

Somerset LMC Newsletter



Oct 2008

NOW MUM'S SORRY SHE WENT TO ICELAND

Issue 145

It just may be that the Credit Crunch has a very small silver lining: there is increasing evidence that the headlong rush to introduce commercial competition into the provision of general practice may be faltering. Notably in the South west, Virgin has withdrawn from its flagship scheme to take over a practice in Swindon.

We have long argued that the Government has misrepresented and misunderstood (to put it kindly) general practice in England. Because GPs are well paid there has been a private assumption in the corridors of power that we are milking the system, that the model and pattern of traditional partnership practices is out of date and anti-competitive, and that GPs are powerful resisters of necessary change who must be swept away. But partnership based practices have developed and evolved to meet the needs of the service over the life of the NHS, and the model is fundamentally very strong and very simple. A group of doctors holds a contract to provide a range of services. Their income depends on the effectiveness with which they personally do the job, so practices are extraordinarily efficient and pared down organisations. Furthermore, partners have a personal commitment to the business which inevitably becomes a personal commitment to their patients over time. The practice thus becomes deeply embedded in the social fabric of their town or village.

A corporate provider will always be looking at the profitability of its enterprises, and it will be no surprise to any of us that not only does it take time to make a commercial practice profitable, it also now seems likely to make much less profit than expected. A wholly employed workforce works less effectively than one made up predominantly of profit sharing partners, and the much vaunted new working models of the commercial sector have mostly already been tried and rejected by practices for failing to offer cost effective service improvements.

A GP who has been working in the corporate sector recently told me that commercial providers were making two big mistakes. The first was to assume that GPs were not innovators, because we are. The second was the arrogant assumption of corporate managers that providing healthcare was just like any other business activity, because it isn't. Interestingly, at a recent conference a panel debate of experienced private healthcare providers concluded that general practice services were unlikely to be a wise investment for shareholder companies.

Meanwhile, you will have seen that a demographic analysis by a firm called CACI has shown that the polyclinic model is unsuitable for much of rural England, including Somerset, which has led to increasing concern over the imposed Government model. With only 18 months of the current Parliament left to run, we can but wonder how many astute commercial organisations are going to want to lock themselves into a long term project to provide GP services.

All this is not to say that commercial providers cannot bring valuable skills and experience to the provision of NHS services, or that there is no benefit in change. The new Yeovil GP led health centre brings with it significant new resources for primary care and an opportunity to develop accessible new services and working arrangements to the benefit of everyone. Our job is to try and ensure that the general practice element of the service is provided by doctors who know the job and the area, and who can offer a genuine commitment to the town and its residents, and who will not walk away when the return on capital looks less attractive than alternative business ventures.

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PRACTICE BASED COMMISSIONING

Ready to move up a gear

For most GPs this year PBC has been something on the sidelines whilst we have concentrated on more pressing concerns, but Wyvern Health has been working quietly and steadily in the background and it is now time for us to look again at the opportunities PBC offers. The PCT's annual contract review with practices includes a look at what has been achieved under the PBC LES, and whilst this may not seem dramatic it is worth remembering that Somerset remains a front runner in England, with a coherent county wide organisation supporting a range of projects to try and slow the rise in emergency admissions.

We have also learned that change is a slow process, partly because tinkering with the complex machinery of the NHS needs to be done carefully, partly because of the labyrinthine complexities of contract and tendering law, and partly because we still do not have timely and accurate information about secondary care activity – that for the last quarter of 2007/08 is still not complete, and the rather clunky arrangement that requires Trusts to upload it to a national system called "SUS" which then downloads it back to the PCT's Ardentia system does not help.

The LMC continues to support the county wide structure because it makes organisational sense, and also because it is the only one that has really produced consistent results, but practice involvement needs to be strengthened. We have always argued that strong practice based commissioning is a powerful weapon for defending traditional general practice, but GPs and practices do need to have a sense of ownership. The Annual General Meeting for Wyvern is to held on 19th November, and we urge all practices to make sure they are represented. Wisely, the Wyvern constitution provided for two or three year appointments for board members so there are no elections this year, but this is still an important event.

As well as referrals, PBC does in theory also cover prescribing although hitherto this has remained a PCT/practice responsibility. Wyvern now wants to look at how prescribing can be more formally included in PBC, although there will need to be discussions about improving the PBC LES to consider how overspends or savings are dealt with, along with some recognition of the effect that both patient demand and doctor habits have on the process.

Just at the moment, the net savings on the prescribing budget would be a helpful additional resource for commissioners, and one that would stay within the direct provision of patient services rather than returning to the general PCT funds. And whilst this happy position probably will not last, PBC control of prescribing will mean that medicines management becomes a corporate professional responsibility and not a PCT imposition.

Improving access to mental health services is one of the few things about which GPs and the Government agree, and Wyvern and the PCT continue to work on the Emotional Health and Wellbeing service that is planned to draw together all the disparate bits of counseling, practice based CPN, and primary care mental health services that presently makes up the rather ragged set of referral options we have. For all the reasons above this is taking longer than expected but better a new system that works next year than a new one that doesn't next week.

Of course, most of us are waiting for PBC to develop to the point where we can introduce local service changes that will immediately and directly benefit our own patients. This really seem to be coming, but the foundations of a sound and durable system need to be built first, and meantime we encourage you to continue to support the existing PBC initiatives as they develop and mature.

SOUTH WEST REGIONAL SHARED & PRIMARY CARE DRUG TREATMENT FORUM

A Region-wide multi-disciplinary group to support practitioners, including Shared Care Coordinators, drug workers, nurses, pharmacists, GP's, service users and carers involved in Shared Care schemes across the Region.

Meets quarterly to encourage best practice by setting evidence based standards whilst keeping up to date with regional and national developments and policies. It also has a link to the NTA and other national bodies.

Aims to provide specialist advice and support for drug treatment schemes and partnerships, and to promote systems developing complementary skills between primary and secondary care. The next meeting in on January 9th 2009, location to be confirmed but likely to be in Taunton.

For more information contact:

Carole.Lennox@somersetpct.nhs.uk

IMAP – A ROUTE FOR ESTABLISHED GPs TO BECOME MEMBER

But you need to get on with it NOW

It is no secret that this editor is not a member of the College, having decided at a young age that on retirement his options were either to be left with a large pile of dusty College journals or by saving the subscriptions for 30 years just enough cash to buy a highly unsuitable yellow sports car. But times and views change, so he is considering signing up to seek membership by "Assessment of Performance", which is not quite a deathbed conversion and will still leave him enough for at least an unsuitable motor bike

Although now all new GPs will complete nMRCP during their speciality training there are a number of GPs who never did "the exam" during their vocational training. There is increasing interest in Somerset about a scheme introduced by RCGP in the last couple of years which recognises that for experienced doctors an exam is not usually so appropriate. "Interim Membership by Assessment of Performance" (iMAP) is a portfolio based assessment for established GPs who did not become RCGP members at the end of their GP training. iMAP succeeds the more demanding MAP scheme and provides an opportunity for a GP to gain membership, but this opportunity is time restricted as iMAP is available until the end of July 2009.

iMAP requires you to complete a portfolio of day to day work and performance in 19 specific areas. The portfolio is a document which asks you what you have done and to explain why you have done it. It covers several areas of Good Medical Practice – clinical care, relationship with patients and working with colleagues – and in these candidates consider and document their prescribing, referrals and so on. Whilst iMAP asks you to re-examine and justify how you do things it does not expect perfection, but wants evidence of a reflective practitioner who is willing to question and improve their performance.

When the iMAP portfolio is satisfactory, candidates have an oral assessment. As it is modelled on the appraisal portfolio iMAP will meet the requirements for appraisal and leave candidates in a strong position in relation to the impending revalidation requirements.

Those who took part in the iMAP pilot reported that they thought an average GP could complete the iMAP portfolio with 3 – 6 months of fairly concentrated work. The current cost is £2,530 so the commitment is not insignificant, but if you are already doing iMAP, or thinking about

it, then one way to make the load a little lighter is to work through the scheme with other local GPs who doing the same. Regional support and expertise are available from the Severn Faculty of RCGP and SGPET is also proposing setting up and facilitating a group of Somerset iMAP hopefuls if the need is there.

If you are interested then please e-mail SGPET for the attention of Martyn Hughes - who is another one who never did the exam - and who is also now planning to address that gap over the next 9 months. If there is enough interest then SGPET will arrange a meeting with a Regional iMAP coordinator as the College faculty has secured a small amount of funding to support groups of doctors working on iMAP

Full guidance, details of the portfolio and criteria and examples of completed portfolios can all be found on the main iMAP webpage on the RCGP Website:

www.rcgp.org.uk/gp_training/imap.aspx

ELIGIBILITY FOR NHS PRIMARY CARE

Students at UK institutions are usually automatically entitled

Until the DH deigns to get round to sorting this out, we have to try and make sense out of the various bits of legislation and guidance that we do have. Eligibility for NHS primary care remains based on residence, and anyone who is deemed to be ordinarily resident in the UK is entitled to register with a GP. "Ordinarily resident" is a common law concept interpreted by the House of Lords in 1982 as someone who is living lawfully in the United Kingdom "voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as settled." Practices may reasonable ask for evidence of this when people from outside the EU or countries with reciprocal arrangements seek GP care – things like a utility bill, NI card or evidence of a fixed address will do.

Anyone who comes to the UK to pursue a full-time course of study of not less than six months' duration, or a course of study that is of any duration but is substantially funded by the UK Government, will be fully entitled to register with a GP for free NHS care in England. This exemption also applies to their spouse, civil partner and children (under the age of 16, or 19 if in further education) if they are living permanently with them in the UK for the duration of their course.

HPV IMMUNISATION – UPDATE

Following the start of the national programme practices are already reporting some tricky dilemmas about to whom they should be offering immunisation. The LMC view remains that wherever possible girls should be immunised in line with the national programme, but there may be exceptional circumstances under which other young women may be offered Gardasil or Cervarix. Both products are licensed and are prescribable on FP 10, but, as we have previously said, the cost is then charged to the practice prescribing budget and there is no IOS fee for administering them.

Apparently some girls who are offered immunisation at school are presenting to practices as they would prefer to have their injections there. The LMC and PCT view is that they should be directed back to their school programme. Some are specifically requesting Gardasil rather than Cervarix, but our view is that if the national programme feels that Cervarix offers an acceptable level of protection, it is unlikely that the circumstances of an individual patient would merit giving her Gardasil – especially given the additional cost to the local health economy. Patients are, of course, free to seek private immunisation from a provider other than their usual registered practice if they feel strongly enough about this.

The Medicines Management view from the PCT is that: *“GPs retain clinical freedom as neither drug is blacklisted. However they are not obliged to prescribe for anyone who asks and should weigh up the risks/benefits (including local and national cost effectiveness) of prescribing on the NHS outside of the national programme. Given the national and local prescribing recommendations we believe GPs will have a reasonable argument why they are not prescribing if challenged.”*

There will be some patients in the older catch up cohort who leave school or college during the year, and they will then be able to complete their immunisation course with the practice on the same basis as those who are not in education at the time of the initial call. Patient and Practitioner Services at the PCT will be checking on their status and sending recall letters and reminders.

STRUCTURAL HEART PROBLEMS & ANTIBIOTIC PROPHYLAXIS

Implementing NICE guidance CG 64

GPs will be aware that NICE this year decided that, as a rule, antibiotic prophylaxis is no longer required for patients with structural heart problems who are undergoing invasive procedures or dental treatment. This is liberating for both them and their professional advisers – especially dentists – and means a lot less amoxicillin will be consumed.

However, we are aware that some cardiologists are uneasy about the NICE guidance, in particular for patients with prosthetic valves who are apparently more likely to get endocarditis, and in whom it is most difficult to treat. But, like all guidance, CG 64 is not prescriptive, and there will be some patients for whom prophylaxis may still be appropriate because of their particular circumstances. In such case the defence organisations are advising that if the cardiologists want their patients to have antibiotic prophylaxis then they should provide it from secondary care.

Martin Fulford, Dental Advisor to Somerset PCT, was a member of The NICE group and he commented: *“The group included a Cardiologist, a Paediatric Cardiologist and a Cardiac Surgeon. It undertook the most comprehensive review of the published evidence ever conducted and unless there is any new evidence that was not considered then the advice stands. Incidentally, I do not understand why dental treatment is considered to require antibiotic cover whilst toothbrushing and chewing are not. The research evidence shows very clearly that both these create a bacteraemia every bit as high as, for example, tooth extraction. Infective endocarditis is indeed a devastating condition but there is no evidence to show that it is caused by dental treatment or prevented by antibiotic prophylaxis.”*

TRANSLATION AND INTERPRETING SERVICE FOR PRIMARY CARE

Don't forget that the provider changed in the spring

Since April 2008 the PCT has been using a translation and interpretation service being provided by **Applied Language Solutions**. At the time practices managers were sent a PIN number for the practice to use to the service along with a 'Little Orange Book' explaining how the new service works and an 'Instant

Telephone Interpreting Quick Start Guide' about the telephone interpreting service including a list of codes for each language.

Some GPs are still using Language Line, which will not be available from January 2009 so it is important that you know how to use the new services. But we understand some patients who do not have good English are being told they have to bring their own interpreter to consultations - which is fine if they prefer to have a family member with them, but they should still be offered the choice of a third party. There is an A4 poster that practices can display in the reception area., and further copies of a larger version can be obtained by telephoning 0800 084 2003 and selecting option 5

Using the new translation and interpreting service is easy. There is a quick five minute presentation on the "Translation and Interpretation page" of the PCT website at www.somersetpct.nhs.uk - [How we do things - Interpreting and translation services](#) explaining how to use it. The PCT also offers free training to practice teams

Despite some initial difficulties the PCT is now receiving positive reports that Applied Language Solutions is providing a good standard of service and is responsive to the needs of staff and patients. As this is a new service please send any comments to keith.whittaker@somersetpct.nhs.uk or 01460 260200.

'RESPECT & PROTECT'

*A Somerset conference on HIV and AIDS
25th Nov 2008 9.30am - 4.30pm.*

at The Great Bow Wharf, Langport TA10 9PN

In 2005-6 264 people living in the South West were newly diagnosed with HIV infection. In the UK it is estimated that over a third of people with HIV are unaware of their diagnosis.

The conference is aimed at health and social care staff who are potentially involved in the care or treatment of people living with HIV as well as those working in health promotion/education preventative roles. Topics will include current HIV treatment and care issues, HIV testing and prevention. Speakers include Dr Kumaran, Consultant in Communicable Disease Control, Jane Currie, Specialist Nurse G.U. Medicine, and Anne Marie Byrne, a woman living with HIV infection

Cost £15 per person For further information contact: Paula.Jackson@somersetpct.nhs.uk Tel: 01935 384072.

SMALL ADS SMALL ADS

SOMERSET CFS/ME SERVICE IS LOOKING FOR A GP FOR ONE YEAR - 8 HOURS PER MONTH

The Somerset Chronic Fatigue/ME Service (CFS/ME) requires a Somerset GP to join the small and friendly multidisciplinary team based in Wells for one year (8 hours per month on Fridays) from January 2009.

Do you have a keen interest and sensitivity to long-term conditions and enjoy the challenge of patients with complex medical problems? This role includes patient assessment; liaison with other Somerset GP's and medical advice to patients, carers and the team. Opportunities will be given to develop knowledge and skills relating to the condition.

For further information and job description, or an informal discussion, please contact:

Jane Truman, Somerset CFS/ME Service Manager, Priory House, Priory Health Park, Glastonbury Road, Wells, BA5 1XJ Tel: 01749 836500 / Fax: 01749 836543

email: jane.truman@somersetpct.nhs.uk

Please send written expressions of interest particularly showing how you match the personal specification to Jane Truman at the above address to be received by Friday October 31st 2008.

PRACTICE MANAGER

CREWKERNE, SOMERSET - CIRCA £43,000 P.A.

An innovative, accomplished, pro-active leader is required to join a happy team. and help lead our friendly, patient centred, seven partner practice. We are looking for a strategic visionary thinker with strong interpersonal skills.

NHS experience is not essential. You will hold a relevant business or financial qualification, have previous experience of leading and motivating staff, be financially astute, IT literate, and comfortable working in a rapidly changing environment.

For an information pack and details of how to apply, please email:

sarah@firstpracticemanagement.co.uk quoting "Crewkerne (XXXXXX)".

Closing Date: 31st October 2008

Jennifer Giggles

For a woman in her sixties Mrs. James was not unpleasant to look at and may have been what some would call, in her early days, 'easy on the eye'. Although past her prime her smile still had a sparkle. Her husband was a serious man, well dressed and bland and they both came from somewhere well north of the Thames. She came quite often with this and that but never with anything of much importance. Today was just another surgery and I spotted her name on the appointments list. This caused me a frisson of anxiety because this otherwise quite unremarkable damsel of the north had one particular foible that could ruin our, so far, therapeutic doctor-patient relationship. Some people have physical deformity that make them look rather silly, some people have odd tics and habits that can cause the unwary or unprepared to stare, smile or even giggle when sobriety is what is required. But this bastion of northern propriety had a speciality of her own that had the potential to cause me to break down with uncontrollable giggles; to have me rolling on the floor, clutching my stomach in real pain as the laughter struggled to get out. I might have been confident of controlling myself if things hadn't gone quite so wrong on a previous occasion.

I can't remember why she came but I do remember that I had two medical students sitting in with me and, no doubt, struggling to stay interested, or at least awake. A rather earnest young man and a girl with a lovely warm smile is how I remember them. If only I hadn't warned them of her peccadillo. Unprepared, they might have not even noticed or at worst just let it pass as of minor interest. It was the preparation that was our downfall.



Mrs. James entered the room, acknowledged the students with a welcoming smile and sat in the chair in her usual prim and proper way. "Well doctor, *yer know like*", she started "It's about these headaches, *yer know like*. They have been much worse since Norman had his fall, *yer know like*". In the corner of my eye I could see trouble brewing, the earnest young man's eyes were watering up and his face undergoing contortions as he tried to keep control. For some reason I thought a change of subject might help, "how is Norman now?" I enquired. "He's still pretty shaken, *yer know like*. He's lost all his confidence, *yer know like*". I kicked myself for asking a question. Examination would stop her talking. I reached for the sphygmomanometer but was too late. My earnest student cracked. He let out an extraordinary high-pitched screeching sound and ran across the room, flung open the door and rushed off down the corridor. His colleague looked to be in equal trouble (they must have caught each other's eye, which had set them off). "Oh, dear" I said somberly "he must be unwell, would you like to check he's alright?" The girl leapt at the opportunity, left equally quickly and ran down the corridor. I continued and finished my consultation and, as far as I could tell, Mrs. James did not seem to be aware what all the fuss was about. After she left, I joined the students in the office where I found them both sat with tears running down their cheeks, exhausted from laughter. I tried to be serious but it took just one '*yer know like*' and I was caught with uncontrollable giggles. Afterwards it was like all my troubles had been washed away with the tears. Laughter therapy really works.

And now she was coming down the corridor to see me again. As always there will be a '*Yer know like*' at the end of every sentence and I was going to have to pretend she never said it. I was going to have to concentrate very very hard to give her the doctor that she deserved.

Jennifer

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

MENTAL CAPACITY ACT STUDY DAY

Somerset Primary Care Trust is holding a study day on the Mental Capacity Act 2005 Friday 7th November at Taunton & Somerset NHS Foundation Trust Postgraduate Lecture Theatre. The morning is led by Aasya Mughal, a Barrister specialising in Mental Health Act issues and Court of Protection advocacy. The day is an in-depth look at the Act and its application in day-to-day clinical and medical practice and is charged at £15 per delegate. To download an application form, please go to www.somersetpct.nhs.uk/mentalcapacityact. For any queries regarding the day, please contact Elizabeth Roberts on 01935 384 095.