Devon Local Medical Committee

Newsletter Issue No 40 March 2004

Devon LMC News

Chief Officer's Corner

Caveats and the New GMS Contract

The final 235 page Standard General Medical Services Contract (available via **www.devonlmc.org**) has arrived and is now (or should be) the subject of discussion between PCTs and GMS practices. Issues have been raised both nationally and locally about how ready either party are going to be to sign up to all 618 paragraphs plus seven schedules. DH (one can't say DoH now as the Department fear people might liken it to Homer Simpson) guidance via NatPact is that they do not wish to see "the issue of caveats" in the actual contract so I responded via email to this on 5th March as below:

"Isn't the issue really that the delay in getting proper accurate information out to PCTs and then to practices has been so protracted that it is impossible for PCTs and practices to fully determine appropriate decisions with regards to much of the detail to be signed up to in the some 235 pages finalised earlier this week? Going over to the default contract will inevitably disadvantage practices and I don't see how that is a good idea for very many reasons. Therefore, it is likely that Devon LMC advice is going to be to sign the contract but agree with the PCT, if necessary in a second agreement, that the contract detail is as good as can be determined in the ludicrously short term available, and that the PCT, the practice and the LMC concerned will work together over the next 3 to 6 months to reach mutually acceptable variances to what has been signed. We should all remember the spirit of the contract and make strenuous efforts to come up to the level of partnership required to make this work for all concerned. We should start talking and acting as though this is a high trust matter and demonstrate some true trust in each other. We should remember that stress and its effects on practices have never been higher than it is now. This contract has the potential to be the maker or the breaker of NHS delivered primary care. I don't want to see repeats of Scarborough in my profession where the arrival of a new NHS GP in a town brings a queue of 2000+ people in the streets to register."

This struck a chord with many of the PCT managers who have the responsibility to implement the contract and the idea of a "second agreement" will be discussed at the nGMS SHA level meeting on Tuesday 16th March. This should be relatively simple and protect practices and PCTs from trying to take decisions that affect the future to somebody else's timescales. We will get further information to you all on this matter in time to sign the needed paperwork.

Enhanced Services

As with the rest of the contract it seems to be all in a rush! Nevertheless, PCTs are now finalising what they know they wish to commission as a positive act but do not know exactly what they would be best to commission to prevent a withdrawal of services to patients. That is, there is no true clarity as to what services GP practices have absorbed to cover the absence of provision from secondary care over the years whether that be by dint of omission or deliberate dumping into primary care. These are the sort of services that could be commissioned as Local Enhanced Services and correlate to the sort of tasks that were defined as "non-core" in the old Core/non-core debate.

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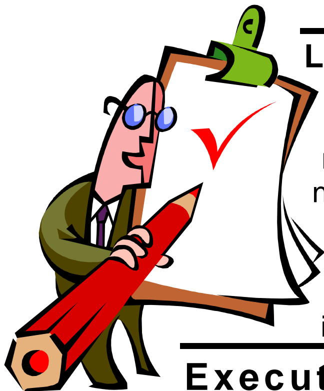
Email: admin@devonlmc.org Web: www.devonlmc.org Tel: 01392 834020 Fax: 01392 833339 Production: Lynn Stubbings Editor: Dr Peter Jolliffe

LMCs around the country have a list of some 35 or so such potential LES but locally we are directly aware of less than that! We are also aware that funding to meet the "Enhanced Services Floor" is not limitless and few PCTs currently believe that they will be able to invest much more than the floor. Thus we have a potential problem in that practices are now providing services to patients that are valued by them and in some cases may even be helpful to their health care! Some, but not all, will be evidence based. Some may well be best provided through General Practice. Some, particularly in the old South & West Devon area may even be being fully or part funded. Funding DES, NES and evident LES schemes may leave little to enable realistic funding of the "basket" of remaining services of the type I am discussing. The "hard line" response to the absence of a properly funded commissioned service is to give notice of withdrawal of the service. This could be potentially harmful to all involved as the service may well be one that could be best provided through General Practice. For this reason the LMC has raised the concept of PCTs commissioning an ill defined basket of LESs from practices with the understanding that individual practices will only be delivering some of the services and the recognition that the allocated funding is merely a contribution towards the cost of what the practice does provide. The PCT, the LMC and the practice would agree to a programme of work aimed at determining which services should be provided at all and where there is no evidence of benefit these should be withdrawn. Where there is good evidence a specification should be agreed and the proper funding identified to both provide the service and give a profit to the practice before removing the service from the basket. With time the basket would shrink with regard to what it contains although the funding attributed to it should remain the same until it is determined that nothing remains within it that should be commissioned or provided. This process should take no more than three years.

THIS IS NOT YET AGREED WITH PCTs!



LMC Survey

Response to our survey has been good in the old North & East with 55% of practices returning it already. In South & West we have so far had about 30% respond. Early examination demonstrates support for the LMC to be the main negotiator for practices but I would prefer a fuller return before making that assumption. The deadline for this was always acknowledged to be too short (hence the grovelling apology in the last issue! *Ed.*) So I am pleased with the numbers so far. Please keep them coming! This is an important source of information for us in very many ways.

Executive Officer – Debbie Galbraith- Various Updates

Housing Letters

North Devon District Council have just been sent a second very stern letter insisting that they stop sending requests for housing application support letters. If you continue to receive such unnecessary requests, I would be very happy for you to forward them to me to deal with. Mid Devon, however, are being very co-operative and are desperately trying to change their systems. If you have received a form from them asking you to help them assess a new format then please can you fill it in so they can set up the new system which I have been discussing with them? If you have difficulty with this please forward the request to me. Exeter Council, after a telephone discussion, have yet to "get back to me" with a date for me to meet with them. Some of the other Councils have again failed to reply!!!

If any GPs feel they have received unnecessary requests please forward them to me to deal with.
I hope we will finally stop this ludicrous waste of your time and resources!

DWP370(N) GPFR Form

I have been in correspondence with Richards Griffiths from the BMA in person, by phone and by email with regards to DWP forms. The current UNAGREED rate for this work is £17.00 and there is no compulsion upon you to do this work, let alone for this paltry fee!

The actual response is that the GPC advise that factual reports are not prescribed certificates within the meaning of paragraph 37 and schedule 9 of the terms of service (and the new regulations) so there is no obligation at all to fill in these forms..

Where no agreement applies (as here) and a report is requested without examination and takes 20 minutes the fee of £53.50 applies under Schedule 11 of the BMA Fees Schedule. IF you wish to do the work, I advise you to have written agreement as to the level of your fee and that it will be paid before undertaking the work.

Any queries? Please let me know at Debbie@devonlmc.org

Executive Officer - Nicola Heywood

nGMS Workshops & Ongoing Training Needs

Impossible Management Tasks No 1001: Put together a set of definitive workshops on the many aspects concerning practice managers about the new contract in the time available between the availability of the final contract guidance/documentation and the signing date deadline of 31 March 04 (in order to remain an NHS provider if GMS).

Situation normal for most practice managers – invent/interpret it as you go and fly by seat of pants seems to be the order of the day as ever! With this in mind we would recommend you follow the LMC guidance and have an undertaking in place alongside the contract documentation that recognises it needs to be finalised over the next 3 – 6 months along with any enhanced service contracts not in place for 1.4.04 and itemising areas not yet agreed eg the contract document itself.

I suspect the contract will continue to generate questions and training needs for many years….just like the Red Book did! Surprise, surprise! With this in mind we are continuing with our plan to put an evolving programme of workshops together as quickly as we can, although we have had to face the fact that they will not be in time for the signing deadline due to other commitments and stretched resources! We will work with as many practice manager groups, PCTs and other bodies (eg NATPACT) as we can and will strive with your help (and sharing of ideas) through the workshops and other training sessions to get a Devon wide consensus on interpretation and application to protect your interests and those of your patients!

Watch your email and our website for further details (due imminently) and please continue to respond as quickly as you have been doing. Many thanks.

Launch of the Exeter and East Devon
Interagency Self-Harm Forum
Thursday 29 April 2004
Postgraduate Medical Centre, RD& E Hospital, Exeter

Come and be a part of this new initiative aimed at improving co-ordination of services and communication between professionals involved in the care of patients who self-harm.

Speakers include - Dr. Peter Aitken, Mr. Derek McCullough WAST, Mr Adrian Harris, Consultant A&E, Dr. Peter Aitken, Dr. Janet Ward, GP, Anna Baker (Audit co-ordinator) & Laurence Mynors-Wallis, Consultant Psychiatrist

Further details of programme and application form can be found on the LMC website: www.devonlmc.org or contact Nicola Webber, Secretary to PRIMARY CARE AUDIT GROUP, Dean Clarke House, Southernhay East, Exeter EX1 1PQ.
Telephone: (01392) 207486/207532 Fax: (01392) 207442
Email: nicola.webber@eastdevon-pct.nhs.uk

Places limited - **Closing date for registration: 1st April 2004**

Devon Area Child Protection Committee

Domestic Violence and Adult Protection Portfolio Representative - Dr Jane Richards

The important overlap between Domestic Violence and Child Protection is being emphasised and clarified and the role and practice of the police in DV incidents has come under increased scrutiny. When police have attended a DV incident a **FORM 61,** with details of those concerned and the nature of the event is completed, and sent to Social Services; this is presently under review. It includes information on any children in the household and it is the responsibility of Social Services under Section 47 of the Children Act to follow them up. The nature of the follow-up will depend upon the level of risk to the children, whether present during the incident or not and whether harmed in any way as a consequence of it.

The police also have responsibilities under the Children Act especially where there are repeated episodes of DV in one household and joint visits by police and Social Services are then recommended. At present health services are not party to the distribution of Form 61 and consideration is being given to obtaining the consent of those involved to information sharing with other agencies, such as health, which need to know and could assist in prevention by provision of services. All agencies and professionals have a duty in law to protect children and promote their welfare.

Dr Hazel Curtis is now Designated Doctor for Child Protection for North & East Devon and also the Lead for Sexual Abuse for the whole of Devon. She is setting up a Child Sexual Abuse Assessment Service for the county and considering staffing, photo documentation and colposcopy, and locations for the assessment to take place.

On the former, the recommendation is that all examinations should be by 2 experienced doctors, ie 2 paediatricians or a paediatrician and a forensic medical examiner.

Equipment requires secure data storage and the funding needs urgent resolution by the police and STA. Proposals for assessment locations include a central Devon Assessment Centre or 3 assessment centres based in police suites in Plymouth, Torbay and Exeter or assessments on Acute Trust premises.

Dr Curtis is holding a Study Day on the subject in May 2004 and information will be available shortly.

Out-of-Hours (OOH) Service - A Paediatric Perspective

Background

Paediatricians working in the acute Trusts in Devon have always welcomed the high standard of referrals from GPs. When the new Out-of-Hours (OOH) arrangements come into force later in 2004, we are anxious that this high quality service should continue.

We are aware of the policy initiatives and drivers for the new OOH service and we recognise the requirement to triage OOH calls.

We understand that the OOH teams will consist of GPs, Nurses (from various backgrounds), Paramedics and Emergency Practitioners, often based at minor injury units (MIUs).

Under the new GP Contract, it seems that children and families will have access to their own primary care team for, at the most, 52½ hours of the week. Children may fall ill and rapidly deteriorate at any hour; paediatric medical and social emergencies are highly likely to occur in the remaining 115.5 hours of the week. It is notable that “children and families” account for 42% of the OOH activity of the emergency Social Services Team.

Sick Children

Paediatricians would request that urgent steps are taken to identify competencies in the recognition of sick children and that these competencies are "tried and tested" in frontline OOH workers of whatever discipline. Competencies in the recognition of significant symptoms and signs of illness in children must be included in the job and person specifications of all staff performing triage.

Even when symptoms and signs are recognised and acted on appropriately, deterioration may occur very rapidly. Ideally, this deterioration should be anticipated and certainly it must be identified. Examples include the infant with diarrhoea and vomiting who develops a rapid pulse, the infant with bronchiolitis who is unable to feed, the seemingly well infant with apnoeic attacks, the asthmatic child who cannot talk, or the diabetic child with a raised blood sugar who vomits or starts over-breathing. If signs of deterioration occur when the child/young person is seen in an MIU, it is vital that a call should be made for a paramedic and/or an emergency practitioner. We would not consider it necessary for MIU doctors and nurses to have an immediate care qualification such as Paediatric Life Support but such skills should be held by paramedics and emergency practitioners.

There have always been variations in referral practices between primary care teams. The new OOH service will enable outcomes after triage to be audited across PCTs. If they are not admitted to hospital, consideration should be given as to how sick children are monitored after triage.

Child Protection

Child protection issues often arise outside of normal working hours. In whatever level of service within the NHS a child/young person is seen, it is vital that awareness of child protection should permeate practice. ***All staff employed by PCTs and NHS Direct working OOH should comply with the Devon, Plymouth and Torbay child protection procedures, their own PCT child protection procedures and, importantly, with the latest Department of Health guidance: "What to do if you're worried a child is being abused".*** Child protection is not just about recognising significant bruises and fractures, (the presentation may be one of an acutely ill child), it is the ability to think about the care of the child in that family setting at that time. Consider what one would do about a child whose main carer is treated for a psychotic illness, or when domestic violence is an issue or when the mother's boyfriend who is a Schedule 1 offender arrives unexpectedly.

If GPs have child protection concerns about a particular family, say on a Friday afternoon, we suggest "posting" a message on the DevonDoc IT system, in the same way as you would for a patient who needs particular care, eg palliative care for advanced cancer. It would be good practice to copy this message to the Health Visitor.

Paediatricians suggest that all staff who have contact with children should attend a half-day/1-day course to raise child protection awareness and that team leaders should attend an Area Child Protection Committee or Health-run 2-day child protection foundation course. GPs, paramedics and emergency practitioners should have attended a 1-day "medical assessment" child protection course. These courses are being run increasingly often throughout Devon; for details contact the Named Nurse or Named Doctor for child protection in your own PCT.

A Final Note

Paediatricians are keen to support the OOH teams and are happy to be called for advice on paediatric emergencies and on training.
With best wishes

Dr Charles Holme, Consultant Community Paediatrician RD & E Healthcare NHS Trust
Designated Doctor Child Protection, Torbay, Plymouth and Devon Health Community

Community Pharmacists Advice to Care Homes Scheme in South & West Devon

Community Pharmacists have been contracted to provide General Pharmaceutical Advice to Care Homes locally for a number of years. This contract has been reviewed by South Hams & West Devon PCT, Torbay PCT, Teignbridge PCT and Plymouth PCT together with the South and West Devon Local Pharmaceutical Committee and The National Care Standards Commission (NCSC). A new scheme called the "Advice to Care Homes Scheme" has been developed and will run from **1st April 2004 to 31st March 2005 in South & West Devon**. This is an excellent opportunity to start utilising the skills of community pharmacists in improving the care of this vulnerable group of patients.

The new scheme will have three parts, and **Part 3** of the scheme is a simple medication review for each resident of a care home who is taking any medication. This optional **Patient Medication Review** will involve a minor degree of participation from GPs. This small amount of participation will benefit the practice in terms of the nGMS Contract. The Organisational Aspiration contains two important elements that this level of participation contributes towards:

- records & information
- medicines management

The service to be offered is a simple level 1, medication review on Form ACH5. Similar Prescription Reviews Schemes are already successfully running in South Hams and Torbay. Pharmacists will ensure that consent has been obtained by a representative of the Care Home, which will permit a Medication Administration Record Chart based patient medication review. The Form ACH5 is quadruplicate; the original will be left with the home to forward to the patient's GP. There is also one copy each for the Pharmacist, Care Home and an anonymous copy for the PCT.

The GP will be asked to action any appropriate changes, and return the original to the Pharmacist for feedback. This closes the audit loop for the Pharmacist, the Care Home and the PCT as suggested by the Counter Fraud Team. We hope that you will welcome this initiative. If you have any queries or would like further information about this scheme, please do not hesitate to contact either:

Joanna Haynes, Primary Care Contracting
joanna.haynes@shandwd-pct.nhs.uk
Tel: 01803 866665.
Fax: 01803 867679

Sue Taylor, Devon LPC
lpcdevon@cix.co.uk
Tel: 01392 834020. Fax: 01392 833339

Some Questions & Answers from the Accountants Seminar held on 3 February 2004

Luke Bennett, Winter Rule, Chartered Accountants, Truro, Cornwall

Global Sum Allocation Factor

Question

Will practices be given enough information to enable them to check their global sum allocation formula or will they have to rely on the calculations performed by the PCT? As a minimum I would have thought practices will need to know each of the indexes that have been applied to get from their raw population to the normalised weighted population (as illustrated in Table I of Annex B of Delivering Investment in General Practice).

Answer

PCTs have been advised to give as much information as possible to practices to enable them to sensibly review their allocation factor. This should include each of the indices used and also the maximum and minimum indices for all practices within the PCT.

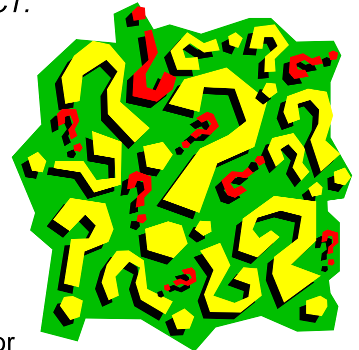
Rurality Index

Question

Under the Red Book the Rural Practice Payments Scheme defined distance on the basis of the normal route, and then made allowances for walking and blocked routes. Table H of Annex B of the new contract guidance only refers to distance. Is this now calculated on an “as the crow flies” basis? Is any allowance made for walking or blocked routes?

Answer

No allowance is made for walking and blocked routes. The view of the GPC is that as the rurality index is measured against an average across all practices, this should not create any significant inequalities.
If there are any practices with unusual circumstances they should raise this with their PCT.



Achievement Payments

Question

Paragraph 5.36 of the SFE states:

“On the basis of that return, *but subject to any revision of the Achievement Points total that the PCT may reasonably see fit to make* –

(a) to correct the accuracy of any points total; or
(b) having regard to any guidance issued by the Department of Health,

the PCT is to calculate the contractor’s Achievement Payment as follows.”

This paragraph seems to give a worrying amount of discretion to the PCT to challenge or delay Achievement Payments – particularly relevant if PCTs have their own financial difficulties. Is there any reassurance that can be given on this point?

Answer

This paragraph should only be applied in the exceptional circumstances envisaged in paragraph 3.68 of “Delivering Investment in General Practice” and only with the involvement of the local LMC.

Seniority Payments

Question

Paragraph 13.21 (d) obliges practices to pay over seniority payments in full to partners within one month of receipt, which raises the following questions:

1) Many practices take into account seniority payments in arriving at an overall monthly drawings figure. Does this paragraph now oblige practices to pay seniority as an identifiable separate drawing?
2) Some practices pool seniority between the partners in the general profit sharing ratio. Will this no longer be permitted?
3) What was the rationale behind introducing this paragraph which effectively dictates to practices an element of their drawings policy where before they had discretion?

Answer

The rationale behind the seniority payments is to improve the retention rate for doctors who might otherwise retire. They recognise that this clause does remove some flexibility that practices previously had, but they wanted to ensure the seniority money reaches the partner for whom it is aimed.

Temporary Residents’ Adjustment

Question

The temporary residents’ adjustment in 2004/05 to be added to the initial global sum is, in normal circumstances, to be based on the average claims of the five years to 2002/03. How will the adjustment be calculated in future years, as there will be no claims made under the new contract on which an average can be based?

Answer

The temporary residents’ adjustment will continue to be based on a five year rolling average. The data for future years will be based on the clinical records submitted by the practice to the PCT for onward transmission to the temporary residents’ own doctors.
Practices would be well advised to keep their own record of temporary residents seen so that they can check the annual adjustment.

Definition of NHS Superannuable Profits

Question

I appreciate that the working party is still to issue definitive guidance on this subject, but I would like to ensure that the following issues are addressed:

1) The apportionment of income between NHS and other sources should in most cases be straightforward, but how are expenses to be apportioned? Will it be pro rata to income or on some other basis?
2) Will the guidance cope with loan interest which may either be a practice loan and included in the accounts or a personal loan and claimed on the partner's tax return? In principle one would expect that the superannuable profit should be the same regardless of the loan structure.
3) How will the guidance cope with practices that do not have accounting periods ended 31 March? It would create unacceptable peaks and troughs of workload for practice accountants if all practices had to move to a March year end. Such a change could also accelerate tax liabilities for many practices.
4) When the balancing payment (or refund) is determined, will tax relief be granted in the year of payment or in the tax year to which it relates?
5) Paragraph 22.10 states that the partners provide the annual statement to the PCT. Is it correct to assume that there is not going to be a requirement for the practice accountant to "certify the accuracy" of the statement, as this would have professional indemnity ramifications.

Answer

Further guidance will be issued in due course, but these concerns are noted by the pension working group.

Specifically the guidance will cope with the issue of loan interest, and the expectation is that the certificate can be produced based on the accounting year which needs not be 31 March. The certificate will be produced by the practice accountants, but signed by the GP.

Comings & Goings March 2004

Welcome to:

- Dr Amelia Tong, Knowle House Surgery, Plymouth
- Dr Claire Woodward, Dean Cross Surgery, Plymouth
- Dr Nicola Whittaker, Waterside Practice, Ilfracombe

Goodbye to:

- Dr Stephen Browne, Southernhay House Surgery, Exeter

VACANCIES	
Bramblehaies Surgery College Road Cullompton Devon EX15 1TZ Tel: 01884 33536 Closing Date: 31 March 2004	**Flexible Careers Scheme Doctor or Retainer Required** To join our team from mid-May 2004 for 4 sessions a week. We are a friendly 4 partner (3.5 WTE) PMS practice in the heart of Devon, with high standards of care, a supportive partnership and an excellent primary health care team. We are looking for an enthusiastic and committed individual to join the team where humour, mutual support and balance are valued, and assist us in delivering a patient-focused service from excellent purpose built premises with a team of attached staff based at the local health centre. Please send handwritten letter and CV to Miss Tracey Pratt, Practice Manager. For an informal chat or visit please telephone the practice.
Torrington Health Centre New Road Torrington EX38 8EL Tel: 01805 622247	**Flexible Careers Scheme or Retainer** Required for 3 or 4 sessions per week at this friendly, mainly rural practice of 5,200 patients. Purpose built health centre and fully computerised (EMIS). For further information Tel: 01805 622247 or if you would like to make an informal visit, please contact Brian Butland, Practice Manager.
Southernhay House Surgery 30 Barnfield Road Exeter EX1 1RX Tel: 01392 211266/01392 425126	**GP Retainer** Required for 2 sessions a week to be negotiated. Both of these vacancies are available from March 2004. We are a small friendly PMS, 3-partner practice (list size approx 6,000) located in Exeter City Centre. For further information, or if you would like to come and have a look around please contact Sue Montford, Practice Manager.

Practice	Vacancy
Corner Place Surgery **46A Dartmouth Road** **Paignton** **TQ4 5AH** **Tel: 01803 557458** **Closing Date: 31 March 2004**	**Salaried GP – 5 Sessions** We are an 8-partner PMS practice with 11,600 patients in the centre of the seaside town of Paignton in Torbay. With our emphasis on patient care through excellent teamwork, we aim to achieve maximum quality points. We are paperless and use the Microtest system. If you would like to combine your commitment to quality and innovative practice with the lifestyle Torbay can offer, please contact Dr Manny Austin for further information or send your CV to the practice.
Rolle Medical Partnership **Exmouth Health Centre** **Claremont Grove** **Exmouth** **Devon** **EX8 2JF** **Closing Date: 31 March 2004**	**Nurse Practitioner/Practice Nurse** Hours negotiable up to 37.5 (could be 2 P/T Posts) Nurse Practitioner degree and Practice Nurse experience desirable. Work will include Minor Illness Clinics, Chronic Disease Management and some administrative duties. Leadership skills would be an advantage. The position(s) will involve working within an Integrated Nursing Team. We are a PMS Plus, 8-Doctor Practice with a large friendly staff team, situated in a Devon coastal town. The Practice is forward thinking, innovative and committed to high standards. For further information, job description and application pack, please contact: Karen Marriott, Office Manager. Telephone enquiries welcome Tel (01395) 273001 ext 220
Delph House Surgery **8 Pinhoe Road** **Exeter** **EX4 7HL** **Tel: 01392 272304**	**(1) Retained Doctor** We are a small, friendly surgery looking for a Retainer 4 sessions/week **(2) Practice Nurse** We are looking for a part-time Practice Nurse to work in a small, friendly practice. Approximately 11 hours per week plus holiday and sick cover. Some experience an advantage. For further details of both posts please contact Sue Power, Practice Manager.
The Westbank Practice **The Surgery** **Church Street** **Starcross** **Exeter EX6 8PZ** **Tel: 01626 890368** **Closing date: 15 March 2004**	**A Golden Opportunity To Become a Practice Nurse** The Westbank Practice (Starcross and Exminster Surgeries) is a successful and expanding PMS Practice that is now looking for a part-time nurse to join this friendly team. The ideal candidate will be an ambitious qualified nurse with good communication and interpersonal skills who is seeking the opportunity to train as a Practice Nurse. The hours will be 12 per week rising to 20 hours to cover sick absence between mid-April and August. Initially the contract will be on a temporary basis with the potential to move into permanent employment for the right candidate. Salary to be negotiated depending on previous experience. For further information please contact: Jan Thomson on 01392 833230. Please send CV with covering letter to: Peter Sanderson, Practice Manager, at the surgery.

Exciting New GP Vacancies – 2 Part-time GPs
(6 sessions each per week)

Your opportunity to join a committed, hard working, GP team, who enjoy a good work-life balance!

We are a friendly, quality PMS+, GP training and dispensing practice with integrated community healthcare team and growing list - currently 8,400 patients. Operating from two South Devon villages we have one Health Centre, built in 1997, and another due for completion in 2005 following a £1.5m investment. EMIS records system. Successful applicants will be performance and people focused team players prepared to fully participate in developing and managing patient treatment and care processes. A generous employment package includes:

- Salary based on £6,000 per annum per session – six core sessions for each post but further locum work will be available
- Golden hello/loyalty payment £12,000 (subject to qualifying)
- Bonus scheme based on team PMS Quality and Outcomes Framework achievement (second year onwards)
- Six weeks holiday, one week study leave, other statutory leave provisions
- Inclusion in a Medical Protection Society group insurance policy
- Sick pay scheme and NHS pension

Informal enquires to robert.hooper@nhs.net or telephone 01803 873551. Letters of application with full CV, quoting 2 referees, to Mr R A Hooper, Primary Care Manager.

The Health Centre, School Road, Kingskerswell, Newton Abbot, Devon TQ12 5DJ

Closing date: 1April 2004

Axminster Medical Practice
St Thomas Court
Church Street
Axminster
EX13 5AG

GP seeking Locum for Sabbatical Leave – July 2004

I am trying to take sabbatical leave in July this year. I am looking for a suitable locum to look after my patients and work with my partners for 4 ½ days a week in a full and varied General Practice with a Cottage Hospital in Axminster. EMIS computer system. Fully modernised Surgery in the centre of Axminster with excellent ancillary staff. Please contact Dr James Vann – Tel: 01297 32126.

POSITIONS WANTED

Dr Shakeen Akhtar
Tel: 07767 350849

I will be looking for locum work in Plymouth/Devon/Cornwall area whilst seeking a full-time/three-quarter position in the area from June 2004. I will consider work before then if there is anything suitable. Registered on South & West Peninsula Health Authority Non-Principal list but currently doing locum work in Yorkshire.

New Contract Documents & the Web Site…

Part of the problem with the new contract has been due to the sheer volume of the various guidance, reports, documents and general paperwork that has been produced. I have tried where possible to post copies of all this documentation on our web site **www.devonlmc.org**

Rather than send you copies of everything, we have tried to be fairly selective in what we have produced and sent out to you. The latest document which will be of particular interest is the ***GPC Guidance – Focus on Standard & Default Contracts*** – we have reproduced one copy per practice and enclosed it with this newsletter. This focus on guidance is only one of twenty similar documents (***at the time of going to press Ed.***) which have been produced. The full set of focus on guidance is available on the above site or via the BMA Site **www.bma.org.uk** – the following is a list of the Focus on Guidance released over the last month.

GPC
General Practitioners Committee

- GPC Guidance - Focus on the Financial Monitoring of Enhanced Services
- GPC Guidance - Focus on The Role of LMCs (Updated)
- GPC Guidance - Focus on Practice Staff Under The New Contract
- GPC Guidance - Focus on how to Access Information - PDF
- GPC Guidance - Focus on GMS Indicative Contractor Budgets
- GPC Guidance - Focus on Choice of Nationally Accredited Systems