

# Somerset LMC Newsletter



**May 2008**

**Issue 141**

## **THE GP-LED HEALTH CENTRE :**

### **MORE OF AN OPPORTUNITY THAN A THREAT?**

The release by the PCT of the timetable for the procurement of the Somerset "Darzi" Centre means that we are at last in a position to consider the implications a little more objectively. The Department of Health requirements for these Centres cannot be altered, but we believe that with a little ingenuity and a lot of co-operation it will be possible to turn this exercise from a party political imposition into an opportunity to make changes that will enhance and protect general practice in Somerset – but we do not say that the process is going to be easy.

Following the release of the initial specification the PCT proposes a 12 week public "information sharing exercise" after which a final specification, which will probably include a preferred location for the Centre, will be produced in September. At that point draft bids will have to be refined and adjusted before they are considered in November. The contract will be awarded by the end of the year, and the successful bidder will be expected to start to provide services from April 2009 although the assumption is that it will take some time for the whole thing to be up and running.

We have always argued that the Department model does not fit a rural county with no large population centre, so to make sense it will have to do more than just offer another GP practice – albeit open for 84 hours a week – and a costly and underproductive walk-in centre. Given that these things have to be provided, how can we ensure that the resources consumed actually contribute something to local healthcare? We believe that the answer is to draw in a number of other organisations that currently provide community health and social care, and with whom the centre can share resources, capacity and risk.

Ian Tipney's letter to GPs repeats the PCT assurance that the Centre is not intended to destabilise existing practices and that there is no intention to reduce our funding. Given the anticipated growth in the population of Somerset of 22,000 over the next five years – mostly in the larger towns – there is room for a new practice, especially as there is no requirement for it to be of any particular size, and careful planning should make the registered list only a relatively minor part of the whole package.

The PCT is looking for bids that will address three concerns: population growth, health inequality, and integration of community services. Of the three possible locations for the centre, Taunton is anticipated to have the biggest increase in population, Bridgwater has the most deprivation, and Yeovil is most in need of a new location for community services. There is thus no clear front-runner, which means GPs need to prepare outline bids in all three locations. We suggest that these should be based on local GP consortia but share a common foundation. This seems to give us the best chance of competing successfully against the commercial sector.

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One of the most encouraging things that the LMC has heard is that PCTs will not be judging bids on the glossiness of their brochures, but on how well they can deliver services to patients that meet local needs. So, whilst a GP bid is never going to be expertly presented as one from a corporation with its own publishing division, we certainly ought to know more about the health of our local communities than they do. That said, the bid process is both complex and technical, so expert help is going to be needed. We think that this is an opportunity for our nascent provider group who could perhaps draw together the skills and expertise needed and help construct the foundation element as well as support each consortium. The LMC is prepared to commit time and money to this work if practices will do so as well

It may be tempting for GPs not immediately affected by all this to breathe a sigh of relief and assume the problem has gone away. But if there is going to be a Centre in your nearest large town would you prefer it to be *genuinely* "GP-led", or run by a voracious corporate entity? And once Centres are established in the towns, you can be absolutely sure that before very long something very similar will be appearing at a community hospital near you.

The LMC will now be circulating a questionnaire to practices about the options for the provider group, please read it carefully and reply as soon as you can. At the same time, dates for locality meetings in Bridgwater, Taunton and Yeovil will be announced. There is enough time to grasp this opportunity to improve patient services and draw extra resources into primary care if we can find the leadership and determination needed to meet the challenge.

We believe Somerset GPs will do so.

#### **FROM THE CHAIRMAN OF SOMERSET LMC**

It was a great privilege to be elected as the new chairman of Somerset Local Medical Committee in April. As Berge Balian's vice chairman for the last four years I was in prime position to appreciate the great efforts that he made on behalf of general practice in Somerset during some very challenging times. Happily none of these challenges have, so far at any rate, proved to be insurmountable.

The LMC is fortunate in having a huge pool of talent in primary care across the county from which to draw its membership. The current committee is very strong and it is my intention that the specialist expertise it contains will be deployed and developed even more in the future. Thus we have members who are immersed in, and so can lead on, the mysteries of practice based commissioning, personal medical services contracts, information technology and the particular circumstances of dispensing practices to name only four of the numerous areas where specialist knowledge is invaluable. Similarly we have an excellent negotiating team who will continue to engage with the PCT on the nitty-gritty of enhanced services. Furthermore I have appointed two vice chairmen for my term in office, Dr Sue Roberts from East Quay Medical Centre in Bridgwater and Dr Simon Bonnington of Oaklands Surgery in Yeovil, each of whom have already brought their own considerable talents to bear on the work of the committee.

We are, of course, continually grateful for the work of the LMC secretariat and especially for the contribution made by Jill Hellens and her team in the office. Jill has been especially active in developing her role liaising with practice managers, that vital group without which not much would actually get done.

In short, the LMC will continue to work in a collegiate way deciding on the facts after listening to and debating the representatives' contributions. It is therefore imperative that practices and practitioners speak to their representatives on the committee, as well as to the officers, so that your views and concerns can be properly represented.

We truly do live in "interesting" and ever changing times but I am convinced that the LMC (that has been in its present form since the inception of the NHS) and the strong tradition of Somerset general practice it represents will be more than equal to the challenge.

Dr Barry Moyse

## **RELEASING MEDICAL RECORDS OF A CHILD UNDER 16**

*Needs to be done with care*

Until a child is 16 a parent or other adult who has “parental responsibility” may ask for copies of the relevant medical record.

However, under the Fraser rules (arising out of the Gillick case judgement) children do have some autonomy in this area. A young person who is deemed competent under the rules is entitled to appropriate medical confidentiality, but note that this is selective and may not necessarily cover all of their medical history.

A practice should therefore not release copies of records without due consideration of their content. If a request is made - certainly for a child over 13 - a GPs should review the notes. If there is nothing contentious - and particularly if you know that the reason for the request: for example, the family is emigrating and wants to take the records with them - then it will usually be appropriate to release the information.

If there is doubt then the practice needs to contact the young person concerned to ask them if they are happy for the record to be released. If not, he or she should be invited in to look at the record with the GP. Sometimes the young person can be reassured, but some times there will be information that he or she wants withheld. This request should normally be respected, but if you are in any doubt at this point, take advice from your defence organisation. Remember that information disclosure should be proportionate, just as for adults.

You do need to be especially careful where there is some sort of marital dispute going on and one party or another wants the records to support an allegation against their partner. Although often parents have access to the records of their children even if they are not caring for them, there are exceptions and you should always take advice in these circumstances.

Anne Allen, who is the Nurse Consultant in Child Protection for Somerset [anne.allen@ydh.nhs.uk](mailto:anne.allen@ydh.nhs.uk) is always happy to advise, and the GMC document “0-18: Guidance for doctors” has answers to just about every question in this area:

[www.gmcuk.org/guidance/archive/GMC-0-18.PDF](http://www.gmcuk.org/guidance/archive/GMC-0-18.PDF)

## **More on Pensions...**

### **CHANGES TO EMPLOYEE CONTRIBUTION RATES APPLY TO ALL GP WORK**

Any Principal or Salaried GP carrying out work as a locum, OOH sessional doctor, or on a hospital contract should, for all work carried out from April 1st 2008), calculate their employee contributions due on that work at the same percentage rate as the deduction given (6.5% to 8.5%) on the main practice statement. Each GP's earnings - and therefore the superannuation percentage they pay for the year - will be based on the either the salary or the profit share declaration sent to PPS (Patient and Practitioner Services at the PCT) by the practice. For the current year, 2008/09, contributions are based on 2006/07 declarations.

However, if a GP substantially changes his or her working pattern during the year this should be notified to PPS. For example, if the doctor worked full time from April – June at an annual profit share of £102,000.00, the superannuation contribution tier is set at 8.5%. If he then reduces his hours to half time and his income is reduced to £51,000.00, the tier for July onwards would be set at 6.5%. In other words, the GP would only be liable for contributions at the percentage applicable on his actual earnings for that month. Please note that If you do not notify PPS it will only be when they receive the doctor's NHS earnings certificate for that financial year - some two years later – that the accumulation of the total years earnings would be added together and would result in a correction of the money due.

The moral of all this is that the GPs/Practices need to keep PPS as up to date with GP income changes as you can, preferably *before* they make the monthly payment you want the change to be applied against.

Could practices also remind any locums they may employ that the changes with the NHS Pension Scheme also relates to them if they are members - anyone using the old Locum B forms should amend them accordingly.

If you have any questions, please phone Sally Barnett (01823 287788) or Alison Reid (01823 287799) at PPS.

**SMALL ADS SMALL ADS .....****SHEPTON MALLET, SOMERSET**

The Park Medical Practice, a 5 partner practice, is looking to appoint a SALARIED GP for up to 8 sessions per week.

- Lively, friendly, democratic forward thinking team
- Emphasis on teamwork
- Paper light EMIS practice
- Purpose built premises in lovely location
- 4<sup>th</sup> wave PMS
- Excellent practice nurse team providing services such as CHD, hypertension, epilepsy, family planning etc
- Access to active community hospital with GP beds/physio/x-ray
- Within commuting distance of Bristol, Bath, Taunton and Yeovil

**Closing date for applications: 30<sup>th</sup> June 2008.**

Please contact either Dr Timothy Walker or Tracey Nicholls for an informal discussion and/or a copy of full practice profile.

Telephone: 01749 334383 or Email:

[Tracey.Nicholls@parkmedicalpractice.nhs.uk](mailto:Tracey.Nicholls@parkmedicalpractice.nhs.uk)

**ST JAMES MEDICAL CENTRE, TAUNTON, SOMERSET****GP PARTNER - 7 SESSIONS**

Due to a pending retirement we are looking for a replacement partner for 7 sessions per week to join our friendly, well organised, forward-looking, 11200 patient practice. Brief highlights include: -

- Fully computerised paper light EMIS
- High QoF achievement
- GP Training and F2 training practice
- Excellent nurse and staff support
- On-site pharmacy

Full Information Pack and application details available by email or post from:

**Guy Patey, Practice Manager, St James Medical Centre, Coal Orchard, Taunton, TA1 1JP. Telephone 01823 285414**

Email [guy.patey@stjamesmc.nhs.uk](mailto:guy.patey@stjamesmc.nhs.uk)

Closing date = Friday 30<sup>th</sup> May 2008

**EDINGTON SURGERY, EDINGTON, SOMERSET****Practice Manager (Part Time 20 Hours)**

The 4 Partners of this rural, GMS, dispensing Practice (list size 7000), located on the Somerset Levels with excellent road links from Bristol and South West, seek an accomplished Manager to lead the Practice through the rapidly changing environment of Primary Care.

You will probably already be in a similar role within the NHS or private sector with a proven track record in business management and the leadership of staff.

Salary is negotiable, circa 20k per annum, depending on the candidate's qualifications and skills.

For Information Pack

email: [malcolm.maggs@fusemail.com](mailto:malcolm.maggs@fusemail.com)

Applications should be made to [malcolm.maggs@fusemail.com](mailto:malcolm.maggs@fusemail.com) enclosing CV and covering letter.

Closing Date: 23<sup>rd</sup> May 2008

**PART-TIME PARTNER**

Our Practice is expanding

We are a friendly GMS practice looking for a Half Time Partner ideally to cover 4 sessions over a 3 or 4 day week, with probability of more sessions in the future.

- Modern, new, purpose built & fully equipped premises (no capital required)
- High QOF achiever
- Opportunities to practice or develop a specialist interest
- Fully computerised (EMIS) paper light
- Nurse led chronic disease management
- Triage appointment system
- On site pharmacy

Informal visits and enquires welcomed.

Practice profile on request Closing date 30<sup>th</sup> May 2008 For an informal chat and further information please telephone

Rowena Turner, Practice Manager Ryalls Park Medical Centre Telephone: 01935 446812

Email: [rowena.turner@ryallsparkmc.nhs.uk](mailto:rowena.turner@ryallsparkmc.nhs.uk)

Website:

[www.surgeriesonline.com/ryallspark](http://www.surgeriesonline.com/ryallspark)

Dear Jennifer,

Thank you for your regular journal entries, often amusing, always informative and thought provoking, which I suspect are the highlight of the LMC newsletter for many of us, including myself.

I work in General Practice for two and a half days a week, and for the PCT for two days a week, including in palliative care, so the paragraph about this in your April column caught my eye, and reminded me of a short Russ Abbott sketch:

Russ as a consultant in a long white coat looming over an unfortunate patient in a hospital bed: "I'm afraid I have some bad news and some very bad news. The bad news is that you have 24 hours to live, the very bad news is that I should have told you yesterday!"

Patient: "Oh s\*\*t!" ... and instantly dies.

At one level it is barn door obvious as soon as we are born that we are going to die, but at another it isn't obvious until we are actually dead. No one would advocate telling all and sundry "you're going to die, boy!", but there is great benefit in patients knowing that they have a life limiting illness, and being able to prepare for their death - to put things in order, to see people and places that they would like to while still well enough, to say things that need to be said.

It is terribly sad to hear, as I have done, someone say "if only I'd known before, we could have done.... if only I'd said..." Once the patient is dead the "if only"s can haunt relatives and friends for ever. On the positive side, I remember years ago talking with a young man and his wife about his brain tumour, that the oncologists had kept saying they would "shrink down" with treatment, but they never explained to him that this was only palliative treatment. As a result of our discussion he was able to write a book for his three year old son while he was still well enough, with all that he would have wanted to say to him over the years, and after he died his widow wrote to me to thank me for telling them both.

Of course we need to offer hope to all our patients, but hope in what? We often can't

offer hope of cure, and of course all of us will die sooner or later. Much has been written about influencing hope in palliative care patients, Robert Twycross in *Introducing Palliative Care* (Radcliffe Medical Press) wrote "Communication of painful truth does not equal destruction of hope. Hope of recovery is replaced by alternative hopes." He goes on to write about hope being focused on being rather than achieving, on relationships, and on being valued.

I think you are a little harsh to describe the concept of disease trajectories as "wonderful management babble" - this is well recognised, and fully described on the national Gold Standards Framework website [www.goldstandardsframework.nhs.uk](http://www.goldstandardsframework.nhs.uk)

The purpose of thinking about how patients with different diseases may decline in different ways is to help plan ahead. I'm sure we all know patients with heart failure or COPD, for example, who have repeated admissions to hospital that don't benefit them, and yet it is very hard to know when to stop this. This can only be achieved by including the patient in the decision, and the point of having some indicators of possible prognosis is to help us choose the right time to have these discussions. Of course you are right in saying that patients want to receive the best possible treatment when they become unwell, but the best treatment will vary during the course of a chronic illness, and will not always include high tech medical interventions in hospital.

As a nation we still find it hard to discuss death and dying in a healthy way, and as GPs we can help change this culture by talking more openly with our patients - although always sensitively and with care.

The standard of palliative care is high in Somerset, and there is much excellent practice, but I remain very enthusiastic about the potential for further development, and I am sure that there is more that can be done.

With best wishes, and thanks for sharing your journal with us all!

Dr. Chris Absolon

## JENNIFER'S JOURNAL

The Gord will surely be pleased with the success of his new policy of micromanaging General Practice and no doubt is bragging how he has got GPs to work on Saturdays for no money. What has happened to our independent status? You will work extra in blocks of 1½ hrs, you will only do GMS work, you will work alone, you will not use nurses, you will see pre-booked appointments only, you will achieve 80% attendance etc.- the micromanagement details in the DES are startling. We have as yet to see how many GPs will actually do all this nonsense. We are being treated like children not as independent contracted professionals. We should ask the Gord to put his DES in the same place as the banana I sent him.

Meanwhile Jennifer has been allowed to sit in on some interviews with potential commercial GP providers and enjoyed listening to their sales pitch:

The supermarket company were very economical, wanting to treat everything with dietary changes – and they could even give you a treadmill test on the checkout on your way out. The Pharmacy chain were keen to find as yet undiagnosed diseases and noted the benefits of polypharmacy. They also stressed the importance of looking good and offered cosmetic make-overs as a treatment for depression. The cut-price store offered great savings on using only generic drugs imported from the third world – and they offered them in every pack size up to enormous. The DIY store were full of enthusiasm and had a great package for self-fixation of fractures. The Off licence group offered a spirited presentation but halfway through it the guy first fell first over, and then asleep in the corner. The local veterinary co-operative barked on a bit but had a good point explaining how they offer a rapid patient turn-over as they didn't need to take a history. Apparently an injection of antibiotics cures most things. Their euthanasia policy was a bit 'iffy' but it would save the NHS a fortune.

After realising how little any of them understood about General Practice, Jennifer is considering putting in her own bid to provide a better service. 90% of 'illness' in General Practice is either down to stress or a virus, so I propose a system where it is really difficult to get an appointment and you have to wait for weeks. All self-limiting conditions will get better before they can be seen (which will be all the viruses and most of the stressed). So few will actually attend their appointment that the doctor will have a nice relaxed surgery. Those that persist and do attend can be put on the waiting list to see a counsellor. (There won't really be one but patients can be encouraged with reminders of how they are moving up the waiting list until they lose interest). And the beauty of it is that the scheme

is so cheap: if you don't ever let the patients get to the doctor then there will be no expensive prescribing or referrals. All sorted!



*Jennifer*

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

## SOMERSET ACCIDENT VOLUNTEER EMERGENCY SERVICE

For those of you who are unaware, SAVES is a Somerset based, registered charity that provides a network of volunteer doctors to support the ambulance service in Somerset. The doctors are all experienced GPs or hospital doctors who have advanced training in pre-hospital emergency care. Most of their work is in helping casualties of road traffic collisions, especially those who are trapped and seriously injured. New volunteers are always sought. SAVES are pleased to announce the launch of their website which can be found at [www.saves.org.uk](http://www.saves.org.uk) Do visit it to find out about the work that they do, or contact Dr James Hickman [james.hickman@northcurryhc.nhs.uk](mailto:james.hickman@northcurryhc.nhs.uk)

## MRSA DECOLONISATION - ALTERNATIVES TO AQUASEPT

Aquasept remains unavailable and we understand that it may have gone out of production permanently. Infection control experts advise that Skinsan (based on Triclosan) and Octenisan (based on Octenidine) are the most appropriate alternatives. Other products such as Hibiscrub are not felt to be as suitable. As they are not currently listed in the BNF you can get info on the recommendations at:

[www.skinsan.co.uk](http://www.skinsan.co.uk)

[www.uk.schulke-mayr.com/Hospital/Product%20Range/H%20Hands/hhands.html](http://www.uk.schulke-mayr.com/Hospital/Product%20Range/H%20Hands/hhands.html)