

Somerset LMC Newsletter



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GENERAL PRACTICE STILL UNDER FIRE

The Government machine spins inexorably on.

It is salutary to be reminded now and again just how ignorant the Department of Health is about what happens in General Practice. Time and again their pronouncements demonstrate that their image of the GP is stuck somewhere in the 1950s. Alan Johnson's remarks on the Today programme about surgeries closing in the afternoon may still apply to a few small rural practices, but for most of us working in Somerset now this has never been the case. Sometimes this ignorance has worked in our favour, as with their assumption that achieving the QOF targets would be beyond our poor organisational capacity, but we now detect a more worrying trend. There has always been a tendency for NHS managers to say GPs "will" do something - for many of them do not even know that we are independent contractors - but latterly this philosophy has started to be applied to patient lifestyle interventions that are really social engineering. This is being reflected in the media, including normally responsible broadsheets like the Independent, which recently ran a leader saying that GPs should be "doing more" to deal with the epidemic of obesity.

Although there may have been a time when some patients would treat the word of the GP as if it was a divine utterance, most folk have always been selectively deaf to unwelcome advice from the doctor. There is evidence we can have a modest effect in reducing smoking, but even with draconian legislation on public smoking, punitive pricing of cigarettes, and its increasing social unacceptability, the fall in the proportion of adults smoking has been small. It is hard to see how any of these levers can be applied to obesity, and with a singular lack of evidence that GP intervention leads to sustained weight loss it is going to take a very concerted national effort indeed to tackle this problem. This needs to start with comprehensive and lifelong nutrition education, as we have previously advocated.

We could dismiss all this as yet another misguided and confused policy direction, but its effect will be to burden GPs with a futile and unachievable task, and one therefore designed to increase stress in family doctors. The changes in working hours and personal obligation introduced with the new GMS contract produced a welcome reduction in pressure on GPs, but the day job is now very intense indeed and with more and more being expected of GPs as individuals, as well as their practices, the latest White Paper requirement that the NHS should only employ or contract with doctors who are in good health may be hard to fulfil.

The emotional price of practicing medicine has always been high but doctors have been prepared to pay it for the benefit of their patients and the personal satisfaction of doing a difficult job well. We do not think that many GPs will feel the same way about meeting fantasy Stalinist targets, whether these are for tractor production or obesity reduction

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SOMERSET LMC NEW OFFICES— OPEN MORNING

Now that the builders have left, the paint has dried, and the furniture van has driven off empty into the distance, We would like to invite you all to an open morning at the new offices on Wednesday 31st October between 9.30 and 2.00 PM. Please come for a cup of coffee and meet the Secretariat staff who will be delighted to show you how we spend your LMC subscriptions. Ring us on 01823 331428 if you need directions.

THE MAP OF MEDICINE

A new online information and decision support tool

The Map of Medicine is provided as part of the NPfIT by our Local Service Provider, Fujitsu. It offers clinicians easy access to evidence based “care journeys” that detail best practice from assessing presenting symptoms, through primary care and into secondary care. At present it includes some 370 conditions - covering all major care settings - and these are regularly updated. Each care journey is peer reviewed by NHS clinicians at least once a year. However, there has been no local GP clinical input.

Logging on is easy, and from the main menu you can pick a clinical condition and then open a hierarchy of algorithms that takes you through the whole care process. Opening each successive algorithm can be a bit slow depending on the amount of traffic on the net but the pathways are logical and clearly laid out. Generally you can click on each node to get more information, but some of the pathways are a bit sketchy at present. Some of the information has clearly not been written by anyone practicing in the real world. For example, the information box at the start of the PTSD pathway reads “Initial consultation in primary care involves a comprehensive physical and psychological assessment” which most certainly ain't going to happen at 9.00 on a Monday morning!

The technical data is obviously accurate, but rather prescriptive. For instance, the pathway for abnormal liver function tests suggests that an isolated raised ALP should automatically lead to a referral to a hepatologist - also unrealistic, since at least 10% of routine ALPs are outside the normal range and there is nothing to say how large a rise is significant. Some of the information boxes in each node link on to the National Library for Health (although the link was down on the day we tested this), the BNF and, most helpfully, Google.

So it's worth a look, and probably adding the link to your desktop. The format is better than Prodigy and although the content has not had the same years of GP input it does offer a usefully different perspective. But local policies, pathways and guidance will always be more useful and should always take priority, and for most of us a quick call or

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email to a consultant colleague may be a better solution to a puzzling problem.

You can access the Map of Medicine at: <http://mom.sou.ncrs.nhs.uk> using the trial username and same password: “Somerset”

TIERED NHS PENSION CONTRIBUTIONS – UPDATE FROM THE BMA

Negotiations on the new NHS Pension Review continue.

The headline gains of maintaining the normal retirement age at 60 and the continuation of the current scheme have been agreed, and GPC and BMA are now looking at the details of the proposals and their implementation.

One of the areas they are now working on is that of tiered contributions. Hitherto there have been disproportionately greater benefits for higher earners, so the proposed contribution rates are as follows:

Drop to 5% for lowest paid (under £15,107pa)

Increase to 6.5% for middle earners (£15,108 - £60,880)

Increase to 7.5% for higher earners (£60,881 - £100,000)

Increase to 8.5% for highest earners (£100,001pa and above)

(Note - the contribution rate is applied to the total income not just the proportion above the various thresholds.)

There are still uncertainties about how these will be applied to salaried staff, part-time working, people holding more than one job, High Cost Living Allowances and practitioner (GP) superannuable earnings amongst others. The BMA intends that no section of the medical profession will be disadvantaged by the new proposals whilst the GPC's aim is to make sure that GPs are treated no differently to any other member of the scheme. We do, however, need to recognise that in a mutual scheme of more than 1 million members, it is impossible for everything to be tailored to suit every separate group's wishes, and this includes the various types of doctors working within the NHS.

The only one person we know who understands the NHS Superannuation scheme for GPs is Andrew Dearden. We are delighted that he has accepted an invitation to speak at the LMC Study Day at Taunton Racecourse on 6th March 2008 - put it in your diary now.

Mental Capacity Act 2005

Main part comes into force in October 2007

The MCA is a liberal, sensible and comprehensive piece of legislation that makes it much easier for patients, carers and professionals to deal with questions about people's capacity to make decisions for themselves. It is necessarily complicated, but the Department for Constitutional Affairs has issued an excellent summary (www.dca.gov.uk/menincap/bill-summary.htm) which is well worth reading. The full Code of Practice (www.guardianship.gov.uk/downloads/Code_of_Practice_-_Web.pdf) runs to 320 pages but is comprehensive and well written. For the first times all areas of personal decision making are covered, as are all causes of mental incapacity, and the Act allows forward planning for a time when capacity might be lost.

We cannot hope even to summarise the Act here, but note the five principles:

- Capacity is presumed unless there is proof to the contrary
- Individuals must be supported to make their own decisions
- Unwise decisions do not mean capacity is lacking
- Decisions about someone lacking capacity must be made in their "best interests"

Decisions made should be those that least restrict a person's rights and freedom.

Assessment of capacity is decision specific and in two parts. Is there a temporary or permanent impairment to the functioning of the mind or brain. If so, is does this make the person unable to make the decision in question? The tried and tested criteria still apply:

- Can the person understand the information relevant to the decision?
- Can they retain it?
- Can they use it making their decision?
- Can they then communicate their decision?

Note that neither written nor spoken language is required for these to be met, but failure in any one means capacity is lacking

Best Interests decisions must include a range of elements such as:

- Encouraging the person to participate as far as they can
- Considering if there any chance capacity will be regained
- Ensuring all the circumstances relevant to the decision have been identified
- Finding out what the previous views of the person were
- Avoiding discrimination
- Consulting with other involved people
- Restricting rights and freedoms of the individual as little as possible

Note especially the last element, when life sustaining treatment is being considered.

- *Do not make assumptions about quality of life*

In other words, a view on quality of life should come at the end, and not the beginning of this process.

Health and Care professionals are also given protection from the theoretical liability for prosecution over acts done in the course of care for which the person has not given consent, so long as they are working in accordance with the Act.

There is much more of importance covering restraint, Lasting Power of Attorney, Court appointed deputies, the new Court of Protection, the Public Guardianship Office and the role of the Independent Mental Capacity Advocate (IMCA) but one other significant change are the new statutory rules about advance decisions to refuse treatment. If these concern treatments necessary to sustain life, the decision must be written, signed and witnessed and include the statement that treatment is refused "even if life is at risk".

Do make sure you record the reasons behind any decision you make under the Act, and seek advice if you are in any doubt. If you think an IMCA may be needed you can contact them on 08448001041 or imca@advocacyinsomerset.org.uk

PRESCRIBING MATTERS

Appliance Contractors

The PCT reports that a number of practices have recently raised concerns about requests for prescriptions from appliance contractors. Incidents involve requests for patients who have died, been admitted to a hospital or care home, and duplicate prescriptions. Note that if such a contractor supplies a product *before* a prescription is issued, this can potentially be regarded by the NHS as a gift with no obligation that a prescription follows. Whilst some contractors do provide an excellent service - including telephone support and various useful extra items - this are high cost prescription items and we recommend that practices have a checking system in place. If in doubt over a prescription request check with the patient and if necessary contact your prescribing adviser.

Controlled Drugs Regulations - Destruction of out of date stock

By now GPs should have returned their individual declarations to the PCT concerning CD use, but please may we remind you that you must NOT destroy CDs without this being supervised by an authorised person. Again, contact your prescribing advisor for advice

Prescribing Small Quantities

Under normal circumstances it is best to prescribe in original packs or for multiples of 28 days. Occasionally you may be asked to prescribe a small number of tablets to synchronise prescription requests and issues. Whilst this may be appropriate, note that for some specially packed products the NHS is charged for a whole pack, however many are actually dispensed. For example, if you prescribe one alendronate 70mg tablet, four are charged for.

7 Day prescriptions

If a patient uses an MDS box the pharmacy will normally make up 4 weeks worth when you issue a 28 day script. But if the medication is not stable out of its packaging for 28 days and the MDS needs to be made up each week then a 7 day prescription is reasonable.

Gardasil

Despite some media coverage that has encouraged some people to seek immunisation with Gardasil LMC advice is not to prescribe this for the time being. The DH has decided to offer HPV immunisation as part of a national programme. This will obviously take a little time to get up and running but will probably start within the next few months.

The immunisation provides protection against an illness that typically takes some years to appear following HPV exposure so, given that the target group are pre-teen girls, there should be no urgency about offering it. This is a new product with an unproven safety record in general practice. GPs are not familiar with it, and good practice in medicines management dictates that prescribers should not prescribe under these circumstances without guidance from a doctor who is experienced in the use of the product.

We do not have definite evidence about its cost-effectiveness and with tight prescribing budgets it is hard to see that prescribing it for self-selected patients on the NHS would be justified.

But we run into a catch-22 with private prescriptions. NHS GPs are expected to prescribe on the NHS products that are available for NHS prescription, according to patient need. Therefore, if the patient needs this immunisation, you should offer it as an NHS service. If they do not need it, you should not offer it to them at all. To issue a private prescription to an NHS patient in this circumstance is possible a breach of contract.

In summary, our advice is that practices should wait until the DH has decided on the details on their programme. Patients who are then outside the target group who want immunisation should be considered on a case by case basis, and where there are particular reasons why a patient may need it ,(a strong family history of Ca cervix perhaps), then advice from an expert should be sought as to whether NHS immunisation is justified. If there is no special case, then patients should be advised to obtain private immunisation from another provider - perhaps you could set up a reciprocal arrangement with a nearby practice.

SMALL ADS SMALL ADS.....

Dynamic full time practice manager required to join a friendly, high quality, 5 doctor training practice (4.75 WTE) with a list size of 7500 patients

- Emis computer system
- Actively seeking to relocate main surgery
- Branch surgery in Westonzoyland
- Recent addition of two young, enthusiastic partners

The successful candidate will have overall responsibility for the day to day management and development of the practice in line with the GMS contract and practice based commissioning. S/he will also continue to support our search for new purpose built premises. NHS or Practice Management experience desirable.

Salary dependent on experience and qualifications

Contact Linda/Dawn on 01278 458551 for a copy of the practice profile

Please apply with CV and handwritten covering letter to

Drs Allen, Soltys, Upton, Pal & Gilmour-White at Brent House Surgery, 14 King Street, Bridgwater, Somerset, TA6 3ND.

Informal enquiries welcome.

Closing date 20th September.

FULL TIME GP COVER FOR 3 MONTHS REQUIRED – Langport, Somerset

We are looking for a Locum to work WTE – over four days, Mon, Wed, Thu & Fri for 3 months from mid November to mid February to cover for a Partner on sabbatical.

You will be part of:

- 11,500 patient Practice
- 7 Partners
- Dispensary Practice

- EMIS paperlight
- Excellent Nursing and administrative support. Staff have character! Onsite District Nurses, Midwives, Counsellor, Carer Support Worker and other visiting staff complement our team.
- Modern, spacious and purpose built premises in beautiful rural location.

Why not visit us. All enquiries to: Brig Teuber, Practice Manager,

The Surgery, North Street, LANGPORT, Somerset. TA10 9RH.

Tel: 01458 254100

E-mail: Brig.Teuber@langportsurgery.nhs.uk

SINGLE-HANDED VACANCY IN SOUTH DEVON

Applicant required to form a six month partnership with the current GP who plans to retire by October 2008, having been in post since October 1979.

The ethos of the practice reflects traditional values and an holistic approach to health care.

The nGMS practice of 1630 patients with an exceptionally well structured Lloyd George system and “In Practice” vision clinical support systems has consistently achieved near maximum QOF points.

The practice is served by a team of 3 receptionists, secretarial support, manager, nurse, volunteer group co-ordinator, carer support worker and the usual attached staff.

Please forward CV and handwritten application letter to

Diane Radford

Practice Manager

95 Upper Manor Road

Paignton

Devon TQ3 2TQ

FootNote

Readers will doubtless be pleased to know that an LMC Officer sits by his lonely candle far into the night to read and digest the torrent of documents pouring out of the Department of Health. You will be especially delighted to hear that their consultation paper on “Part IX of the Drug Tariff - Stoma and Incontinence Appliances” contains an interesting first in striving for “clear transparency”; presumably as opposed to the opaque sort of transparency we are used to.

JENNIFER'S JOURNAL

The Modern Patient:

" I used to chill out with a bit of cannabis. It kept me calm and away from the doctors. Then suddenly I went psychotic. Before I knew it I was one of those new atypical anti-psychotic drug. It helped a bit but unfortunately, as expected, I developed diabetes. Not to worry but now I needed aspirin, a statin, an ACE Inhibitor and a glitazone. Well, just my luck; I now went into heart failure and they added a diuretic and a betablocker and upped the ACEI dose so that my BP fell so low that I fell over and broke my leg. I survived the operation but didn't like the calcium tablets and alendronic acid that I had to take. Not surprisingly in this situation and with the help of the statin I became depressed. Initially the antidepressant seemed a good idea until its dysrhythmic effect induced AF and I required warfarin, amiodarone and a referral for cardioversion. A PPI was added for fun, cos that's what everyone does these days and then my thyroid was mucked up by the amiodarone and I started thyroxin.

So in no time at all I'm taking, thyroxin, lansoprazole, ramipril, frusemide, bisoprolol, warfarin, aspirin, calcium, alendronic acid, rosiglitazone, simvador, fluoxetine and olanzapine.

I'm on the recall for QOF under depression, chronic mental illness, AF, heart failure, diabetes, thyroid disease and recalled for the template on amiodarone. I was kept pretty busy but when the warfarin caused a cerebral bleed I was added to the stroke recall, and when my kidneys packed up (are you not surprised?) I attended for CKD screening. When the computer spotted the cannabis smoking I was on the smoking template and summoned to the COPD clinic and the 'let me bully you into not smoking' clinic. Of course I blamed side effects of the statin, for when I completed a full house by joining the dementia and cancer recalls.

I'm at the surgery three times a week, every week of the year. The staff know me really well and apparently I earn them lots of money because of all these QOF payments. I used to be the most frequent attender but there are lots like me now.

On holiday, when I was unwell, I went to see a private GP who had resigned from the NHS. He said I had iatrogenic disease. It sounded quite nasty. I thought that I had enough diseases already. I thought he was a lovely doctor until he suggested that I was costing the NHS a fortune and earning the drug companies enormous profits. He said I should stop all my pills and to get back to normal. Well, don't worry, I didn't believe him. I know that my doctor wouldn't give me drugs unless I needed them. It's only thanks to my doctor and all those clever drugs that keep me alive. I'm sticking with the experts and specialists in the NHS. I mean I may be very poorly but I might be dead without them. A little drop of weed is a lot more dangerous than people realize."



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

Jennifer

LOCAL SECURITY MANAGEMENT SPECIALISTS AT SOMERSET PRIMARY CARE TRUST

Can help with security problems in the practice

Security Management was added to NHS organisations after a 2003 report highlighted the number of attacks on NHS staff in the workplace. The idea is that counter fraud protects NHS money and time, while security management protects staff and assets. Miss Tracey Edwards and Mr Stacey Fuszard fill this role at Somerset PCT. They offer advice and support in a number of areas including tackling violence and abuse against NHS staff; appropriate use of technology, e.g. CCTV and radio communications, effective use alarm systems such as movement sensors and personal attack buttons; and training of NHS frontline staff in conflict resolution;

The LSMS' are keen to hear about the incidents of physical & non-physical assaults, harassment, theft, criminal damage, antisocial behaviour in and around where you work and general security concerns. You can fax incident reports to them for speedy attention on 01935 848279. For more information contactor stacey.fuszard@somersetpct.nhs.uk (01935 848229) or tracey.edwards@somersetpct.nhs.uk Tracey Edwards (01935 848228)