

# Somerset LMC

## Newsletter



**Aug 2007**

**Issue 134**

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### **PATIENT DATA CONFIDENTIALITY**

*It is part our shared responsibility to minimise the risk*

The LMC has been made aware of two significant and worrying breaches of patient electronic data confidentiality in the last few days. Both were perpetrated by individuals within the NHS system, and whilst this is in some ways reassuring, with literally hundreds of thousands of NHS employees and contractors having access to NHS data these events should wake us up to the fact that electronic data is at risk and should be guarded jealously.

In the first case an employee of a Primary Care system supplier used their employer's access codes to open and inspect the GP clinical notes of a particular patient. Fortunately the practice had installed monitoring software that recorded all access to the system so this breach was detected. The employer moved swiftly to dismiss the individual concerned, and the PCT has confirmed that the practice's system was not vulnerable to hacking by anyone else, but the damage has been done. And we have no idea whether this may have happened elsewhere in practices that were not keeping a log of external access.

In the second instance an NHS employee looked up their partner's investigation results on the laboratory web browser, and then with breathtaking presumption rang to make a GP appointment on their own to discuss them!

Both of these examples concerned very sensitive information, and not just routine tests.

There are several lessons to learn from this. First, none of us should use our access to NHS information systems to look up anything that does not relate to the care of a patient being treated by the practice or service you are working for. You should *never* look up the results for a family member, even if they are with you at the time and give their consent. We would also strongly advise against looking up your own results – whilst, of course, you have every right to see these, it is much better to go through the proper channels.

Second, you should regard all breaches of confidentiality as significant. All NHS employees and contractors have signed confidentiality agreements, and we have to create an environment in which everyone takes these very seriously indeed. If you become aware of a breach make sure that you act – which may include informing the NHS employer, although we would advise you speak to your defence organisation if contemplating such a step.

Examples like this can only make us more uneasy about NPfIT and the national care record. Already your demographics are available to anyone with CAB access who knows your name and approximate date of birth, and we think that the BMA position of opposition to the uploading of clinical records without specific patient consent is the right one to take. The real benefits to individual patients of a central record do not, at present, seem great enough to justify the risks.

## **Family Nurse Partnership – The Future of Health Visiting?**

*A Somerset Pilot is under way.*

The Department of Health, and what used to be called the Department for Education and Skills, currently the Department for Children, Schools and Families, are running a series of ten national pilots of a new programme of intensive parenting support. This adopts a model developed by Prof. David Olds in the United States that trains “family nurses” – all health visitors by background in our local pilot - to make frequent and regular contacts to deliver a very structured and intensive programme to first time parents . Unlike previous superficially similar projects, this one draws on a wide range of psychological, sociological and educational methodology to train the nurses in techniques that allow them to make a real difference to patterns of family thinking and behaviour.

Mothers are identified as early as possible in pregnancy and can be referred in to the project by any health professional although the pilot project is initially only running in Bridgwater, Frome, Taunton and Yeovil. 100 first time pregnant young women will be recruited for the pilot project. The named Family Nurse then sees the pregnant woman regularly up to her delivery, and then weekly, fortnightly and monthly until the baby is two. There are a range of material and resources that are used, and the Family Nurse has access to a number of other professionals for advice, including a psychologist.

The US outcome data is very impressive. In the short term birth weight averages rise, and prematurity falls. In the medium term numeracy and literacy at school entry is improved and accident rates are reduced. Other benefits included a reduction in risk taking behaviours such as alcohol and drug abuse as well as a reduction in smoking in pregnancy. But the biggest payoff is in the long term where work is now showing that employment rates rise, and offending and abuse within the family fall significantly.

The pilot is targeting first time pregnant women under 20 years, or between 20-24 years who are unsupported, not in education, training or employment. So far 53 have been

recruited to the programme, only 6 have declined, and just one has dropped out.

The Family Nurse Partnership Pilot is at this stage a feasibility study, Birkbeck College are evaluating the data from the study so it will obviously take some time for the report, to appear but it looks as though the model will work well in the UK. If so, this will be the first time that we have had a tool that really can break the cycle of deprivation so we will be pressing the PCT to continue to fund this work after the pilot funding ends.

Further details from

[Joanne.Seal@somerset.nhs.uk](mailto:Joanne.Seal@somerset.nhs.uk)

## **SINGLE POINT OF ACCESS FOR ADULT URGENT CARE/ADMISSIONS**

*Should save time and trouble as well as reducing admissions*

The scheme to provide a single contact point for health professionals who want to arrange an admission or increase the level of care for a patient is due to start for the whole of Somerset on **25<sup>th</sup> September 2007**. The contact number is **01749 836701**.

The idea is a simple one. The nurses at the SPA centre will have accurate and current information about all the care options available across the county at any time, so rather than the GP having to spend time ringing round to arrange, say, social care or a step up bed he or she can hand over this task to the SPA team. The team will also be able to offer to make all the arrangements, including booking an ambulance, for patients needing an acute medical bed except in the case of a medical emergency.

This is a big project - there are currently some 350 DGH admissions of Somerset patients per week - and the team is going to take a little while to get up to speed. So to begin with you may want to continue to send straightforward admissions in directly. Ultimately one of the huge benefits of the new system will be to log all admissions so we can develop new protocols and services for dealing with what we might now regard as automatic admissions like a suspected ectopic.

Staffing at the SPA centre will be adjusted to match demand, but as we do not yet know how long each case will take to be processed, if all the team are busy there will be an answering system offering a call back as soon as a nurse is free. Please be patient to begin with, as although the scheme has been piloted, this is a very major expansion.

The scheme will have access to the local NHS demographic database, but obviously we will have to continue to provide clinical information – quite what is needed will depend on the circumstances and it may be that this can be done in your initial phone call rather than by letter; one of the objectives of the scheme being to reduce the bureaucracy of admission procedures whilst ensuring that concise and accurate information accompanies the patient wherever he or she goes. Again, please be patient with the process, as it will need to be refined over time.

Do note that young people under 18 and patients needing admission for acute mental health problems are excluded. Schemes like this work well elsewhere but the circumstances in Somerset have the potential to make ours very successful indeed.

If you want more information, a detailed pathway document and quick referral guide will be on the PCT intranet, or ask Sue Sutton who will be able to answer any specific queries on 01935 384022 or [sue.sutton@somersetpct.nhs.uk](mailto:sue.sutton@somersetpct.nhs.uk)

## **SOMERSET COMMUNITY DRUGS AND ALCOHOL SERVICES TENDER PROCESS**

### *First steps towards an integrated service?*

Somerset Drug and Alcohol Action Team, which is the multi-agency body now responsible for organising services for substance mis-users, is in the process of tendering for an organisation to provide a new integrated drug and alcohol service in the county for an initial period of 5 years starting from April 2008. The LMC has been asked for a view on these developments. We feel that it is undeniable that the current service is fragmented and confusing, with different eligibility criteria and treatment rules for potential service users, and the major benefit will be to pull all the

community resources into one system. The new specification envisages open access/referral centres at the core of the service, with the majority of prescribing for stable users in GP practices, supervised by shared care GPs (now recruited in 43/75 Somerset practices) who are in turn supported by GPSIs in substance misuse. Merging the disparate services should provide enough resources to achieve a 3 week referral to treatment time with extended opening hours, and it may at last provide more integrated care for people with combined alcohol and drug problems. Most important, perhaps, will be the ability of the service to employ specialists in drug treatment such as change experts, but the treatment principle of harm minimisation remains the core.

Whilst we welcome all these developments, the LMC hopes that the inevitable disruption caused by reorganisation is not allowed significantly to harm patient care. It is also vital that patients with complex mental health and addiction problems are not allowed to fall between two stools. We have been reassured that existing staff will be transferred to the new single employer and that the relationship between existing drugs workers and the PCT will be unaffected.

Finally, the current National Drugs Strategy, which has provided extra resources for drug services for the last 10 years, is due to end next year. Although all the agencies concerned – PCT, police, probation and local authority – are committed to the integration, quite how far the service will be able to develop a really effective community alcohol service remains to be seen.

## **OUT OF HOURS SESSIONAL PAYMENT**

### *Bank Holiday rate changes in 2008*

From next year the Unscheduled Care Service is planning to change payments for Bank Holiday weekends to £84/hr for the whole weekend rather than £75 for the weekend and £100 just on the Bank Holiday day. This better reflects the workload distribution through these weekends and is actually a rise of a few pence per hour on average so the LMC agrees that the proposal is reasonable. Christmas Eve to Boxing day stay at £100/hr. Meantime, the LMC has opened discussions on an inflationary increase in all the rates for next year.

## CONSULTATION ON IMPROVING THE PROCESS OF DEATH CERTIFICATION

### A Long Expected Document...or a Solution in search of a problem?

This important document was published on 24<sup>th</sup> July and calls for comments by the end of October. It comes as part of the government's response to Dame Janet Smith's Inquiry into the criminal activities of the late Dr Harold Shipman. Unusually for a Department of Health (DH) document it is ascribed to a named author and is written relatively well despite "issues around" the inevitable influence of the DH house style. A Bill concerning death certification will be placed before Parliament in November and the Regulations will, if approved, come into force in 2010.

The proposals include the appointment of a Chief Coroner and a Coronial Advisory Council. National standards and training will be set for Coroners who will be more likely to be full-time in future and who will be placed in the local government structure. It will also be made the legal responsibility for the doctor completing a death certificate to report a death to the coroner under the same list of circumstances as at present. The document accepts that this is what happens in practice now but at present the *de jure* responsibility actually lies with the Registrar.

The documents points out that, at present, it costs bereaved relatives £148.50 more in extra fees to cremate a body than to bury it. Seventy percent of all funerals are now cremations. Some religions require cremation and so their adherents have no choice but to pay the extra fees which is inequitable. It is also argued that the present arrangements mean that there are unequal safeguards in the process leading to permission to cremate compared with those leading to a burial. In the former three doctors are involved compared with only the one required to complete a death certificate for a burial. But even the extra safeguards involved in the cremation certification process are unaudited and unreliable. It is also alleged that relatives planning a burial require better assurance that all the circumstances surrounding the death of their loved one were as they should be and so the proposed changes to the system are long overdue. With 500 000 deaths registered annually in the United Kingdom, we wonder how many families will really benefit from change.

The crucial background is that one of Dame Janet's key recommendations, made over three years ago, that *all* deaths should be reported to the Coroner. We believe that the government was, for once rightly concerned that such a move could cause unnecessary delay in arranging

funerals and also distress to relatives for little or no gain to the administration of justice. It is also aware that for some religions prompt burial, like cremation for others, is a crucial part of adherence to tradition.

It is therefore proposed that in future any death that would *not* normally be reported to the Coroner, will be notified to a Medical Examiner (ME) by the doctor responsible for the patient's care who will, as now, complete a death certificate. There are no changes proposed to the present certificate and, interestingly, the document specifically rejects the inclusion of data concerning ethnicity. The ME will be a medical practitioner of at least five years' standing "attached" to the PCT clinical governance team who has undergone specialist training of three days' duration, revised every two years. The ME will be assisted by a ME Support Officer who will be responsible for collating information for the ME to "investigate as necessary" the death. This will include speaking to the doctor who wrote the death certificate and other clinicians involved, reviewing medical records and speaking to relatives where required. All this will be done speedily and, when the ME is satisfied, he or she will be able to authorise burial or cremation which may then take place before registration of the death. If the ME is unsatisfied he will be responsible for reporting the case to the Coroner with a recommendation whether or not a post mortem examination would be helpful. The Registrar will also retain the duty to report to the Coroner. Because of the close working relationship with the Coroner that will be necessary for the process to work smoothly it is suggested that MEs might be co-located with Coroners, although the proposals stop short of suggesting an integrated system.

There are quite detailed assessments of the initial impact of these changes and, rather touchingly, they are naively estimated to be cost neutral. This is because funding will come from those paying for funerals. It is estimated that £42m is raised annually from cremation fees in England and this will fund the service. The current cremation form system will be replaced with lower fee (*sic*) that will be added to the cost of all funerals. In other words cremation should cost less than now, but a burial will cost more. .

The questions for which answers are requested are as follows:

1. **To avoid unnecessary delays, and upon receipt of authorisation from the ME, would it be desirable to allow the deceased to be buried or cremated before the death is registered (as is the case now when the Coroner issues a cremation certificate or burial order)?**

*We recommend that the answer be "yes" not least to mitigate the effects of delay that this new system seems likely to add, especially when it is newly introduced.*

2. **In order to attract medical practitioners with the right level of expertise and experience, and also to maximise flexibility of the service to minimise any delays to funeral arrangements, would it be desirable to appoint MEs on a part-time basis?**

*It would appear to be contrary to a policy of equal opportunities in employment to recommend anything else.*

3. **Would it be beneficial to co-locate MEs with Coroners where this was agreed locally? If so, what would be the specific benefits?**

*Please see above where Dame Janet Smith's recommendation that all deaths be reported to the Coroner is discussed. Would it really be beneficial to have another service offering independent medical advice to Coroner's when local MEs could provide it? Are we really to believe that "local agreement" will play any part in nationally directed legal requirements?*

4. **Would it be appropriate and practical to have a professional line of accountability between the National Medical Advisor to the Chief Coroner and MEs? What do you consider to be the advantages and disadvantages of this proposal?**

*As far as this rather opaque question goes, it seems that it may in fact be hinting at exactly the point made above i.e. having a single ME service rather than two. To ask the question, "Quis custodiet ipsos custodes?" may be going too far even for this government in this context. After all, not even Inspector Morse had to solve a murder where the Coroner did it.*

5. **Would it be appropriate for MEs to be contacted to provide medical advice to Coroner's in certain cases?**

*See 3 & 4.*

6. **Are there circumstances where deaths are discussed with the Coroner unnecessarily and should, in the future, more appropriately be discussed with an ME?**

7. **Is a qualifying period necessary to achieve the desired aim of ensuring the Coroner investigates appropriate cases?**

*The obvious answer here concerns the 14 day rule, where the doctor completing the death certificate has not seen the deceased but where the patient was looked after by another practitioner, perhaps absent on leave at the time of death, or by other members of the health care team, for example district nurses or nursing home staff.*

**If you have any comments you would like to contribute to the LMC response, please email them to [lmcoffice@somerset.nhs.uk](mailto:lmcoffice@somerset.nhs.uk)**

**SMALL ADS SMALL ADS SMALL ADS.....**

**MEDICAL SECRETARY**

**Hamdon Medical Centre**

(14.5hrs per week over 3 days)

to join our rural, friendly, computerised (EMIS) practice.

Enquiries/Job Description please contact Kerrie Inglett, Practice Manager, Hamdon Medical Centre, Matts Lane, Stoke sub Hamdon, TA14 6QE. Tel: 01935 822236.

**MEDICAL CENTRE**

**PART-TIME SECRETARY**

If you have previous medical secretarial experience, preferably within a GP Practice, with a sound knowledge of the EMIS clinical computer system, MS Word and Excel we would like to hear from you.

The hours are 13 hours/week, preferably worked over two or three days, working closely with another part-time secretary to provide full cover. There is also the possibility of extra hours providing cover within our Reception Team.

A full description of the vacancy can be found at [www.warwickhouse.org.uk](http://www.warwickhouse.org.uk).

For more details please contact Jane Watts on 01823 447374 or [jane.watts@warwickhousemc.nhs.uk](mailto:jane.watts@warwickhousemc.nhs.uk)

Letter/CV, stating your availability, to

Mrs Jane Watts  
Practice Administrator  
Warwick House Medical Centre  
Upper Holway Road, Taunton, TA1 2QA

Closing date : 17<sup>th</sup> August 2007

## JENNIFER'S JOURNAL

The statin crash is going to be a big one. If you invest in any of the six drug companies that make statins think about selling. Jennifer has seen the future.

This year the NHS will spend one billion pounds on statins and another billion administering and monitoring the process. I read that our experts say we should have 14 million people on a statin next year. They have all gone completely barmy. When the crash comes, experts and their analysis of statistics will lose all credibility. We may be able to ignore them all for years to come.

The fun has already started and Jennifer is collecting the evidence. Mascitelli and Francesca from Italy challenge the 'beatification of statins' in the International Journal of Cardiology. John Abramson of Harvard Medical School points out what is clear to see from all the trials: there is no evidence that statins benefit women at all; furthermore there is no evidence that statins benefit men over 69 at all. In secondary prevention for high risk patients, men benefit from statins on the basis that 50 need to be treated to save one fatal MI. Dr. James Wright of the University of British Columbia tells us that if a 50 year old male smoker with high blood pressure and the worst diet in the world takes a statin, he can reduce his risk by 2% over the next five years. What a waste of money. I bet no one would pay out of their own pocket for that.

The best bit, still slower to emerge, is that atheroma has nothing to do with cholesterol anyway. (Unless you are a vegetarian rabbit force-fed huge quantities of fats that is.) Cholesterol is important stuff – it is a vital neurotransmitter in the brain. We need cholesterol and it doesn't half make food taste better as well.

And then there are the dangers of statins themselves. Do you like the way trials report the benefits as relative risk and the side effects as absolute risk? Are we being conned here?

Despite being seriously teratogenic you can buy simvastatin without prescription. How could any sensible expert recommend that? Who is going to buy it? Someone who has been scared witless by the propaganda, I presume; and then the dose is one the experts now say is useless anyway. Exercise related muscle problems are common as are depression, confusion, poor memory and disturbance in cognitive function. Polyneuropathy and erectile dysfunction have joined the list. Myositis and liver damage are rare but well recorded problems.



'The Great Cholesterol Con' by Malcolm Kendrick looks at the same 'evidence' as the experts and has very different conclusions. It is a compelling read.

Jennifer is struggling with her conscience. Avoidance of stress and a balanced diet is the solution. Patients have been brainwashed into demanding statins. Experts insist that I prescribe statins to nearly everybody. I believe that for the vast majority of them it is quite unnecessary and possibly dangerous. My mother-in-law takes a statin and it is probably making her a lot more daft than she really is. If I suggest she stops them and she thinks I'm trying to kill her! Statin mania has a lot to answer for, so sell your shares before the crash.

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

*Jennifer*

## FOOTNOTE

We are now in a position to provide a cast iron certain explanation for the atrocious summer. In May the PCT published its "Heatwave Plan" which prints out onto 28 pages of, it must be admitted, rather widely spaced text. However, as you pull on an extra sweater this evening you may be reassured that, *inter alia*, in the event of a heatwave the Department of Health will issue a public information leaflet that will be available in all sorts of places like NHS Walk-in centres. Nice to have that problem sorted.