
Somerset LMC

Newsletter

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Time for the ballot at last

But which way to vote?

It has been an extraordinary 6 months since the original national meeting of LMCs on 9th January at which the New Contract was supposed to have been released. Even now, there are significant items that are not fully explained or costed. But despite all this, most GPs agree that we have to get on with the vote so that, if accepted, changes can be implemented from April 2004.

We would not presume to advise colleagues on how to cast their votes, but the LMC *is* prepared to commend the contract. That is not to say that it is all good, but in our view the alternatives are worse. We are well aware that some doctors are bitterly opposed to GMS2, but it may be useful to consider how it compares with where we are now, and where we might go if it fails.

The first casualty will be our national negotiating structure. The GPC has done a remarkable job over the years in holding GPs together - we are, after all, notoriously independent and articulate. But it cannot survive as an effective body if we turn down this contract, and we know just how important a powerful united voice is going to be when dealing with this government.

Next will be the demise of a national standard for general practice. Negotiations will, as with our consultant colleagues, fall to PCTs. PMS will seem to be a safe haven for most practices, and the LMC has looked at how this might be introduced on a PCT wide basis to protect the

interests of all GPs, especially those in smaller practices. But once in PMS practice funding is disengaged from any national standard and will be part of the PCTs budget. Does history suggest that your PCT is mature enough or powerful enough to invest in primary care and resist the demands of the hospital sector?

Staying in the current GMS contract is not going to be viable for long. We all know that the Red Book arrangements are out-dated, and the Department of Health is not going to be interested in changing them. We will have to pay the clawback, seniority and pension changes will not take place, and *if* an out of hours opt out is introduced it will cost a lot more than £6000 – PMS doctors will forego these benefits too.

The latest concession on the MPIG allows us to maintain our current income and work to achieve the Quality and Outcomes Framework without penalty. This in turn means that there is time for a more robust allocation formula to be developed and properly tested. The GPC negotiators made some mistakes – as we all do – but GMS2 is a good deal. Try comparing incomes and working times with colleagues in most of Europe if you are unconvinced.

However you intend to vote, please make sure that you do vote. It is hard to overestimate the importance of this ballot for the future of general practice. Don't be left out.

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Letters in Support of Housing Requests

Attached is the suggested text for a letter that you might like to give or send to patients asking for a letter to give to their local authority housing department in support of a housing request:

Dear Patient,

This letter is to explain how the Housing Department gets information about your health to help them when they look at your housing application.

You will know that there is a shortage of council housing in this area. To make sure that houses and flats go to the people who need them most, everyone applying for housing gets a points score. This includes some points if you are in poor health.

When you apply for housing you need to tell the housing officer if your health, or that of someone who lives with you, is not good. The housing officer may then talk to a health expert who will help them allocate the right number of points. Occasionally the expert will write to your doctor, with your permission, for particular information about your health.

Please do not ask your family doctor to write directly to the housing department as he or she does not know about all the other things that the housing officer has to think about when they look at your application. A letter from the doctor will not automatically add to your points.

If the housing department cannot work out the right number of points to give you, they will ask their expert to contact the doctor directly.

Remember that if your health changes a lot whilst you are on the waiting list for housing, you should let the housing officer know so that they can have another look at your points.

Police Referrals of patients to GPs for the “Recording of Injuries”

It's a sporadic irritant during a duty surgery for a patient to turn up having been directed by a police officer to attend to have their injuries recorded. It is generally not appropriate for GPs to be involved in this process. A home office circular (24/98) states that “A medical report may be unnecessary if the injury is, by any common sense judgement, of a minor nature and likely to be temporary.” In our view this is likely to embrace most injuries that do not require an A&E Department attendance or examination by a Forensic Medical Officer (police surgeon)

On 4th June 2001 the Chairman of the Association of Chief Police Officers wrote to Chief Constables “An issue.....is the practice of some police forces directing people (who require no medical treatment) from police stations to their GP in order for evidence of an assault or injury to be recorded, by the GP, on that person's medical record. The Cabinet Office has agreed with GPs and ACPO that the documentation of injuries in these circumstances is not an appropriate use of GP's time.”

If such a patient presents a phone call to the referring officer may be helpful.

LMC Discussion Paper on The Future of Out Of Hours Services

Planning has started in anticipation of a vote in favour of GMS2

If GMS2 is accepted PCTs will become responsible for out of hours services from 1st January 2005 at the latest, although they can take over from 1st April 2004 if necessary. The LMC is working with the PCTs to ensure that the transition is as smooth as possible, and we anticipate that in Somerset a handover time in the late summer or early autumn of 2004 is possible.

The full text of the LMC position paper is on our website at www.somersetlmc.demon.co.uk

Summary

To ensure the continuation of a safe patient service the transition from GP to PCT responsibility for primary medical care out of office hours must be carefully managed. GPs will continue to be required during the out of hours period, but as an expensive resource they could be more effectively deployed. The LMC preference is for a centrally contracted flexible service covering the whole county that can be adjusted to meet local needs.

Conclusions

- 1 The LMC preference would be for a single out of hours provider organisation covering Somerset but flexibly contracting with PCTs to meet their local needs.
- 2 The LMC will be advising practices to opt out of out of hours working so that individual doctors who wish to work sessions can opt back in to working for an integrated service.
- 3 During the overnight period there is much to commend a centralised model with secondary GP triage supporting a smaller GP resource on the ground providing a visiting service, along with paramedic practitioners as first responders and access to 24 hour nursing and mental healthcare. Further work needs to be done on obtaining access to social care during this time.
- 4 The LMC supports the suggestion that most of the functions of the GP Support Centre should be subsumed by NHS Direct.
- 5 Closer working with secondary care should mean more efficient use of resources, better care for patients, and the possibility of reducing admissions by more effective medical assessment.
- 6 Recruitment of GPs to the out of hours service will critically depend on ensuring that they are well supported and have access to resources that are need to provide safe care. Their contracts should require arrangements for adequate time off before and after prolonged or overnight duty shifts.
- 7 The out of hours service must integrate properly with GP practices from day one both in terms of communications and also in being seen to deal properly with out of hours calls.

GPC Interim Guidance on Destruction of Paper Records

Proceed with caution!

As more practices move towards storing incoming paper records in scanned form, there is a need for more clarity on how this should be done. Work to this end is being done by the RCGP/GPC joint computing group and the DoH. In the interim the GPC reports

that whether a practice may destroy documents that have been transcribed into a computer system has not yet been tested in law so the decision rests with individual practices. Their view is that this is acceptable only if an *unalterable* image of the original document can be produced - apparently this is the criterion that lawyers themselves use. The accepted document scanning standard is TIFF v4 or equivalent. If you can not scan to this standard, documents must be kept and stored in an accessible form, though not necessarily filed in the patient's notes. File formats should be limited, indexed, and referable to patients.

Somerset LMC

Of course, all of this presumes that you have secure arrangements for backing up, which ought to include taking semi-permanent copies onto CD or DVD at intervals.

Gloucestershire LMC last year asked how long appointment books should be kept. The answers they got were "for ever" from a defence organisation, 25 years from the GPC, 7 years according to the Regulations, and 3 years from the Health Authority. This seems to be a very good argument for moving to electronic appointment systems!

Assessing the health and social care needs of Older People

Report from Heather Roughton, SAP Project Manager for Somerset

The National Service Framework for older people was published towards the end of 2001 by the Department of Health, and introduced the concept of the Single Assessment Process (SAP), as Standard Two emphasizing that care should be 'person-centred care'. The NSF applies to both health and social services.

The DH guidance (www.doh.gov.uk/scg/sap) requires local NHS bodies and Social Services Departments to review their practice to ensure that the needs, wishes and perceptions of older people are central to their assessment. A group of professional advisors were responsible for drafting a model for the assessment of older people with complex needs. Authorities are required to have the process fully working by April 2003.

The work in Somerset has been steered by a project group representing the range of disciplines working with older people. This now reports to the Local Implementation Group - which replaced the former Programme Board for Older People's Services for strategic planning purposes.

The DH guidance also looks at the implications for different members of the health and social care professions, and one part specifically relates to GPs. It is not intended that every older person who comes to the surgery will be involved in the SAP, as many will

have specific needs with no wider repercussions. However it is often the GP or a member of the practice team who can determine whether further enquiries are necessary.

There can be particular problems when out-of-hours services, secondary care or social services are involved, who may not have access to information known to the GP. Future development for Health Information systems will ensure that information is held in a way that makes it easier to share with other care professionals when appropriate, and with proper safeguards. This will include not only basic personal information, but also an agreed format to summarise key clinical information. The systems development is likely to take longer than the next 12 months to achieve, but the general principles of working in partnership while protecting patient confidentiality need to be agreed.

Editor's comment: This is not as alarming or bureaucratic as it seems! The intention is ensure that older people, who often do not seek the help that they need, gain access to the right services, no matter which person they first contact. However, compliance with NSFs is not in GMS GPs terms of service and the LMC recognizes that in the current climate GPs will want clear evidence of cost effective patient benefit before making any changes to their practice.

Requests for Information where there are Child Protection Concerns

LMC advice is to respond promptly

When social services undertake a “child in need” assessment because of a child protection concern they are required to seek information from all the relevant agencies.

Under the Children Act all involved professionals are required to share information when a child may be at risk of harm. The Act does not seem to specify exactly how this needs to be done in every case, so a GP may feel that a phone call to the key worker will suffice, especially if they have nothing to say. However, if you do have concerns then we strongly advise that these are put in writing and a proper record

kept in the medical notes. It may be that technically one could argue a case for making a charge for typing the letter (as opposed to providing the information) but frankly this is splitting hairs and should be avoided. The LMC advice is therefore that GPs should produce a brief factual report without charge under these circumstances. Avoid third party references, and do not express an opinion unless specifically asked to do so – remember that your letter will very likely be seen in court at some stage, and that you may be called on to give evidence.

Coping with Acute Hospital Bed Crises

We have come through another winter without a serious outbreak of respiratory infection but despite this local acute hospitals have had capacity problems and even now – on the 2nd June – EST has circulated a warning that bed availability at Yeovil is limited. The inexorable rise in medical admissions and the national shortage of nursing home beds means that we will have to live with this situation for some time. The LMC has asked the PCTs to devise a better system for dealing with patients needing admission when local capacity is full, and this should be based on a systematically planned and fully funded Local Development Scheme/ PMS Plus model – ultimately to be turned into a local enhanced service. The full text of our short paper is on the website, but the main LMC recommendations are:

Help for practices from the PCT

When a bed crisis is declared by an Acute Trust, we would ask PCTs to undertake the following:

- Negotiate with the Trust the best arrangements for medical admissions – this might include streaming them through A+E, giving the MAU extra resources, or encouraging practices at the edge of the catchment to refer to adjacent DGHs.
- Rapidly pass on to practices, the ambulance service, and the out of hours service what the plan is, how long it will apply for, and what the escalation arrangements are.
- If early discharge, deferred admission, or assessment without admission are part of the plan, to activate the LDS/PMS plus/LES previously agreed.
- If the crisis reaches the point where GPs are expected not to refer patients for assessment, then the PCT should have agreed with local GPs in advance who should be managed at home *and to accept medicolegal responsibility* for this element of the plan.
- To report back to practices after the event on how the crisis was handled and what changes should be made to the plans for dealing with similar problems in the future.

We will keep you in touch with developments.

Wheelchairs for Short Term Clinical Need

Somerset PCTs presently contract with the Red Cross for a short term wheelchair loan service for patients with a clinical need. Most referrals (1150 in 2002/03) come from GPs, and outstrip the number budgeted for. From April 2004 the contract will probably move to Somerset's Joint Equipment Service.

We have been asked to restrict the number of referrals made this year to try and keep to the budgeted number of 900, and also to encourage patients to return chairs within the 3 month time scale intended: about 20% of users do not return chairs on time.

Note that the Red Cross has a public loan service for users needing a chair for social purposes, and that people needing a chair in the longer term should be referred under the Exeter Mobility Service contract.

Small Ads

Retainee required, at Vine Surgery, Street for up to 4 sessions a week from 1st Sept 2003.

Friendly 4 partner (2 male, 2 female) progressive PMS training practice providing all services with additional special interests in extended surgery, rheumatology, sports medicine, research, and teledermatology. Excellent premises, local cottage hospital, visiting consultants and other practitioners. Website www.vinesurgery.co.uk. Contact: Sue.Davies@vinesurgery.nhs.uk or Carey.Wolfe@vinesurgery.nhs.uk Tel 01458 841122

Wanted: A GP Retainer. *We are looking to appoint a GP retainer for 2-3 sessions per week to work in our semi-rural PMS practice in the Mendips. 4 partner training practice with 6000 patients. Friendly, dynamic, innovative, with good team working, we are continually striving to achieve best practice in patient care. Contact Tracy Hole 01749 342314 or send CV and covering letter to Grove House Surgery, West Shepton, Shepton Mallet, Somerset BA4 5UH*

Registrar's National Conference – Reminder. 3rd and 4th July at the Moat House, Stratford upon Avon. “GP or not to be?”

Contact Lynn Shields on 0121 486 1157 or mobile 07759 648426 or visit www.pmde.org/gp2003/ for details

FootNote

A wise old (well, he might admit to early middle aged) GP pointed out to us how Advanced Access is a perfect model for New Labour's view of the NHS. It can be easily measured and ranked in a league table. It requires lots of nice young managers with little experience of health care to come and tell us how to do it properly. It can easily be incentivised. But best of all, it allows not very ill, mostly mobile young people to visit the doctor at short notice, whilst making it harder for older chronically ill patients to see their own GP. It would, of course, be wholly unjustified to draw any parallels at all with New Labour's target voters.

Editor Dr Harry Yoxall

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