

Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE OCTOBER 2008 Edition

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Proverbially 'money makes the world go round'. It looks as though we may be about to find out that a lack of it has an even greater effect.

The Government has promised to stabilise the situation. Its pockets may be deep but not bottomless. The risk is that the Treasury will be hit by lower tax revenues as businesses fold, and more will have to be paid out to those former employees who are now on benefits. And if they are going to refinance the banks they will need to raise huge sums from somewhere, quickly. The Treasury will have to balance the budget somehow. They may demand savings from all major spending departments of state. They might, for instance, save considerable sums by withdrawing our forces from one or both of the Middle Eastern Theatres. In healthcare they may look to claw back any surpluses that PCTs have managed to accumulate – which may jeopardise programmes for premises upgrades. The list of treatments 'not normally funded' may be expected to increase. This means that more people will become chronically unwell, afflicted as much by a malaise in society as by their own condition. It is to be hoped that our civilised society will be sufficiently well established not to send the weakest to the wall.

REFERRAL RATES

Leaving the current crisis aside for a moment, you should be aware that for months now referrals to secondary care have been increasing markedly, both

locally and nationally. This is causing much concern to the PCT's financial planners since they cannot understand why it should be happening; certainly the GPC is not urging GPs to increase their referral rate. GPs should be concerned also, since they are the gatekeepers to secondary care. Should the PCT's funds soak away into referrals then funds earmarked for less immediate, but important, purposes (e.g. practice premises upgrades) may be reduced. So why might it be happening? *(In what follows the male embraces the female!)*

If a doctor does not refer he is relying on his experience and judgement to give him the confidence to accept the risk that he may be wrong in diagnosing and treating the case himself. Much of that necessary experience comes from knowing the patient well. Part-time doctors are less likely to meet 'their' patients. Out of Hours doctors are unlikely to know the patient at all. The confidence also comes from high morale. Will extended opening hours improve that morale? Also, new techniques and treatments are becoming available. The patient's hopes and fears, combined with any lack of confidence felt by the doctor, provide pressure to use them. It is regrettable that no one in the PCT predicted this, but will they now have the money to commission him or her anyway?

NEW DESs

We understand from the PCT that they are still waiting for the Statement of Financial Entitlements (SFE). They need this before they can issue the paperwork for the 5 new DESs, but they intend to hold the necessary training for the disabilities DES as soon as possible

(probably in November), without waiting for the SFE to come through. We have emphasised to them how important it is that bureaucracy should not get in the way of delivery.

GPs have been waiting long enough for the chance to earn some money from these clinical enhancements.

SUPPORT YOUR SURGERY – PHASE 2

All practices should by now have received from the GPC a pack of notices, leaflets and guidance on how to contact MPs and the local Overview and Scrutiny Committee.

We have heard no suggestion in this county that the patients have not been properly consulted by the PCT about the GP-led Health Centre. This is now the subject of tenders from the 4 remaining bidders, one of which is a consortium of local doctors. Because of that we do not feel that a complaint to the OSC would be appropriate in this case. However, it is right that the government, through the local MPs, and the media, and the public should be kept aware that:

- There do exist successful GP practices that deserve to be expanded and supported as a higher priority than opening new health centres.
- If the health centre is sited without proper regard for where it is needed and where it can most easily be accessed it will represent a great waste of taxpayers' money. We don't yet know where the one for this county will be, but the principle is true.
- Depending on who gets the contract there is a risk that the provider will be thinking more of its shareholder's profits than the welfare of the patients.
- The short-term nature of the contracts could lead to higher turnover of GPs within them, which will not be good for long-term care, such as is currently available in GP practices.

The strengths, or positive points, of General Practice, which should always be stressed to patients and the press alike, are five-fold:

The Point	Positive	What it means	Evidenced by:
Personalised Care		<ul style="list-style-type: none"> • Identifying with your usual GP • Maintaining that relationship • Trust • Confidentiality • Security of Information 	<ul style="list-style-type: none"> • Availability of your own GP • GPs disciplined for breaching confidentiality rules
Continuity of Care		<ul style="list-style-type: none"> • Structure of GP Practices • Ongoing evaluation of care 	<ul style="list-style-type: none"> • GPs stay with practice for years. • QoF
Quality of care			<ul style="list-style-type: none"> • QoF
Value for Money		<ul style="list-style-type: none"> • Made affordable for the NHS by having the full cross-section of patient population: from the chronically sick to the fit and well. • Gatekeepers for the NHS – increased and generalist experience allows risks to be properly assessed. This permits a very low referral rate. 	<ul style="list-style-type: none"> • Average cost to the NHS of a GP appointment is about £24 • A walk-in clinic appointment might cost about £80 • An outpatient appointment in a hospital could cost about £200
Service for All		See above	

PAY 08/09

The SFE amendment implementing the DDRB recommendations has now been published. It is not backdated to 1 Apr 08; it will be effective from 1 Oct 08 but has been structured in such a way that those (few) GMS contractors who will gain from the award will at the end of October receive a lump sum equivalent to any arrears that would have been payable had the amendment been backdated. The global sum now stands at £56.20 per patient.

SENIORITY FACTOR

The interim seniority factor for England and Wales in 2008/09 was announced as £105,534. This would imply that the committee deciding these figures believes that GP income has increased by some 5%. GPs superannuable income from NHS sources will now have to be 2/3 of this higher figure in order to qualify for the full seniority payment.

PRACTICE BASED COMMISSIONING (PBC)

PBC is in the doldrums, but deserves to get a following wind. We have made the point to the PCT that clusters need to be treated like commissioners, able to formulate and run with their own commissioning ideas, and that we need proper support from the PCT in this. The PCT has said they would also welcome suggestions from PBC clusters.



THE FUTURE OF A&E

There is a Project UTOPIA within the Acute Trust to reduce the multiple ways of accessing secondary care to one. But even under UTOPIA there will still be 2 A&E centres – it is recognised that the county is too large to rely on only one.

CERVICAL CYTOLOGY

If you did not know already, you should be aware that a cervical cytology screening report would generate a 'normal' letter to the patient even though there are incidental findings of infection or endometrial cells seen during the screening. Incidental findings are not

pursued by the screening programme, but are passed to GPs for their action. The tricky bit for a GP is that once the patient has received a 'normal' letter it is much harder to tell them about the incidental findings. We are taking this up further, but that is how things stand at the moment.

MINIMUM HOLIDAY ENTITLEMENTS

You may be aware that from 1 Apr 09 the minimum holiday entitlement is to be raised by law. We are grateful to the Wessex LMCs for permission to reprint the useful calculation sheet attached, which allows you to calculate what holiday your people will be entitled to during the change-over year and subsequently, for full-time and various degrees of part-time work.

SECURITY FOR LAPTOPS ETC

The Department of Health has selected the McAfee Safeboot product as the system of choice for protecting data, particularly when it is in transit in laptop computers. The PCT's plan is to get it out to laptops as the first priority and then to roll it out to all 84 practices once the logistical and practical issues are sorted out. These relate to how the practice network domains are set up and how the software can be managed across the whole environment. The intention is to roll out 'as soon as possible', which is reassuring though imprecise.



SCREENING FOR MCADD

Screening for MCADD (Medium Chain Acyl CoA Dehydrogenase Deficiency) is due to start for all babies screened at the Bristol Newborn Screening Laboratory from October 1st. MCADD is a serious condition caused by lack of an enzyme required to convert stored fat to energy. The incidence is about 1:10,000 births. The short-term effects are low blood sugar, coma and sudden death and the long-term effect is neurodisability. The test will be performed on the newborn blood spot and should identify about 60 cases per year in England. Once babies are identified and given simple treatment, the

risks of acute, life-threatening episodes needing emergency and intensive care, and of death, are substantially reduced. All screen positive results will be notified by the NSL to the GP to ensure appropriate follow-up care is in place. Further information can be obtained by contacting the Bristol Newborn Screening Laboratory or by following this link: www.newbornscreening-bloodspot.org.uk

LMC WEBSITE

We have a hit-counter on our website and are depressed to realise that very few people are accessing the site. Now it may be that you already know the answers, or have alternative sources of information, but we do try to have useful stuff on the site and would recommend it to you. You may say that self-recommendation is no recommendation at all, in which case you owe it to your sense of curiosity to judge it for yourself. Go to: www.gloslmc.com and then please let us know what you think.

KEEPING GPs IN THE PICTURE

We intend from next month to circulate to all GPs, usually via practice managers, a quick note about the main issues to be discussed at the next LMC meeting to give you a chance to feed your thoughts to your local LMC member. We will also send out a quick after-meeting note with the highlights. A letter is coming out separately explaining all this, and giving contact details for your representatives.

PATIENTS MOVING BETWEEN PRACTICES

The GPC urges all practices to have no agreements with other practices that unreasonably prevent patients from moving between practices.

LOCUM DOCTORS' CPD

Should locum GPs require financial assistance with attending CPD training they might try an approach their PCT or Deanery, but the bottom line is that locum doctors need to factor CPD costs into the fees that they charge.

GMC REGISTRATION

There have been cases, not yet in this county, where a GP has inadvertently let his GMC Registration lapse. It can take weeks to re-establish the registration and

during that time, of course, the individual is unable to practice as a GP - with consequent loss of income. These cases sometimes arise when the GP is paying for it by cheque rather than direct debit, the GP then moves house and forgets to tell the GMC, and the practice does not pick up on the lapse either. Therefore:

- Check your current registration status - this can be done via the GMC website.
- Always inform the GMC of your change of address.
- All Practices should have a system in place that checks the status of each and every GP working in the practice. This should include the GMC registration and MDU/MPS cover.

BMA PROMOTING DOCTORS IN THE MEDIA

Do you have a case study that could help the BMA? They want to do a series of interviews, each involving a GP and one of his/her patients together, about some particular aspect of their relationship. The BMA needs suggestions for raw material. This might be a chance to raise your practice profile as well as doing something for the profession as a whole. Even if you cannot guarantee to have the patient available for interview the BMA would still like to hear from you.

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NEWS FROM THE FRONT

Seen in the inbox of one GP Surgery 'somewhere in England' from its PCT:

"If you have an N3 connection (Internet) then you are part of the Connecting for Health programme even if you are not engaged with certain aspects such as Choose & Book or GP2GP.

The N3 connection means that you must sign the Information Governance Statement of Compliance to ensure that you are adhering to all current legislation. Failure to do this would mean that the PCT had to report you to the Healthcare Commission who in turn would investigate and report this to MI5 as it is classified as a risk to national security.

Ultimately the Healthcare Commission following the investigation could make recommendations on the suitability for continued practice."

The idea that GPs could represent a threat to national security has generated much mirth among the English LMCs. You will be relieved to hear that the GPC has ensured that the ISGoC Toolkit was considered by the JGPITC, and that the ISGoC Team present to the JGPITC. So do not be alarmed. But you ought to sign up.

MAX'S MUSINGS

My aged aunt and her husband (perhaps her third; I lose track) were on a Baltic Cruise and came back with interesting information. In the Baltic States a patient has to pay a fee of about £15 at every visit to the GP. If the patient cannot afford this fee then the state will pay it back to the patient. They seem happy with the system, and it reduces the numbers of worried well out in the waiting room. Perhaps a similar system could be used here? People complain about prescription charges, but understand that they must be paid. There is little logical distinction between paying a flat fee for a prescription and one for seeing the GP in the first place – it is just a different medical service. If George Orwell's pigs in *Animal Farm* were in charge they would soon be able to persuade us all that not only is there no distinction, but it would be morally wrong not to pay the fee, since only thus can we make the system more efficient and cost effective for society as a whole. The founding principle of the service that it should be free at the point of use has already received several knocks, and this would be a further one – but can we fully afford a national health service based on this principle any longer? On the other hand, £15 for a 10 minute consultation is equivalent to £90 an hour or about £175,000 a year. Have we just found another stealth tax for this Government which will allow them to make the GPs more affordable? While they are at it, perhaps the time has come to fine those who fail to keep their appointments?

The discussion continues on whether to legalise cannabis. I can see that if it were to be legalised the Trading

Standards inspectors could have a high old time testing its quality. The Government would be able to tax it as well, provided they did not charge too much, which would merely spawn an illicit smuggling enterprise. Legalising cannabis may reduce the crime rate into the bargain. But, and it is a big 'but', it fries the brain, as I see all too often in my waiting room and seems to do so more thoroughly and quickly even than alcohol. This is why I stick to champagne and claret; I shall have to be licensed and revalidated soon and will need a clear head.

Medical research has just come up with another blinder. We are assured that gazing at a beautiful sight can relieve pain. (You heard it first from W. S. Gilbert in 'The Mikado'.) Subjects in this recent study were invited to look at beautiful Old Masters or ugly (modern?) paintings while being lasered, to see which felt worse. The study reported a 30% reduction in pain amongst those looking at the beautiful paintings. I suspect many of those looking at the other paintings were afflicted by pain even before the added annoyance of being laser pulsed. But, if it really is true, then I wonder if you would get the same benefit from looking at a print. I don't think even my practice profits would run to hanging a really large Rubens just above the disposables tray in our practice nurse's office. And since proverbially beauty is in the eye of the beholder, how can we judge what to hang up in our surgeries to soothe the pain of most people? A portrait of some curvaceous and nubile young thing might soothe my pain in the neck but I fear it will do little for the majority of my patients. Perhaps my practice manager could create a samples page, such as is used when choosing wallpaper or coloured paint, using 'thumbnail' prints of likely contenders (not the Wreck of the Medusa,



I think!) for the patients to look at in the waiting room and allow them to choose. The sampler might even work of itself; I think I

detect another income stream in the making.

Seen on the Internet. The Japanese eat very little fat. The Mexicans eat a lot of fat. The Chinese drink very little red wine. The Italians drink excessive amounts of red wine. The Germans drink beer and eat lots of sausages and fats.

The French eat pâté de foie-gras, full fat cheese and drink red wine. All these nations suffer fewer heart attacks than the British.

So eat and drink what you like - speaking English is apparently what kills you.

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



STATUTORY MINIMUM HOLIDAY ENTITLEMENT – INCREASING AGAIN FROM 1ST APRIL 2009 *(with thanks and acknowledgement to Wessex LMCs Ltd)*

The annual holiday entitlement of an employee increased to 4.8 weeks (i.e. 24 days per annum) from 1 Oct 07 and this is again increasing to 5.6 weeks from 1 Apr 09. Bank holidays can be included in the holiday entitlements (only where the contract of employment states clearly that Bank Holidays will be paid for only when worked). The tables below show the calculations.

CALCULATION FOR CALENDAR YEAR 2009

Step 1 - Calculate for the 3-Month Period 1 Jan – 31 Mar 09.

4.8 weeks per annum = 2 days entitlement per month (24 days ÷ 12 months)		
Formula :		
Days per week worked ÷ 5 days (full working week) x entitlement per month x number of relevant months of year		
Days worked per week	Formula	Total (keep un-rounded)
1 day	$1 \div 5 \times 2 \times 3$	1.2 days
2 days	$2 \div 5 \times 2 \times 3$	2.4 days
3 days	$3 \div 5 \times 2 \times 3$	3.6 days
4 days	$4 \div 5 \times 2 \times 3$	4.8 days
5 days	$5 \div 5 \times 2 \times 3$	6.0 days

Step 2 - Calculate for the 9-Month Period 1 Apr – 31 Dec 09.

5.6 weeks per annum = 2.33 days entitlement per month (28 days ÷ 12 months)		
Formula :		
Days per week worked ÷ 5 days (full working week) x entitlement per month x number of relevant months of year		
Days worked per week	Formula	Total (keep un-rounded)
1 day	$1 \div 5 \times 2.33 \times 9$	4.2 days
2 days	$2 \div 5 \times 2.33 \times 9$	8.4 days
3 days	$3 \div 5 \times 2.33 \times 9$	12.6 days
4 days	$4 \div 5 \times 2.33 \times 9$	16.8 days
5 days	$5 \div 5 \times 2.33 \times 9$	21.0 days

Step 3 - Add Step 1 and Step 2 totals, rounding up to the nearest whole day.

Days worked per week	Exact Totals	Rounded up =
1 day	$1.2 + 4.2 = 5.4$ days	6 days
2 days	$2.4 + 8.4 = 10.8$ days	11 days
3 days	$3.6 + 12.6 = 16.2$ days	17 days
4 days	$4.8 + 16.8 = 21.6$ days	22 days
5 days	$6.0 + 21.0 = 27.0$ days	27 days

MINIMUM ANNUAL LEAVE ENTITLEMENT BEYOND 2009

5.6 weeks per annum = 2.33 days entitlement per month (28 days ÷ 12 months)		
Formula for a full year:		
Days per week worked ÷ 5 days (full working week) x entitlement per month x number of months in year		
Days worked per week	Formula	Total
1 day	$1 \div 5 \times 2.33 \times 12$	6 days
2 days	$2 \div 5 \times 2.33 \times 12$	12 days
3 days	$3 \div 5 \times 2.33 \times 12$	17 days
4 days	$4 \div 5 \times 2.33 \times 12$	23 days
5 days	$5 \div 5 \times 2.33 \times 12$	28 days

Partnership Agreements – BEWARE

Your practice could be at risk of losing your contract

(With thanks to Wessex LMCs Ltd, for permission to largely reprint this article.)

Partnership disputes are on the increase. A frightening proportion of these partnerships do not have a current and effective partnership deed.

If a partnership deed is not carefully drawn up to cover all likely issues then the Partnership Act 1890 will automatically apply to all issues where it is silent or unclear. This may well have unintended results.

Even worse, if no current partnership agreement exists this will create a **'partnership at will'** which is fully governed by the Partnership Act 1890.

Some consequences of being a partnership 'at will':

- Any partner may dissolve it at any time with no formal procedure.
- Death or bankruptcy of a partner will automatically dissolve the partnership.
- No partner has the right to expel another for any reason.
- No partner has the automatic right to carry on the partnership.
- The assets will be frozen immediately on dissolution.
- Staff will be made redundant on dissolution.
- All partners are entitled to an equal share of the assets.
- All partners have equal liability for the debts.
- No new partner may be appointed without a unanimous decision.
- All partners may take part in the management of the partnership.

The absence of a partnership deed does not prohibit a PCT from contracting with a partnership. However, if a partnership ends it is essential to comply with all of the requirements of the Standard General Medical Services Contract (part 25, 538) - **Variation provisions specific to a contract with a Partnership**. This may prove very difficult in a hostile situation where no partnership deed exists and may be of key importance if the PCT for any reason wishes to withdraw the contract from a practice. **We have been advised of well-documented and authenticated examples in other parts of the country where the PCT has withdrawn the contract when a partnership ended and has subsequently put the contract out to tender.**

We very strongly advise you to ensure that you have a current and effective partnership deed which will over-ride the Partnership Act and make provision for future succession to the contract, division of profits, removal of a partner if there is a very good reason (the so called 'green socks' clause) etc.

It is of course essential to go to a lawyer with special knowledge and experience of general practice and partnership law. The cost of this service will be noticeable at the time, but is insignificant when put in the balance with the damage that can be caused by not having a good, frequently updated, partnership agreement.

In the event of problems you may have very good reason to be grateful for a carefully drafted legal document that has anticipated and covered most eventualities.

PLEASE BE WARNED!

This area is like a very large minefield – unseen, and very damaging when you least expect it, but you can make a clear path through it.