Somerset LMC Newsletter

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Inside this issue:

PRACTICES AND THEIR LMCS

Slowly emerging from the shadows of the future is perhaps the biggest change in 100 years of general practice in England. We do not mean the change from PCTs to CCGs – despite the troubles of the Health & Social Care Act, the profession has already incorporated that into their thinking. But let us start at the beginning of the story.

In February the GPC celebrated the 100th anniversary of the first national meeting of representatives from local "Panel Committees" from across the country. These were set up in wake of the 1911 National Insurance Act to ensure that the new Local Insurance Committees fulfilled their statutory duty to consult with general practitioners, and the resulting network of LMCs relating to the GPC has proved remarkably resilient. Apart from boundary changes over the years, GP representation has remained remarkably consistent. Somerset LMC has records that go back to 1935, and the oldest, in Warwickshire, date from 1914.

On the other side of the table, things have been very different. Since 1990 the GP contract holder has gone from the Family Practitioner committees to the FHSA, Health Authority, local PCTs, county PCT, and now the NHS Commissioning Board. NHS primary care organisations appear to have a life expectancy of about 5 years. The problem is that such ephemeral bodies find it almost impossible to have any organisational memory: none of the people that the LMC negotiates with now were here before the locality PCTs were formed.

Even now, general practice is a fairly static profession. Many GPs will work 30 or more years in one practice, and most will stay settled in one geographical locality even if not in one practice. Patients certainly like that continuity; in an uncertain world "their" doctor is often an important landmark, something that perhaps we do not always fully appreciate. But the way GPs organise themselves is changing, as it always has. Partnerships have been slowly coalescing and enlarging as the technical and organisational requirements of modern primary care make it harder for smaller practices to provide the full range of services required. Until now the process has been slow and incremental, but that could be about to change. Federations are emerging as a new tier of mutual organisation that is almost unprecedented UK general practice. The setting up of Out of Hours co-operatives in the 1990s (in 1992 BONES in Bridgwater was a national test case over the old item of service payment arrangements) showed GPs that, although they were theoretically in competition for patients, there was much to be gained by co-operation. The introduction of the QOF QP indicators now provide a direct financial incentive for GPs as commissioners to work together, and the delegation of part of the CCG budget to localities will be an even stronger driver. Sharing back office services and even strategic management allows smaller practices access to the same skills that the largest enjoy, and co-operation as providers puts general practice in a very strong position to bid for new contracts.

Although the threat to partnership based general practice from commercial providers has proved less than once we feared, the re-emergence of mutuals in the financial services market suggests that despite the wishes of some more militant free marketeers the failings of the banking system mean that the public has no appetite for aggressive capitalism. In this climate a federal

model for primary care with individual practices retaining their individual characters whilst sharing many functions may be an idea whose time has come.

LMC LEVIES

No increase for 2012/13

Somerset LMC recognise that GP practices like the rest of the country are feeling the financial strain, and have therefore decided not to make any increase to the Levies, either Statutory or Voluntary for this financial year, like others we will endeavour to live within our means despite further erosions of our financial reserves . There has not been any rise to the levies for a period of 4 years and the financial committee have agreed to review this in 2013, when it is envisaged that there will probably have to be a modest increase . We hope that, by then, there may some sign of a small rise in practice income as a result of representations being made to the NHS employers and the Doctors and Dentists review body by the BMA.

We have also been informed by PPS that no deduction of Levies was made in the April payments, they will therefore make an adjustment at the end of May.

WHERE WE ARE WITH GP FEDERATIONS…

The way forward now looks a little clearer.

Thanks to the many of you who responded to the recent CCG/LMC survey on the value of GP Federations. Although there were some doubters, roughly 70% felt it was important to continue to develop federations, 20% were uncertain, and 10% thought it not important. Given this level of support, the LMC will continue to explore how federations can best support GPs and practices in their day to day work. We think that there are now three broad areas in which practices can work together – as commissioners, as providers, and for mutual support. The first is likely to follow naturally from the implementation of the Health and Social Care Act and the formalisation of CCGs, and we already have the outline of a constitutional model for this. For obvious probity reasons the second function needs to be strictly separated, and even where practices continue to work in a fairly informal manner there needs to be two separate constitutional arrangements. This does not stop the same people meeting at the same time and electing the same officers for both functions, but business should be conducted in technically separate parts of the meeting. The LMC therefore plans to re-establish the provider Confederation group to help co-ordinate some of this work.

WHEN IS A LOCUM NOT A LOCUM?

When he is an employee!

We tend to assume that when a locum turns up to work for a session in general practice he or she is acting as a self-employed professional and therefore liable for his or her own tax and NI contributions. For an *ad hoc* locum who is in the practice for an occasional day that is probably true, but for a doctor who is working a regular fixed session or rota for a longer period it may not be the case. There is no single statutory test that defines whether a person is an employee or self-employed, but HMRC guidance Link poses a series of questions that help define which category a worker falls into. The position of long term locums is not easy to define from this, but one important discriminator is who is responsible for finding a substitute if the locum is unable to work – if it is the locum, then he or she is much more likely to be deemed to be self-employed. Locums who work in several places are usually deemed to work from home and so travel to each practice is tax allowable as a business expense, but if he or she works in just one practice then this may be designated their workplace, so travel costs to it cannot be claimed.

Recent legal cases have also emphasised that to be a self-employed partner the individual needs to share in the risks as well as the benefits of partnership, so "fixed interest" partners could conceivably be regarded as employees unless they can clearly be shown to be partners in other ways by, for example, being signatories on the bank account, having voting rights at partners meetings or having an entitlement in the event of winding up the business. As always, we strongly urge you to make sure your arrangements are periodically reviewed by a specialist accountant.

Our thanks to Lentells Limited for the information on which this item is based.

PMAR REPORTS AND REQUESTS FOR ACCESS TO PATIENT RECORDS UNDER THE DATA PROTECTION ACT

The release of information from patients medical records for insurance purposes has for many years been the subject of an agreement between the Association of British Insurers (ABI) and the BMA. This itemised the information that should be disclosed and specified the fee for providing it.

In recent years the growing computerisation of records has led to some practices sending unedited print-outs of patient notes in response to such requests.

In response, some insurers are now offering a reduced fee of £50 for such reports, and at least one has withdrawn from the ABI/BMA agreement and has started to make applications for records under the Data Protection Act. Apart from only offering a maximum fee of £50, including all costs, this means that the GP has to check the printout closely to ensure that third party and other inappropriate information is not disclosed.

Disclosure

The LMC has always advised that practices should *not* send unedited printouts in response to a PMAR request, partly because that is not in the spirit of the ABI/BMA agreement, and partly because it is a fundamental principle that only relevant and necessary personal information should be disclosed.

With the proper consent, an insurance company is allowed to request a DPA disclosure on behalf of a patient, but the LMC believes that most patients do not know that when an insurance company requests a copy of the records this includes every piece of information in the notes – far more that is disclosed in a traditional PMAR. We are therefore very doubtful as to whether all patients are giving *informed* consent when approached in this way.

This raises the question of whether the patient ought to see the printout before it is sent – he or she is the data subject and therefore the person who is entitled to decide what he or she wishes to disclose to a third party. It also seems sensible that patient is advised to get the printout returned to them by the insurance company as it is not clear that the DPA requires practices to produce the same information again and again for further insurance purposes.

The practice is required under the DPA to provide the requested data within 40 days after the fee has been paid. If payment does not accompany the request you are expected to seek this within a reasonable time, perhaps one working week. The 40 days does not start until payment has been received by the practice, so if you are sent a cheque this should be cleared into your account first. The DH has some useful guidance at Link

LIMITED AVAILABILITY OF DERMATOLOGY APPOINTMENTS

You will be aware that the dermatology service has been under pressure to meet its waiting list targets for some time. Unfortunately this difficulty has recently been increased due to the absence of two consultant dermatologists on sick leave and a reduction in the number of GPwSIs in dermatology working on the county. TST (which is the employing trust for YDH dermatology as well) is working hard to get cover, but there is a national shortage of consultant dermatologist locums and we do not anticipate that full replacement can be provided.

Whilst the Trust and the commissioners are looking at how this situation can be eased, referrers are asked to warn non-urgent patients that there is likely to be a considerable wait before they can be seen.

"ECOTHERAPY" ON PRESCRIPTION

Health professionals can now refer patients with enduring mental health or emotional issues to a programme run by Mind which enables them to experience the therapeutic benefits of conservation work and/or gardening. Those completing a course experience increased levels of wellbeing, improved confidence and a reduction in social isolation. If you have patients who you feel could benefit from this programme, please contact the manager, David Topham, on 01823 334906 or davidtopham@mindtws.org.uk. The course involves 12 sessions of 2.5 hours and is funded by Ecominds.

GP TRAINEES SUBCOMMITTEE NEWSLETTER

The latest edition can be found at Link

CCG Clinical Operations Group GP Election 2012

Report of Returning Officer

GP Representatives

An election for the CCG Clinical Operations Group for the county of Somerset was held on the 24th April 2012.

On the 3rd April nomination forms were despatched to all practitioners on the list entitled to vote in one of 9 Federations in the county of Somerset with nominations to be returned by latest noon on Tuesday 24th April.

In 8 Federations the number of nominations did not exceed the number of representatives required and no election was necessary. These Federations and the unopposed candidates are listed below. There remains a vacancy in the west Mendip Federation.

Federation	
Bridgwater Bay Health	Dr David Rooke
Central Mendip	Dr Geoff Sharp
Chard Crewkerne and Ilminster	Dr Sarah Pearce
East Mendip	Dr Helen Kingston
North Sedgemoor	Dr Matthew Dolman
South Somerset	Dr Iain Phillips
Taunton and Area	Dr Rosie Benneyworth
West Somerset	Dr Ed Ford
West Mendip	Vacancy

Practice Manager Representative

On the 3rd April nomination forms were despatched to all Somerset Practice Managers entitled to vote in the county of Somerset, with Nominations to be returned by latest noon 24th April 2012.

The number of nominations received by noon on the 24th April did not exceed the number of representatives required and no election was necessary. The unopposed candidate is listed below.

Mr Michael Whitburn	Frome Medical Practice

Jill Hellens

Returning Officer

25Th April 2012

SMALL ADS ..... SMALL ADS.....

URGENT CARE GP - Yeovil Emergency Admissions Unit

We looking for more GPs to provide their GP skills working in the EAU. This service has been developed as a pilot collaborative between the Somerset Clinical Commissioning Group, the South Somerset GP Federation (Pathways providing) and the Yeovil NHS Foundation Trust.

The GP is based within the EAU Unit, working with a multi disciplinary team to ensure appropriate care is delivered in the right place, at the right time. GPs will work as an integrated team member with full support of the EAU staff and full access to diagnostics. GPs will NOT be required to work as an emergency care doctor seeing patients outside their competency.

The shifts are fixed from 1.30 until 6.30 p.m., Monday to Friday, and GPs can volunteer for as many or as few shifts as they wish. Pay is £75.00 per hour weekdays, £125 per hour Bank Holidays.

GPs Interested in working in this service and are on the Somerset Performers list and would like further information please contact: Dr Paul Scott or Karen Lashly. Paul.Scott@nhs.net; karen.lashly@prestongrovemc.nhs.uk 01935 474353.

SALARIED GP (MATERNITY COVER): SOMERTON SURGERY

Details: Up to 8 sessions available from August 2012 in Somerton Surgery.

Contact: Applications or informal contact to Len Chapman 01935 470816 len.chapman@pennhillsurgery.nhs.uk. Closing date 1st June 2012.

GP PARTNER: EXMOOR MEDICAL CENTRE

Details: Required 6 sessions per week to start 1st October 2012. A full candidate brief is available to download at www.exmoormedicalcentre.co.uk, password: Partner.

Contact: Dr Andrea Trill andreatrill@gmail.com for more details. Closing date 11th May 2012.

ASSOCIATE GP: GLASTONBURY SURGERY

Details: 6-7 sessions for August 2012 (start date can be flexible).

Contact: Dr Ian Strawford or Andrea Ball, Practice Manager on 01458 833666. Informal visits welcome by prior arrangement. Please send application & CV to Andrea Ball, Glastonbury Surgery, Feversham Lane, Glastonbury BA6 9LP.

www.glastonburysurgery.nhs.uk.

NURSE PRACTITIONER: GLASTONBURY SURGERY

Details: 20 hours per week.

Contact: Andrea Ball, Practice Manager on 01458 836109 or email andrea.ball@glastonburysurgery.nhs.uk. www.glastonburysurgery.nhs.uk.

HEALTHCARE ASSISTANT: NORTH CURRY HEALTH CENTRE, TAUNTON

Details: Salary £8.30ph for experienced HCA. Part time 14 hours p/w over 4 days.

Contact: Applications in writing with CV to Mrs Lisa Wallis, Practice Manager, North Curry Health Centre, Greenway, North Curry, Taunton, TA3 6NQ. Tel. 01823 490505 or email reception@northcurryhc.co.uk. Closing date 2nd May.

www.northcurryhealthcentre.co.uk.

DISPENSER: NORTH CURRY HEALTH CENTRE, TAUNTON

Details: Salary £9.00ph for experienced dispenser. Part time 12 hours p/w over 3 days.

Contact: Mrs Lisa Wallis, Practice Manager, North Curry Health Centre, Greenway, North Curry, Taunton TA3 6NQ. Tel. 01823 490505 or email reception@northcurryhc.co.uk. Closing date 2nd May.

www.northcurryhealthcentre.co.uk.

PRACTICE NURSE: RYALLS PARK MEDICAL CENTRE, YEOVIL

Details: Vacancy for part time practice nurse, salary will depend on experience. Hours are negotiable.

Contact: Rowena Turner, Practice Manager on Tel. 01935 446812. Closing date 11th May 2012.

INTERIM SENIORITY FACTORS FOR 2012/13

Have now been published for GMS GPs in England, Wales and Northern Ireland. The figures are: £96,646 (England), £82,261 (Wales) and £84,565 (Northern Ireland). Further details and an explanation of the methodology are available on the NHS Information Centre's website www.ic.nhs.uk.

DR WHIMSY'S CASEBOOK: PRESCRIPTION CONCORDANCE

Dr Whimsy has been dusting off his archive and discovered these two consultations from over 20 years ago, when most GPs did out-of-hours and knew a bit about diabetes. Still relevant, they remind us not to take it for granted that every patient can describe the pharmacokinetics of second order elimination.

Routine follow-up of an elderly diabetic lady

Dr W: Mrs. Furnace, I really can't understand why your long term sugar readings are still high. You have been taking the tablets, haven't you?

Mrs F: Oh yes, doctor. Twice a day, like you said.

Dr W: And your blood pressure is still a bit raised. You've been taking both sorts of tablets for that too, haven't you?

Mrs F: One for the morning and one for the evening, just like you said, doctor.

Dr W: Did you remember to bring all your tablets to show me this time?

Mrs F: I certainly did, doctor. Here they are.

Dr W: Right, thanks. Um... these are the paracetamol tablets for your arthritis. I expect there are some other tablets in your bag there?

Mrs F: No, doctor, those are all my tablets.

Dr W: Mrs. Furnace, where are your diabetes tablets?

Mrs F: You gottem in your hand, doctor.

Dr W: And your blood pressure tablets?

Mrs F: You gottem right there, doctor.

Dr W: You mean, you take the paracetamol for your diabetes and for your blood pressure?

Mrs F: That's right, doctor. They'm very good. They'm making me feel so much better.

Dr W: What do you take for your arthritis?

Mrs F: Same ones, doctor, they really help. I reckon they'm good for everything.

Dr W: Um, Mrs. Furnace, have you got a minute?

Out of hours home visit, 1:30 a.m. Discussion with the anxious wife of a robust but Demented octogenarian with a chest infection

Dr W: Well, Mrs Trendelenberg, I think it would be best if I gave him an antibiotic. He'll need to take them three times a day.

Mrs T: *[downcast]* Oh no. Oh dear, oh dear.

Dr W: What's the matter?

Mrs T: Well, it'll set off his epilepsy.

Dr W: Not at all, it'll make him better.

Mrs T: No, it'll give him a fit.

Dr W: How will it do that?

Mrs T: Well, I can only just remember to give him his Epilim twice a day, and if I have to give him these antibolotics I'll forget the Epilim and he'll have a fit.

Dr W: OK then, I'll give him an antibiotic that he only has to take once a day.

Mrs T: Oh dear, oh dear.

Dr W: What is it, Mrs Trendelenberg?

Mrs T: When will I give it to him?

Dr W: Well, I'll give him one now, and you could start the prescription with his afternoon Epilim.

Mrs T: *[horrified]* Oh no, oh dear.

Dr W: *[tetchy – heck, it's two o'clock already]* What's the matter now?

Mrs T: Oh, doctor, if he takes two tablets at once that would be an overdose, wouldn't it?

Dr W: *[resigned]* OK, give him the antibiotic later in the evening.

Mrs T: All right, doctor. *[Pause]* Doctor, why are you giving him the tablet once a day?

Dr W: To make it easier for you to remember to give it to him.

Mrs T: Shouldn't he have the one he takes three times a day?

Dr W: Why?

Mrs T: Well, it's three times as strong, isn't it?

The views expressed in this column are those of the author and not necessarily those of the LMC.

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