

# NORFOLK LOCAL MEDICAL COMMITTEE

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Principals' Edition

## The Chris Town Contract

Remember the John Wayne Contract? Well, as he rode off into the sunset his ghost has come back to haunt us, embodied in the form of Mr Chris Town, Chief Executive of a PCT in Peterborough, and a key figure in the Department of Health's GP contract negotiating team. His advice to other PCT Chief Executives about the interpretation of para 2.19 (iii) in the Guidance seems to have been crucial to Norfolk PCTs' interpretation of what is Essential and what is Enhanced. His advice is completely different to the GPC's advice to date, including their recent Focus on...Enhanced Services. Mr Town has advised other PCTs that para 2.19 (iii) means that GPs are expected to carry on Essential services as whatever they were doing before under the Red Book. We think that Mr Town's copy of the Guidance must be missing the 6<sup>th</sup> line of that paragraph and he should be sent a fresh copy. It appears that it is his advice that is the principal reason that Norfolk GPs are not being commissioned to provide a Treatment Room Local Enhanced Service. What do you think about this? Why not let your PCT have your views.

## Treatment Room Enhanced Services

Strange world isn't it? Whilst our PCTs quote Mr Town, or say they are waiting for national guidance or that the 5 months they have had to think about it is not long enough, some areas of the country have introduced Treatment Room Local Enhanced Services. Step forward Doncaster PCTs - who have commissioned these at two levels, for between £6k and £9k per average practice. But the irony is that Doncaster LMC freely concedes that its specifications were actually based on Norfolk LMC's LES paper! So if Doncaster PCTs think it's perfectly straightforward, why is it so difficult in Norfolk?

## Exception Reporting - some tips

The key to an accurate disease register, prevalence and clinical data entry is appropriate use of the Exception Reporting READ codes, and a very helpful Focus On...Exception Reporting was sent to all Practice Managers on 18.03.04. Three tips:-

- "High level" exception reporting from one domain does not preclude "lower level" entries from counting if they have been done.
  - Some exclusions are in perpetuity - allergy or sensitivity to a drug - but most others have to be re-recorded every year.
  - Some lifelong recordings, such as "never smoked" have to be re-entered if the patient joins a disease register anew - eg if they go on to develop angina.
- If your practice has found some useful tips or traps please send them to the LMC and we will include them in a future flyer.

## APPENDIX D

West Norfolk GPs have been asked to sign up to an unnecessary Appendix (D) to their contracts. Following approaches from the LMC it had agreed to withdraw this and it will no longer form part of the contract documentation. In essence it was an attempt to impose "standards" on the clinical care provided in pursuit of the management of common chronic diseases. GPs are reminded of two things: 1) the new contract specifies that, under Essential services, GPs should manage chronic disease in a manner determined by them and 2) the optional Quality and Outcomes scheme is perfectly suitable for the adoption of evidence based standards. (Well, maybe not - what's the point of doing spirometry every 2 years, for example - but we think you'll get the drift).

## IOS for Flu Vaccs

In response to continuing pressure from the LMC office, supported by several practice managers, Southern Norfolk PCT sought further advice on its plans to with-hold the IOS payment unless practices used one of two specified vaccines. The PCT has now withdrawn this proviso following confirmation from the NHS Confederation, that that it "agreed with the GPC view and that the national pricing agreement on flu was clear"

## Seniority - Qualifying Service

Having changed their minds on whether any NHS service counted (as opposed to post-GMC registration as now seems to be the case), we think the recent 16-page FAQs sheet from the GPC (available on the GPC website and circulated to all Practice Managers) gave the wrong answer. It states that locum work only counted for seniority if the work was superannuated as opposed to being counted if it was performed within the NHS, which is pretty clear in section 13 of the SFE. This could mean ten or more years' seniority in the balance for some GPs. Enquiries at the GPC have resulted in the possibility that the answer is wrong and we are awaiting confirmation.

## Indemnity - Out of Hours

Apart from whether there is Life on Mars, one of the Great Unanswered Questions is whether GPs working for Anglian Medical Care (the new EAAT service which takes over out of hours in Gt Yarmouth from 1st June and the remainder of the county on 1st July) will be covered by Crown Indemnity, just like employees of other NHS Trusts. If they are we would like to think that GPs' day-time only work should be reflected by a reduction in current medical defence subscriptions. However a recent article in one of the comics seem to indicate that they may indeed be subject to increases!

## PCT Locum Payments

The new contract provides for a range of discretionary and obligatory locum payments (see sections 9 - 12 of the SFE) to be provided by PCTs under the circumstances of GPs' maternity/paternity leave, sickness leave, suspension and prolonged study leave. PCTs are obliged to consult the LMC and agree on the discretionary elements and the level of payments, but despite us reminding them, nothing has been agreed yet.

## Pre-Op Assessments

On March 12<sup>th</sup>, the LMC was shown the final draft of a NNUH proposal for GPs to do routine pre-operative assessments within 12 weeks of impending surgery, ie well after the original referral letter would have gone. As this was the first time we'd heard of it we were surprised to read "that all GPs had been consulted already during February", and that the trust was aiming to have LMC agreement "by 17<sup>th</sup> March". The consultation period expired on March 19<sup>th</sup>. We replied, in time thankfully, by welcoming the initiative, pointing out that it was "new work", noting that it would make an excellent Local Enhanced Service and observing that the funding for the service could come from the acute surgical services commissioning stream because the hospital would no longer be in need of it. We await the reply.

## ACCENTURE

Be Afraid, Be Very Afraid. If you haven't heard, you soon will. Those clever IT boffins at the Department of Health have been given £3.2 Billion (yes billion) to implement a new national IT strategy. (That would be, say, about £30 million for the Norfolk Health Economy if divvied up into proper health care and would Solve All Our Problems At A Stroke). Anyway, there's going to be a huge computer in Sheffield which will act as the server to all patient records in the East and North East of the country, local practice servers will be chucked away, there will be a Henry Ford cum Hobson's style of Choice of System, and it will link practices to hospitals and everywhere else. Accenture is the consortium which will implement this in our region - they also do the IT for the Stock Exchange and Sainsburys so that's all right then. More to follow in future editions .....

## Training Practices and the Summarisation of Patient Notes

We have been informed that the drive to increase training capacity, and funding allocated to deaneries to facilitate this, means that many deaneries are able to provide support to training practices, or those practices aspiring to become training practices. Such support can include

funding for the summarisation of records, or the transfer of summaries from paper to computer. This would have beneficial effects in the context of the New Contract. Training, or potential training, practices might consider clarifying the situation with the deanery with a view to applying for such funding where possible and appropriate.

### **Nurse Practitioner (NP) referrals**

A mini-row with the NNUH is evolving over whether NPs should be entitled to refer ill patients direct to the MAU for assessment, as would be logical. The NNUH seems to think that this will cause an increase in referral/admission rates and insists that the referral comes from a GP. (By the way, which of us think that we get a much better service from the admitting nurse on MAU than the on-call house officer?) This would be a very difficult problem for practices that are Nurse Practitioner led and with no permanent GP on the premises. Undoubtedly this policy will have to change, but it all seems so short sighted to even think it up in the first place.

### **GPs working in the NNUH**

Again some progress to report - the LMC and the local BMA office have produced a joint proposal for reforming the terms and conditions of GPs working within the NNUH. It includes suggestions to abolish the term "clinical assistant", revise the definition of "session", and suggested increases in rates commensurate with *at least* the back-fill locum costs. The NNUH seems genuinely sympathetic and has not objected to the paper yet; the trouble is, it is likely to be regarded as a "cost pressure" and PCTs looked to for funding. If nothing comes of this initiative, GPs so-involved may have to think seriously as to whether it is really worth continuing; after all, there should soon be similar opportunities for GPs with Special Interest within the primary care setting. A good example is upper GI endoscopy - we know of a GP who does an OGD session for the NNUH and one for his PCT. The jobs are identical (except the PCT also includes some admin time allowance) but the rate of pay is more than double in the PCT job.

### **Hospital Sick Notes**

At the risk of triggering the Groundhog Day syndrome, this is another item on hospital sick notes - or the lack of them. GPs have been diligently sending us examples of where the hospitals have failed to provide a Med 3 when they should have. The best example was a post-operative patient (lap chole) who, on being told to take three weeks sick leave, spotted an "ask here for a sick note before you go" sign at the nurses station at 2pm on a weekday afternoon, only to be informed that "the doctor has left the ward and you should go to your GP". The March award for the best damp squib goes to the NNUH's latest Hospital Information Booklet (viewable on-line if you can be bothered) which, on page 25, grudgingly admits that "if you are off sick for more than 7 days while under the care of a hospital doctor, you will need a sick note from that doctor". Still, that's better than nothing. Keep them coming please!

### **Whatever happened to.....Appraisals?**

For Locum GPs, that is. Not a lot it seems. Some locums are getting understandably nervous

about this as Revalidation is looming and two successful Appraisals are thought to be the key to uneventful Revalidation. The Dept of Health policy is that "no GP should be out of pocket as a consequence" and the GPC's policy is that all GPs should be appraised on equal terms. But PCT aren't exactly rushing to get on with appraising, and funding, the locums on their lists. We will pursue this. You can find all you need to know on how to go about your appraisal on <https://www.appraisals.nhs.uk/menu.html>

### **Revalidation**

The GMC has produced a very useful Fact Sheet on Revalidation. If you haven't received a copy log on to [www.gmc-uk.org](http://www.gmc-uk.org) >site map> revalidation> drop down menu >information and papers > "fact sheet"

### **Had You Ever Wondered....?**

Why most (>80%) practices across the country are better off with an MPIG than a Global Sum? Logic would suggest that it should have been 50/50 split. Well, here's the answer:-

The allocation formula, when applied to practices, did originally produce a roughly 50-50 distribution of those practices which needed the MPIG and those which did not. This distribution has been 'skewed' because monies available for the global sum funding stream were transferred into the quality funding stream. This has had the effect of reducing the total amount of money available for the global sum. GPC long argued that there was insufficient money in the global sum funding stream, leading to practices needing the MPIG in the first place. The transfer of money into the quality funding stream has exacerbated this problem. As there is less money available for the global sum, this means that practices which might have made more money than their Red Book equivalent payments (GSE) will now not do so. The major problem with the global sum is the Government's insistence that it was not prepared to put any of the new money in that particular funding stream.

### **GPs shouldn't admit patients to the NNUH - again**

Once again we have been asked to stop referring patients for acute admission to the NNUH for the usual "reasons" ..even though the increase in admission rates arises via A&E and not from GP referrals ..even though there is usually no alternative care for many of our ill patients, ..even though our professional duty and our terms of service oblige us to refer ..even though we are often just seeking a second opinion or a specialist investigation. The LMC was even asked to send GPs a letter supporting the NNUH over this - no, your post has not been delayed!

### **Every Child Matters Building a brighter future for Norfolk's children and young people**

From: The Every Child Matters Project Team

Work is underway to improve outcomes for children and young people in Norfolk by developing a multi agency, integrated service. This work is the Every Child Matters Project, which is far-reaching in its scope and being tackled in stages, over time

In simple terms, the key messages about this project are that it will:

Centre the focus of all services for children and young people on the child or young person and his/her needs, and be strongly preventive in orientation.

See children's social services, and those provided by the county council in its role as Local Education Authority, brought together under the leadership of a new Director of Children's Services

Over time, develop a fully integrated service that brings together local authority staff working in services for children and young people with their appropriate NHS colleagues

A multi-agency board has been set up to take matters forward. It is chaired by the Chief Executive of the County Council and includes three NHS representatives from each of the east, central and west Norfolk health systems.

A good deal of consultation, involvement, research and analysis is underway to develop a series of proposals for change that will be considered by the NCC Cabinet in June. They will include high level proposals for a new, integrated, multi agency model of service and any proposed high level changes in Education and Social Services to enable the integration of these services led by a new Director of Children's Services. Critically, they will also include the results of work to develop a common view about the next steps towards the development of Children's Trust(s) in Norfolk.

GPs can read more in a special edition of 'Norfolk Matters' which will be distributed widely. You can also take part in some of the workshops, etc that will be advertised and promoted.

Contact the Every Child Matters project team on 01603 228851 or email: [everychildmatterscomments@norfolk.gov.uk](mailto:everychildmatterscomments@norfolk.gov.uk)

Contact your local representative:  
Sue Gurr, West Norfolk PCT  
Shelagh Nicholls, Norwich PCT  
Amanda Cousins, Great Yarmouth PCT

### **British National Formularies**

Every GP should automatically receive the new edition of the BNF. If not practices must advise the DoH of any changes to their GP complement via [dh\\_bnf\\_amendments@talkingnumbers.com](mailto:dh_bnf_amendments@talkingnumbers.com) giving the practice name, address and a list of all GPs, highlighting any changes.

Non-principal GPs and locums receive copies if they are (NANP) members and their current address details are known. If not they must supply the DoH with their name and address. GPs who did not receive the October copy need to e-mail their details to the above address now to receive April's edition. GPs who do not receive the April edition can order one by e-mailing [dh@prolog.uk.com](mailto:dh@prolog.uk.com) or call the publication order line on 08701 555 455.

### **Attached**

We have been asked by Dr Hugh Kennedy, the outgoing Chair of the NNUH Consultant Staff Committee, to circulate the attached details of a

Masquerade Ball that is being planned for May  
and to which they are keen to invite GPs