LMC NEWS

Cornwall & Isles of Scilly Local Medical Committee

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Happy New Year

Its quite difficult to be perky and optimistic at times, Today on my way into the LMC office I heard about a report saying its a critical year for the NHS and its delivery of services and budgets, and the press has been full about how much GPs earn and what little they do for it.
However let's remember that general practice vaccinated thousands of Cornish residents with flu jabs, despite supply problems, quietly and efficiently over the past few weeks, without any committees, practices just got on with the job and did magnificently. Every day patients receive good quality care from caring individuals.
So lets start telling our patients what we do for them, and our staff, how much we appreciate them.

LOCAL MEDICAL COMMITTEE ELECTIONS 2007

This is on the front page because it really is important that members consider the election coming up and who is willing to stand for the LMC.
Local Medical Committees have quite a history, they predate the NHS as they were started in 1911 in the National Insurance Act of 1911 and the establishment of doctors panels. In 1948 they were recognised as the voice of General Practitioners.
We all know getting decisions amongst partners can be difficult, and amongst 300 plus GPs would seem like herding cats, but that is what the LMC tries to do.
It represents the interests of general practice in discussions on enhanced services, QOF, practice disputes it can help with, act as a conciliator, a GP friend when some of the stresses get too much for GPs or they need somebody outside the practice to discuss things with, push the PCT for improvements in premises, discuss the movement of services from an acute setting into the community, send representatives to the national annual conference from which national policy is agreed and the GPC then acts on it for you.
We also try to add value by having a newsletter,a relaunched website, next month a conference (see next page) at an amazing price. If you are interested, now may the time to put your name forward.

Our thoughts go

to the family and practice of Dr Stephen Forsdick, GP in St Austell who died on Christmas Eve,and to the family and friends of Rob Cheetham who died earlier in December.

Patient Surveys

Unsurprisingly there seems to be quite a bit of confusion about what the survey is doing and to whom. I hope the following helps.

There are in effect 2 surveys at present.

Survey 1 is to measure the second component of the access DES and this will be sent directly to your patients IPSOS Mori. The names will be coming either from your system using Apollo or from the PCT and the Exeter system. Most practices we have heard from have asked the PCT to extract the data using the Exeter system. This still contains questions which there are concerns about, but they are relevant to general practice.

Survey number 2 is about giving patients a choice of where they are referred to, and having the referral discussed with them. This will be achieved by questionnaires which will be sent to practices to hand out to patients. Patients will then be asked to complete the form and send it back (in the pre addressed and pre-paid envelope) to Ipsos Mori.

A payment for practices to administer this survey is, we understand, being discussed nationally.

BMA Division Meeting

Just a short note to let you know the next meeting of the BMA Division is being held at the Knowledge Spa, RCHT. The meeting is open to all BMA members whatever their area of practice or qualification and students are welcome

Any queries to John Hyslop, Hon Secretary at: john.hyslop@cornwall,nhs.uk

Conference Update
27 / 28 february 2007

You should by now have received a more detailed programme for the two day conference next month. There is still room as bookings, for the first half day have been very slow. This is disappointing and obviously if the demand is not there, we will not put on such events again.

Day one is aimed at those looking to the future of general practice at a more strategic, but stll practical level, whilst day looks at detailed, practical practice issues.

Day one starts with lunch, and features a speaker from the PCT on the future of health services in Cornwall, Dr Fay Wilson from the GPC on national politics and the national direction of general practice, Dr David Jenner trying to relate those national and local themes to you practice.

All that, including a good lunch for £35, can you afford not to send somebody or attend yourself?

Day two (for Practice Managers) includes a variety of speakers, but trying to be more practical. Dr Wilson starts us off by trying on a practical level to outline what practices might be thinking about doing to get themselves ready for whatever is round the corner, there are sessions on the IT system and what's' next (Simon Barton), managing stress in a practice, staff training, appraisal (Helen Dinsdale), employment law (Richard Griffiths from the GPC), constructing a business case for PBC (Paula Bland. Including lunch for an amazing £50.00!

There are also opportunities to meet colleagues you have not seen for some time, which is of incalculable benefit. Please contact Dawn at the office for bookings.

Patients opting out of the national database

You will by now have received some explanations from Dr Simon Barton on the latest, I know some patients are already asking to be put on the "opt out list", and so we thought a short summary might help. LMC's are debating how practices can best handle the issues of confidentiality.

A national publicity campaign is about to start. If you want any publicity material you can get it from:

http://www.connectingforhealth.nhs.uk.publications

The usual site of http://www.nhscarerecords.nhs.uk/ is also useful. There is one amendment from the information Simon sent round in that the Read code should be 93C3 and not 93c3

Pensions

The Department have announced the Secretary of State has exercised her prerogative and capped the pensions increase. There is a question nationally about whether she has a prerogative to exercise as this is a clear contract, and that is being investigated.

What can I do, I hear you cry.
Well its funny you should say that, if you go to

http://petitions.pm.gov.uk/GPPension

You will find a petition you can sign, its going directly to Number 10 and you just never know. A legal challenge is likely and desireable.

Web Site

We are sorry that the web site is not up to date, Our web updater disappeared some months ago and has not been seen since. We have been out to a couple of organisations for quotes of setting up and reorganising a completely new site, and hope to have it soon.
The new site should be easier to use, clearer and will include sections so that practices across Cornwall can discuss issues together. We will also carry the usual sections on the LMC, papers, useful links and information.

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Applications with CV to include two referees and covering letter or enquiries to:
Mrs Julia Clothier, Practice Manage, The Surgery, Trekenning Road , St Columb Major, TR9 6AA
E-mail julia.clothier@petrocdocs.cornwall.nhs.uk
Tel: 01637 880359/262 Closing Date: Thursday February 12th 2007

7th Plymouth Symposium on Obesity and the Metabolic Syndrome

Making it work

Medical Centre, Derriford Hospital

Thursday 10 May 2007

Speakers this year will be drawn from those of national and international standing who have either made interventions work, or who have contributed significantly to our understanding of what underlies obesity and diabetes risk. Did you know that sleep duration is a factor, or that a study stretching from Madeira to Estonia is examining the role of physical activity across Europe? What can the American Pathway programme tell us about the prevention of childhood obesity, and what plans does Plymouth have for obesity management? Where does PCOS fit into the metabolic syndrome, and how is it best approached.

Costs: Code 1 Standard price—£90.00
Code 2, Members of PMS and its Dependent NHS Trusts, Universities of Plymouth and Exeter—£60.00
Code 3, Students, Nurses and PAMS—£40.00

Contact:
Mrs Kerry Godley—McAvoy, University Medicine, Level 7 Derriford Hospital, Plymouth PL6 8DH
Telephone 01752 763498
Fax 01752 792471
E-mail kerry.godley@phnt.swest.nhs.uk

Strategic review of Health services

The Committee thought you should see its contribution towards the review of health services in the county. It is repeated below.

Contribution to the Review of Health Services
Primary Care Services in Cornwall & Isles of Scilly

Review continued

The LMC as democratically elected representatives of general practice, (which is still the single largest supplier of health care in the county) feel that we are in one of the best positions to shape the future. The needs of primary care often reflect the needs of patients; for example the ability of a doctor to refer quickly for a scan or an opinion, the need for appropriate support in the community, and the need for quality primary care. However we will concentrate on the specific needs of primary care as that seems more appropriate at this stage.

The LMC believes that overall the standard of general practice is very good, but can be better. The past few years has seen the NHS within the county concentrate on all other elements of the NHS with the exception of primary care. That may have been because primary care was regarded as being in a stable condition, certainly most targets have been acute focused, there has certainly been a belief that primary care was well funded, even to the point that many NHS managers have said, there are too many GPs in the county; we can't afford them all. This very statement underlies the lack of understanding of primary care within the PCT. Why? Because most of the GPs earnings are related to list size and paid at a national rate, they have chosen to have more GPs, by earning less themselves. Secondly many practices support the number of GPs and nurses by profits from dispensing. However things are now changing: the increasing age of the population, which hits general practice hard, increased population and an increasing range of activities which can be carried out in general practice, all mean that we need to look at primary care as a priority for investment. Despite all these, the county has not had a primary care strategy for many years and has only invested the minimum monies it has had to. A small amount of money goes a long way in primary care.

The Lift programme has turned out to be very expensive and the PCTs have not been able to support the building programme they once planned to. What is the county going to do with Lift, if we can't afford it and we can't find alternatives we are near a real problem in primary care? It also questions the policy of handing over the community hospitals for a short term gain. The HA and in the past the PCT used to have an open process for considering improvement grant applications, indeed for many years they were considered with the LMC. They are now considered behind closed doors and practices do not know

The review of Health services in Cornwall, continued

available budgets, criteria or grounds of appeal. This seems to have been a step backwards.

Many of the investments have been brought about because general practice has fought hard to achieve them e.g. surgery at Probus. Many other schemes have been imposed centrally by the PCTs with little or no involvement from primary care e.g. orthopaedics referrals going to physios, where schemes elsewhere in the country have proved to work with GPsWSI, i.e. a clinical person to catch a person and take responsibility for them, not a physio who can only accept the responsibility of a physio. One of these schemes works well, the other has taken a long time to get going, still sees limited people and still has an acceptance problem. One of the schemes was bottom up, the other top down, which way of working does the PCT want to support in future?

Confusion is rife across many areas of primary care, some parts of the county pay for a minor injury service others don't, some practices get a payment for MRSA, and pre op work most don't. The LMC wishes to see clarity and an equality of access to services across the county.

There are amazing opportunities for monitoring people remotely, and placing diagnostics in more rural centres. The LMC believes these should be explored by the PCT, PBC Commissioning Groups, and the LMC, and an agreed strategy for moving services nearer patients, in line with government policy, be agreed and actually implemented.

The implementation of the new out of hours service has impacted on patient health. The LMC understands that the PCT is monitoring this closely but receives no feedback on how its is being managed and the impact on primary care.

The pressure on acute providers is meaning that on a monthly basis we are hearing about initiatives from the acute sector to move work without funding to primary care, these need discussion, agreement and possibly funding. The LMC is not against transferring work to primary care, but it does need to see the resources to support the work transferred with them. Practices do not have spare capacity just lying around waiting for a use.

PBC is a major initiative, it has a fantastic opportunity to be the engine of change within the county, if it is supported, encouraged and allowed to develop. However, it has had a slow start locally and little has happened, practices don't feel involved or supported, and nobody knows what support will be available from next April. Limited budget information is available, limited quarterly financial information appears months after the event, no information on any other service is available, no comparative information has been supplied. Despite this GPs have still shown a desire to be involved, though the LMC fears this interest is waning and will die completely unless a clear programme of support is forthcoming soon.

Choose and Book has been mismanaged from the start by a confusing national programme, a system that did not work to start with, too many project managers at the PCT as they left because it was a mess and being mismanaged, and now, at the last minute, and too late, the PCT are considering a DES. This has not been before the LMC and cannot be implemented until it has been. This problem was known months ago and yet again when its too late to make a difference the PCT appears to go into panic mode. Its just too late to make a difference for the target the PCT has to hit.

The LMC considers there needs to be a comprehensive review of community nursing in its entirety, with comparative data from other areas on costs, activity levels and staffing, and how community nursing works with general practice including where are they located, should we be aiming for all co-located or central teams as in the case of south restormel. Finally the LMC believes that the future for community hospitals is unclear, recently the PCT has bid for development monies for three of the hospitals, the impact of this of this bid on other units, the PCTs vision for community hospitals, how that has been arrived at, what did the patients say is not known at the LMC. The Committee believes that it would be helpful for this complicated area to be fully understood by general practice, partly because they use community hospitals and secondly because as commissioners they may be forming views about the use of monies. They should therefore be informed, simply, of the PCTs strategy.

The LMC hopes that this paper contributes positively to the work on the health review, it may not answer many questions, but that is because the LMC considers that areas raised need discussion and debate.

Decontamination of surgical instruments

The LMC would like to remind practices of the new guidelines with regard to decontamination of surgical instruments in primary care.In short the guidelines state that decontamination of instruments should take place in an accredited environment or practice should use disposable instruments. The accredited environment is described as a CSSD department. It is therefore important all practices are using either CSSD or disposable instruments by 1st April 2007.

You are reminded that as part of the new contract you have to have in place suitable methods of sterialisation and that failure to do this may not only leave you at risk professionally but also practices who are non compliant with these new guidelines may be decommissioned from providing enhanced services and additional services,particularly minor surgery, IUCD fittting cervical screening from April 07 onwards by the PCT.

PCT Premises Costs

In an effort to garner as much income as possible the PCT is shortly going to ask you to inform it how much money you have received from any other users for rent for you building, that they have already paid an annual, economic rent on. This relates purely to a premises on which the PCT pays a rent be it cost or other. This is unusual but quite within the regulations.

Practices are reminded that they can recharge to costs of any use the PCT and its staff may make of the presmises for example electricity, gas, cleaning, maintanence, comsumables etc. If you have not been charging it is suggested that you write to the PCT with a costing before submitting the first invoice.

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NICE guidance and the PCT questionaire

We have picked up from practice the latest PCT, the LMC is going to discuss with the PCT the actually requirement from NICE and will inform practices of their obligations in the next edition of the newsletter.

Dr Basil Bile, returned from down under and welcomes the new year

'Tis the time of year for New Year Resolutions, mercifully most of them short lived. I am proud to share with you all playmates that over the last half-century none of mine have ever made it unbroken as far as daybreak on January 2nd. However I may just make an exception to my own golden rule on this occasion. I am hereby giving notice that from Jan 1st 2007 I shall henceforth answer all loaded questionnaires by giving the opposite answer to that clearly expected of me by the condescending tone of the question.

Example:
Which of the following paragraphs comes closest to your own views? Please tick one box:

The NHS should put more resources into helping people keep well and promoting healthy lifestyles even though this would mean spending less on local hospitals
The NHS should put more resources into local hospitals even though this would mean spending less on helping people keep well and promoting healthy lifestyles

This is clearly aimed at halfwits. You will notice dear readers that the option of leaving the funding balance exactly as it is between the two alternatives is not given to us. And it will not have escaped your beady eyes that the adjective *"local"* is craftily inserted in front of the word "hospital". According to my chums who inhabit the murky world of psychology we are being shamelessly manipulated towards selecting option (a). I have therefore ticked box (b). And where I hear you ask is this poser posed? Why, in a clump of freshly sacrificed rain forest issued as something that glorifies under the grandiloquent title of "A Public Engagement Document".

Personally I think that engagements should be private affairs rather than public ones. If I remember rightly, and the event remains more than a little hazy to this day, my betrothal intentions towards Belinda were shared with her in the very private setting of a cupboard underneath her parents' stairs. I was in a half-Nelson at the time and Belinda was asking the question.

On to weightier matters, quite literally. If there is one thing I hate more than proselytising goodygoodiness it is the sanctimonious proponency of holier-than-thou political correctness. Combine the two into an NHS target and the hackles on the back of my aristocratic neck assume the proportions of the hedges in Hampton Court Maze. The spoilsport brigade are now in full hue and cry mode in bloodthirsty pursuit of the rotunder members of the Cornish citizenry, which I guess accounts for some 90% of the Grand Duchy's residents in our neck of the woods. Obesity is the latest target folks, a target that should be easy enough to hit judging by the size of most of them. Fortunately I am not in this morphological category being as I am simultaneously wide boned and stockily muscular. As it happens I take after both my mother and my father, as my waist size is an exact sum of both of theirs. Isn't genetics wonderful?

So whilst we are being entreated on all sides to starve the fatties into submission, might this humble practitioner sound an evidence based warning? A Mr Bob Cox from Northumberland is only still here today because of his enormous beer gut. The 18 stone gent was climbing into his northern loft when the step ladder gave way. As he fell a huge piece of splintered wood from the ladder pierced his body from his hip to shoulder, but his magnificent belly protected his internal organs. "Being fat probably saved my life," he said. And so say all of us. Then again, had he been lighter perhaps the stepladder wouldn't have given way in the first place. Ho hum….