# Somerset LMC Newsletter

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## HEALTHCARE IN CHINA

Although the assumed benefit of travel is to broaden the mind, it is also valuable in reminding the traveller of what is good about home. It is easy to be critical of the NHS, especially from the inside, but the privilege of having a service that is free at the point of delivery is enormous. Whatever limits we may have to apply to it, or co-payment schemes we have to adopt, the fact that medical care imposes no direct financial burden on the patient is something very precious indeed. Two weeks travelling in China and seeking something of their healthcare system brought into sharp focus the differences between the mature and state funded service of the capitalist UK and the rapidly changing but now fee charging system in the People's Republic. Although healthcare in China is cheap, wages are low and the labyrinthine system of reimbursements based on age, employment, rurality and the contribution of the commune rarely covers the full cost. Emergency care is free, but charges are progressively levied after the first few days and for some these are unaffordable – hence the sight of a man with sophisticated external fixators on his fractured lower leg begging in the street: presumably a migrant worker far from his home commune (who only pay local health costs) who was obviously unable to work to pay his bills.

Chinese health care, like the rest of the country, is undergoing change at a phenomenal rate. Everywhere we went the old Soviet era hospitals are being razed to make way for 21st Century buildings and sophisticated imaging like CT is available almost universally. There is no primary care, and patients turn up in outpatients and choose the doctor they would like to see from a long list on the board – rationed by price and availability of appointments. There is usually a nurse who can triage them in to the right specialty, and nowhere we went seemed unduly busy - the doctor typically sees 30 patients a day. Medical salaries are modest, but they are supplemented by bonuses determined by how well the hospital is doing, and taxation and basic living costs are low.

Clinical practice is rather different to ours. About 40% of care uses Traditional Chinese Medicine (TCM) which is based on acupuncture, *Tui-na* massage therapy (which cured my cervical root pain!) and remedies made by boiling various herbs, minerals and animal products and drinking the decoction. Rather like homeopathy, TCM treatment is based on patients and their symptoms, not scientific diagnoses, and interestingly TCM is often preferred by pregnant women and parents for their small children. Antibiotics are rather freely used for febrile illnesses, many of which we would diagnose as viral, and there is a preference for giving them intravenously. Indeed, we saw a doctor in a gynae clinic quietly writing up a patient record with an IVI running into her own arm! Chinese patients do seem to be just as stoic as their historical reputation suggests.

There is much that we can learn from Chinese experience. First, the refreshing ability of a community to rebuild its hospital without the paralysing bureaucracy of public administration – they just knock down

the old building and put up a new one. There is also an admirable level of integration between health and social care: although the model of care is rather medical, low wage costs mean that there are always enough members of staff available. But perhaps most important is the recognition that scientific medicine does not have all the solutions to patients' distress and that the art and craft of empirical practice has much to offer.

A visit to China is fascinating and rewarding but do go now, whilst there is still something of Imperial and Maoist China left to see apart from the tourist sights. Especially if you are interested in healthcare the trip we made with the legendary Harry Field and Zhang Zhong Jiu of Mastertravel offers the inquisitive if not highly intrepid traveller a perfectly balanced itinerary in excellent company.

## REFERRAL FOR IRON INFUSIONS AT TST

Taunton referring GPs who have patients who need parenteral iron therapy can now refer patients directly to Alison Western, Transfusion Practitioner. She has a monthly clinic in which patients can be seen and usually then proceed to treatment the same day. The referral form can be found on the TST Intranet: See Transfusion (under Pathology ) and click on "alternatives to blood transfusion".

http://intranet.tsft.nhs.uk/pathology/BloodTransfusionMPH/AlternativestoBloodTransfusion/tabid/5375/language/en-GB/Default.aspx

## LMC POSITION ON PRACTICE LEVEL BUDGETS FOR PBC/GP COMMISSIONING

The current notional practice PBC budgets are expected to evolve into real Commissioning budgets no later than April 2013. However, they should for the present be seen as a means rather than an end in themselves and considerable further work is needed before they become fit for purpose. In the meantime the LMC position is as follows:

- The methodology for calculating PBC/ Commissioning budgets is incomplete, and we do not yet have an accurate way of reducing them to practice level.
- The "fair shares" budget appears to be the "least bad" of the current options for allocating money at a high level. Wyvern, the PCT & the LMC have looked at using various funding models for prescribing budgets, and interestingly the numbers come out broadly the same whichever of the formulae is applied. However, this may not be true for hospital activity budgets.
- There are variations between localities and within localities in activity costs leading to quite wide differences in nominal practice in spend against budget. Some can be explained - eg proximity to a DGH – but others are not yet understood. Before accepting any model we need to distinguish appropriate variation from that caused by *excessive* subjective variation in referral rates between clinicians.
- Applying additional local factors to the raw fair shares budget may later lead to significant shifts in funding. For example, the percentage of private secondary care referrals varies widely between practices and should be considered. Similarly the impact of training doctors on referrals should be taken into account. Practices should therefore not assume that their notional budget will translate into a real one without further correction, and a current apparent underspend may disappear when the methodology is more accurate.
- Where variation is due to subjective differences in referral threshold, the reasons for this need to be explored. Practices may need to establish systems to bring their activity closer to the presumed best level. This is a hard task – it will take time and may need resources from commissioners.
- Financial risk management should therefore continue to be done at county level in the short to medium term. The risk contingency will need to be sufficient to prevent instability, so most practices are likely to face downward pressure on referrals.

## HEALTHCARE NEEDS OF ARMED SERVICES VETERANS

November 11th is a poignant reminder of many different struggles and the past endeavours of our soldiers, sailors and airmen. Unfortunately we also need to remember recent and current conflicts - 79% of veterans now accessing NHS care are under the age of 45. A poll last year found that some GPs were reluctant to raise the subject of whether their patients were veterans and others expressed confusion about how best to navigate the health system on behalf of their veteran patients. Helpful guidance has now been published at www.rcgp.org.uk/PDF/Veterans-Sep2010_Online.pdf

***Identifying Veterans***

On leaving the Services veterans are given a personal copy of their summary medical record together with information on how their new GP can obtain their full Service medical card if needed. The DH and the MoD are currently working on a new scheme to directly register service leavers and transfer their medical records to their NHS GP. Reservists remain the responsibility of the NHS (and their GP) until they are mobilised – at which point they transfer to the Defence Medical Services. On return from operations they revert to the NHS, but have access to military-related health and mental health support.

***Priority Treatment***

In 2008, the War Pensioners' entitlement to priority treatment in the NHS was extended to include all veterans. This means that for conditions related to military service, the DH directs that veterans at their first outpatient appointment would be 'scheduled for treatment quicker than other patients of similar clinical priority'. You should therefore include this information in your referral letter.

***Mental Health***

Combat Stress (www.combatstress.org.uk/) is the leading military charity specialising in the care of Veterans' mental health. On average, the Veterans who seek help come to light 14 years after Service discharge. Too often this delay can lead to marriage break-up, unemployment, social isolation, and substance misuse – in short, a total unravelling of a normal life. Post-traumatic stress disorder (PTSD) can occur in a small minority of veterans. Reservists can access mental health support through the Reservists Mental Health Programme. Combat Stress have a group in Somerset.

***Post Conflict Syndromes***

Extensive observational research carried out after the First Gulf War found that Service personnel after the conflict reported a variety of legacy health (chronic fatigue, headaches and various other non-specific symptoms). However, it has so far proven difficult in large, well-conducted studies to demonstrate that specific factors such as depleted uranium or vaccination schedules are a cause of such ill health.

*Thanks to the Royal British Legion for the text of this article*

## RETROSPECTIVE PRESCRIPTION REQUESTS

The PCT and the LMC are still getting reports of appliance contractors either asking for retrospective prescriptions or supplying appliances before they have the prescription. This is not allowed under the Pharmaceutical Regulations unless requested by the prescriber as an emergency supply. If you get any such requests please can you report them to your locality medicines manager who will write to the company concerned reminding them of the regulations. So far the record is five issues to the same patient without a prescription! One of the benefits of the NHS repeat dispensing service to GP practices is the potential benefit on ordering and waste. Under a revision to the Regulations coming into force on 31st December appliances provided by a pharmacy or appliance contractors are included in the paragraph

*"**When providing drugs** to patients in accordance with **a repeatable prescription**, provide appropriate advice in particular on the importance of only requesting those items which they actually need; and destroy any surplus batches which are not required or where he has been informed by the repeatable prescriber that the prescription is no longer required."*

For appliances the supplier should also be checking records to ensure prescribing patterns do not indicate excessive requesting.

## SHOULD WE TREAT OLD AGE WITH STATINS?

There is an interesting dilemma for GPs as to whether we should be giving every patient over the age of 75 a statin. Statistically, of course, we should. Simply by virtue of their age everyone of 75 has a more than 20% ten years risk of having a vascular event, and according to NICE should therefore be offered 40mg simvasatin indefinitely. Yet many GPs baulk at taking this rather counter -intuitive approach: giving medication to patients with no known disease indication is rather alien to traditional practice.

But the Utilitarian argument is strong. We now treat 2,400 more patients in Somerset with a statin than we did last year, statistically preventing 12 strokes or heart attacks at a drug acquisition cost of £12,000. At £1000 per event that is outstandingly good value, and far more cost effective than most of what we do. For example, as a county we spend twice our total statin costs on treatments for COPD for which there is no mortality evidence.

The Libertarian will, of course, ask what the benefit will be for the individual patient offered the treatment, and will want to consider the whole cost of the treatment from the reported loss of well being some patients attribute to statins to the total price of providing it, including GP time, lab costs, prescribing costs and so on. The NNT for primary prevention is about 200, so even after 10 years treatment each patient has only a 5% personal likelihood of obtaining benefit – unless, of course, he or she has other risk factors like diabetes or peripheral vascular disease.

The best answer would seem to be to discuss the question with older patients as and when you see them, although some practices have sent out a standard letter with useful results. Although this is technically not within the GMS contract there is a growing body of evidence that statins are at least as effective in older patients, and preventing just a couple of events would certainly lead to PBC savings. There is also the suggestion that statins may reduce the incidence of dementia which is something patients are often interested to hear.

## NOROVIRUS PREVENTION

To try and avoid a repetition of problems hospital trusts had last year with Norovirus, Infection Control are mounting a publicity campaign to make patients more aware of the problem and how to prevent spread of the virus this winter, especially in health and social care settings. Information is going to Care Home Managers, District Nursing Teams, Head Teachers and School Nurses to raise awareness of this infection and the implications for institutions of an outbreak.
Leaflets and posters will be distributed to practices as soon as they are printed, and Norovirus restrictions on admissions will be posted daily on the NHS Somerset intranet in the event of any outbreaks in the county.

nww.somerset.nhs.uk/welcome/directorates/nursing-and-patient-safety/who-we-are-what-we-do/infection-control/norovirus-current-restrictions/

## BEWARE RELEASING COPIES OF NOTES CONTAINING MISFILED INFORMATION!

*Useful advice from Derbyshire LMC*

We all know that occasionally things get misfiled in patients' notes, particularly letters, reports and results that have to be scanned in. Sometimes items are scanned into the wrong patient's notes. This creates a problem if the record subsequently released whether to a new practice, the patient, a solicitor, or any other party. If you respond to a request for copies of records under the Data Protection Act but accidently send them with a misfiled letter relating to another patient you are in breach of the Act by releasing confidential health information about the patient whose letter has been misfiled. We urge all practices who do not have one to draw up and implement a protocol for checking that misfiled items are not included when a patient's record is sent away from the practice.

## WYVERN HEALTH ANNUAL GENERAL MEETING

We have been asked to remind practices that the Wyvern Health AGM will take place on WEDNESDAY 17TH November 6.15 PM at Taunton Racecourse.

http://www.wyvernhealth.com/Documents/newsletters/AGMAgenda.pdf

## SALARIED GP CONTRACTS

The LMC has had some worrying reports that some practices may be offering salaried doctors employments contracts that are significantly worse than the BMA Standard Contract. You will be aware that it is a contract requirement for GMS practices to offer salaried GPs terms and conditions at least as good as those in the standard contract and it is not acceptable simply to state that any variation is done with the consent of the doctor as this could be deemed to be coercive.

Whilst salaried GPs form an essential part of the primary care workforce, the LMC believes that for most practices the modest extra cost of appointing a partner is far outweighed by the long term benefits of having a colleague with a full and long term commitment to the practice, as well as helping us to maintain the independence of the profession – though, of course, practices will need to take accountancy and other advice in their particular circumstances,

The LMC is planning a survey of salaried GPs but if as a salaried doctor you have concerns now you can contact the non-principal representative on the committee, Dr Theresa Foxton in absolute confidence (tmfoxton@doctors.org.uk).

## CLOPIDOGREL AFTER CORONARY ARTERY STENTING

Just a reminder that it is *essential* for patients to continue clopidogrel for the recommended duration after stent insertion to prevent instent thrombosis: the risk rises sharply 5-6 days after stopping as the medication wears off. It is often helpful to write a completion date in the "instruction" field of your prescription, and to ensure that enough repeats are authorised at the outset to reach that date. If you think a patient is reacting badly to clopidogrel you should contact the cardiologist as soon as possible for advice on whether to continue or consider an alternative such as prasugel.

## SMALL ADS .. SMALL ADS.. SMALL ADS

### FULL TIME/PART TIME PARTNERSHIP – WEST SOMERSET HEALTHCARE, WILLITON

**Contact:** Alison Foulkes, Practice Manager on 01984 632701 or Alison.foulkes@willitonsurgery.nhs.uk.

### SALARIED GP – WEST SOMERSET HEALTHCARE, WILLITON

**Details:** 4 sessions per week for period of 4 months.
**Contact:** Alison Foulkes, Practice Manager on 01984 632701 or Alison.foulkes@willitonsurgery.nhs.uk
Closing date 19.11.10

### SESSIONAL SURGEON/GP – EAST QUAY MEDICAL CENTRE, BRIDGWATER

**Details:** 2 sessions per week working on a self employed basis.
**Contact:** Rachel Stark on 01278 440400.

### SALARIED GP – SAMPFORD PEVERELL SURGERY, TIVERTON

**Details:** 2-6 sessions per week (job share considered). Jan/Feb start date.
**Contact:** Pam Wreford, Practice Manager on 01884 820304 or pam.wreford@nhs.net.
Closing date 30.11.10

### SALARIED GP (MATERNITY COVER) – PENN HILL SURGERY

**Details:** 2-4 sessions available from February 2011.
**Contact:** Len Chapman, Practice Manager on 01935 470816 or len.chapman@pennhillsurgery.nhs.uk.
Closing date 3.12.10

### PRACTICE MANAGER – LYNGFORD PARK SURGERY, TAUNTON

**Details:** Due to retirement. Part time and job share considered. Salary 30-40k.
**Contact:** Jane Evans, Practice Manager 01823 327394 or jane.evans@lyngfordparksurgery.nhs.uk.

### COUNTY MEDICAL OFFICER—ST JOHN AMBULANCE, BRIDGWATER HQ

**Details:** Doctor with 5 years experience required to take the clinical lead and coordinating the Medical Team in Somerset.

### ASSISTANT COUNTY MEDICAL OFFICER—ST JOHN AMBULANCE, BRIDGWATER HQ

**Details:** Doctor required to monitor health and fitness of members. Experience of Occupational Health required.
Both posts are voluntary with expenses covered. Based mainly at the new Bridgwater HQ but some travel within the county will be required.
**Contact:** Mrs Julie Hope, Commissioner SJA Somerset, St John House, Woodlands Court Business Park, Bristol Rd, Bridgwater TA6 4FJ 01278 726744 or Julie.hope@somerset.sja.org.uk

**TXT FROM THE URBAN DOCTOR**

Do you have trouble understanding the QIPP agenda? Do you only know it as a witty quibble or a fashionable leather bedroom accessory? If so then let me explain.

QIPP is the answer to all our problems in the NHS. It is the 5 year more-for-less plan and it will follow sweeping reform of the NHS itself. The Government has realised that we are many years behind our neighbours and that we need reform on an industrial scale in order to catch up. They appreciate that this is the 13th five year plan that has been introduced to bring about improvement and productivity, but this really is the one: we are now to copy the world's most successful industrial economy.

Firstly, all existing political structures within the NHS shall be summarily removed and replaced by the Central Committee. The Health Secretary shall become known as the General Secretary. All PCTs, and SHAs shall be removed in a Great Purge. The intellectual elite within Primary Care shall be collectivised into Consortia who will deliver the QIPP agenda. The entire process will be monitored by an internal police unit with wide-ranging powers known as the CQC.

The QIPP plan will drive up productivity within the NHS by the closure of A&E units and other hospital services. This will save money and improve patient care by aggregating secondary care into larger collectives. Production surpluses will be brought back into the central state and accountability for governance will be held by Consortia answerable to the Secretariat.

**Case Study**

Musgrove Park Hospital in Taunton is changing its voice recognition switchboard to facilitate savings within the hospital.

The new recording states "Good evening. Thank you for calling Musgrove Park Hospital Taunton. Please tell me the name of the ward, or department or person you wish to have discontinued in the next financial year".

This innovative approach allows citizens a real voice in changing frontline services and has lead to the award of Beacon status and will be replicated throughout the country.

The QIPP plan will also release further millions by the increasing the functionality of the Federations. Too long have the Central Committee been aware of the unnecessary workload shifts from primary care to secondary care engendered by the autonomy of the intellectual elite. The introduction of new controls at the point of referral shall improve patient care and empower the cadres within primary care.

**Case Study**

Each member of the intellectual elite within Somerset has been given an OP referral budget. The Referral Management Centre has now taken out a partnership contract with a top national credit agency. All referrals received through choose and book will first go through a credit check with the agency. Any comrade with a poor credit rating on their referral budget will be re-educated when the patient is returned to them for on-going care.

This innovative pathway design will free up significant resources for the Central Committee and once more make those who work with patients on a daily basis feel in control of their own destiny and workload.

It is easy to feel disempowered in an organisation of 1.4 million comrades, but with your help we can prepare for a more constrained economic future to provide quality care for our patients based on the two core principles of a wing and a prayer.

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



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