

# Somerset LMC Newsletter



May 2006

Issue 125

## DRUG AND THERAPEUTICS BULLETIN

*Please write and protest to the Department of Health about their decision to stop providing this important resource for doctors.*

The latest edition of the DTB contains the unwelcome news that the DH is ending its funding for the general circulation of the Bulletin, so that in future it will be available on subscription only. Although the subscription charge will be modest, the reality is that most doctors will not pay it, either on principle, or because they will be sharing one copy within a practice. This will inevitably reduce the ability of the Bulletin to produce its accustomed authoritative and exhaustively researched articles.

DTB is a bit like that teacher at school you did not really get on with, but who in hindsight was the one who really taught you the subject. It may seem to be rather negative, but perhaps that is just in comparison to the relentlessly upbeat tone of pharmaceutical company publications, and there is no doubting either its credentials or its independence.

The more cynical of us (Oh, come now, surely there is at least one idealist left?) might suspect that this is precisely why it has been dropped. Any voice that might dissent from the party line is bound to be unwelcome in some political circles. But this implies a level of subtlety we are not used to from the Department of Health - this is, after all, the organisation that was responsible for the oxygen supply fiasco. It is far more likely that the decision was a reflex response to the need to reduce central costs, but that does not make it any more sensible.

D&TB is unlike other prescribing guidance because it is genuinely objective and unconstrained by bureaucratic or political influences. It can, and does, report promptly on new products, long before the wheels of NICE have started turning, and it has a breadth of editorial interest and experience that is invaluable.

The Departmental decision is counterproductive because the range and quality of advice to prescribers will be diminished. It also reflects a worrying willingness to sideline high quality objective information of modest cost for no convincing reason.

So please write now to the Secretary of State to register your protest:

Rt Hon Patricia Hewitt MP  
Secretary of State for Health  
Department of Health  
Richmond House  
79 Whitehall  
London SW1A 2NS

DTB have asked if copies of letters could be sent to them at [dtbengland@which.co.uk](mailto:dtbengland@which.co.uk)

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## THE SUSPENDED GP PERFORMER - GUIDANCE FOR GPs

### *The Secret of Survival is in the Practice Agreement*

The GPC have issued guidance to help practices avoid making a bad situation even worse if you are faced with the need to stop a GP in your practice from working because he or she is underperforming for any reason. Although the chance of it happening to any of us individually is small it is by no means negligible. There are two reasons for a GP to find him or herself “suspended from the list of performers” by their PCT. The first, and most serious, is as a result of a final decision by a Fitness to Practice Panel. The second, and most common, is while an investigation takes place and is intended to be “neutral.”

Whether neutral or punitive, a suspension is bound to be a serious matter for the individual and for the practice concerned. Under such circumstances the last thing anyone needs is for the whole ghastly business to cost money too. This useful document has been published by the GPC to help practices make the best of a bad job and argues that the secret lies in a properly worded practice agreement between partners (or contract for salaried doctors).

A partnership agreement should contain provisions for the eventuality of suspension by the PCT. In particular the responsibility for paying for locum cover under these circumstances should be explicitly set out. There are two contrasting ways of doing this:

- By stipulating that the suspended partner will continue to receive normal drawings but will indemnify the others against locum expenses
- By stipulating the opposite, that the suspended doctor will *not* receive drawings and will *not* indemnify the other partners.

In either case the suspended doctor’s income will fall to below 90% of its normal amount and, under Part 4 Paragraph 11 of the Statement of Fees & Allowances, the practice becomes eligible for help. First the PCT can undertake to provide and pay for locum cover. More realistically the PCT may provide financial assistance, up to £978.91

per week (05/06 figure). That will not go far these days but a decision made by the Secretary of State on the SFE – a “Determination” – may mean more help is available.

Imagine that a partner is suspended who had previously agreed to indemnify the practice against excess locum expenses out of his or her own drawings. Then, under the Determination, he or she is entitled to additional payments to make up their income to 90% of what it was before the suspension.

On the other hand, the doctor may have agreed not to receive drawings to allow the practice to employ a locum. His income is clearly now less than 90% and he can apply for assistance personally.

The nightmare alternative is seen if the practice had instead kindly agreed that drawings could continue and no indemnity was necessary but ***the PCT decided the practice, being quite large, could cope without a locum.*** Everyone would be out of pocket...except the PCT.

Another good reason to dust off that practice agreement...or even to make one for the first time?

## MEDICAL STUDENT ATTACHMENTS TO SOMERSET PRACTICES

### *Developments at the “Taunton Academy”*

Hosting Bristol medical students in primary care in Somerset is going very well, with excellent feedback from both the students and the University. We currently have 6 fourth year students per term, with four terms a year. Each student does a 2 week residential and a 2 week non-residential attachment, so we filled 48 slots last year. The numbers will increase next year.

Payment is pretty generous, for 2 weeks residential it is £788 + £90 accommodation, and for 2 weeks, non-residential £603.20. Compared with F2 attachments this means for, say, 4 students (8 weeks) income will be £3515 residential or £2412 non-residential as opposed to an F2 for 8 months at £4703, 12 months at £7055 (as far as we know).

Practices can choose how many students to

take. Some just have one, we manage about four - there are eight potential "slots". We ask for your availability at the beginning of the year, but it is not set in tablets of stone. You can take two at a time if you have the capacity - some brilliant practices have already baled us out by doing this, and found it worked fine. If you take students from other medical schools as well there is no problem if they overlap. You do not have to be a training practice but there are useful, but not compulsory, "teaching the teachers" days provided by Bristol Medical School as well as local support from us. Perks include medical school library rights, good study days, and the students are usually very rewarding.

If you want to see the syllabus it can be downloaded from [www.bris.ac.uk/depts/primaryhealthcare/studentwelcome.htm](http://www.bris.ac.uk/depts/primaryhealthcare/studentwelcome.htm) (click on "year 4")

There are other teaching opportunities as well. We also have some wonderful doctors teaching small groups of 3<sup>rd</sup> year students on a regular basis. These are "taster" sessions based on GP focused history and examination of individual systems, and teachers for other years are wanted if you can get to Bristol - do ask.

For more information contact:

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## NATIONAL LIBRARY FOR HEALTH PRIMARY CARE QUESTION ANSWERING SERVICE

**Warning: This site may be addictive!**

If you have not chanced upon this service may we commend it to your attention? If you have a question about any aspect of primary care and want the best evidence based answer available, you can ask it through this site. The speed and authority of the replies is impressive, but as they only use good quality evidence there may be some questions that cannot be answered. The range of questions on the site is fascinating, and well worth a browse. But be warned: if, like this editor, you have a magpie mind you may find it irresistible. [www.clinicalanswers.nhs.uk](http://www.clinicalanswers.nhs.uk)

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## SECTION 136 MENTAL HEALTH ACT ASSESSMENTS

### *Are not the GP's responsibility*

You may be aware that the contract for police surgeon (forensic medical examiner) services changed on 14<sup>th</sup> May from a service provided by rotas of local practitioners to one provided by a company called Veritas. We understand that Veritas have a different skill mix with more nurses involved. There has been some concern that this might result in practices being contacted by the police when a Section 136 MHA Assessment is needed on a person being detained. The GPC have issued the following clarification of the practice's responsibilities:

***A GP is not required to attend a police station for the purposes of assessing a patient under s136 of the Mental Health Act. He or she may be obliged to attend under the practice's GMS/PMS contract***

- ***IF the patient has specifically asked for their GP***
- ***AND if in the doctor's opinion the patient requires treatment under essential services (or additional/enhanced services if the practice is contracted to provide such services)***
- ***AND the police station lies within the agreed practice area***
- ***AND the time is during the in-hours period. Otherwise no obligation.***

***Also please note that if a GP were called to aid a police officer in the execution of his duty then a fee for this is payable.***

### HOW TO BE CREATIVE IN THE NEW NHS

Those of you who think the only response to the endless demand from our masters for policies and procedures is to send your practice manager on a creative writing course may take heed from Warwick House in Taunton. Writing under the pseudonym **Edward Charles**, their practice manager celebrates the publication on May 6th of his first novel, ***In the Shadow of Lady Jane***. Details at

<http://www.edwardcharlesnovels.org/>

## SOMERSET BOOKING MANAGEMENT SERVICE

### *Data Security under Choose and Book.*

You may have seen articles in the medical press expressing some concern about the confidentiality of patient information submitted through Choose and Book. Kevin Hudson, the Somerset CAB programme manager, has written the following paragraphs to explain the actual position in the county, and the LMC is now satisfied that it is safe and secure.

### *Demographic Data*

Staff with spine access can see the demographic details of patients but this is the limit of their access. By demographic details we mean name, address, contact telephone number, NHS number and date of birth. But this is no different to the information an NHS employee can gain from access to the longstanding database that allows staff to trace patient's NHS numbers (NHS Strategic Tracing Service).

### *Basic Referral Information*

Unless they are connected with the Practice, the BMS or the Provider, and have been given appropriate access to local electronic workgroups, staff will not be able to see that a referral has been made. The basic access of authorised non-clinical staff allows them to see that a referral exists for a patient, who made it, the specialty and clinic type, the priority and the options chosen. This group of non-clinical staff includes practice receptionists, BMS staff and provider booking staff.

### *Clinical Details about the referral*

There is then a higher level of access available only to clinicians and their secretaries (in practices and at the provider) that allows them to access the attachments to Choose and Book, namely the actual referral letter and any other attached documents including test results. It should be stressed that neither BMS nor booking staff have access to the text of the attached referral letter.

### *Implications of this in Somerset.*

In the RMC, a nurse advisor screens *paper* referral letters to see whether an alternative

provider can be suggested. This process does not happen in Choose and Book and the BMS Choice Advisors can only suggest choices within the options selected by the GP Practice. It is therefore important that GP Practices "tick" as many clinically suitable options as possible. But the current system also allows a GP to narrow the choice and be specific about provider and clinician should that be clinically appropriate in an individual case. Finally it should be noted that in all Somerset Providers, consultants are presently not reviewing referrals on-line. This means that consultant medical secretaries and/or the hospital outpatient access team are downloading and printing referrals for the consultants to review by paper. Therefore in many ways the process within the provider and the circulation of referral documents is currently little changed from existing systems.

## TRAVELLING ABROAD WITH CONTROLLED DRUGS

*Please make sure patients going have thought about this before leaving*

With the growing number of opportunities for cheap travel even patients with serious illness may be leaving the UK, and they may not realise that there are restrictions on taking prescribed controlled drugs both out of and in to the country. Furthermore, the regulations may be very different overseas – codeine, for example, is prohibited in a number of countries and if in doubt patients should contact the relevant embassy for advice. Anyone carrying controlled drugs across a UK border should keep them in their hand luggage, and is expected to have a letter of confirmation from the prescribing medical practitioner. If the amount carried is more than the specified limit for that substance, the patient needs to get a personal licence from the Home Office. This has to be filled in by a doctor and can be downloaded from

<http://www.drugs.gov.uk/drugs-laws/licensing/personal/> where there is also a link to the list of specified quantities. Forms need to be submitted 2 weeks before the travel date. Note that providing letters or completing forms for this purpose is not an NHS service and you may charge for it.

## THE PROVISION OF OUT-OF-HOURS CARE IN ENGLAND

*Report by the Comptroller & Auditor General 5<sup>th</sup> May 2007*

This document was featured heavily in the news media on the day of publication although the results of the local elections and subsequent cabinet reshuffle soon crowded it off the agenda. It was written by Sir John Bourne of the National Audit Office. The NAO scrutinises public spending on behalf of Parliament and Sir John is an Officer of the House of Commons. It is a most thorough and rigorous report that is presented in mostly good English that is a pleasure to read. A particular joy is the way in which the report is set out so that the chapter and paragraph headings form a continuous narrative. This is given below, together with some extracts from the text given inside square brackets.

The previous OOH service was unsustainable. The Carson Review and other strategic documents set out a vision for change [particularly highlighting integration of services to make a seamless service for patients]. A new system for OOH arrangements was implemented during 2004-5.

There were some shortcomings in the commissioning process. A lack of time and expertise resulted in patchy preparations. There were widespread problems with contracts. Various factors undermined the rigours of competitive tendering processes [lack of experience and capacity in PCTs which had numerous other commitments at the same time].

Out-of-hours providers are beginning to deliver a satisfactory standard of service. Access problems do not seem to have compromised safety. Providers are not meeting all the Quality Requirements yet, especially those relating to speed of response. Patient experience is generally good, but one in five is dissatisfied. Management information is still poor. There is limited progress toward integration with other services.

Costs are higher than anticipated. There were misunderstandings about funding, in particular the £6,000 foregone by [WTE] GPs. [The £6000 figure was a negotiating figure. The DH reckoned on £9,500 per WTE GP and]

...made provision of £320m to reflect the known costs of the existing service, but the costs of the new service were higher...by 22% overall. [One reason for this was the lack of transparency in the costs of the existing service, not least the underwriting of it by GPs. Furthermore, misunderstanding the significance of the £6k figure led some PCTs to underestimate costs from the outset]. GP pay rates remain the key driver of costs [in what is considered to have been an immature market].

Commissioners are entering into contracts with multiple providers and the market is maturing. The provider market is maturing **[but a funding gap is likely to remain in the meantime and some PCTs will need to draw on their unified budgets to top up OOH in the short term]**. Case studies and visits reveal much good practice [Sir John is especially impressed by OOH arrangements in Hereford where GPs work with a commercial provider, Shropshire where the Ambulance Trust works closely with triage GPs, Bassetlaw where half the practices provide Saturday morning surgeries, Nottingham where cooperation includes a GP and practice nurse working in A&E and Maidstone where Call Care Ltd completes 62% of calls with nurse advice only.] Commissioners are beginning to make tough decisions [e.g. in sacking unsatisfactory providers]. England performs well against UK and international comparisons.

The report concludes that significant savings could be made by “benchmarking against the best services” and suggests that, even making allowances for the increased costs of providing OOH in rural areas, £134m could potentially be saved. It also recognises, however, that contracts based on cost alone are not allowing investment in training, facilities or innovation.

It is hard to draw any specific implications for Somerset, but the high cost of GPs means there will inevitably be further pressure to use doctor hours as efficiently as possible, and pay rates are likely to remain static at best.

## “COLLABORATIVE ARRANGEMENTS” 2006/2007

### *Practices should now set their own charges for certain forms and reports*

Under the 1977 NHS Act PCTs are responsible for providing certain medical services, known as Collaborative Arrangements, for local authorities. Until this year the DDRB used to set the fees for this work they have not done so for 2006/07, and we anticipate that in future practices will have to decide on their own fee scales.

The Collaborative arrangements include (This is not an exhaustive list)

- Notification of infectious disease
- Reports for social services, including child protection
- Attendance at child protection or other case conferences
- Housing reports requested by local authorities
- Mental health act work (including a request for an opinion where no "section" is completed)
- Requests by other local authority departments for medical reports
- Requests for blue badge reports

*Note that Certificates in connection with incapacity and council tax must be provided without charge.*

If Practices are requested to do this work it is actually the *PCT* that is responsible for payment but as there is no longer any national guidance you should set your own fee scale for any relevant work undertaken after 1st April.

Competition legislation and the Office of Fair Trading prohibit the LMC or the BMA from advising on fees, and it is also illegal for individual doctors or staff even to discuss their fees outside their practice, presumably on the grounds that you might be setting up a cartel. The penalties for breaching this law are severe and can be up to 10% of practice *turnover*, not profit. (Paradoxically, GPs are encouraged to put up lists of patient charges in the waiting room, so unless you ban anyone working in another practice from

entering your premises it is hard to see how these fees will not be easily discovered!)

None of this work is within your GMS contract, and unless specified is not part of PMS either, so you now need to decide which of these services you wish to provide and then establish your fees for so doing. However, we do advise a degree of caution on both contractual and ethical grounds. The BMA obtained a legal opinion last year which advised that a three month notice period should be given when withdrawing from collaborative arrangements and the LMC suggests that you should continue to observe this, even though the circumstances have changed with the DDRB decision

Practices should now notify PCT that as there is no DDRB recommended fee, any request for collaborative work received after the set date will constitute a contract between the practice and the PCT and the practice's fee schedule will apply.

Although Somerset PCTs are generally good about making timely payments, practices may not be aware that they may use the provisions of the Late Payment of Commercial Debts (Interest) Act 1998 which allows you to apply interest to outstanding debts at no more than Base rate +8%.

<http://www.payontime.co.uk/downloads/commercialdebts.pdf>>

<http://www.payontime.co.uk/downloads/commercialdebts.pdf>)

If you really run into delays, do not forget that debts are recoverable through the Small Claims Court. If practices intend to operate this scheme they should also include this information in their letter to the PCT.

The LMC advises that you should be cautious about turning down collaborative arrangement work, since there may be ethical considerations as well as the need to maintain the doctor-patient relationship. Where a child is at risk, for example, the LMC would always strongly advise doctors to continue to fulfil their obligation to the child and that any fee is considered secondary.

*With thanks to Cleveland Local Medical Committee*

## WARFARIN MONITORING UPDATE

*Please don't do routine tests for valve replacement patients on Fridays!*

Anticoagulation monitoring is one of the success stories of the new contract, with very real improvements in patient safety as practices have become more systematic in their service provision. We are now at the stage of making fine adjustments to protocols, one of which should be to avoid routine Friday INR tests on patients with valve replacements. For most anticoagulated patients a slightly low INR for a few days is of relatively little clinical risk, but for those with a metal heart valve it is greater. The lab cannot routinely telephone all low results back but we do not want patients at risk to have a low INR for the next three days (or more over a Bank Holiday) before action is taken. If you cannot avoid doing an INR on a Friday, and you use the Somerset Pathology service in Taunton or Yeovil, please try and check the results of any valve replacement patients yourself using the web browser. It is also helpful to routinely indicate on the request why the patient is warfarinised – writing “AVR” or “PE” is actually quicker than “on warfarin” and a lot more informative.

## Oxygen Supply

*The Saga continues....*

We understand that some practices are still having problems with HOOFF forms submitted to Air Products. If a HOOFF form is incomplete, Air Products should now return it to the practice for amendment. However, if you sent a HOOFF in before 1st February, whether it was valid or not, it was automatically destroyed by Air Products, with no record made to that effect because this was before the start of the new contract! Please ensure you continue to keep a copy yourself, and also send one to the PCT.

Air Products are also expecting practices to notify them if a patient changes address. We have pointed out that the GP is not necessarily made aware of this, especially if the patient moves out of the area. Quite what happens if a patient moves over a long weekend remains to be seen.

## Small Ads Small Ads.....

### PART-TIME SALARIED GP

#### Sessions Negotiable (minimum of 4 per week)

We are currently looking for a salaried doctor to join our friendly forward thinking practice located in one of the sought after rural areas of the country. If you are an enthusiastic and motivated GP who would like to join a dynamic team then we would like to hear from you.

- Twin site practice with around 10,000 patients / 8 partners (6 WTE)
- Extensive team of dedicated support staff including our innovative and successful integrated nursing team
- Established teaching & training practice with 2 GP trainers
- Personal development and special interests encouraged, supported by a monthly programme of protected in-house learning
- Very high QOF achievement with enviable reputation for quality management
- Local community hospital under the clinical supervision of the practice
- Excellent financial package and working conditions
- An interest in women's health and family planning is desirable.

CV and applications to / or further information from :

Mrs Alison Foulkes, West Somerset Healthcare, The Surgery, Robert Street, Williton, Taunton, Somerset, TA4 4QE  
Tel: 01984 632701

Email:

[Alison.Foulkes@willitonsurgery.nhs.uk](mailto:Alison.Foulkes@willitonsurgery.nhs.uk)

## JENNIFER'S JOURNAL

We sat together to watch the Tony Blair personal DVD message to all GPs. It was tremendous stuff. Tony on the balcony, low camera angle, Cheri two paces behind, Patricia Hewitt on his right, a Union Jack as a back drop, and even a picture of Margaret Thatcher on a piano in the room behind just visible. Land of Hope & Glory was the background music. Tony addressed us as if we were the most important people in the NHS - it was a call to arms. 'The NHS is in crisis and we need you, our loyal GPs to rescue us from a total breakdown and bankruptcy. I know that every man and woman amongst you will do their duty. God is on our side and we will prevail'. Heady stuff but Jennifer knew what was going on.

An earlier meeting in private with Patricia had revealed all : NHS debt due to be over £1 Billion: someone had finally twigged that increased productivity cost more money and not less. And it was going to get worse Payment by Results now had a list of tariffs so the hospitals had it sorted; get the punters in and claim the money. Clearly NHS Direct protocols had been written just for them: "call an ambulance" , "go to A&E" , "seek urgent specialist help" . Furthermore, with previous experience from sparring with fund-holders , the acute trusts where the kings of coding. Huge departments could be set up to win the coding game where smart adjustment of codes means profit. The hospitals were going to bankrupt the NHS. Something must be done to counter this, but what?

Yes, you guessed, Practice Based Commissioning. Give the GPs the budget and get them to fight to hold on to the money and keep patients out of hospital; that would be an effective counter. Those with fund-holding experience would already be up to speed on coding and could fight back. Keep these troublesome GPs and hospitals squabbling with each other and out of the Government's hair!

But it seems to Jennifer that there are some problems with all this. The PCTs are in the middle of yet another reorganisation, so they have no clear direction and the staff are all under threat of redundancy. They seem unable to collect useful data and are not in a fit state to contribute. Next, there is no money to pay for any of this. Fundholders had full management allowances but now primary care is being expected to do it all for nothing. The national hotch-potch of conflicting policies doesn't help, whereby practices must compete for patients but work together as a locality for commissioning. The immediate referral required of 'choose and book' does not sit with encouraging the reflection required for seeing if, in fact, referrals can be avoided and dealt with within primary care.



I wondered over my second bottle of Chardonnay (French and only lightly chilled of course) whether that such a total cock up was deliberate in order to ensure PBC fails, but I fear not. It is simply policy made up on the hoof with departments not talking to each other. But our Tony never gives in and hence his personal appeal to the GPs - He looked tremendous on the palace balcony waving to the cheering crowds. So, can the caring head-tilted Patricia and the deceptive genius of Tony persuade GPs to pick up the gauntlet of PBC and save the NHS? Will GPs rally to the cry, pull together and work for no money? Will they put personal greed aside and put Tony and Country first?.....Not looking too good really!

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

**Jennifer**

### FootNote

#### *Slow Correspondence from Secondary Care*

A GP in the west of the county reports that he recently received a discharge letter from the BRI one year and 9 days after the patient went home. We think this is a record...unless you know better?