



Chief Officer's Corner

AN ARTIST'S IMPRESSION?

The team was ready to travel to London and we had planned how to read the expected 500-page document on the evening of Thursday 20th February. Nobody believed that there could be any further delay in the launch of the proposed new GMS Contract but we had forgotten how many examples of "control-freakery" this "New Labour" Government has displayed! A phone call 30 minutes before we left Exeter with a hope that we would have something to read on our arrival caused some interesting discussions that continued with other delegates on our arrival at BMA House!

Ultimately our GPC Negotiators decided that they would share with us what they hoped would finally be agreed and in the best tradition of Blue Peter they showed us a PowerPoint presentation that "they had prepared earlier" (although it had been amended overnight!). As we listened it was made clear that the contract had not yet been signed off by either party although the GPC and the NHS Confederation, after a stunning amount of hard work and long hours on both sides, had reached what they had both imagined to be a final version on Wednesday morning. I wonder who felt they had to intervene and put their personal stamp on it? Mr Blair was in Italy but this perhaps left his personal advisers with too much spare time on their hands!

As I type we still have no idea if the final version of the contract is ready to come out to all GPs. I do know that Mark Wood has done a good summary of what was presented to us and that Adrian Midgley has tracked down an electronic version of the PowerPoint that was shown to us www.leuty.dsl.pipex.com/contract.ppt - both are worth a good look, but Mark's commentary is particularly helpful.

"The Devil is in the detail" is a quote that is often used. I am told there will be 500 pages of detail here what with the contract itself and appendices. We are assured that "the money is good" but that cannot alone be the deciding factor. John Dean and I spend an increasing amount of our time working with stressed GPs few of whom are poor! The workload that you are all straining under must have been addressed properly by any new contract before you sign up to it. It is possible that this new contract will allow you to set the amount of work you do commensurate with the level of workload that you believe you can sustain. If that generates an income with which you are content then perhaps the major problems have been solved. I do not yet know how much work equals how much money. I suggest you open your post urgently, particularly if it looks like a volume of "War and Peace"! We saw an artist's impression" on Friday 21st. I want to see the finished construction.

Commentary on the New GMS Contract
By Mark Wood, 21st February 2003

Friday 21st February was to have seen the unveiling of the new GMS contract to LMC leaders at Congress House in London. The media were duly tipped off that GPs are set to receive "a thirty-three percent pay rise". As I sit here at the end of the day the whole process does seem to be a ridiculous dichotomy between some very exciting ideas within the contract, and a surreal approach from the government. The GPC was unable to publish a finished and priced contract - a fact that generated a great deal of anger from LMC delegates. The chronology around this was that the GPC and the

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Confederation reached a final deal that was signed at 10.00am on Wednesday morning. This was then sent to the DoH for rubber-stamping. The GPC was expecting the document to be returned by 4.00pm on Wednesday so that they could prepare for the presentation on Friday.

Unfortunately, the contract was held at the DoH, and we understand that the stumbling block is either Number 10 or Number 11 (or both!). The GPC negotiators are saying that the "official reason" for the delay is that the government needs to cost the contract carefully. However, it is clear that the government has known every dot and comma of the contract at every stage, and the idea that they need to peruse it further, to the point of wrecking the launch is not plausible.

The question really is what game is being played. At one level, it may be that there is an argument going on at the very top of government about the exact level of funding. Alternatively, the jaundiced view is that it may be that the government wants to wreck the contract (although this is quite an extreme view).

We are now told that the fully priced contract will be available at the beginning of this week (beginning 24.2.). It will be posted and e-mailed to all GPs. The Road Shows will still take place (on 14th and 18th March). Ballot papers will go out on 20th March and the ballot will close on 11th April. If you think your details may be wrongly recorded by the BMA then please phone their helpline to let them know where you live. The vote is open to ALL GPs (Principals, Assistants, Locums, etc).

The day was spent going through the details of the contract, even though there was no definitive word on the funding. I do not intend to go through the detail of issues that were dealt with at the launch of the contract framework.

The main points are as follows:

1. New Investment

Apparently, the current £6.1Bn per year that goes into general practice will become £8.0Bn (an increase of almost 33%) over three years. Of the extra £1.9Bn, £1.3Bn will be directed to quality payments.

2. Who holds the contract?

The contract will be between the PCO and the practice, but will be based on national tariffs for services.

3. The Contract "menu"

There will be 5 types of service:

- **Essential** - seeing ill people & management of chronic disease
- **Additional** - CHS, contraception, vaccinations & immunisations etc.
- **Directed National Enhanced** - optional for each surgery, but obligatory within a PCO (e.g. flu immunisations, minor surgery, improved access, service for violent patients)
- **National Enhanced** - optional services (e.g. anticoagulant monitoring, IUCDs, drug and alcohol services)
- **Local Enhanced** - response to local need

4. Out-of-Hours

In hours is defined as 8am to 6.30pm Monday to Friday. The average price for opting out will be c. £6000 per year for a list of 2000 patients (pro rata). Opt out legislation will be in place by April 2004, and the opt-out will be available to all by 31/12/2004.



Dr John Chisholm and other members of the GPC Negotiating Team Presenting the proposed New Contract

5. The Global Sum

This will form the bulk of practice income. There will be no reimbursements etc. Your practice will simply receive the Global Sum (GS) and you decide how you use it. There are funding streams for Dispensing, Premises and IT separate to this Global Sum. The GS will be worked out on a complex formula that assesses workload and costs. It includes: age, gender, list turnover, morbidity, NH/RH, rurality and market forces.

The following is an example of how the GS will be calculated: Take the practice population (say 10,000) and weight them for age and sex. Then add uplift for the percentage list turnover. Add another uplift for % of patients in NHs or RHs. Multiply by a morbidity factor (analogous to deprivation). Multiply by a rurality index (dependent on population density) and uplift for "market forces" (e.g. in central London you would have to pay your receptionists more). Once these various factors have multiplied your 10,000 you end up with a "notional population" of (say) 10,763. Each notional patient attracts a set amount each year. If this is (say) £50 then your GS would be £50 x 10,763 = £538,150. There will also be an addition to this based on historic TR activity to pay for TRs (which will not be IoS).



Dr Hamish Meldrum
GPC Joint Deputy Chairman

6. Quality

£1.3Bn will be attached to quality (c. £35,000 per WTE per year!). This is the ceiling on what can be earned, but what proportion of that ceiling you get will be dictated by performance against a list of indicators. These indicators add up to 1,000 points as follows: Clinical 550 Organisational 184 Additional Services 36 Patient Experience 100 Holistic Care 100 Quality Practice Payment 30.

Of the 550 points available for clinical work, 101 are offered for CHD performance against a basket of markers (BP < 150/90, patients on aspirin etc), 8 points for management of hypothyroidism, 99 for management of diabetes etc, etc. Organisational quality is measured through records and information, education, practice management etc, etc.

Essentially, the practice tries to score as near to 1,000 points as it can. There will be "aspirational payments". These can be up to a third of the overall quality payments and are made in advance to help you achieve a target (e.g. your practice currently scores (say) 500, but you have a plan in asthma management and medicines management to take you to (say) 650. You can apply for the aspiration payment. The PCO is responsible for making sure your aspiration is bona fide (e.g. if you currently score 10 and say that you aspire to 900 next year they may turn you down!). Quality markers do allow for exception reporting. Good access gives you a "bonus" of 50 points! This bonus is in addition to the 1,000 quality points.

7. Seniority

Seniority will go up by c. 30% across the board, and years are counted from qualification not entry into general practice. This means we will all move up 4 years immediately.

8. Dispensing

Dispensing is not mentioned in the contract and will be dealt with as an entirely separate entity.

9. Pensions

The accrual rate is 1.4 and the negotiators wanted it to become 1.6. The government would not budge, but GPC actuaries have advised that as pre-GP earnings are treated as GP earnings for the purposes of pensions then the "real" accrual rate is almost 1.5. The GPC also wanted an extra 11% of dynamisation to be backdated to the 1990 contract. The government refused, BUT has agreed that ALL NHS earnings will henceforth be pensionable. The government has also accepted that part-time partners can include ALL extra NHS locum work as pensionable.

10. Enforced Allocations

The regulations around this can be viewed as "glass half empty" or "glass half full". The contract is a fudge on this issue. The negotiators say they have got a system that will make it VERY uncomfortable for PCOs to make forced allocations. BUT, if you read the regulations ultimately the PCO can force allocations (even if it is more difficult).



Dr Mark Wood asking the GPC about TRs & Patient Allocation.

11. Regulations

If the contract is accepted there will be practice-based contracts from 1.4.2004. There will be a contract dispute and appeals mechanism that will include the right to practice.

12. Premises

There will be an extra £200M for development in England. Cost rent will continue but will be based on need rather than room number or size. PCOs will have discretion to pay notional rent on improvements (even when the GP does not own the building). The PCO may have an option to buy land (with GPs consent).

13. Career Structure

There are a number of options for developing careers outside the traditional linear way.

14. Computers

As of 1st April 2003 all IT systems should be 100% reimbursed anyway - regardless of the new contract. This will continue into the new contract.

So, is this a good contract? The answer to that probably depends on your perspective. It looks as though substantial new money will be available - in many cases for doing what we already do. There are a number of "bottom lines" that have been breached though - especially around forced allocations. This may be an issue in some parts of Devon (especially the cities), and forced allocations may prevent practices from achieving quality targets.

My personal view is that it is a vast improvement on the current contract in that it sets limits to our work, allows us to opt out of OOH and pays us significant new money for quality.

This is your Contract, Your Future. You decide!

Road Show Details

Friday 14 March 2003

St Mellion Golf & Country Club: Two Presentations 17.00 & 19.30

- Baydoc Co-operative to operate from 15:00 hours
- Plymdoc Co-operative to operate from 18:00 hours
- Tavidoc to commence Message Handling Service from 18:00 hours
- Kingsbridge, Salcombe & Chillington Practices to commence MHS from 18:00 hours
- Primecare to commence as normal at 18:00 hours

Tuesday 18 March 2003

Tiverton Hotel: Two Presentations 17.00 & 19.30

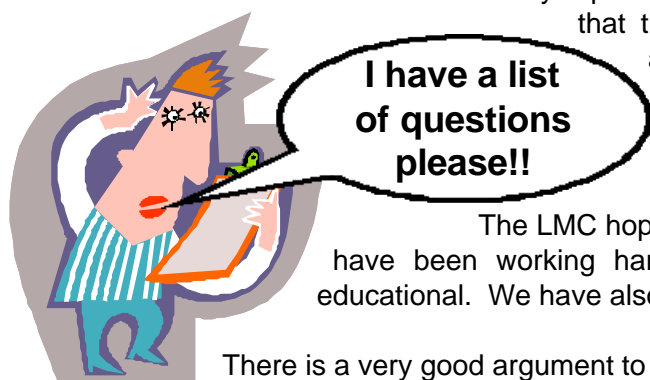
- Wakleydoc & West Devon Co-operative to operate from 15:00 hours
- Iscadoc to operate from 16:00 hours
- Tarkadoc, Mid Devon and Templerdoc Co-operative to operate from 18:00 hours

COMMUNITY HEALTH COUNCILS – A Tough Act to Follow – Dr Peter Jolliffe

On 31st January the abolition was announced of the patients' watchdog, the Community Health Councils, with effect from 1st September 2003. My personal belief is that this abolition has been poorly thought out and that issues regarding the quality of some Community Health Councils in the metropolitan areas have had a national knock-on effect. These are causing the abolition of organisations that have worked well within the NHS to help further the needs of patients within an increasingly complex service. The LMC's relationship with the CHCs in Devon has certainly been excellent in my time here and they have generally displayed excellent common sense, kindness and courtesy in all their dealings. They will indeed be a tough act to follow and I hope that many of the people that have made up the CHCs will be able to be included within replacement systems that are being set up.

The Government and the Department of Health are setting up the Commission for Patient and Public Involvement in Health, which announced its new regional structure on the day that CHCs heard of their fate. The Commission is "a new independent body representing the voice of the public in health matters". A bold statement, which I sincerely hope that those involved in the Commission will be able to achieve in the future. There will be 9 regional offices across England with a responsibility for producing and implementing standards and quality control for "Patient Forums" which are hoped to be the bedrock of the new system and which will be established in all Primary Care Trusts and NHS Trusts with new powers of inspection and representation on Trust Boards. The Chair of the CPPIH, Sharon Grant, said: "This is the beginning of a long journey and I believe that the arrangements we have announced today (31st January) will provide firm foundations for the future. There will be a place in every community where people will have the opportunity to become involved in health in its broadest sense, supported by considerable regional resources and an influential national body."

I hope that they can be as good as what they attempt to replace and indeed as an optimist I hope they will be even better than what they replace. I hope they are truly independent of government and that they function in a way that truly supports patients and assists the providers of health care rather than hinders them in their work.



Appraisal Update

The LMC hopes that all GPs will find the appraisal process helpful. We have been working hard with PCTs to ensure that the main focus will be educational. We have also been asked to approve appraisers.

There is a very good argument to be made for the idea that all GPs should be trained in the appraisal process and be equally comfortable as appraiser or appraisee. This has not happened and we are aware that some colleagues have concerns. For those of you feeling anxious about appraisal we invite you to contact the LMC office (**01392 834020**) to arrange to discuss your worries.

It may also be that during the appraisal itself difficult issues are raised concerning for example partners or practices as well as individual health or career related problems. We should like to remind all GPs in Devon that they have access to a wide range of support to help with difficult situations. We strongly advise that where such issues arise a clear plan is made which involves external advice. This could be from Peter Jolliffe or John Dean at the LMC or for health related advice through the Occupational Health Service in your area. **IF YOU ARE UNSURE CONTACT THE LMC.**



To help you get started we have included a quick crib sheet and a detailed paper from Dr John Dean with this newsletter, they are also on the LMC website **www.devonlmc.org**

DEVON AREA CHILD PROTECTION COMMITTEE - Dr Jane Richards

DISCLOSURE AND CONFIDENTIALITY



Sharing Information in Child Abuse Cases The GMC in its publication on Confidentiality includes the following 2 paragraphs under the heading “Children and other patients who may lack competence to give consent

38. Problems may arise if you consider that a patient is incapable of giving consent to treatment or disclosure because of immaturity, illness or mental incapacity. If such patients ask you not to disclose information to a third party, you should try to persuade them to allow an appropriate person to be involved in the consultation. If they refuse and you are convinced that it is essential, in their medical interests, you may disclose relevant information to an appropriate person or authority. In such cases you must tell the patient before disclosing any information, and, where appropriate, seek and carefully consider the views of an advocate or carer. You should document in the patient's record the steps you have taken to obtain consent and the reasons for deciding to disclose information.

39. If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you should give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient's best interests. You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children, where concerns about possible abuse need to be shared with other agencies such as Social Services. Where appropriate you should inform those with parental responsibility about the disclosure. If for any reason, you believe that disclosure of information is not in the best interests of an abused or neglected patient, you must still be prepared to justify your decision.”

In this context we have consulted the two largest medical defence organisations in the UK on their policies on disclosure of information in Child Protection and these are their replies.

Medical Protection Society – from Dr Gerard Panting Communications and Policy Director

“Where there is cause to suspect that a child may be the subject of abuse, appropriate action must be taken to ensure the safety of that child and perhaps others who may be subject to abuse by the same abuser.

The threshold for sharing information with authorities such as Social Services and the NSPCC is, in my view, relatively low. The doctor does not have to satisfy himself that abuse is taking place but must simply be aware that there are grounds for further investigation by an appropriate authority.

When making such reports to Social Services or when receiving requests for information from Social Services, GPs are rightly aware of the conflict of responsibilities to child and parents where the parents or a parent are potential abusers. In these circumstances, the GP should attempt to obtain the consent of the parents to disclosure of relevant information, albeit the notion of consent in these circumstances is somewhat artificial as, in the face of refusal, the GP should nevertheless make it clear that there

is no option but to disclose relevant information.

Doctors who are not ready to share relevant information about the child and/or parents with Social Services place themselves in a vulnerable position should the child later come to some harm as a result of inaction.

Consequently, we advise doctors to take appropriate action in notifying Social Services or co-operating with Social Services inquiries where there are reasonable grounds to suspect child abuse. If information confidential to the parents is required during the course of the investigation, the GP should, in the first instance, attempt to obtain the consent of the parents to disclosure of that information but where this is not practicable or where the parents refuse, the GP must take a view as to the relevance of that information to the investigation and where that information is material, disclose it.

Needless to say, any MPS member following this advice who found himself or herself the subject of criticism could expect to receive the Society's full support and help.”

The Medical Defence Union, over the signature of Dr Patrick Dando, Head of Advisory Services, stated:

“The advice that the MDU gives to its GP members is from the GMC’s booklet, ‘Confidentiality - September 2000’, and the sub-heading entitled ‘Children and other patients who may lack competence to give consent.’

Paragraph 39 in my view makes the position clear for doctors, that a doctor who holds information giving rise to a suspicion of child abuse must disclose the information promptly to the authorities, unless it is not in the best interests of an abused or neglected patient, which is a matter for the doctor’s judgement. The GMC expects the doctor to be able to justify the decision made.”

The British Medical Association in their “Summary of action in cases of child protection” produced by the Medical Ethics Department state:

- If doctors believe that a child may be suffering, or may be at risk of suffering, significant harm, they should refer these concerns to the local authority social services department. In addition to the social services department, the police and NSPCC have powers to intervene.
- Doctors should aim to discuss any concerns with the family and, where possible seek agreement to making referrals to social services **unless to do so would place the child at increased risk of serious harm.**
- Doctors may be asked to contribute to social services’ core assessment of a child. If to do so would not increase the risk of the child suffering harm, consent to disclosure of information should be sought. If consent cannot be sought, or is not forthcoming, doctors may release information essential to protect the child from serious harm in accordance with the GMC’s rules.”



Forthcoming GMC Elections – Dr Nicky Toynton

You will be aware that the whole format of the GMC Council will be altering with the forthcoming new elections. The new Council will only have 15 elected members from England drawn from 5 new constituencies. Ours is South and South West running from the Sussex coast to the Mid Welsh border! We can elect three doctors only and I hope that we will be getting behind the GPs that stand for election.

In Devon and Cornwall we have been ably represented by elected members Drs Nicola (Nicky) Toynton and Andy Stewart, as well as Sir Denis Pereira-Gray in a non-elected capacity. In the brave new world Nicky will be standing again whereas Andy will be continuing on the (non-elected) Performance Committee. Nicky works as a GP Principal at Yealmpton Surgery in the South Hams with Dick Page so is kept up-to-date with LMC type issues! The LMC and I urge you to give her and other GP candidates your support. I believe we are into “single transferable votes” again so I will be putting her number 1 on the ballot!!

Comings & Goings 2003

Welcome to:

Dr Stuart Murray, Blackdown Practice,
Hemyock
Dr Cord Bredemeyer, Roborough Surgery,
Plymouth
Dr Karen Bates, Richmond House Surgery,
Teignmouth

Dr Andrew Ryan, Devonshire House,
North Tawton
Dr Alexander Rowe & Dr Olivia Hussey,
Kingsteignton Medical Practice

Goodbye to:

Dr Timothy Harlow, College Surgery,
Cullompton

Surgery	VACANCIES
Collings Park Medical Centre 57 Eggbuckland Road Plymouth PL3 5JR Tel: 01752 771500 Closing Date: Friday 28 February 2003	<p align="center">PRACTICE MANAGER</p> <p>Required for 15-20 hours per week over three days per week at a practice based in Hartley, Plymouth. Salary: £20,000 - £23,000 pro rata (depending on experience). Responsible for the business affairs of the Practice including staff management, computer development and finances. For an information pack please contact Lee Rickard on Tel: 01752 771500.</p> <p align="center">Letter of application with CV to Mrs Rickard, Deputy Practice Manager.</p>
Barton Surgery Horn Lane Plymouth PL9 9BR Tel: 01752 407129	<p align="center">PART-TIME PRACTICE MANAGER</p> <p>Required as soon as possible for a friendly 3-partner practice in Plymstock. Experience preferred. Flexible hours. Apply in writing with CV to Dr John Mahony</p>
Holsworthy Medical Centre Dobles Lane Holsworthy EX22 6GH Tel: 01409 255276	<p align="center">GP RETAINER/ASSISTANT</p> <p>Required for up to 4 sessions per week. We are a friendly 7-partner rural training practice looking for a Retainer to join our team. We endeavour to offer a high standard of service to our patients supported by an effective multi-disciplinary support team. We are computerised (EMIS), paper light and committed to developing our staff. Our recent relocation to new, well-equipped purpose built premises adjacent to the Holsworthy Hospital provides an excellent working environment. Should you be interested, for further information please contact: Peter McLean, Practice Manager.</p>
Highlands Health Centre Fore Street Ivybridge South Devon PL21 9AE Closing date: 7 March 2003	<p align="center">PART-TIME PRACTICE NURSE - IVYBRIDGE</p> <p>Required for friendly, semi-rural practice entering 5th wave PMS. Practice Nurse experience desirable, but not essential, to work for 12 hours per week in a post involving a wide range of treatment room duties. Flexibility essential to cover holiday/sickness and practice development. Salary dependent on experience. Training available as required. For further information and an application pack, please contact June Oaten or Wendy Ascroft on 01752 897111</p>
Redfern Health Centre Shadycombe Road Salcombe Devon TQ8 8DJ	<p align="center">PART-TIME PARTNER - Sensational Salcombe</p> <p>Enthusiastic part-time partner required to replace the retiring senior partner from April 2003. The successful candidate will join 3 full-time incredibly youthful partners, together with our highly trained and equally youthful primary care team! We are a semi-rural practice with approximately 4,500 patients. EMIS. OOH local co-op. Cottage hospital admitting rights. Great sailing, surfing, pubs, cream teas! Contact our Practice Manager, Sue Sharp, (01548 842284) for more details or send a handwritten application and CV to the practice.</p>
East Street Surgery South Molton North Devon EX36 3BU Tel: (01769) 573811 Maria.Hosegood@gp-L83047.nhs.uk Closing date: 25 April 2003	<p align="center">REPLACEMENT JOB SHARING PARTNER</p> <p>The post is permanent for 4 sessions per week from August 2003</p> <p>We are a friendly, innovative 5-doctor training practice in North Devon (3 WTE), working from a purpose built practice. We are a 3rd wave PMS pilot practice, which would enable us greater flexibility in offering this position as a Partnership or salaried option depending on the applicant. We have excellent practice nurses working alongside us to provide good quality care for our patients, and an enthusiastic supportive clerical team. We work closely with the Primary Health Care Team and a modern local community hospital. We are paper light (In Practice systems – Vision 3). We are part of an out of hours co-operative (TarkaDoc). Informal enquires welcome. Please send application letter together with your</p>

CV to: Maria Hosegood, Practice Manager.	
<p>Beaumont Villa Surgery 23 Beaumont Road Plymouth PL4 9BL Tel: 01752 663776 Email: felicity.barry@gp-l83018.nhs.uk www.beaumont-villa.co.uk Closing date: 11 April 2003</p>	<p style="text-align: center;">PRACTICE MANAGER</p> <p>We are a friendly 4-doctor progressive practice with a branch surgery at the University of Plymouth, who are looking for a skilled manager to replace our current manager on retirement.</p> <p>The successful candidate will have proven management, financial, HR and IT experience with exceptional communication and organisational skills. Previous NHS experience is desirable but not essential.</p> <p>Salary and hours negotiable according to experience and qualifications. Informal visits are welcomed. For further information: Mrs Felicity Barry</p>
	<p style="text-align: center;">HOUSE EXCHANGE</p> <p>WANTED family to house exchange for 4 weeks sometime in 2004. We live near to Hennock and are looking for a family to swap with in North East Australia. If you know of any interested parties please contact me, Dr Alan Fitter, on 07647 277582. Job swap not included!</p>
	<p style="text-align: center;">GRADE E PRACTICE NURSE – APRIL 2003</p> <p>Required for a friendly seaside practice looking after 6,800 patients with a high proportion of elderly patients.</p> <p>We are looking for an enthusiastic nurse to work within a team committed to personal, professional and practice development.</p> <p>Duties would include the normal range of nursing responsibilities, including chronic disease, NSF led clinics.</p> <p>Experience is desirable, but not essential, as all appropriate training would be offered to the successful candidate.</p> <p>Timetable is negotiable within the time limits of the practice 8.15am – 6.00pm.</p> <p>5 weeks annual holiday plus study leave. NHS pension scheme.</p> <p>Please ask for further information or send written application with CV, advising current salary to Mrs A Mungeam, Practice Manager.</p>
<p>Rolle Medical Partnership The Health Centre Claremont Grove Exmouth EX8 2JF Tel: 01395 273001 Closing Dates for both posts: Friday 7 March Practice Nurse Interviews: 2 April</p> <p>Clerical Post Interviews Interviews: 3 April</p>	<p style="text-align: center;">PRACTICE NURSE</p> <p>Required to cover maternity leave in a busy GP Practice in Exmouth. The post is to commence in mid May for approximately six months, working 8 hours per week. Salary is dependant upon qualification/experience. The post entails covering general treatment room duties and knowledge of working with diabetes and coronary heart disease is desirable but not essential.</p> <p>For an application/information pack please send a handwritten letter and CV to Mrs Karen Marriott, Office Manager.</p> <p>An enthusiastic CLERICAL/RECEPTIONIST required for a busy GP Practice, to cover maternity leave from May. Initially a fixed term contract for approximately 6 months with the possibility of a permanent position in the autumn. Good communication skills are essential and the position requires flexibility and ability to work as part of a busy professional team.</p> <p>For an application/information pack please send a handwritten letter and CV to Mrs Karen Marriott, Office Manager</p>
<p>The Raleigh Surgery Pines Road Exmouth Tel: 01395 222499 Closing date: 14 March</p>	<p style="text-align: center;">PRACTICE ADMINISTRATOR/MANAGER</p> <p>Required for busy General Practice in Exmouth Previous NHS and/or Primary Care Experience desirable. Must have Personnel Management, IT, Leadership, Financial and Organisational Skills Salary Negotiable according to experience 30 hours per week Written applications and C.V. to Dr David Spiers and Partners</p>



PENINSULA
 — MEDICAL SCHOOL —
 UNIVERSITIES OF EXETER & PLYMOUTH

Community Clinical Teachers Phase 1, Year 2 – Exeter & Plymouth

2 posts: each 5 weekly sessions, or job share arrangements

Grade: Clinical Academic

The posts are central to the development and delivery of the exciting and innovative community element of the undergraduate medical course at the Peninsula Medical School.

The Community Clinical Teachers for Phase 1 will develop and implement the detailed programme of learning for students during the first two years of the course, based at either Plymouth or Exeter University. The community course makes a very substantial contribution to the programme and offers outstanding opportunities for imaginative and forward thinking teachers.

Working closely with the existing Community Clinical Teachers and the Community Sub-Deans, you will be active in local clinical practice in the community of Devon & Cornwall, and have experience of teaching in healthcare.

For a further discussion about the post please contact Mrs Ruth Baker on 01752 764409 or email ruth.baker@pms.ac.uk although applications should be made in accordance with the details shown below.

For an application pack please email: jobs@pms.ac.uk or telephone 01752 764261 quoting reference number 5144/PMS.

Closing date: 21st March 2003

Courses, Conferences & Information

South West Informatics Learning Network

“Telemedicine & Telecare” is a **FREE** study day for clinicians and associated healthcare professionals

Holiday Inn, Taunton - Friday 28 March 9.30am – 4.30pm

For further information contact Daniel McCarthy, Health Informatics Policy Unit Tel: 01392 207304.

Email: daniel.mccarthy@eastdevon-pct.nhs.uk

RCGP National Spring Meeting - Bristol University

Friday 4 April – Sunday 6 April 2003

Topic: Defining Value in a Complex World

This is a healthy mixture of talks by national leaders and parallel sessions many by local GPs.

Speakers: David Haslem, George Alberti, Julian Le Grand, Barbara Starfield.

Social Programme

Jonathon Dimbleby (BBC Radio 4 Any Questions) live on Friday night

Gala Dinner at the Bristol Exhibition Centre Saturday night

Details of social programme, registration and conference are accessible on website www.severnfaculty.org or Margaret Luck, GP Speciality Support Manager Tel: 0117 9753925.

Managing Osteoporosis in the 21st Century

Emerging Insights for 2003

Afternoon/evening of Thursday 20 March 2003

Saunton Sands Hotel, Croyde

Chairman Dr Richard Haigh (Consultant RDE Exeter)

PGEA approved

For more information ring Ray King 07787 106179 or email: king.r.5@pg.com