Somerset LMC Newsletter

April 2009

Issue 149

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LETTERS IN SUPPORT OF HOUSING APPLICATIONS

Every GP is used to receiving requests from patients who are applying for social housing who feel that their medical condition is relevant to the application. Traditionally most doctors provide them with "housing lines" without charge as a *pro bono* service.

The official source of medical advice for local authority housing departments used to be via health authorities, and arguably GPs should not have been part of the process. But realistically only the family doctor was likely to have the kind of knowledge needed to help housing officers make sensible decisions and generally patients would come straight to the practice for help.

The advent of housing associations changed the position as there was no duty laid on health authorities to provide them with medical advice; and then the latest set of NHS changes finally broke the old formal link between PCT public health departments and housing.

This all means that inevitably more requests will come to GPs for housing letters, Providing these is, of course, not part of the GMS contract and, by extension, is unlikely to be part of any PMS agreement. You may, if you wish, levy a charge—but given that this group of patients is almost by definition disadvantaged, few of us will choose to do so.

One simple approach may be to consider giving a "yes/no" answer as to whether the person is "vulnerable" in terms of the 1996 Housing Act. Roughly speaking, the test is whether they are more likely to become homeless ,or to suffer more adverse effects from being homeless than other people. The Act specifies some groups who should be given housing priority, such as the old, those with mental illness , learning) or physical disability; younger people who have been in care, ex-prisoners and ex-service personnel as well as those at risk of domestic violence. There is also the usual catch all of "any other special reason".

But this level of information may be just too minimalistic to be helpful to the housing decision maker, and when medical information is sought it is more often the effects of illness on the individual rather than the exact diagnosis that really matters. A very useful short guide can be found at http://www.homeless.org.uk/policyandinfo/issues/health/discharge/factsheets/Factsheet2.pdf

ON SHAKESPEARE'S BIRTHDAY, A PLEA FOR REAL ENGLISH.

Readers may know that the incumbent LMC Chairman is a firm advocate for the use of plain language. Indeed, members speaking at LMC meetings who use vogueish jargon words are invited to pay 10 pence in to the Chairman's "Issues" box for Medecins sans Frontieres. In recognition of this sterling work Dr Chris Howes, LMC member for Shepton Mallet, is proposing the establishment of an annual LMC Managementspeak Award. In time a "Barry" could become a coveted prize eagerly fought over by Department of Health apparatchiks and their like. Nominations for 2009, which must be from a genuine NHS document, should be submitted to the LMC office before mid-May . So far we particularly like "using goalposts to drill down to reach achievable milestones."

PRESCRIBING MATTERS

28 & 56 day Prescribing

It has been alleged that some practices might be considering adjusting their prescribing duration according to the medication in question, so that, for example, ACEIs are given for 1 month but ARBs for two. Quite coincidentally this might have an impact on the relative number of prescriptions and hence on various prescribing targets. Unfortunately, not only does this not work, it would also, of course, be unethical.

Medical Standards of Fitness to Drive – Warning about hypoglycaemia risk with Exenatide (Byetta) or Gliptins

Exenatide is licensed as a treatment for use in type 2 diabetes, in combination with metformin and/or sulphonylureas (SU). There is a small but significant risk of hypoglycaemia when exenatide is used in conjunction with an SU. There is a similar risk when gliptins (DPP4 inhibitors) are used with an SU, the hypoglycaemia risk is similarly raised. The DVLA has indicated that these are therefore felt to be a potentially high risk treatment for drivers holding Group 2 (LGV or PCV) licences and that individual assessment will be required.
http://www.dvla.gov.uk/media/pdf/medical/aagv1.pdf

Availability of Pharmaceuticals

We have already seen some unexpected problems with the supply of prescription medication and it seems that these are likely to continue. There are a number of reasons including a global shortage of acetonitrile (a petrochemical by-product) delaying QA assay processes and the release of new batches of products, and a reverse in the traditional pattern of parallel importing - as the value of sterling falls - leading to an outflow of UK packed products to mainland Europe. At the same time PPRS price reductions in February caused a reduction of stock holding in the supply chain and more recently manufacturers have started to introduce quota arrangements for pharmacies and dispensing practices as a way of keeping control of supply. This latter development is a serious concern and the LMC and the Local Pharmaceutical Committee have both raised it with our national bodies.

Emergency Oxygen Provision for Overseas Visitors

You may have seen a recent newsletter from the PCT about the latest changes in oxygen supply arrangements which also included the advice that overseas visitors who are oxygen users should not have routine supplies through the NHS. Please note that the position is different if the need is urgent. The BMA advises: "As NHS contractors, GPs have a duty to provide immediately necessary treatment to any patient within their practice area regardless of whether or not that patient is otherwise entitled to NHS care. GPs are entitled to use their clinical judgment to determine what constitutes immediately necessary care". There is a good summary for primary care of the latest BTS Oxygen guidelines at
http://www.bjpcn-respiratory.com/download/3255

PATIENT PARTICIPATION GROUP

If you do not yet have a patient participation group, we urge you to consider attending one of the locality meetings that are being organised by the Patient and Public Involvement team at the PCT to discuss how you might go about setting one up. They will be from 7 to 9 pm on:

- Thursday 30th April Lyngford House, Taunton
- Thursday 14th May The Exchange, Bridgwater
- Wednesday 27th May The Charlton House Hotel, Shepton Mallet
- Thursday 28th May The Hollies, Bower Hinton (nr Yeovil)

Practices will get invitations to attend their nearest meeting, but for more information contact Margaret Grizzell 01460 260201 or Margaret.Grizzell@somerset.nhs.uk

ROYAL MEDICAL BENEVOLENT FUND, BRIDGWATER GUILD

Dr Anne Reed has been the secretary of the Bridgwater guild since 1982, and now feels that she should pass on the baton to someone else in the hope of revitalising the Guild, or perhaps forming a joint one with Taunton. The role of secretary is not taxing as appeals now come direct from HQ. Many doctors are aware of the continuing need for the financial support that this organisation offers to doctors and their families who fall into difficulties and it would be good to see some new initiatives, such as local fund raising events. If anyone feels they can give a little of their time, please contact Anne at aerreed@hotmail.com

CORRESPONDENCE COLUMN

Dear Jennifer

I started to read with much amusement your work of complete fiction about the Summary Care Record. Then I realised that someone who is convinced of conspiracies everywhere will always manage to find a "Great Plot".

I know you have never been one to let the facts get in the way of a good diatribe – an irony heightened by your reference to propaganda from the Government.

For example, you incorporated unrelated facts to imply that just because a large number of smartcards may be commissioned, all of them would allow access to the SCR. It would appear that you have a problem with figures as you have added two and two to make 1.2 million! And the reference to lawyers with no justification or explanation was equally misleading.

There are so many inaccuracies that I feel I should set the record straight, but unfortunately I can only cover a few of them here. So, now to the facts.

There will be no connection of GP clinical records to the spine as you state. The only information that GP systems will upload will be drugs, allergies and adverse reactions. Nothing else will be sent without patients and GPs being consulted again. Your implication of snooping is simply untrue – and moreover the software is incapable of doing so.
See: http://www.connectingforhealth.nhs.uk/systemsandservices/nhscrs/scr/patient/storing

Contrary to your assertion, once a GP transfers clinical information with implied consent he or she is no longer responsible for the control of that information. A scandalous suggestion? Surely we do it every day when we write letters to consultants? The situation is entirely analogous; medical data transferred to a third party, without specific written consent to share the medical record, for the benefit of the patient. If the recipient breached confidentiality about something in the letter he or she would be held responsible, not the GP. Medical defence bodies agree: any GP can contact their own for confirmation.

In your article you - of course - turn a blind eye to all the secretaries and administrative staff who currently see the details of your patients medical histories as this would weaken your argument. This is simply disingenuous rhetoric.

And the Tories promising to end NPfIT? Oh dear! How wrong! When Gordon Brown made this claim very recently at a hearing of the Public Accounts Committee the Conservatives, through Stephen O'Brien, were very quick to say that this was not their position at all.

However, "there's no such thing as bad publicity". Certainly NHS Somerset would thank Jennifer for bringing the SCR to the attention of GPs, saving them considerable effort. There is a need for further open debate and consideration of the SCR, and if any reader of the LMC newsletter would like to have a genuine discussion about the pros and cons the Project Manager and I would be more than happy to visit their practice.

Justin Harrington
NHS Somerset GP IT lead

The LMC is currently gathering information about the SCR and the implementation proposals and will produce recommendations shortly.

MARATHON RUNNER FOR CANCER RESEARCH UK

Readers who refer to TST will know Mary Tighe, who has for many years worked in the Oncology department at Musgrove. She is running in the London Marathon on April 26th for Cancer Research UK and would be grateful for any sponsorship from the world of Primary Care. She says "I'm approaching retirement now and feel I would like to put something back, having met such lovely patients over the years. It is in support of all our current patients and in memory of those we have cared for in the Department - I'll carry a list of 26 names with me on the day and run a mile for each of them. I have a little website at:
www.runningsponsorme.org/doctormary and GiftAid can be added if appropriate. Thanks so much"

Small Ads Small Ads Small Ads.........

SALARIED GP WANTED: VICTORIA PARK MEDICAL CENTRE, BRIDGWATER

Up to 5 sessions a week, this is a rare opportunity to join 2 partners in a fast growing PMS practice of just under 4000 patients. We are a well-organised, friendly team based in a purpose built surgery within an award winning community centre with a full complement of support staff. In addition to the usual GP work we have an interest in drug and mental health work. Outside clinical interests are positively encouraged.
Informal visits and discussions are welcomed. For more information and an information pack contact Practice Manager Paul Cawkwell before Thursday 30 April 2009 on 01278 437100 or paul.cawkwell@victoriaparkmc.nhs.uk

PART-TIME PARTNER: GROVE HOUSE SURGERY, SHEPTON MALLET

We are looking for an enthusiastic part time partner to join us in our friendly, well organised team. Initially 5 sessions from 1 September 2009. Practice comprises of 4 Partners and one associate GP PMS, a teaching practice of 6000+ patients, EMIS PCS & high QOF achievement. There will be opportunities to lead on key strategic and clinical issues.
For more information please contact Rachel Witcombe, Practice Manager or Dr Janet Millar on 01749 342314 or email
Rachel.Witcombe@grovehousesurgery.nhs.uk
by 24 April 2009 - Interviews 23 May 2009.

PRACTICE NURSE REQUIRED: IRNHAM LODGE SURGERY, MINEHEAD

40 hours per week to include alternate weekends. Based mainly at Butlins Branch Medical Centre but also at the main surgery sites. Job share considered and part-time applications also welcome. Band 5 equivalent. (NB: we are not an Agenda for Change practice)
For further details please contact Sharon Rowe, Practice Manager, on 01643 700480, email sharon.rowe@irnhamlodge.nhs.uk, or to apply please send your CV and covering letter to Sharon Rowe by email or post to Irnham Lodge Surgery, Townsend Road, Minehead, Somerset, TA24 5RG by Friday 27 March.

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Email: somersetgplocums@hotmail.com

A little song to hum on Monday mornings...

I feel tired on my treatment, dear doctor, dear doctor
I feel tired on my treatment, dear doctor……. so tired.

Then get *fit*, dear patient, dear patient, dear patient
Then get fit, dear patient, dear patient……. get *fit*.

With what shall I get fit, dear doctor, dear doctor
With what shall I get fit, dear doctor……. with what?

With *exercise*, dear patient, dear patient, dear patient
With exercise, dear patient, dear patient……. with *exercise*

But my blood pressure's too high, dear doctor, dear doctor
But my blood pressure's too high, dear doctor……. too high

Then *diet*, dear patient, dear patient, dear patient
Then diet, dear patient, dear patient……. *diet*

But the diet is too hard, dear doctor, dear doctor
But the diet is too hard, dear doctor……. too hard.

Then take a *pill*, dear patient, dear patient, dear patient
Then take a pill, dear patient……. take a *pill*

But, I feel tired on my treatment...

With thanks to Dr Phil Wilson

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