

NORFOLK LOCAL MEDICAL COMMITTEE

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Conference of LMCs 2004

We went, we voted, we came home again. All motions which we submitted appeared on the agenda and one was placed second to a composite - thus we proposed it. The motion stated that, "whilst supporting the principle of Patient Choice at the point of referral" insisted it should be appropriately resourced and must not interfere with the consultation itself". This was passed unanimously.

Predictably Conference business was dominated by concerns over GMS2, DES, LES, NES and QOF and motions were passed on pretty much every element. Local concerns over funding, definitions, red tape etc seem to be reflected countrywide. Frustratingly, there was little enthusiasm from the GPC for a stricter re-definition of Essential Services. The one definite gain in Norfolk is the out of hours solution, which many other areas are still struggling with.

The general consensus was that 2004/5 was a dust-settling period but if GPs' incomes do not rise, and especially if the QOF doesn't deliver, then the gloves will come off next year. One motion (207) was a quiet revolution and not widely reported in the comics. It instructed GPC to renegotiate clause 483 of the new contract - which currently defines the services for which GPs cannot charge. The motion included charging for any services provided outside core hours.

Finally - congratulations to Dr Brian Balmer (Essex LMCs), on his re-election to GPC.

AMC - Violent patients and Out of Hours

GPs who expressed interest in doing AMC shifts will have received the letter from Lyn Reynolds regarding the possibility of being asked to attend patients on the Special Allocation Scheme. The letter had the Committee's support after consultation with the office. Primetime will continue to provide the "in hours" SAS (when most of the clinical contact with these patients takes place) and will triage the out-of-hours. Only patients requiring to be seen ooh will be

MEDICAL SECRETARY

to

THE NORFOLK LOCAL MEDICAL COMMITTEE

Norfolk LMC is looking to appoint a Medical Secretary, preferably a practising GP, who can offer the Committee four or more sessions per week. The post is currently reimbursed at £153.96 per session + 14% in lieu of NHS superannuation (uplifted annually in line with The Doctor and Dentists Review Body award)

The postholder has traditionally worked from home and/or practice, liaising with the LMC office (often electronically) and regularly meeting with the Chairman, Executive and Principal Executive Officer.

Previous Medical Secretaries have brought their individual talents and interests to the post and the Committee and the Secretariat are willing to be flexible and to tailor the post around the right candidate. Amongst the responsibilities of the current incumbent are the pastoral care of doctors, heading up the liaison with Norfolk's six PCTs, with commissioners and with secondary care trusts, as well as reading and responding to constituents' correspondence, reading and interpreting guidance and HSCs, working with neighbouring LMCs the GPC etc., and handling the media. The Medical Secretary would also be expected to assist in the compilation of agendas and attend the monthly LMC meetings. For more information please see the contact points below or approach the office for a comprehensive job description.

The Chairman's commitment of 2+ sessions a week allows him input into the workings of the office and the PEO has discrete areas of responsibility as well as generally supporting the officers in the performance of their duties.

The Committee offers 6 weeks annual leave and the LMC office provides full secretarial and IT support.

For more information please contact:

Dr Ian Hume	Chairman	(p) 01379 642023 (h) 01379 650321
Dr Peter Harvey	Med Sec (after 19.07.04)	(h) 01263 732716 (p) 01263 714917
Mrs Susan Payne	PEO	01953 608060

referred on to AMC. The original purpose of the Special Allocation Scheme was to allow GPs to unilaterally withdraw from seeing violent patients and AMC offers significant concessions to those doctors who do not wish to get involved.

Anglia Medical Care - why not share shifts?

At the time of writing, the system is working (although the EDP has been trying to stir things up because, *shock horror*, German locum doctors were doing a couple of shifts). However the high interest shown in shifts for July needs to be maintained and one innovation suggested by AMC is for two or more GPs to share a shift (drivers will facilitate a swap during a session).

Potential shift-sharers should contact AMC in the usual way (email seems to work best) and discuss how the payments will be divided.

GPs in hospitals - It's not over till it's over

We may have lost the last battle but the war is there to be won. We refer to the lack of response from the NNUH to our proposals to overhaul the pay and conditions of GPs working hospital sessions. Don't give up - we are meeting with the acting Chief Exec and the acting HR Director - so hopefully some good news in the next flyer.

Advert. The Norfolk County Domestic Violence Homicide Review Steering Group is looking for GP input (reimbursed) - for further information contact the LMC office on 01953 608060

Locum Rates (Competition Act 1998)

To follow on from the item last month, as readers know, the BMA has been prevented from publishing its guidance since 1999 as it was deemed anti competitive. The position of smaller, more local organisations, such as locum groups and LMCs, was originally felt to be outside the scope of the Office of Fair Trading's concerns and local guidelines were permissible. The GPC has recently confirmed that this is also illegal. The actual basis for this is the determination that an LMC is considered an "Association of Undertakings" (an Undertaking is a company, partnership or individual operating as a sole trader), and any such Association which enjoys a dominant position (deemed to be greater than 40% of the market in which they operate) is prohibited from publishing rates. We believe this is still debatable - would this mean, for example, that the LMC would have to represent >40% of locums in the area? Furthermore, we speculate that it should be permissible to publish the results of a survey of local locums' rates. Perhaps the next Medical Secretary would like to take up this challenge!

We Care 2000 Appeal

Most GPs are at least vaguely aware of this high profile Norfolk charity. The office was approached by its Appeal Committee Chairman about Section D of the Carer's application form which calls for the signature of a referee, possibly a GP. We know GPs are overwhelmed by requests for signatures and the usual LMC advice is to decline. However in this instance the charity has taken the trouble to ask us first and as it is a local worthy cause may we suggest that GPs look at requests sympathetically. However it would be perfectly appropriate to charge a reasonable fee.

Fee for Disability Living Allowance

The fee for factual reports requested by the Dept for Work & Pensions to adjudicate claims for Disability Living Allowance is set to almost double following an agreement reached on 1st July between the BMA and the DWP. From 1st October 2004 it will rise from **£17 to £32** →

providing GPs meet new targets on turnaround times for completion. In addition the report is now shorter and asks for factual information rather than the functionally based questions (such as walking or ability to prepare a meal). GPs will be asked to complete the report, ideally within ten working days. However, if after twenty days from receipt of the request the GP has neither completed the report nor notified the Disability and Carers Service within the DWP of a delay, they may not be entitled to receive payment for their work but nor will they be required to complete it.

The Government's Proposal to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services

The LMC has responded to this consultation document as follows:

- ▶ This must not become yet another unwelcome additional administrative burden on GPs and their staff; Norfolk LMC believes that the onus must be on the patient and the PCT to deal with the necessary documentation
- ▶ It must be made very clear at what stage in the individual's health-seeking process their identity and residence need to be demonstrated
- ▶ GPs would welcome the issue of brief and unambiguous algorithm charts to assist their staff in dealing with overseas visitors
- ▶ As far as the imposition and collection of fees is concerned, as these patients will be seeking healthcare as a private arrangement with independent contractors, it follows that GPs should retain this independence and apply and collect fees without the involvement of the PCT or any other NHS body

Higher Professional Education for GPs in Norfolk and Suffolk

The **Higher Professional Education Scheme** has been up and running in the Eastern Deanery for over two years and the feedback from participants has been very positive. GPs (*of whatever provider status, and with no distinction between part-time and full-time*) who have completed their vocational training within the last year are eligible to join the scheme. The government has made funds available to support such doctors to be out of practice for up to 20 days in the 2 years after joining the scheme and participants also receive a small education allowance. *Please note that the scheme has been changed to allow the study time to be spread over two years rather than one.*

The next intake is in August 2004. If you will have completed your vocational training after 1/8/3 and are interested in joining the scheme or finding out more, please contact me **as soon as possible**, preferably by e-mail. **NB DON'T DELAY - You cannot join the scheme if you wait more than 1 year after finishing your VTS.**

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Erectile dysfunction and other stories

Unlike the condition itself, this topic has been quite a long-stayer in the annals of this newsletter. There is still the Catch-22 of "severe distress" with TAG reporting that whilst GPs can prescribe on the NHS for severe distress, it has to be diagnosed by a consultant - but there is still no consultant level service which results in referrals being refused. Let's hope the situation will have been resolved by the time the departing Medical Secretary is in need of it.

In addition, a practice has sent us a copy of Eli Lilly's patient leaflet "Man Matters". It states that their GP "**will be able to**" offer a private prescription. We have written to Lilly in protest.

However, a battle lost has been whether to charge for issuing the said scrip. Our advice has done a u-turn recently after GPC helpfully produced its *Focus On Private Practice* (sent to your PM and on the website). This states that GPs *may not* charge for issuing private scrips (exceptions in Schedule 5, Regulation 25).

Private Practice and GPs

Following on from the above theme, the above-mentioned guidance is in the form of a FAQ sheet on what private practice may be undertaken by GPs (see also the item on this year's Conference). The very first FAQ is intriguing as it refers to the possibility that GPs are indeed able to offer some private services, in particular minor surgery procedures not available otherwise on the NHS. This was predicted by Norfolk LMC which is why we advised PCTs to adopt exclusion lists rather than capping funding. Whilst GPs would have to set up a separate private practice and get the permission of their PCT's Director of Primary Care we see no reason why such permission should be withheld. Free-lance GPs are also freely entitled to charge any patient for any service, provided they are not acting as a locum to a named GP Provider at the time.

Sale of Goodwill - anyone understand it?

Goodwill is an asset generated by a business which is able to return "super profits" from its activity. This would happen if the fees earned by a practice substantially exceeded the cost of supplying the service - which might happen if, for example, practice partners' earnings were substantially greater than the cost of employing a salaried or locum GP to provide that service. ("Not always the case", I hear you exclaim!) Generally, the climate for that business would not be that of daily direct competition with alternative providers, but would be the result of the successful outcome of being awarded a monopoly provider status (*Goodwill* having been factored in to the contract price to enable "contestability" between potential providers), for example being commissioned by a PCT to provide enhanced services.

Because GP practices have, historically, been monopoly providers of medical services to their list of patients, practices were banned from selling the (inevitable and quite substantial) *Goodwill* to, for example, incoming partners. Even though *Goodwill* is an asset for GP partners and selling off bits would be a nice windfall, the GPC is against the whole idea for very sound reasons which it has set out in "Focus on Sale of Goodwill". If you're tempted, read this guidance first (see the website or your PM has an electronic copy).

Cash to Accruals Conversion for GSEs

Whilst we are on the theme of impenetrably incomprehensible topics, we've had further guidance on this current mini-row, which readers may have spotted in the comics. The principle is actually quite simple, Global sums were estimated from the returns from practices of income *received* in-year, but accountancy methods dictate (and should be reflected in the global sums as it is money up front) that the GSE should represent income *earned* in-year. So it follows that as, generally, prices of things are going up the Accruals Conversion Factor should be slightly positive, eg 1.05. but, in its wisdom, the government thinks has set 0.9956 although nobody knows why. The guidance note from the GPC recommends that practices should not sign off their GSE statements without the caveat that it is subject to national renegotiation. The LMC has written to all PCTs on behalf of practices but an individual letter would do no harm.

Salaried GPs - more guidance

An impressively detailed guidance note from the GPC has clarified some grey areas in relation to employing/being employed as a salaried GP. Practices should take special note of the definition of full time (37.5 hrs/week) and that it is expected that salaried GPs should have one session *per week* for protected CPD included in this (pro-rata). The note also includes a table to calculate exactly what annual and study leave a less than WTE salaried GP should expect. Again your PM has an electronic copy or visit the website.

Registration of Private GP work

A change in the procedure for registering as a private GP (which must now be with the Healthcare Commission) includes the need for NHS GPs to register as well "if they do private work at a different location from their NHS practice". If you think this may include you, the Commission may be contacted on 020 7448 9200.

The LMC Website (www.norfolkimc.org.uk)

Those guidance notes referred to in this flyer and others (Salaried GPs, Cash to Accruals, Private Practice, Sale of Goodwill and Out of Hours) are posted as usual on the website. The office is looking at how the website will be managed in the future and is hopeful that the departing Med Sec may be persuaded to continue his stirring work as Webmaster! - LMC office).

And Finally.....

This is the last joint Payne-Harvey produced newsletter and it seems fitting for me to add a final word to all our readers. One of the more gratifying elements of the job has been compiling items for this flyer every month or so because so many GPs have mentioned how much they enjoy reading it. I wanted a snappy and varied collection of topical items which I hoped would interest, inform and occasionally amuse GPs - but something which could be read in just a few minutes over coffee. All the more detailed stuff I've posted on the website, to which I refer in the Flyer from time to time. But I hope the next Medical Secretary will want to do "their own thing" and I, for one, am looking forward to what he or she comes up with!

Peter Harvey, July 2004