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RIDING A PUSHMI PULLYU?

Jeremy Hunt is not a stupid man. Far from it – he has a first in PPE from Oxford, speaks fluent Japanese and he built up (and sold very profitably), a successful PR company. So why is Government health policy going so horribly wrong? The answer, we think, is that it is trapped between two opposing and irresistible forces, and consequently is falling, perfectly balanced, into the void between the two.

On the one hand there is the electorate's assumption that the NHS will continue to be provided free at the point of delivery and funded out of general taxation. Fiddle with that and the Conservatives will disappear into oblivion at the next election as their voters switch to Labour or UKIP. On the other is the need to deal with the endlessly growing demand for all NHS services, at every level of care, whilst NHS resources remain the same.

There would seem to be only two possible responses to this. The Government could continue with the centralisation bit of its agenda, pull the NHS back into a full command and control system and hike up taxes to pay for it. Alternatively, they could push on with their commercialisation agenda objectives, contract out everything they can, make NHS Trusts fully autonomous, and open a real market in health care. But neither of these will be politically acceptable – certainly not to readers of our favourite right wing newspapers – and with less than two years until the next election Conservative political strategists must be getting anxious.

The result is the mess we find ourselves in. The reason why there seems to be no discernable policy direction in Government pronouncements is that there *isn't* a policy direction. Perhaps one cannot blame them for that when all the choices are invidious, and it may explain why GPs are at one and the same time the essential ingredient of the new NHS through their membership of CCGs , and at the same time the authors of all its misfortunes because they gave up out of hours.

But the problem with this political impasse is that the gap between NHS resources and public expectations just keeps getting bigger with an estimated savings requirements of £50bn by 2019-20. There is very little more efficiency to be squeezed out if any semblance of compassion is to be retained (remember that thing called the Francis report?) and with all services running hotter and hotter it is only a matter of time until something blows up spectacularly. Or, perhaps more likely, things begin to progressively degrade, work pressure becomes intolerable, and a growing number of staff vote with their feet and abandon the sinking ship.

The perception that everything in the Health Service is unstable may be why Somerset practices are having so much difficulty in recruiting experienced staff, especially GP partners. Young doctors are understandably wary about making a long term commitment when the future is so uncertain, but a salaried GP does not share in the planning and management burden of running a practice, so the pressure on the remaining partners rises just a little bit more.

We cannot offer any easy answers but it is clear that the squeeze on resources is going to last for many more years. Practices need to plan for the long haul, which means making the workload sustainable, and that, in turn, means anticipating that the demands of your contract and the new market that is growing around it will continue to increase. As profits fall it may be tempting to reduce your number of GPs and staff, but the risks in that course of action are considerable, and it is better to plan now for a fall in income over the next 2-3 years rather than assume that it will be possible to continue with the usual GP strategy of just working a bit harder to maintain your take home pay. After all, a Ford Fiesta will get you to work just as well as a Porsche.

GP LOCUMS & THE AGENCY WORKERS REGULATIONS

Adding another layer of complexity to the use of locums by practices

From small issues come potentially big problems. This is invariably true of employment law where the mixture of people – at times dissatisfied – and complex regulation can be explosive. And regulation does not come much more complex than the Agency Workers Regulations 2010.

The purpose of the regulations, which came into force on 1st October 2011, was to afford temporary workers engaged via an agency similar rights to their permanently employed counterparts. The difficulty has been that in doing so the legislation, which enacts European law, has created uncertainty where once there was certainty, and disharmony where there was once order. This is undoubtedly true when it comes to GP locums. The old certainty of engaging a locum via an agency and not being expected to offer that person any particular rights was swept away, and with it the harmonious relationship whereby practices knew precisely where they stood with respect to a locum agency.

So, what in summary do the Regulations say? For a start they provide "basic working and employment conditions for assigned temporary workers that are no less favourable than if they had been recruited directly by the hirer (you)" covering remuneration, paid holiday, working hours, overtime, maternity and anti-discrimination provisions and – certainly within the medical sphere it appears – pensions. The majority of these rights apply after the completion of a 12 week qualifying period, so you may be advised by a locum agency not to engage beyond 3 months. However, the Regulations contain pitfalls: amongst them the right of your locum to have access to "collective facilities and amenities" (including anything from the staff room to staff car parking and food and drinks machines) from Day One, and some rather interesting rules about periods of time which may or may not be included when calculating the 12 week period. Amongst the latter are the so-called "anti-avoidance provisions" aimed at preventing employers from deliberately curtailing assignments to avoid the legislation. Breach of these could cost you, your locum agency, or both, up to £5,000 in addition to the compensation awarded by an employment tribunal to an aggrieved locum.

As these Regulations only apply to workers supplied by a "temporary work agency", a locum agency is likely, in common with your practice, to be potentially liable for a breach of the right of locums to have the same basic working and employment conditions as direct recruits. Liability is not shared, however, but apportioned on the basis of fault. It is therefore important that practices understand the relationship which they have with an agency, can assess for themselves the liability associated with any locum taken on via a contract with an agency, and are clear as to the legal implications of their or the agency's actions.

This situation is complicated by agencies who contend that the Regulations do not apply to them contending that their locums are wholly self-employed and thereby excluded from the legislation. My advice on this is to always err on the side of caution. It is simply not worth being found liable. It follows therefore that unless you are prepared to act in complete accordance with the Regulations you must check any assurance by a locum agency that they are excluded. You should request a letter of comfort containing full details of the evidence on which they claim not to be caught and confirming that on such a basis you are unlikely to be caught either. Better still, if your agency is sure of its position then you should seek a written indemnity under which the agency – and not you – will be responsible for any breach of the Regulations. Whilst I suspect that no locum agency will be prepared to provide you with such a guarantee, at the very least you should retain your letter of comfort on file. Should an issue later arise over the rights of your locum you can use that letter as evidence before an employment tribunal that you are not the party principally at fault. Whilst this may not absolve you of all liability it will certainly help.

For more information on this or any other legal issue, the author, Adrian Poole, can be contacted on 01935 846802/adrian.poole@porterdodson.co.uk. Adrian is a partner of Porter Dodson LLP, specialises in employment law and routinely provides training to Practice Managers and GPs via the LMC.

CREMATION FORMS – WEST SOMERSET

Information from the Medical Referees

College Way Surgery GPs act as Medical Referees for Taunton Crematorium and have to check all cremation forms. We have had a few problems with the some forms recently leading to their being rejected. Please can we remind you of the following to avoid problems in the future.

1. Medical Practitioner signing form Cremation 4 (1st part) are expected to have seen the deceased both before and after death and to have spoken to the Medical Practitioner completing Form Cremation 5 (2nd part).
2. The Doctor completing Form Cremation 5 (2nd part) must have seen the deceased after death and is expected to answer in the affirmative at least one of the questions 2-5 on the form.

Full guidance on completing the cremation forms can be found at www.justice.gov.uk. *Guidance to medical practitioners completing forms 4 and 5.* If you have any problems in completing the forms queries can be addressed to any of the GPs at College Way.

Dear Editor

Unscheduled Care in Somerset

I am grateful to the LMC for giving me the opportunity to respond to the leading article of your June Newsletter. It is a timely debate and - as demonstrated by the two examples, - this is not an easy knot to unpick.

At the heart of both anecdotes appears to have been a patient who did not fit neatly into an available pathway. The first seems to have had no requirement for medical treatment, but required social support, falls prevention and safe passage home. Given her contact with the Piper service on 49 occasions and her four previous admissions, it would appear that multiple opportunities to prevent this admission had been missed, which indicates one possible focus for attention. Community hospital beds are commissioned for treatment and rehabilitation, so admission was not appropriate, whether or not a bed was available.

The second case neatly demonstrates one of the problems that lies at the heart of unscheduled care: the unrealistic expectation that Community Hospitals can act as second line DGHs with a fraction of the resources. The current differential between DGH facilities and those of Community Hospitals in terms of diagnostics services, full time medical cover, access to specialist opinions and the complement of backup nursing staff that can be called upon, is immense.

Whilst it may seem superficially appropriate to admit a patient to a community hospital in these cases, put yourself in the position of the admitting doctor, most likely one of your GP colleagues. Without any additional diagnostic facilities or familiarity with the patient, you are asking him or her to take on the risk of diagnosis and treatment. Presumably the patient had already had their urine tested and as examination was recorded as unremarkable, what clues were available for the poor recipient GP? I shall not speculate here on diagnostic possibilities.

Somerset Primary Link and the Hospital Matrons are not acting to frustrate GPs, as most of you will acknowledge, SPL in particular are now an essential part of the working GPs toolkit. What they are trying to do is assess, given the facilities and staffing available at the different community hospitals, whether it is safe and appropriate to admit.

Applying the friends and family test, I have to ask, in this case, would you really send your nearest and dearest to a community hospital bed as your first choice, without them having been through a diagnostic unit first?

Solutions to these problems do exist. Reducing silo-working between health and social care, improving communication, acknowledging the need for 24 hour, 7 day services and investment in bringing services into the community by investing in diagnostic facilities and community specialists would be a start. With increasing pressure on Primary Care it is also essential that warning signs are acted upon, so that a crisis is prevented. Finding tools that identify these at-risk patients and having the resources available to provide adequate home support is going to be a challenge, but not impossible given the will to redesign services.

Somerset Partnership has demonstrated in mental health services that for every pound invested in community services three can be disinvested from inpatient services. There has to be a will to strengthen community medical services to allow disinvestment and promote innovative re-design. Somerset CCG has initiated a review of future community services in Somerset, which should be welcomed. As GPs this is your opportunity through federations to really influence change and promote innovation in how future services are provided. We need to get away from the idea of hospitals being defined in terms of beds, instead considering them as hubs for services which are provided for the convenience of patients, with the primary aim being to prevent admission. Moving investment from a reactive to a preventative service has long been a goal for enlightened primary care, but has lacked the support of government. With GPs holding the reins of CCGs, perhaps this is finally an idea whose time has come.

Andrew Dayani
Medical Director, Somerset Partnership

See disclaimer on page 4.

Dr Whimsy's Casebook: Access

It's Friday morning. One of our busy receptionists, Miss Ferlexis, answers the telephone.

AF: Sunnyside Surgery. Hello, I'm Anna. How can I help?

Mr M: Hello, my name's Mudd. I'd like an appointment with Dr Whimsy at 10:30 on Monday morning please.

AF: [giggles]

Mr M: I'm sorry – is that funny?

AF: Forgive me, Mr Mudd, the idea of having the appointment you want is so sweet. Dr Whimsy doesn't have any free appointments at all on Monday, let alone one at 10:30.

Mr M: May I ask why?

AF: Certainly.

Mr M: [pause] Well?

AF: Well what?

Mr M: Are you going to tell me why?

AF: I'm waiting for you to ask. Would you like me to tell you?

Mr M: [sighs] Yes please.

AF: I'm sorry, that information is confidential.

Mr M: Why?

AF: The doctors don't like us to tell patients when they're on leave in case they get burgled... oops.

Mr M: I take it he's on holiday then.

AF: Just a long weekend. He's back on Tuesday.

Mr M: So I've got the weekend to ransack his house. Please let me have an appointment on Tuesday morning then.

AF: I'm sorry, Mr Mudd, he's with the CCG all day Tuesday.

Mr M: What's the CCG?

AF: The Clinical Commissioning Group. It's the government's idea to save money by sacking the regional administrators and getting the GPs to run the health service for them. He has a locum that day if you'd like to see her.

Mr M: Dr Whimsy's been my doctor for years, and I want to see him. He and my prostate go back a long way. Besides, the government says I can see who I choose. How about Wednesday?

AF: That's his day off.

Mr M: He hasn't had a day on yet. Thursday?

AF: The morning's not good, I'm afraid. He's on the Federation committee.

Mr M: Federation?

AF: They provide local support and facilities. Really nice people – you wouldn't want to be without them. Amazingly nice. Lovely.

Mr M: Thursday afternoon?

AF: LMC.

Mr M: Of course. An exceptionally fine team, good looking, too. Some of them. How's Friday?

AF: Sorry, a postgraduate education meeting all day – the doctors have to keep up with new developments in medicine, you know.

Mr M: Not that they have time to put them into practice. That takes us to Monday week.

AF: Let's have a look. That Monday morning he's at the County-wide Medicines Management meeting...

Mr M: Oh, for Pete's sake...

AF: ...then in the afternoon he's reporting to the Federation Medicines Management meeting.

Mr M: [weak voice] Tuesday?

AF: Well, early on Tuesday he's teaching, then there's a Significant Event meeting for the rest of the morning.

Mr M: What's a Significant Event meeting?

AF: That's another government requirement, where they all discuss unusual cases and patient complaints.

Mr M: What sort of complaints?

AF: Mainly people who can't get appointments.

Mr M: You don't say. Wednesday's his day off again. Thursday's out, I suppose?

AF: 'Fraid so.

Mr M: Because...?

AF: QOF inspection.

Mr M: QOF?

AF: Don't let me ruin your day.

Mr M: OK, let's have a laugh then: tell me why he can't see me that Friday.

AF: Business meeting, Care Quality Commission inspection, meetings with the practice accountant, the protection society solicitors, the multidisciplinary team...

Mr M: STOP! Please – no more. When can he see me?

AF: As it happens, the following Monday morning's good. That's what you wanted, isn't it?

Mr M: Give or take a fortnight. I might be better or dead by then. But quick – what have you got?

AF: 10:30, just like you asked. Oh no, it's just gone to another patient who can't see their own GP. I'll give you 10:40. Make the most of it though: mornings will be more difficult in the future.

Mr M: More difficult? How's could that be?

AF: Well, when he's forced to do out-of-hours again he'll need the morning to recover.

This column is written for humour and does not necessarily represent the views of the author, his/her practice, or the LMC.

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