

Somerset LMC Newsletter



Feb 2008

Issue 139

ABSTAINING IS NOT AN OPTION

All GPs in practice or training should vote this week

The GPC ballot paper offers a stark choice: how much are we prepared to sacrifice for a point of principle? And will a vote either way affect the GPC's tactics?

Lord Darzi's remarks to the BBC last weekend that the days of the traditional GP were numbered and that "polyclinics..are...the way healthcare should be delivered in the future" only serve to confirm that we are in for a long struggle. Despite some anodyne remarks from the Department that "this is not the end of small GP surgeries" the minister has made the views of the Government abundantly clear. Yet again the urban solution will be imposed upon rest of the country – but, hey, that doesn't matter, there are no Labour marginals in Somerset.

What will strengthen our hand the most is evidence of unity amongst the profession. The GPC has recognised that to a considerable extent whether we select either imposition A or imposition B as "less worse" than the other will soon be water under the bridge. Far more important are the supplementary questions about the relationship between the profession and the Government. Strong support for the GPC will empower them to embark on what is likely to be a long struggle for the hearts and minds of our patients, especially those who really need and use NHS primary care.

But we have a problem. Although it is still a relatively minor one in Somerset, there are parts of the country where the differential between GP partners and salaried doctors has become worryingly wide, and this is a matter that must be addressed.

The introduction of a better salaried option under both PMS and the 2004 GMS contract was intended to offer flexibility of medical staffing, in particular by allowing new GPs to obtain a range of experience, and older ones to wind down towards retirement. It also meant that doctors could more readily work in different practices if they were moving around the country for family or other reasons. Because salaried doctors had no financial or organisational commitment to the practice and also had employment benefits in the form of sick pay, paid study leave, and so on, their remuneration was proportionately less than partners. However, as partnership incomes rose and some practices started to replace partners with salaried doctors, concern rose that the profession was dividing into two or even three tiers as more qualified GPs were able to find neither partnerships nor salaried posts and joined the locum market as sessional doctors.

We now see some rebalancing taking place. Partner incomes are falling and the workload placed upon them through the myriad of changes in primary care is increasing. This will, we hope, encourage practices to replace partners with partners, for the strength of British primary care has always been in the independent contractor physician as the key provider of care.

As practice cash flow is squeezed and more GPs complete their training there

Inside this issue:

GPC Ballot	1
Choose and Book	2
GMC Guidance 0-18 Year Olds	2
Military Personnel	3
Paediatric clinical Assessment Service	3
Somerset PALS	3
Dental Helpline	4
Jennifer's Journal	4

is a risk that practices may be tempted to offer less than generous terms to salaried or sessional doctors. We believe this to be dangerously short sighted. Salaried doctors must be offered proper contracts and fair terms, and, wherever possible, the option of progressing to partnership over time. We have a new generation of GPs who are better trained than ever before and who are eager to become traditional partners – we must ensure that they are embraced by practices and not left bitter and disillusioned

Meantime, we urge you all to vote. Please select one of the options; a spoilt ballot helps nobody, nor does abstention. This is a test of our will more than a poll about contract options.

If you do not get a ballot paper please contact the Electoral Reform Society on 020 8889 9203

UPDATE ON CHOOSE AND BOOK

As the PCT is proposing an LES for electronic booking we anticipate that most practices will continue to use CAB. The LMC has raised a few queries with the Referral Management Centre recently, and their replies are useful:

Why are patients sometimes told there is not appointment available at their chosen provider and that the RMC will call back when one can be found?

Most slot unavailability comes in spikes when Trusts reduce their "polling ranges" in order to meet the 18 week targets. T&S recently made the last of their staged reductions in polling ranges, and all outpatient services are now polling to 5 weeks. There are no further reductions planned.

Why are practices being asked to fax copies of letters to Community Hospital clinics?

All referral letters for T&S clinics are downloaded by staff at MPH, passed to the consultant for review, and then forwarded out to the community hospitals if the patient has booked into the out-reach clinic. There appear to be delays in this process which may be being exacerbated by the current rapid reduction in waiting times. However, staff at the community hospitals should be chasing the booking office at Musgrove for these referral letters, not Practices.

If a gynaecology patient wants, for example, to see a female consultant, should this be stated at the top of the letter?

Making such requests at the top of the letter will not necessarily prevent a patient being mis-booked into the wrong clinic as the letter is reviewed only after the patient is booked. A practice can be more certain of referring to a female consultant by using the named clinician option in Choose and Book Trusts will be rewriting their DOS to deal with the new release of CAB and there may be further improvements that can be made at that stage

Isn't it time 2 week wait patients went onto CAB?

We are waiting for an anticipated change to the CAB system before progressing with this. We are very concerned about 2 week wait patients who might not make their booking. With CAB at present, if the patient leaves the GP Practice without their booking, there is a chance that the Trust will not know that a referral has been made. The proposed change to CAB eliminates this potential blind spot, and once we have a solution we aim to move forward on 2 week wait referrals through CAB.

GMC GUIDANCE ON TREATMENT OF 0 – 18 YEAR OLDS

A couple of useful points to note. If you have a difficult decision about information sharing, the guidance suggests a sensible list of people whom you might consult for advice: a designated doctor, for child protection, the relevant Caldicott guardian, an experienced colleague, or the GMC itself. We would add - probably as first choice – Anne Allen, nurse consultant for child protection in Somerset who is based at YDH.

The guidance also has a reminder about "parental responsibility", and therefore with whom a child's medical information should normally be shared. This includes divorced parents and unmarried fathers who are named on the birth certificate, and the fathers of children born after 1/12/03 – though in an era of multiple serial relationships it can be tricky to be sure of this if it was not clearly written down at the time. Other fathers can obtain parental responsibility through the courts. Adoptive parents have parental responsibility.

TREATMENT OF SERVING MILITARY PERSONNEL

Serving members of the armed forces normally obtain their medical care through the Defence Medical Services (DMS) which is made up of a mixture of military doctors and employed civilian clinical staff. Serving personnel *cannot* register with an NHS practice. However, if they are either away from their home base on leave, or have been given permission to live off the base, they may approach a practice to be seen as a TR or for “immediately necessary” treatment. If there is a DMS facility nearby military personnel in all of the services are normally expected to go there, with 5 miles being the working definition of “nearby”. Otherwise, NHS treatment should normally be provided only for the immediate problem, and personnel should be referred back to their home DMS facility for continuing care as soon as they are fit to travel.

News from Somerset Foundation Trusts

PAEDIATRIC CLINICAL ASSESSMENT SERVICE AT MPH

Important change to outpatient booking arrangements

It has been estimated that up to 40% of paediatric referrals to T&S end up being either booked into the wrong clinic or could be managed in primary care with suitable advice

Accordingly, from 1st April all paediatric referrals via Choose and Book to Musgrove Park will be routed through a new Clinical Assessment Service. Referrals will be made in the normal way, attaching a referral letter, but when the parent or responsible adult contacts the RMC they will be given a telephone appointment time. These appointments will be within a one hour window and will be a minimum of five days from the original referral date.

Meanwhile, a consultant will review the referral and either accept it - ensuring that the patient is routed to the correct clinic, or the referral will be rejected in CAB and the GP will receive a written Clinical management Plan for the patient within 5

days. The patient will then be phoned by the hospital at the pre-arranged time and either offered a choice of appointments within appropriate clinics or be told that the consultant has reviewed their (child's) case and has given advice to the GP. In the latter case the patients will be asked to contact the surgery.

This is part of a much larger reorganisation of paediatric services into a locality “patch” based system which the LMC recognises does have real benefits, but please let us know if the new arrangements cause any problems.

SOMERSET PALS SERVICE

Still here and still helpful

Although they may have dropped out of the limelight during all the recent NHS changes, all NHS Trusts still have a Patient Advisory and Liaison Service (PALS). Its remit is to

- Provide information about the NHS and respond to other health-related enquiries
- Help resolve concerns or problems when using the NHS
- Provide information and referral to agencies and support groups outside the NHS

Improve the NHS by listening to concerns, suggestions and experiences and ensuring that the people who design and manage services are aware of these

PALS can help NHS providers as well as the public - in our case they can be really helpful in negotiations with demanding patients - and they are invaluable for patients who have got stuck somewhere in the referral or treatment process; for example, if an admission keeps getting delayed. PALS offers an awareness session for frontline staff and which may be a very useful part of your staff training programme

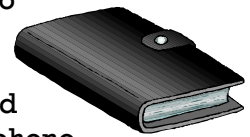
Heather Stanton, the PCT PALS officer, can be contacted on 0800 0851 067.

JENNIFER'S JOURNAL

Jennifer's very first journal over three years ago lampooned the evidence that the elderly must take calcium and vitamin D to prevent fractures and so it came as no surprise to see the BMJ tell us this month that these supplements actually cause a four-fold increase in heart attacks and so aren't such a good idea after all. It seems that they had fewer fractures because they weren't living long enough to have them! The BMJ quotes not just NNT – the number needed to treat, but now NNH- the number needed to harm. Yes, the caring profession now calculates how many people have to take a drug before we kill someone with it. A NNT of 20 is considered pretty good but to me that means that 95% have to take the damn drug for no benefit and to be exposed to potential harm just so that 5% can gain. Evidence-based medicine still makes little sense to me.

It is tiresome when experts, 'evidence' and the likes of NICE impede my freedom to look after my patients. It then becomes irritating when the computer, data collection, Read codes and QOF targets also interfere with my core job. But the last straw is when politicians try to mess it all up. All this rowing and unpleasantness is most upsetting. For the Government to unilaterally change our contract is despicable and ridiculous when you realize that they haven't even thought through the details of it all. I now have to let my patients know about the Government spin and stupidity and I am finding it very difficult during the therapeutic consultation to harangue my patients with politics and hand out leaflets. To recruit them at the same time as care for them is not easy. At the end of the day, I suppose old-fashioned professionals like myself find politics rather vulgar. But don't worry Jennifer will stand united with her colleagues to defend personal care and family medicine from the idiots in Government.

These stressful and worrying times remind me of an error I made many years ago. On call from home one evening a patient phoned in complaining of abdominal pain. The patient seemed simple and had a silly voice and so I quickly concluded that it was in fact one of my sisters amusing herself by pretending to be a patient. When she persisted with the pretence I finally asked her if she had any bananas. When she said she hadn't I advised her to borrow one from her neighbours and to 'stick it up her arse'. She then put the phone down on me. Subsequent reflection and a trip to the surgery to look at the names and addresses on the computer confirmed that I really had just told a patient in distress to shove a banana up their arse. With no telephone number to ring I finally made a late night visit to the house expecting to possibly see her with a banana in the expected position. Fortunately the neighbour didn't have any bananas, her abdominal pains had got better and she graciously accepted my explanation. So how many of you can say that you told a patient what to do with a banana and avoided a trip to the GMC? I can think of a few politicians who would benefit from a therapeutic banana. Why don't we start a campaign where every doctor sends the Gord a banana with an invitation to put it to therapeutic use? If we all sent one he might get the message and the media would love it. I can see the headlines- "Gordon takes bananas on the chin"- or somewhere ! My banana is already on its way. I wonder what the NNH is when it come to bananas and the Gord?



Jennifer

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

DENTAL HELPLINE FOR SOMERSET

A reminder that for patients with dental queries there is a Dental Advice line on 0845 769 7691

Patients who *do* have a regular dentist, can call between the following hours:

6pm to 8 pm	Monday to Friday
9am to 6pm	Saturday, Sunday and Bank Holidays

Patients who are non-registered and *don't* have a dentist can call between:

8.30am to 8pm	Monday to Friday
9am to 6pm	Saturday, Sunday and Bank Holidays

At all other times, NHS Direct are available for help.