

Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE JUNE 2008 Edition

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Well done all for your superb response to the Support Your Surgery campaign. Naturally we hope that this will persuade the government to be more open to negotiation and less willing to make impositions in future.

The next phase of our work will be to persuade and help the PCT introduce a pattern of Darzi Centre that will suit the needs of this county and will not destabilise existing GP practices. For the longer term we must continue to promote general practice to as many as possible. The LMC publicity group have come with the following 5 Positive Points about General Practice which we feel should be at the forefront of any positive message:

- Personalised care.
- Continuity of care.
- Quality of care.
- Value for Money.
- Service for all.

(and we need to ensure that all our practices do indeed live up to these standards.)

LMC CONFERENCE

Highlight of the month was the London Conference of LMCs. This year's conference was even more robust than usual. You will have seen extracts in the national papers. Our LMC perspective is at Annex A. You really ought to listen to highlights from Dr Laurence Buckman's rousing keynote speech to Conference (which got 3 standing ovations) on



persuade and help the PCT introduce a pattern of Darzi Centre that will suit the needs of this county and will not destabilise existing GP

<http://uk.youtube.com/watch?v=oqYVVNHT7x8>

'GP URGENT' CALLS FOR AN AMBULANCE

'GP Urgent' calls in Gloucestershire are now routed with the same priority as '999' calls (target is to answer within 5 seconds) but with one critical difference – the operator is alerted to the fact that it is a medical professional at the other end. You will therefore be spared the irritating questions reserved for members of the public who dial 999.

Please use the special phone number:

0845 120 6342

for 'GP Urgent' calls for ambulance support, particularly when in the surgery environment. The operator will understand why the receptionist is calling rather than the GP (who is busy saving the patient's life!) but it would help if you have the answers to the questions they will ask. A guide to these is at Annex B, which you might like to hang where it can be got at in a hurry. Another number will shortly be issued for calls of a more administrative nature from practices to the Ambulance Trust, so as to keep non-urgent conversations off what is now an emergency-only line.

GMC CONSULTATION – NOTIFIABLE EVENTS

You have until 18 Jul 08 to provide a response to the suggested additional events that must be notified to the GMC as they may affect your continuing registration as a doctor. The existing events are:

- Accepting a police caution.
- Being charged with a criminal offence.
- Being convicted of a criminal offence (not including minor driving offences which you accept a fixed fine penalty).
- Having had your registration restricted, or being found guilty of an offence by another professional regulatory body.

The proposed additional events are:

- Receiving a Penalty Notice for Disorder.
- Receiving a warning for the possession of cannabis.
- Being given an Anti-Social Behaviour Order whether as the result of civil or criminal proceedings.

To have your say go to:

https://gmc.e-consultation.net/reportingconvictions/index_https.asp

ACCREDITATION

An article by Dr Christine Haseler

Clinical Lead Care Services Directorate

The Care Services directorate is the provider arm of Gloucestershire PCT. Most doctors previously employed by 'the PCT' are now employed by Care Services. This includes clinical assistants, hospital practitioners, clinical medical officers, senior clinical medical officers, some consultants, doctors working in minor injury units or community hospitals (whatever the contract) and out of hours doctors. GPwSI and secondary to primary care are still contracted by the PCT although this may change. Gloucestershire PCT commissions services both from individual GPs and Care Services.

The governance structure of the NHS is laid out in Standards for Better Health, (Department of Health, 2006 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665).

There is specific guidance about work devolved to GPwSI in implementing care closer to home (April 2007 <http://www.dh.gov.uk/en/Publicationsand>

[statistics/Publications/PublicationsPolicyAndGuidance/DH_074430](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074430))

Care Services wishes to ensure that all doctors contracted to provide services are quality assured. The process that has been endorsed by Gloucestershire PCT is based on Implementing Care Closer to Home and resulted in the accreditation application forms and competency frameworks. The PCT is happy to accept any other accreditation system if it provides the same quality assurance.

The application form for accreditation is generic, for all contracted posts. Care Services is aware of the difficulties of this form and will be reviewing the form and updating it before the next round of accreditation in 2009 – 2010. Accreditation is initially for 12 months and for 3 years thereafter.

For employed doctors the elements that need to be completed in the accreditation form are the front page with personal details, the work plan of GP work and employed work, reflection on infection control in sections B15 and B16 and details of continual professional development in section G. Section J (resuscitation) and Section K (immunisation) also need to be completed. If appropriate the Clinical Support document needs to be completed, for those working with a consultant.

Contracted doctors may need to supply additional information, especially where the service is provided in non-PCT premises.

This is a basic set of governance information for quality assurance. Feedback is very welcome and Barbara Workman and Frances Beavis (on global address list) are happy to help complete forms where there are questions.

GMC GUIDANCE – CHARGING PATIENTS

The basic rule remains that you cannot charge your own patients for non-NHS work. They need to go to another practice or be treated by you at no cost to the patient. What is not allowed is for you to have a mutually beneficial bilateral agreement with another practice whereby you each send such cases to each other. That is restricting patients' choice. N.B. This a change to the previous guidance concerning reciprocal

arrangements. A useful guidance document is at Annex C.

GMC GUIDANCE – CONSENT

You should now destroy the GMC guidance '*Seeking patients' consent: the ethical considerations (1998)*', which has been replaced with effect from 2 Jun 08 by the A5 sized booklet '*Consent: patients and doctors making decisions together*', which reinforces and expands *Good Medical Practice (2006)*. The key precept is that healthcare decisions must be made in partnership with the patient on the basis of shared information and discussion. The patients' informed decisions must be respected.

NATIONAL DIABETES AUDIT

The Gloucestershire PCCAG used to carry out an electronic diabetes audit survey, but their work programme has now changed. The PCT would very much like to sign up to the national diabetes audit, which has been going on for 5 years now. But to do so without the support of their GP practices would achieve little. The LMC's main concerns were patient confidentiality, practice workload and what the practice would gain from any involvement.

We have been assured that the patient identifiable details collected for the audit are limited to:

NHS number: used to link patient data from multiple sources (primary care, specialist secondary care, specialist paediatric care, HES and PEDW) and then destroyed.

Year of birth, for analysis of age bands within the NDA toolkit.

Postcode: converted into deprivation quintiles based on super output area and then destroyed.

In essence there are absolutely no patient identifiable data used in running the analysis queries or available in the analysis at all. The NDA has PIAG approval under Section 60 of the Health and Social Care Act to collect patient identifiable data without explicit consent. However, the NDA recommend the use of posters and leaflets to inform people with diabetes about the audit. GMC guidance covers this eventuality and advises that there is a secure basis in law for disclosing information that has been approved by PIAG.

Data collection would be electronic and automatic, involving no activity from the practice at all.

There is the chance to compare oneself with others and glean tips on best practice.

KINGS FUND REPORT ON POLYCLINICS

You can download a copy of this report from:

http://www.kingsfund.org.uk/publications/kings_fund_publications/index.html

It reckons that the move to a polyclinic should only be taken if the gains in quality of care, access and cost benefits justify it. It quotes interesting statistics which you might like to think about. 'Taking the proposals in Healthcare for London (NHS London 2007b) as an example, the suggested population served by a polyclinic is 50,000. In some cases two might be located together on the same hospital site, implying populations of 100,000. Currently, the largest GP practice list in London is 27,000 patients (NPCRDC 2007). The average practice list size for London is 5,300 and, for England as a whole, 6,400 (NPCRDC 2007).' (In Gloucestershire the sizes of practice vary from 1,760 to 18,700, with an average of 7,200.) 'Across England, and particularly in London, most GPs are based in practices with between one and five GPs. This indicates that the introduction of polyclinics on the proposed model would entail a major centralisation of GP services, and therefore a significant increase in the distance that people have to travel to access these services. There is some evidence to suggest that the negative relationship between practice size and travelling times may also extend to other components of access. In two patient surveys, scores for access – based on location, opening hours, waiting times, availability of doctors and reception staff by telephone and same-day urgent availability – were higher for smaller practices (JL Campbell et al 2001; SM Campbell et al 2001).'

OCCUPATIONAL HEALTH

You have all been circulated to ask whether you wish to go on an LMC list of those able and willing to provide Occupational Health advice and treatment. The draft list is at Annex D.

You have until end Jul to request to be put on the final version, to be issued in Aug.

UK RESIDENCE



Patients sometimes ask for letters from their doctor to confirm that they are registered at the surgery in order to provide evidence that they are resident in UK to the Home Office. GPs are not contractually obliged to provide reports that do not come under Schedule 4 of NHS (General Medical Services) Regulations 2004), therefore GPs are entitled to charge the patient a fee for providing this information.

OVER 65s GMC REGISTRATION FEE

At present, when a doctor reaches the age of 65 he/she can apply to the GMC for exemption from paying their Annual Registration Fee, but still remain registered and therefore able to practice. However, this has been contested under the Employment Equality (Age) Regulations 2006 and the GMC had been advised that this exemption is unlawful. As the GMC has to comply with the law, the exemption is to be withdrawn with effect from 30th June 2008.

This change will have an effect on doctors who have the 'exemption' and will have to pay their registration fee by 31st October 2008 in order to remain on the GMC/GP Register - if they don't pay their name will be taken off the register and they will be unable to work.

The GMC has contacted all doctors likely to be affected by this change.

TREATMENT OF OVERSEAS VISITORS

The situation is complex, and we have discovered that the guidance issued by us in Sep 07 needed amendment to reflect that. The revised version is at Annex E; please destroy/delete previous versions.

MAX'S MUSINGS

My uncle was in the Forces. They had an annual budget in cash terms and faced the annual threat that if they did not use it they would lose it. (Hmph! That is exactly what the GPC is saying about GP practices - but I digress.) The net result

was that the civil servants in the Ministry of Defence would hold back a significant quantity of their budget against the unexpected until it was too late to order the long-lead items needed for really important projects. But the money still had to be spent before the end of March, my uncle says, so desk officers would lash out many thousands of pounds on equipment without spares support, or equipment that was not even needed, just to balance the books. It was usually too late even to order small arms ammunition. It is small wonder that the Services are now flush with computers. Dreadful waste! And I see that the same holds good for the National Health Service. I am just glad that the Foundation Trusts are very sensibly allowed to carry over any surplus into the new financial year. The same should apply to PCTs and indeed every other business involved in health. Meanwhile, can anyone suggest some good 'urgent buys' for next year in time to give industry the warning that we will definitely need them even though we can't let the contract at the moment?

I wore my green 'Support NHS General Practice' sticker for 3 weeks on my trilby. I feel it made people look up to me. Even more than normal. Or were they looking up at me. Mind you, I doubt that a Darzi Centre will be imposed on our rural area, so it won't cause my practice much grief, but I am very willing to show any amount of solidarity with those who may be financially harmed by it. I hope they will then return the favour by supporting us when we come to defend ourselves against the recent, particularly poisonous, Pharmaceutical White Paper's proposal that a GP practice lying within a mile of a pharmacy should be stopped from dispensing altogether. Besides being rampant protectionism for our colleagues in the pharmaceutical business, what is the logical basis for this surreptitious, hamstringing attack? It would be better to give the patient/public/customer a real market choice and say he can get his prescription dispensed anywhere. This government is fond of competition: well let them now introduce some!

Further 'news' from the frontiers of science is that we are all getting older and will probably suffer not only from the general memory loss and dithering I

see so much of in the surgery, but possibly from full-blown Alzheimer's. But I saw on the same date in my son's 'Independent' that 'People who eat a Mediterranean diet are less likely to be obese, have a lower risk of breast and bowel cancer and half the rate of lung disease. Tests also showed that it reduced the risk of Alzheimer's by 40 per cent.' "Hooray!" I thought, "The antidote!" Unfortunately the article



waxed lyrical about glutinous



olive oil, repulsive pulses and 'bonne à tout faire' basketfuls of vegetables. But it said nothing whatever about red wine, which as far as my experience goes is the principal constituent of the true Mediterranean diet. I await next week's thrilling instalment with a dry mouth and an eager, not to say racing, heart.

This Newsletter was prepared by Mike Forster, LMC Lay Secretary & the LMC Office



SERVICES AVAILABLE TO ASSIST GPs WITH HEALTH & OTHER PROBLEMS

Nationally available services:

Irwin Mitchell (Solicitors)

(Contact Paul Bourne IRO Project Manager) Tel: 0114 2721705

(Solicitors dealing with allegations of unlawful
discrimination & other complex law cases)

National Counselling Service for Sick Doctors 1 Park Square, London NW1 4LJ
Tel: 0870 241 05351

Doctors Support Network Tel: 07071 223 372

Doctors for Doctors Tel: 08459 200 169

Doctors' SupportLine Tel: 0870 765 0001

The BMA Counselling Service
24-hour support. Tel: 08459 200 169

BMJ Careers Chronic Illness Matching Scheme www.bma.org.uk/public/chill.nsf
opportunity for doctors who have a chronic
illness or disability to receive informal careers
advice from another doctor.

Sick Doctors Trust Tel: 0870 444 5163
Website: www.sick-doctors-trust.co.uk

The British Doctors & Dentists Group Tel: 01252 316976 or 020 7487 4445
Doctors recovering from chemical dependency
Monthly group meetings.

Financial help:
BMA Charities Tel: 020 7387 4499 incl. Cameron Fund

Royal Medical Benevolent Fund Tel: 020 8450 9194

Royal Medical Foundation Tel: 01372 821011
www.epsomcollege.org.uk/rmf

National clinical assessment authority (investigates performance of doctors)
Telephone: 0870 267 0850
www.ncaa.nhs.uk

One to One (counselling service for training grade doctors in the South West Deanery)
Telephone: 0845 130 5354

Gloucestershire LMC

NOTES FROM THE LMC CONFERENCE 2008

Despite the continuing governmental aggression towards GPs, the uncertainty of what will happen to the MPIG etc and the imminent imposition of Darzi Centres across the country, the Conference was surprisingly upbeat. Gloucestershire LMC was represented by Drs Alvis, Bayley and Yerburgh, with Dr Fellows attending as the GPC representative for Avon and Gloucestershire. The Secretary was an observer.

The Chairman of the GPC, Dr Laurence Buckman, gave a rousing opening speech, receiving 3 standing ovations. His theme was that GPs should be allowed to get on with healing the sick for an apolitical NHS. Patients' health needs should not be subverted by political wants; policy changes should be evidence-based. Patients should be treated as patients, not as customers. Continuity of care mattered to many. He predicted that if Darzi Centres failed it would be private firms, not the Government, that would take the blame. Better premises were the key to better services. He praised practice accreditation as a proof of the quality of care that GPs provided. He also called for better use of PBC, and for a proper career progression for the next generation of GPs as partners or permanent staff rather than as locums. He promised that in the coming year the GPC would continue to do its utmost to promote general practice. The Support Your Surgery campaign was the start, not the finish.

There had been 1,236,085 signatures on the Support Your Surgery petition, which was a resounding success, and the petition was handed in to No 10 on the first day of the Conference. It was unfortunate that the delivery coincided with other news items which took precedence on the front pages of the newspapers.

Discussion on agenda motions was rarely contentious, voting was usually heavily in favour of the motions put (sometimes unanimously). One area that was hotly debated was whether GPs should be allowed to charge their own patients for work not done under the NHS. While this was narrowly passed, a subsidiary motion calling on the GPC to negotiate this with the government to achieve this was narrowly defeated. Make of that what you will.

The 2 motions proposed by Gloucestershire LMC that were specifically discussed were in the 'tilting at windmills' category:

- Dr Bayley, despite her personal reservations on the motion, put a strong case that the European Working Time Directive should apply to all GPs. This was voted down, largely on the basis that GPs can decide for themselves what hours to work, and should retain that freedom.
- Dr Yerburgh urged that GPs should have the right to take industrial action, and this course should be seriously contemplated, and that GPs should be balloted to see whether they would be willing to resign from NHS general practice. All parts of the motion were voted down, and the last point was ignored altogether by moving to the next business.

Otherwise, particular points of interest were:

- There was an overwhelming vote that the conference had no confidence in Lord Darzi as a Health Minister, or in his review of general practice, or his ability to be free of political control or a predetermined outcome. There was no evidence that his proposed Centres would improve patient care or provide good value for money. Indeed, they would not only risk destabilising general practices but might well be intended to do so.

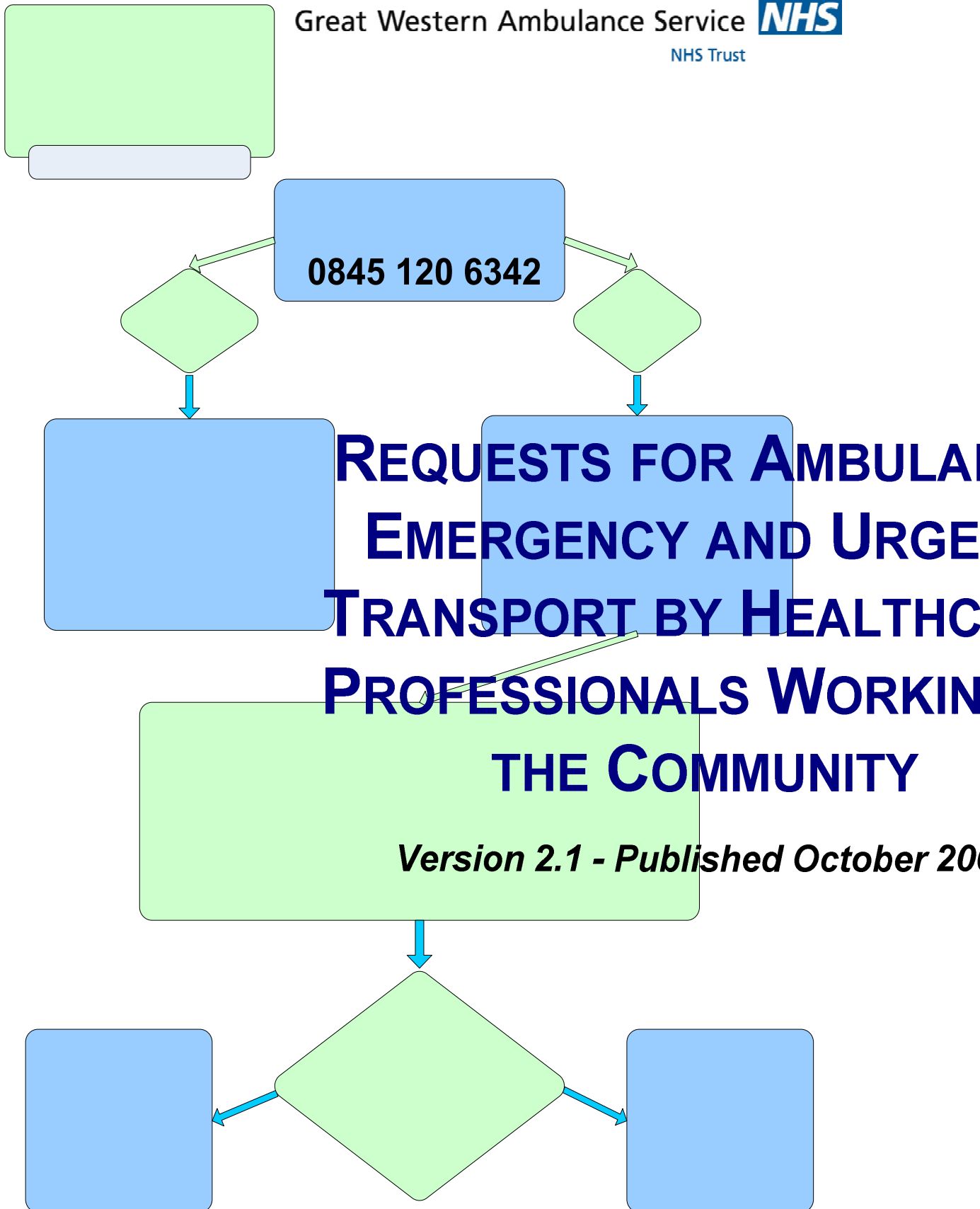
- Criticism that Martini style healthcare ('Any Time, Any Place, Anywhere') was not good for patients. There was strong support for small practices.
- Choose and Book was supported in principle, but until it was fit for purpose should not be mandatory.
- The conference voted down a motion of no-confidence in the GPC.
- In order for the GP Defence Fund to let LMCs know what their Voluntary Levy would need to be in any given year the LMCs would need to let the GPDF know their projected populations by the end of Aug in the preceding year.
- In Islington, the PCT intended to view the contracts of salaried GPs to ensure that they meet the minimum terms set by the Government, and if they did not then they would issue remedial notices. (Are we in this county confident that our contracts are fair and in place?)
- Following the court ruling that pension capping was unlawful the financial implications were being worked out. Interest would be payable on late pension payments.
- The Conference recognised that the government of a sovereign state could alter laws at will, so it would be futile to ask the government to agree not to make unilateral changes to the nGMS contract.
- There was a degree of scepticism about the National Care Record ('the Spine') and Conference reaffirmed that patient data should only go on the Spine on an opt-in basis.

A few humorous notes were struck:

- One distinctly fat GP assured the conference members that obesity was a glandular problem. He mentioned several glands that might be the trouble, but admitted that in his case it was the salivary glands.
- In the same vein, a new disease currently called 'Alzheimer's bulimia' was defined. The symptoms are eating like a pig and then forgetting you have done so.
- Cambridge (who had last year produced a motion likening Choose and Book to the Loch Ness Monster) this year spoke entirely in Polish with a running translation into English. It was done amusingly, but their serious point was the need for nationally agreed standards of translation services, and that PCTs have a duty to make medical services available to all patients.

In summary, the Conference showed a high degree of solidarity in the profession on most subjects, and a determination to support the GPC in their work in the coming year to protect the profession.

Great Western Ambulance Service **NHS**
NHS Trust



(If you have a defibrillator then instead of being on an 8-minute response you will be on a 19-minute response tasking – but it will still be a Category A tasking.)

**DELAY
IN ANSWERING
CALL**

BMA WEBSITE – FREQUENTLY ASKED QUESTIONS – CHARGING PATIENTS

<http://www.bma.org.uk/ap.nsf/Content/faqschargingpatients0409?OpenDocument&Highlight=2,CHARGING,PATIENTS>

April 2008

(Reprinted for ease of reference)

May GPs charge their own patients?

The GMS contract prevents contractors from charging their patients for most services. There are however instances where charges may be made. Schedule 5 of the National Health Service (General Medical Services Contracts) Regulations 2004 lists the strictly limited circumstances in which GPs may charge fees for providing treatment to their NHS patients. Similar arrangements apply to the other contractual options.

May GPs charge for non-essential services?

Practices that opt out of the provision of additional, enhanced or out-of-hours services, may not charge any of their registered patients for supplying a similar service privately. To this end, under their NHS contract, GPs may not charge a patient in their practice for seeing them out-of-hours even though the patient may have requested it and may be happy to pay for it. If the patient is a registered patient they may not be charged.

May GPs work for or hold shares in an organisation which charges their practice patients for treatment?

It may be possible for GPs to work for such an organisation, or hold shares in such an organisation, but this would need to be completely separate from the existing practice the GP works in or the contract held. Any GP working for such an organisation must make it clear to a patient that they have a financial interest in the company providing the service.

Can a GP set up a separate company to charge their registered patients?

It should be made very clear that only under very specific circumstances could charges to patients potentially be made. Please be aware that this is a very new area of enterprise and has not yet been tested, so we can only give very general advice and our interpretation of regulations.

In terms of setting up private companies to charge patients for services, the GPC guidance 'Charges to NHS patients' makes it clear that our legal advice sees the prohibition of charging patients as lying with the 'contractor'. This means that if a partnership holds a GMS contract and wishes to be involved in setting up a company to provide non-NHS medical services to patients registered with their practice, were that company to be made up solely of those members of the practice who are currently the partners in the contract, it may be difficult to show that the organisations are different and that it is not the contractor who is charging. Therefore it may be advisable/necessary to ensure that the company includes non-contractor members. Additionally any money the private company makes must be kept quite separate from practice accounts – i.e. money cannot be redirected back into the existing GMS practice, however the Directors of the company, share holders etc. can receive payments from the company.

However again it is important to realise that none of this has been tested in law to date as it is an area of new and private enterprise. As such, the BMA cannot give advice on whether proposed business models set up for this purpose are acceptable, nor accept any liability for such companies being set up.

Practices that choose to do this should also be aware of the potential ethical and professional issues with having a company offering private services so close at hand to its NHS patients. It would be essential for the practice to be absolutely transparent about

what it was doing its own financial interest. The practice/GP in question would need to ensure that any patient who chose to use the private services was aware they are equally entitled to an NHS referral where the service is provided on the NHS. The patient should be aware there are other choices as well as the private service offered. We would also suggest that the PCT is made aware of what is happening for the sake of transparency.

May GPs charge non-registered patients privately?

GPs are permitted to charge patients not registered with them for services they otherwise provide as NHS or non-NHS services. Practices may advise patients if they are aware of other local practices willing to provide such services to non registered patients.

However, practices should be aware that the making of a reciprocal arrangement is a restrictive practice. To set up such an arrangement could be deemed price fixing and hence fall foul of competition law. A patient wishing to purchase a private service is free to use any practice and not be tied to any advice from their registered practice. This should be made clear if the practice is not providing the service itself.

May GPs charge for Hepatitis B vaccinations in connection with travel?

Immunisation against infectious Hepatitis (Hepatitis A) is available free of charge on the NHS in connection with travel abroad for patients travelling outside "Northern Europe". However Hepatitis B is not routinely available free of charge and therefore GPs may charge patients for this vaccination when requested in connection with travel abroad. If a patient needs a Hepatitis Vaccine for treatment of a condition, e.g. post human bite, no fee may be charged.

May GPs charge for Hepatitis B vaccinations on the grounds of occupational health reasons?

GPs increasingly face patients requesting Hepatitis B for occupational reasons because they are dental nurses or about to enter medical school. In order to determine the need for, and advise patients about the risk, some knowledge of occupational health is required. GPs may not, under Schedule 5, charge a patient for Hepatitis B in these circumstances, but a fee may be chargeable to a third party. However, a GP need not provide Hepatitis B immunisation for occupational reasons under essential or additional services. Such patients may either seek vaccination privately (e.g. through an independent travel clinic) or, as would be most suitable for those about to embark on training/work within the NHS, through an occupational health service including an Hepatitis B Local Enhanced Service where this can be negotiated with the PCT.

May GPs charge for issuing a private prescription?

GPs may write private prescriptions for patients which they may wish to do particularly in relation to drugs not available through the Drug Tariff. However GPs may not normally charge for providing such a prescription, but a dispensing doctor may charge for dispensing the prescription. The only occasion when a doctor may charge for a private prescription is in relation to travel overseas.

May GPs charge for dispensing a private prescription for 'black/grey listed' drugs?

Prescribing doctors may not charge. Dispensing doctors can supply 'black/grey' listed drugs and make a charge for the supply of the drug as set out in schedule 5, section 24.

May GPs sell OTC drugs such as aspirin?

No. GPs are under obligation to provide NHS patients any drugs or appliances needed for their treatment without charge.

DRAFT LIST OF
SOURCES OF OCCUPATIONAL HEALTH ADVICE AND TREATMENT

Both employers and employees may at times need occupational health advice and treatment. Such medicine falls outside the GP's NHS contract, so the GP is not allowed to charge the practice's registered patients for such work, even if that GP were qualified and knowledgeable.

The following practices/performers have special occupational training or experience and are willing to be approached by individuals, whether employers or employees, who are not registered with them under the NHS. The doctors would be able to give advice on occupational health matters. They will be able to give advice on vaccinations. They can also carry out the vaccinations and monitoring of the results, should that be necessary. The cost of this service would fall on the employer, or the person consulting the doctor, since this work is not covered by the NHS. You should agree the fees and who will be paying them beforehand.

Doctor	Organization/Practice	Address	Contacts
Hutchison*	Jesmond House Surgery	Tewkesbury	01684 292813
Hollands	Underwood Surgery	Cheltenham	01242 580644
Williams	11 Royal Crescent Surgery	Cheltenham	01242 580248
Baddeley *	The Beacon Medical Practice	Painswick	01452 814050
Steinhardt & Maxted	Hucclecote Surgery	Gloucester	01452 617295/6
Gwynn	The Avenue Surgery	Cirencester	01285 653122
Fellows	Severbank Surgery	Lydney	0844 477 8645
Weiss	Mitcheldean Surgery	Mitcheldean	01594 542270
Champion	Cheltenham Road Surgery	Gloucester	01452 522575
Occupational Health Dept	Gloucester Royal Hospital	Great Western Road, Gloucester	08454 225 564 Judith.Evans@glos.nhs.uk
Occupational Health Dept	Cheltenham General Hospital	2 College Lawn, Cheltenham, GL53 7AN	08454 224 084

The GPs with an asterisk by their name are prepared to undertake Occupational Health work but not immunisations.

OVERSEAS PATIENTS AND ASYLUM SEEKERS

Although a root and branch review is still expected in this area, we have redrafted last year's guidance to make it clearer.

The basic rule is that, regardless of residential status or nationality, GPs should give 'emergency or immediately necessary treatment' free of charge. This is treatment which cannot be reasonably delayed until the patient returns home (and does not normally include pre-existing conditions or illnesses). It is for the GP to decide whether the case falls into this category.

As regards other treatment, the DH lays down 4 categories:

- Asylum seekers (closely defined legally as those with an 'outstanding application for refuge in the UK' – so not illegal immigrants) are entitled to the same services as any person ordinarily resident in the UK. They need to prove their status as asylum seekers.
- EEA visitors (i.e. European Union countries plus Iceland, Liechtenstein, Norway and Switzerland) are entitled under the NHS to free treatment for chronic conditions, including routine monitoring. The following types of healthcare services can be obtained by such eligible overseas visitors: blood tests, blood pressure checks, routine maternity care, cholesterol checks, insulin, oxygen, renal dialysis, warfarin tests. These visitors need only produce a European Health Insurance Card, or if that has been lost a Provisional Replacement Certificate, or (until the EHIC becomes universally available) a passport, identity or residence card. Exceptionally, visitors from Ireland need only provide a passport.
- Visitors from countries with which UK has a bilateral agreement are entitled to NHS hospital treatment in England that is needed promptly for a condition that arose after their arrival in the UK. At primary care level it depends on whether they have registered with you: if they have done so they rank as any normal patient; if not they can only receive emergency and immediately necessary treatment. Such people include:
 - o The nationals of almost all of the former states of the USSR and New Zealand. Such nationals need to provide a passport only.
 - o The residents of the following countries: Anguilla, Australia, Barbados, Bosnia-Herzegovina, British Virgin Islands, Channel Islands, Croatia, Falkland Islands, Gibraltar, Isle of Man, Macedonia, Montenegro, Montserrat, Serbia, St Helena and the Turks & Caicos Islands. Such residents can provide as proof a passport or proof of residence (e.g. an identity or residence card).
- All other visitors (including Americans, Canadians and Japanese, for instance) have no right to free primary care under the NHS except for emergencies and immediately necessary treatment. Of course if they later become ordinarily resident in UK then, whatever their nationality, they come under the normal NHS arrangements.

The above does not cover situations where people come to the UK without an explicit referral in order to access treatment. These people fall outside the NHS. Where there is no entitlement to treatment under the NHS it is still open to practices to charge a fee for their services.

There is no further documentary requirement under the Dept of Health guidance. The PCT confirms that there is no need to collect proof of country of birth or of when the prospective patient arrived in UK.

For those who prefer to learn pictorially a logical flow chart is attached.

