SOMERSET LMC NEWSLETTER

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HOW CAN WE MAKE GP COMMISSIONING WORK?

The publication of the White Paper Consultation responses and the NHS Operating Framework this week make it clear that the proposed changes are to go ahead, and the success of Somerset in being made a "Pathfinder" group means that we must now turn our minds to how GPs are going to become NHS Commissioners.

To begin with, we need to clarify the terminology. The new formal commissioning body (with an Accountable Officer, Director of Finance, and so on) will be a Consortium – or, if there are to be several, the Consortia. At present Wyvern describes its separate clusters of GP practices as commissioning "Localities", leaving us the term "Federation" for groups of GPs working together as potential providers. However, these definitions have not been universally adopted, and it may be better to accept that a Federation is a natural group of GP practices, based on geography, a history of shared working or a community hospital who wish to work together for mutual benefit – whether that is to draw up local commissioning proposals or to offer provider services. The LMC believes it is possible to manage the potential conflict of interests this implies. www.somersetlmc.co.uk/

It is clearly a difficult time for GPs to take over commissioning. A combination of major structural change, static funding and the inexorable increase in NHS demand means the service has to make - in the words of the Health Select Committee – "unprecedented" efficiency gains if the quality of care is to be maintained. The only chance of doing that is by a radical change in the mechanics of commissioning, which is just what Mr Lansley proposes. And whatever your view of his politics, he is by far the best informed and boldest Secretary of State the Health Service has seen for many years.

Given the parlous state of the national finances, the continuation of current NHS funding is as good an offer as we are going to get. Although GPs can certainly make supply side efficiency improvements by commissioning more cost-effective services in close co-operation with secondary care and public health colleagues it would be disingenuous at best to assume that demand side reductions will not be necessary: we believe some cuts in services are inevitable. Add in the knock on effects on healthcare of reductions in social services funding and the future starts to look pretty bleak.

Or does it? When money is tight we are forced to concentrate on doing what really matters. Here is an opportunity to roll back the tide of risk averse bureaucracy that has been rising for years. Every patient safety initiative and service provided "just in case" will have to be rigorously tested for cost benefit and rejected if found inadequate. Some patients will not get the treatment they want, because the NHS can only provide for need. Some NHS staff who cannot demonstrate that their role measurably improves patient care will lose their jobs, and clinicians will have to concentrate on doing their jobs rather than feeding the monster. This will not be easy. The more hysterical media will shriek about cuts, unsettled staff will wave shrouds, and plenty of political opportunists will look for ways to make trouble. But if we hold the line and find a consensus on commissioning clinically appropriate, cost-effective and compassionate services we can build an NHS that is affordable both now and for the future.

UPDATE FOR SESSIONAL GPS

A regular column of particular interest to GPs not based in a specific practice

NHS White Paper

The GPC has published a new guidance document for sessional GPs in its series on the NHS White Paper. It explains why and how you should become involved in these changes, and discusses other potential impacts on the working lives of sessional GPs.

www.bma.org.uk/images/

Sessional GP Conference

The British Medical Association is holding a one day educational conference for sessional GPs on Friday 11 March 2011 at BMA House, London.

- How to develop your career as a salaried or locum GP.
- How to meet the challenges of appraisal and revalidation.
- The different issues to consider when setting up and working as a locum GP.
- The impact of the NHS White Paper on sessional GPs, and the opportunities it provides.
- Employment rights
- How to get access to professional support, and the differing roles of organisations that provide this.
- Representation.

The fee for attending the conference is £76.38 (inc VAT) for BMA members and £235 (inc VAT) for non-members.

www.bma.org.uk/whats_on/

RAPID ACCESS REFERRALS TO TAUNTON TIA CLINIC

We have asked to request that referrers would please either use the clinic referral form (http://195.105.0.247/stroke%20website/Rapid%20Stroke%20Template1.htm) or include the same information in your referral letter so that an ABCD score can be calculated. This ensures that the referral is given the appropriate priority for an appointment.

TIPS ON PRESCRIPTIONS FOR DRUG MISUSE

There is some mystique around 'blue scripts' and generating them for stable opioid dependent patients in shared care. Such prescriptions are signed by the GP who alone therefore has legal responsibility for the medicine taken by the patient. The shared care workers are only able to give general advice about this so the practice must have a system for generating the scripts appropriately without their direct input.

Some patients will be able to request repeat prescriptions in the usual way but difficulty arises if the script is not generated on time for any reason, leading to either an unpleasant couple of days of withdrawal for the patient or a precipitate a lapse back to heroin. It may also beget the fiddly need to re-titrate their dose back up, as after missing three days treatment the user may become relatively opiate naïve.

One solution is to see the patient fortnightly and write the script in their company. Very sound practice, but time consuming and unnecessary for stable patients. Remember that holidays and other absences need catering for. I generally prefer devolution to a suitable trained prescribing clerk to generate scripts: practice staff already process palliative care opiate requests so adding methadone or buprenorphine is not a big step and the medication will be checked when you sign them.

Forward dating the scripts about ten days ahead allows pharmacies to collect them or the scripts to be posted or even collected by the patients in advance. Most pharmacies collect now and this avoids the "lost script" scenario. It is worth starting most scripts on a Tuesday, running for two weeks, as it generally avoids bank holidays.

If this all sounds complicated then please e-mail me and I can talk it through or visit and advise. Andrew.Allen@ryallsparkmc.nhs.uk Deputy Clinical Lead Turning Point Somerset

CAMERON FUND CHRISTMAS APPEAL

Somerset is very fortunate in having its own Benevolent Fund to support GPs who are unable to work through illness or accident, or who face other personal difficulties. The Somerset Fund is now self sustaining, but the national equivalent, the Cameron Fund, is always short of funds to help GPs in difficulty. Donations, of any size, are always very welcome.

www.cameronfund.org.uk/

MONEY MATTERS IN SOMERSET

The recession and ongoing credit crunch has seen Job Seeker's Allowance claimants rise by 137% in two years in Somerset. Homeowner repossessions increased sharply in 2009 and the number of people in arrears with their mortgage continues to remain high, despite low interest rates. Citizens Advice Bureaux report unprecedented numbers approaching them for debt advice.

Whilst pockets of poverty are noticeable in disadvantaged wards and communities, much it is hidden. Research undertaken by the Somerset Community Foundation identified that 77% of all Income Support, Attendance Allowance, and Disability Living Allowance benefit recipients live in Bridgwater, Taunton or Yeovil.

We are now entering a time of public sector cuts and we have yet to see the true impact of this, compounded by changes to housing benefit and support for mortgage interest.

The position is bleak for many individuals and families; the traditionally poor have been joined by a "new" poor. Unemployment, increased food and fuel bills, inability to secure existing debts, rising repossessions, a freezing or withdrawal of credit has made life tougher for many previously unaffected families. More people are seeking assistance from front line services and more people are seeking out limited, unsecured credit for their every day needs, whatever the price.

The availability of credit is much reduced, especially for those on low incomes. They are seen as a higher risk by many lenders and are the target of commercial credit providers charging legal interest up to 272.2%.

"Money Matters in Somerset" is a comprehensive county wide multi-agency group aiming to address financial exclusion and ensure people receive the education, support, services and advice needed to enable them to become financially included and remain so. It seeks to promote financial inclusion and works to secure resources amongst partner agencies and from external sources.

Supporting affordable credit alternatives is vital in Somerset, although it is not a panacea; at best only around 5% of home-credit customers will choose a lower cost provider. Nevertheless, 5% of almost 20,000 potential home-credit customers would mean that 1,000 additional people would save around £343 (in interest charges each) per typical loan, or a third of a million pounds a year. This could be achieved by doubling the current number of credit union loans to this group.

Posters and cards advising the Somerset Mortgage Advice Line number and the telephone numbers and service points of the four credit unions in Somerset are being sent to practices and we hope you will think about making use of these.

PLEASE OFFER FLU IMMUNISATION TO PREGNANT WOMEN

Although the DoH has included pregnant women as an "at risk" category for the current immunisation round, there is concern that many are either unaware or not coming forward for a flu jab. Because GPs may have little contact with women in pregnancy (or, on a few occasions, none at all) we have asked the midwifery service to make sure the message goes out from midwives, but please do make every effort to both ensure that immunisation is offered by the practice and that staff know to book expectant mothers in to a suitable appointment if approached. Fifteen pregnant women died in the UK from influenza last winter, and as H1N1 is now circulating this is a matter of urgency.

"JUST CAN'T WAIT" CARDS

Some patients with bowel or bladder conditions causing urgency find it very difficult to leave the security of a place where they know they have access to a lavatory when needed. An organisation called the Bladder and Bowel Foundation will supply, for a modest fee, a "Just Can't Wait Card" stating the holder has a medical condition and requesting access to lavatories in shops and businesses that are normally reserved for staff. These cards are widely accepted and patients report they are very helpful.

www.bladderandbowelfoundation.org.uk

HOUSING LETTERS

There has been another flurry of requests to GPs, notably in Mendip, for letters in support of housing applications. Whilst we have every sympathy for hard-pressed housing officers, providing this information is not part of the GMS contract. This topic was covered in our April 2009 edition http://www.somersetlmc.co.uk/

SIMON BONNINGTON'S LETTER FROM CANADA

Where the grass may be greener but is covered in several feet of snow…

We've now been in Atlantic Canada for six months, living and working in Annapolis Royal, Nova Scotia – the Cradle of Canada, where the earliest continuous European settlement was established in 1605. It's a small town, voted by the UN as "the most liveable small town in the world".

The Community Health Centre here hosts not only the GP Offices for five Doctors and a Nurse Practitioner, but also a 24hr Emergency Room, X-ray, Lab, ECG Dept, Physio, Addictions Counselling, Public Health Nurse, 4 Inpatient and 3 Palliative Care beds & Diabetes Clinic. The sort of policlinic that would have Darzi's political ghost turning in its grave. Practice here is in many ways identical to the UK, but some facets are far advanced and some lag way behind the times, but potential frustrations are laconically accepted by populace and doctors alike. Most political and Health Authority insistences can safely be ignored and there is no direct impact on remuneration, there being a healthy spirit of co-operative blocking of sound-bite initiatives and the like.

Nova Scotia has a population of around 900,000, on a land mass the size of Eire. Since Canada is a legislation of federated Provinces, we have our own DoH, complete with an elected Minister & Deputy Minister, assorted mandarins and Quangos. There are nine District Health Authorities, with population sizes equivalent to the old PCTs. Each has several Vice-Presidents, one for each facet of Health Care Provision. According to the email listings there are 167 Administrators & Assistants at Annapolis Valley DHA, serving about 82,000 people. And you thought NHS Somerset was bad!

Many of the personalities and characters of Somerset's administrative team seem to have Doppel-gangers over here. Perhaps the job begets the person? This season's bee in the bonnet for the DHA is waiting times. Ooh. I've seen that one before… except the DHA's website refers the disgruntled to a statement from the Federal Advisor on Wait Times: *"Canadians need to be aware "just because there is a wait for care does not mean that the wait is medically unacceptable."* 18 months for a Knee Replacement or Upper GI scope appears a little steep in light of more recent NHS standards, but as with so much I encounter, it is reminiscent of practice 15-20 years ago in the UK. There are no exacting targets to be met, no performance indicators to achieve, and thus more clinical freedom to treat the patient as a person and not as a statistic. Indeed, we have asked for a definition of a 'reasonable' wait time for a Primary Care appointment. Nothing specific has been forthcoming. Ah well, can't be that important then. And there's no financial impact either, so no driver for change.

I shall not be swift to suggest solutions already tried and exhausted, but you'll be delighted to hear that Open Access is now the buzz-word. And also that I can draw my colleagues attention to the evidence of the unintended consequences of falling for the flawed logic that nature appreciates a vacuum.

GUIDANCE FOR GPS ON MEDICAL CERTIFICATES FOR DWP

The DWP website has a very useful FAQ section for doctors that answers many common queries about Med 3 certificates. In particular, it makes it clear that GPs are not obliged to provide medical evidence for patients appealing against a DWP decision.
www.dwp.gov.uk/

EARLY SUPPORTED STROKE DISCHARGE

Readers may know of the laudable national project to accelerate the discharge of stroke patients to home from hospital. There is evidence that this reduces mortality saves money and improves recovery in as many as half of all patients. Somerset has started to implement the plan with the first phase in Williton and Taunton, and if they have the right home and medical circumstances patients are now discharged as soon as the hospital MDT feels their condition is stable. They are then supported at home by a team of physios, OTs and, and can contact the hospital team for help if need be. The first few patients have been through the system without problems so it is now to be expanded and then extended to South Somerset in late January before the rest of the county is included at the end of March. The Practice is only likely to be contacted if something unexpected happens and as the discharges are very carefully managed we think this is actually less likely than at present. In theory up to 400 patients a year could benefit from early discharge, but if you have any concerns or problems please can you feed them back to Rachel.levenson@somerset.nhs.uk

LETTER TO THE EDITOR

I was surprised to see the promotion of statin prescribing for the over 75s in the LMC newsletter, when there has been no new evidence or guidance on this recently. There seems to be little current evidence of statin benefits in the over 75s, with very few studies looking at this age group. NICE does not explicitly recommend primary prevention use of statins for them, but some people are extrapolating the recommendations about younger people to this older age group.

A good example of this is the BMJ article from Feb 09 which the PCT team quote. If you read it you will see that the American cardiologist authors recommend statins in almost everyone, which is no surprise. But only one study used in the meta analysis includes the over 75s, and this shows no reduction in mortality or morbidity with statin use in the over 75s.

There may be true biological benefits in statin use in the over 75s, or the position could be similar to the use of HRT and anti-arrhythmics to change CVS morbidity, where initial enthusiasm did not stand up to scrutiny. I feel we need some better evidence before wholesale recommendation to our older patients.

Dr John Higgie, Minehead

MEDICAL OFFICER FOR TAUNTON AMATEUR BOXING CLUB

Although some doctors feel that boxing is a dangerous activity, at an amateur level for boys the risks are probably less than for sports that GPs traditionally endorse like rugby and horse riding. Boxing clubs provide a carefully regulated environment in which boys (usually!) can learn the physical side of their sport as well as acquiring other life skills, and the experience of the editor's own practice is that lads who have not had an easy life can and do acquire real self esteem and confidence through club boxing that helps them become constructive members of society.

Taunton ABC needs a medical officer to replace the current GP postholder who is retiring. The main task is to undertake brief standard medicals for the members (a small fee is offered for this) without which the club cannot continue. These can all be done in a couple of sessions a year. If anyone is interested in helping please contact the LMC office and we will put you in touch with the current club doctor.

CHILD DEATH OVERVIEW PANEL REPORT – FATAL ARRHYTHMIA

The West of England CDOP recently discussed the case of a child who died of a fatal cardiac arrhythmia. For several years prior to his death, he had important symptoms that pointed towards a disorder of his heart rhythm, and he had seen several health care professionals. Unfortunately, the significance of his symptoms was not recognised. The panel therefore recommends:

- Any child who has an episode of collapse (syncope, or near syncope) which does not have a typical vasovagal character should be referred for cardiac assessment. Particular "red flags" that require urgent referral should be collapse during (as opposed to after) exercise.
- All children with recurrent collapse should have a 12 lead ECG and this should be analysed by a clinician experienced in the analysis of paediatric ECG.
- Children regarded as having potential congenital arrhythmia disorders should have correspondence posted and faxed directly to a paediatric cardiologist by the diagnosing clinician.

A TRADITIONAL JOKE FOR CHRISTMAS

It was Christmas Eve in the surgery and the GP was just hanging up his stocking when a mother and daughter slipped in at 6.29. "Doctor" said the mum "She's been putting on weight, feels horribly sick every morning and she must have trapped wind as her belly bulges all over as though she's swallowed a puppy." A few moments with the Sonicaid confirmed a well advanced pregnancy. "But that's impossible! She's never kissed a boy, never mind had sex with one!" The GP rose and walked over to stare out of the window. "What are you doing?" said the mum. "Well, last time this happened there was a very bright star in the East."

SMALL ADS .. SMALL ADS.. SMALL ADS ..

MATERNITY LOCUM
PARK MEDICAL PRACTICE

Details: Required for up to 6 sessions (as full days) from March/April 2011. Gynae experience would be useful.

Contact:
louise.abson@parkmedicalpractice.nhs.uk or thelma.thompson@parkmedicalpractice.nhs.uk.

"A CHRISTMAS CONTRACT, OR A GHOST STORY FOR CHRISTMAS"

By Dr Charles Dickens author of "A Tale of Two CTs", "Great Expectorations", & "Hard Times."

The story so far: Dr Jacob Marley was dead to begin with. Ebenezer Scrooge, his partner, never altered the brass plate. Sometimes he answered to Dr Scrooge, sometimes to Dr Marley, it was all the same to Scrooge. He employed poor little Dr Bob Cratchit as a salaried GP to do all the work while Scrooge went to meetings. One Christmas Eve, of all good days, the ghost of Dr Jacob Marley, a dreadful apparition, dragging the audit trail he forged in life behind him, visited Scrooge in his surgery and told him that he would be haunted by three Spirits.

The first was the *Ghost of Contract Past*, a vague, shifting figure, now with one hand then with many hands receiving forms and giving money. The Ghost took him to old Dr Fezziwig's practice and asked if he knew the place. "Know it? I was a trainee here!" Scrooge watched his young self working hard, long hours as an apprentice but strangely enjoying his work. As they watched the shadow of the surgery Christmas Party Scrooge commented that Fezziwig had had the power to make his burdens light or heavy and then, feeling guilty, that he should have liked to have a word with his poor, overworked salaried doctor. Unable to bear the pain of the memories of lost times, Scrooge extinguished the Spirit by ramming a Dutch cap over its head.

The Ghost of Contract Present was next, its capacious bosom wrapped in a sensible business suit, sitting on a throne of paperwork and speaking impenetrable jargon. Walking through general practices they watched doctors squabble and moan but then agree that it was a shame to argue and ask was there a LES? Scrooge and the Ghost visited many surgeries, never staying long or actually finishing a job, on an endless round of QOF visits, DSQS visits, contract review visits, medicine management meetings, performance review panels and QOF appeals. Scrooge noticed the Spirit had grown older, tired and slow. "My time with issues around the earth is brief," the Spirit told him, "it ends with issues around the stroke of midnight on 31st March 2013," but parts of him were dying already. Scrooge saw two wretched, abject, frightful, hideous, miserable children clinging to the Ghost. The girl was called Want of Imagination and the boy was Ignorance of What Doctors Actually Do. Scrooge asked if they had no refuge. "Are there no PFIs? Are there no walk-in centres?" boomed the Spirit of Contract Present and vanished. Scrooge was terrified to see a Phantom, draped and hooded that slowly, gravely, silently approached him like a mist.

"I am in the presence of the *Ghost of the Contract Yet To Come*?" said Scrooge. "Ghost of the future I fear thee more than any Contract I have seen." Scrooge followed in the shadow of its dress and they found themselves at a future GP Commissioning Consortium board meeting. "No," said a great fat American doctor with a monstrous backside, "I don't know much about it either way. I only know the NHS Commissioning Board closed his practice when the money ran out." Next the Spirit took Scrooge to his surgery. It was a surgery still, but not his. The furniture was not the same, and the figure in the chair was not himself. It was a nurse practitioner. He joined the Spirit again and wondering why and whither he had gone, accompanied it until they reached an iron gate: a graveyard, overrun with weeds, choked with too much burying. The finger pointed from a grave to him, and back again. "No, Spirit! Oh no, no!" Scrooge crept towards it, trembling, and read upon the stone of a neglected grave

"TRADITIONAL GENERAL PRACTICE"

The views expressed in this column are those of the author and not necessarily those of the LMC.

LMC AWARDS 2010

Nominations sought in two categories

2010 Barry

An annual accolade for the most incomprehensible or meaningless piece of NHS jargon you have seen in the last 12 months – the lucky winner being honoured by publication in our January edition.

2010 Broad Shoulders Award

Although it sometimes seems that nobody anywhere will accept responsibility for dealing with the patient problem you have in front of you, there are a few organisations and people (SPL and the Partnership Crisis Teams come to mind) who always seem to say "yes". We would like to recognise their helpfulness with a box of rather good chocolates for the one receiving the most nominations.

Please send you suggestions for both awards to harry.yoxall@somerset.nhs.uk

We wish all our readers a Very Merry Christmas and a Happy New Year

The LMC office will be closed from Friday 24th December and will re open on Tuesday 4th January.

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