

Somerset LMC Newsletter



April 2007

Issue 131

Time for Direct Action?

The slumbering giant is stirring

GPs will generally put up with an awful lot rather than do anything that will harm patient services. We value our relationship with our patients, and will usually accommodate more and more work rather than do something to inconvenience them. As a consequence it has always been hard for us to agree on any concerted action in response to unacceptable political or management decisions. But perhaps this time things are different – there is no denying the rising tide of anger at the machinations of the Government in recent months. The campaign of negative spin, the attempts to blame the profession for the failings of the Department of Health, and the contemptuous decision to offer no inflationary increase to contract payments for a second year have tried the patience of the profession, and there is now a widespread view that something must be done.

The GPC decision not to advocate specific action has disappointed many, and though we accept that any proposals must be very carefully considered indeed, our national representatives must now regard themselves as being on a yellow card from their electorate.

But whatever we decide to do, it will not be plain sailing. Mr Blair singularly failed to repeal any of Mrs Thatcher's draconian anti-trade union laws, and between these and the legislation against anti-competitiveness there is precious little clear water. Department of Trade and Industry guidance on "*Industrial Action and the Law*" includes the telling phrase "Anyone organising a strike or other industrial action would be liable to legal proceedings by employers, and others such as their customers and suppliers, who are damaged by such action", the only body exempt from this being an official trade union that has jumped through all the hoops, including arranging for an independent ballot. So whilst it is arguable that as independent contractors we can choose to accept or refuse work that is not specified within the contract and therefore none of this applies, it is certainly true that proposals for joint action must be carefully managed by practices and their representative organisations. And just to ram home the point, the DTI guidance goes on "The fact that a union is responsible for organising industrial action for which there is no immunity does not prevent legal proceedings from being brought against the individual organisers."

The LMC is, of course, not a trade union – this is the function of the BMA. And despite the restrictive law the BMA is still our most powerful defence against bad politics and bad management. We all tend to treat it like the Fire Brigade by taking no notice of it all until we want it in a hurry, but to maintain it as a strong organisation doctors must support its democratic structures. The Annual General Meeting of the Somerset Division will be held early in May in the Postgraduate Centre at Musgrove Park Hospital – please try and attend, for the BMA structures are like so many other manifestations of civil liberties: you don't know what you've got till it's gone.

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SOMERSET LMC NEW ADDRESS

East Reach House
East Reach
Taunton
TA1 3EN

Tel: 01823 344314
Fax 01823 344390

SOMERSET CHLAMYDIA SCREENING Programme

An important public health initiative

We are all aware of the rise in the rate of Chlamydia amongst sexually active young people. But as a largely asymptomatic infection it has been difficult to help women avoid the pain and distress caused in later years by the impact of this infection on sexual and reproductive health. The costs in secondary care commissioning are also rising due to the need for treatment for pelvic inflammatory disease, and support for sub fertility. This is of particular note within the South West where a recent joint report from the Health Protection Agency found that this region has the second highest admission rate for these problems in the country. Evidence from the USA and Sweden has found that implementing a Chlamydia screening programme reduces the incidence of pelvic inflammatory disease by around 50% after one year.

At January's LMC meeting the committee welcomed the advent of the Somerset Chlamydia Screening Programme which is due to be rolled out across the county in the spring following the pilot phase currently taking place in the Bridgwater area. The LMC supports the Somerset model which follows a self management programme offering multiple screening and treatment options, often in non-health settings. A DIY screen, a highly reliable laboratory test, and - in the majority of cases - treatment with a single oral dose of antibiotic will be available for all sexually active people between the ages of 15 and 24, making this approach highly acceptable to the target group.

Screen results will be received at the Somerset Chlamydia screening office (CSO) from the laboratory and users will be informed of their results by their chosen method, which could be a text message. If the results is positive the patient will receive individual telephone advice and guidance on dealing with their infection. A choice of places to obtain treatment will be offered where health professionals working to patient groups directives (PGDs) will offer appropriate treatment or referral. The CSO will also undertake responsibility for contact tracing and treatment. The GP will be

informed of the result if the test was initiated in the practice

In phase 1 of the programme, beginning in April, practices using the courier system provided by Taunton & Somerset NHS Trust are invited to join the programme as "screening only" locations. If you are interested ,or for further information, contact Sara Hincks at the CSO on 01749 836512 or email to SomersetCS@somersetpct.nhs.uk

PATIENTS REQUESTING A CHANGE OF GP

We recommend that practices have an explicit policy on requests for a change of doctor

Although patients are technically registered with a practice rather than a GP, most practices continue to have a designated "usual" GP. We have no doubt that this has considerable advantages in patient safety terms, as well as providing continuity of care which is the key strength of UK general practice. If a patient really does not get on with their allocated GP , practices should be flexible enough to allow them to transfer, but there have to be limits to this. GPs regarded as more sympathetic or pliable will be overwhelmed and those who are more hard-nosed (and very often better clinicians for that) will be relatively underworked. But patients do need to have a good reason for wanting to change, not just that they don't like being told that they should lose weight or stop taking sleeping pills, or whatever. At the same time the practice needs to be able to show that it can accommodate reasonable demands - for example, in some practices offer open "men's health" slots so patients with sexual problems or prostate disease can see a male doctor, and most practices offer similar "women's health" appointments.

It is also good practice to allow patients to request a change of usual GP within the practice, although it is fair to ask that this be in writing to the practice manager. The practice should consider such requests carefully and make a reasonable decision: if there is a genuine personality clash or relationship breakdown, the patient should be offered a different doctor. If they are a manipulative drug addict trying it on, then they should not.

The practice should be aware of such requests for clinical governance reasons - if all the requests are to move from one particular doctor's list then does he/she have learning needs or, indeed, a performance issue that needs to be addressed?

So, whilst a patient may wish to see a particular doctor for a particular "specialist" problem, this does not mean that doctor can become their "usual" GP. If the patient wishes to change he/she may have to accept whoever the practice can offer rather than his or her first choice, and, if the proposed new doctor is also unacceptable, changing to another practice may be the only option.

Finally, note that a practice *cannot* routinely refuse to register a patient wishing to transfer from another practice unless their list is formally closed.

EMAILING CONFIDENTIAL INFORMATION

You must take steps to ensure reasonable data security

Most of us are increasingly using email to correspond with hospital clinicians and other professionals about the care of patients. It offers great advantages of speed and reliability, and quite frankly it's hard to see how one could manage without it. However, as we have pointed out before, NHS net mail is not encrypted, and although our correspondence is generally of little interest to anyone not involved it is therefore not secure. For relatively low level exchanges it seems reasonable to anonymise information by using just a patient reference number (hospital or NHS) to identify him or her. Obviously this is not entirely secure, but a casual hacker is unlikely to have access to the relevant database to be able to extract the patient identifiers. Anyway, the content of most of these mails is hardly dynamite "Potassium now 5.6, what shall I do" or "I suggest increasing his furosemide to 40mg" may be strictly speaking confidential messages, but few patients would prefer us to send a formal letter which might take several days to be answered. And, if you are in any doubt about this, you can always ask them.

But there is some material that is more sensitive, and the elegant solution suggested by Neville Roberts, the new Chief Information Officer at the PCT, is to send this as an encrypted word document within an ordinary email. The precise procedure for this differs slightly between the various versions of MS Word, but it is basically easy. Click on "tools" and then "options". Select the tab that says "security" and enter the password. Thereafter, whenever anyone wants to open that document - whether on your computer or sent as an email attachment - they will have to enter the password.

The only downside is the need to notify the recipient of the password, but the same one can be used for any number of documents. Incidentally, NHSmail addresses are encrypted, but they are so secure as to be unworkable - you cannot, for example, auto-forward mail to a more convenient address.

NHS QUOTE OF THE WEEK

Medical ward nurse in response to a GP's telephone query about the discharge medication for a confused patient: "*Oh yes, we know he is illiterate - so that's why we carefully wrote down the instructions for him.*"

"DNA" HOSPITAL APPOINTMENT

One explanation

A GP was admitting a patient as a medical emergency when her elderly husband explained that he was supposed to be at an urgent outpatient appointment shortly. It was clear that the ambulance was going to take a little while, so the GP said he would ring the outpatient department to check if the patient could, under the circumstances, still be seen if he was a little late. The doctor rang the phone number on the appointment letter, and an answering machine directed him to second number. On ringing this another machine redirected him to a third number, He duly rang the third number where a machine, inevitably, sent him back to the first number.....

Tim's Wine of the Month

April is here so we can be heartened by the sight of daffodils popping through the long grass and feel generally more optimistic.

A New Zealand Sauvignon Blanc reflects the mood - there are dozens to choose from (the ubiquitous Oyster Bay is hard to beat as everyday plonk) but in my view the best all rounder, year after year, is Jane Hunter's Sauvignon Blanc (£9.95) which retains all the gooseberry zest of its peers whilst adding enough tropical fruit and length to make it really interesting top notch wine.

Those involved in Practice Based Commissioning or Connecting for Health will require the Wine Society's Santa Rita Maipo Cabernet Sauvignon 2003 - not cheap at £20 but so good it will make you forget that its all going to fall apart and you will inevitably get the blame.

PRESCRIBING MATTERS

Ciclosporin

We understand that some practices have recently been asked to prescribe and monitor treatment with ciclosporin. This is a "Red" drug under the Traffic Light Scheme and therefore this should be undertaken in secondary care as there is an element in the current contract price for trusts in the region to cover the cost. Where a patient attends a trust outside the region there should, in theory, be a local consultant responsible for prescribing and monitoring although in practice this may not be appropriate. Incidentally, if a patient is having medication provided by secondary care we suggest that you do add it to their medication list with something like "Red drug, provided by hospital" in the dosage field, so that any interactions with your own prescribing are apparent.

Diamorphine PGDs

Please note that it is no longer legal to include diamorphine in a PGD. All prescriptions must be for a specific named patient.

GMS GLOBAL SUM "FORMULA REVIEW GROUP"

The joint GPC/ NHS Employers group looking at a possible replacement for the infamous "Carr-Hill" resource formula for the core funding of GMS practices has reported.

We find this to be a sad document of which one gathers the authors are rather ashamed. The nub of it is the "overall funding envelope" (or amount of money available, as old fashioned people might say). Interestingly, the report believes that Carr-Hill would have worked, given enough money to start with, but now they have, in effect, rejigged C-H and believe that they've come up with a formula that would prove less destabilising given the "funding envelope" although it still implies considerable losses for some practices. Precisely where these would fall would depend upon whether a rurality factor was used but, probably due to underlying dispute within the group, they lamely conclude that they "cannot recommend" one way or the other whether rurality should "play in" especially as those pesky "leafy suburbs" (sic) would also gain at the expense of inner London practices. I think we can safely conclude that Somerset would be considered far too "leafy" to benefit. As far as small practices and the Cost of Unavoidable Smallness (CUS) no practice with a list size over 2232 would benefit, which means only a very few practices in the county would be eligible. The reports emphasises that it is impossible to derive meaningful figures for individual practices by putting our own sums into their extraordinary formulae, and warns us against trying.

As in future more of our income is expected to be gained from QOF and ES, it is hard to see the DH wanting the MPIG to stay for ever. However, with QOF being tightened and ES being frozen or going the way of little bitty bits for doing things we don't want to do like CAB, we believe that the LMC should for now defend the present formula and MPIG as representing the best way of maintaining practice stability and so services to patients.

SMALL ADS SMALL ADS.....**Somerset Coast*****Come to the sunshine coast of Somerset!***

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For more information please contact Pat Halls, Practice Administrator, Highbridge Medical Centre, Pepperall Road, Highbridge, Somerset TA9 3YA. Tel: 01278-764223.

E-mail: pat.halls@highbridgemc.nhs.uk -

Website: www.hbmc.co.uk

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Email guy.patey@stjamesmc.nhs.uk

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For an application pack and informal discussion please contact:

Jane Evans, Practice Manager, on 01823 327394/333355, or email

jane.evans@lyngfordparksurgery.nhs.uk

JENNIFER'S JOURNAL

These days decisions in the NHS are meant to be based on value for money and patient choice. - quality has long been forgotten. The trouble is, patients don't always choose the cheapest option so the PCT's latest challenge is to manipulate the GP's judgment and patient's choice so that they come up with the approved patient pathway. However, this doesn't always work out for the best. For example, musculoskeletal interface services were invented to save money, avoiding expensive orthopaedic surgeons. SMTC was invented (at an enormous cost) to offer choice, so patients need not go to their local DGH. Put the two together and the nonsense begins:

Jennifer sees a middle-aged chap with what she is pretty certain is a classic torn knee meniscus. Direct access to a local orthopaedic surgeon is blocked and so the Taunton based patient goes off to Bridgwater to the interface clinic. The physio there says 'I think you've torn your cartilage. I will order an MRI scan'. The patient returns to Taunton, and then makes another trip to Bridgwater to have the MRI scan. He goes home again, and then makes yet another trip to Bridgwater - to see a different physio this time - who says 'The MRI scan shows that you have torn your cartilage, and you need to see a surgeon for arthroscopic resection'. So after 3 trips to Bridgwater, 2 consultations with different physios and an MRI scan we discover what we knew already.

But I fear the journey has only just begun! The Interface service refers my patient onto to SMTC for the surgery. The patient drives to Shepton Mallet and is seen in a pre-op clinic. 'You need an arthroscopy' says the surgeon. The patient comes home to Taunton and then makes a second trip to SMTC for the arthroscopy. A different surgeon does a 'diagnostic arthroscopy'. The patient returns to Taunton only to make a third trip to SMTC to see a third surgeon (different chap again) who tells him that the arthroscopy showed a torn cartilage but the knee also showed some general degenerative changes and he really needs a TKR and so they did not treat the torn meniscus. Unfortunately, he was too young for a new knee and so he would have to soldier on.



Six months have now passed since my referral. My patient has seen two different physios, three different surgeons, had an MRI scan and an arthroscopy. He has driven 276 miles (with a bad knee) having had to make 3 trips to Bridgwater and 3 to SMTC. He has had no treatment and is no better. Was my patient's experience rapid? No - it took 6 months. Was it effective? No- he has had no treatment. Local? No- he has travelled 276 miles. Was there continuity of care? No - he saw 2 separate physios and 3 separate surgeons. Was it cost effective? No - except SMTC get paid just the same whether they get any work or not.

Each clinician involved, no doubt, did their job well but the patient pathway was a farce. Managers are too busy following political and financial imperatives from above to realise the nonsense they are making of patient care. Joined up thinking is lacking. If you need treatment for a torn cartilage in Somerset, Jennifer suggests that you bypass choose and book, the referral centre and interface services and fax a letter through to your local consultant orthopaedic surgeon, or failing that, go private.

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

Jennifer

SPONSORS SOUGHT FOR MARATHON RUN On 22nd April Dr John Scanlon, his wife, Dr Ruth Wells, and their two children, Claire and Edward, will all be running a marathon on Tresco, Isles of Scilly to raise money for the Cystic Fibrosis Trust. With his brother joining them there will be five family runners out of a total entry of 125. Ruth and John only took up running 18 months ago and raised over £2000 last year but they hope to beat that figure this time

You can sponsor them by ringing them at home on 01823-412796 (evenings), by e mail john.scanlon@blackbrooksurgery.nhs.uk or even more easily on line at www.justgiving.com/scanlon

John swears this is his last time running a marathon!