

## I say I say I say !

A number of deliberative, or 'listening', events are taking place as part of the consultation process on community health and social care services. Between 50 and 100 people (selected from the electoral roll) will give their views on what they want from services in their everyday lives.

DH and the consultation partner Opinion Leader Research (OLR) will run four regional events around the country. The event in Gateshead has already taken place. During the debate, people voted on a range of ideas and discussed why they had made certain choices. Most of those taking part thought a routine health MOT might be a good option, for example. One table suggested awareness programmes would help people understand which services are available, and how they could get access to them. Around 1000 people will take part in a national event on 29 October. Other events will also be run by NHS, local government and voluntary organisations locally.

Anyone else who wants to contribute to Your health, your care, your say can do so in the online survey which is on the Department of Health website <http://www.dh.gov.uk/Home/fs/en> (Click online questionnaire under Your Health Your Care Your Say). The questionnaire asks whether the following would be a big improvement – GP surgeries opening earlier in the morning, later in the evening, and on Saturday mornings, whether patients should be able to register with a GP anywhere.

Please have a look at the questionnaire – it would be interesting for the Government to have the opinions of GPs as well as patients!

## Sex in the surgery

The RCGP Sex, Drugs and HIV Task Group invites you to the 2nd National Conference on Sexual Health and Contraception in General practice.

Date: 15 November 2005

Venue: The Royal College of Physicians, Regents Park, London.

For details [emailshoc@gp-e84025.nhs.uk](mailto:emailshoc@gp-e84025.nhs.uk)

## Is your Partnership Agreement up to date?

Since the advent of the new GMS contract it is even more vital to ensure that partnership agreements are kept up to date. If they are not up to date, and therefore not valid, the partnership will effectively be operating as a 'partnership at will' which could be dissolved at any time by any of the partners. The GMS regulations (paragraph 86, schedule 6) provide for continuation of GMS contracts as rolling contracts with partners free to come and go, subject to the PCTs being informed. However, if a practice is operating as a 'partnership at will' and the partnership is dissolved the GMS contract would end and the PCT could offer the contract to another party.

Other side effects of the dissolution of a 'partnership at will' are: staff would automatically be made redundant; there would be no restrictive covenants in force; assets would have to be put up for sale; and no party could use the existing name or telephone number of the old partnership.

Partnership agreements now need to take account of a number of issues raised by the new contract, these would apply equally to both GMS and PMS practices. These issues include: the treatment of late receipts and profits out of period eg QOF aspiration/achievement payments; partners leaving in year; the need to bring private earnings into account for expenses calculations; and how to deal with the variety of partnership options eg fixed share partners and non-GP partners.

If you need help or advice on Partnership Agreements please let us know.

The above article (in a slightly different form) originally appeared in the Trent LMCs Buying Group Newsletter produced by Chris Locke at Nottingham LMC. We felt it worthy of repetition for those of you who may not have seen it.



## Temporary residents

Following the introduction of the new GMS contract concerns have been expressed that some practices may be routinely refusing to see patients as temporary residents. Although there are no longer Item of Service payments for seeing temporary residents, practices are reminded that their global sum (GMS) or contract price (PMS) includes a payment to reflect their historic average temporary resident activity.

A patient asking for an appointment as a temporary resident should be triaged (or not) in exactly the same way as patients who are registered with the practice and an appropriate appointment should be offered within the same time scale as would be offered to a registered patient. Clearly, if the patient is unhappy with the timing of the appointment he is offered he may choose to shop around other practices. Practices which are not formally 'closed' or which have not notified their PCT that they are 'open but full' could well be open to criticism from the GMC if they fail to offer appointments to temporary residents. There is an expectation that even practices that are closed or open but full will accommodate temporary residents who are staying in the same household as patients on their list.

In areas of particular difficulty with capacity it might be worth local practices getting together to work out strategies for coping with temporary residents. The LMC would be happy to facilitate such discussions and the PCTs could also become involved if necessary.

## Primary Care Development Scheme (PCDS)

The PCDS replaces the "Golden Hello" payment which ceased on 31 March 2005. The new scheme is designed to allocate specific funding to under-doctored areas to help improve recruitment.

The LMC is seeking to identify the under-doctored areas within Derbyshire and has asked all practice managers to provide the LMC with information about numbers of WTE doctors, vacancies for doctors and nurses over Grade F, and doctors aged over 55. We have received information from about half of the practices in Derbyshire but are conscious of the fact that we may not have heard from those practices who are most overworked and stressed. We need information from these practices also in order to put forward a good case for attracting this funding into Derbyshire.

## Medical records

Some practices are sending incomplete medical records on to the next practice when a patient transfers. This usually means that practices don't print and forward letters and other reports that are often scanned and "attached" to the GP electronic patient record (EPR).

Sometimes the incompleteness is highlighted by a note advertising that the records are "available on request" but other times the gaps in the record are only obvious when the records are under review (e.g. for a medical report). The Joint GP IT committee would like to remind practices that they are required to forward the complete medical record when requested to do so by their PCT. However, fully summarised "paper-light" records will generally be sufficient, providing they have been carefully examined to ensure that no important patient details have been omitted. Practices are reminded that it is their duty to ensure that all scanned letters and supporting documentation are explicitly linked in the appropriate place within the patient's records, to ensure that vital information is transferred safely and efficiently and that context is maintained.

## Immunisation of students

GPs are frequently asked to provide Hep B immunisation for medical students before they start their courses. Medical Schools should not use the good will of GPs to avoid taking proper responsibility for managing the very real and serious risk of infection. Medical Schools should be providing an effective occupational service that provides the full range of risk reduction procedures. If a GP gives a Hep B immunisation he may well be providing a false sense of security which could place students at increased risk of HIV, Hep C, etc. GPs would be colluding with the failure of Medical Schools to take full responsibility for managing the risks involved effectively if they go along with part provision of occupational health care.

## How to contact us

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