

Somerset LMC Newsletter



April 2011

Issue 165

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SO WHAT'S THE HURRY WITH COMMISSIONING?

We hope that by now you have all had the letter sent by the LMC on behalf of the Transition Group, which invites nominations for the elections to the interim GP Commissioning consortium. The deadline for nominations is 18th April, which the TG accepts is very tight, now the Government has announced its "pause", what is the hurry?

The original plan was for the Wyvern to have handed its PBC responsibility directly on to the new, much larger, and more autonomous iGPCC. But, perhaps inevitably, putting together the process for a fundamental shift in NHS organisation from managerial to clinical leadership took longer than expected, and the TG needed to consult on the electoral process for GP members of the iGPCC as well as organising the election itself.

Meanwhile, Wyvern's funding arrangements ended on 31st March and so its PBC responsibilities reverted to the PCT. This means that existing projects can continue, but nothing new will happen until the iGPCC is up and running. However, the demands of QIPP and the urgent need to make efficiency savings does not go away. Bitter experience tells us that if a health economy is not in balance in the first two months of the year it is astonishingly difficult to claw back into the black without swingeing cuts. We therefore do not have time for the luxury of a long process, for the elections are just the beginning – the new Board will need to be trained and brought up to speed before the members can start to make informed decisions.

Well, one might ask, why do GPs have to get involved at all? Should we not just hand the problem back to the PCT and get on with the day job? This may be tempting, but there are some good reasons why those siren voices should be ignored. First, GPs have the knowledge and the decision making skills to change pathways and processes to do things better at lower cost. Of course the iGPCC will need managers, and close discussion with secondary care colleagues is essential, but Mr Lansley's fundamental belief that we are the best placed people in the NHS to lead commissioning is correct. Secondly, embedding GPs at the heart of the commissioning process goes a long way to protect the future of the profession, and especially the independent contractor model which has served the NHS so well over the years. Thirdly, there is a great risk that QIPP pathway changes made without GP involvement will transfer more and more unfunded work into general practice. We are busy enough as it is, adding extra would lead to serious problems.

Somerset is still a national commissioning pathfinder, and our federal model with two constituent federations also having pathfinder status, is, we believe, unique. We have the ingredients to make GP

commissioning work, and using the skills and experience of Wyvern can step up to the next level. All GPs working in a Somerset federation are eligible to stand: partners, salaried doctors and sessional GPs. If you or another GP are potential candidates but cannot complete the formal nomination paperwork by 18th April please contact the LMC office, but most of all please make sure you use your vote to ensure that the iGPCC has the democratic legitimacy to lead lasting and significant change.

CQC REGISTRATION

The LMC recommends that practices await guidance from the GPC

We are aware of growing anxiety, especially amongst practice managers, about both the process and workload of CQC registration. There are certainly some people around who are suggesting that this is going to be an enormous and complex task.

Part of the problem is the way in which current information from the CQC is phrased, as it tends to fit better with a 24 hour bed based care provider than an office based service like general practice. However, if you look at the actual requirements www.cqc.org.uk/, most of what practices need to do is already either an expectation in some element of your contract, or existing good practice. However, we do need clarification on just how some of these requirements will transfer to primary care – for example, requirement 16 is to notify the death of any service user to the CQC. Given that nearly all the population has an NHS GP, do they really want to set up a duplicate national death notification system? But the real task here for practices is to collate all the relevant policies and redraft them in the format required by the CQC. This is going to be a significant job, but the GPC is planning to produce a suite of protocols that practices can adapt for their own use, so we will not all have to start re-inventing the wheel. The LMC will try to fill any gaps in the framework documents if we can.

The CQC is currently gaining experience of primary care through their work registering dental practices, and although you may have seen press comment about this being problematic, remember that the dental

contract and its associated requirements have been more limited than ours. Indeed, private dentists who have no NHS contract have not been externally regulated in this way at all up to now. The CQC have told the GPC that their local compliance officers will be in a position to engage with LMCs and practices in May/June 2011 once the dentist's registration has finished and the compliance officers have had adequate training. The Commission will also be holding regional events across the UK in June-July 2011 at which they will explain the application for registration process. These events will be open to all GPs.

Although there are CQC registration toolkits being produced by commercial companies, the feedback the GPC have received on their draft toolkit has been positive – in particular it has been said that its suggestions should already be in place in most practices – and the LMC suggests that practices should wait for it to be released before spending money on a commercial one.

Although practices need to start thinking about this matter, you cannot apply for registration with the CQC until 1st October, and they will not be charging a fee or checking for compliance before 1 April 2012. Meantime, there will be a consultation on the annual fee for GP registration in the autumn. One LMC concern about this is that the CQC charge separately for all premises registered, which could make some branch surgeries non-viable, yet again disadvantaging rural communities.

For more information see:

cqc.org.uk/guidanceforprofessionals.cfm

QOF CHANGES FOR 2011-2012

The summary of the QOF indicators available on the BMA website has been updated to include more details about the Quality and Productivity indicators: [Link](#)

The GPC's 2010-2011 Annual Report

Is now available on the BMA website. They've had another busy year! [Link](#)

PHYSICAL HEALTH NEEDS OF PEOPLE WITH SEVERE MENTAL ILLNESS

Outcome of PCT Audit

Practices have been sent a copy of the final report of a clinical audit on the physical health needs of people with severe mental illness. The audit used practice QOF data to assess how well practices were meeting NICE guidance on patients with bipolar disorder and schizophrenia. The local results match the known national picture that this patient group suffers from health inequalities both in the identification and the management of physical health and lifestyle concerns such as diabetes, hypertension and smoking.

The QOF mental health indicators have been changed for 2011/12 to make explicit what was previously implicit with regard to the content of the annual health review for these patients. This should help to identify health problems, but there is often a risk of "diagnostic overshadowing", that is the patient's primary mental health diagnosis leads to other concerns being overlooked. These patients have a significantly reduced life expectancy, much of which is due to poor physical health arising from smoking, obesity, lack of exercise etc. They can and should benefit from appropriate interventions such as smoking cessation, statins and blood pressure management.

CHILDREN NEEDING BEHAVIOURAL OR EMOTIONAL SUPPORT

The Local Service Teams that used to provide "Tier 2" support for school age children have now been wound up as part of the local authority cost saving programme. If you have child with behavioral or emotional needs who does not meet the criteria for a CAMHS referral (taking into account level of need and combination of severity, context and duration).

you should refer via Somerset Direct, which can be done by email (childrens@somerset.gov.uk) or telephone (0845 345 9122). Please use the latter if it is urgent

SMALL ADS .. SMALL ADS.. SMALL ADS ..

SALARIED GP (MATERNITY COVER): PENN HILL SURGERY

Up to six sessions available from August 2011 in Penn Hill Surgery, an urban/ PMS/ EMIS 10500 patient practice in Yeovil. Applications or informal contact: Len Chapman, 01935 470816, len.chapman@pennhillsurgery.nhs.uk

by 13 May.

SALARIED GP (MATERNITY COVER): SOMERTON SURGERY

Up to six sessions available from June 2011 in Somerton Surgery, a rural/ PMS/ EMIS 5500 patient practice. Applications or informal contact: Len Chapman, 01935 470816, len.chapman@pennhillsurgery.nhs.uk

by 3 May

GP PARTNER: HENDFORD LODGE MEDICAL CENTRE

Details: Up to 8 sessions per week

Contact:

Richard More

Richard.More@hendfordlodgemc.nhs.uk

Or

Sian Brammer

Sian.Brammer@hendfordlodgemc.nhs.uk

NURSE PRACTITIONER: HENDFORD LODGE MEDICAL CENTRE

Details: Up to 10 sessions per week

Contact:

Nicola Hardwill

Nicola.Hardwill@hendfordlodgemc.nhs.uk

CHRONIC DISEASE PRACTICE NURSE HENFORD LODGE MEDICAL CENTRE

Details: Would consider part time or full time

Contact:

Nicola Hardwill

Nicola.Hardwill@hendfordlodgemc.nhs.uk

I.T & AUDIT LEAD WELLS HEALTH CENTRE

Details 37 hours a week, Circa £18k-£20k depending on experience

Contact: Tracey Holle – Practice Manager 01749 672137

Tracey.Holle@wellshc.nhs.uk

Pathology Collection Service

We have been asked to remind practices that there will be no courier collections on **Friday 29th April 2011.**

Dr Whimsy's Casebook: Caveat Emptor?

Last year I noticed a new disclaimer on my computer when I logged on:

The authors and reviewers have sought to provide accurate data and indices for this software. We accept no responsibility for errors or omissions. The clinical and decision support systems and the drug database are not diagnostic tools. Their use cannot replace clinical judgement. Logging into the software and using the information will be taken as your acceptance of this.

In other words, I am using my medical computer system at my (and my patients') peril, and if it loses a lab result or fails to merge vital information into an admission letter, it's my fault despite the maintenance costs and what their sales blurb promised. And surely they don't have to tell me to use 29 years of training and experience to judge what I look up? It's not as if I punch in "diarrhoea" and immediately treat the patient for diphyllbothriasis.

Nonetheless, if somebody can get damages for driving with a cup of hot coffee between their knees, perhaps I ought to cover myself. With this in mind I have stuck the following disclaimer on my door:

While every reasonable effort has been made to maintain good clinical practice, this doctor accepts no responsibility for errors or omissions, nor for the consequences thereof. The doctor works in an advisory capacity which does not obviate your duty to exercise autonomy, to employ common sense, and to acquire and enact personal health education. Any opinions expressed are solely those of this GP and do not necessarily represent those of the Practice or of the wider community of physicians. It is recommended that you consult an independent health adviser before making a decision to contact your doctor. All diagnoses are valid for 30 days: within that time faulty advice will be replaced by a second opinion only on production of a valid receipt. The doctor reserves the right to talk as if you have the IQ of a tapeworm, to refuse requests to 'get a letter from your GP' without payment of an iniquitous fee, and to change the subject unpredictably for the purpose of collecting Quality and Outcomes data. Patients are obliged not to bring more than five problems to a ten-minute consultation, to remove mountaineering gear, corsets and lice if they expect to be examined, and not to wait as far as possible from their GP's room if they have a mobility problem. If you are illiterate or unable to read this notice please tell a receptionist. Passing through this door is taken as your acceptance of these conditions. Blood pressure, lipid tonnage and 5-dehydroepiandrosterone can go down as well as up.

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

ADMINISTRATION OF MEDICINES TO CHILDREN IN NURSERIES AND SCHOOLS

National guidance on this perennial problem

The "Statutory Framework for the EYFS" (Early Years Foundation Stage) outlines the policy for administering medicines to children in nurseries: <http://nationalstrategies.standards.dcsf.gov.uk/node/151379>

"Managing medicines in schools and early year settings" sets out the framework for Local Authorities, PCTs and schools to use to ensure that children requiring medicines receive the support they need. This guidance contains information about Health Care Plans for such children, involving the parents and relevant health professionals.

www.education.gov.uk/publications/eOrderingDownload/Managing%20Medicines%20Nov%2007%20version.pdf