
Somerset LMC

Newsletter



Issue 101

Nov/Dec 2003

“Boarding Out Medicals” for Children in Care

Are not part of your GMS/PMS Commitment

The LMC was surprised to learn from the local office of the body that now regulates all care homes, the National Care Standards Commission (NCSC), that there are over 100 small children’s homes in Somerset. Some of these are set up to care for just one child, using staff working rotating shifts over 24 hours with as many as three carers on duty at any one time. Little surprise, then, that the cost may be over £4000 per week.

We have mentioned before our concern that young people with such high levels of need can place a considerable burden on already thinly stretched specialist services, and other agencies have a similar view. However, a number of GPs have recently raised with us the specific matter of the “Boarding Out” medical examinations that are required by the placing Social Services Department. Most children in these homes are placed by hard pressed local authorities in and around London or the midland cities. Under the 1989 Children Act young people in care should really be placed within 50 miles of home, so one can but wonder why so many are ending up in Somerset. Part of the requirement laid on the relevant authority is that they should arrange for the children to be medically examined annually and this is where the problem lies. So far as the care provider is concerned, this is just another chore, and the young people concerned for the most part want nothing to do with it – so appointments are made and not attended, which is another half hour of GP time wasted. And just to rub salt into the wound, some Social Services Departments are notoriously slow payers, so even after the examination has been done the fee can take many months to arrive.

To complicate matters, most of these young people can be considered “Gillick competent”, and are therefore able to decide whether or not to consent to the examination at all. We therefore suggest that when you are asked to book an appointment for a Boarding Out

medical, you send the following letter to a named senior officer for the home:

We understand that you have asked thatwho is in your care should have a Boarding Out medical for the social services department of the placing local authority.

This service is not part of the NHS services provided by GPs, and we are only able to undertake it on the following conditions:

- 1. The appointment will not be booked until we have received from you the relevant forms from the placing authority.*
- 2. We need confirmation in writing from a senior officer at the home that the young person in question has consented to attend for the examination.*
- 3. If the appointment is missed or cancelled at the last moment we will not offer another one. You will have to make other arrangements for the examination to be carried out.*

Please also note that Somerset Local Medical Committee, which represents GP practices in the county, has asked us to inform them of any care home or organisation that regularly books appointments that are not attended so that this information can be passed on to the NCSC.

Finally, if like one GP you have been waiting 18 months to be paid by a local authority, we would be happy to advise on how to take the case to the Small Claims Court.

GMS 2 Timetable

What should you be doing now?

PANIC! Run around like a headless chicken! Hide moaning in despair in the Health Visitors Cupboard!

Feel better? OK – now think about:

- 1. Keep working on those disease registers.** Do make sure patients are properly coded with up to date diagnoses – Patients with hypertension should be coded as “Essential Hypertension” and not (for example) “Blood Pressure Raised [D]. Make sure everyone in the practice has a laminated card by their computer reminding them what to do.
- 2. Start doing some financial projections.** Cash flow is going to be real problem with the delay in achievement payments for the QOF until the end of next financial year. Talk to the bank about setting up a business loan (tax allowable) so that partners drawings and practice cash flow are ensured. If the bank doesn’t offer a good deal, change bank.
- 3. Look again at Enhanced Services.** Not just the obvious ones, but also the less popular NES. Can you set up an agreement with neighbouring practices to bid for locality services between you? Remember, any service lost to general practice will be hard to regain
- 4. Recalculate your Global Sum and MPIG.** We are not going to get the nationally calculated figures until the last minute. Many of them may well be inaccurate. You must have your own calculations ready to argue the toss with the PCT straight away if things look wrong – once the MPIG is agreed; you are locked into it unless you switch to the Global sum.

Referrals for Private Care

Not all GPs were happy with the request that we passed on in the last Newsletter that GPs include in private referrals some indication as to what level of care the patient was seeking. One correspondent has replied:

The first item in this “Special Anniversary” edition of the LMC Newsletter is totally unacceptable. I’m disappointed by the lack of the usual incisive commentary and would offer my own version:

“My patient is requesting a consultation and initial clinical investigation only. He or she intends to revert to the NHS for investigation and treatments”

Translation: My patient is fully aware of the long waiting lists for outpatient consultation and surgery and believes (rightly) that paying a consultant £150 will allow them to (unfairly) queue jump over those equally or more deserving patients who either do not know of or cannot afford this short-cut.

“My patient is requesting a consultation and any necessary diagnostic and investigational tests required to reach a sound diagnosis”

Translation: My patient would like to see a physician privately but expects his NHS GP to prescribe any treatments irrespective of their value or cost-effectiveness on the NHS

“My patient is requesting complete private care including surgery and/or admission as appropriate”

Translation: My patient has private health insurance/has won the lottery

Does anyone else have a view on this?

What to do about 'Flu?

Trying to make the current NICE guidance on 'flu work in general practice illustrates just how difficult it is to fit nice tidy paper protocols fit the messy and chaotic world of real medicine. So what is an ordinary GP to do?

First, it would be a great help if we could have a reliable clinical diagnostic protocol for influenza. The best we have come across is:

"A prostrating illness with at least 4 of the following symptoms and signs: Fever over 39 degrees, with sweats, sore throat, cough, myalgia, and headache" there is usually no significant rhinitis.

The NICE guidance also refers to "Influenza-like illness", which presumably means that the diagnosis is clinical rather than virological – in other words, the same diagnostic criteria should apply.

Secondly, we need to know whether there is evidence of true 'flu circulating in the local community. At present there are a significant number of patients with some of the above symptoms, but usually with quite marked GIT disturbance as well. Although 'flu can cause GI upset, we have only had two 'flu A isolates in Somerset so far this winter, so this appears to be a different virus. The local Health Protection Team is setting up a small monitoring group and will tell PCTs and GPs if the situation changes.

Thirdly, it is not too late to encourage the "at risk" to take up the offer of 'flu immunisation, even though the current vaccine probably only offers partial protection against the Fujian strain prevalent in parts of the UK and the injection takes 2-3 weeks to generate maximum immunity. The Chief Medical Officer's letter of 5th November mentioned that four children had died of influenza A but that the total number of childhood deaths from respiratory illness was "far lower than in the last two years". More recent evidence from the Health Protection Agency nationally confirms that under fours have the highest incidence of infection in this outbreak, but that of the five children who have now died, none was in a high risk group. Furthermore, although the attack rate appears to be lower in the elderly, morbidity and mortality may well prove to be higher.

In the current climate of unease about childhood immunisation it may well be even more difficult than usual to persuade parents and children of the benefits of a 'flu jab –especially when two injections are needed for children, it needs to be repeated annually, and the degree of protection is uncertain. The CMO letter emphasises the need to immunise children in the "at risk" group as well as adults, and it may be worth trying to identify and make contact with the parents of the most vulnerable children, including asthmatics who have recently needed oral steroids or had a hospital admission. The *lower* limit of "Chronic Respiratory Disease" in this context is not clearly defined, so if the parents of any wheezy child request immunisation we recommend that you offer it.

Treatment and prophylaxis of 'flu is another vexed subject. Zanamivir is licensed for the treatment of flu, but it is not easy to learn to use a diskhaler (BMJ 2001: 322; 577-579).

Oseltamivir is an oral treatment indicated in NICE guidance for the treatment of at-risk patients over a year old, and also for the prophylaxis of unimmunised (or so recently immunised that the injection has not yet worked), at-risk patients, over 13, able to start treatment within 48 hours of exposure. Health Protection suggest that "exposure" means "living in the same household as, or in very regular close contact with, the index case" As you can see, it is much better to try and get such patients to accept immunisation rather than try and treat them later!

Life gets really complicated if either a member of staff or a patient living in a residential care institution develops a 'flu like illness, because NICE says that all high-risk residents – presumably including all the over 65s – should then be offered oseltamivir prophylaxis within 48 hours of exposure *irrespective of whether or not they have been vaccinated*. If his situation arises we suggest that you contact the Health Protection lead of your PCT for help, because not only will all the at-risk patients have to be identified and prescriptions obtained from the relevant practice, but it will also necessary somehow to obtain a supply of oseltamivir as pharmacies are unlikely to be holding significant stocks locally.

A helpful algorithm for triaging flu calls can be found at: www.doh.gov.uk/zanamivirguidance/triage.pdf

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Referral Management Centres

Should GPs endorse them?

The LMC has considered the pros and cons of Referral Management Centres, and has concluded that on balance they offer a number of benefits.

1 Referral Tracking

Referral within the NHS has hitherto been chaotic. Without any checking system it has been impossible to make sure that a referral is despatched, that the hospital has received it, and that an appointment has been sent in response. An RMC can use simple IT to log and monitor all referrals. The patient will know that the referral has gone because RMC staff will contact them, and the PCT will be able to check the progress of referral and initiate action if waiting list targets look like being exceeded.

2 Referral Diversion

Not all referrals require a consultant opinion. Some can be dealt with by, for example, a specialist physiotherapist or a nurse practitioner. Yet others may be better handled by a GPSI working for the PCT. Clinical assessment of referrals should mean that the most appropriate person sees the patient – quickly, close to home, and at the lowest reasonable cost.

3 Implementing Choice

The Government's "Choice" initiative requires patients to be offered a number of referral options. GPs do not have the time to discuss these with every patient who is being referred, nor will they wish to spend consultation time on e-booking. These tasks, which are the responsibility of the PCT, are much better undertaken by someone employed specifically to do them.

4 Referral Monitoring

GP referral rates vary widely. Part of this is personality based – anxious and obsessional doctors refer more than confident and casual ones. This is part of the art of medicine and should not (and probably cannot) be changed. However, other variations may reflect a doctor's learning needs which should be identified and addressed.

5 Patient Transport

The perennial problem of booking patient transport can be addressed if objective criteria can be applied by a disinterested person working to a previously agreed protocol.

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However, there are some counter arguments that need to be considered:

- **Loss of Clinical Relationships**

GPs value their personal knowledge of a consultant's skills, practice, and personality when making a referral. This will be lost if referrals are directed generically or to a different provider. Patients also usually prefer to see the same specialist if they have previously been treated for a related condition.

- **Loss of clinical autonomy**

GPs often have a deep understanding of their patient's illness and referral decisions are guided by more than the clinical facts expressed in a letter. A decision to divert a referral based just on the correspondence may therefore well be incorrect.

- **Imposition of a command and control system**

The obligation to refer is both contractual and ethical. If PCTs and NHS Trusts are driven purely by targets, this obligation will be lost in a process set up purely for managerial purposes. GPs who are high referrers could find themselves criticised for attempting to do their best for patients.

- **Loss of confidentiality**

Adding a further stage to the process means that potentially information will be seen by people not involved directly in the care of the patient

On balance, the benefits of an RMC outweigh the disbenefits, but if such a structure is to be introduced, it is important that PCTs acknowledge GP concerns and structure the RMC accordingly. In particular, the LMC considers that:

5.1 The RMC should be responsible for Choice and E-booking

Once the decision to refer has been agreed with the patient, any further discussion about choice of referral centre should be the default responsibility of the PCT unless the GP indicates otherwise.

5.2 GPs should have the option to refer to a named consultant

Where indicated, GPs must continue to be able to refer to a specific consultant without having to justify this to the RMC. In this case the RMC would be responsible for e-booking and tracking, but nothing else.

5.3 GPs should be able to veto diversion of referrals

If a referral diversion is inappropriate, the GP should be able to veto this without having to give a reason if this would potentially breach confidentiality about matters not directly related with the referral

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5.4 Clinical information in referrals should be protected.

Every effort should be made to ensure that personal information is not disclosed other than on a “need to know” basis. It should be possible for information to remain sealed until it reaches the hospital doctor concerned.

5.5 Referral statistics should not be used punitively

Whilst analysis or referrals may be of educational value, the LMC will strongly resist and attempt to publish “league tables” of referral activity, or to use such data for any purpose other than to improve the quality of the service.

5.6 Patient Transport should be arranged by the RMC

To ensure equity and proper use of resources.

5.7 The RMC must not be coercive

Patients may well wish to see a particular consultant at a particular hospital. They should not be put under pressure to accept an alternative for administrative reasons – for example, to improve waiting list figures.

We would welcome your thoughts on this topic – please write, email, or phone the LMC office.

The full Text of the LMC paper is on the website. www.somersetlmc.demon.co.uk

Comment Cards for Care Homes

Until recently, practices used to be asked at intervals by the relevant inspecting authority whether they had any comments to make about nursing and residential homes in their locality.

The NCSC plans to revive this idea, and will send comment cards at the beginning of each month that practices can return if they wish to make any comment about the local homes that are undergoing inspection. NCSC understands that if things are going well we may not feel the need to return the cards, but they do feel that this is a good way of ensuring that there are no major concerns, in local general practices.

Deaths on GP Premises

From November this year all GPs are required under a new Terms of Service obligation to report the death of any patient on any GP premises where they are working - including, for example, surgeries and primary care centres. This does *not* extend to in-patients in Community Hospitals. You have to send a written report to any PCT involved – so if you have a practice in Taunton Deane, and see a South Somerset patient in premises owned by Mendip, then you have to report to *all three* PCTs. The report must include patient details (including NHS number), the date and time of death, the names of any clinicians treating the patient and also those of anyone else present when the patient died. This is just the first of what will doubtless be a large number of “post-Shipman” requirements.

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GP Registrars Newsletter

The Autumn/Winter edition of GP Registrars News has been published and is available at www.bma.org.uk/ap.nsf/Content

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Half-time Jobshare partner or equivalent required for large, sociable, forward thinking and well organised practice in Taunton. Currently nine partners (mix of full time, part time and job-share) making 6 whole time equivalents. Serving mixed population (including area attracting deprivation payments) in thriving county town. Training practice (medical students, pre-registration house officers, registrars). Paper light, highly computerised (Torex S6000). Aiming for high quality points on new contract.

Enquiries to Gale Berryman, Blackbrook Surgery, Lisieux Way, Taunton TA1 2LB Tel: 01823 259444. (gale.berryman@gp-L85014.nhs.uk).

Part-Time Salaried GP North Curry, Somerset £ Negotiable

We are a friendly, two partner dispensing practice in Somerset looking for a salaried doctor to join us in our rural surroundings. North Curry is a beautiful village on the outskirts of Taunton within easy reach of the M5, Quantock and Blackdown Hills.

**Three Sessions per Week
Golden Hello if Applicable
Emis Computer System
No Out of Hours**

For Informal enquiries contact either: Dr James Hickman or Dr Nick Chapman on 01823 490505
Application is by CV with covering letter to: Mrs Julia Mercer, Practice Manager, North Curry Health Centre, Greenway, North Curry, Taunton, and Somerset, TA3 6NQ. Julia.mercer@northcurryhc.nhs.uk

FootNote

One day the doctor's wife walked into Boots and told the pharmacist she needs some cyanide. The pharmacist said, "Why in the world do you need cyanide"?

The doctor's wife then explained she needed it to poison her husband. The pharmacist's eyes opened wide and he said, "Lord have mercy! I can't give you cyanide to kill your husband! That's against the law! They'll throw both of us into prison and I'll lose my license".

The doctor's wife reached into her handbag and pulled out a picture of her husband..... ..in bed with the pharmacist's wife. She handed it to the pharmacist.

The pharmacist looked at the picture and replied, "Well now, you didn't tell me you had a prescription."

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Mobile Phones-Government Contract

Somerset LMC, in partnership, with Somerset Health Informatics Service, has now opened a Government Contract Vodafone mobile phone account for GPs, Nurses and Practice Staff.

The contracts on these phones are extremely competitive. A summary of the charges are listed below.

- £50.00 Hardware credit or 6 Months free line rental on new connections or out of contract upgrades.

Connection Charge	FOC
Monthly Access	£5.37
Call Charges	
PSTN	4.5p/min
Vodafone - Vodafone	4.5p/min
Voicemail	4.5p/min
Cross Network Calls	18p/min
International Calls	20% off VVT Tariff

SMS (text) are charged at 5p per message.

The new GTM contract has been awarded for the next three years, with the possibility of a further one-year extension. As with the existing contract, individual mobile phones will be supplied on a 24-month minimum term and customers will continue to have the option of taking either an equipment credit of £50 or 6-month free of charge line rental.

Each phone comes with the option of taking out additional insurance to cover theft, loss or breakage at £3 per month. The cost of replacing an in-contract broken or lost phone is very expensive - £105 for the most basic Nokia 3410.

If you would like to order a phone or would like further details please contact Jill Hellens at the LMC office. 01823-344314 or jill.hellens@somerset.nhs.uk