

Somerset LMC Newsletter



Jan 2005

Issue 113

“Choose and Book”

About to derail?

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Somerset LMC Website

The LMC website has recently had a complete make over, and can now be found at

www.somersetlmc.co.uk

we feel the new design is professional and the lay out very user friendly. It is continually developing and any suggestions from our readers and Web users are always welcome.

By now we suspect everyone is aware of the National Audit Office's comments about the Government's "Choose and Book" scheme for hospital appointments. The target was for 205,000 of the annual 9,000,000 referrals to secondary care to have been made using the system by the end of December. The actual number was 63, at a cost of £52,000 each.

Good value for money so far then.

The NAO has said that the scheme "cannot be delivered without support from GPs" but a survey they undertook showed that many doctors "knew little about the plans and felt negative to some degree" which finding is no surprise to the LMC. Most of us are unconvinced that it is a good use of NHS resources to offer patients five alternative choices of provider, or that for GPs to be doing so is a sensible use of our time. Paul Cundy, the GPC IT subcommittee chair, has said "with the electronic booking system there are 20 steps before I can start a discussion with the patient. I can only put in a request for an appointment, which is not confirmed, and it has to be done during the consultation."

Not a very auspicious start to this great new programme. Perhaps it would have been wise for the Government to have a think about things and try to engage with GPs? Well, clearly they think not. Dr John Reid was interviewed on the Radio 4 Today programme on 18th January, and his remarks were a revelation about the attitude of New Labour. First, the interviewer asked: "have you got problems?" Dr Reid pointedly avoided answering the question and in due course went on to say "by the end of the year, on schedule, people will have Choose and Book" and "...70% by December and next year all... will be online."

And it got worse. A GP emailed the programme with a concern about the extra time that Choose and Book was going to take. Mr Reid replied "we have ...actually added 5 minutes to the general consultation...and we will add more."

Finally, the interviewer said "GPs are saying this system is unusable." "No they are not" replied the minister.

Wrong again Mr Reid. Very, very wrong.

Referrals to Secondary Care

Please use the Referral Management Centre for everything

The LMC has always supported the idea of a Referral Management Centre, particularly as this has been expanding to take on the arrangement of patient transport, and, in due course, responsibility for “Choose and Book.”

In our view the system is working well, and offers benefits for everyone – not least in ensuring that really accurate activity data is available.

The RMC does not prevent the GP and patient deciding on a referral to a specific named consultant at a particular hospital, and such referrals will continue to be logged and passed straight on. But it does mean that a generic “Dear doctor” referral can be sent to the provider with the shortest list or most appropriate service, and we know that this is what patients want. The Shepton Mallet Treatment Centre is due to open in July, and if their facilities (which PCTs have already paid for) are to be used to maximum efficiency the RMC needs to have detailed information about the type and volume of referrals coming out of general practices.

Over the next couple of years hospital trusts will start to be funded on a cost per case basis. “Payment by results” means that each time a patient is seen the trust receives a standard payment. This will inevitably encourage them to increase activity, and until we know what practice based commissioning is going to look like the RMC is a vital tool for primary care to not only monitor trust activity but also use the hospital services budget to the best advantage.

If you are writing to a consultant about a patient already under his or her care, then there is no need for the letter to go via the RMC, although it can do. However, if you are writing about a new patient, and the letter may result in an appointment being sent, please do make sure the RMC records these.

Requests to Ambulance Service for Urgent Admission

The Ambulance Trust has a performance target of getting “urgent” (GP request) patients admitted to hospital no more than 15 minutes after the time agreed with the doctor during the initial phone call. WAS at present achieve this in

about 91% of cases, and they are aiming for 95%.

Obviously, the longer they have, the easier it is to meet the target. When booking an admission, do remember that the time quoted is to the hospital and not to attendance – with journey times of up to an hour in Somerset this makes a significant difference. If the patient is going in for, say, investigation please give WAS as long as possible. Not only does this help them concentrate on the most clinically urgent patients, it also allows them to use their resources more efficiently.

Occasionally you will get a phone call from Ambulance Control asking if they can have more time. Please help if you can. One common reason for this is when ambulances are held up at hospitals waiting to unload because there is no bed for the patient to go into. This happened over the New Year weekend when Yeovil, Taunton and Weston all had patients queued for admission. However, if the admission is pressing or the patient is deteriorating you can either ask for the original time to be honoured, or if necessary promote the call to a 999 emergency admission.

We have asked WAS to see if there are particular times when they are under greatest pressure so that GPs can try and avoid these. So far, and hardly surprisingly, it seems that Mondays generate about three times as many GP admission requests as Sundays, but if you can try and arrange admissions earlier in the day that would help.

The LMC has also suggested that it should be possible to book an “urgent” admission for the following morning as this is quite often appropriate.

Use of NHS Communications for Party Political Purposes

The LMC was disturbed to hear that practice managers have been sent an envelope full of copies of the Chancellor’s pre-Budget statement to distribute. We understand that this is not the first time that material that is essentially political has been distributed in this way. The committee regards this as an inappropriate use of NHS Primary care facilities, and we will be asking a Somerset MP to raise this in the House. Every practice manager who responded to a straw poll indicated that the material went straight into the bin.

Commentary on the Freedom of Information Act 2000, Enacted 1st January 2005

The Freedom of Information Act creates a new right of public access to information held by public authorities. The Act defines general practices as public authorities and from October 2003 practices were obliged to devise a "publication scheme".

The publication scheme is a list of the type of information the practice holds, a description of how it can be obtained, details of any charges and an explanation of the type of information held but exempt from the Act. We believe that all Somerset practices have adopted one of the model schemes available and registered them with Information Commissioner. Much of the information in the publication scheme is the same as that contained in practice leaflets but it also includes some very raw financial information about funding for GMS or PMS received from the PCT, the practice drug budget and a bit about private fees

From January 1st practices also became obliged to respond to requests about the information they possess, however this is recorded, from any individual regardless of whether that individual is the subject of the information or affected by its use. Requests must be made in writing (which includes electronic means), must state the name of the applicant and an address for correspondence with a description of the information requested. Practices must respond within 20 days, unless a fee is payable (see below) in which case the limit is extended until the fee is paid. Practices cannot request to know what the applicant wants the information for and are even obliged to help the applicant if the description in the initial request is inadequate to allow a proper response.

Practices can decline to provide information of the same type made by the same applicant repeatedly in a short time or when the application is judged to be vexatious under Section 14 of the Act. But note that applications are not confidential, and if the practice should ever find itself obliged to spend hours and hours away from patient centred work dealing with an FOIA application there would seem to be no reason why you should not make this public.

The basic premise of the Act is that all information should be disclosed unless there is an overriding reason not to. Readers will be

fascinated to learn however that the list of information exempted under the Act concerning central government is extensive and includes major areas including economic planning and foreign and defence policy quite apart from internal workings of Parliament and the great catch-all of "security matters." For our purposes however types of information exempt from the Act include personal information regulated by the Data Protection Act 1998, information the disclosure of which would harm the commercial interests of the practice or a third party and information "whose disclosure would harm the public good" more than not releasing it. Information held elsewhere need not be disclosed. For example practices could direct an applicant to their publication scheme or the Department of Health website.

If a practice does not comply the applicant may apply to the Information Commissioner for a decision notice, which will set out the steps needed to comply with the Act. Therefore it might be sensible for practices unsure about whether any information requested is exempt to await direction from the Commissioner. If the practice fails to comply with the decision notice an enforcement notice will be served. Failure to comply then might be considered contempt of court for which a judge may impose an unlimited fine and this is also one of the 700 new imprisonable offences introduced since 1997.

In a Statutory Instrument issued in December the government made clear that no fee was chargeable by a public body unless locating, retrieving, collating and providing the information is estimated to cost more than £450 based on an hourly rate of £25 per worker involved. A "reasonable" fee is allowed to cover the costs of communicating with the applicant and for copying, printing and postage.

The Lord Chancellor's Department is to produce guidance on keeping, managing and destroying public records, and the DH is expected to issue specific NHS advice to PCTs shortly.

Cynics have reported unusually high activity in Whitehall shredding machines before Christmas. The Government has said that this merely reflected sensible stocktaking before the Act came in.

Commentary on the New NHS Community Pharmacy Contractual Framework

A good majority of pharmacies in England & Wales voted in favour of the new NHS Pharmacy Contract (nPC) that is to be introduced on April 1st 2005. This aims to make pharmacy an integral part of the "NHS family" in providing primary care and helping patients care for themselves, through responsive and innovative services. The format is familiar to us from GMS2 with three tiers of services: "National Essential" and "Advanced" services, plus locally enhanced services commissioned by PCTs. Pharmacy LESs are not funded from the Medical LES pot.

ESSENTIAL SERVICES include dispensing, repeat dispensing and the disposal of unused drugs along with health promotion, "sign posting" (the provision of information on where patients seeking advice not available from pharmacies can obtain help), and support for self-care, including taking referrals from NHSD and giving advice to carers. Support for people with disabilities is also an essential service. This includes meeting the requirements of the DDA 1995 and providing two levels of support for "eligible" patients. Eligibility will be decided on the basis of a score derived from the answers to questions on a nationally produced assessment form. Level one will demand the appropriate labelling of drugs for those with impaired vision, removing and repackaging tablets from blister packs and keeping appropriate records. Level two will involve supplying "multi-compartment compliance aids." Each level will attract a fee.

- It is likely that GPs will be asked to comment in cases where patients previously in receipt of these services are found not to satisfy the criteria set out in the assessment form.

Clinical Governance and Public Involvement requirements, including a practice leaflet and the undertaking of regular questionnaires are also essential services.

Advanced services require accreditation of the pharmacist, as at present for post-coital contraception, and specific requirements for premises, notably the provision of a suitable, private consultation area. Medicines use review and prescription intervention service are advanced services over and above the basic interventions related to safety that are part of essential services.

- Any advice resulting from a (normally) face-to-face consultation with the pharmacist would be recorded and reported to the patient's GP using a nationally agreed template.

Locally Enhanced Services will be negotiated between individual contractors and PCOs. LES specifications were not available for this assessment but will include services such as minor ailment and smoking cessation services, anticoagulant monitoring and services for drug misusers in the community.

- The existence of local, formally commissioned minor ailment, smoking cessation and anticoagulant monitoring services could clearly reduce GP workload although advising patients to "See your GP," would doubtless be the default advice in any specification!

Funding of nPC will be according to a formula based on the number of items dispensed to produce a Global Sum. The new Drug Tariff reimbursement for generics will nationally release £300m to be used to fund nPC, excluding any Pharmacy Local Enhanced Services. Pharmacy IT is vital to nPC and the electronic transmission of prescriptions (ETP) is designed to support essential services like repeat dispensing. A condition of nPC will be the use of NPfIT compliant systems connected to N3, the new integrated data network for the NHS.

Medicine Supplies when working Out of Hours – A clinical Governance Issue

We have been asked by Taunton Deane PCT to inform GPs when working OOH shifts to please supply a full pack of medication, **Do NOT** split packs or remove drugs from packaging.

The move to full packs has been made to comply with the Carson Report on OOHs medicines supply.

There may be potential medico legal implications for GPs who split packs.

Implementation of many of the services under nPC will therefore depend on the development of NPfIT including the outcome of discussions on “role based access control” to patients’ unified medical records.

It is disturbing that funding for PCTs to commission LESs under nPC is still only at the stage of “being modelled.” Although the document confirms that the £300m released is not intended for LESs, the next section goes on to state

that “PCTs will be charged by the PPA for their contribution to the cost of... [nPC]...which will be met from money released from [their] drugs bill through lower generics prices.”

- We are promised more information but the scope for double counting and consequent cost pressures on PCTs seems to the LMC to be a considerable risk that could affect general practice.

Small Ads Small Ads Small Ads Small Ads

Vascular Evening For GPs:AAA Screening

At Brettons Restaurant East Reach Taunton Thursday 10th March 2005 7.00 for 7.30 PM

Further Details to Follow:RSVP to Dr David Berge, Dulverton Medical Practice, Dulverton, TA22 9DW david.berger@dulvertonsurgery.nhs.uk Tel: 01398 323333

Police Surgeon Work Available

Based in Bridgwater and Taunton

Care of Prisoners medical needs and fitness for detention and interview in custody forms the majority of the work, which is a contrast to general practice.

Pay is mainly according to work done - call out fee paid according to time taken, with mileage.

Part Time commitment or equal share of Rota available. Introduction to the work will be available.

Please contact Dr Tilsley on 07860 258851 or at North Petherton Surgery 01278 662223 or e mail timothy.tilsley@northpetherton.nhs.uk

WELLINGTON MEDICAL CENTRE PRACTICE NURSE – F GRADE REQUIRED

18 – 25 Hours Per Week

An opportunity has arisen for a practice nurse to join our busy friendly team. The ideal candidate will be an experienced practice nurse with a special interest in coronary care management but applications from nurses with more limited experience will be welcomed.

For an informal chat, telephone the Practice Manager, on 01823 663551. Please apply in writing or by e-mail, enclosing CV to:

The Practice Manager, Wellington Medical Centre, Bulford, Wellington, Somerset, TA21 8LQ. E-mail: Lydia.Daniel-baker@gp-L85059.nhs.uk

The closing date for applications is **Friday 28th January 2005**

Inappropriate Requests for Reports from GPs – No. 128

A gem this month. A patient working in a sports club was informed that she was going to have to move from her reception job to work as a lifeguard in the pool. She approached her GP for a letter excusing her from this.....due to her advanced state of pregnancy!

Jennifer's Journal

The start of a new year and time to see if you are cut out for the new modern NHS.

After much research (Bella, Woman's Own and She magazines), I have produced a questionnaire to help you find out whether you should stick on in there, retire, or retrain. Be as honest with your answers as you are when recording systolic a blood pressure

1. When prescribing which is the most important:

- a) Compliance with NICE guidelines and local protocols
- b) Anything as long as it is cheap
- c) Patient-centred consideration of quality and safety?

2. Your Practice Nurse records a BP of 154/92 and sends you the patient. Do you:

- a) Follow the practice protocol and collect a lot more readings
- b) Sack the nurse and change it to 145/85
- c) Unmask and treat hidden depression and forget about the BP



3. The use of drugs to 'treat' risk as opposed to disease :

- a) Must be a good idea because the Government say so
- b) Can be done at low cost if use cheap drugs and acceptable risk is defined by what can be afforded.
- c) Is an invention by drug companies to make us prescribe dangerous drugs to healthy people, with only minimal hope of any individual benefit.

4 The PCT pharmaceutical adviser sends round yet another email with money-saving prescribing instructions. Do you:

- a) Immediately enact the guidelines seeing them as important well researched useful instruction.
- b) Email back with some suggested improvements that could save more money
- c) Don't read it but email back a virus hoping it might destroy the PCT's computer

5. Confronted with an ethical problem do you:

- a) Write to the PCT for a protocol
- b) Not know what ethics are. Never felt the need for them
- c) Reflect on you own thoughts so far; share them with trusted colleagues and make a balanced judgment.?

If you mostly answered (c) You are hopelessly out-of-touch with the modern NHS. You are behaving like a romantic from a bygone age and a financial disaster for the practice. Big brother has you marked. Quit while still ahead and get a job on the antiques road show.

If you answer mostly (a) There is some hope for you. You have learnt to keep your head down, do as you are told and follow protocol. You don't like conflict and would make an excellent loyal dependable factory worker. Your lack of desire for saving the NHS money, however, prohibits a future as a doctor. Retrain now as a nurse and apply for one of those 3000 matron jobs that they are looking for.

If you answer mostly (b) Congratulations! You are the sort of doctor the modern NHS needs. Your own personal motivation to work is greed. You understand the importance of budget control and population management. You accept that personal care is potentially dangerous and interferes with corporate responsibility. Your future is guaranteed.

Jennifer