

Somerset LMC Newsletter



March 2006

Issue 124

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WHO'S AFRAID OF THE BIG BAD WOLF?

Changes in healthcare delivery are inevitable, so look to your future

Granted it was a long time ago, but I seem to remember being taught in O level Economics that to manage a market, one had to consider both the demand and supply sides. I am sure I am missing something that is obvious to Ms Hewitt and her department, but just what is she doing to manage demand in the NHS? The proposed PBC/PBR "market" is actually nothing of the kind because the real demand side, (driven by the familiar three Horsemen of the Apocalypse; Expectation, Demography and Technical Advance), is not taken into account at all. As demand rises exponentially, simple mathematics shows that *no* increase in supply funding - whether stepwise or linear - can ever match it.

So does this mean practices should reject PBC? No, it doesn't, but it does mean we need to go into it with our eyes open. We should certainly not let it be the means by which the Government pushes responsibility for healthcare rationing down to GPs and consultants, but we can use it as a way of protecting our trading future as small businesses by making sure there are few opportunities for APMS.

Yet there is an even more important underlying question that we have to consider. Whatever the colour of the next Government, there will be more and more private players in healthcare and we need to consider just who will be our friends and who are our rivals.

To begin with there is clearly some strategic benefit in forming practice clusters, especially if these can be fitted together to form larger organisations that carry some weight: for example, a commissioning co-operative that covered 5 million people across the South West would be hard to ignore. However, even this would be small beer compared with some of the wolves. United Health Group, currently portrayed by some of the medical press as the most rapacious of them all, commissions healthcare for 55 million people and their risk managements products are used in the care for perhaps 100 million worldwide. As the number one player in the US health market with an annual revenue of \$45 Billion, they are very big indeed.

But are they about to devour us wholesale? Not according to Phil Jackson, their UK Marketing Director. At a meeting of GP PBC leads in Taunton he portrayed the company as primarily interested in managing information, recognising that where general practice was strong there was little scope for them to be involved in direct provision. The quality and coherence of the information that they provide to commissioners was a revelation and their huge wealth of experience in developing tools for measuring and projecting need and demand made for a very impressive presentation. With data of this quality commissioners could not only make sound

contracts with providers, but also monitor their own performance.

So perhaps things are not quite as we have assumed, and having a very large friend to walk with through the dark woods of NHS commissioning would be an interesting option. Certainly I have been left wondering less whether general practice has a future, and more whether it will be the PCTs that have the most to fear.

REFERRAL DIVERSION

Please notify the LMC of any referrals diverted to alternative providers without the consent of the patient

It is supposed to be the central principle of "Choice" that patients can decide between referral destinations offered by the PCT after a discussion with their GP. The LMC accepts that some patients do not necessarily need a consultant assessment, and that an intermediate care service may offer quicker, nearer, cheaper, or more appropriate care. Some PCTs have established such services, notably in orthopaedics, and they generally proved to be effective.

There will be some circumstances where a referral is processed by the intermediate care service and passed straight on for a consultant opinion, and others where a clinical assessment confirms that this is appropriate. The LMC is clear that in these cases the referral should go to the original destination *unless the patient has specifically agreed to it being changed*. If you become aware of any cases where a PCT has instructed otherwise please can you let the LMC office know so we can inform the Strategic Health Authority.

You may find it helpful to add a disclaimer under your destination choices box (see *LMC Newsletter July 2005*) along the lines of:

If "Referral to a named consultant" is indicated above, then this was the option selected by the patient after a Choice discussion. Any medical, legal, or process complaint arising out of a diversion of this referral will be the responsibility of the Chief Executive of the PCT authorising this action.

THE "MY HEALTH BOOK" PROJECT

Update

Although a small start, the inclusion of a register of learning disability patients in the QOF for 2006/07 is a first recognition of the particular health needs of this patient group.

Last year Somerset Partnership started a pilot of the "My Health Book" project in South Somerset, and service users with learning disabilities have now been using this communication aid for almost 6 months. If you have not seen it, it is a loose leaf folder with text and symbol headings for recording health needs and treatment preferences.

Initial results from service users and their carers are promising. They see "My Health Book" as a way of improving both their own and their GP Practice's knowledge about their health.

It has also demonstrated a significant incidence of physical health problems in patients with a learning disability. The independent research team have reported of the participants in the study that:

22% have Epilepsy

10% have Asthma

6% have heart problems

4% have diabetes

Once the pilot has been rolled out across Somerset, we will have more accurate figures about the health of people with learning disabilities in the county. Prior to the rollout, the next stage of the project in Spring/Summer 2006 will be to collect the views of the four Somerset practices currently taking part in the pilot.

The team are extremely grateful for the assistance of these practices in completing the study. If you have any questions or comments to make about the research, please contact Rachel Menday on 01935-470600 or email on:rachel.menday@sompar.nhs.uk

PRACTICE NOTEPAPER

Is a legally important document, so you have to get it right

Under The Business Names Act (1985) any business partnership, including a medical practice, is required to include the names of the partners on the letter heading either in the business name or as a list. This is because all the named partners carry joint liability in relation to the business. Practices may include the names of other members of staff (e.g. salaried GPs) on their letter head so long as they put a qualifier by their name (e.g. salaried or staff GP) so as to distinguish them clearly from the partners. If you do not do this, these doctors/staff members may be open to carrying joint liability with the partners. If doctors use their own individual letter headings you can add the full list of partners as a footer, just so long as they appear somewhere on the front page of any correspondence.

CHANGES TO CONTROLLED DRUG PRESCRIBING

Coming in the summer

Yet another piece of fall out from the Shipman Enquiry are some further changes in CD prescribing, although these do all seem sensible. We do not have a firm date for implementation, but they include

- Maximum of 30 days supply per script for Schedule 2,3 and 4 drugs
- Software changes to mark prescriptions "CD" and add the patient's NHS number. (Clearly this may cause problems in urgent or emergency care situations where handwritten prescriptions are issued and the NHS number may not be known)
- A special form for any private CD prescriptions which will be collated by the PPA
- When CDs are collected from the pharmacy the prescription form must be countersigned by the patient or his or her representative.

CARE DIRECT

Lines open from 08.00 to 18.00 weekdays and 08.00 to 16.00 Saturdays, adult services are on 0845 3459133, children's services on 0845 3459122

Most of us are now familiar with this "front end" call handling service for social services and have used it to make contact with a social worker or to refer a patient for social care of some kind.

It also seems that GPs are increasingly suggesting that service users contact Care Direct themselves, which both the LMC and the service support. This not only saves the GP time but also encourages people to take more responsibility for their own "problem-solving", whilst giving Care Direct staff a chance to explore a wider range of issues/services which they would not otherwise do with a time-pressed GP ringing on behalf of a patient.

SPONSORS SOUGHT!

Be generous - this could have happened to you.

Two GPs who should be old enough to know better had a weekend off, and in a moment of weakness, (We would never dream of suggesting that alcohol might have been involved) entered a charity auction. I am sure they were delighted to wake up the next morning only to remember that they had won two free entries to.....The Tresco Marathon!

Nothing daunted, John Scanlon and Ruth Wells started training from scratch, and just make sure that they are too embarrassed to pull out we are inviting you to visit their websites and make a contribution to the Cystic Fibrosis Trust.

Go to www.justgiving.com/johnscanlon or www.justgiving.com/flutyruhy

CHILDREN WITH CONJUNCTIVITIS

Do not need to be excluded from school

Please note that the Health Protection Unit has advised that children with conjunctivitis can attend school as usual and DO NOT need to be excluded.

DOMESTIC VIOLENCE IN SOMERSET

How to be aware, and how to advise both victims and perpetrators

The national statistics about domestic abuse are alarming. 25% of all violent crime is committed within the family, with one in six men and one in four women experiencing such abuse in their lifetimes. On average a woman will be assaulted *thirty five times* before seeking help – and the statistics go on in the same vein.

Domestic abuse is to do with inappropriate power and control, usually by men over women, although 19% of victims are male. It is more likely to occur in pregnancy, and there is a strong association with other abuse – for example, of children and domestic animals. Nationally 2 women a week are killed by their current or ex-partner.

Apart from inadequately explained or late presentation of injuries, especially if repeated, be aware of the possibility of abuse if a patient has symptoms of stress or depression without any apparent cause, and be especially suspicious where a partner or family member shows controlling behaviour such as always accompanying the patient into consultations or not allowing you to speak to them directly on the phone.

If you suspect a problem, ask about it. Victims often say they wish someone had asked them because this gives them permission to speak in a way that they just cannot do spontaneously. And, as with other forms of abuse, an initial denial does not mean there is not a problem,

just that the victim is not ready to deal with it there and then. The most important thing to do if you do uncover a problem is to ensure that the victim has a safety plan which will involve assessing the risk and empowering her to take steps to protect herself and anyone else who may be vulnerable in the home. The police are extremely good about helping if the danger seems to be great.

Remember that domestic abuse occurs in all parts of society, and wealthy middle class victims may be even more likely to hide it because of a fear of loss of status if the problem is exposed. Adult victims in Somerset have been identified from the age of 17 to over 80.

Somerset Change has been established to help address these problems. There is a free helpline (which does not show on a phone bill) **0800 6949999** to point callers to sources of local and national help and they are also offering training sessions for practices to help make all staff aware of the issues. We urge everyone to take advantage of this – details from the Victim Services Co-ordinator – it makes for a very sobering and revealing couple of hours.

Somerset Change also offers a voluntary perpetrator programme, which is a challenging commitment to over 30 sessions dealing with a whole range of issues and behaviour modification. It is emphasized that this is not anger management; perpetrators are usually good at controlling their anger and directing it specifically at their chosen victims. Details of this from RMackie@somerset.gov.uk

LMC MAIL SERVICE

The LMC Office is frequently asked by a range of organisations to pass on information to GPs and practices. Rather to our surprise, nobody else seems to have a comprehensive and updated list of suitable email addresses, and as a consequence such requests are coming more often. We do try to ensure that only relevant material is forwarded to you, and this is done using the “LMC Mail service”. Any correspondence that arrives from this address is not generated by us, but has been judged in the LMC office as third party information that is likely to be of interest. Please let us know if you feel we are getting this wrong!

FOOTNOTE

Our PCT has an initiative in place whereby a well meaning pharmacist goes round Nursing Homes and does a medicines review. This week I had 8 such forms to review. So far the changes asked for have been mainly along the lines of “change number of tabs prescribed from 100 to multiples of 28” (for occasionally used analgesics), or would I “check U&E” on someone on ramipiril and frusemide (which I had done last month)

But it was the “put specific instructions on the Anusol cream” that really got me....I *just* resisted the temptation to tell them to “just stick it up your a....”

SMALL ADS SMALL ADS**MINEHEAD/EXMOOR**

Full time replacement partner, job-share considered, required for friendly, progressive, well organised 5 Doctor (4.25 WTE) training practice.

- EMIS computer system.
- Good income.
- Purpose built premises.

Attached Complementary Health Centre and Pharmacy.

Usual staff including Nurse Practitioner. Work varied and interesting including local cottage Hospital and nurse run MIU. Plenty of opportunities for GPwSI's. A good quality of life with lots of local leisure activities in glorious countryside.

Write or phone for further details: Mrs Kate Atkins, Practice Manager, Irnham Lodge Surgery, Townsend Road, Minehead. Somerset. TA24 5RG. Telephone: 01643 703289.

e-mail: kate.atkins@irnhamlodge.nhs.uk

Website: www.irnhamlodgesurgery.nhs.uk

QUANTOCK MEDICAL CENTRE**NETHER STOWEY, SOMERSET**

- Friendly rural 2-partner practice.
- 2 sessions per week
- Holidays and study leave included.
- Ideal for Retainer scheme.
- List size 3100
- Fully computerised EMIS System

Please contact Marion Maddison, Practice Manager, enclosing C.V. to Quantock Medical Centre, Nether Stowey, Bridgwater, Somerset, and TA5 1NW.

Please Telephone 01278 732696 for informal enquiries and you are very welcome to visit the Practice.

CONFERENCES**AVON LMC SPRING CONFERENCE 2006****“ Politics, Privatisation and Primary Care”
Thursday 27th April 2006**

The University of the West of England, Bristol

A Conference for GPs, Practice and Community Managers, Colleagues in PCTs and other health bodies in order to critically examine current government plans for the NHS and where this will take the GP profession in the medium and long term.

Speakers already confirmed:**Rt. Hon Frank Dobson MP:**

Former Secretary of state for Health

Andrew Lansley MP:

Shadow Secretary of State for Health

Dr Laurence Buckman:

Deputy Chairman GPC

Professor Nick Bosanquet:

Professor of Health Policy, Imperial College London. Special adviser to the Commons Health Committee

Ms Sally Brearly: The Patients Forum

All enquiries contact **Di Green at Avon LMC**

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E-Mail: avonlmc@btconnect.com

OSTEOPOROSIS AND FALLS

A Way Forward for Somerset

11th May 2006, Musgrove Park Academy, Musgrove Park Hospital, Taunton 9:00 AM-5:00PM

Free Medical Meeting, for hospital Specialists, GPs, Allied Health Professionals and NHS, Social Services and Voluntary Sector Managers.

Places are limited please E-Mail or Telephone your name, designation, contact address, telephone number and any dietary requirements to:

E-Mail: mail@osteodorset.org.uk

Telephone No: 01202 443064

www.osteodorset.org.uk/conference.html

JENNIFER'S JOURNAL

Now, I'm not one to eavesdrop (too many guilty secrets of my own) but I did just happen to leave a microrecorder on in one of the doctors' rooms the other day and thought I ought to share this conversation with you:

Patient: I got your letter doctor and I am a bit muddled. You say that you are changing my atorvastatin10 to simvastatin 20. When I last saw you, my cholesterol was excellent at 3.7 but with no further blood tests you want to change my tablets and increase the dose. Has atorvastatin been discovered to have nasty side-effects and drug interactions?

Doctor: No, not at all, it has fewer interactions than simvastatin, actually. And it is more powerful at lowering cholesterol. It is an excellent drug; that is why I put you on it.

Patient: Well why are you changing it?

Doctor: Because our pharmaceutical adviser says so.

Patient: I don't understand. You're the doctor. Aren't you in charge? Pharmacists may advise you but it will be you I am suing when your drug changes upset me- not the pharmacist!

Doctor: Well it's very complicated. If we make this change we save money on the drug budget and I can hit a target which gives me more cash into the practice - a sort of bribe really.

Patient: So these decisions are not clinical or in the individual patients best interest at all then doctor?

Doctor: No, not really , but I will try and spend my bonus payment wisely.

Patient: I'm still not happy doctor because my mother-in-law, who is a devil at taking her pills, recently had her simvastatin 80 changed to two 40mg tablets instead. She said she won't take an extra tablet but I finally persuaded her to take them. But now, and you're not going to believe this, her blood test has come back and they've changed her to atorvastatin – the drug you said was too expensive for me to have!

Doctor: Well you see, it is important to prescribe responsibly....

Patient: Responsibly! You call all this fanning about responsible? I used to trust you, doctor. You've looked after all my family for 20 years - and I really thought your patients came first. But all you care about is money! You dish out whatever cheap rubbish comes along to save a few bucks.



I *was* going to ask you about my wife and her heart disease, She recently saw the specialist at the hospital and he prescribed perindopril. I assume that you *do* listen to specialists do you doctor? There's not much point in having them otherwise. Anyway, she has a letter saying you won't give her any more perindopril because it is too expensive. Your pharmacist is at it again, no doubt? But I won't discuss it, doctor, because I am going to move my whole family to another practice. I am going to find a doctor who puts patient care first and short-term fanning about with cheap drugs second. I hope you manage to sleep with a clear conscience !

And then he left. The surgery droned on..... "what's this felodipine? I was on amlodipine""I've had Prozac for years and now they give me fluoxetine; it doesn't work the same" "diclofenac upsets my stomach; voltarol was alright" "these cheap inhalers taste horrid and don't work"

It sounded as though the poor chap was running the complaints department of the NHS Prescribing Authority!.

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

Jennifer