

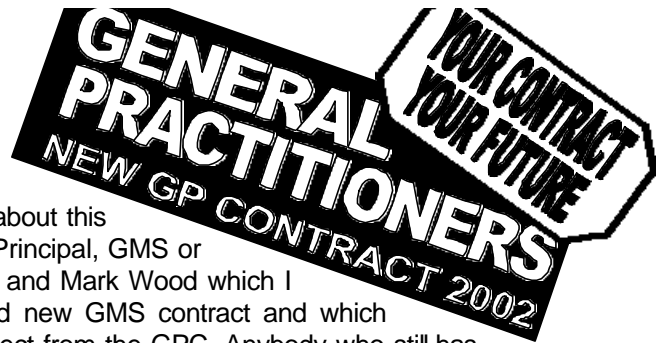
# Devon Local Medical Committees



Newsletter ~ Special Issue ~ No 21 ~ May 2002

## Chief Officer's Corner

Extraordinary meeting of Devon GPs – 17<sup>th</sup> May



By now you will all have received a letter and a flyer from me about this important event in the lives of all GPs, whether Principal, Non-Principal, GMS or PMS, full or part time. Below are articles from Charlie Daniels and Mark Wood which I believe will help you in your deliberations about the proposed new GMS contract and which should be read in context with the paper you have received direct from the GPC. Anybody who still has not a copy please see it on our website at [www.devonlmc.org](http://www.devonlmc.org) or borrow one from a local colleague! It is worth reading, perhaps several times. We have not yet all the answers to your many questions and concerns, but bring them with you to the meeting at The Langstone Cliff Hotel, Dawlish Warren and I hope that answers will be provided for you by the GPC Negotiators.

Please come, and remember that car-sharing makes sense! I hope to see every GP who is not off sick, on holiday or providing the "Saturday afternoon type out-of-hours service" at this meeting. Please remember that Practice Managers are very welcome too – they will be as vital when/if the new contract is accepted as they are now and will have an important role for the future whatever GPs decide.

### A New Era - The LMC is dead! Long live the LMC!

The LMC, in the 91st year of its reign, is once more changing as the old health authorities disappear. The strategic health authority will no longer hold our contract and by October the PCTs will take over that responsibility. We are looking at a new structure where the two old LMCs will become one as Devon LMC (sounds familiar?). The constituencies will be based on the PCT areas, however the four sub-committees will still be the workhorses and the negotiating committees will continue. We will make certain people responsible for looking at the work of the eight PCTs, making sure your interests are safeguarded.

This year is probably the most vital year for GPs since the NHS inception with the publication of the new proposed contract "Your Contract, Your Future".

It is important that we get feedback about the new contract and following the GPC presentation at Langstone Cliff Hotel, I would be grateful if you could let us know what is good or bad about it and what needs to be changed. The LMC Conference in June has set aside one day to debate it and motions have to be in by early June.

I would like to thank three stalwarts of the LMC who have taken a back seat. Phil Green, Jack Shelley and Nigel Brennan all have done a truly Queen Mum type service for the LMC over the years. None of them have fully retired so you won't be able to see them Lying-in-state in Ambassador House quite yet!

See you all on Friday 17<sup>th</sup> May at Langstone Cliff Hotel.

Dr Charlie Daniels  
(Chairman of the Shadow Devon LMC Executive)

(If you are entitled to PGEA please sign the registration form  
on arrival at the Conference)

Devon LMC News



# Commentary on the New Contract Framework

**Dr Mark Wood**

**Chair North Devon LMC & North Devon GP Forum**

The new framework contract for general practice was unveiled on Friday 19<sup>th</sup> April by the GPC Negotiating Team. The contract at first reading appears a little daunting, and it is easy to see the potential problems. It is well worth reading a few times, however, as reflection and re-reading do improve the understanding, and make the opportunities more apparent.

This is without doubt the most important document to hit general practice since 1948. If you do nothing else in this millennium, read this contract framework. Your opinion does matter. The LMC is holding an event to inform and allow feedback to the negotiators. Devon Doctors On Call will be providing a full service for all practices in Devon that are currently part of a co-op from noon on 17<sup>th</sup> May in order to release all GP Principals. The event will be held in Dawlish (as this was the only venue that could cater for the numbers at short notice). I would urge all GPs to attend. This is truly “Your Contract, Your Future”, and the LMC has gone to considerable lengths to ensure that you have every opportunity to be fully informed. Full details have been sent out to practices.

The purpose of this paper is to spell out the implications, potential benefits and pitfalls. It is not intended to give any recommendation about acceptance or rejection of the contract.

The process from this point is that a ballot of the whole of general practice nationally will take place to establish whether we agree with the principles. There will be further negotiation regarding the sums of money involved, and we will then vote again on the costed contract. It is therefore a menu without prices. The profession needs to decide whether the food looks good. Arguing about the bill may come later. There will therefore be no reference to funds in this commentary, and the assumption will be made at every point that the finance will be adequate (or even generous!).

## The Contract

The contract will be held between the PCT/PCG (known as PCOs – Primary Care Organisations) and the practice. This is a major change, as at present the contract is held by the individual GP. This will have major implications if there is a practice split. There is no mention in the contract of who would continue to hold the contract, or whether one partner being expelled from a partnership of (say) five would be entitled to his/her own contract in new premises down the road. Simon Fradd’s view is that this would need to be dealt with by the practice agreement. This would mean everyone re-writing their practice agreements (and incurring the costs involved). Personally, I do not agree with this approach, and I feel it is essential that the contract makes it explicit what the PCO should do with regard to the re-allocation of contracts in the event of a partnership split. If this were not to happen it is possible that the “ejected” partner could become unemployed.

## Patient Lists

Individual lists would cease, and the patient would simply be registered with a practice. The proposal at present is that temporary resident (TR) payments should be made on historic data. If a major change takes place (e.g. a holiday camp opens next to your practice) then adjustments will be made. This does not cover the “one-off event” (e.g. Chulmleigh (say) has few TRs, but one summer Michael Jackson does a one-off concert in a field, attracting 80,000 people), where a practice might be hit with a short but high TR load with no reward.

## Funding

Tear up all old notions from the Red Book and start again. The idea is that for our core income practices will be allocated a sum of money per patient to cover everything except premises and IT. There is no BPA, staff reimbursement, shoe leather allowance etc. just a single sum per notional patient.

- The notional patient number will be worked out on a complex formula using age, sex, deprivation, rurality etc. A list of 1,800 may therefore have a “notional size” of (say) 2,372.

There will be other monies available for providing “enhanced services” and higher quality. These sums are envisaged as being “substantial”.

## Funding Streams

**Essential Clinical Services ECS:** (Para 18): ECS will constitute the management of people who are (or believe themselves to be) ill. This is a basic stripped out service, with no chronic disease management, screening, public health etc.

**Additional Clinical Services ACS:** (Paras 19-26): These include cervical screening, contraception, vacs & imms, CHS, antenatal care, chronic disease management etc.

- ECS and ACS will be paid for out of “The Global Sum”. It is expected that most practices will provide both ECS and ACS. Each element will have a price per notional patient that the practice receives (as mentioned above).
- There is an ongoing dispute around vaccination targets. The government continues to insist on coverage and will not accept “informed dissent” (parents declining MMR for little Johnnie). This may change with negotiation. Vacs & Imms are intended to be the only ACS that will be performance monitored by targets. Targets will otherwise only apply to quality payments (see below).
- Practices can (after a defined application process) withdraw from ACS. The proportionate split between ECS and ACS has not been defined. In this event the PCO will be responsible for providing ACS.

**National Enhanced Services:** These will be nationally negotiated and costed. These might include warfarin monitoring, intermediate care etc.

**Local Enhanced Services:** To be negotiated locally with practices (with LMC backing if desired).

With regard to both types of enhanced service, the funds for this will be protected at a minimum level, and come down via the unified budget. PCOs will have the option of increasing the basic amount.

In relation to local enhanced services, there is not the automatic right for the LMC to be involved, and the contract talks of “...provision of both types of service through an open competitive process...” This could allow the PCT to play one practice off against another for the delivery of enhanced services.

## Out Of Hours

Practices will be allowed to opt out of OOH care. “In hours” has been defined as 8am to 6.30pm, Monday to Friday. The opt-out will:

- be at *practice* level. The practice will decide to opt out, leaving responsibility for their patients to the PCO.
- trigger a reduction in income, yet to be defined. This reduction will come out of the global sum (i.e. the money for ECS and ACS).

It is not clear whether GPs who are part of practices who opt out would be allowed to work for (say) a deputising service commissioned by the PCO to provide the service. It is certain that the practice could not opt out of OOH care with the NHS and then offer OOH care privately. The contract does state that remote areas may not allow GPs to opt out. The contract does not define a “remote area”, but the negotiators were very clear that this means “very remote” (e.g. the Hebrides), not simply rural

like Devon. Once a practice has opted out, the legal responsibility for OOH care rests entirely with the PCO.

## Dispensing

Very little is said about dispensing, other than it will be the subject of a full-scale national review.

## Supply Management

The contract talks of *considering* the option for PCOs or practices to commission home visiting services. There is no specific detail around this, but presumably this would be another “opt-out” arrangement that would come at a price (from the global sum). Some of the medical press have hailed this as “the end of the family doctor”. The reality is that any practice could currently employ a locum to do home visits if it so wished. The new contract simply places a higher degree of formality around such arrangements, and may transfer the legal responsibility to the PCO.

## Paragraph 38

This is the part of law that dictates what GPs can and cannot provide privately for their patients. This is under review.

## Quality

Outside of the global sum (ECS and ACS) and enhanced services (paid out of the unified budget), there is the new concept of quality payments. These will come from an entirely separate and **unlimited** source. If every practice in the country achieved quality level 5, everyone would receive the top payment. In effect, the NHS would pay more to GPs for a better quality service. The negotiators believe that the quality payments will be large, and in answer to a direct question they stated that they envisaged the new contract rewarding very high (level 4) quality for a reduced list more than low quality for a large list. Therefore, quality payments will be large enough to offset losses from the global sum by having small list sizes.

It has been agreed that quality parameters will be based on evidence. They will also exist under three headings: clinical, organisational and patient experience.

There are 5 levels (although level 5 is extraordinary, and most practices will be operating between levels 1 and 4). Level 1 is a basic standard, and practices will receive a small payment each year for achieving it. Levels 2 and 3 have a number of increments and are seen as steps on a journey to achieving level 4. Once a practice moves into level 2 it is assumed that it is aiming at level 4. Within levels 2 and 3 practices must show continuous improvement to receive the payment. If they show regression for 2 years then the payment is lost and they revert to level 1. Practices achieving level 4 may remain in “steady state” and receive the funds. The payments become progressively bigger as level 4 is reached.

Each practice negotiates with its PCO regarding its aspiration for the coming year. If this is deemed realistic the practice receives an “aspiration” payment to help resource the service. This is then monitored, and the achievement payment made if the aspiration is matched or exceeded.

## 48-Hour Access

There is no specific mention of this in the contract. There is the possibility that it would constitute a quality indicator. However as the principle has been agreed that such indicators should be evidence based this may create much debate, as such access parameters have no evidence base as yet.

## Pensions

Although the contract framework talks of all NHS pay being pensionable (para 85), the negotiators have made it clear that the government has not agreed to this. At present 11% of GP earnings are not pensionable. No other workers within the NHS have any of their pay placed outside the pension system. The government has no moral case for its refusal to include all earnings. Indeed it has reneged on a previous undertaking to make locum earnings pensionable. This is a serious conflict.

## Non-Global Sum Payments

The global sum will cover all practice costs other than premises and IM&T.

- Innovative ways of financing premises development are suggested.
- IM&T costs are to be reimbursed fully via the Guaranteed Fund.

## Child Care

PCO will have to provide or commission crèche facilities for all GPs and their staff.

## Staff

There will be no separate staff reimbursement. Staff costs will be paid for out of the global sum (which will take current staff reimbursement into account). Practices may approach PCOs to take over or assist in practice management, including staff supply. This will clearly be at a cost.

## GP Career Structure

The contract does talk of different methods of career advancement. What this will mean in reality is a little uncertain.

This commentary is by no means an exhaustive treatise on the contract framework. It is intended to highlight some of the more major issues that may flow from the contract and to stimulate debate.

***Read and re-read the contract and its various explanations and above all, come to the meeting on the 17<sup>th</sup> May.***

***Your future is at stake as never before.***



**Drs John Chisholm, Simon Fradd and Hamish Meldrum  
presenting the New Contract in London**

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For further information please contact either Mr C Poole, Bond Pearce,  
Darwin House, Southernhay, Exeter EX1 1LA. Tel: 01392 211185 or  
Course Organiser: Dr Adrian Rogers. Tel: 01392 258562

## VACANCIES IN DEVON

<p><b>Grosvenor Road Surgery</b> 17 Grosvenor Road, Paignton Devon TQ4 5AZ Telephone: ....01803 559308 Fax:.....01803 526702 Email: <a href="mailto:Grosvenor.road@GPL83122.nhs.uk">Grosvenor.road@GPL83122.nhs.uk</a> <a href="http://www.grosvenor-road-surgery.co.uk">www.grosvenor-road-surgery.co.uk</a> Closing Date: ASAP</p>	<p style="text-align: center;"><b>RETAINER – Paignton</b></p> <p>Required from June 2002 for 3 to 4 sessions per week. Vacancy arises as our present retainer is leaving the area.</p> <p>We are a warm friendly progressive 4 partner training practice in the heart of the “English Riviera”.</p> <p>All enquiries to – Andy Cory, Practice Manager</p>
<p><b>Chatto Road Surgery</b> 104 Chatto Road Torquay Devon TQ1 4H Tel: 01803 314277</p> <p style="text-align: center;">Closing Date: 30 May 2002</p>	<p style="text-align: center;"><b>FULL-TIME PARTNER REQUIRED</b></p> <p>In the heart of Sunny Torbay! Full-time replacement partner to join our friendly team. Partner emigrating. Seaside town with moors nearby – 3rd Wave PMS, 2 full-time, one part-time partner, 4,500 patients – young list with 16% over 65. Good skills mix with a nurse practitioner who sees most ‘same day’ appointments, a practice nurse and health care assistant. Almost paperless - EMIS. Good premises – substantially converted on cost-rent scheme. Good OOH coop. Enhanced ‘golden hello’ of £10,000 on joining. Please send CV together with a covering letter to Dr Peter Moore.</p>
<p><b>Imperial Surgery</b> 49 Imperial Road Exmouth EX8 1DQ Tel: 01395 224555</p> <p style="text-align: center;">Closing Date: 22 May 2002</p>	<p style="text-align: center;"><b>PRACTICE NURSE</b></p> <p>Needed to assist in providing excellent primary care to our patients. 18hrs/week over 3 days and overtime to cover for colleague when on leave. Pay according to experience, + NHS pension. Range of treatment skills including diabetic care desirable but training offered where necessary.</p> <p style="text-align: center;">Apply with CV to the Practice Manager.</p>
<p><b>Topsham Surgery</b> Holman Way Topsham Exeter EX3 0EN Tel: 01392 874646</p> <p style="text-align: center;">Closing Date 31 May 2002</p>	<p style="text-align: center;"><b>HALF-TIME SALARIED PARTNER</b></p> <p>Topsham Surgery has a vacancy for a half-time Partner in a 5-Partner (3.25), 3<sup>rd</sup> Wave PMS+ Practice. We are a semi-rural Training Practice operating from both modern converted premises in the picturesque town of Topsham and from a large branch surgery in Countess Wear caring for 6,100 patients across the area. We are forward thinking, fully computerised (Exeter system), paperless and have GP links. Out-of-hours is provided by the local co-operative.</p> <p>We are looking for a GP to become fully involved in the Practice and take forward our development plan. We have an excellent Practice team to provide support!</p> <p style="text-align: center;">For further details please contact Linda Taylor, Practice Manager.</p>

Teignmouth Medical Practice  
2 Den Crescent  
Teignmouth  
TQ14 8BG  
Tel: 01626 777616

Closing date 14 May 2002

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The event is open to anyone so long as there is a doctor (even if retired) or medical student on board. The entry fee remains at £5 per person to include lunch.

Profits to RNLI

Saturday 15th June, 2002, Royal Dart Yacht Club, Kingswear

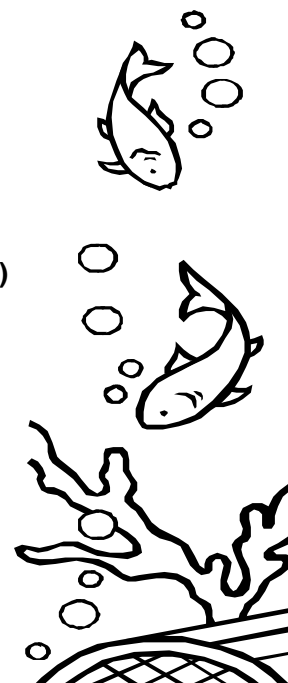
Full details and entry forms available from:

Norman Doidge, (Devon Medical Sailing Rally),

Albany Surgery, Albany Street, Newton Abbot, Devon, TQ12 6BU

Tel 01626 364333 (Home), 01626 334411 (Surgery)

e-mail [norman@ndoidge.freemove.co.uk](mailto:norman@ndoidge.freemove.co.uk)



## IMPORTANT NOTICE



### CLOSURE OF SECRETARIAT OFFICE

Please note that the Secretariat Office will be closed on the following dates:

Friday 17 May from 12:00 noon (GP Contract Framework Conference, Dawlish)

Tuesday 18 June from 12.00 noon until Friday 20 June 08:30 hours (main LMC Conference - London)

If your problem is **urgent and important** please leave a message on John Dean's mobile (07831 430324) or Peter Jolliffe's mobile (0796 8484116) and they will get back to you as soon as possible.