

# Somerset LMC Newsletter



## January 2006 CHOOSE AND BOOK

Issue 123

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### *Where are we now?*

A few days ago a GP was asking me about how they could refer a patient with a mental health problem using CaB. I explained that CaB was not yet being used for psychiatric referrals, and anyway there was only one provider of the service.

"I see." came the reply. "So, he cannot choose and I cannot book."

It seems a little ironic that the more ill the patient is, the less choice he or she is likely to have, but that said, just what does CaB presently offer?

First of all, it is a very considerable technical achievement. Setting up the national network, installing hardware, writing the software to allow GPs to access the registration database, and bringing providers up to the point where they can take part has been a huge challenge that has very nearly been completed. The web based software is now very good – the patient details come up in seconds when you put in the NHS number – and despite some glitches it is easy to use and reliable.

Many of you will know that Taunton Deane PCT was chosen as one of the national pilot sites for implementation, and two practices (including that of the medical secretary who was hoist by his own petard in insisting on pilots!) were selected for extra help and support. The National Implementation team have proved to be very good, very effective, and very supportive and the trainers put into practices were also excellent. Pilot practices found their suggestions and technical problems were dealt with promptly and we were pleased with the speed and thoroughness of the response. It is also important to remember that although CaB will one day support all NHS referrals, at this early stage it is for new GP to consultant referrals only, and quite a few areas such as maternity, mental health, and 2 week cancer referrals are presently (and very wisely) excluded.

Actually using CaB is straightforward, and it does have benefits for the practice. In particular, if the referral is made with the patient present it cannot be lost or forgotten anywhere in the system, and with e-referral no hard copy letter is required.

There is some advantage for the patient. He or she can decide if they wish to travel to get a quicker appointment, or whether they will wait longer for one that is more convenient. And just occasionally a search suggests a service provider that you may not have thought of. CaB also shaves a couple of days off the referral process and ought to offer some flexibility over appointment days and times.

But there are still significant problems. The format of the Directory of Service varies between Trusts, it is still usually not possible to make a named consultant referral, some clinics are not easy to find, and some of

the referral destination options look suspiciously as though they are there to make up numbers rather than because they provide an equivalent service to a full department at the DGH. Patients still have to contact the Booking Management Centre at the RMC, and then telephone the relevant Trust to actually make the appointment, and we are still getting reports of problems in getting through to the hospital concerned when they try to do this.

Tangled up in all this is the increasingly unhealthy behaviour of the Government concerning "Choice". Presumably because a focus group in Islington told them that this is what floating voters appeared to want, it has become an obsession that is rapidly distorting the public services. What real people actually want is to have an acceptable service reasonably quickly available from their local hospital, and preferably to be able to park somewhere on the site. Some will choose to go to a different provider, such as the Shepton Mallet treatment centre to get a faster service, which is fine, but it is distressing to see hard pressed and committed NHS managers contorting themselves to comply with central directives that are patently party political and have very little to do with patient care. It is a shame that this has so tarnished the image of CaB, but ministers have only themselves to blame.

Choose and Book is a good idea that will deliver real benefits, but not yet. We would regard it is at the stage of "Beta testing" – operational, but not yet ready for general use. So until the new Directed Enhanced Service is implemented we would encourage practices to ensure that at least one GP is using it regularly, partly to make sure that providers are kept aware of what they need to offer, and partly so that the practice is up to speed with the rapid evolution of the system, but not to regard it as a priority for clinical care.

## **A TALE OF THE NHS AND PRIVATE PROVIDERS**

*Cases may make bad medicine, but this may make you think*

On 21<sup>st</sup> December mother-in-law arrived to stay with us for Christmas. She was quadraplegic and in declining health, but

determined to come to Somerset for what was to be her last visit. Moving her was a major task that involved a lot of equipment including a sophisticated pressure relieving mattress onto which she should have been moved from her ripple chair as soon as she arrived. As we started to unload her from the adapted vehicle in which she traveled, we discovered that the mattress pump had fallen out of the van during the journey. We need to sort out an alternative at once.

I telephoned the out of hours service direct line to ask for the contact number for the district nurse on duty. They could not give me this, said the operator, but if they could have all the patient details someone would ring me back. An hour and a half later, we had a call. The problem was explained, but the answer came that the nurse had no access to the relevant supplies and therefore could not help us.

And there it might have ended, but as two GPs we had more avenues to pursue. We rang three local nursing homes with our problem, two were very sympathetic but had no spare equipment. The third, Hamilton Park in Taunton, had a pressure mattress not in use. A few minutes after our inquiry the proprietor rang back: yes, we were very welcome to borrow the mattress, and no, there would not be a charge. At the same time we rang the mattress manufacturer's 24 hour service line and explained the problem. They promised to see what could be done, and shortly after 9.00 the following morning their service engineer arrived with a new pump. As this was a model they did not make any more, they had a loan machine that was no longer required. Would we like it? No charge was made for the pump or the visit.

We also discovered that there is a major UK supplier of equipment for the disabled based in Chard called Karomed . They have a 24 hour, 365 days a year rental service telephone line, 01460 66033. They aim to respond to a call-out request within 4 hours.

Full details on

<http://www.karomed.com/rentals.php>

## INFORMATION FROM T&S TRUST

### *Urgent Orthopaedic referrals*

From 3rd Jan there has been a Trust grade doctor rostered to take GP calls and requests for admission from 9.00 to 17.00 from Monday to Friday. There is till a SpR on call, although he or she may also have some commitment to theatres. A consultant should always be available for advice in addition. Outside normal working hours the on-call team should be contacted.

### *Trust Goes Smoke Free*

From early March smoking will not be allowed anywhere on the MPH site. The following will be added to all outpatient letters to patients “*Musgrove Park Hospital is smoke free, you will not be allowed to smoke during your stay. If this might cause you difficulties please contact the Support to Stop Smoking Service on 01823 323808.*” Because oral nicotine could cause anaesthetic problems there is an extra bit added to in-patient letters: “*Please note: certain nicotine replacement therapies (NRT) cannot be used prior to surgery.*”

### *One-Stop Menstrual Dysfunction Clinic*

All the general gynaecologists accept referrals about women with menstrual problems but Guy Fender now offers a service for the outpatient treatment of women with menstrual disorders caused by endometrial polyps and small endometrial fibroids. The clinic sees those women in whom benign endometrial pathology has been identified. Investigations in clinic can include transvaginal ultrasound and mini-hysteroscopy. Women can also choose to have any necessary procedure identified (such as electro-polypectomy or resection of small fibroids) under local anaesthetic, so avoiding the need to return for a GA procedure.

### *Early Pregnancy Assessment*

T&S report that their EPAC has become overburdened and they have to redesign services. Their focus will be on those women with bleeding or pain at less than 12 weeks and women with a history of ectopic pregnancy. New guidance is being prepared, but please note that one important change is for women with previous miscarriages who should now be referred directly to a consultant obstetrician to be seen in an antenatal clinic.

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## SHEPTON MALLET NHS TREATMENT CENTRE

### *Agreements on how to deal with any complications*

As the number of patients treated by SMTC has risen, some questions have arisen about post-operative treatment and complications. Mendip PCT is in continuing discussion with the Treatment Centre but the following may be of help:

- The SMTC is keen to see patients to assess complications whenever possible and to provide treatment when appropriate. Clearly if it is a simple wound infection then sending a patient to the SMTC is not needed but the SMTC need to be informed of all such incidents.
- SMTC specialists are happy to talk to GPs about any potential complication or issue arising from surgery. If available at the SMTC they are happy to speak to GPs directly, otherwise they will call back as soon as possible.
- OOH contact is via their usual phone number (01749 333600) where the GP can speak to their resident medical officer (or a specialist if needed) .
- If it has been agreed between the GP and an SMTC doctor that a patient needs to be assessed at the SMTC but cannot get any transport to Shepton Mallet, then the SMTC will pay for a taxi to take them. On arrival the SMTC will issue the taxi company with a note indicating SMTC will accept payment, and to whom the invoice should be sent.

### **St. Margaret's Hospice Charity Walk 2006**

*Advance notice – put this in your diary now!*

On Sunday 28th May 2006. Walk across beautiful South Somerset between Taunton and Yeovil. Linking the two hospice centres. You can walk from 4 to 34 miles in either direction with five starting and finishing points between St Margaret's Taunton and Yeovil Showground, next to St Margaret's in Yeovil. You may start from Stoke St. Gregory church, Langport Guildhall, Martock Market House or Odcombe Village Hall. Route directions will be provided on the day. Registration will be £3.00 per adult. Children under 16 free but must be accompanied.

## LMC RECOMMENDATIONS TO PRACTICES ON ACCESS TO IT SYSTEMS BY NON-NHS ATTACHED STAFF, PARTICULARLY CARER SUPPORT WORKERS

### Background

A number of practices now have a Carer Support Workers (CSW) attached, and a smaller number have other social services staff working with them. This paper indicates some areas that you will need to consider when deciding if such staff can have access to your clinical IT system.

### Principles

The Data Protection Act makes it clear that confidentiality of patients' personal data should, with very few exceptions, be paramount, and the rules governing the sharing of such information are tight. Practices need to ensure that information is only shared with consent, and then only in as far as is necessary for the person receiving the information to provide the service required by the patient.

### Consent

The best approach to consent is to have a default arrangement that it is obtained at the "point of entry" to a service. For referral to a CSW, this will be when the doctor or nurse suggests that the CSW may be able to help a patient or their carer. Formal written consent is generally not required for information sharing within the NHS, but patients must at least give verbal or implied consent when anything leaves the practice. For example, implied consent is given when a patient agrees to a hospital referral, and verbal consent is acceptable if you ask a patient whether you can discuss their problems with another agency, such as social services. It is unrealistic for specific consent to be sought to share information within the practice team, but patients should be able to keep certain information restricted, where this is appropriate.

### The Practice Team

Is generally defined as the partners and employees of the practice, along with health workers attached from an NHS Trust. CSWs, because they are in part funded by the PCTs, are arguably part of the team as well, but the LMC advises that they should be considered as "associates" rather than full team members.

### Information Sharing

There is no doubt that patients get a better service if they are cared for by integrated teams able to share *relevant* information. The Single Assessment Process form, now increasingly used in Somerset, that may be completed by either a social worker or community nurse specifically asks the patient/service user to consent to this. CSWs are more effective where they have direct access to at least the email part of the practice system and after consent is obtained also to demographic information about the patient. Some clinical information, such as the outcome of any health needs assessment, may be relevant and helpful.

### Recommendations

1. Add a section to your practice leaflet and put up a notice summarising your position on confidentiality and information sharing, especially with CSWs and other social services attached staff. Emphasise that patients may ask for certain information to be strictly confidential.
2. When referring to the CSW the clinician should check that the patient verbally consents to the referral. Special care needs to be taken to ensure, where relevant, that both carer and the cared for person have consented.
3. If the CSW receives a referral from outside the practice, he or she must ask the practice to verify with the person concerned that he or she agrees to the CSW looking at relevant parts of their health record.

4. The CSW could then have access to the registration section of the notes of these patients. He or she should generally not have access to the details of the clinical record, but if the patient has agreed might perhaps view the summary page and be able to make appropriate factual entries in the notes.

5. The CSW should sign the practice staff data confidentiality agreement.

6. The CSW should understand the legal status of the medical record and ensure that entries are factual (or attributed if this is not known), legible, and do not contain any unnecessary third party references.

*Please note that this document is for general guidance only. Your Caldicott Guardian is responsible for advising on the proper handling of information in any particular case*

### **CHILD DEATH REVIEWS AS PART OF THE CONFIDENTIAL ENQUIRY INTO MATERNAL AND CHILD HEALTH (CEMACH).**

CEMACH was set up in April 2003 and is the successor organisation to two previous national confidential enquiries, the Confidential Enquiry into Maternal Deaths (CEMD) and the Confidential Enquiry into Stillbirth and Deaths in Infancy (CESDI). Since 2005 the National Patient Safety Agency has been responsible for CEMACH, which is now to extend its remit to encompass both morbidity and the establishment of a new national enquiry into child health.

CEMACH is currently carrying out preliminary work in three areas: An Overview of Child Deaths, Unintentional Injury (with a focus on head injury), and Child Protection.

In the South West the Child Death Review will seek to obtain an overview of all child deaths from the age of 28 days up to 18 years over a one year period. Data on all child deaths will be collected and a detailed local review conducted on each, with a focus on identifying preventable and avoidable factors. Data collection commenced on 1<sup>st</sup> October 2005 and the protocol is available on [www.cemach.org.uk/child\\_health\\_enquiry1.htm](http://www.cemach.org.uk/child_health_enquiry1.htm).

If you hear of the death of a child outside hospital please ring 0117 342 0170 and leave a message giving your name and contact details as well as information about the child who has died. The SW CEMACH Regional Office will then make contact to complete the notification form. If appropriate you may be invited to the review meeting, and if the GP is unable to attend any relevant notes will be requested

This project has Multi Centre Ethics Research Committee approval, and under Section 60 of the Health & Social Care Act consent from the family does not need to be sought before collecting data on their child's death. CEMACH are also seeking GPs to participate in the regional reviews being held in Bristol and Exeter from July 06 to March 07 and they are able to pay travelling expenses but not locum costs.

### **ELECTION OF REGIONAL MEMBERS OF THE GENERAL PRACTITIONERS COMMITTEE**

Election of the geographically based members of the GPC is divided up into annual groups so that the committee maintains continuity. The constituency of Somerset and North & East Devon is one of those due to elect a member in March this year. The sitting member, Dr Roger Bulley, has indicated that he wishes to stand again, and any other eligible GP wishing to stand must ensure that his or her nomination form is received at BMA House by 5.00pm on Friday 16<sup>th</sup> February for an election to take place. *Please contact the LMC office for an information pack as soon as possible if you are interested.*

## FUEL POVERTY AND ENERGY ADVICE IN SOMERSET

### *An important Public Health matter*

Fuel poverty damages people's quality of life and health, as well as imposing wider costs on the community. The likelihood of ill health, notably respiratory and circulatory disease, is increased by cold homes. Condensation linked to poor heating can also promote the growth of fungi and increase the numbers of house dust mites.

The need to spend a large portion of income on fuel means that fuel poor households may have to make difficult decisions about other household essentials. This can lead to poor diets and / or withdrawal from the community. 6.5% of properties in the south west are in fuel poverty and incidence of fuel poverty is considerably higher in rural areas of Somerset. The average thermal efficiency (SAP) of properties in the south west is the lowest in the country.

Free impartial energy efficiency advice is available to **all** households in Somerset from the **Energy Efficiency Advice Centre (EEAC)** in Bristol. EEACs can provide information on the grant schemes available for Somerset residents and can usually make direct referrals to such schemes. Grants and discounts are available for insulation measures such as loft, cavity, hot water tank jacket and draught-proofing and also heating. EEAC can be contacted on tel: **0800 512 012**

**Energywatch** is the independent watchdog for gas and electricity consumers. They provide free, impartial advice on a range of energy issues. They also take up complaints on behalf of consumers who are experiencing difficulty in resolving problems directly with their energy supplier. They can be contacted On:

tel: **0845906 0708** [www.energywatch.org.uk](http://www.energywatch.org.uk)

**Enact Energy** is an energy consultancy company that is operating in Dorset and Somerset. Funded by the major utility companies under the Government's energy saving requirements, they can help low income owner occupiers or tenants of privately rented housing obtain free or low cost insulation and other energy saving resources. GPs who refer into their scheme

are offered a small referral fee to spend on patient services. Enact can be contacted on tel: **0800 093 4050**

More information is available from: [Phil.Lincoln@somcoastpct.nhs.uk](mailto:Phil.Lincoln@somcoastpct.nhs.uk)

### **Urgent Medical Admissions and Hospital Bed Crises**

To nobody's great surprise we have had the usually flurry of emails this month from acute hospital trusts warning of medical bed capacity problems. The steady reduction in medical beds over the years and the rising number of urgent medical admissions makes this a mathematical inevitability, now no longer confined just to a winter peak. The LMC produced a statement on this matter in 2003, which we think still applies:

*"GPs request admission based on their clinical assessment of the patient and their personal risk management policy. Admission rates vary between GPs but it is extremely difficult to reduce individual doctor's acute referrals; whether or not this would in fact be appropriate or desirable.*

*GPs are required under the terms of their contract to refer patients when this is appropriate. Furthermore, the GMC has specifically stated that inadequate resources do not relieve a doctor of his or obligation to provide care.*

*GPs therefore cannot stop making urgent referrals for secondary care assessment.*

*In the LMC view responsibility for managing admission demands primarily rests with the receiving Trust. If the Trust does not have capacity to admit all referred patients, then transfer on to other units should be arranged by them after an initial assessment. We have long pressed for active Medical Assessment Units in which patients with symptoms or signs worrying to the GP can be investigated and observed. However, in practice very few patients are not admitted after a GP referral. If pressure on beds is great then a trust may be able to avoid admissions or discharge patients early but special arrangements must be made to communicate any such with the GP practice."*

SMALL ADS SMALL ADS.....

## BMA SOMERSET DIVISION

**Chairman: Mr David Wrede**

You are invited to attend an evening meeting At the Postgraduate Centre, Musgrove Park Hospital on

**Wednesday 1<sup>st</sup> March 2006**

at 7.30 pm

Buffet supper available from 7.00

Starting with a presentation by

**Dr Kiran Patel**

*Consultant Cardiologist and Honorary Senior Lecturer, Sandwell & West Birmingham NHS Trust, Chairman of the South Asian Health Foundation, NICE Expert on Ethnicity and CVD*

### **“The Epidemic of Coronary Heart Disease in South Asians”**

followed by a discussion on cross-cultural medicine and Inequalities in Health

As Somerset becomes ethnically more diverse local NHS clinicians need to know at least a little about the differences in the pattern of illness between different groups, and also to develop an awareness of the cultural differences that are relevant to health care. We look forward to seeing you at this meeting which is open to all health professionals

For catering purposes it would help us to have rough estimate of numbers so if possible can you let us know a week before the meeting if you plan to come:

[harry.yoxall@somerset.nhs.uk](mailto:harry.yoxall@somerset.nhs.uk)

(01823 344314)

*This Meeting has been kindly sponsored by Astra Zeneca Pharmaceuticals*

## **DORSET & SOMERSET URGENT CARE SERVICES**

### **THREE SOMERSET GP CLINICAL ADVISORS**

**Salary - £10,500 plus superannuation per annum for each of the three Post Holders.**

**Each post holder working three and a half hours per week(Flexible working)**

**Contract – sessional contract on a fee for service basis**

Three experienced GPs are required to help advise and support the newly integrated Dorset & Somerset out of hours service. Three Somerset GPs will share this important role and join the team of existing Dorset GP Clinical Advisors. The key function of the role is based around the pillars of clinical governance.

GP Clinical Advisors will offer advice and involvement in clinical audit of the GPs work as well as support for the new ECPs. Their work will also focus on complaints and adverse incident reviews and trend analysis. Another important aspect will be a link to the Wessex Deanery and the development of GP Registrars on placements.

We would welcome a call from anyone who is interested in applying for one of these roles. For informal information related to the role, please contact Norma Lane, Associate Director - on 01202 851319.

Please contact the Human Resources Department on 01202 851666 (24-hour recruitment line) for a copy of the Job Description and application form.

**Please note that the closing date is 27<sup>th</sup> February 2006**

## JENNIFER'S JOURNAL

**Jennifer has a rare opportunity to interview Professor Wise, visiting from abroad.**

**J-** I understand that you have very little hypertension in your land professor. I am surprised since our lands have so much in common and yet we are full of it.

**P-** I believe that you still have a disease called essential hypertension. We eradicated it years ago.

**J-** How did you manage that?

**P-** We just discovered that it didn't actually exist at all. There is a rare condition of central hypertension which does not respond well to the sort of drugs that you use. These people usually get enlarged hearts, have strokes and damaged kidneys despite the generous administration of polypharmacy.

**J-** What about all the other hypertensives?

**P-** Oh they don't exist. I assume you are referring to that quaint custom of yours where you blow a sort of rubber balloon up around someone's arm, listen to blood flow and write down some numbers. I gather that you then give people lots of drugs and get lower numbers. The lower the numbers, the more money your doctors earn. Extraordinary ideas in your land, Jennifer.

**J-** I think you are referring to the measurement and treatment of essential hypertension. Thousands of lives are saved every year by treating this. We have stacks of evidence.

**P-** Poppycock. What evidence?

**J-** Lots of big important trials ; Evidence Based Medicine - it is irresistible.

**P-** Who sponsors these trials? The companies that sell the drugs. Those who promote them are usually in their pay or stupid. It is all a big lie.

**J-** But you can't just dismiss EBM.

**P-** Can't I? In your system you blanket treat lots of healthy people on the off chance that someone who might benefit from the drug gets to take it. You have lost contact with true science.



**J-** Well how can we move forward professor?

**P-** You must remove health care from the politicians. Drug companies are huge employers and lobbyists. Your NHS is run by drug companies. They provide all the research that drives the sale of their drugs. They spend more on advertising their drugs than they do on research. In our land all research is fiercely independent and funded separately. Our health service is run by a board independent of Government.

**J-** So the quality of research improved?

**P-** Not just improved; we now do relevant research. In our land you only take drugs if they will benefit you personally. You don't take them on the off chance that someone else might benefit while you pick up the side-effects.

**J-** Can I come to your land? It sounds so sensible.

**P-** No, no Jennifer. You are not ready for a land free of greed, lies and ambition. For a start nobody is going to think you are funny.

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

**Jennifer**