Somerset LMC Newsletter

August 2011

Issue 168

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GRASPING THE NETTLE

I have a charming and very stoical patient who suffers from disease in just about every organ system. At the last count she had nine consultant teams looking after some element of her care, each dealing with a separate condition. Recently she has developed a progressive anaemia, and it is hard to know whether this is yet another problem or a new manifestation of one of her existing disorders. My difficulty was knowing who to ask for advice: there is nobody in the hospital identified as a lead consultant who will look at the whole patient. Each specialist is busy treating one little bit. In the end I just wrote the same letter to all of the consultants who were dealing with a disorder that might cause anaemia . All were very helpful, assuming that the problem was indeed in their area, and all suggested appropriate actions - all of which were different .

This is perhaps a microcosm of the danger that fragmentation of the NHS presents. Especially at a time of financial restraint, service providers will retreat into their core work and the temptation to abandon that which is not contractual or is not paid will increase. Gaps will inevitably appear, particularly where health and social care provision touches, and more patients will find themselves lost and bewildered.

One answer is to use the opportunity of Clinical Commissioning to strengthen the links between GPs and consultants that have become too distant over recent years. Working together to ensure that care pathways are continuous and comprehensive, as well as cost effective, should help us achieve that, and the evening meetings with consultants organised by SGPET also give an opportunity for us to put faces to names.

But the contrary pressures are also strong. Consultants non-clinical contract hours are under pressure, and the sheer volume of work pouring in to primary care, even before the current re-organisation – makes it hard for clinicians to lift their eyes from the grindstone. There is a growing risk that medicine will become a purely technical job with doctors in all fields working shifts to provide protocol driven care to whoever is next on the list. Continuity is already weakened in hospitals with patients moving between clinical teams as they move between wards and changes in junior doctor staffing may mean that only the consultant has any idea about the course of the patient's illness, and even consultant continuity is under threat in the drive for more efficiency and shorter lengths of stay. And now community nursing faces the challenge of a change from practice to locality based teams, which inevitably means a distancing of the relationship with the practice and its patients

Which brings us back to a familiar theme for this newsletter. We hear time and again that very many patients – not just the elderly and the chronic sick – value a long term relationship with "their" doctor. They want to take their problems to someone they know and trust, secure in the knowledge that the GP will be a guide and advocate as well as a provider of technical care – and that, in the end, is why most of us are doing the job.

OVERSEAS VISITORS' ENTITLEMENT TO NHS TREATMENT IN PRIMARY CARE

Is still not very clear

The first question to ask is whether the person is a visitor - on holiday or a short-term stay or he or she is "intending to reside for a lawful and settled purpose". Such purposes include, amongst others' permanent employment, formal training, or joining an already resident relative as a dependent

For visitors, there is a duty on practices to provide immediately necessary treatment to any person in their practice area, regardless of whether or not the patient would otherwise be entitled to NHS care.

Practices may choose to treat anyone as an NHS patient for primary care purposes if they so wish. Because of the complexity of the entitlement rules this may well be the easiest solution for simple things.

European Healthcare Arrangements –visitors from EEA countries should not be charged for any treatment which becomes necessary during a temporary stay in the UK, other than normal charges that UK residents pay. However, they should only be registered as Temporary Residents . It is important to establish their entitlement to free NHS treatment. Visitor from EEA countries and Switzerland should demonstrate their right to healthcare treatment by producing a European Health Insurance Card (EHIC).

Eligible overseas visitors to the UK under the current European healthcare arrangements are entitled to a full range of services including, for example, any necessary blood tests for diagnosis or monitoring, appropriate disease monitoring checks such as BP, routine maternity care, provision of medication including oxygen, and renal dialysis (although the latter two should normally be organised before travelling)

Bilateral Healthcare agreements – there are a number of bilateral healthcare agreements where the visitor is entitled to emergency or immediately necessary treatment. In essence these agreements focus on healthcare treatment that becomes necessary during a visit. They do not cover situations where people come to the UK (unless with an explicit referral) to obtain treatment. DH guidance states that GPs may treat overseas visitors that do not require immediate and necessary treatment, on a private basis. If a visitor is accepted onto the GP's list for free NHS primary care treatment if referred to secondary care it is likely that they will be charged by the hospital. Remember that the Channel Islands are not part of the UK nor part of the EU, therefore if it is not 'immediately necessary' treatment the patient can be charged. The DH weblink below should take you to the current guidance.

Resident or Intention to Reside (Settled Status)

To qualify for full NHS care a person must have an identifiable reason for residence in the UK, and that show a sufficient degree of continuity to be properly described as "settled". There is no "six month" rule in determining residency - the question is whether the reasons given constitute "settled status" as above.

A practice may reasonably ask for evidence of reason and duration of stay as it may help with the process of registration if an applicant can provide documentary evidence of this or her current address and demonstrate that he or she lives lawfully in the UK. GP practices are not required to check, record or take copies of any such supporting documentary evidence, nor are they obliged to carry out checks on a person's immigration status. This needs to be done in a non – discriminatory way as the NHS Ombudsman has found against a practice that insisted on the provision of particular information. A reasonable policy might be to ask people registering who do not have an NHS medical card (or number), and have not previously been registered with an NHS GP for proof of identity, such as a passport or Identity Card and proof of residency in the form of a rental or housing agreement, a utility contract or bill, or perhaps bank correspondence. Students should be able to produce an admission letter from the college or university and a marriage certificate or civil partnership registration document may be required if a surname has changed. LINK

Based on an article by the TVPC agency

THROMBOPROPHYLAXIS IS PREVENTING MATERNAL DEATHS

But Strep A infection is on the rise

The eighth Report of the Confidential Enquiries into Maternal Deaths, now retitled as the rather more punchy "*Saving Mothers Lives*", has recently been published, and the executive summary is well worth a read link The 10 pages of carefully written text are a microcosm of what is good and bad about the NHS and they give an encouraging picture of a fall in maternal mortality for the period 2006-2008 with a reduction in the inequalities gap, but they also raise concern about variations in practice, a rising incidence of streptococcal infection, and the impact of increasing maternal obesity. The overall maternal death rate fell from 13.95 in 2003/05 to 11.39 in 2006/08 largely due to a reduction in VTE from 41 to 18 deaths , attributable to the start of routine thromboprophylaxis for high risk cases during this time. (There is now some concern that we have may have taken this too far with up to 40% of women having postnatal treatment, but that is another story). Fatalities from ectopics fell from 31 to 17, and sepsis is is now the commonest cause of direct pregnancy associated death (overtaking eclampsia), though indirect causes – such as cardiac and neurological causes – now predominate. The worrying rise in Strep A infections reflects the change in the virulence of the organism that has been seen elsewhere, but the report suggests GPs should have a low threshold for treating sore throats in pregnant women with antibiotics as well as making sure pregnant patients take care to avoid transmitting infection from the respiratory to the genital tract and are aware of the transmission risk from household contacts. It also reminds us of how quickly overwhelming septicaemia can develop and the need for swift action if it is suspected.

GPs have long suspected that their gradual exclusion from maternity care is not always in the best interests of their patients and we know that communication with the midwifery service about women's previous medical and social history is patchy. The LMC is in discussion with the Maternity Services Liaison Committee for the county how this can be improved and we will let you know what is concluded.

INVESTIGATION OF CLOSTRIDIUM DIFFICILE CASES DETECTED IN PRIMARY CARE

Not all are due to GP antibiotic use!

Although the number of hospital reported C. diff cases has been gradually falling, the number reported from patients in the community has risen with a total of 91 reported in Somerset so far this year, against an anticipated number of 65. There was a surge in May - and also, interestingly, at the same time last year although the infection is not usually seasonal. There are several likely reasons for the rise. First, GPs and nursing homes are more alert to the problem and more likely to submit stool samples. Secondly, the testing methodology currently looks for the presence of the organism – which some people carry without developing disease – and the presence of the gene that can produce toxin, so a norovirus episode could increase the number of samples submitted and identify patients with C. diff where there is no actual C.diff infection. Thirdly, some 40% of the patients in primary care had been in hospital in the preceding 6 weeks and could have acquired the infection there.

There is a plan to change the test procedure for primary care to look for C. diff toxin once the organism and the toxin gene have been identified, which correlates much better with actual infection, and in the longer term perhaps to type the isolates so we can get a better picture as to whether cases are related or co-incidental. It is expected that the Microbiologists and/or the Infection Control Nurses will contact you to undertake a clinical assessment to determine if patients meet the case definition before advising on treatment.

Meantime, the ICNs will be undertaking good old-fashioned case investigation to try and work out whether this is a blip or a trend, and to see if there are any common threads. If you have a patient who has C. diff isolated please expect a phone call asking for more information. The C. diff community management algorithm which has previously been agreed by the LMC can be found at Link

SIGN OF THE TIMES?

Extract from a letter to the PCT from a Somerset practice manager

The mother of a young woman has complained that we have asked to see her daughter (age 16) before prescribing a pill to alter her menstrual cycle so her daughter can go to the Prom at the end of the month. The GP has asked to see her before prescribing it.

The complaint is that the daughter is too busy and "also having dress, hair and make up appointments" so could "do without being messed around by the surgery".

CONSIDERING PRIVATE HEALTH INSURANCE?

The LMC recommends you look at the policies available from WPA

GPs have very mixed opinions about private health insurance. On the one hand, there is a perception that we ought to demonstrate our confidence in the services that we work with (and will shortly be commissioning) by using them, and on the other a feeling that as wealthy individuals we should make our own provision and not burden the increasingly stretched NHS.

Whatever your views on the matter, it is worth seeing how things have changed and policies have become much more sophisticated and individualised in recent times. In response to enquiries from members over the years, the LMC has been looking at some of the options available, and recommends that if you are considering starting or renewing a health insurance policy you should look at the products available from Western Provident Association (WPA). Based in Taunton, WPA have been growing in a largely static market often due to recommendations from existing customers They have a reputation for settling claims promptly and locally for being excellent employers.

WPA's Flexible Health policy offers a range of cover from just fast track access to private surgery up to complete private care (with a co-payment option). The former is not expensive, particularly as WPA give a discount for self employed professionals in recognition of our lower claim rate. Given the disruption that can be caused when a GP is off sick, this is something that practices may wish to consider purchasing as a practice expense. Also of interest may be their NHS top-up policy that allows both individuals and employers to buy selective cover to supplement NHS provision. The basic policy includes , for example, access to private manipulative therapy services for things like back pain but you can add in extras like the provision of advanced cancer drugs not yet approved by the NHS or screening tests and scans if advised by a specialist.

The LMC has negotiated an additional discount for Somerset GP practices, so if you want to know more please go to the dedicated LMC page at wpa.org.uk/slmc

OUT OF HOURS FAX RECEIVED.

"*Patient in on rest bite – has ulcers on legs, leaking all over*" The practice wondered if he needed a tetanus booster or whether this was a euphemism for a starvation diet!

BERGE BALIAN GOES ON A LONG WALK…

Ex-LMC Chairman raising funds for charity

Two friends and I are planning to walk around the Isle of Wight over the weekend of 2nd, 3rd and 4th September. We will be walking 67 miles over 3 days. This is going to be a difficult and painful experience for me, given my current fitness levels and the fact that the other two are ex-forces and have specifically been training for this (my training plans have sadly not yet materialised!).
In order to make the task a little easier to complete, we're going to raise money for charity. I'm raising funds for "Help for Heroes" and I would greatly appreciate your support. I've set up a web page on the "JustGiving" website, to make it easier for you to donate. It's easy to donate online with a credit or debit card - just go to my "JustGiving" page:
www.justgiving.com/Berge-Balian
Alternatively, you can text your donation to "70070", texting the code DYIR76 then the amount you want to donate (text £....).
Thanks very much!

SESSIONAL GPS NEWSLETTER FROM THE GPC

Covering matters of interest to sessional GPs and the work of the Sessional GPs Subcommittee on your behalf. This July issue also has special reports on the motions passed at the Annual Representative Meeting (ARM) and the Annual Conference of Local Medical Committees which relate to sessional GPs. Also included are items on:

- NHS Reform and Sessional GPs
- Revalidation
- Information Cascades
- Sessional GP conference 2011

Contacting the Sessional GPs subcommittee about concerns in your area.link

SOMERSET ATRIAL FIBRILLATION UPDATE

12.30 to 17.30 21st September 2011 at the Taunton Conference Centre, SCAT
A cardiac update course for healthcare professionals involved in the management of arrhythmias and stroke prevention in atrial fibrillation. Includes presentations on acute management of AF, cardiac ablation, stroke prevention and What's new in AF.
Details link
Booking BHFarrhythmianurses@tst.nhs.uk or 01823343595

PERCEPTION, THE NINTH LETTER AND THE US DOLLAR BILL.

Apologies for the cryptic title, but I hope all will become clear.

Since my last report we have seen the first newsletter issued by the iGPCC. This was not greeted with universal approval, indeed there were requests to be unsubscribed which followed. In these days of information overload, I have some sympathy, but would ask that you resist the urge to disengage so quickly.

Let me explain why. Whilst there will be different views on the content or tone of the newsletter, I feel it is important is that all of us, as the constituents of the iGPCC , to both remain engaged and also ensure that our federation delegates remain accountable. I have previously, explained the name change from GPCC to CCG – clinical commissioning group. In Somerset, the PCT/Wyvern/LMC "Transition Group" organised elections to the interim board. But before the group becomes fully independent, further elections and subsequent appointments will have to be statutorily undertaken, hence the LMCs previous insistence on the ninth letter preceding GPCC.: iGPCC.

The iCCG Board members suspect they would have more standing that amongst their peer CCGs if they dropped the " i" . However, the LMC has voiced the view that to do so would give the impression that the board is now fixed, with no opportunity to change its membership, which might, for some GPs and others, be an ideal excuse never to engage in the first place. Unfortunately, the regulations do not allow for the use of the term interim, so the body will be known as Somerset Clinical Commissioning Group (SCCG).

Meanwhile there are already presumptions circulating that the SCCG is just Wyvern re-incarnated and we can all carry on business as usual . For some scepticism to exist is perhaps healthy, but at the same time, it brings a responsibility for open-minded scrutiny of the actions of the board. Disengagement is definitely an unhealthy option - remember that the new organisation has a budget getting on for a hundred times the size of that under the control of Wyvern!

Despite these technicalities, real progress is being made. Extensive training has been organised for the Board, and the PCT is handing over the first commissioning responsibility (for medicines management) to the SCCG at the end of July . The Partnership/Somerset Community Health tie-up has been delayed but once complete will be the next major contracting area to be delegated.

So, what has all this to do with the dollar bill? Well, on the reverse side, as well as the motto *E pluribus unum,* (one from many) which has its own connotations here , is an image of the all seeing eye….

So, let us ensure that whilst the ninth letter will no longer precede SCCG, we remind our delegates of that image and the scrutiny under which we hope they will continue to develop. We also urge them to remember another ninth letter word … 'involvement'.

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

SALARIED GP/MATERNITY COVER GP: FROME MEDICAL PRACTICE

Details: Required from Oct 2011 until July 2012. Closing date 19th August, interviews on 26th August.

Contact: Please apply with CV and covering letter to Tracey McCulloch, Frome Medical Practice, Park Rd, Frome BA11 1EX or by email tracey.mcculloch@fromemedicalpractice.nhs.uk. www.fromemedicalpractice.co.uk

DISPENSER: EXMOOR MEDICAL CENTRE

Details: 12 hours per week regularly and 35 hours per week for 11 weeks per year to cover holiday within Dispensary. Dispensary or pharmacy experience desirable but not essential. Closing date 31st August.

Contact: Kathryn Kyle or Dr Andrea Trill on 01398 323333 for enquiries. Formal applications with CV & covering letter to Kathryn Kyle, Practice Manager, Exmoor MC, Oldberry House, Fishers Mead, Dulverton TA22 9EN. www.exmoormedicalcentre.co.uk.

SALARIED GP: TAMAR VALLEY HEALTH

Details: 6-8 sessions per week Callington and Gunnislake Health Centres. Closing date 20th August.

Contact: Kathie Applebee, Strategic Management Partner for more details. Kathie.applebee@call-gunn.cornwall.nhs.uk. www.tamarvalleyhealth.co.uk.

SALARIED GP: MID DEVON MEDICAL PRACTICE

Details: 3 sessions per week in our Witheridge Surgery (Tues pm & Wed all day) with opportunity to cover annual leave etc at all 3 surgeries. Commencing Autumn 2011.

Contact: Jane Hunt 01884 860205 janehunt@nhs.net. Closing date 31st August.

Dr Whimsy's Casebook: Post-Graduate Education

It's a typical Monday afternoon. Dr Whimsy has just returned from a leisurely lunch at the golf club and is taking coffee and liqueurs back at the surgery. Having nothing to do, he has his feet on the desk and is reading Heat magazine. The telephone rings. His pedicurist answers it and hands him the receiver.
Pedicurist: Sweetie-Daddykins, it's somebody called Dorothy I. Deeres from the PMT.

Dr W: Dotty! It's been ages – I haven't heard from you since, gosh, must be ten o'clock. I expect it's important.
Ms D: It certainly is, Dr Whimsy. I have been doing some extensive research and came across a condition which GPs are not aware of. You'll need to write this down; do you have a pen there?
Dr W: Ready and waiting.
Ms D: Have you taken the cap off, and are you holding the pen pointy end downwards?
Dr W: Hang on a sec - yup, fire away. Oh no, I need something to write on. Ah, thank you, Fluffy-Pumpkin. No, not you, Dotty. OK, go ahead.
Ms D: Write down D - E - M - E - N - T - I - A.
Dr W: Hmm, I've heard of that. Impaired function, loss of capacity, dissociation from reality – I think I saw a case on TV a few months ago. Wasn't it the Health Secretary?
Ms D: Probably. Anyway, you obviously know something about it. What you *won't* know is that patients can exhibit sudden changes in behaviour which could be triggered by something such as a bladder infection. In fact, *[sotto voce]* it can sometimes cause the actual symptoms of dementia.
Dr W: No kidding? Well, thanks for the tip, Dotty. 'Bye now.
Ms D: Wait a moment, Dr Whimsy. You have to do something about it when it happens.
Dr W: Who, me?
Ms D: I'm afraid so. First, you have to see the patient...
Dr W: *WHAT?*
Ms D: I'm sorry, but it's what we pay you excessively for. Then you have to do various tests, including a urine test.
Dr W: Yuck. That's one for the nurses, I do believe.
Ms D: Perhaps so, but then you have to treat it.
Dr W: Good old rispercillinazide. I have a pile of pre-printed prescriptions for it *[rustles papers]* somewhere under these travel brochures.
Ms D: Too expensive, Dr Whimsy, especially the generic – I might have to hint at blaming you for ward closures to pay for it. No, I was thinking of something non-pharmacological. You could start with Music Therapy. Do you play an instrument?
Dr W: I do indeed.
Ms D: Good, take it along with you. What do you play, incidentally?
Dr W: Cymbals and Klaxon.
Ms D: Hmm. Perhaps there's a quieter alternative. How about Animal Assisted Therapy? I'm sure you have a furry pet they could cuddle up to, a coypu or something?
Dr W: Well, there's my son's tarantula.
Ms D: Perfect. Anything that will tick the box, eh? Oh, and don't forget to give them lots of simvastatin – we don't want them furring up, do we?
Dr W: Of course not, Dotty. It wouldn't be natural.
Ms D: Hold on a minute...there's something else coming up on the ticker-tape...miasma...atheisma...ashcan...
Dr W: Asthma?
Ms D: That's it. It says here that it's a good idea to treat, er, what you said, with a view to improving the symptoms.
Dr W: Gosh, it never occurred to me. Is that for real?
Ms D: That's what it says here. It also says you should make sure the patient sticks the right end of the inhaler in their mouth.
Dr W: The inhaler? Oh, is that the thing which gives off a puff of smoke? I thought it was for diagnosing deafness.
Ms D: Uhh? How does that work?
Dr W: You squirt it up the patient's nose. If a cloud of dust shoots out of their ear it means the drum is perforated. You can get smoke rings if you work at it.
Ms D: Thank you for that, Dr Whimsy. I'll include it in my next briefing.
Dr W: You're very welcome, Dotty. Bye-bye. Now, how far did we get, my little Floozle-Poozle? No, not you, Dotty.

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