



Cornwall & Isles of Scilly LMC Newsletter

Seasons Greetings



Dawn and Susan at the LMC office would like to take this opportunity to wish you all a very Merry Christmas and a happy, healthy and prosperous New Year.

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- Items for the Newsletter should be sent to the Editor, Dawn Molenkamp at Sedgemoor Centre, Priory Road, St Austell PL25 5AS Tel 01726 627978, Fax 01726 76247,

- e-mail dawn@kernowlmc.org.uk

Your Chairman writes.....

Having just been up to the LMC Secretaries' Conference on the 1st December, I can report the latest from the GPC.

Firstly, the QP indicators will no longer be in the QoF for 2012/13. They will be replaced by a requirement to reduce A+E attendances. The details are still awaited but the feeling is that this will be achievable and is appropriate.

Of particular relevance to our rural County is the new guidelines on Practice boundaries. This does appear to have been moderated by GPC consultation, as Practices will be able to determine the location of their outer boundaries, agreed with the PCT-and this may be the same as existing boundaries. There are pilots being initiated of the DoH model which might suit cities but these are voluntary, and the number of patients out of your usual area will be capped. I am not aware that this will involve Cornwall at all.

The BMA Council has now elected to oppose the Health and Social Care bill in it's entirety based on increasing concerns about competition and privatisation. The GPC still intends to support GPs in establishing CCGs , as to abandon them now would be counterintuitive. Cornwall is up to speed with CCG development, being neither an early adopter nor dragging it's heels. As you may know, Mid Cornwall CCG has now been merged with Kernow CCG, whilst ECCG is still ploughing it's own furrow, although I understand that it is forging working relationships with it's neighbours.

On the subject of Revalidation, I can confirm that there is still no definite date for all GPs to be revalidated. The latest RCGP draft guide is still very much a draft and therefore not binding. There is essentially no change to appraisal therefore and you can continue to complete your appraisal in whatever form you like, as the only requirement is that you have one. Whilst it is probably pragmatic to expect that eventually there will be a requirement to use an online tool, there is no such obligation. The who and how of remediation and how locum GPs will be served by Revalidation is still to be decided. The role of the Responsible Officers still requires clarification.

And so with less than 3 weeks to Christmas, the LMC is in discussion with KCCG about it's constitution, and is still in discussion with the PCT about the PMS Contracts and the LESs specifically, and the QIPP agenda generally. KCCG has been given responsibility for the latter and has asked for LMC representation.

Have a safe, warm, and happy Christmas.

Indemnity Cover for Practice Nurses

Following the Royal College of Nursing (RCN) announcement that indemnity cover for work undertaken by practice nurses as part of their employment will no longer be provided by the RCN indemnity scheme, we again remind practices to check their indemnity arrangements to ensure that the work carried out by their practice nurses and all practice staff is appropriately covered.

National Awareness and Early Diagnosis Initiatives The Importance of General Practice and Primary Care

Introduction

Cancer patients in the UK have worse outcomes in terms of 1 year and 5 year survival than patients in other Western European countries. From international survival data it has been calculated that 5000 fewer patients would die from cancer each year in England if we matched the average W European outcomes and 10,000 fewer if we were to match the best outcomes which are achieved in Australia, Sweden and Canada. In addition there is also significant variation in outcomes for UK patients between different regions in the UK and even between neighbouring PCTs.

Analysis of the data indicates that the single most important factor contributing to our worse outcomes is diagnosis at a later stage of disease.

NAEDI Primary Care Project

Funding from the Department of Health has been made available through Cancer Networks to support local initiatives to help General Practitioners drive the earlier diagnosis of cancer.

Overall, the standard of primary care in Peninsula is high, with more patients diagnosed through the two week route than nationally and fewer cancer emergency presentations than nationally. However, there is variation between practices and part of our project is to review the available data at our disposal to better understand this variation and the reasons behind it.

In addition, there is funding available to support practices to review their own 2 week referrals and their patients whose cancer was diagnosed through other routes. The aim would be to enable practices to identify, for example, internal system improvements, training needs or potential pathway redesign that would facilitate earlier detection of cancer.

We will be promoting tools such as the risk assessment tool developed by Dr Willie Hamilton, the national primary care cancer audit template, the RCGP SEA template, the Macmillan GP Cancer Revalidation toolkit and the safety-netting guidance produced as an outcome of the national SEA project. In the New Year, we will also be organising some half day events for GPs and Acute Trust cancer clinicians to come together to discuss cancer referrals and how we can work better together to improve early diagnosis for our patients.

Finally, we also have funding available to support small groups of practices coming together to 'peer review' their cancer referrals and develop action plans.

Further Information

If you would like to hear more about our project or are interested in working with us to review your own cancer data and referrals, please contact Annie Sillitoe at the Peninsula Cancer network for more information.

Annie.sillitoe@nhs.net

Changes to the Blue Badge Scheme

From April 2012 GPs should no longer be receiving requests for information to support Blue Badge applications.

Many local authorities use assessment by the applicant's GP to help determine eligibility in such cases. However, there is a widespread perception that, in order for badge eligibility decisions to be fairer and more objective, assessments should be undertaken by professionals who are specifically trained in mobility and who are independent of the applicant.

<http://assets.dft.gov.uk/publications/blue-badge-scheme-local-authority-guidance/blue-badge-local-authority-circular.pdf>

NHS Pensions Reform

Most thinking people accept that there is a need for reform of public sector pensions, but the extent and depth of the changes is worrying to those of us in the public service, albeit, in the case of many GPs, as independent contractors. But what will the changes mean in practice?

It has been suggested that Public Sector pensions currently cost 1.4% of GDP and this would rise to 1.9% if they were not to be reformed: a significant increase, but not quite the matter of life and death that it is sometimes portrayed to be. It also means that it is unfair to cast them as giant Ponzi schemes, for although there is no specific savings pot for NHS pensions, a rolling cost of under 2% of Government budget is perfectly manageable. And it is partly the consequent saving in running costs that allows the NHS scheme to be both generous and efficient. About 21.5% of GPs gross pay goes in superannuation, and private schemes with similar benefits would probably cost nearer 28%.

The proposed changes fall into two groups, those arising from the Hutton report, and the operational changes already in the pipeline. Both may have an impact. High earning doctors will already have fallen into various tax traps, and inflation increases after retirement have now been switched from an RPI to a CPI basis, though we may have to concede that this is fair enough for us as most GPs will own their houses at retirement so housing cost increases do not affect our disposable income. We also do not have to worry about the end of final salary schemes as ours already depends on the actual contributions made, so the painful bit will be the likely hike in contributions. A rise in the top rate for employee contributions from 8.5 to 14.5% is possible, which may make the scheme very close in cost to a private one.

The Government has issued firm assurances that benefits already accrued will not be reduced, and the widespread fears about taxation on the retirement lump sum may be partly assuaged by these. However, as GP incomes stagnate or fall, and pressure for pension reform grows, many doctors getting towards the end of their careers may be tempted to retire, and many of them will not return to NHS work. We risk slicing off the top end of the profession and losing half a generation of skill and experience almost overnight.

But our greatest concern must be the increase in retirement age, initially from 60 to 65, and then, if Lord Hutton has his way, up to the planned state pension age of 67 to 68 for current young workers. Although we may be living longer, and enjoying better health in late middle age, the Government cannot slow the aging process and the technical demands and sheer intensity of modern medical practice make full time working beyond 60 potentially harmful for both doctors and their patients.

Some pension changes may be inevitable, but we must ensure they are proportionate, fair and safe. It is not clear that the current proposals meet these criteria. For full details on the BMA position on NHS Pension Reform see www.bma.org.uk/nhspensionreform.

With thanks to Dr Harry Yoxall and Somerset LMC .

HPV Vaccinations Update

The Department of Health (DH) has announced that from September 2012 Gardasil, rather than Cervarix, will be used in the HPV vaccination programme. The BMA [co-signed by Central Consultants Dermatology & Venereology subcommittee and Public Health Medicine Committee] wrote to the DH earlier this year calling for them to consider the latest evidence and cost-effectiveness of Gardasil, which protects against the two types of HPV virus that cause cervical cancer and genital warts.

The programme was introduced in 2008 after the Joint Committee on Vaccination and Immunisation (JCVI) recommended that the HPV vaccine should be offered routinely to girls aged 12 to 13 years, as well as a catch-up programme for girls up to 18 years of age.

The DH press release is available here: <http://mediacentre.dh.gov.uk/2011/11/24/hpv-vaccine-to-change-in-september-2012/>

Cornwall RCGP CPD Meetings

4th Jan 2012 Wed 7:00-9:30pm Personality Disorders in Patients & Psychological Strategies to Manage
Ten minute consultations: Dr. Susan Jones and Dr. Sue Candy
Psychology Associates

1st Feb 2012 Wed 7:00-9:30pm Varicose Veins Management: Mr. Ken Woodburn
Consultant, Vascular Surgery, RCHT

7th Mar 2012 Wed 09:30 – 4:30 Consultation Skills Workshop Morning + Afternoon
Enhance your Telephone Consultations & Alternatives to “No” – Preventing Standoffs
Fee: RCGP members All day £105 Half day £65 and Non RCGP members All day £115 Half day £75

Focus on Travel Immunisations

The GPC has published Focus on travel immunisations, to explain which travel immunisations are available on the NHS and which can be charged for privately. The Red Book regulations were written to cover the immunisations available at that time and consequently do not reflect today's clinical practice, and the subsequent new GMS contract (2004) took those regulations and carried them into the new contract as an additional service. Consequently everything in the Red Book was transferred unchanged and included in the global sum of payments rather than the previous item of service system.

The change in availability of immunisations and the nature of foreign travel has made these regulations difficult to interpret, and confusion over how they apply to current practice. This document reflects the present situation and is intended to help practices by clarifying the existing regulations as they currently stand. The document is available on the BMA website:

http://www.bma.org.uk/health_promotion_ethics/vaccination_immunisation/focustravelimm.jsp

Firearms Licensing

The BMA has issued this interim guidance for GPs on firearms licensing:

The BMA has agreed in principle that where an individual has been granted a firearms licence, or an existing licence has been renewed, the police will subsequently contact his or her GP to enquire whether there is any medical information that might have a bearing on the individual's suitability to hold a firearm.

Although aspects of this agreement were discussed and agreed in principle in November 2010, the BMA was expecting confirmation and further discussion with ACPO on when implementation of the new procedure would occur to ensure GPs were informed and suitably advised prior to the letters being sent out.

Unfortunately this has not happened and police forces have already begun to issue letters to GPs (without the BMA's prior knowledge) which do not provide sufficient instructions or advice. We are currently seeking further discussions with ACPO to try to resolve these issues.

Where doctors wish to respond to these letters and provide relevant medical information, consent to the disclosure of that information should ordinarily be sought as the letter does not currently indicate that consent has been given. If the patient does not consent to disclosure, this should ordinarily be respected, although the police must be informed to that effect. If, however, the doctor believes that the patient presents an immediate risk of serious harm to themselves or others, information should be disclosed even in the face of an explicit refusal.

Doctors are under no obligation to respond to these letters, but should they decide not to, doctors should inform the police as it will otherwise be assumed that there is nothing relevant on the medical record.

Although the letter from the police states that it does not have to be retained, in the BMA's view doctors should record the request for information in the medical record and indicate what action, if any, they have undertaken. The BMA will be updating its guidance as soon as this matter has been resolved.

Peninsula Medical School Primary Care

Minor Surgery Course

2 & 3 February 2012

The Conference Centre, Buckfast Abbey TQ11 OEE

Consultation Skills Workshop

7 March 2012, 9.30 am – 4.30 pm

Duchy Hospital, Truro TR1 3UP

For more information please contact Liz Bell, Administrator, RCGP Tamar Faculty Tel: 01392 722744

liz.bell@pms.ac.uk

The Cameron Fund

The GPs' own charity

Supporting GPs in times of financial need



We would like to thank your Local Medical Committee and your constituent GPs for their continuing support over the past year. Our charity is the GP's own charity and only supports GPs, including those who are retired, and their dependants.

During 2010, over 111 new requests for help were received by the Cameron Fund. These referrals were received either directly from the doctor concerned, from a referral made by their LMC secretariat or from other sympathetic organisations. We are delighted to report that in 2010, the last year for which complete figures are available, the Cameron Fund was able to help 158 new and existing beneficiaries by providing assistance to the value of £169,341.

With the ever increasing calls upon our resources and as Christmas approaches, we are again seeking your help so we may continue to be in a position to provide sympathetic support for those of our colleagues who find themselves in either financial or medical distress.

The Fund tries to make Christmas for its beneficiaries a little bit special with a seasonal gift. However, the work of the Fund needs to continue year round and particularly in the current economic climate the ever increasing calls upon the Fund's resources mean we need your financial support more than ever. We write now asking your LMC and constituent GPs to consider giving generously to the Fund this Christmas.

We would like to remind you that the LMC or any of your colleagues or their dependants, who may be in need of help from The Cameron Fund, should contact Jane Cope. (Tel no. 020 7388 0796 or email janecope@cameronfund.org.uk.)

We thank you in advance for any financial support that your GPs or the LMC may be able to give to The Cameron Fund.

Finally may we wish you all the very best for festive season and also wish you a happy and healthy New Year.

Dr David Wrigley
Treasurer

Charity Reg No. 261993

Company No. 993060

Registered Office: Tavistock House North, Tavistock Square. London WC1H 9HR

PRACTICE IMPERFECT

Chapter Three

Dr Gareth Groper limped distractedly down the corridor on his way to the staff coffee room. He noted the door to consulting room 3 was ajar and peeped in to see one of his partners at the Soddem and Gomorra Group Practice, Paul Bearer, peering intently at the computer screen. As Gareth entered the room the door hinges, denied oil as a cost-saving measure after the last vituperative practice meeting, squeaked loudly. Paul jumped out of his skin, and with cheeks flushing deep crimson hurriedly switched to screensaver mode, a lovely photo of his labradoodle, Lansley.

“Just browsing the latest NICE guidelines” he explained uncomfortably.

“And were they?”

Paul looked back helplessly.

“Nice. Were they nice?” persisted Gareth.

Paul’s deep crimson went an interesting shade of puce. Gareth had long suspected that his partner’s viewing habits in practice hours might not have been entirely to do with clinical medicine, but might be rather more focussed at times on surface anatomy.

“Just seen Bathsheba in floods of tears coming out of the bogs” remarked Gareth. “Said she’s had a complaint”.

“Probably diarrhoea judging by the amount of time she spends in there”, retorted Paul. “Anyway” he continued belligerently, “if she’s expecting any more time off for so-called stress she can think again. If Bathsheba can’t stand the heat then it’s high time for her to get out of the kitchen. Busy time of the year for us, no time for partners to be throwing sickies. Perhaps we could persuade her gorgeous sister to join us instead. I hear she’s just completed her vocational training. ”

Gareth’s hip twinged and he began to feel a little giddy. Perhaps taking four tramadol had been overegging the omelette. He hoped he’d be OK to drive to his home visits after morning surgery was finished.

Occupational Health Assessors commentary:

Bathsheba, in particular, appears in need of help; she has shown no sign of asking for it and neither has it been offered. What is the Practice policy when there is a complaint and what support is provided? She is salaried, so where is her supervisor and why is he or she not being involved?

Gareth is now unsafe to drive. He should not be visiting anyone except his own GP, with someone driving him there, who should put him on sick leave.

PRACTICE IMPERFECT contd.

He is unfit to work and if he continues the performance issues will need to be addressed, whereas it is his self-medicating dependencies that are causing them and they, in turn, are due to his maladaptive self-care mechanisms.

He needs urgent help, or his career is at risk; a pity as he, at least, is aware of what his colleagues are doing.

Paul Bearer shows no overt psychological symptoms. The writer seems to be inviting us to fantasise about exactly what he may be looking at on his computer and it is easy to imagine the worst. Although they may or may not be criminal in themselves, he should not be viewing them at work and on a work computer and so this is likely to be a definite Performance issue.

We must also consider that he may, like his colleagues, have personal problems which he is trying to solve on his own. He appears callous and sexist and very likely is, but he might also be burnt out being now near the end of his working life.

Drs Ben Charnaud, Anne Reed and Andy Stewart
GP Occupational Health Service

Joint Strategic Needs Assessment

A survey was sent out to all GPs in Cornwall and the Isles of Scilly in October. Many thanks to those of you who have replied. Pat Owen from the PCT and Robin Miller from the Council would be very grateful if those who didn't reply could give us your views on how you can contribute to, and use the Joint Strategic Needs Assessment (JSNA)

They would be very grateful if you could spend 10 minutes completing the following survey by end of December.

Questions to steer the JSNA (Joint Strategic Needs Assessment) Survey

<https://www.surveymonkey.com/s/cornwalljsna>

The survey asks about Community Network Area Profiles (for both population and health and well being) they are available at

Cornwall Council - Community network profiles

<http://www.cornwall.gov.uk/default.aspx?page=20177>

More Information on the JSNA is available at

Cornwall Council - Cornwall Joint Strategic Needs Assessment

<http://www.cornwall.gov.uk/default.aspx?page=26764>

GP Partnership South Cornwall

St.Keverne Health Centre on Lizard Peninsula

6 sessions/wk, increasing to 8-9 during internal holiday cover

If you are enthusiastic about the broad spectrum of family medicine, continuity of care, serving a close-knit rural/coastal community in an Area of Outstanding Natural Beauty, getting your work/life balance right supported by a dedicated Practice team, then we look forward to hearing from you.

Profitable rural dispensing practice	3000 patients
PCT owned premises	Consistently high QOF achievement
Nurse-led CD management	Generous annual leave

We expect from you

Sound sense of humour	Self-motivated learning
Skills in contraceptive device fitting and/or minor surgery and joint injections	
Ability to deal with minor injuries and emergencies	Flexibility

Start August 2012. You will become one of 3 equal GP Partners after a 7 month salaried position. Opportunity to locum 4 sessions/wk from February.

Deadline for applications with CV and hand written covering letter : 16th January 2012.

Interviews to be held the following week.

You are welcome to contact our Practice Manager Fran for further information, or to arrange an informal visit/ chat/ look around the practice. Address: St Keverne Health Centre, St Keverne Helston Cornwall TR12 6PB.

Tel: 01326 280205, e-mail: Fran.Hough@st-keverne.cornwall.nhs.uk

GP Vacancy Oak Tree Surgery, Liskeard

- | | |
|---|------------------------------------|
| * 8 session GP vacancy | *Salaried with view to partnership |
| * List size 11,000 | *Purpose built PFI premises |
| * Join our dynamic, progressive and supportive team | *Dispensing |

Informal visits welcome. Please contact Emma Holdcroft, Practice Manager, on 01579 335320 or email emma.holdcroft@oaktree.cornwall.nhs.uk

FULLTIME GP PARTNER

STILLMORE HOUSE MEDICAL PRACTICE,

BODMIN, CORNWALL

We are a friendly, pro-active, semi rural practice, looking to appoint a full-time partner to join our existing team from May 2012. We are a long established GMS practice.

6 GP Partners (4 full-time, 2 half-time)

Dispensing practice

Local Community Hospital inpatient responsibility

High QOF achiever

Work with Peninsula Medical School for student placement

List size 10,400

Member of North Cornwall Commissioning Group

Minor surgery

Part telephone triage appointment system

Out of hours coverage by Serco Healthcare

For more information or informal discussion please contact Mrs Sue Carthew, Practice Manager 01208 72488 or 72489

Or applications by CV with covering letter to: sue.carthew@stillmoor.cornwall.nhs.uk

or by post to:

Mrs S Carthew, Practice Manager, Stillmoor House Medical Practice, Bell Lane, Bodmin, Cornwall, PL31 2JJ

Westover Surgery, Falmouth

Practice/Business Manager vacancy

Friendly, popular and busy 9000 patient practice seeks experienced practice manager to take on this new role.

We are looking for an excellent communicator with a proven track record

20hours/week Salary dependent on experience but in region of £40k pro rata

For further details please ring Mark Crouse, GP Partner at Westover Surgery 01326 211879 for informal discussion.

Dr Basil Bile writes.....

News that a bogus doctor succeeded in deceiving NHS Managers for years whilst holding senior management posts causes some glee. Using a CV that the judge described as a work of fiction, Conrad Luis De Souza was paid £361,000 of tax payers' hard-earned loot and was subsequently sentenced to two years and three months for his pains. And was he finally detected by sharp eyed NHS Mandarins? Sadly, and perhaps predictably, that was not the case. He only fell from grace because he unwisely tried to use his father's DNA to escape a paternity suit. It was only when investigators were pursuing enquiries into his using a swab from his father coupled with forged documentation that his misdemeanours came to light. Alarmingly he had been employed by the NHS for a decade, having been a Clinical Adviser with Lambeth, Southwark and Lewisham Health Authority for four years before ascending to the giddy heights of Deputy Clinical Director for the South East London Managed Clinical Cardiac Care Network.

The lawyer representing the Department of Works and Pensions said that "health trusts had given anxious consideration as to how it was Mr De Souza could continue for so long without being discovered." I should imagine they bally well have! Perhaps the fact that in his managerial roles he blended in completely by doing bugger-all except attend endless interminable pointless meetings whilst dunking hobnobs in his blackberry and nettle tea could have something to do with his long tenure.

"Dr" De Souza's claims on his CV included degrees from the Universities of Cambridge and South California, which he used in his dishonest contention that he was a GP. It is immensely reassuring to know that the powers that be in the NHS put such high value on Curriculum Vitae, and that they are so fastidious in checking them before appointing folk to responsible positions. Mercifully he never practiced as a Family Doc and never put his paws on any patients. If he had turned up at the Abandonhope Surgery offering to do locums I would hope we would have spotted he was bogus fairly promptly, certainly sooner than ten years. The first time he poured himself a blackberry and nettle tea and reached for the packet of hobnobs would have been an absolute give-away.

It is perhaps not a coincidence, while we are on the subject of bogus qualifications, to note that dreadful self-opinionated old bore, none other than the eminently ghastly Gunnislake Gob, has suddenly and mysteriously departed from his practice and retired completely from stethoscope brandishing. No one has seen or heard from him since. Rumour has it that the longest serving lady partner in the practice, the Gob's heir apparent as Senior Partner, discovered some incriminating material in his consulting room whilst accidentally rummaging through his drawers. My solicitors, Messers Bluff, Swindle and Lye, have strongly advised me not to name her, but it is suffice to say that Maggie Thatcher and Angela Merkel look like wimps by comparison, if you follow my drift.

A pair of fluffy handcuffs, a fully illustrated copy of the Kama Sutra (Icelandic version so everyone is heavily clothed in animal furs), a doll stuck full of pins with a label saying "my female partners" on it, numerous articles of ladies underwear, an empty bottle of gin, and an undated University of London MBBS medical degree with the Gunnislake Gob's name written on it in crayon, were all uncovered. The GG was presented with a bag full of this character destroying evidence at a practice meeting in June and promptly resigned, much to the blessed relief of his partners, staff, patients, local nursing homes, PCT, BMA, RCGP, MDU and WI.

I am aware through reliable sources that CCTV footage has recently emerged of a certain female GP entering an Adult Shop in Plymouth making certain purchases in a rather furtive manner after seeking extensive advice from the rather seedy gentleman behind the counter. Articles purchased included a pair of furry handcuffs and an illustrated version of the Kama Sutra (Icelandic edition). Intriguingly one item she purchased never made it into the evidence bag that proved to be the downfall of the hapless man she has now replaced as Senior Partner. It is not entirely clear from the rather fuzzy CCTV film exactly what it was she bought, but it did require a heavy duty battery....
