no longer deemed appropriate and may be dropped; citing the recent Hall Report.

So long as the decision has a good evidence base then the LMC has no objections to this change. What it is concerned about, however, is the lack of consultation with either the GPs, who hold the contracts for child health surveillance, or the responsible Primary Care Trusts.

The LMC has written to Dr Reading and will raise the issue as a matter of urgency with the PCTs. In the meantime, however, please check with your own PCT before you or your HV implement these recommendations to ensure that you are not in breach of your obligations under your Child Health Surveillance contract.

Regarding the reimbursement for this service, it is our understanding that so long as you are providing child health surveillance in accordance with an "agreed" programme the fee will continue to be paid in full.

The Freedom of Information Act

We initially raised this issue in the May Flyer and now have received an example of a model publication scheme prepared by Wessex LMCs and which they are happy to share. To be posted on our website.

We are expecting the GPC to publish guidance very shortly and hopefully details will be included in the July Flyer. Don't forget, PCTs should host these schemes on their websites.

Meeting Between LMC and NNUH Consultant Staff Committee

At a second meeting between officers of the LMC and the NNUH Consultant Staff Committee the LMC raised the issue of referral pathways and the consultants related the difficulties they commonly experienced in getting hold of GPs.

A common topic of correspondence to the LMC

office has been instances of the NNUH (out or in-patient services) writing, requesting that we refer patients on to another speciality (or, sometimes, to a different consultant in the same speciality).

Your Pension - Provider or Performer?

Since the introduction of PMS, Norfolk LMC and Eastern Support Services are concerned with regard to the administration of the NHS Pension Scheme for Providers and Performers in PMS practices.

For Providers, the pension scheme is administered by Eastern Support Services who make deductions from the PMS monthly payment and maintain records, deal with estimates of benefits, purchase of additional service and retirements etc.

If you are a Performer, ie employed and paid by the practice, your pension is administered by the practice. It is responsible for notifying the Pensions Agency of your employment and should make deductions from your salary and deal with all the administrative matters regarding this on your behalf.

If you are unsure about your pension position please speak to your practice manager in the first instance - if you still have concerns please write to Sue Sargent at Eastern Support Services, St Andrew's House, St Andrew's Business Park, Thorpe St Andrew, Norwich NR7 0HT.

The consultants felt it was a "hang-over" from fundholding days and agreed to remind their colleagues that, if common sense dictates, GPs are happy for in-house referrals and that, instead, GPs would be invited to say that a referral *shouldn't* go ahead.

The LMC officers also raised a problem of referrals initiated by our non-medical primary care colleagues (community paramedics, practice nurses) being stonewalled by the hospital "until the patient is seen by a GP" and the office would be pleased to receive examples of where non-GP referrals have been problematic.

In turn the consultants reported difficulty in finding and talking to GPs, or indeed returning their calls, due to the obstacle course of practice telephone systems (often switched to Medicom etc over

lunchtime), brick wall receptionists and part-time GPs on days off. The LMC office is going to try to compile a directory of direct dial practice telephone numbers and/or individual practices' "preferred" ways for receiving communications - eg fax or email.

NHS Net Addresses

Now GPs are having new NHS Net addresses we'd like to hear from you if there have been any problems with the change, particularly sending and receiving email from a remote site.

A copy of a guidance produced by Eastern Support Services, the organisation overseeing the introduction of the service, has been included with this mailing, marked for the attention of your practice manager

The National Care Standards Commission

The NCSC is a nationwide body which has taken over the regulation and inspection of Care Homes in Norfolk. The categories "Nursing" and "Residential" no longer apply - homes are now categorised as "Care" or "Care with Nursing". There are about 470 Care Homes in Norfolk, some 76 of which having "with Nursing" status.

It was clarified that if an establishment is a "Care Home With Nursing", there should be no distinction within it between "residential" and "nursing" beds; the criteria of what a home is able/prepared to do is set out in its Statement Of Purpose. If GPs are finding a discrepancy between expectation and reality in a home ask to see the Statement and look for the types of services covered, and the Admissions Policy.

Amongst other items discussed was a proposal from the NCSC to send out a confidential GP Comment Card relating to a specific Care Home prior to an inspection. This asks 10 simple yes or no questions about what that home is like. We think this is a good idea and would encourage GPs to fill these in.

We also clarified that GPs were not prepared to write drug charts or prescription pro formas over and above an FP10, and this was supported by the NCSC.

Liaison with Other Hospitals

The meetings between the LMC and the N&N consultants was prompted by the large volume of correspondence from GPs about various problematic areas. We would be very happy to initiate similar liaison with JPH and QEH if there is a need for it but we receive very little correspondence in this area from GPs in the "east" and "west"; insufficient to form the basis of a meeting. We have to assume that things are Hunky Dory unless GPs tell us otherwise!

Hospitals and Sick Certificates

An example of the previous item - we are still receiving numerous reports of hospitals/wards (including the "west" and the "east") either telling patients to go to their GP for a certificate, issuing a certificate but only for the period of the patient's stay in hospital and most annoyingly denying all knowledge that they are responsible for issuing a certificate that covers the patient's absence from work until either they can return to work or need to see their GP.

Please, please - we accept that you won't turn your patient away because it is not their fault that the hospital is not complying. But do blast off a fax to the ward or let the LMC office know. This is a huge and unnecessary waste of GP time and we must get the message through otherwise they will continue to pretend it is none of their business.

Private Referrals

We have been asked to remind colleagues that if you agree to refer a patient privately this referral remains within your Terms of Service and therefore you may not make a charge for the referral letter.

Driving Medicals for the Elderly

Norfolk County Council has decided that it wants GPs to do medicals for Volunteer Drivers aged 75 and over to confirm that they are "fit to drive". (We also gather the Ambulance Trust is doing something similar). Needless to say this is NOT a contractual obligation and we advise GPs to decline, but if you are prepared to do it a reasonable fee may be charged. We have written to the Council about it.

Requests for Non Statutory Forms and Letters

Readers will know that this is a favourite topic in this flyer, examples such as the one above, requests for letters stating the bleedin' obvious, non-statutory sick notes, spurious requests for references, etc. The GPC has recently asked LMCs to keep the examples coming as there is still more work which needs doing between the BMA and the Cabinet Office. So please do continue to send examples in to the office.

When is a Violent Patients Scheme Not a Violent Patients Scheme ?

Answer - in West Norfolk PCT. We emphasise that the scheme currently being rolled out does not satisfy the DoH's Directives and government policy and therefore is not fit for purpose. Two reasons - (1) patients are not catered for by the scheme out of hours and (2) the scheme envisages a quorate meeting of panel members to enable a violent patient to be placed on the scheme. We will keep on at the PCT until it has a proper scheme in place.

NHS LIFT

The GPC has published a guidance aimed at GPs and other practitioners providing GMS or PMS services in England who are considering agreeing to enter into occupation of premises built or refurbished under an NHS Lift Project.

The LMC office is aware that LIFT developments are planned in West, North and Southern Norfolk, several of which involve GP Practices, and that a decision is imminent regarding the "preferred bidder". Anyone wanting a copy of this guidance please contact the LMC office.