# Somerset LMC Newsletter

**March 2011**

**Issue 164**

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## WHY GPS MUST LEAD COMMISSIONING

As if in keeping with the dreary weather, each day my inbox seems to accumulate more directive emails. This week, for instance, we must make sure that our sphygmomanometer cuffs are cleaned regularly and that we never issue more than 2 weeks of temazepam on one prescription. No doubt these are good ideas: although the LMC is not aware of any deaths from sphygmomanometer transmitted infection, it does seem more socially acceptable that the cuffs are not ingrained with the dirt of ages. But these protocols reveal the real problem that lies at the heart of NHS decision making, and that is the management of risk. And how are individual patients' needs and preferences considered in a protocol driven service?

We have noted before that if you give clever and motivated people a salary they will find ways of justifying it. Directives, reports, recommendations, protocols and procedures come pouring out. But if the author is not actually in the front line and providing services to patients these must be of limited value. Only GPs know what GPs do.

And what GPs do is manage risk – constantly, all the time, we are making clinical decisions on the basis of the best information we have to hand, filling in the clinical picture bit by bit over time. Yet not so long ago a PCT manager declared that a particular clinical pathway had to be "designed so that there is no risk". Already the structures that surround us are making it harder to make judgements based on likelihood rather than certainty, and if we let them become so rigid that there is no room for clinical decision making then the whole structure of primary care comes crashing down. QIPP will be swept away in an instant and the NHS will be broke in weeks.

Which is why we have to grasp the commissioning nettle, for the sake of our patients, ourselves and the principles of the NHS that GPs still overwhelmingly support. And we need to get on with this, because we cannot afford for there to be any break in the pace as the PCT hands over the baton. The Commissioning Transition Group, made up of LMC, Wyvern & PCT members, is proposing a county wide umbrella body with a GP majority of elected delegates from the emerging GP Federations. This offers the strength and stability of a large group able to continue existing relationships with the County Council and local providers, along with the flexibility to encourage federations to develop their own innovative local commissioning proposals and manage their own internal affairs. This means that delegates will not be representatives from their federation – it would obviously be undemocratic if a 30,000 patient federation had the same voting rights as a 100,000 patient one – but rather they will have a dual role, with a county wide responsibility a board member and also time allocated for a co-ordination and communication job within their home federation. To emphasise the parity between federations and the interim GPCC it is proposed that once the costs of existing work programmes have been met, the rest of the transitional £2 per patient should be split equally between the centre and localities.

Please do respond to the consultation email you have received, and please also consider if you would be able to stand for election, or to support a colleague in doing so. If that is too big a commitment, there will also be a

need for GPs to join one of the task groups that along with secondary care colleagues will be improving clinical pathways for the future. Training and financial support will be available. This is our chance to bring the NHS back to reality, and we should not lose it.

## THE SOMERSET END OF LIFE REGISTER

*You should apply now for a user account*

This Register is part of Somerset's End of Life Strategy and is a communications tool to improve co-ordination of care and to better meet the end of life care wishes of patients, so more can die in the place of their choosing and with their preferred care arrangements The Register replaces the current practice of faxing special messages. However, "Do Not Resuscitate" forms for the Ambulance Service (and care home, if applicable) will still be needed. Core information for those patients on your Palliative Care register - i.e. those thought to be in the last year of life, and who have given their consent – should be submitted including main diagnosis, resuscitation status, along with other information such as carer's details and the patient's wishes.

All Somerset Practices can now access the Register which is very simple to use. The ambulance trust and the out of hours' service, community staff, hospices and some departments (including medical admissions units) within the acute hospitals can also view it. The ambulance trust and out of hours' service use the Register in a slightly different way as information from the Register populates their own systems.

Practice Managers can set up user accounts for clinicians at
http://intranet.somersethis.nhs.uk/ServiceDesk/ITServiceDesk/UsefulForms/EndofLifeCareRegister/tabid/637/Default.aspx
You can also contact the end of life care coordination team at Wells, which is particularly useful for community nurses as they can then add/amend patients without having to return to the practice. Security is of utmost importance, so the web based Register is only accessible from certain locations, and practices only have access to their own patient data. All the relevant documentation including Advance Care Planning and Do Not Attempt Resuscitation forms, amongst others, can be found on the End of Life section under Nursing and Patient Safety on the NHS Somerset intranet, which is in turn accessible from the GP Desktop. To apply for a user account or to discuss further please contact Julie White, Julie.white@somerset.nhs.uk, 01935 384099.

## ABDOMINAL AORTIC ANEURYSM SCREENING PROGRAMME GETS UNDER WAY IN SOMERSET

The LMC is pleased that the NHS has at last recognised the value of AAA screening for men (we have long argued that this meets the Wilson criteria) and the Somerset programme is about to start. Men will be offered a single screening ultrasound in their 65th year (age 64-65) that will be provided in their GP practice when possible. Some practices will already have had lists of patients to check for suitability. Over 5,000 men a year will be screened, and those older than 65 will be able to ask for a test. Please do not encourage all of them to do that just yet! The national programme literature is available in several languages and an easy reading format for patients with learning difficulties.

Screening takes about 5 minutes and the screener just needs access to the internet, electrical power and a couch. A modest sessional sum can be invoiced for the minimal costs incurred by hosting the service. However, it is up to practices to decide if this is enough for them to agree to do so and some have chosen to waive the fee , as many practices have done. Clinic lists will be printed off by the service and will be available to the practice

The screeners have all been recruited from within the NHS and are comprehensively trained. They are supervised by a Senior Sonographer who in turn reports to the programme board.

Abnormal scans are reviewed and patients then allocated to three or twelve monthly follow up unless the aneurysm is more than 5.5 cm in which case the GP is informed and the patient referred on to the TST vascular team that is linked to the service. All patients with abnormal results will be offered health advice and support form a specialist vascular nurse..

The programme has been very well planned to suit as many men as possible and we anticipate a good take up in the county

Contact Karen.Bentley-Hollins@tst.nhs.uk
*Late News! The first pilot screenings in Somerset have already turned up two AAAs*

## EQUITY AND EXCELLENCE: LIBERATING THE NHS – OPPORTUNITIES FOR THE FRAUDSTER?

*Information from the Counter Fraud Service*

The National Fraud Authority estimate that fraud currently costs the NHS £263m annually although some experts believe that the true annual cost of NHS fraud could be £2.8bn. NHS Counter Fraud Specialists have had a significant impact but times are changing, with significant public spending cuts and the most fundamental changes to the NHS since its inception. Experience tells us that fraudsters adapt to change extremely quickly, often more quickly that those implementing the change, and unless adequate consideration is given to fraud risk management and strong financial governance there will be opportunities for the fraudster. We are entering a period in which there will be a significant shift of budgets and responsibilities away from PCTs and SHAs to GP Commissioning Consortia and it would be naive to assume that many of the current fraud risks will not affect the GPCC. Contractor fraud, employee fraud, invoicing fraud and patient fraud will all continue to be a threat to increasingly tight budgets. The two key controls in preventing and detecting frauds are segregation of duties and regular financial reconciliation, but the scale and speed of change in the NHS risks shifting resources and management focus away from these important fraud prevention actions. Firm management of fraud risks can be cost effective, both in reducing direct and indirect losses through fraud and in 2009/10 the counter fraud provision at Somerset PCT was rated amongst the top 4% of NHS organisations in the country. In the newly structured NHS, fraud will continue to be a threat to the resources available for patient care. To keep up to date with the latest counter fraud developments see www.dascfs.nhs.uk.

## PATIENT LEAFLETS FOR LIMITED CLINICAL VALUE/LOW CLINICAL PRIORITY PROCEDURES

As the finances of the NHS become tighter, we need to make sure that the money we spend in prescribing and referral is well used. That means we should not be using resources on intervention that are not evidence based. This is a new idea for some patients, who may have been used to getting more or less what they want from the NHS. The Flexible Healthcare team has developed a series of patient information leaflets for Limited Clinical Value/Low Clinical Priority Procedures that may be useful for you to share with patients who request such treatments. See

http://nww.somerset.nhs.uk/welcome/directorates/

## ATTACHED STAFF – LICENCE TO OCCUPY PREMISES

*Practices will need to sign a new legal agreement*

Whether the practice are owner occupiers or head lease holders, the change of employer for attached staff who work for Somerset Community Health from the PCT to the Partnership Foundation Trust will be of significance. If they are to continue to work out of the practice without establishing any sort of right to do so against your wishes, you need to sign a "Licence to Occupy " which specifies the terms under which you provide accommodation. A draft document is with the LMC's lawyers at the moment, but as soon as it is agreed the PCT will circulate it and we ask that you complete and return it as soon as possible.

## DOMESTIC VIOLENCE NOTIFICATIONS

*We advise you keep these for 3 months*

GPs will recently have been finding in their in-trays copies of the police log following a domestic violence report particularly if there are children in the family. This is one of the laudable local initiatives on information sharing between agencies in these circumstances.

The LMC encourage practices to adopt the Somerset Safeguarding (the multidisciplinary co -ordinating team) recommendation for dealing with these. Make a summary page entry on the notes of each person in the household using a "Domestic Violence" code and add a brief explanation. However, do note that these are records of allegations, and not confirmed or proven incidents, so you may need to include this in your comments. The actual report should be dealt with as a Case Conference minute and kept separately for three months before being shredded.

## AVON, SOMERSET & WILTSHIRE CANCER SERVICES NETWORK

General Practice profiles were launched by the National Cancer Intelligence Network (NCIN) and the National Cancer Action Team in 2010.

They bring together a range of process and outcomes information relevant to cancer in primary care and provide comparative information for benchmarking and reviewing variations at general practice level.

They help understanding of:

- take up of cancer screening
- utilisation of Two Week Wait urgent referral route
- proportion of patients referred urgently who are subsequently diagnosed with cancer
- endoscopy procedures
- emergency presentations of new patients with cancer
- emergency admissions of all patients with cancer.

More information can be found at:

www.ncin.org.uk/cancer_information_tools/gp_profiles.aspx

Dr Alison Wint, GP and Associate Medical Director for ASWCS can also provide information and advice and can be contacted on: alison.wint@nhs.net

Practices can sign up to access the profiles by registering at https://www.cancertoolkit.co.uk

If practices do not want to sign-up electronically, data about the practice can be provided in PDF format. The senior partner for each practice will need to sign an access agreement with the NCIN to confirm confidentiality.

### Somerset Colorectal Cancer Support Group

Exists to help bowel cancer patients and their families who are seeking support beyond that provided by the NHS. The Group has the backing of a clinical advisory team that includes a GP. Its main aims are

- provide support and information to people with experience of bowel cancer – patients, their families and carers
- lobby for improvements in medical and support services to bowel cancer patients and their carers
- raise awareness of bowel cancer and its symptoms
- raise funding to support the Gastrointestinal Surgery Department at Musgrove Park Hospital, Taunton

Contact: www.somersetbowelcancer.org.uk

## LMC CATEGORIES FOR SAFETY ALERT NOTIFICATIONS

Readers will be aware that there has been a pretty steady stream of these alerts for some time, but some of them are of little interest to GPs. We do not, for example, often use paediatric ventilators in primary care!
The PCT is expected to circulate all safety alerts, but the LMC agreed with the Patient Safety Directorate some time ago that it might be helpful for practices if the LMC scanned the alerts first and ranked them according to their likely importance for primary care. This does not mean you should not look at them all, but it may give a busy practice manager a way of deciding which need prompt action.

The LMC categories are:
**Category 1.** Important, should be seen by every GP on their next working day, or needs immediate action by practice manager
**Category 2.** Significant, should be brought to the attention of GPs as soon as convenient, or needs action by practice manager or relevant practice lead as soon as possible
**Category 3.** Of interest to GPs but infrequently encountered , or unlikely to relate to everyday GMS work Practice manager should ensure any clinicians to whom it is likely to be relevant are aware.
**Category 4.** This alert is unlikely to be relevant in normal GP practice.

In practical terms this is likely to mean:

1. Do it now!
2. Do it when you can
3. Add to the agenda of your next relevant practice meeting
4. You can probably file unless you know one of your clinicians works in the relevant area.

## SMTC Update

UKSH is now offering treatment for some conditions in ENT, urology, gynae & oral surgery. Details of the procedures and specialists concerned at www.uk-sh.co.uk
From 15th March appointments will be available for extended hours from
9am - 9pm Monday to Friday , 9am - 5pm on Saturday , 9am - 1pm on Sunday

*Open evening for referrers*
16 March 2011 at the treatment centre between 5pm and 8pm contact kmathurine@uk-sh.co.uk or 01749 333 697

## LETTERS TO THE EDITOR

Dear Sir

**Promotional Gifts to GPs**

Pharmaceutical companies are finally prohibited from handing out the smallest of gifts to doctors, in case they are seen to exert inappropriate influence on our prescribing habits. Today we received a dozen mugs and a supply of pens from a certain provider of independent treatment centres. Is it just me that finds this slightly ironic?

I'll try hard to ensure that these inducements don't affect my referral habits.

I remain, Sir, your obedient servant.

James Hickman

(*The 2010 Bribery Act was due to come into force in April but has been deferred until the summer. We understand that the Ministry of Justice has said that "corporate hospitality" and promotional gifts are not forbidden, but they are referred to in the Act so action can be taken when they are being used as bribes. The standard will be what is "normal & acceptable" in the industry concerned, and whether the offer is relevant to the business in hand. So, we may yet see a return of branded pens and post-it notes! Ed).*

Dear Sir

**Time out of General Practice and the Medical Performers List**

As the GP responsible for putting doctors on and off the PCT performers list I would like to remind colleagues about the need to tell the PCT when you are not practicing as a GP in the UK. The Performers List Regulations state that if you are not in British general practice for a period of 1 year you are removed from the list. To get back onto the list in the following year should be a straightforward application as long as you can provide evidence that you intend to provide GP services in the area of the PCT concerned.

However, if you are out of British general practice for 2 years you will not automatically be re-instated. You become a "returner" and will need to follow the returner protocol on the Severn Deanery website – that will generally now involve sitting a knowledge test and doing an OSCE in the London Deanery. This is followed by an interview and usually a period of reorientation/ retraining in a training practice at your expense. Please bear this in mind when planning extended periods abroad or out of practice for other reasons.

Yours sincerely

Ian Kelham

## SMALL ADS .. SMALL ADS.. SMALL ADS ..

**GP PARTNER/SALARIED GP: HIGHBRIDGE MEDICAL CENTRE**

**Details:** 8 sessions.

**Contact:** Enquiries/CV and covering letter with 2 references to Joanne.farnworth@highbridgemc.nhs.uk or telephone 01278 764230. Closing date 21st March.

**PART TIME SALARIED GP: HENDFORD LODGE MEDICAL CENTRE, YEOVIL**

**Details:** 8 sessions, ideally April/May start date.

**Contact:** Practice Manager at sian.brammer@hendfordlodgemc.nhs.uk or telephone on 01935 470200.

**PART TIME SALARIED GP: ABBEY MANOR MEDICAL PRACTICE, YEOVIL**

**Details:** 6 sessions, ideally April/May start date.

**Contact:** Practice Manager at sian.brammer@hendfordlodgemc.nhs.uk or telephone on 01935 470200

**ASSOCIATE GP TO COVER HOLIDAYS: EXMOOR MEDICAL CENTRE, DULVERTON**

**Details:** 24 weeks per annum to provide holiday cover for partners; 12 wks working 5 days and 12 wks working 2.5 days per week. **Contact:** Enquiries/application letter and CV to david.berger@exmoormc.nhs.uk or daveberger@gmail.com or telephone Dr Berger on 01398 323333 (Mon/Wed/Fri only).

Closing date 1st April and interview date 26th April.

**SALARIED GP: THE FOR ALL HEALTHY LIVING COMPANY, WESTON SUPER MARE**

**Details:** To join a team of salaried GPs, job share considered. www.forallhlc.org.

**Contact:** For further information contact Dr Paul Seviour on 01934 427527 or

paul.seviour@gp-L81670.nhs.uk or the Practice Manager on 01934 427426 or

Shirley.smith@gp-L81670.nhs.uk.

**HMS RALEIGH (Torpoint) – FULL TIME GP**

**Details:** Full time/Job share civilian GP to assist the principal medical officer in treating Navt/ Royal Marine personnel and new recruits

**Contact:** Surgeon Commander James McIntosh 01752 811228 Raleigh-medpmo@nrta.mod.uk

## DR WHIMSY'S CASEBOOK

### Specialism

*The year is 2014. Dr Whimsy is on the telephone to the district hospital.*

*Switchboard:* Musgrove Park Quaternary Referral Centre; how can I help you?

*Dr Whimsy:* Hello, Dr Whimsy here. I'd like to speak to a physician for some advice, please.

*Switchboard:* A what?

*Dr Whimsy:* A physician. It's a kind of doctor who, ah, treats people with drugs.

*Switchboard:* A doctor who drugs people... you want a psychiatrist?

*Dr Whimsy:* No...

*Switchboard:* An anaesthetist?

*Dr Whimsy:* No, but I see what you're getting at: let's have a gastroenterologist, please.

*Switchboard:* No problem. Upper or lower GI?

*Dr Whimsy:* Oh... um, upper GI please.

*Switchboard:* Putting you through....

*Receptionist:* Upper GI – can I help?

*Dr Whimsy:* Yes, my name's Dr Whimsy. I'd like to speak to somebody for advice about a patient who has...

*Receptionist:* Pharynx, oesophagus, stomach or duodenum?

*Dr Whimsy:* Er, stomach, I think.

*Receptionist:* You *think*?

*Dr Whimsy:* Well, in my patient it probably involves the bit between the stomach and the gullet, where...

*Receptionist:* So do you mean the cardia or the lower oesophageal sphincter?

*Dr Whimsy:* *[chuckles]* You mean there's an *upper* oesophageal sphincter?

*Receptionist:* I'm sorry?

*Dr Whimsy:* Forgive me, I'm just a GP.

*Receptionist:* *[tetchily]* Cardia or lower oesophageal sphincter? Above or below the Z-line?

*Dr Whimsy:* Right. Z-line. Yes, lower oesophageal sphincter then, please. Final answer.

*Receptionist:* I'll put you straight through....

*PA:* L.O.S. What do you want?

*Dr Whimsy:* Hello, I'm Dr Whimsy. I'd like to speak to somebody...

*PA:* Mucosa, submucosa, muscularis or adventitia?

*Dr Whimsy:* Uhh?

*PA:* *[sighs]* Which bit of the sphincter? Epithelium, glandular, muscular or connective?

*Dr Whimsy:* Gosh... epithelium, I suppose.

*PA:* Are you *sure*?

*Dr Whimsy:* What difference does it make?

*PA:* Mucosa's sick, muscularis is on study leave, and adventitia doesn't talk to GPs. I can give you submucosa if you want.

*Dr Whimsy:* Well, if you think it will help...

*PA:* Putting you through.... Sorry, the line's busy. Please try again in a couple of weeks. *[Click...dialling tone]*

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