Somerset LMC Newsletter

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Issue 155

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The Future of Community Health Services in Somerset

A once in a lifetime opportunity for general practice?

Something very strange has happened in the looking-glass world of the Department of Health.

Most of us know that PCTs have been gradually divesting themselves of their role as providers of community health services, thereby becoming pure commissioners. Locally, Somerset Community Health has been made a semi-autonomous "arm's length" organisation, and it had been assumed that eventually it would mature into a fully independent community trust. In the current financial climate the Government has, perfectly sensibly, decided that it cannot afford any more new NHS organisations with their costly board structures, but for reasons that presumably make sense to someone they have also decreed that PCTs have to have a plan for the new future of their community services by the end of March 2010 for implementation by 1st April 2011.

Amongst the options are transfer back to the acute hospitals, merger with Somerset Partnership or an existing community trust from another area, or, in theory, two PCTs could combine and then re-divide into provider and commissioner bodies. But none of these is without problems – which leaves either takeover by a non-NHS provider or an initiative from within the local NHS.

Despite the very short timescale the LMC, Wyvern Health and the Somerset GP Provider consortium have agreed that the services provided by SCH are so important to GPs' day to day work that we should submit a joint expression of interest to the PCT in developing a new host body for SCH. The current consensus view is that this might be a social enterprise based on a community interest company made up of clinical professionals and governed by a board that would include a range of clinicians and managers from health and social care locally.

Somerset is probably unique in having a PCT, an LMC, GP commissioning and provider groups and one social services directorate all with the same boundaries, and with the strong local tradition of joint working that gives us an excellent foundation for a new organisation. It is important to note that this does not mean that GPs or GP bodies would become responsible for the day to day running of SCH – there is already a very competent management team who will do that – but we would able to catalyse the development of a clinically led, widely representative and genuinely local governance structure that would allow SCH to continue its current integration and development programme, whilst bringing community health and general practice closer to the goal of coherent primary care – and perhaps, one day, even the holy grail of integrated practice and district nursing teams. SCH staff, whom we know and respect, do not need any more upheavals, but they want and deserve assurances about both their future within the NHS and also the continuity of their NHS pensions which we think we can offer. We also believe that closer structures and working would also makes us much better able to protect clinically as opposed to politically essential services as the lean years of funding begin to bite.

There are, of course, risks, and at present nothing is certain: with an election

looming the Government may think again about the wisdom of unsettling a significant body of voters. We could do a great deal of work only to find that the PCT and SHA prefer another proposal, or we could find that the SCH service and management budget is simply not adequate for the job. And whist we can protect against any direct financial risk, integration could put workload pressure on practices if we do not have an explicit and shared understanding of where the boundaries of the service are to be. Yet we believe that in the whole history of the NHS there has never been such an opportunity for general practice to help shape the direction of primary and community care, and to develop real partnership working with other primary care clinicians to the benefit of everyone. We hope you will agree.

NEW MED3 FORMS FROM APRIL 2010

A significant improvement and clarification.

The Department for Work and Pensions has drafted a new medical certificate for benefit and SSP purposes that they propose to introduce in April. This has a number of advantages. First, just one certificate replaces both Med3 and Med5, and the criterion for signing the form is an "assessment" not an "examination". This allows you to complete one after a telephone consultation or after receiving information from another clinician such as a physiotherapist, and not just another doctor as the Med5 currently specifies. There is no longer an expectation that patients need a "back to work" certificate – in fact, this has never been statutory – and best of all there is an option that says the patient "may be fit for work taking account of the following advice" which gives some tick box choices or a free test area. Note that you can now only issue 3 monthly certificates during the first six months of illness. The whole thing is much more clearly laid out. It is clear that the DWP has consulted GPs and heeded their remarks in designing the new form, which is consequently much better for patients, employers and GPs. Details at: http://www.dwp.gov.uk/healthcare-professional/news/statement-of-fitness-for-work.shtml

FINAL SENIORITY FACTOR FOR 2006/07

Reduction on estimated sum makes more doctors eligible

The distinctly unsatisfactory method for determining GP seniority payments based on 1/3 and 2/3 boundaries is unlikely to change, and, indeed, the whole future of seniority payments is in some doubt. But for the moment we have some good news: the final average GMS WTE earning figure for 2006/07 was £92,140, down from the working estimate of £95,355. This means that some GPs near the relevant boundaries will either be eligible for payment or move up to full payment, so do check the position with your accountant if you are in any doubt. In theory PMS practices can negotiate individually, but we anticipate that the PCT will continue to use the GMS figures for both contracts.

EMPLOYMENT & SUPPORT ALLOWANCE

Was introduced as a replacement for Incapacity Benefit for new claimants from 27 October 2008.

The item on ESA in last month's Newsletter has prompted some requests for an explanation of the benefit. Our thanks to John O'Dowd from Minehead for this synopsis:

Assessment Phase

ESA is paid at a lower basic rate during the first thirteen weeks of a claim. This is known as the assessment phase. The only exception to this is for those classed as terminally ill.

Work Capability Assessment

Claimants who are not terminally ill have to go through more stages of the Work Capability Assessment (WCA). This may include completing a self-assessment questionnaire, the ESA50, and attending a medical examination. Once the WCA is completed a decision maker decides whether the claimant continues to get ESA and if so, whether they are in the support group or work related activity group.

Work Related Activity

Claimants who are able to undertake work related activity are placed in this group. They are paid a work related activity component. This is subject to attending and taking part in work focused interviews and a work focused health related assessment. Sanctions apply to people who fail to comply without good cause. Their ESA can be progressively reduced down to the assessment phase level.

Limited Capability for Work Related Activity

Claimants with more severe illnesses or disabilities who are assessed or treated as having limited capability for work related activity are placed in the support group. They are paid a support component.
This is paid at a higher rate than the work related activity component.
The support component is not subject to any conditions and is paid as long as the claimant remains in the support group.

VAULT SMEARS AFTER HYSTERECTOMY

Responsibility for follow up smears under the national programme has shifted to the consultant team

Practices should no longer be taking follow up vault smears after hysterectomy. As a rule, women do not need smears if they have no cervix but if the gynaecologist is concerned there might have been incomplete excision of neoplastic change, follow is now considered to be part of their post-operative care. Taking adequate vault smears (knowing which part of the vault to smear and ensuring that the 'corners' of the scar are adequately sampled) is not easy in primary care, so national advice is now that it should be done colposcopically.

Patients requiring vault smears should **not** be referred back to the GP for this at any stage; it is the responsibility of the gynaecologist to follow up his/her patient, whether this entails a single vault smear and discharge from screening, or smears every 6/12 months for 9 years or more. Patients with vaginal intraepithelial neoplasia (VaIN), should also really be under colposcopic management since vaginal cytology is very unreliable.

This change will probably reveal a number of women who have been having unnecessary vault smears as evidence of their value has changed. So if you have patients attending for vault smears we suggest you contact the gynaecologist for advice about future management.

SMALL ADS SMALL ADS SMALL ADS…….

Apologies: Due to enormous demand we have had to prune advertisements drastically this month

FULL TIME PARTNER: BRANNAN MEDICAL CENTRE, BARNSTAPLE From July 2010. 9 GP town centre forward thinking mixed PMS practice in modern purpose built premises. EMIS. High QoF Score. Job share considered. Long term commitment, clinical confidence and team worker required. Contact Dee Brown Tel 01271 329004 or email deebrown@nhs.net.
Closing Date is 26th March. Interviews w/e 17th April 2010.

PARTNER/SALARIED GP: LUSON SURGERY, WELLINGTON Half-time (4 sessions) In 3.25 FTE 5800 patient town/rural practice, with emphasis on personal care. Excellent staff and attached team community hospital beds. Paperlight EMIS, high QoF scores, no extended hours or OOH. Informal visits welcome. Contact Martin Ellacott 01823 662836 or martin.ellacott@luson.nhs.uk Interviews end March/early April.

SALARIED GP: WINCANTON HEALTH CENTRE Starting May 2010. Four partner 7,900 patient GMS practice in Wincanton. New premises planned for April 2011. Eight sessions required but happy to consider part time combinations. Salary negotiable according to experience. Informal visits welcome. Please contact Janet Loe 01963 435703 or email janet.loe@wincantonhc.nhs.uk.

SALARIED GP: PRESTON GROVE MEDICAL CENTRE 6 sessions p/w from April 2010 for 7 partner PMS/training/Emis 13000 patient practice in a recently extended modern health centre. Strong emphasis on quality, education and personal development. Salary at BMA rates.
Contact Karen Lashly 01935 474353 karen.lashly@prestongrovemc.nhs.uk.

HALF TIME PARTNER: CROWN MEDICAL CENTRE, TAUNTON 4 sessions a week in 5 WTE partner progressive GMS practice in modern purpose-built premises (no capital outlay) paperlight EMIS. High QoF scores. Share of extended hours. No OOH. 1 yr mutual assessment. Contact Claire Gregory 01823 282151 claire.gregory@crownmedicalcentre.nhs.uk.
Closing date 1st March, interviews anticipated 16th April.

LONG TERM LOCUM: VINE SURGERY, STREET 5 sessions for approx 6 months in 3 partner high achieving semi-rural PMS practice. Paperlight EMIS. Contact Dr Vriend or Dr Thomas 01458 841122 robert.vriend@vinesurgery.nhs.uk.

SHORT TERM LOCUM: CREWKERNE HEALTH CENTRE As soon as possible: 8 sessions p/w in 7 partner practice for 3 months. Familiarity with iSoft Synergy an advantage but not essential. Contact Mrs Louise Walker 01460 72435, louise.walker@crewkernehc.nhs.uk.

PRACTICE MANAGER: HIGHBRIDGE MEDICAL CENTRE Approx £40,000 p.a. subject to experience. Six-doctor PMS 14000 patient practice in purpose built premises, you will probably already be in a similar role within the NHS/private sector with a proven track record in business management and the leadership of staff.
Contact Chris Edwards 01278 764219 or chris.edwards@highbridgemc.nhs.uk. Closing date: 11th March Interviews: 18th March.

PART-TIME RECEPTIONIST: WARWICK HOUSE MEDICAL CENTRE 1 yr fixed term contract. Contact Jane Watts 01823 447374 jane.watts@warwickhousemc.nhs.uk. Closing date: 5th March.

TEMPORARY MEDICAL SECRETARY/ ADMINISTRATOR: HAMDON MEDICAL CENTRE 25hrs p/w. Closing date 5th March. Contact Kerrie Middleton 01935 822236. kerrie.middleton@hamdonmc.nhs.uk.

TXT FROM AN URBAN DOCTOR
"I Have To Appraise You Like I Should"

I've had this gnawing feeling inside me for the last 4 weeks. Why? Because I've received an email telling me that this quarter I have been selected to have my annual appraisal.

I mean, no way! No way was it 12 months since my last one. I remember the feeling of relief when I returned the pre-appraisal forms last year. But…… it *is* right.

What happened to all those promises I made to myself? I was going to keep a learning diary, but I didn't. I was going to create a file for all those talks and lectures I attended, but I didn't. I was going to write an analysis of my consultation style, but I didn't. I was going to make sure this year would not be as stressful as last year, but I haven't.

So now here I am, staring at a blank Word Document that I need to populate in order to prove to the world that I am keeping up to date. I need to show that I did not use up a much valued half day, spend £40 on lecture fees, and drive down to Exeter to fall asleep at the back of the hall. I know I read all those DOH updates, prescribing updates, Swine flu updates, updates of updates, but where is the evidence? All the continuing professional development talks at my surgery, I've been to nearly all of them, but there is no CCTV footage to prove it.

The actual appraisal itself is a useful experience and the appraisers are very supportive and helpful, but I'd rather perform cataract surgery on myself than fill in that blasted pre-appraisal form. The problem is, I've done it 7 times already and I really am running out of rubbish to write.

Commentary - what do you think are the main strengths and weaknesses of your clinical practice? Same as last year really, truth be told. But I can't write "same as last year" though, so I write some wishy-washy stuff that makes me cringe. I read it back to myself at the same time as reaching for the cyclizine.

How do you feel your relationships with patients have improved since your last appraisal? Oh I don't know! It's not GCSE results for goodness sake. Why must it improve every year? Ummm it's getting better because I'm using patient info leaflets. Phew! Thought of something.

And so it goes on. Every box filling me with pain and antipathy towards the whole process. And just when I'm really losing the will to live along comes another nail in my coffin.

What factors in your workplace(s) or more widely significantly constrain you in achieving what you aim for in your colleague relationships? I've managed a different answer 7 times but I'm really stumped this time. It's no good. I'm a complete blank. Oh, I'll dig out appraisal 2004 and copy that one. They won't notice!

At last! A sense of euphoria as I reach the end of the document. All my supporting paperwork is collected and sent off to my appraiser for his opinion. I pity the poor chap. But I do promise you one thing. Next year I'm going to be so prepared for the appraisal that all I have to do is just click one button on my computer and it is all done.
The views expressed in this column are those of the author and not necessarily those of the LMC

LANDS END TO JOHN O'GROATS FOR BRITISH PARALYMPICS

Drs Paul Denner and John Beaven from Essex House Medical Centre, Chard are undertaking the James Cracknell organised Ride Across Britain from John O'Groats to Land's End in June this year. There will be 9 days of cycling averaging 110 miles daily.

Paul has previously undertaken 4 international bicycle rides, for the National Deaf Childrens' Society and Cancer Research, but this is the first time he has encouraged one of his partners to "come along for the ride" (John is an active member of 1st Chard Wheeler cycling club) The R.A.B. is helping to raise funds for the British Paralympics, particularly with a view to 2012.

If anyone would be kind enough to consider donating to this worthy cause go to the Just Giving website (www.justgiving.com) and in the box labelled "sponsor a friend" put either "Paul Denner or John Beaven" and that will allow you to access "Paul and John's Page".

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