

LMC NEWS

Cornwall & Isles of Scilly Local Medical Committee

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LMC Conference

The conference was held last week in Falmouth and the Office was pleased to see so many people and practices attending. We will produce a fuller consideration of the event in a forthcoming edition but many comments have been really positive.

Some comments helped us to change things as we went along, as you know it's still early days in terms of us organising such an event, and the fact that it all went off smoothly and the range of speakers were positively appreciated has encouraged us.

Hold a space for a fuller report on this year and the chance for your contribution into next year

Deanery Conference, St Mellion May 13 to 15, 2008

The South West Peninsula Deanery, working together with the Royal College of General Practice (RCGP), Peninsula Postgraduate Health Institute (PPHI), Local Medical Councils and Professional Education and Training (PEAT) are pleased to bring you a conference to share best practice and develop the quality of Continuing Professional Development in Devon and Cornwall

13 May 2008 Clinical Updates on diabetes/ Renal Medicine/Cardiology/Dermatology/Rheumatology

14 May 2008 workshops on CPD/career planning/ co-mentoring/appraisal and revalidation

15 May workshops on team development/ negotiating skills/nursing leadership advances

Visit www.peninsuladeanery.nhs.uk for programme, fees etc or contact Judy Hollett on 01752 437424

My GP is great, Doctors are lazy and overpaid

When considering your voting to the poll, you might also wish to wonder at the current perception from large parts of the public which is neatly summarised in the headline to this short article. This means that whilst GPs may be still able to have a higher satisfaction rating than most other professions, there is still a groundswell which was not there a few years ago. The LMC believes that we need to work hard to tell our patients what we do for them, so the thought of any other alternatives would result in significant public angst.

Extended Hours—BMA Climb down ?

You will have read about the so called BMA climb down, and we thought that this information would be useful.

Before announcing their view, the GPC had been pressurised into opting for A or B. They spent a long time deciding whether they should give a lead or reflect the views of the members and spent a considerable time trying to find some solutions to the current problems that we face. The feeling is that it is the immediate issue is not the battle, over whether extended opening is going to occur or not, but how it will be delivered and whether GPs are prepared to provide this service.

There is universal condemnation about the way the Government has failed to agree contract changes with the GPC and has proposed a "final offer" (now referred to as imposition A) but also threatening to impose a much more penal contract (now referred to as imposition B) if this was not accepted by the profession. Both of these are detailed in an attachment at the end of this email.

These are the only two contracts that are being considered by the Government. If Imposition A is rejected then Imposition B will be the contract we will have to work to from April 2008. There is no possibility that by rejecting Imposition A & B will result in the Government returning to the negotiating table to give us a better deal. This is the unanimous view of the GPC Negotiators.

The GPC also debated **"That the GPC has come to the conclusion that Option A is less damaging for general practice, because the alternative option will harm the underlying fabric of NHS general practice more quickly and more lastingly."**

This motion was overwhelmingly supported by the members of the GPC.

There have been many emails from GPs and reports in the medical press about the possible consequence of accepting or rejecting Imposition A. Imposition A retains the maximum amount of money in the GMS and PMS contract, and restricts the PCTs ability to use current funding to commission services from the Independent Sector. As described, Practices would lose the C&B and access funding but all this money would be reinvested via a Directed Enhanced Service (DES) for extended which would have to be offered to all Practices. This does not mean that you have to provide extended opening as described in the DES.

If the profession rejects Imposition A we will get Imposition B, this will result in 135 QoF points being removed rather than 58.5, all the QoF clinical thresholds will be raised (between 5 and 20%), the C&B and access funding will be given to the PCTs with the 135 pt QoF funding and it will up to the PCTs how they commission extended opening. The concern of Imposition B is that practices will lose considerably more money, and give far greater flexibility to PCTs to introduce the Independent Sector. Many are concerned that if the GPC does not stand up to the Government now they will just come back for more next year. Rejecting Imposition A does not prevent them returning next year, and many consider Imposition B makes that more likely. You are being being polled at the moment and you are urged to complete this, you will get a chance not only to vote on accepting or rejecting Imposition A but also to show your anger at the Government etc.

We cannot win a battle over extended hours, and we need to move the debate onto the much more important issue of the future of general practice and the part that the Independent Sector will play in that, as well as the gradual and systematic removal of the gains achieved in the 2004 nGMS contract. Over the past few weeks there has been considerable media activity and contacts with MPs both nationally and locally. If you see the media coverage it is not totally supportive of general practice, especially in relation to pay and availability of appointments but there is more support from patients and MPs about the future of general practice in the last couple of weeks.

The BMA will continue to put pressure on the Politician, the Media and keep informing our patients. What we need to achieve is to get the DoH back to the negotiating table and ensure the future of modern general practice, with many of the traditional values that are so important. We need to continue to inform our patients of the dangers of widespread introduction of the Independent Sector. The Government seems to believe that introducing the Independent Sector will lead to a raising of standards and provide care at a lower cost. The GPC does not agree with the Government that the introduction of the Independent Sector will necessarily achieve these ends. One only has to look at ISTCs to demonstrate that.

We have informed the PCTs that if the funding for C&B ceases then the LMC believes that many practices will stop using it.

There are still too many unanswered question. As yet we have not seen the full details of the DES for extended opening. We know it will be 30 minutes per 1,000 patients but until we have the detail it is difficult to comment more. The 1.5% investment guarantee would be welcomed if it was an uplift in the contract value but if the DDRB awards a 0% uplift, will be able to access this funding but it will be for additional work.

Existing Hours of Availability

We have recently received this advice from the GPC regarding any future requests for information from practices. Whilst the current contract, under regulation 77, whereby contractors must produce information reasonably required by the PCT for the purposes of or in connection with the contract or reasonably required in connection with the PCT's functions. Because of this the LMC understood the request from the PCT to establish existing levels of access. They now have that information and any other requests for information, especially for an extended hours enhanced service, the details of which are not yet fully known, or agreed nationally, could be regarded as unreasonable, and you are with the contract to refuse to supply any further information.

Requests for a Doctors letter / report for housing purposes

GPs are often asked for a letter to support a housing request or a medical report, and there seems to be some confusion about what is chargeable, and the rates. The contents of this article have been agreed with the Heads of Housing from all six Cornish Local Authorities.

The requests come from either the Authority / Housing Association or the patient.

If the patient requests, often a letter, in support of their need for improved housing, this is a personal request from the patient, and they are liable for any charge you may wish to make. Obviously many practices feel it difficult to ask many of their patients for a fee, but if you do, it should be made clear at the outset that a fee is chargeable, and you should agree the fee beforehand. Due to the rules of competition we cannot suggest or agree a fee for you, but it should be reasonable and reflect the time and effort involved.

If the request comes from a Local Authority and the patient is homeless the Council is obliged under the Homelessness Act 2002 to carry out certain enquiries about the person, because of this the Council is liable for a fee, and again you should negotiate it with them before hand. There used to be a nationally agreed set of scales but they no longer exist. The Council may seek to impose a fee (we know one states that they will only pay £15.00), if you consider this insufficient then you can refuse the request or negotiate a fee you both consider is reasonable. Again the fee should reflect the reasonable costs involved. Some Councils request a vast amount of information which would take considerable time to collect and present, it is reasonable that this is reflected in the fee, others have a "tell us anything you think is useful" request, both will merit different approaches.

Apparently Councils rarely request reports on patients who are not homeless, but when they do a fee is payable. The same rules apply for negotiating and reasonableness.

The current contract provides that GPs must supply a certificate for those with a severe mental illness for an exemption from the Council Tax or eligibility for a Council Tax discount.

All councils seem to do slightly different things, with some never asking for medical reports from GPs and using an independent service, most have not adopted this course. We can but hope that the new, single Council adopts a simple approach to this problem

RCGP Leadership Programme

A new programme to develop national GP leaders has been announced by the RCGP. The team offering the programme are drawn from a consortium consisting of Centre for Leadership Studies at the University of Exeter, the OD Partnerships Network and the Peninsular Medical School Postgraduate Health Institute.

The programme is run over a twelve month period and includes a mixture of intensive class room work, tutorial support and on line study.

If you would like to discuss this programme with one of the programme team please contact them using the email addresses below and they will arrange a mutually convenient time to have a telephone conversation.

Valerie Iles v.iles@reallylearning.com

Dr Kieran Sweeney kieran.sweeney@pms.ac.uk

Or through the Programme Administrator Nicola Nightingale on 020 8916 9855

Centralised Care Record

We have been asked to circulate this letter, and as it also represents the view of the LMC we have happily reproduced it below.

Dear Colleagues

Simon Barton recently wrote to all practices with information on the new Centralised Care Record. I believe this is the first step in the process of organising an upload of our patients' records by NPfIT/CfH. There is currently an absence of clarity from the BMA about how practices should deal with this very important issue.

Following recent media reports about failures of various government departments quite a number of patients have approached me to ask that they opt out of sharing of medical information in the centralised way proposed by Connecting for Health.

I am a strong believer in the use of new technology including the storage of electronic patient records on a local database, and the sharing of information when it is appropriate to patient care. I am concerned however about the increased use of centralised databases and in particular the proposed National Summary Care Record, which will eventually turn into a detailed care record if CfH plans are enacted. I believe they increase the risk of breaches of confidentiality. The State will have control and access to our medical records and I do not believe this is a good thing. The financial cost of creating and maintaining the centralised record is enormous and not a good use of NHS resources.

The technology and the security of the confidential information has not been tested. Hundreds of thousands of smart cards have been issued to NHS staff. These cards can be abused (several thousand have already been "lost") and I have no confidence that every NHS staff member will use their cards appropriately 100% of the time. The Secondary Uses Service is also a potential risk to confidentiality as the anonymisation process is not felt to be satisfactory.

I am currently advising patients to think seriously about allowing their medical information to be uploaded onto a central government computer. For further information I advise them to visit this website

<http://www.nhsconfidentiality.org>

Some of the information on the site is slightly emotive and there are some minor inaccuracies which I have asked them to address. However there is also some very important and useful information for practices and I would encourage all GPs to have a look. There is a letter which patients can download and submit to the practice, asking for their records to be coded 93C3 - *refused to consent for upload to national shared electronic record*.

I urge all practices to seriously consider their position on this issue. I would advise practices to at least delay agreeing to an upload of your patient records until more information is available. Once the records are uploaded we have lost control of the information.

If your practice considers that it is not ready to upload the patient records onto the spine I believe it is very important that you document this decision and communicate it to your practice managers, staff and the PCT. I strongly encourage practices to take this action now.

Thank you for your attention

Dr Mark McCartney

Pensilva Health Centre, School Road , Pensilva, Liskeard, PL14 5RP

01579 362249

Save our Surgeries

We understand that a patient in Worcestershire has set up a web site to highlight the dangers to general practice and provide patients with sample letters to send to their PCT, MP etc. We think you may wish to draw this to the attention of your patients.

www.saveoursurgeries.co.uk

Where are you registered?

Just a quick reminder that it is in your interest and the interests of partners and staff, all should be registered with another practice.

This is especially important when dealing with staff sickness when conflicts of interest may arise, and its just a lot cleaner for all if that relationship is not confused.

**The Clays Practice , Central Cornwall
Full Time Salaried GP**

12 month contract with a view to Partnership
8 sessions p.w. plus internal locum opportunity
New L.I.F.T. premises in 2006
List Size 10,000 (expanding)
Fully computerised
Good QOF achievement
GMS Rural Dispensing Practice
4 Partners (+ ¾ salaried)
Members of Mid Cornwall PBC Group
3rd & 4th year medical students
www.theclayspractice.co.uk

Salaried GP required to join our team, centrally located in this beautiful county within easy reach of North and South coasts and the county town of Truro. Practice profile available on request.

Closing date: 31st March 08. Proposed interview – mid April to start late June/ July.

Apply with CV to Judith Old, Practice Manager, The Clays Practice, Victoria Road, Roche, St Austell PL26 8JF. Judith.old@theclays.cornwall.nhs.uk.

Old Bridge Surgery, Looe—Partnership Opportunity

PARTNERSHIP OPPORTUNITY IN ATTRACTIVE CORNISH LOCATION

This is a chance to work in possibly the loveliest surgery location in the country, near the beach. A reorganisation means that Old Bridge Surgery requires a new part-time partner working 2 days per week (4 sessions)

We achieve high standards of patient care and QoF achievement and want to continue with the surgery's development. With a list size of 9,800 patients and 2,000 holidaymakers per annum to care for, we are a busy GMS Practice, operating from our main site in Looe and 2 nearby part-time branch surgeries (one of which has an on-site dispensary).

Our clinical system is Microtest, which enables the practice to run paper-lite. The Practice has a Nurse Practitioner working successfully with the existing team of nurses and Health Care Assistants. There are also on-site community staff, including a Community Matron.

We are ideally looking for someone to start in May 2008, but we are willing to wait for the right person. That person will be an enthusiastic team worker and have a good sense of humour to fit in with the current partners who like to achieve a good work/life balance.

For further information and a Practice profile, please write to Ron Dutton, Practice Manager, Old Bridge Surgery, East Looe, Cornwall PL13 1HA telephone 01503 266965.

Humble apologies for allowing the quite dreadful Desmond Drivel to be inflicted upon you in the last issue of this esteemed organ during my unavoidable absence. The chap is clearly a few capsules short of a calender pack and will be hearing shortly from my legal advisers Messers Pounce, Fiddle and Flee. In the meantime I am somewhat damp and draughty but very close to the corridors of power as I have chained myself to the railings of Downing Street as a protest at HM-ruddy-Gov's continuing doctor-bashing tomfoolery. Someone called Mr Hain keeps creeping up to the front door and pushing brown envelopes through the letter box, but no sign of the Health Secretary who has had such a low profile that most of us have forgotten his name. Gordie Broon seems to be the one issuing the constant NHS diktats right, left and bally centre. If you ask my ever humble opinion, politicians are like babies' nappies- they should be changed often and for the same bally reason.

The cause of my Gandhi-like stance in central London? Well, someone has to do something as we Family Docs are constantly harangued from all sides re our shortcomings whilst at the same time being urged forward to achieve ever dafter targets and toil for ever more effing hours. "Not on your Nelly" quoth I to the constable by way of explanation as he tried valiantly but vainly to cut through my handcuffs just now. Sadly, due to budgetary restrictions, the Met have had to put all wire cutting equipment in store and are only equipped with one pair of kitchen scissors between them so it looks like I may be here for a while yet. I foolishly swallowed the key of the handcuffs in a moment of bravado after attaching myself to the Prime Minister's front drive defences. On reflection that was a tactical error. My toileting requirements are currently on hold as I have strategically ingested enough loperamide to ensure a bowel transit time of approximately one month meaning that the re-emergence of the key into the outside world is likely to be some time hence. The handcuffs were purchased from an Adult shop in Tottenham Court Road. If that was an Adult's shop then frankly I would

hate to see what objects were purveyed from a Pervert's Shop. Blushingly I paid for my purchase. The offer of half-price on what I think is probably an electric toothbrush and some chocolate flavoured condoms was however too good to resist. The latter have proved a comfort to me when my food supplies have been running low here in the cold damp open air, and the former a disappointment as it did rather make my gums bleed. I am thinking of asking for my money back under the trade descriptions act as the photo of the lady's face on the box had an expression suggesting quite delirious satisfaction with the product.

Having rather a lot of time on my hands has at least given a chap the opportunity to reflect on where it all went wrong. Nowadays no one wants a GP who can think for themselves. It's all about unquestioning blind obedience and carrying out orders however stupid. If I'd wanted to get job satisfaction from achieving targets set by others I would have become a foot-in-the-door encyclopaedia salesman. Come to think of it, that's exactly what I have become, forcing statins and antihypertensives on folk who previously were quite content without them. Such gloomy ponderings sent me back in time to the days of hope and aspiration, namely my final medical examinations. I remember it as if it were yesterday. Some fossilised old fart of an examiner handed me a glass case.

"Tell me what this is Mr Bile" he commanded in a tone I took an instant dislike to. I studied the case and its contents until he grew restless.

"It's a knee cap, or as we doctor's call it, the patella" I announced triumphantly.

"That, Mr Bile, is the human brain. I find it hard to understand how after five years of studying medicine you can come to your final examination knowing absolutely nothing!"

"That's a bit unfair Sir," I protested, "I thought the exam was tomorrow..."