

SOMERSET LMC

NEWSLETTER



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Issue 129

FULL PELT INTO THE FOG

Where will the NHS be going in 2007?

Inside this issue:

NHS in 2007	1
Digital Diabetic Retinopathy Screening	2
Chronic Kidney Disease and EGFR	2
National Care Records Service	3
Desktop Label Printers	4
"Choice"	4
Oxygen Supply	4
LMC Commentaries	5
Health Reference Forms/General Dental Council	5
Small Ads	5
Jennifer's Journal	6

The Somerset Local Medical Committee and all the Secretariat Staff would like to wish all their readers

a Very Merry Christmas and a Happy New Year



The LMC Office will be closed from 12 Noon 22 December and will reopen on Tuesday 2nd January 2007

"Leaders undermine the morale of their own troops at their peril. If, at the same time you continue to bombard them with a continuous torrent of flawed legislation, much of which replaces previous legislation before the ink on it is dry, you create a mess that can only be cleared up by long term planning." The words of Lord Ramsbotham, not about the Department of Health, but concerning Home Office comments on the Probation Service. Yet the sentiment is familiar to us, as it is to workers throughout the public service. Tim Cantopher, a psychiatrist specialising in occupational stress, wrote in the magazine *Public Servant* that public sector workers are being "sacrificed on the altar of our leaders egos" and that "governments all suffer from the delusion that regulation will make things better. It only makes people less efficient. When mistakes are made by public servants there is routinely an enquiry followed by the identification of a scapegoat and then a new ream of regulations which eventually destroys the service itself." Strong stuff indeed, but it chimes with the prevailing GP view that far from becoming localised and responsive, the NHS is ever more monolithic and insensitive; with financial balance the be all and end all. Hardly surprising, given that Ms Hewitt has staked her continued tenure of the Department on achieving this for the year, but should trusts actually be making a profit whist there are still so many unmet health needs? And should they really be spending money on advertising? It may only be a matter of time, but for the moment not many GPs or patients are thinking of nipping down to Tesco for a quick CABG.

Meanwhile, all is not well with the profession. GPs coming up to retirement face a pension cap - not the Department's fault of course, it was those devious GPs and their fiendish half dozen part time negotiators who forced the DH into believing their own statistics, so no reason for them to stand by their agreement. And at the other end new doctors face real uncertainty about the future, with restricted and restrictive training programmes increasingly hedging them about. The Working Time Compliance Officer (Yes, there is indeed such a thing) of a local trust contacted a practice with an F1 house officer attached because the doctor had logged 41 hours one week and it was *imperative* that she did not work more than 40. The next week an email arrived to say that under no circumstances were F1 doctors allowed to do home visits unaccompanied - presumably, therefore, they should not be allowed to handle a cup of tea at more than 50 degrees, and certainly not to come into contact with any infectious disease.

It does not take very long to see that this is why Tony's Billions poured in to the NHS have not produced the dramatic changes he expected. Disempowered, deskilled and demotivated staff trapped in a morass of regulation just cannot do the job. We urgently need to introduce some reality by publicly setting achievable limits to the NHS and ensuring that doctors are independent professionals able to manage risk and use resources wisely for their patients' best advantage. Let us hope that the Government's New Year's resolution is to stop distorting the public service for political ends and to be a little more appreciative of its workers.

UPDATE ON THE NEW DIGITAL DIABETIC RETINOPATHY SCREENING PROGRAM

On course to provide digital photographic screening to NSF standards for all Somerset diabetic patients during 2007.

The county wide database of diabetic patients has now been established on a dedicated system, and appointments for screening are being sent by the screening centre in Taunton. Digital photographic screening and primary grading started in Glastonbury in August, and secondary grading (for QA purposes) is taking place at MPH. During December 2006 the service will extend to Bridgwater, Wellington, Minehead and Crewkerne Community Hospitals. Yeovil should follow early next year, though a suitable location has yet to be confirmed. A newly appointed Screener/Grader started work in December this with three more to follow next year.

From January 2007 the "old" screening program will cease to exist, and optometrists have been made aware of this. Therefore, you will not see any more of the screening outcome forms which you have been receiving up till now. Instead, you will be receiving new computer generated letters which can be tailored to suit the screening outcome. Possible letter contents can be summarised as:

1. No retinopathy, re-screen in one year
2. Mild retinopathy, re-screen in six months or one year
3. More advanced retinopathy, refer to hospital eye service

No referable retinopathy, but other pathology detected which needs referral

Note that re-screen appointments are generated automatically by the screening centre, and if referral to the Hospital Eye Service is needed, then this will be arranged directly. *All the letters you receive are for information only.* Separate letters to explain the screening outcome are sent to patients after every screening visit, though these letters do not contain the same amount of medical information as those to the GP.

The new screening software contains

information about when patients were last screened, and it is hoped they will be re-screened using the new method at the right time. However, since not all the screening centres will be live/fully operating on January 1st, some patients will initially be asked to travel a significant distance to receive their screening check.

Roger Gray, the Clinical Director for the service, reports that he is very impressed with the quality of the photographs obtained so far, and with all the quality measures embedded in the new system he believes this should be an excellent new screening service.

We can but hope that patients will be prepared to travel in order to take advantage of it, and practices need to be planning now how they will arrange the retinal checks required by the QOF for those who are not able to do so

CHRONIC KIDNEY DISEASE AND EGFR

Still not a very clear picture

You will be aware by now that all the biochemistry laboratories used by Somerset practices are routinely reporting eGFR: but what should we be doing with it?

I doubt whether most of us have come across many patients with Stage 5 or 4 CKD for whom a diagnosis of significant renal disease had not already been made, and nearly all such patients will be under the care of a consultant. But what about the considerable numbers of patients with Stage 3 CKD?

Local nephrologists emphasise that an eGFR in the range 30 to 60 is usually a marker for cardiovascular risk rather than a signpost to inevitable progressive renal failure. It should be considered in the same light as, say, a high cholesterol, which is why these patients are set lower BP targets. Indeed, Prof Feest (who covers East Somerset) suggests that CKD3 patients should be encouraged to buy their own BP monitors. But the decision on whether to treat to the QOF target BP of 140/85 is a clinical one. In the words of the GPC negotiator responsible for the QOF "You have to use common sense and clinical judgement to decide whether to treat those with minimally



reduced eGFR. Age is not a key criterion, but their clinical state is.”

The conclusion from this is that a reduced eGFR is important for everyone, and we should be putting all patients with an eGFR below 60 on the CKD register and monitoring their BP at least annually. However, as we know eGFR declines physiologically by 1ml/minute/ year over the age of 40, a lot of otherwise healthy older people will have Stage 3 CKD on paper. You need to have a conversation with such patients so that they can decide whether to they wish to take further medication to reduce their blood pressure(which does have proven benefits) and accept the concomitant risks of drug side effects, postural hypotension etc; or whether they prefer to have the situation monitored with annual eGFR measurements. You may wish to include in the discussion the fact that eGFR is just that – an estimate – and that the margin of error is wide: according to David James, Consultant Biochemist at Musgrove, the figure given will only be within 30% of the true result 90% of the time, and in 2% of people the error will be 50% or more. This means that you must not base treatment decisions about drugs like metformin and fenofibrate solely on the eGFR.

Incidentally, Prof Nicholls, the Exeter nephrologist covering West Somerset, has said that there is little or no evidence that ACEI/ARB treatment has any particular benefit in patients with stage 3 CKD who have a stable eGFR so patients who elect to be treated can reasonably be given an alternative anti-hypertensive if they do not get on with a first line choice.

What everyone agrees is that a progressive fall in eGFR is what matters most. A fall of 5ml/min should trigger consideration of referral in Stage 3, 15ml in Stage 1-2, And do remember that the most important investigation in patients with CKD is to dip their urine – proteinuria or haematuria requires action.

By March 2007 we anticipate that you will have a sizeable CKD register, but with a fair number of patients exception reported. For

the future, we understand that the GPC is looking again at the relationship between eGFR and normal aging so

things may change next year, but meantime aim to check the eGFR on those with Stage 3 CKD at least annually.

For more information about eGFR go to :

<http://www.renal.org/eGFR/about.html>



NATIONAL CARE RECORDS SERVICE

First signs of a rising tide of public opinion demanding “opt-in”

The slightly battered juggernaut that is Connecting for Health continues to inch forward, and the next phase in Somerset is the progressive installation of the Patient Administration module of Cerner Millennium into hospitals in the county. This should have relatively little impact on GPs, although some hospital clinicians are uneasy about the functionality of some the elements. For example, we have been warned that A&E attendance reports may be disrupted.

Meanwhile, there appears to be growing concern amongst some well informed patients about the Government proposal to (eventually) upload some patient data from GP systems to the national care record. According to the GPC patients who have written to the DH have had a letter rejecting their request to opt out of inclusion in a national electronic database of health records, and the BMA has sought urgent assurances from the Department of Health over the way the National Care Records Service will operate. The GPC goes on to say they have always maintained that patients must be able to retain the right not to have their data uploaded, should they choose to do so. We agree with their view that denying patients this right will only undermine that process and is totally unacceptable, and that the letter from the Department of Health to patients who have indicated they will wish to opt out seems to be at the very least ill considered.

In a separate communication, Sir Liam Donaldson the Chief Medical Officer sent a message to family doctors saying they should forward to the Health Secretary any



communications from patients using cut-out coupons from a national newspaper to say they do not wish to be part of the national care records database summary care record. The GPC also suggests that the CMO's intervention in sending a letter to GPs telling them to forward communications from patients is particularly unhelpful. We agree that GPs should not forward these letters: it is likely that some patients might think it a breach of confidentiality if a letter sent to their GP is forwarded to somebody else without their consent.

Most practices will by now have had at least a couple of patients wishing to be excluded, and a number of GPs are also uneasy about the data upload – in a debate at the Conference of LMCs in the summer a significant number of delegates indicated that they themselves would opt out. For the moment we suggest that you flag the notes of anyone contacting the practice with such a request with a “.93C3” Read code (Refuses consent for upload to national electronic patient record), but this matter is clearly far from resolved.

HOT TIP!

You can print Address Labels from desktop label printers



An LMC member writes: If you want an address label for an envelope or whatever, you can print these from your label printer. As this is the most useful thing I have discovered today I felt the need to share it!!

Open Label trace as normal. The default option is for printing laboratory labels.

But if you click on the tab marked "admin" there are two options:

1. Mailing label - Name and address printed , so useful sending a letter by post.
2. Patient details - Name and address + tel no + NHS no [but not date of birth]

Editors note: If you haven't got a Codegate label printer on your desk you should have – well worth the modest price and both software and hardware seem extremely reliable.

“CHOICE” MAY LEAD TO WORSE CARE.

The curious case of the disappearing Briefing Paper

In November a paper was published bearing a DH logo that had been produced by a research team working for the NHS “ Service Delivery and Organisation” R&D programme. This contained some uncomfortable facts about choice. Whilst patients like to be regarded as consumers of healthcare it found that most severely ill patients prefer decisions to be made on their behalf by a well-informed and trusted health professional, and that there was only evidence that patients want the opportunity to go to a distant hospital for non-urgent surgery if there are long waits locally and a history of poor service. It notes that wealthy and educated populations are more likely to benefit from choice, and, most damning of all, “ some studies suggest that increasing choice may result in a deterioration in the quality and cost-effectiveness of services”. A fairly comprehensive demolition of the whole policy, one might say.

Curiously, the SDO publication is currently unavailable in soft or hard copy. The reason they gave in response to my email query was “ The electronic version has been temporarily taken off our website and is being re-formatted to make it clear that it is a research summary and not a Department of Health policy statement.” Hmmm. You can still find it on the LMC site.

OXYGEN SUPPLY FOR USE IN THE SURGERY

Oxygen can be lifesaving in a number of medical emergencies, and it is good practice to have a supply in your surgery. The practice has to meet the cost of this as there is an element in your contract for “stock items” but it is not expensive. Probably the most convenient source is BOC who now have the domiciliary oxygen contract for the county. In our experience they are helpful and very prompt at arranging cylinder exchange or refill after use.

They currently charge £6.94 per refill, cylinder rental depends on size but includes a headset.

You can contact BOC on

0800 111333



LMC COMMENTARIES – A NEW SERVICE.

Ever wished someone would read all those fat NHS documents and tell you if they matter or not?

The eagle eyed may have spotted a new option on the LMC Website home page called "LMC Commentaries". This will develop over the next few weeks to build up a list of recent major documents relating to the NHS and will attach to each a short LMC commentary on their importance and relevance to general practice. Written by an LMC officer, the commentaries are designed to give you an honest assessment of each paper, but do not be surprised if the tone is pretty cynical. Go to:

http://www.somersetlmc.co.uk/LMC_Commentaries/commentaries.htm

HEALTH REFERENCE FORMS FOR PROSPECTIVE REGISTRANTS WITH THE GENERAL DENTAL COUNCIL

The General Dental Council has recently declared that all new dental health workers must in future have a health reference form completed by a doctor, or, in some circumstances, a supervising dentist. All dental professionals, (including dentists, dental nurses and technicians and orthodontic therapists) applying for registration must provide certain information about their health. The BMA has significant concerns about the current GDC guidance notes issued for the completion of health reference forms and the wording on the actual form to be completed by the doctor. The Association considers that GPs should normally only provide factual reports on patients and that procedures that require investigation (such as freedom from infection) should not normally be carried out by a general practitioner. If an opinion is required then this should be obtained from an occupational health physician with the appropriate expertise.

You have no contractual obligation to do this work and the GMC has confirmed that it is also their view that GPs are not required to do it. If you do choose to take it on the BMA suggested fee for patients registered with the practice is £73.50 for a report on a pro forma (with no examination). However, if arising from the report you need to arrange investigations such as a chest x-ray or tests to verify freedom from infection then these constitute "treatment" under GP contracts and cannot be charged for.

SMALL ADS SMALL ADS SMALL.....

ARE YOU GOOD IN AN EMERGENCY?

S.A.V.E.S.

is a Somerset charity affiliated to BASICS. We work alongside the ambulance service to provide enhanced pre-hospital emergency care particularly at road traffic accidents. We are looking for more doctors to develop an interest in pre-hospital emergency care.

It is:

o *Exciting*

o *Scary,*

o *Invigorating,*

Sometimes cold, dark and wet, But mostly it is immensely rewarding, front-line, real clinical medicine.

Due to retirements we particularly need doctors who live or work in the South-East and North-East of the county and a patch West of Taunton. The charity will help with training and equipment.

If you might be interested please contact

Dr James Hickman on

james.hickman@doctors.org.uk or 01823 490505.

NUFFIELD HOSPITAL SOMERSET – TAUNTON

PART-TIME GP / PHYSICIAN

2 evening sessions per week

We are currently looking for GP / Physician to join our multidisciplinary healthcare professional team to provide Weight Management Programmes at the Nuffield Hospital Somerset.

We are looking for someone who is empathetic to the needs of patients with weight problems and who would be available, initially, to conduct one or two 2-hour evening sessions per week.

CV and applications to / or further information from: Margaret Turner, the Weight Management Team at the Somerset Nuffield Hospital. 01823 286991

Email address:

margaret.turner@nuffieldhospitals.org.uk

JENNIFER'S JOURNAL

A friend of mine once told me how he certified Father Christmas on Christmas day. Granddad, who was getting more and more frail, always insisted on dressing up as Father Christmas and handing out the presents. Well, he had just got all toggged up when he collapsed and died in the hall. I imagine the children could cope with granddad dying, granddads do, but Father Christmas dead - now that's not possible! Anyway, I knew the old chap was only dressing up because the real Santa came to see one of my doctors at my surgery yesterday.

"We had a lot to get through. His BMI came up as morbidly obese, his BP was horrendous, he was a hopeless alcoholic and incredibly unfit. He had an appalling diet and his risk status was off the chart.

I was telling him that he shouldn't try and do a year's work in one night when he suddenly broke down in tears and asked for a sick note, saying that he couldn't go on - so here we are, just before Christmas with the whole world dependent on him and he wants to pull a 'sicky'. There's no understudy; Christmas would be ruined for millions. What if they find out it was me that declared him unfit for work.?

"Surely, its not that bad" I tried "I mean, one big push and it will be done."

"Not so easy" he said " The European work directive means that I'm only legal in countries that don't celebrate Christmas. I've had the 'social' hassling me about child employment and minimum wage. I've been accused of racism regarding the elves and even the RSPCA want to prosecute me for the way I treat the reindeer. I know Rudolph is getting on a bit and, no, I haven't got an up-to-date veterinary certificate, but he is a tryer. Air traffic control want a flight plan in triplicate; MI6, the CIA, FBI- they're all bugging me, suspicious that I have connections with terrorist organisations; the planet huggers are picketing the North Pole saying my activities are melting the ice cap..... It's all getting too much; just give me a sick-note until the New Year. I need a break" he sighed. "I've not had a Christmas off in 2000 years - I'm knackered."

"You can't do this" I said, "The world needs you. Could you live with yourself if all those little children got no presents this year. You would be despised, receive hate mail, your lovable character tarnished forever. Your reputation may never recover. You must battle on, stiff upper lip....." . I got quite animated.

"OK doc, you have a point, I'll struggle on. But before I go could you just sign all these certificates- latest policy from the North Pole."

"Let me see -

Certificate to say medically fit to be in charge of a sleigh.... fit to work with reindeer.... fit to climb up and down chimneys.....Certificate to say now free from alcohol.

Certificate to say safe to go into children's bedrooms in the middle of the night..... it goes on and on!"

"Yes doc. I can't travel without these and if I mess up it will be your fault because you'll be saying I'm fit. But, as you say - mustn't let the kiddies down."

"OK,OK here's a sick note for six months." I quickly scribbled it out and he was gone in a flash. In case you're worried that he won't be working this Christmas, I have since discovered he wasn't the real one after all. He was a benefit fraudster exploring a new way to extract a sick note from suckers like me."



HAPPY CHRISTMAS!

Jennifer

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