CHARTERED ACCOUNTANTS, TAX CONSULTANTS & FINANCIAL PLANNERS

ALBERT GOODMAN

PRACTICE NEWS SEPTEMBER 2016

Welcome to the latest issue of the Albert Goodman e-Update specifically for medical practices.

If you have any feedback on the contents of this newsletter, or would like to discuss how this may affect your practice please click on the feedback link. Likewise, if you are not a client of ours and would like to see if we are the right team for you please forward Keith Miller, our medical practice specialist, your details who will be delighted to get in touch for an informal chat.

Thank you for taking the time to read this newsletter.

Keith Miller
keith.miller@albertgoodman.co.uk
01935 423667

CONTENTS

NEW FRAUD WARNING TO GPS

GPs are being warned that with editing software now freely available online it is becoming easier for their signatures and official documents to be forged.

Writing in the latest MDU Journal, medico-legal adviser Dr Ellie Mein said the MDU had supported members with cases ranging from forged prescriptions and genuine sick notes that have been altered to prolong the duration of the patient's sick leave, through to more elaborate letters that have been created entirely from scratch.

She said: 'There are even various sites online that offer advice on how to convincingly forge a sick note or that allow you to buy replica NHS sick notes.'

In one case, a GP received a phone call from the local university asking for clarification on a letter apparently signed by the GP. It appeared to support a student in extending a coursework deadline due to ill health.

But the GP did not recall signing the letter and did not recognise the circumstances described.

A review of the patient's notes showed the person had not been seen for at least two years and although the letter was written on paper with the practice letter head on it, the signature was similar, but not identical, to the GP's.

Dr Mein continued: 'In situations where a document is entirely fake, or an original has been altered and a doctor is asked to comment on its authenticity by an external organisation, the MDU advises that it's not a breach of confidentiality if you simply confirm that you didn't create the document, or that any altered documents aren't as they were when you originally signed them.

'However, no other information should be given about whether the patient is actually registered at the practice or comments made about whether the medical information is correct.'

Dr Mein said that when faced with seemingly fraudulent documents doctors often feel understandably aggrieved and ask if they should involve the police or remove the patient from the practice list.

'But although you might be left feeling that there's been a breach of trust, removing the patient from the list without a prior warning could leave the practice vulnerable to criticism. The GMC also has guidance on ending your professional relationship with patients. Bearing this guidance in mind, it is often helpful to ask the patient in to discuss the letter or form in question and to make a judgment after that discussion as to the best way forward.'

Top of page

SENIOR DOCTORS URGE GOVERNMENT TO SOLVE JUNIOR CRISIS

Senior doctors today stepped in to the junior doctors' strike debate by calling on the Government and Prime Minister to bring all parties back together to facilitate a solution.

Prof Derek Bell, president of the Royal College of Physicians of Edinburgh, urged for a negotiated solution to the dispute over the junior contract in England – and he was backed by Dr Katherine Walesby, chair of the physicians trainees' committee.

He said: 'We need to restore stability in the junior doctor workforce in England not create further uncertainty.

'An ongoing dispute is in no-one's interests and the potential impact on our patients, the NHS workforce and the long term sustainability of the NHS is profound.'

NHS Employers expressed shock and sadness that the BMA Council supported the call from the Junior Doctors Committee for further industrial action despite the BMA agreeing a deal with Employers and the Government in May.

It said: 'The proposed action is extreme in its scale and timing and shows scant regard for patients, nor to their colleagues who will have to work under even greater pressure when this industrial action goes ahead.

'Trusts will be working hard to minimise disruption, but many thousands of operations and appointments will need to be cancelled or rearranged causing distress, delay and pain to our patients.'

Junior doctors will stage a full withdrawal of labour for five days, between the hours of 8am and 5pm from Monday 12 September – Friday 16 September inclusive, followed by further dates to be confirmed.

This follows a vote by junior doctors in July to reject the proposed contract.

The BMA claimed it had made repeated attempts over the past two months to work constructively with the Government to address the outstanding areas of concern.

It said: 'Despite this, the Government is refusing to acknowledge junior doctors' concerns and is continuing with plans to impose the contract in October.'

Key concerns raised by junior doctors include the impact that the contract will have on those working less than full time, a majority of whom are women, and the impact it will have on junior doctors working the most weekends, typically in specialties where there is already a shortage of doctors.

The Government has said that a new contract is needed to deliver more seven-day services but the doctors argue that the Department of Health's own documents show that the NHS does not have a plan as to how it will staff or fund further seven-day services.

The BMA wants the Government to lift the imposition and' restart meaningful talks.'

Dr Ellen McCourt, BMA junior doctors' committee chair, said: 'Genuine efforts to resolve the dispute through talks have been met with an unwillingness to engage and, at times, deafening silence from the Secretary of State, leaving junior doctors with no choice but to take further action. This is despite a pledge from Jeremy Hunt that his door is always open.'

She added: 'This is not a situation junior doctors wanted to find themselves in. We want to resolve this dispute through talks, but in forcing through a contract that junior doctors have rejected and which they don't believe is good for their patients or themselves, the Government has left them with no other choice.'

Top of page

GMC SAYS SCALE OF JUNIOR ACTION CANNOT BE JUSTIFIED

The GMC has warned that the scale of industrial action contemplated by junior doctors cannot be justified and it has urged them to pause and consider the possible implications for patients.

It said they should think about the impact not only in terms of the immediate action but also in terms of the cumulative impact on patients, the additional risk posed by the withdrawal of emergency cover and the effect of removing all doctors in training every day for five days every month.

'This will mean the cancellation of tens of thousands of operations and procedures, outpatient appointments and tests. The GMC cannot second guess the situation facing each doctor in training in England – that must be a matter for individual judgement. But given the scale and repeated nature of what is proposed, we believe that, despite everyone's best efforts, patients will suffer. In light of this, the right option may be not to take action that results in the withdrawal of services for patients.'

GMC chair Prof Terence Stephenson said the Council recognised the frustration of doctors in training and their legal right to take industrial action.

But it was extremely concerned about the impact which a prolonged campaign of industrial action would have on patients' care and on the public's trust in doctors.

In a statement today he warned: 'The further action announced by the BMA will inevitably add to the cumulative impact of past industrial action on patients' care.

'Further, the BMA's announcement marks a substantial escalation of the previous industrial action in that it involves: the removal of emergency care (as well as routine appointments); a rolling programme of action of indefinite duration; the removal of junior doctors' services for five days of each month (rather than one-off days of action); and much

shorter notice to NHS employers of the first bout of action which leaves little time to prepare.

‘The health service is under huge pressure. During previous industrial action all doctors went to considerable lengths to make sure that patients continued to receive a good and safe level of care. We know that doctors will again want to do their utmost to reduce the risk of harm and suffering to patients. However, for the reasons given above, it is hard to see how this can be avoided this time around.

‘To suggest otherwise would be a disservice to the enormous contribution made by doctors in training to the care and treatment of NHS patients every day. We therefore do not believe that the scale of action planned at such short notice can be justified and we are now calling on every doctor in training to pause and consider the implications for patients.’

The GMC expressed the hope that the Government and the BMA would resume talks.

GMC chief executive Niall Dickson, Chief Executive and Registrar, has set out the latest GMC advice for doctors. It covers those contemplating industrial action as well as doctors in leadership roles, senior doctors and those not in training.

Niall Dickson said the question each doctor must ask before taking action was whether what they proposed was likely to cause significant harm to patients under their care or who otherwise would have come under their care. ‘This is a matter of professional duty and we expect each doctor to comply with it.’

ADVICE TO DOCTORS

The GMC gave the following advice:

‘ADVICE FOR DOCTORS CONTEMPLATING INDUSTRIAL ACTION

We ask every doctor contemplating further and escalated industrial action to pause and consider the possible implications for patients. Not only in terms of the immediate action but also in terms of the cumulative impact on patients, the additional risk posed by the withdrawal of emergency cover and the effect of removing all doctors in training every day for five days every month.

This will mean the cancellation of tens of thousands of operations and procedures, outpatient appointments and tests. The GMC cannot second guess the situation facing each doctor in training in England – that must be a matter for individual judgement. But given the scale and repeated nature of what is proposed, we believe that, despite everyone’s best efforts, patients will suffer. In light of this, the right option may be not to take action that results in the withdrawal of services for patients.

Any doctor who does decide to take action must take reasonable steps to satisfy themselves about the arrangements being made during the period when they are withdrawing their labour. This means making sure that senior doctors and managers have enough time to make alternative arrangements – action without warning or with inadequate warning is not acceptable. They should engage constructively and at an early stage with those planning for the care of patients during industrial action to make sure that patients are protected. They have a responsibility for continuity and co-ordination of care, and for the safe transfer of patients between different teams.

If, during the industrial action, it becomes clear that patients are at risk in a local area because of inadequate medical cover, and doctors in training are asked in good faith to return to work by employers, we expect they would fulfil this request. In the event of an emergency, we know doctors in training will always come forward. Where contingency plans are overwhelmed, it is vital that doctors taking action can be contacted and are available to help.

ADVICE FOR DOCTORS IN LEADERSHIP ROLES

Doctors in leadership positions should do everything possible to organise services during the industrial action to make sure that patients are protected, as they have done during the action to date. They should assist employers, who will have been preparing for this action and putting in place other options for emergency care.

Although hospitals will inevitably face increased pressure during any period of industrial action, doctors in leadership positions should only call doctors in training back to work where there are genuine and significant concerns about the ability of the hospital to provide safe care to patients.

Doctors who have a management role or responsibility must support their organisations in acting immediately on any patient safety concerns.

Doctors in leadership roles should encourage an open, respectful culture and take action about any concerns about bullying raised with them, including online harassment.

ADVICE FOR SENIOR DOCTORS AND THOSE NOT IN TRAINING

Senior doctors and those not involved in the dispute should continue to provide medical care during the industrial action and, as far as is possible, make sure that patients are protected, where necessary providing cover in place of those taking action. They should assist employers and clinical managers who will have been preparing for this action and putting in place other options for emergency care.

ADVICE FOR EMPLOYERS

The GMC does not regulate employers but we would expect them to engage with their medical workforce to develop robust plans that protect emergency services and minimise the impact on patients. Where there are concerns about the capacity of the organisation to cope, these concerns should be raised at the earliest opportunity with doctors, including those taking action.

Employers are required to meet our standards in relation to doctors in training. In particular, they should make sure that doctors are supported in the learning environment and given appropriate clinical supervision, including during a period of industrial action.

During the industrial action, concerns have been expressed about the design of rotas for doctors in training. We would therefore remind employers, who will be working hard to make sure patients continue to receive safe, high quality care during the action, that our new standards for medical education and training – Promoting Excellence – require organisations to design rotas that make sure doctors in training have appropriate clinical supervision and minimise the adverse effects of fatigue and workload. Where there are concerns, we expect postgraduate deans to address these with their local NHS Trusts or GP surgeries.'

Top of page

BMA SUSPENDS INDUSTRIAL ACTION

The BMA is suspending next week's planned industrial action.

But it said future dates planned for October, November and December will still go ahead, unless the Government calls off its plans to impose a contract that has been rejected by junior doctors.

The BMA said while it had provided more than the legally required seven days' notice ahead of industrial action, NHS England had said that it needed more time to plan for escalated action.

Dr Ellen McCourt, BMA junior doctor committee chair, claimed: 'Patient safety remains doctors' primary concern which is why, following discussions with NHS England, the BMA has taken the decision to suspend next week's industrial action.

'While the BMA provided more than the required notice, we have taken this decision to ensure the NHS has the necessary time to prepare and to put in place contingency plans to protect patient safety.'

Top of page

NEW WORKLOAD RESOURCES FOR GPS

The GPC has issued new resources for GPs to help them reduce unnecessary workload from secondary care providers.

This follows the failure of many NHS managers to introduce agreed changes to the standard contract.

After lobbying by the BMA as part of its Urgent Prescription for General Practice campaign, NHS England agreed to make a series of changes to the standard contract this year that governs the relationship between GP practices and NHS secondary care providers.

This included:

- Ensuring secondary care providers take responsibility for rearranging appointments with patients who miss clinical appointments. Previously these patients were sent back to their GP for a re-referral, wasting valuable GP appointments.
- A commitment that hospitals would communicate test results requested by hospital clinicians directly to the patient, so that patients no longer have to make appointments with GPs to chase up these results.
- Enabling hospitals to make direct onward referrals to other services for a related condition, rather than ask patients to see their GP to make a fresh referral.

But despite these changes, the GPC said feedback from GPs suggests they have not been implemented in many parts of the country.

GPC chair Dr Chaand Nagpaul said: 'Following sustained lobbying from the BMA, the NHS standard contract for secondary care trusts was changed during recent negotiations to ensure systems are in place to prevent unnecessary workload being diverted to GPs that could and should be handled by secondary care providers.

'NHS England estimates that around 15m appointments are wasted because GPs are forced to carry out unnecessary administration like those caused by these issues with the standard contract.

'Despite these new requirements, it is clear many NHS providers are not implementing these changes. The BMA has already ensured NHS England issued an instruction to managers reminding them of their responsibilities. However, alongside this the BMA is providing GP practices with template letters to redirect inappropriate demands back to hospitals to fulfil their contractual obligations.

'Practices will also have templates to inform their CCG of any breach of the standard contract, as they have a statutory responsibility to ensure providers comply with their contractual terms. These new resources will also help reduce work and bureaucracy for hospitals themselves, by ending the reprocessing of new referrals when patients miss a clinic appointment

Dr Nagpaul said given the enormous pressures on general practice, there needed to be an end to the 'scandalous situation' where thousands of patients see a GP purely for the bureaucratic purpose of re-referring after a missed hospital appointment.

It was a waste of precious resources, and was directly denying patients access to GP services. 'We must use GP appointments for medical reasons, and liberate time for GPs and their staff to care for patients.'

Top of page

NEW GP NEGOTIATING TEAM

The GPC in England has a new English GP executive team for the next two years.

Joining GPC chair Dr Chaand Nagpaul, will be Dr Richard Vautrey, who has been reappointed as the committee's deputy chairman, alongside Dr Mark Sanford-Wood and Dr Gavin Ralston.

Dr Nagpaul said the team would provide strategic leadership and work with a range of policy leads as part of wider reforms within the BMA's GPC.

'This will include closer working with Local Medial Committees to deliver on the priorities of our recent Urgent Prescription for General Practice and the Government's recently announced GP Forward View.'

Dr Richard Vautrey, a GP in Leeds, has been a member of the executive team since 2004.

Dr Mark-Sanford Wood is a GP locum from Devon, and has been on the GPC since 2011

Dr Gavin Ralston is a GP from Birmingham and has been serving as the chairman of NHS Birmingham's Cross City Clinical Commissioning Group.

He said: 'General practice and indeed the NHS as a whole is at a crossroads and now more than ever we need to make certain that general practice has a strong voice. I am really pleased to be taking up this role and looking forward to using my experience both as a GP and a commissioner to ensure that general practice thrives and not just survives, which is a necessity for the NHS as a whole to work well for patients.'

Top of page

GP FINANCES AND PATIENTS 'SUFFERING FROM CAPITA'

GP leaders have warned that patient safety is being compromised by multiple failures in back office support services currently run by Capita.

The alert comes after a qualitative survey by the BMA of LMCs revealed serious failures in a range of areas Capita is now responsible for as part of its contract with NHS England to run Primary Care Support (PCS) services.

The GPC said this included:

- Serious problems with the management of patient records, including:
  - Long delays in collection/delivery of records when patients transfer from one practice to another.
  - Failure to process urgent requests for records in a timely manner if the patients has an immediate emergency.
  - Large build-ups of records awaiting transfer to a new practice.
  - Wrong records delivered to practices resulting in time wasted by the GP attempting to reroute them.
  - Records not being updated so they often appear with patient's previous addresses on the records.
- Delays in providing funding for GP trainees, resulting in many practices having to fund their salaries from their own overstretched budgets.
- Failures in maintaining supplies to GP practices, including GP practices suffering shortages of key materials like prescription pads, fit note certificates and syringes.
- Delays, failures and mistakes in ensuring NHS pension payments are properly recorded for GP locums.

GPC chair Dr Chaand Nagpaul said: 'Clear evidence is emerging that there are a range of systematic and endemic failures in the way Capita are running crucial back office support services in general practice.

'Local GPs are reporting to the BMA that they are facing unacceptable delays in patient record transfers and mistakes in maintaining supplies of crucial medical equipment, like syringes and even prescription paper. Many GP practices are also not getting funding transferred correctly from other NHS bodies to cover staff costs and pensions, which means they are having to dip into on their already stretched budgets to cover these costs.

'These mistakes are directly impacting on the ability of many GPs to provide safe, effective care to their patients. They are in some cases being left without the essential information they need to know about a new patient and the tools to treat them.'

The GPC leader said NHS England was ultimately responsible for the 'chaos' caused by trying to cut the cost of this essential service for practices by privatising it.

He has written to NHS England expressing grave concern about the issue and has received an apology for these failures.

But he added that urgent action was needed to correct these shortcomings before patient care was further compromised.

Top of page

LATEST GP EARNINGS FIGURES NOW OUT

Latest official figures for GPs' earnings are now available in full on the NHS Digital website.

They show that for 2014-15, the average taxable income for combined GPs (contractor and salaried) working in either a General Medical Services or a Primary Medical Services practice (GPMS) in the UK was £90,600. This compares to £90,200 in 2013-14 and is an increase of 0.4 per cent.

Contractor GPs working under a GMS or PMS (GPMS) contract had an average taxable income of £101,500 in 2014-15.

This is a rise of 1.7 per cent on their taxable income of £99,800 in 2013-14, which is statistically significant.

When considered by contract type:

- GPs working under a General Medical Services contract (GMS) had an average taxable income of £98,000 compared to £96,000 in 2013-14, which is a statistically significant increase of 2.1 per cent.
- GPs working under a Primary Medical Services (PMS) contract had an average taxable income of £108,000 compared to £106,800 in 2013-14, an increase of 1.2 per cent, which is not statistically significant.

The average taxable income for GMS or PMS (GPMS) salaried GPs in the UK in 2014-15 was £53,600, compared to £54,600 in 2013-14. This is a decrease of 1.7 per cent, which is statistically significant.

Top of page

GP PARTNERS GET ADVICE ON DEALING WITH BURNTOUT COLLEAGUES

GPs have been urged to attend to four key issues if their partners suffer burnout, a growing problem for GPs.

These are:

- Fulfilling obligations under the core medical services contract.
- Partnership obligations as defined in the partnership agreement
- Disability discrimination and
- Professional conduct, including patient safety.

Solicitor Daphne Robertson, of DR Solicitors, says an important consideration when a partner is unwell is the implication for the GMS/PMS/APMS contract.

She warned GPs in her blog: 'If you seek to terminate the relationship by dissolving the partnership, you risk terminating your contract too, so it is critical to follow procedures for retirement (link to retirement checklist post) set out in a valid partnership agreement. In the current environment, dissolution would almost certainly lead to your contract being re-tendered, possibly even the possible closure of the practice. You could also be sued for breach of contract. Her company is advising practices to check the partnership agreement takes account of the consequences of burnout, because the problem is growing.

Partnership obligations If the stressed partner does not seek treatment, or their condition continues or worsens, then GPs are urged to consider their rights and obligations as defined in the partnership agreement. Ms Robertson said: 'At the outset, when faced with a partner suffering from stress, you should be wary of relying on any provisions in the partnership agreement allowing for compulsory retirement due to absence or a failure to carry out duties. You should first establish whether the partner in question has a disability and what steps might be taken to limit liability in this regard.' An appropriate independent expert (not the partner's GP) should examine the partner, and provide a report that sets out:

- A diagnosis;
- The condition's effect on the partner's ability to carry out their duties;
- A prognosis;
- The steps that might reasonably be taken to assist the partner.

She went on: ‘An independent health report may recommend that a partner take periods of rest and then return to work in a phased manner. A failure to allow for this, even if a threshold set out in the partnership deed providing for compulsory retirement after a given period of absence is crossed, or a provision requiring that all duties are carried out is breached, could give rise to a claim under the Equality Act for failing to make reasonable adjustments to allow for the partner to remain engaged ‘If a medical report provides evidence that supports a retirement on ill-health grounds, the partners may discuss the possibility of voluntary retirement. In situations where this is not agreed and legal advice has been sought to confirm that compulsory retirement would not constitute unlawful discrimination, then the partners would wish to rely on a provision allowing for compulsory retirement after prolonged absence.

‘It is common to allow for compulsory retirement after a period of absence of between nine and 12 months. Practices with partnership agreements that do not include such clauses will be unable to retire a partner in this situation.’ She added that compulsory retirement could lead to a partnership dispute, notwithstanding the provisions of the partnership agreement. A well-drafted partnership deed would include provisions allowing for dispute resolution.

DISABILITY DISCRIMINATION

Ms Robertson advised: ‘If stress results in a partner being unable to carry out their work properly on a long term basis, an Employment Tribunal may decide that the partner is suffering from a disability within the meaning of the Equality Act 2010. ‘The Equality Act says that dismissing someone or subjecting them to some other detriment because they have a disability, or otherwise failing to make reasonable adjustments to allow that person to remain engaged, gives rise to unlimited liability for disability discrimination. ‘GPs are usually aware that the Equality Act protects partners as well as employees. They can then bring or threaten disability discrimination claims where they feel that their colleagues have forced their retirement because of stress related illness or are trying to engineer their removal for this reason. ‘As set out below, appropriate support should be provided to any partner who is suffering from stress. This will prevent their condition becoming a disability and/or limit liability for discrimination, should it become necessary to terminate their engagement.’ Patient safety GPs with concerns about a colleague’s condition and patient safety must act in accordance with their obligations to safeguard patients and the GMC guidance on Good Medical Practice.

This states they must ask for advice from a colleague (such as another partner or GP at the LMC), their defence body or the GMC. If still concerned they must report the matter in line with GMC guidance. Ms Robertson said all practices should have a properly drafted whistleblowing policy.

Any report should be carefully documented in case your actions are later alleged to be discriminatory or you are accused of acting in bad faith towards your partner. Providing there were no concerns about patient care, in the first instance the troubled partner should see their own GP or otherwise seek specialist professional guidance.

She said it would be appropriate for the senior partner colleague who has responsibility for HR issues to address such matters informally (but confidentially) with the individual, keeping themselves appraised as to progress made. *Further information from Daphne Robertson on 01483 511555 or **d.robertson@drsolicitors.com**

Top of page

GPS’ INDEMNITY COSTS: NEW PLEA FOR ACTION

A defence body is urging the Treasury to take urgent action to address the clinical negligence crisis and give respite for GPs from indemnity costs.

In a submission ahead of the Budget and autumn statement, the MDU called on the Treasury to commit to a ‘radical intervention’ to stop rocketing compensation costs.

Dr Michael Devlin, the union’s head of professional standards and liaison said the clinical negligence crisis was putting a strain on the NHS by diverting funds that should be used for all NHS patients.

The ‘toxic claims climate’ was also affecting GPs directly as their indemnity subscriptions were increasing at rates higher than wage or house inflation.

Said Dr Devlin: 'The MDU has seen clinical negligence claims inflation rise steadily at a rate of around 10% for several years. In the last three years alone, the MDU has paid out over £100m for high value claims over £1m involving GPs and private practitioners.

'Clinical standards remain high but this rampant claims inflation is largely a result of legal and economic factors. That's why we are stepping in and asking the Treasury, as part of its Budget commitments to give an undertaking to urgently address the outdated legal system.'

He said the MDU understood GPs' frustration as they were not responsible for the rising costs of claims and had no control over them.

'The Department of Health review of GP indemnity has recognised that rising indemnity costs could 'act as a break on willingness' of GPs to join or remain in the profession or increase their workload, which is worrying.

'Rising claims costs will not go away and are only going to get much worse. Something must be done to relieve the pressure on GPs and the wider health service. The reforms we advocate would see patients compensated appropriately but in a fairer and more affordable way.'

The MDU has asked the Treasury to prioritise a number of legal reforms meaning negligently damaged patients would be properly cared for but additional billions of pounds would be available for NHS and local authorities to spend on all patients.

The reforms it wants include:

- Repeal of an outdated 1948 law which means compensation must be calculated on the basis of private rather than NHS care – S2(4) of the Law Reform (Personal Injuries) Act.
- Defendants such as medical defence organisations to be able to buy defined local authority and NHS care packages that meet patients' reasonable needs – currently these must be funded privately.

Top of page

NHS FUNDING PROBLEMS 'HITTING THE ELDERLY'

An increasingly fragmented health and social care system is failing older patients because it is unable to cope with the increasing pressure from an ageing population with more complex needs, a doctors' report warns today.

This follows warnings from the King's Fund and Nuffield Trust that vulnerable, older people in England are having to fend for themselves because Government-funded care is being scaled back, with spending on care by councils falling by a quarter in real terms in the five years up to 2015.

'Growing older in the UK', a BMA's briefing paper on ageing and health, highlights the increasing demand and 'inadequate' resources facing the UK's health and social care system.

It is estimated that four in 10 people aged over 65 years old and seven in 10 over 85 years olds have a long-term illness. Out of sixteen million adults admitted to hospital in England in 2014-2015, almost half (47%) were aged over 65.

The report calls for more to be done to support and improve people's health and wellbeing as they grow older in the UK, including:

- Action to tackle the social isolation of older people through a focus on 'social prescribing' – connecting people to non-medical and community support services.
- A focus on tackling the under-diagnosis and under-treatment of mental health conditions in older adults, to help ensure that parity of esteem between older people's physical and mental health becomes a reality.
- A focus on developing a 'carer friendly health service', whereby carers are identified, provided with adequate information and advice, and their expertise listened to and respected. Carers should also be supported to look after their own health, as well as that of the person they are caring for.

Prof Parveen Kumar, BMA board of science chair, said: 'Far more needs to be done by the government to support

greater co-ordination and integration of health and social care services and ensure that these services can cope with the growing needs of older patients.

“In particular, we must tackle the under-diagnosis and under-treatment of mental health conditions in older adults, to make sure that their mental health is treated as importantly as their physical health.’

Currently only a small proportion of older people with depression seek treatment, with research suggesting that although 20-40 per cent of older people in the community show signs of depression meriting treatment, only 4-8 per cent consult a GP.

Top of page

GENERAL PRACTICE FORWARD VIEW: LATEST

New planning guidance from NHS England requires CCGs to develop local action plans detailing how they will deliver the aims set out in the General Practice Forward View.

These will need to set out how CCGs will invest funds to ‘support and transform’ general practice, it said.

The local commissioning groups must provide plans outlining their approach to implementing the General Practice Forward View by 23 December 2016.

Latest guidance gives more details on how extra funding announced in the General Practice Forward View will be used to help transform services: Published by NHS England and NHS Improvement, Delivering the Forward View: NHS Operational Planning Guidance for 2017/18 and 2018/19 the document aims to give NHS trusts and commissioners help for planning the years ahead.

Guidance confirms that there will also be further local recurrent funding to improve and increase capacity in general practice, totaling £138m by 2017/18 and increasing to £258m by 2018/19.

This will contribute to the overall ambition of investing an extra £2.4 billion in general practice services by 2020/21.

£6 A HEAD TO IMPROVE GP ACCESS

Said NHS England: ‘In 2016/17, this recurrent funding is being made available to the General Practice Access Fund pilot schemes (formerly known as the Prime Minister’s Challenge Fund) and a number of additional areas across the country which will accelerate delivery of improving GP access in 2017/18. This will also enable London to begin a capital wide programme of improving access from 2016/17.

‘The investment will be extended in 2018/19 to enable the whole country to start developing additional capacity, so that from April 2019 every CCG can expect a minimum additional £6 per head to improve access to general practice.’

NHS England said CCGs would be able to commission extra services, making the most of new technologies and the wider workforce.

This might include commissioning provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) and at weekends, meeting local population needs as appropriate.

Health service bosses say this should help reduce demand on both general practice in-hours, and urgent care services.

Top of page

NEW LANGUAGE TESTS FOR POTENTIAL GPS FROM OVERSEAS

The first batch of overseas doctors wanting to work in the UK have now taken the GMC’s new-look Professional and Linguistic Assessments Board (PLAB) test.

This is the main route for international medical graduates who want to practise in the UK.

It involves a knowledge-based written test and a practical assessment of clinical skills.

Passing the test means a candidate has demonstrated the level of medical knowledge and clinical skills required of a doctor in training in the second year of the Foundation Programme – this is the same level UK graduates are required to be at to gain full registration.

The written knowledge test, PLAB 1, will be broader and candidates will receive more detailed feedback on their performance.

Most of the changes have gone live, but others, will be implemented next year.

Changes also include:

- New practical scenarios and questions that will assess candidates' professionalism and understanding of ethics as well as their clinical skills.
- A new limit on taking the test. Candidates must pass the written and practical parts of the test within a maximum of four attempts at each.
- A two-year limit in which to apply for a licence after passing the test.

GMC chief executive Niall Dickson said: 'This improved test will help make sure doctors are reaching the high standards we require to practise safely in the UK. I hope the changes will give patients confidence that doctors who come to work in this country from overseas will be capable of delivering high standards of compassionate and skilled care and treatment.'

Top of page

£1M VAT VICTORY FOR CONSULTANT

A consultant dermatologist has been saved from a crippling £1m-plus tax bill after his accountant settled a VAT case out of court.

HMRC contended that the specialist's company should have registered for the tax as the business was largely providing 'cosmetic' procedures as opposed to procedures for medical purposes.

But the doctor's camp successfully argued that although he carried out non-medical procedures, the amount was miniscule compared to medical procedures and was certainly below the VAT registration limit of £83,000 on a rolling annual basis.

The case, reported on the front page of the latest issue of Independent Practitioner Today – the business journal for doctors in private practice – underlines the need for doctors to keep meticulous records.

Any consultants with concerns about their VAT position were advised in the article to take advice about the whole issue. It is feared some may have done non-medical treatments exceeding the registration threshold.

Accountant Susan Hutter said: 'The confusion arises with HMRC as their definition of 'cosmetic' is different to the medical definition.

'Although the patient may think they are going to the doctor for a cosmetic procedure, – i.e. because after the procedure they look better than before – the actual definition as to whether or not the procedure is non-medical depends on whether or not there are any medical benefits.

'If the treatment improves, repairs or enhances the skin, including repairing sun damage, then it is a medical procedure.'

She said it appeared HMRC originally thought any procedure that included the use of Botox, fillers or laser was almost certainly non-medical, making it purely cosmetic and therefore VAT chargeable.

But she told Independent Practitioner Today: 'We clearly proved that the procedures carried out by our client, apart from a miniscule amount, were for the protection, maintenance or restoration of skin related diseases/disorders.

‘Therefore the primary purpose of the services was for medical not cosmetic benefit. Had HMRC been successful, they could have gone back to the commencement of trading and demanded the VAT from that time to date.

‘As this was more than 10 years ago, the VAT itself could have been in the region of £1m plus.’

Mrs Hutter, of Shelley Stock Hutter, London, said the case’s success was helped by the consultant keeping excellent records of all treatments and appointments.

In virtually all cases, apart from the very few, these proved they were all medical procedures.

Top of page

JUNIORS STILL PLAN SOME ACTION OVER CONTRACT

Junior doctor action over the imposed contract is still set to continue despite Saturday’s announcement of a suspension of further junior doctor industrial action in England.

The BMA said the cancellation of strike action ‘follows feedback from doctors, patients and the public, and discussions with NHS England about the ability of the NHS to maintain a safe service if industrial action planned for October, November and December were to go ahead.’

But the newly elected chair of the BMA junior doctor committee, Dr Ellen McCourt, said: ‘We still oppose the imposition of the contract and are now planning a range of other actions in order to resist it, but patient safety is doctors’ primary concern and so it is right that we listen and respond to concerns about the ability of the NHS to maintain a safe service.’

Junior doctors in England were due to stage a full withdrawal of labour for five days, between the hours of 8am and 5pm on 5, 6 and 7 October (weekend covered) and then 10–11 October; 14 – 18 November and 5 – 9 December.

Dr McCourt was on Saturday formally elected to the post of chair of the BMA junior doctor committee. She had been interim chair of the committee since July.

Top of page

aisma
association of independent specialist
medical accountants

Keith Miller

Keith joined Albert Goodman in 2006 from a local Somerset firm of Accountants where, having qualified as a Chartered Accountant in 1988, he had been a Partner since 1990. He recently went on to achieve further success becoming a Certified Financial Planner in 2006.

Although best described as a General Practitioner, providing financial and taxation advice to an expanding portfolio of high net worth individuals, limited companies, sole traders and partnerships, Keith specialises in assisting medical practices and solicitors on all aspects of financial and taxation advice. He leads our GP medical team and is a member of AISMA, the Association of Independent Specialist Medical Accountants.

As a qualified Certified Financial Planner, he is ideally suited to obtaining a detailed understanding of the issues facing proprietors and their personal objectives in order to make a key contribution on strategic and tax issues, as well as dealing with the very complex areas of Capital Gains Tax and Inheritance Tax planning

Leave Feedback Register a Colleague