Somerset LMC Newsletter

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IS COMMISSIONING THE FUTURE FOR GENERAL PRACTICE?

Despite its radical proposals, the NHS White Paper seems to have generated remarkably little real opposition, and more of a nagging unease that the challenges may be too big to be met. Can the NHS really achieve the changes and simultaneously make substantial savings in the cost of care?

For general practice the greatest change is the shift from commissioning by managers with clinical support to commissioning by clinicians with management support. And there is no doubt that we would do things differently – GPs are used to running tight organisations and we are well aware of some current tasks that add no value to the care we deliver. The concern amongst managers is that GP commissioners will find it impossible to keep to budgets, but in fact doctors are much more likely to respond positively to cost-saving changes in practice proposed by colleagues than those imposed by managers. Clinicians are also more likely to understand that the causes of differences in, say, referral activity are complicated and that some variation in practice is not just acceptable, but positively to be encouraged.

Somerset is in a good position to tackle the new challenges and may well be asked to do so sooner rather than later, so it is wise to start thinking about these now. If GP practices are to be the core elements for commissioning, the first step must be to consider how to organise ourselves. The White Paper suggests commissioning groups of 100-160,000, but this does not fit well with local circumstances, geography, or the configuration of key partners. Social services, for instance, is a county wide structure with five localities, Somerset Community Health is also county wide but has eight localities, and Taunton & Somerset NHS Foundation Trust takes some 60% of admissions in the county from across a whole range of boundaries. The LMC also has deep concerns over the accuracy of the notional PBC budgets, partly because of data quality and partly because the methodology was never intended to be used for small populations. If these are taken as they are, parts of the county would show a large overspend that does not appear to be explained by disproportionate numbers of referrals, instantly destabilising any local consortium.

We have perhaps come to take for granted the remarkable success of Wyvern in introducing a suite of admission prevention schemes that have shown real benefit across the county. Establishing a new formal organisation at the same county level reduces structural costs to a minimum and offers formidable commissioning authority in dealing with providers, though at the same time we must be flexible and responsive to local needs across the very different localities and populations in the county.

The new Consortium or Consortia cannot be derived just from Wyvern, but the skills, knowledge and commitment of their Board and management will be indispensible to the new structure and must not be lost. So whilst it is too

soon to thinking about particular staff appointments – certainly until the budgets are known - we need to get on with drafting the map to get us from where we are to where we want to be. The LMC Study day on 23rd September is planned to be the start of that process.

Whilst the White Paper consultation may produce some policy adjustments, it seems unlikely that the central tenet of GP commissioning will change and given the complexity of the processes and the need for very close liaison with PCT commissioners during the transition, we believe it is right to start to make plans and looks forward to seeing as many practices as possible represented at the Study Day

DOCTOR, I WANT A SECOND OPINION….

The impression that a patient is automatically entitled to a second opinion if they are not happy with what the first doctor has said is widespread, and probably goes back to a ministerial comment during parliamentary debate in the early days of the NHS. In fact, there is no legal right for a patient to have a second opinion from the NHS, though in practice few GPs would deny an insistent patient an appointment with another doctor, whether that is with a specialist or another GP.

Enquiries of the PCT suggest that they have no formal policy on this, so our thanks to Jenny Fletcher for doing some research across the wider NHS.

The GMS contract (clauses 47.1 to 48.2) includes a general obligation in the management of patients that includes "the making available of such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services under the Act and liaison with other health care professionals involved in the patient's treatment and care". "Necessary and appropriate" are the key words here.

The NHS choices website states that although patients do not have a legal right to have a second opinion, they have the right to ask for one. "A healthcare professional will rarely refuse to refer a patient for one unless there is sufficient reason."

http://www.nhs.uk/chq/Pages/910.aspx?CategoryID=68&SubCategoryID=156

The Citizens Advice Bureau website states – "You can ask your GP to arrange a second opinion either from a specialist or another GP. However, the GP does not have to do this if they do not think it necessary. You have no right to a second opinion. If a GP is unsure about a diagnosis, they could be found negligent if they failed to refer you to a specialist and you suffered as a result of this. If you have not been referred for a second opinion and have suffered as a consequence, you may wish to complain."

http://www.adviceguide.org.uk/index/your_family/health/nhs_patients_rights.htm (relevant section is under treatment from a GP.)

BMA guidance for consultants states that general guidelines are available from the BMA ethics department. When the Patient's Charter was in existence, it made clear that within the NHS referral for a further opinion was dependent upon agreement between patient and doctor. However, although it is generally acknowledged that patients do not have an automatic right to a further opinion, doctors should always respect a patient's wish to obtain one unless there are justifiable reasons for refusal (e.g. it is perceived that the patient might come to harm as a result). http://www.bma.org.uk/ethics/doctor_relationships/SecondOpinion.jsp

Yet every so often a patient comes along who remains dissatisfied with a second, or even third, opinion, and almost always the reasons for this are more to do with his or her personal, social or psychological circumstances rather than their physical condition. This does make the problem hard to manage appropriately, and sometimes the GP feels obliged to carry on making referrals, even though this reinforces the patient's perception that the problem is a physical one, and is therefore counterproductive.

One option is a referral to the PCT Exceptional Treatment Committee which may certainly be valuable as this offers a level of authority and decision weight that should help ensure NHS resources are used appropriately. But is in some ways this is just a blocking move. It can be better instead to organise a formal MDT meeting with the patient and as many involved professionals as possible – whilst this may seem very time consuming, it may nip a problem in the bud and help the everyone to find a better way forward.

2 WEEK CANCER WAIT REFERRAL FORMS

Cancer Services at TST report that quite a lot of referrals are still being made using out of date forms. They keep a full suite of current forms at http://www.tsft.nhs.uk/OurServices/OncologyDepartment/InfoforGPs/tabid/1758/Default.aspx so it may be easier just to pull one off from there when making a referral rather than trying to keep lots of electronic or paper copies in the practice. They also make a special plea that both home and mobile numbers of patients are given as they often have to ring rather than write to patients to arrange appointments.

As the number of referral forms continues to grow, the LMC is asking the commissioners to consider having a central database for all forms that are specified in their contracts with providers, both so that the most up to date version is always available, and also so providers cannot introduce unnecessary forms without proper consultation.

CHANGE IN OCCUPATIONAL HEALTH SERVICES FOR GPS AND PRACTICES

We have been informed that T&S have served notice on the PCT that the Occupational Health service they provide for other NHS organisations will cease on 31 Dec 2010. The PCT have decided that they will now provide an 'in-house' OHS which will be managed by Somerset Community Health. The new service will continue to be available to General Practices and formal communications about how it will run will be circulated in due course. In the meantime all the usual services are available via T&S until the end of the year.

TIME LIMITS FOR REGISTRATION OF A DEATH

The Registration Service have a statutory time limit for registering deaths of 5 calendar days from date of death if registering from a normal Medical Certificate of the Cause of Death, or 14 days if registering from a post mortem. Normally GPs issue certificates as soon as possible after a death, but relatives are sometimes slow in making an appointment to see the registrar. The service are therefore currently not meeting their Key Performance Indicator in this area, so the County Registrar has asked if GPs can encourage relatives to register deaths promptly on collecting the certificate from the practice. **Please can you also remember to put your GMC number next to your signature on the certificate** as the service now has to check that the signatory is properly registered with the GMC.

NHS TREATMENT OF NON-UK RESIDENTS

Recent Adjustments to the eligibility rules

Most of us now know that eligibility for NHS treatment depends on residence not nationality. Any person who is normally resident in the UK is entitled to register with a practice as an NHS patient. Recent draft guidance from the DH on charging overseas visitors has slightly clarified the position on the treatment of non-residents. A GP practice has the discretion to register anyone, regardless of their residency status, as a full or temporary NHS patient for primary care purposes. There is no minimum period that the person needs to have been in the UK. However, if the person is **not** automatically eligible by reason of residency **and** the reason for refusing registration is not discriminatory, then the practice can offer to treat him or her on a private basis. Emergency or immediately necessary treatment **cannot** be charged for.

Registration with a GP and/or possession of an NHS number does not automatically confer the right to free hospital treatment. GPs should refer patients for secondary care if necessary, and it is then up to the hospital provider to determine whether their care is chargeable. It is helpful to indicate in the referral letter if you believe that the patient may not be eligible for secondary care.

Reciprocal arrangements (including those from the EEA countries) no longer apply in primary care as they are no longer needed.

SMALL ADS .. SMALL ADS.. SMALL ADS

SALARIED GP– SOMERSET BRIDGE MC BRIDGWATER
Details: Up to 8 Sessions a week
Contact: Kathy Bartley or the partners for an informal chat on 01278 454562 or e mail for an application pack
Kathy.bartley@redgatemedicalcentre.nhs.uk
Closing Date Friday 15th October 2010

PRACTICE MANAGER– WESTLAKE SURGERY WEST COKER
Details: 25 hours a week Circa £28000 pro rata
Contact: Jenny Shepperd 01935 862212
jenny.shepperd@westlakesurgery.nhs.uk

SALARIED GP-BECKINGTON PRACTICE
Details: 2 Sessions per week from mid-October 2010 preferably Mon and Tues mornings
Contact: Robert Slade-Practice Manager 01373 – 867989
robert.slade@beckingtonfamilypractice.nhs.uk

SALARIED GP-HIGHBRIDGE MC
Details:4-6 Sessions a week on a fixed term initial 6 month contract.
Contact: Joanne Farnworth 01278 764230
Joanne.farnworth@highbridgemc.nhs.uk

Dr Whimsy's Casebook

Explaining the Drug Tariff

Dr Whimsy is on the phone...

GP: Hello, Mrs Stencil, it's Dr Whimsy, returning your call. What can I do for you?

Mrs S: Now listen here, doctor. Do you remember when I asked you for Beconase and you told me you'd only prescribe generic becometalzone because I'd get the same medicine but it would save the NHS money?

GP: Vividly.

Mrs S: Well, I just got a letter with my prescription saying you've changed it back to Beconase, so I want to know why I couldn't have Beconase in the first place.

GP: I'm so glad you've taken the time to call me about this, Mrs Stencil, and let me see if I can explain. Every now and then the Department of Health negotiates with the drug companies to set a price list, and at one of their meetings they agreed to make Beconase cheaper than generic beclometasone, so now it makes sense to prescribe branded Beconase.

Mrs S: Right - so despite what you said, generics aren't cheaper than branded drugs.

GP: Well, not all of them nowadays.

Mrs S: And that's why you switched my husband to Epanutin capsules when he was perfectly happy with his phenytoin tablets?

GP: Yes, the generic became nearly forty times more expensive.

Mrs S: Good Heavens! And at their next meeting I suppose these people could change it all back and you'll be fiddling with our prescriptions again.

GP: More than likely, but one of a modern GP's jobs is to make sure that we prescribe cost-effectively, and the NHS have people who keep us up to date with the price list, and they frequently tell us what we should prescribe to save money.

Mrs S: So every time they do this you have to change the prescription on your computer for everybody who's taking it, then write to tell us why you're messing us about.

GP: Well, we have staff to help us with repeat prescriptions, but it's often difficult to remember every time we do a one-off prescription. We also have to bear in mind that sometimes a small quantity can cost more than a larger quantity – for instance, your Beconase is twice as costly in the 180-dose form as in the 200-dose form.

Mrs S: Sounds like it's not just *me* who's confused. But let me see if I've got this straight: the government pays one lot of civil servants to fix prices with the drug companies, then they pay another lot to find out what the first lot have been doing so they can tell you how to get around their price list, then you have to spend your time and pay your staff to save the government some of the money they spent doing all this.

GP: That's it in a nutshell, I suppose.

Mrs S: It's nuts all right, but it's clever how they make you take the blame *and* pay for it. I mean, apart from the confusion and irritation to patients like me, isn't this a waste of your time and skill? After all, you're a doctor, aren't you?

GP: You might very well think that, Mrs Stencil, but I couldn't possibly comment.

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

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