

NORFOLK LOCAL MEDICAL COMMITTEE

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Principal's Edition

Just Four Weeks To Go!

Lately most of the office's attention has been taken up with the New Contract. It has been in correspondence, or face to face meetings, with PCTs and practices alike. The officers wish they could have visited more practices but our resources in terms of hours available are very stretched just keeping up with developments nationally. Because things are progressing so quickly there may well have been further developments since this newsletter was prepared (4th week in Feb), but the following is an update on the important issues.

Out of Hours

All the PCTs are saying that they will take on the financial risk of the difference in the cost of the minimum specification for a safe service, and the funds which they say are actually set aside. We wrote to the Strategic Health Authority about this and it cheerfully confirmed that this was the case across the whole Region, if not the whole country and still insists that PCTs must live within their budgets. Our question as to whether the Dept of Health underestimated the true cost of an out of hours service remains unanswered.

All Norfolk PCTs are aspiring to a July start, but some with more conviction than others. GPs will probably, therefore, remain responsible for out of hours cover for at least three months after 1st April - and remember that the night visit IOS fee is abolished as this is resourced in the global sum.

Saturdays Mornings A Reminder

Irrespective of the opt-out, Saturdays will become part of Out of Hours from April 1st for both GMS and PMS practices. There will no longer be any requirement to open the surgery and conduct consultations on Saturdays. Saturdays will be just like

LOCAL ENHANCED SERVICES - SURVEY RESULT

We wrote to all practices asking for indications of support for a range of possible positions on Local Enhanced Services, particularly with respect to services which practices provide but which are not funded within the Global Sum (or MPIG). In just over a week well over three quarters of Norfolk practices have replied and we thought you might be interested in the results. Firstly a reminder of the questions we asked:

Option 1 - that the LMC should endeavour to persuade PCTs to fully commission and fund the Local Enhanced Services identified in the LMC document and support the practice if it declines to continue to provide them if this is not achieved

Option 2 - that the LMC should endeavour to secure agreement in principle with PCTs over Local Enhanced Services but we would accept "token" funding during the first year

Option 3 - The LMC should advise practices to accept that services provided historically by them, but not specifically identified as funded additionally, should remain available, but that new areas of work should be funded in future

Option 4 - non of the above and asking for suggestions

	Option 1	Option 2	Option 3
NPCT	6	6	1
SNPCT	11	11	
BPCT	6	5	
WNPCT	6	6	2
NNPCT	4	5	1
GYPCT	3	5	

Option 4 - No actual alternatives were put forward. 9 practices used Option 4 to offer comments, overwhelmingly around support for Option 2, often emphasising the need for realistic reimbursement after the first year, and a view that if this is not forthcoming they would revert to Option 1. One practice believed that LES should not take precedence over NES.

As you can see opinion was evenly divided between options 1 and 2, with very little enthusiasm for 3. The office has therefore concluded from this that Norfolk GPs will not tolerate the assumption by PCTs that all existing work will be continued and that *at least* a formal recognition of non-core services as supplementary should be incorporated into contracts. We have written accordingly to PCT Chief Executives and Primary Care Leads. See Appendix 1.

Just to remind practices that most (though not all) PCTs are not currently intending to commission phlebotomy services apart from the specific instances covered by anticoagulation and rheumatology testing, and that no PCT has yet indicated an intention to commission what we are now calling "enhanced treatment room services" such as pre-op testing, pre-specialist treatment ECGs, post-op stitch and dressings, shared-care monitoring, parenteral depot and subcutaneous treatment, catheter/ stoma and ulcer care.

Practices should not be distracted by suggestions that these services should be continued because there has been a historical funding somewhere along the line. The MPIG funding is just for Essential and Additional services. Should "enhanced treatment room services" not be mentioned in contracts, then the correct procedure would be to refer the cases requiring them to the community or secondary sectors.

Sundays. Practices may choose to open in order to provide services appropriate to out of hours or they may extend the existing cover provided by co-ops or deputising firms. The choice is theirs. PCTs are aware that "routine" Saturday surgeries are permissible but they would be subject to separate commissioning as enhanced services.

"Core" or "Normal" Hours

Some GPs remain uncertain over these terms. Core Hours are all hours which are not Out of Hours. During Core Hours the practice is responsible for the medical cover of its patients. Normal Hours are when the surgery is actually open, ie the doors open and there is someone at reception to see people or take phone calls. It does not mean that GPs need to be there during all Normal Hours, let alone undertake consultations. Neither Core nor Normal hours affect practices' responsibilities to provide Essential and Additional Services.

MPIG/Global Sum?

It would appear that all practices in Norfolk will be funded through the MPIG as to our knowledge no practice has done better with their Global Sum. We have received reports of some PCTs suggesting that practices will have to sign "Default" contracts. To quote the GPC's Guidance "Preparing for Implementation"

"If contracts cannot be agreed there will be arrangements for a default contract to take effect. Default contracts should only be used as a very last resort and it is

not anticipated that they will be used at all. If there are outstanding issues, such as final agreement over the price of a local enhanced service, or the exact level of the overall budget, it will be better to sign the standard practice contract, highlighting the areas of disagreement, so that the contract is in place by 1 April. Any areas of disagreement can be dealt with through the dispute resolution procedures that are set out in the contract guidance, in paragraphs 6.33 to 6.38 of "Delivering Investment in General Practice".

Whether a practice is funded by GS or MPIG won't affect its contractual obligations to provide (just) Essential and Additional services.

Signing the Contract

Signing the contract does not commit the practice to accepting their indicative MPIG, but the services that are to be provided should be specified, and unambiguously. Make sure that your practice understands exactly what is being expected in terms of Enhanced Services - the level of service and the methods of payment. After signing, remember to notify the PCT in writing that you wish to opt out of Out of Hours as soon as possible. The PCT will be obliged to nominate an opt-out date within 28 days of the receipt of this letter.

Lists - Closed or Full?

Conflicting advice on "full" vs "closed" lists has been doing the rounds and the following, we are assured, is accurate.

Practices retain the freedom to choose whether or not to register a patient or patients; they simply need to ensure that they give a reason and that the reason is reasonable and not discriminatory. There is actually no need to make declarations of "full lists" as such, since allocations may still take place, as now. The term "full list" is used to distinguish the situation where a practice exerts the above freedom for all patients, from the situation of a "closed list", under the new contract. When the latter occurs it is in order that the practice may shield itself from allocations. Thus the right to not register a patient, in a reasonable and non-discriminatory way, remains intact and was not negotiated away. The status quo pertains, albeit with a written note, and it matches the patients' ability to choose a practice.

Additional Services - Accreditation

Under the old Red Book many of the services were subject to Approval by incorporation into Lists, such as Child Health Surveillance, Minor Surgery and Obstetrics. These lists are being abolished and there will be an assumption made by PCTs that those practices providing Additional services will ensure the competence of those providing them.

Home Visits

The new contract is quite clear about practices' responsibilities to domiciliary visits. For the purposes of providing Essential and Additional services home visiting may be required should, in the opinion of the GP, the patient's clinical condition necessitate it. The new contract guidance does suggest that PCTs would be quite right to consider commissioning additional home visiting for other cases, perhaps to ensure visits are carried out early in the day, or to facilitate the convenience of patients. However, we are not

aware that any PCTs have plans in mind at present. Oh, and a lack of personal transport alone is not a reason to expect a visit.

Directed Enhanced Services

Quality Information Preparation: Some practices have queried their QinfP payments. Everyone agrees that even the most generous interpretation of PCTs' obligations will not match the actual expense of summarising and updating notes. The level of payment was subject to a minimum, but any more was essentially discretionary. However, the benefits of having well summarised, lean and accurate notes will contribute to the success of the QOF - from where much of the new income will derive.

Minor Surgery: Practices must be quite sure what minor surgery services are being commissioned by the PCT and should be quite clear in their new contracts. "Directed" applies to the PCTs - they have to fund a service of sorts - and not to practices who do not *have* to provide *any* Enhanced Services. Being a DES, the item of service fees generated are non-negotiable, £41.29 for an injection and £82.58 for a cutting operation. PCTs are currently considering carrying over 2/3 of historical spend on minor surgery to fund this DES. The LMC believes that this will not go very far. Practices therefore are strongly advised to be clear about what operations are commissioned, how many, and for how much. It would also be prudent to anticipate the procedure for advising patients whose minor surgical requirements are not covered by the Service, either by virtue of exclusion or exhaustion of available resources. It would be inadvisable to continue offering minor surgery if it is not clear that the appropriate IOS fee would be payable.

Flu Vaccs: The GPC has confirmed that IOS fees must be paid so long as a patient receives the immunisation regardless of the type of vaccine used. Also existing arrangements apply in terms of obtaining supplies of vaccine.

National Enhanced Services

Minor Injury: Most PCTs are having not a little trouble with this service. Being a NES, the pricing quoted in the Supporting Documentation is merely "benchmarking". Practices should not concentrate unduly on this, instead they should scrutinise what is commissioned and what is not. Is it a retainer plus a fixed fee for unlimited services? Is it a retainer plus an IOS fee up to a maximum number of cases? Or is it a retainer plus an undertaking that all cases seen and dealt with will attract an appropriate payment? Remember that practices can choose whether to accept or decline a minor injury service and if they decide upon the latter it would be well advised to have a policy for referring minor injuries - as defined in the supporting documentation - elsewhere. We have advised PCTs that it seems to make sense to encourage practices to manage minor injuries as the knock-on consequences for the A&E service may well prove costly.

Anticoagulation and Rheumatology: We anticipate all PCTs will commission these services in some form or other, but there are several levels of service. Practices should be clear which level of service is being commissioned by their PCT - and indeed whether or not they actually want to provide it in the first place.

IUDs: Those practices in receipt of this NES

should also be eligible for fitting IUDs for non-contraceptive indications, and on equivalent terms. The PCTs have suggested that each clinician who fits IUDs should do at least 10 a year, which we think is reasonable.

Quality Aspiration Points

Most practices have submitted high-ish aspirations in the region of 900 - 1000. One PCT (Edinburgh) has actually encouraged practices to aspire to 1050, which is what this LMC suggested originally; in order to maximise cash-flow. Now for the real work!!

Appraisal

The funding for appraisal for practice-based GPs is incorporated in the Global Sum. It is up to individual practices to decide whether the preparation and/or appraisal is in extra or existing time. The LMC believes that locum GPs should have Appraisals funded directly by PCTs in terms of preparatory time and undertaking appraisal.

The LMC Levy - New Arrangements

The LMC has agreed a new method of collection of the levy from April 2004. The statutory levy will, henceforward, be based on a practice's global sum or MPIG, whichever is being used, as opposed to individual principals' superannuable income. The office will be writing to all practices shortly once it has had an opportunity to discuss the practicalities with Eastern Support Services.

LMC ACCOUNTS

Last year's accounts have now been certified by the accountants. The LMC would like to take the opportunity to thank Messrs Lovewell Blake for all their help during the past year both with regard to its own internal accounting and also for advice and support with regard to the implementation of the new GMS contract. Copy attached - see Appendix 2.

HOSPITAL SICK NOTE SAGA

Further correspondence between the office and the NNUH Medical Director has confirmed that hospital clinical staff should provide Med 3s at appropriate times and for appropriate durations. The Medical Director has asked us to forward any further examples of instances when this has not happened and we are sure that GPs will oblige. Please keep sending in instances where you have had to do a Med 3 when it was perfectly possible for the hospital to do it. We need details of the department involved, when it happened and a brief description of the clinical circumstances.

We have written again to the QEH citing a specific example - but to date have not received a reply. Similarly our correspondence with the JPH dated 3rd July 2003 and 15th January 2004 has failed to elicit a response.

MIDWIFE REFERRALS

The NNUH Obstetric and Gynae Directorate has confirmed that it is perfectly happy with direct referrals of cases from community midwives irrespective of the condition which is presented. We don't know if this is an "issue" for the James Paget or the Queen Elizabeth Hospitals but we are sure that GPs in these catchment areas will

let the office know if it is.