

Somerset LMC

Newsletter



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Issue 150

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PRO BONO PUBLICO?

The publication of the national statistics on GP income this week provoked relatively little press comment, partly because the figures relate to 2006/07, and partly because the trend is downwards, which makes it hard for even the most hostile media commentator to make much of a story out of them. Interestingly, average GP income in the Southwest is lower than the rest of southern England, but even after the attrition of several years of static core contract funding most family doctors in Somerset still earn well compared to other equivalent professionals – and, of course, we have the security of an NHS pension to which we can look forward. Practices have achieved this by absorbing more and more work, so far with considerable success, but the spiraling complexity and demands of service contracts means most of us are just about at the limit. It is therefore no surprise that growing numbers of GPs are seeking to reduce from a full time working commitment: few of us can work 50-60 hours a week at this level of intensity for long. But for most of us there is a choice, for we still retain considerable control over our working lives. For many of our patients, this is not the case as hard economic times reduce income and security and cast the shadow of unemployment across the lives of even established professionals.

Against this background many of us find it at best uncomfortable and at worst positively unethical to be making automatic charges for all non-NHS services like insurance certification and private medical examinations. This does not mean that the LMC advises you to provide everything for free – neither the plumber nor the lawyer would do the same for you – but the negative impression and bad publicity generated by levying a standard charge whatever the circumstances does good for neither the practice nor the profession as a whole. We have heard of some GPs being criticised for unsympathetic application of fixed fees across the board and, whilst it is of course every practice's right to charge as they wish for private services, it is often viewed negatively by the public if, for example, charities are billed. This is particularly the case when fees are applied to small items like certificates to confirm a medical condition that entitles the sufferer to particular help. Most GPs would also not wish to charge a patient who had lost his or her job and needed some sort of information from their records when seeking a new one, so it is worth ensuring that your systems are flexible enough to allow discretion in these sorts of cases.

At the same time we must be wary of opening the floodgates to allow a torrent of GANFYD (Get A Note From Your Doctor) for everything from the use of an electric golf buggy to getting toenails cut, and levying a charge for unnecessary paperwork is a useful resistor. So, where you do choose to make no charge or to reduce the fee, you should still issue a full price "fee waived" invoice so the recipient does not assume that your services are always free. But if we are to claim that traditional general practice is different because we are part of our local community, then we must be prepared to demonstrate this by accepting that there is some work we should undertake without payment "for the public good".

EXTENDED HOURS - WHERE ARE WE NOW?

Twelve months after the first practices began to offer extended hours 54 of the 75 Somerset practices now do so (72%). Some PCTs have achieved 100% coverage, but we are pretty typical of England as a whole. Experience suggests that whilst patients may express a *wish* to have their GP available during extended hours, few will actually *choose* to see the doctor in the evening or on Saturday morning if they have a wide choice of appointments during the normal working week. Indeed, most of us will more than once have had the experience of offering a patient an evening appointment after work only for him or her to choose one in the middle of the afternoon, which puts the lie to the CBI allegation that the UK economy was losing billions because workers could not get to see their doctor outside working hours! However, despite having many other things we might think are more important to worry about, the Government still sets much store by this target, and for most of us working the additional hours is a relatively minor burden even if the appointments tend to be filled by the old familiar faces.

When the contract changes were imposed, there was always the threat that if practices did not offer the service, PCTs would have to find an alternative provider. Although we suspect that this was never realistic for the whole of a rural county like ours, there are now only a couple of places in Somerset where no practices open outside core hours, and government desperate for achievements to bolster its record might well start to increase pressure on commissioners.

We think this may be an opportunity for federations, and particularly sub-localities of federations, to start to think about how they might work together and perhaps offer a shared extended hours service. With assured funding via the DES, and a PCT willing to look for constructive solutions, this could be an ideal way to start to develop the skills and experience necessary to be able to bid for new work, including Mr Brown's Vascular Screening - now, inevitably, rebranded as "NHS Health Checks". We know that fragmenting provision rarely helps patients, but if we believe that continuity is important we need to take a strategic view that looks beyond the pressures of the day to something bigger and better.

SOMERSET LMC POSITION ON ADOPTION OF THE NHS ELECTRONIC SUMMARY CARE RECORD

One major component of the NHS National Programme for IT (Connecting for Health, CfH) is the establishment of a national electronic medical record database, the Summary Care Record (SCR). In its present form this consists only of data extracted from GP clinical systems, and it is limited to Read Coded information on prescriptions, allergies and adverse reactions. It is planned that further information will be added in due course, but diagnosis codes linked the prescriptions are *not* presently uploaded. Implementation of the SCR has gone ahead in five pilot PCTs, including Dorset. Somerset volunteered as a "fast follower" with accelerated implementation on a practice by practice basis over the next 18 months.

Current Proposal

Prescribing information and changes will be uploaded regularly from GP practices. This data will be accessible as "read-only" by A&E Departments and Out of Hours services. The theoretical advantages for patients are obvious, and more real benefits are likely to accrue when hospital pharmacies and others can check patients' current medications. An important incidental advantage will be that it will be harder for individuals to obtain drugs of abuse by deceit.

Data risks

A considerable number of people will have role-based smart card access to the SCR, though far fewer than the 1.5M sometimes claimed. Each time a record is opened the access is logged by user. It will be possible for patients to find out when and where their record has been accessed and to verify whether this was with their consent. Some records, notably those of individuals in the public eye, will have an additional security check before they can be viewed. Whilst this means any data breach can be traced to a particular card, it can, of course, only be discovered after the event.

Technical Problems

Practice systems upload changes to the SCR as medications and other relevant codes are added to the medical record. This uses a moderate amount of bandwidth, so whilst internal work in the practice is unlikely to be affected, other external processes may be slowed down, - for example, integrated Choose and Book software. This may be an especial problem for practices with branch surgeries with narrow internet links, but we are assured that Informatics will be

working with system suppliers and CfH before installation to check that your system has enough capacity for this not to cause problems.

Consent Model

After considerable debate the Department of Health has adopted an "opt-out" consent model. During the implementation process there will be widespread local publicity (Public Information Programme, PIP) and all adult patients (over 15 ¾) will be sent a letter inviting them to contact their practice if they do *not* want their records uploaded. They will have 16 weeks to reply. Once uploaded the system, for medico-legal reasons, does not allow the record to be deleted if it has been opened at any time, though if a patient withdraws his or her consent it can be hidden and archived in a way that would only allow access after a legal process has been gone through. One good reason for choosing this model is that the evidence suggests requiring positive consent leads to an uptake of less than 20% and potential users are much less likely to look up records if there is such a small likelihood of their being anything to find.

Each access to the record will require the specific consent of the patient, except where they are unable to give this and their medical problem is serious.

Experience in Pilot PCTs

Information from Dorset and Essex LMCs suggests that a substantial majority of patients support the scheme: *"Many patients think this is what the NHS does already. They do not appreciate the tribal disconnected nature of the organisation. Most patients readily grasp the concept and advantages of a shared care record, with limited but key pieces of information."*

Nationally, between 0.5 and 1% of patients register objections to the upload. If an individual opts out and has a ".93c3" code added to their notes he or she will never have an SCR unless they request the practice to remove the code.

The workload for practices is generally slight, with relatively few queries or objections. Early wave adopters will get additional PCT support.

Medicolegal Concerns

The underlying concern of practices is whether "opting-out" consent is valid, and so whether it is acceptable for them to upload patients' information on this basis. Most advice, including from the BMA, is that it is legally acceptable to do so, although we still await a final opinion from the Information Commissioner. Nonetheless, some practices have taken the principled view that for information of this sensitivity only fully informed positive consent is adequate. Taking

this position has some implications. First, practices will need to write to patients themselves, setting out the benefits and disadvantages of the upload in a fair and understandable way. Second, it would be unwise to blanket code all records with ".93c3", for whilst it may be legally correct that there has been "no consent" for the upload, if the predominant model across the county is of implied consent, patients may reasonably expect that it will apply in their practice unless they are specifically informed to the different.

Considerable publicity has been given to various criticisms of the SCR, notably the report *"Database State"* issued by the Joseph Rowntree Reform Trust Ltd, an organisation that campaigns on civil rights issues and is not the same as the Joseph Rowntree Foundation. This labels the SCR as "amber" suggesting that it should be independently reviewed before implementation. However, the methodology and conclusions of the report have themselves been criticised.

Conclusion

In principle the SCR offers benefits for patients and a large majority of the public think it is a good thing. We do not believe practices put themselves at risk by embracing it. As with all large databases there is a risk that information could be abused, but for most patients this risk is likely to be slight. There are great potential benefits in managing medication information at the primary/secondary care interface.

Practices who feel on principle that the consent model is inadequate should be starting to plan both how they will inform their patients and can ensure that the data of those who specifically request it can be uploaded.

DATIX SAFETY ALERTS FROM THE PCT

The LMC has been invited to add a rating to the safety alerts circulated from the PCT to help practices form a view on how quickly they need to act upon them. We have proposed three levels:

Red (important). This alert contains significant information that is likely to mean a change of clinical or organisational arrangements in the practice and/or an immediate short term action.

Amber (relevant). This alert needs to be considered by the practice but not as an immediate priority.

Green (notification). This alert is unlikely to have a significant impact on most general practices.

SMTC COLONOSCOPY REVIEW – FINAL REPORT

Most readers will know that a number of patients who had had colonoscopies at SMTC were recalled after a concern was raised about the completeness of some of the examinations, and the Centre is grateful to practices for their help in this process .

SMTC was unique at the time in recording all endoscopies on DVD, and of the 1828 colonoscopies independently reviewed, 97 patients were reinvestigated. There was no evidence of any missed diagnoses though 6 cases of colorectal cancer were subsequently picked up, none of which were evident on the original DVD. As some time had passed between the original and follow up investigations it is not possible to say when the tumours developed, but even in the best hands endoscopies specifically looking for malignancy will miss about 5%. Following this episode SMTC has improved their procedures and also appointed a new very experienced endoscopist to lead the service.

The LMC meets with senior management of SMTC from time to time and we have found them to be very open and keen to support general practice in providing services for patients. Some of the recent press comments on the Centre does seem to have been unfair, and it is interesting that endoscopy referral from practices to the Centre have not fallen, suggesting that most GPs remain confident in the service.

The full text of the report can be found on the PCT website: www.somersetpct.nhs.uk (follow: about us/board meetings/April/

SOMERSET BEACON CENTRE IN TAUNTON

The first patients were seen in the outpatient clinic of the new Somerset oncology centre on Monday 11th May and radiotherapy treatments using the three new linear accelerators will be starting there soon. The building is stunning – beautifully designed and built to a high standard of finish, and the staff are most impressive having had additional members recruited from all over the UK. GPs who visited on the open day on 6th May had a fascinating tour, and the new machines are extraordinarily impressive. For those of us who learned about radiotherapy in the 1970s when the dose was administered by opening and closing a little door behind which sat a

chunk of radioactive cobalt, the most impressive thing was the “multi-leaf collimator” which is programmed to move baffles in and out of the electron beam as determined by a 3D CT image of the tumour

ENDING OF RECIPROCAL HEALTH AGREEMENTS WITH CHANNEL ISLANDS AND ISLE OF MAN

As from 1st April this year Channel Island and Manx residents visiting Britain will need health insurance as they are no longer eligible for automatic NHS care. Provision of NHS primary care services remains at the discretion of the GP but secondary care is now restricted to emergency treatment

(<http://gouk.about.com/od/tripplanning/p/emergencydoctor.htm>)

as a consequence of new Regulations that have been enacted to prevent health tourism. Likewise, if you happen to be travelling to any of these Crown Dependencies do make sure you have suitable insurance. Note that the EHIC card does not cover emergency health care in the Channel Islands because they are not part of the EU.

REDUCTION IN GPC LEVY FOR 2009/10

The LMC is grateful to the overwhelming majority of Somerset GPs who pay the voluntary GPC levy. Whilst our national negotiators do not always achieve all we want, general practice would be far worse off without the tireless efforts of our national team who pay for themselves many times over. Due to careful husbandry the treasurer has announced that despite an ever increasing volume of work, the GPC levy for this year will be reduced by about 20% for the current year. Where practices have already paid at the old rate, the GPC will offset this against next year's contribution.

CHANGE IN REPORTING UNITS FOR HBA1C

As of 1st June and for the next two years all NHS Biochemistry laboratories will be reporting HbA1c results as both the current units of measure (%) and the new IFCC standardised units (mmol/mol). From 1st June 2011, only the IFCC results will be reported – by then we assume the QOF targets will be expressed in the new units! Full details at:

[http://www.diabetes.org.uk/upload/Professionals/Professional%20membership%](http://www.diabetes.org.uk/upload/Professionals/Professional%20membership%20)

Small Ads Small Ads Small Ads.....**SALARIED GP WANTED AT HAMDON MEDICAL CENTRE**

Approx 2 sessions per week with additional locum opportunities. We are a 2 partner plus one full time salaried GP, friendly, well organised EMIS rural practice with 5200 patients. For more information please contact Kerrie Middleton, Practice Manager on tel. 01935 827007 or

Kerrie.Middleton@hamdonmc.nhs.uk by 30 June 2009.

PART-TIME SALARIED GP WANTED FOR DR DAVIES & PARTNERS, STREET

We are seeking a part-time GP to work Thursdays within this friendly Practice. Additional sessions may become available, and we are flexible about timings where necessary. Well-organised and staffed PMS teaching Practice working in excellent surgery premises, with adjacent pharmacy, dentist and complimentary practitioners, and a community hospital. Informal discussion encouraged. For further information please contact Practice manager Liz Seekings or Dr Deb Gompertz on 01458 841122 or email liz.seekings@vinesurgery.nhs.uk or deb.gompertz@vinesurgery.nhs.uk by June 5th.

PRACTICE NURSE REQUIRED FOR VINE SURGERY, STREET

We are seeking an enthusiastic part-time Practice Nurse for 12 hours per week to join our friendly, dynamic and comprehensive nurse team at the surgery. The post is for all basic Practice nurse duties. Further training will be provided as required. Chronic disease experience is not necessary. For further information please contact:

Practice Manager Liz Seekings or Senior Nurse Elaine Hockett on 01458 841122 or Elaine.hockett@vinesurgery.nhs.uk by June 5th.

WANTED GPwSI ORTHOPAEDICS

Want to add some variety to your practice? Wondering if there is medicine beyond QOF?

Why not become a GPwSI in Orthopaedics.

Up to 2 days a week available in ½ day sessions. Join a happy team of 4 doctors and 3 ESPs in the EASE clinic in Yeovil. Training provided.

For an informal chat contact:

Dr. Steve Holden on 01935 470200 or email Stephen.Holden@hendfordlodgemc.nhs.uk

NHS SOMERSET—PROFESSIONAL EXECUTIVE COMMITTEE MEMBER

Ref: 630-EA106-09

NHS Somerset are now looking to appoint a Professional Executive Committee (PEC) Member.

The key role of the PEC is to support NHS Somerset in the following areas:

- developing its vision and strategic direction
- commissioning and supporting commissioning
- clinical effectiveness and clinical governance
- leading clinical communications with partners and stakeholders

To be eligible to apply you must fulfil the following criteria:

- be able to demonstrate an interest and commitment to delivering service improvement
- be an advocate for service quality, clinical governance and patient involvement
- be able to demonstrate an understanding of the wider system and have good networks in place, which can be built upon
- have an understanding of and commitment to working corporately
- be a registered healthcare professional, work within Somerset, and carry a caseload (if you do not currently have a caseload, please contact Dr Donal Hynes on the number below)
- be able to devote 3½ days per month for PEC work

NHS Somerset will provide you with an excellent development opportunity to work at a strategic level. You will be provided with mentoring support

PEC remuneration is: £7,525 allowance and £10,000 backfill/locum payment.

For an application form please visit www.jobs.nhs.uk for further information and to apply. You are also asked to submit a CV please cut and paste your CV into the Supporting Information box at the end of the application form (please note the format of your CV will change). Alternatively, you may email it to gemma.partridge@somerset.nhs.uk.

If you would be interested to know more about the role please contact Dr Donal Hynes, PEC Chair, on 01935 385 009 for an informal discussion.

The closing date for applications is 7 June 2009 and interviews will be held on 10 July 2009.

Jennifer's Summer Quiz on Revalidation

It must be nearly 10 years since the RCGP commissioned Janet Grant, Professor of Medical Education at the Open University (and an educational guru to boot) to write a scheme for Revalidation. It was a brilliant programme of formative learning that paid full attention to all the methods for determining GP's education needs. But for years since then the pseudo-educationalists and politicians have kicked it around and now the GMC has muscled in on it. No doubt thousands of committees have modified, abridged, deleted and added to the document so that Janet Grant's original is no longer recognisable - we now have the "RCGP Guide to the Revalidation of General Practitioners, Version 1.0". A once exciting educational programme now reads more like a sixth-former's tick-box exercise. I am sure you have all read the document so here is a quick test:

1. Q.: Which of the following obstacles must you surmount?

Appraisal..... Revalidation..... Recertification..... ..Licensing.

A: This is a bit of a trick question really, because you need all four!

2. Which of the following may produce policy statements independently which will change the present plans? RCGP, GMC, DH, AoMRC (Academy of Medical Royal Colleges)

A: Another trick question because they're all sticking their oar in, presumably just for the hell of it.

3. Q: If you occasionally teach medical students, are a trainer and do the odd bit of data collecting for research will you need to produce certificates from the University Medical School and The Post-graduate Deanery, as well as a statement from a 'recognised research institution' and a statement from the Research Governance Team in the local primary care organization?

A: Yes, from all of them. A bonus point if you know what a Research Governance Team is.

4. Q: Why do you need the above certificates?

A: I can think of no rational explanation. Points awarded for venting your spleen in an amusing fashion.

5 Q: What is an MSF?

A: It is a multi-source feedback from colleagues. The only one the College actually have is an online questionnaire giving your staff and colleagues an opportunity to bitch about you. Quoting the RCGP "... should take 10 to 20 minutes to complete, but it may take longer if reflection and consideration are required". So the plan is to do it without reflection and consideration then! I believe there is no evidence that this is accurate or useful but there is evidence that it is harmful to anxious GPs. They have no alternatives.

6. Q: When does Revalidation start: 2009, 2010, 2011, 2012.....

A: Nobody knows. The RCGP have suggested April 2010 and have stated that any evidence collected before April 2009 won't count (why not? They're my best bits!). They advise GPs start collecting 'evidence' from April this year but this has now been challenged and it seems that it is unlikely anything will happen in April 2010 at the earliest anyway.



We should be proud of our leaders who for political reasons have allowed an excellent educational and positive process be turned into a tick box nonsense. Perhaps they are chums of the doctors who came up with QOF.

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

Dear LMC

Noting the highly successful rebranding of the PCT as NHS Somerset we believe it is time that the image of the LMC was reviewed, given that you have been "Somerset LMC" since 1916 and need to move with the times. After an extensive review at a very reasonable cost our consultants can recommend that a more contemporary and cutting edgy profile would be facilitated by changing fuddy-duddy "Somerset LMC" to "LMCSomerset": in particular by leaving no gap between the two elements we will be emphasising your passion for inclusiveness. Let us help you go forward under a new banner and embrace the age of change!