

# Somerset LMC

## Newsletter



**Feb 2007**

**Issue 130**

### **GP PAY & GOVERNMENT SPIN**

*Batten down the hatches and weather the storm*

It is pretty obvious that the heavily critical coverage of GP pay in the left leaning broadsheets, and to a lesser extent elsewhere in the media, is not exactly spontaneous. Clearly New Labour's news management department has been up to something: but why just now? It is interesting to speculate why they have chosen this particular moment. One likely explanation is that there is more bad news about NHS finances just around the corner, and this is part of a general softening up campaign to shift the blame - although in reality the money that has been spent on the extra GP income over and above that anticipated is tiny compared with the resources that have disappeared into political fiddling with the service. By her own declaration Mrs Hewitt has just a couple of months to ensure that the NHS is in balance if she is going to stay in her job. No prizes, then, for predicting a positive number on the bottom line, but a nice little furore over GP pay might just be enough to prevent too much scrutiny of the way in which this figure was reached. But perhaps this is all to do with imminent DDRB report. You will remember that the GPC submitted information to the DDRB about GP remuneration, whilst the Department chose not to. It will certainly be easier for the Government to ignore any DDRB findings if the newspapers are full of articles about GPs being overpaid.

Of course, there is still much embarrassment and anger within the DH about their unwise approach to the GMS contract negotiations. They wanted 40% of GP pay to be performance related and in their arrogance assumed that the profession could not deliver. But, of course, (and as the GPC said all along would happen) practices did deliver. The Department's current problem is thus entirely of their own making.

But we suspect that this is really all about the huge cultural gap between medicine and modern politics. Doctors are trained for years in scientific method to observe and record accurately, to use clear language, and to value truthfulness. The apparatchiks of modern politics often come from an advertising or media background where all methods of persuasion are legitimate, language is carefully designed to confuse, and truth is subsidiary to the objective of the day. The deliberately misleading presentation of GP remuneration and the very intense anger that this generates in the profession graphically illustrates this divide

We all realise that the effect of the new contract has been to deliver several years pay increase in a short period and GPs are now well paid. So we must not allow ourselves to be harassed into the kind of direct action that would be all too easy for the Government to portray as due to greed. Time is on our side here, for the nature of media coverage is such that today's news lines tomorrow's dustbin, and no amount righteous frothing in the paper will cause permanent harm if we can foster good relationships with our patients and be seen to be working to improve their care. We should not dignify this dishonourable campaign with any response at all.

#### **Inside this issue:**

<b>GP Pay and Government Spin</b>	<b>1</b>
<b>"Surgery Line"</b>	<b>2</b>
<b>GP Pensions</b>	<b>2</b>
<b>Combination Inhalers in Asthma</b>	<b>3</b>
<b>NHS operating Framework</b>	<b>4</b>
<b>Tim's wine of the month</b>	<b>5</b>
<b>Immunisation</b>	<b>5</b>
<b>DLA and AA</b>	<b>5</b>
<b>Fees for local Authority Work</b>	<b>5</b>
<b>Transferring medical Records</b>	<b>5</b>
<b>Small Ads</b>	<b>5</b>
<b>Jennifer's Journal</b>	<b>6</b>

## **“SURGERY LINE” TELEPHONE SYSTEMS**

*Worth a look if you are thinking about changing or upgrading your phone system*

Replacing your telephone system with up to date technology can be very costly, and a company called NEG Surgery Line has come up with an ingenious way in which you can offset the cost. They have negotiated a bulk agreement with some non-BT telecoms providers to purchase call capacity at less than the BT local call rate. Callers to the surgery continue to pay the present BT charge, and the difference potentially provides for both the practice's costs and the company's profits without the caller having to pay extra.

NEG now provide phone systems for many hundreds of practices, and as patients are not paying a premium charge, the Department of Health is happy with the system. NEG install new branded phone hardware (which can include things like cordless headsets) and set up the system to match your needs. Incoming calls are picked up by the Surgery Line software and stacked or forwarded according to your requirements. Crucially, the system is flexible enough to accommodate the Monday morning peak as well as a direct transfer to the OOH service or other numbers. It also has useful extras like a 6 hour power back up supply, integrated panic button and on demand call recording. For a fairly modest subscription this can be extended to full recording of all calls. NEG also reckon to be able to offer very competitive charges for outgoing calls as well, but you will still need an ADSL/ISDN line and, of course, a BT connection.

The biggest hurdle is the need to change your phone number to an 0844 “lo-call” one, though NEG say they will leave a redirect message on your old number “for ever” if you wish. Also, the best deal comes with a 7 year contract, and the calculation that many practices can have a “nil-cost” system is based on this assumption. Patients who have call packages like BT Option 3 or Talk-talk will pay more because 0844 calls are excluded from flat rate packages. And despite the benefit to callers of virtual call stacking when the lines are busy, the LMC is well aware of how irksome it is having to wait for up to a minute at the start of a call whilst

some disembodied voice goes through a series of irrelevant options before you actually join the queue – and knowing that you are paying for the privilege of doing so.

So, if you are planning a surgery move or a major phone upgrade, this is worth a look: practices using Surgery Line confirm that NEG is an efficient and responsive company. But if you are reasonably happy with what you have, we do not think that the benefits will outweigh the costs, at least for now.

For more information about Surgery Line call them on 08000 968626

## **GP PENSIONS**

*Worth reviewing your position*

The LMC position on retirement has always been the same: retire when you want or need to, rather than trying to pick the right financial moment. Recent uncertainty about dynamisation leads us to reassert that view. GP superannuation is, of course, based on your actual earnings and contributions, and is not a final salary scheme. Each year the value of your nominal pension pot is “dynamised” and therefore increases. The basis for dynamisation has varied over time, but during the last few years it has been linked to average GP NHS income, and as this has risen so pension value has increased more than the DH anticipated (though not the GPC who predicted this all along), leading to the proposed pension cap. Some GPs who have been hanging on at work will be disappointed by this cap and it can be seen as a warning that we should not put all our trust in an NHS scheme which will always be in the hands of politicians. However, the current scheme serves GPs well and the proposed changes to it will still give doctors a good retirement income whilst being fairer to lower paid NHS workers. At some stage you are going to have to think about whether to change to the new pension scheme (if you have the option) and it is very important that you take advice from someone who really understands the NHS scheme. General calculations suggest that if you plan to retire before the age of 63 yr and 3 months you will probably be better off with the current scheme, if you intend to go after that it may be best to switch

You probably know that you are allowed to buy "added years" of pension contributions by increasing the percentage of your NHS income that you pay in employees contributions from 6% up to a maximum of 15%. At the moment this looks like a good buy in actuarial terms as it is suggested that if you retire at 60 you only need to live to be 67 to start to profit. However, we believe that this is the last year that you are going to be able buy added years on the current scheme, and as the contributions start on your birthday some of you will need to decide now if you want to pursue this.

*Disclaimer: This item is for general information only. The LMC is not allowed, and does not presume, to offer financial advice*

### **COMBINATION INHALERS IN ASTHMA**

*Advice from Dr Chris Swinburn, Respiratory Medicine Consultant at T&S Trust*

You will be aware that the PCT has been encouraging practices to look at their use of long acting bronchodilators (LAB), particularly in combination products. Dr Swinburn has sent us the following information which may help you in this:

"There have been two recent important main changes in our approach to the management of asthma, First, we now know that there is a dose response curve for inhaled corticosteroids (IHCS) so that the greatest relative benefit is seen at low doses. Whilst in the past we used to double the dose if symptoms persisted, each doubling generally becomes relatively less efficacious in improving symptoms, whilst the cost and potential for side-effects mounts.

At the same time the very good safety profile of LAB has become clear. Initially we were concerned that these might worsen the situation by relieving symptoms but not treating the asthma with potential for increasing asthma exacerbations and even death. This is absolutely refuted by well conducted controlled trials which show that these agents, when used in the presence of IHCS, are extremely efficacious (generally more so than any increase in dose of inhaled steroids) and also, their long-term safety profile in terms of exacerbation is excellent. **But LAB must not be used without IHCS in asthma.** A recent a trial in the USA of their

use in asthma without IHCS (which would never have been allowed in this country), **resulted in increased exacerbation rates.**

The current UK approach to the management of asthma that is still symptomatic despite low dose IHCS and prn short acting bronchodilator would be to introduce LAB before winding up the dose of IHCS.

Combination inhalers also have a useful role. There are two currently on the market. Seretide (Glaxo) is a useful product that suffers the disadvantage of complete inflexibility in its dose regime with a given inhaler. It is a common misunderstanding that the dose of Seretide can be increased or doubled during exacerbation. It cannot because this will overdose the patient on the Salmeterol component. Furthermore there can be confusion between the Accuhaler and MDI versions because of their different relative composition and strength

The other preparation (Symbicort, AstraZeneca) is more interesting in so far as it can be used in a flexible manner **in mild to moderate asthma** because of the different properties of Formoterol. Both combination inhalers are highly effective, probably result in better compliance, are I believe cheaper than both components supplied separately, and, of course, result in only 1 prescription charge for the patient. Curiously, for reasons which are not understood, a given dose of LAB and IHCS in a combination inhaler is more efficacious than both constituent drugs administered at the same dose but separately. Combination products are not for everybody. Many patients with asthma can be managed on low dose IHCS and rescue bronchodilator. If they are not, the addition of an LAB is a logical next step. If this sorts them out there is a certain attractiveness in using combination products."

#### **FootNote**

After the sad tale of the stray greyhound that was taken into a Glasgow police station, forgotten about and then found dead 10 days later, disturbing news of a seal being held by the PCT has come to our attention. Hidden at the back of the agenda papers for the January meeting of the PCT is a section stating that the "PCT's Common Seal" was used three times in December during licence agreements with ATOS.

Something must be done!

## **THE NHS IN ENGLAND: THE OPERATING FRAMEWORK FOR 2007/08 & FAILURE IN 2006/07**

*Health Warning: Pour a large gin and find a comfy chair before reading this item!*

This is the document that was published in December most famous for containing the statement that the NHS will be in financial balance by the end of the present financial year. It also contains an annex containing ten "principles for the NHS." These are

1. The NHS will provide a universal and comprehensive service with equal access for all, free at the point of use, based on clinical need, not ability to pay.
2. We will help keep people healthy and work to reduce health inequalities
3. We will work continuously to improve quality and safety
4. We will strive for the most effective and sustainable use of resources
5. We will treat every patient with dignity and respect
6. We will shape our services around the needs and preferences of individual patients, their families and carers
7. We are committed to equality and non-discrimination
8. We will support and value our staff
9. We will work in partnership with others to ensure a seamless service for patients
10. We will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

Fairly obviously number 10 is in fact two principles rather than one, presumably because 11 would not have been a nice round number. Frankly they could have left out number seven to make space. Can anyone imagine the NHS saying it was against equality and for discrimination? But certain traditions must be observed these days and mantras uttered. Leaving that aside, there is a paragraph under each principle expanding it if not exactly setting out more detail. The author's favourite is number eight, "we will support and value our staff." promising

career development: many acute trust staff will, no doubt, be given exciting "opportunities to progress" their careers *outside* the NHS this year.

It is also possible that readers may be confused about exactly what the new PCTs are for. The document is as clear as the execrable NHS-management lingua franca will allow. Like Gandalf daring to utter the Black Speech of Mordor in Rivendell we will risk desecrating the limpid prose of the Somerset LMC News and quote in full. PCTs will:

- Sign off costed Local Development Plans (LDPs) that will show income and expenditure balance and clearly state assumptions about activity levels with "best case," "worse case" and "likely" scenarios.
- Agree contracts with providers which reconcile with the LDP and manage contracts in ways which are consistent and compatible with the national contract
- Profile and monitor income and expenditure basis on a month by month basis
- Show how growth monies and those generated through improved efficiency will be deployed
- Agree contingency actions to respond to worse case scenarios
- Profile and monitor workforce numbers and the payroll on a month by month basis
- Have reporting and monitoring of the LDP and contracts sign-off at each board meeting.

Is that clear? You will have noted that PCTs will have to account for their costs every month. It was not a coincidence that two days later the House of Commons Health Select Committee, which has a Labour chairman and majority (including Dr Howard Stoate GP, MP for Dartford and normally a government apologist on any conceivable occasion), published its report "Failure in NHS Financial Management." It concluded that cuts in training budgets as an easy way of reducing deficits were depressing morale and could affect quality of care. Other "soft targets" included mental health and public health services. Rather than blaming "intractable historic problems" the MPs found that many deficits were associated with "the extraordinary growth" in staff costs. Serious

underlying failures have occurred at all layers from the Department of Health right down to PCTs. The DH made estimates of new staff contracts that were “hopelessly unrealistic” and targets, such as the four hour wait in A&E had been “imposed without regard to cost” they called for effective costing of government policy in future. A vain hope, we fear.

## **SNIPPETS**

### ***Tim's Wine of the Month***

“With regard to the GPC's up and coming negotiations with DH about pension cap etc etc my lot are surprisingly militant and would happily join the revolutionary fight in support of the GPC's stance on withdrawal of cooperation for non-patient centred services

But when you join the barricades remember to take with you a bottle of **Concha Y Toro Carmenere**, a juicy, fruit packed lovely from Majestic. At under £8 a bottle, you can afford to drink two and throw the empties at the opposition!”

### ***Immunisation of Children Immigrating to the UK***

With a rising number of children moving to Somerset from abroad, some practices are noticing an impact on their recorded Childhood V&I achievement. You may find the following helpful:

There is guidance on vaccination of children with unknown or incomplete immunisation status in the Green Book; the link is

<http://www.dh.gov.uk/assetRoot/04/14/11/24/04141124.pdf>

Country specific immunisation schedules are available from the WHO website; the link is

[http://www.who.int/immunization\\_monitoring/en/globalsummary/countryprofileresult.cfm](http://www.who.int/immunization_monitoring/en/globalsummary/countryprofileresult.cfm)

### ***DLA and AA Report Fees Rise***

The Department for Work and Pensions has agreed to an increase in fees paid to GPs for the completion of factual reports for disability living allowance and attendance allowance, and has confirmed that a new fee of £33.50 was effective from 1 January 2007.

### ***Fees for Work for Local Authorities***

Have also risen modestly. For an extract from records (15 minutes work) the fee is now

£32.50 and for a formal report (30 minutes) £66.00. The same rates apply to written reports supplied at the request of a coroner.

### ***Transferring Medical Records***

*Reminder: You MUST send a COMPLETE record when a patient leaves your list*

Despite the slow but encouraging progress on the electronic transfer of records between practices (GP2GP), for the foreseeable future we are going to have send paper copies. Please remember that you have a contract obligation to send the full record, including all correspondence, with the returned notes. It is a breach of contract, and medicolegally unwise, to do anything else. It is not enough to put a note in the Lloyd George envelope inviting a subsequent practice to contact you if copies of letters are required.

### ***The Price of Success?***

From the financial report to January's PCT meeting: "A sum of £3 073 000 is held in managed programmes as a potential contribution to the restructuring of NHS SW." The total budget is £618m of which primary care gets £165 m (GP, dentists pharmacists ,opticians).

### **SMALL AD.....**

#### **OPERATIONAL / PRACTICE MANAGER REQUIRED FOR DULVERTON SURGERY 2 DAYS PER WEEK.**

Please come and organise us with an inch of our lives. We are a 3,900 patient rural dispensing practice in the heart of Exmoor with 2.5 hands-on WTE partners. We want to work closely with an operational / practice manager to make our practice as efficient as possible, while maintaining the highest quality of life for us and our employees.

Salary in range £26K pro rata, more available for exceptional candidate.

For informal chat, contact Dr. Andrea Trill ([andreatrill@yahoo.com](mailto:andreatrill@yahoo.com)) or Dr. David Berger ([daveberger@gmail.com](mailto:daveberger@gmail.com)), Dulverton Surgery 01398 323333

CV with covering letter to Dr. Andrea Trill, Dulverton Surgery, Dulverton TA22 9DW or by email to [andreatrill@yahoo.com](mailto:andreatrill@yahoo.com)

#### **Closing Date**

Wednesday, February 28<sup>th</sup> 2007

## JENNIFER'S JOURNAL

*Tiring of New Year Resolutions Jennifer instead offers these predictions for 2007:*

### January

Tony Blair announces he wants a Holy War against the infidels and is sectioned under the mental health act. Cynics think it a ploy so he is unfit to plead regarding the selling of peerages.

### February

Gordon Brown dramatically withdraws from public life for 'personal reasons' and David Miliband becomes PM. He calls an immediate election and we have a hung parliament with the two Davids on a job share at number ten. The door is painted Green.

### March

Now that Tony has gone, the DH is back in charge of the NHS, but they haven't a clue what to do, having not thought up a policy of their own for years.

### April

New Research shows that having your personal data held on a national computer spine increases your chances of dying. Cancelling the scheme will save billions of pounds and thousands of lives. The Government resolves to persevere with it.

### May

A PCT Chief Executive is promoted to lead the NHS after only 6 months in post. He managed to move from his previous post to the one after next without ever making an appearance at the PCT. Minimal impact means less chance of messing things up.



### June

Shepton Mallet Treatment Centre is taken over by MRSA. Many heads roll when implicated in the attempted cover up.

### July

Choose and Book undergoes NHS Modernisation. Patients can 'choose' anything they want so long as it is the cheapest option.

### August & September

To reduce the risk of overspending, the NHS closes for these two months.

### October

Clearly fed up with paying GPs for meeting Access targets the Government raise the bar. They initially want patients to see a doctor of the chosen gender, sexuality, age and skin tone within 13 minutes of thinking they may possibly be about to become ill. This is modified to an appointment with any clinician within 30 minutes to discuss his or her risk status concerning any know life hazard.

### November

NICE produce a paper showing that Evidence Based Medicine will bankrupt the NHS. They realise that treating lots of people when only one actually needs the treatment is too expensive. GPs asked to use their clinical judgment to give the drug to the needy one only (drugs to the highest bidder?). Patients repeatedly asked 'do you feel lucky?' Some patients make a legal challenge against being denied treatment but the Judge rules that since they most likely don't need the treatment, on the balance of probabilities, treatment should be denied.

### December

The last remaining full-time GP in Somerset is given an award for stoicism before attending his assessment under the Mental Health Act and joining Tony in the asylum.

*Jennifer*

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