Somerset LMC Newsletter

February 2014

Issue 188

Inside this issue:

NO PATIENTS SHOULD BE MORE EQUAL THAN OTHERS

As we have said before, the LMC has no party political allegiance, and although different members have, over the years, made no secret of their personal and opposing leanings, it would be fair to say that we distrust all governments and Secretaries of State for Health pretty well equally. In recent years Conservative, Labour ("New" or otherwise) and Coalition administrations have all introduced policies which we believe to have been bad for general practice and bad for our patients.

So, at a time when this Newsletter should be leading on developments in our nationally unique pilot proposals for an optional alternative to the Quality and Outcomes Framework as a tool for improving the quality, sustainability and integration of primary healthcare, it takes something pretty extreme for us to use these columns to exhort readers to take a stand against a general health policy rather than a concrete contract proposal.

Over a few days in the middle of February reports appeared in the media - including The Times, The Guardian, The ITV News website and the Health Service Journal – that NICE had rejected a Government plan that "wider societal benefit" should be taken into account when deciding whether to approve a treatment for NHS use. In other words, the usual £20,000 per Quality Adjusted Life Year that NICE uses as its cost approval indicator could be adjusted if there were likely to be non-health benefits, such as returning productive individuals to the work force. At first glance, this seems perfectly reasonable and soundly Utilitarian, but take a moment to consider the implications. The obvious beneficiaries of this policy will be middle-aged men because they earn the most and will presumably therefore be deemed to be the most productive. But if a middle aged man and his wife have agreed that he will work and she will be the home-maker, how is her productivity calculated? And what happens when someone reaches 65 or 70? Will he or she simply be denied a more expensive treatment on the grounds of age - Ministers apparently say not, but how else will it work - even though they may have many years of economically productive life ahead of them? What about the chronic sick? Or young disabled people? Do we just throw away the founding NHS principle of equal access to health care, now embodied in the NHS Constitution? Indeed, the front cover of the Constitution states boldly "The NHS Belongs to Us All". But, if the Department of Health has its way, not to us all equally.

So where has this ill-conceived and unworkable idea come from? Just *who* is suggesting that the provision healthcare should essentially be to be reduced to a productivity analysis? Although the policy of both the major parties has for years involved chipping away at the NHS as the provider of all public health care, but never before has there been such a blatant and apparently casual move away from the established consensus that equal access to health care is a given policy for all mainstream parties in the UK.

The LMC is preparing a motion to the Annual Conference of LMCs calling on the GPC to oppose this seriously flawed policy.

PRESENTATION OF CHILDREN WITH TYPE 1 DIABETES – DO YOU KNOW THE "FOUR TS"?

The incidence of Type 1 Diabetes in children is rising, especially in the under fives, yet more than one in four will present in diabetic ketoacidosis, some of whom will be extremely sick. Still some will die. There is evidence that there will have been an average of three recent presentations to GPs before the diagnostic penny drops. For this reason Diabetes UK has launched a campaign for more prompt diagnosis – the "Four Ts"

TOILET: Constantly going to the lavatory, new bedwetting, very heavy nappies in babies and toddlers.
THIRSTY: Always demanding *and drinking* the drinks.
TIRED: Lacking stamina, complaining of tiredness.
THINNER: Clothes won't stay up, looking gaunt.
Parents who spot these will be directed to the GP and will expect, correctly, to at least have a fingerprick blood sugar done. The interpretation of this may be clear if >11 but the result may be equivocal, and this test does not on its own give a complete diagnosis. **All children with a raised capillary BS should be referred directly to Paediatric secondary care the same day**. If the capillary blood sugar is only a little raised you may wish to discuss the matter on the phone with a paediatrician first, but you should do so promptly and not delay . Any hint of Diabetic Ketoacidosis is a medical emergency and requires instant emergency admission. Remember, abdominal pain in these circumstances suggests DKA is imminent.

Further information from Dr Tamsyn Nicole (YDH) Dr Geeta Mogdil (MPH) or the Paediatric Diabetes Nurse Specialists on 01 935 384694 or 01 823 343666. There is also a Somerset-wide protocol and a "Diagnosing Children" Pathway on the Diabetes UK website.

TELEPHONE ACCESS TO ACUTE MEDICINE CONSULTANT ON DUTY AT TST

Could a phone call avoid an admission?
Please may we remind you that the Acute Medicine (MAU) consultant on duty at MPH is available by phone (contact via switchboard) between 08.00 and 22.00 daily if you are unsure about an admission and would like advice or to discuss alternatives. If possible, please do not call first or last thing (these are handover times) but it would still be better to call rather than send in a patient if you think there may be other ways of managing the problem. There is also an SpR on call 24 hours.

WHAT SHOULD YOU DO IF YOU INADVERTENTLY VACCINATE A PREGNANT WOMAN WITH THE MMR VACCINE?

Useful advice from a recent Vaccine Update
There are no known adverse events resulting from vaccination with MMR vaccine during pregnancy or shortly before becoming pregnant. The vaccine is not recommended in pregnancy as a matter of caution and any woman who receives the vaccine in these circumstances should be advised that there are no safety concerns, either for the mother or the baby. Women who have been immunised with MMR vaccine in pregnancy can therefore be immediately reassured. Public Health England does follow up all such exposures so a Vaccine in Pregnancy (VIP) form should be completed.
http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/VaccineInPregnancySurveillance/

LABIAPLASTY AND CHILD PROTECTION

The TV programme " Embarrassing Bodies" has heightened awareness of 'enlarged labia'. The Independent Funding Review Panel has since received requests for 'labiaplasty' for girls under 18, some as young as 13. Some requests have been supported by both mother and GP , and have been seen in Secondary Care.

It is very unusual for perceived large labia to be a medical problem. There is an important question of informed consent – and safeguarding - in a minor if surgery is considered. There are natural stages of pubertal change in the genitalia, which may not be complete until late teens - so it will be the norm for funding for under 18s to be refused by the CCG. However if there really does seem to be a medical concern , girls must be referred to a paediatrician in the first instance to obtain a holistic review of the child and her needs.

The IFRP terms are clear that labiaplasty is not a commissioned service and will only be considered in exceptional cases such as trauma. Beware being pulled into collusion with a patient over such physical concerns –presenting with this "problem" may suggest unfulfilled emotional or psychological needs or incomplete psychological development in the child, which should ring alarm bells for the GP. Be very clear that this is potentially a safeguarding matter. See: http://www.rcog.org.uk/news/joint-rcog-and-britspag-release-issues-surrounding-women-and-girls-undergoing-female-genital-co

Dr Tamsyn Nicole (Designated Doctor for Safeguarding Children) and Dr Andrew Tresidder.

CONSIDERATIONS FOR GP PRACTICES WHEN RENTING ROOMS TO A THIRD PARTY

Important Changes to the Premises Directions

Paragraph 49, which included the table regarding private income percentages, was removed from the National Health Services (General Medical Services Premises Costs) Directions 2013 revision and this means that there is now no prescribed amount of private income to the practice (e.g. Cremation forms, PMA reports, medico-legal reports and occupational health medicals) that could trigger an abatement of premises costs by the Area Team (AT). We anticipate, however, that if the AT were to become aware that a practice was using its reimbursed premises to make significant private income they would wish to discuss the matter. But if you lease or sublet to a third party any part of the practice premises that are covered by a cost or notional rent arrangement with the AT, then they are entitled to reduce the rent payments:

"*Abatements in respect of contributions towards recurring premises costs from third parties:*

48. Where a contractor's practice premises, or any part thereof, are or form part of the premises that are owned or rented by any person other than the contractor, and that person -

(a) is required by any agreement (which includes a licence or a lease) to make or makes any contribution towards any recurring premises costs in respect of which the Board is providing financial assistance to the contractor in accordance with this Part; or

(b) is by any agreement (which includes a licence or a lease) to pay or pays the contractor any amount -

(i) by way of rent in respect of the practice premises or any part thereof, or

(ii) in respect of the running costs of the practice premises,

the Board must set off that contribution or that amount, equitably, against the payments made to the contractor pursuant to this Part."

The calculation will be based on the space used by the third party provider, which will determine the amount of rent and service charges they pay. This has been introduced to stop practices receiving double payments from both the NHS and third parties for premises space. NHS England will only pay for space used for NHS purposes, but each case should be looked at carefully to ensure that the abatement is reasonable and equitable. Please contact the LMC office if you would like advice in such a situation.

However, if space is being exclusively used by the NHS extended primary care team, e.g. community nurses, the LMC would not expect the practice to receive a rent abatement unless the community provider was paying rent to the practice. Otherwise, it is the GPC's view that it would be reasonable to expect the commissioners of the community nurse service, i.e. the CCG, to pay the premises costs element of the contract direct to the Area Team, who can then use this funding as part of practices reimbursement payment. Alternatively, the provider could pay the AT directly, do note that practices can still charge occupants for the services they receive including heating & lighting, cleaning, receptionist time, use of facilities, and so on.

Our thanks to Derbyshire LMC for the main content in this article.

INCREASING BENEFITS FROM THE SCR

Now proving a real help for Secondary Care

Now that over 2/3 of Somerset patients have an SCR we have been getting some very encouraging feedback from local Trusts about how valuable clinical staff are finding the information. The TST Head of Clinical Systems Management said "all of the staff that I talk to who have got access to it, find it invaluable and would not want to go back to working without it, especially in ED and POAC." TST also believe that they are having to ring practices for prescription information far less than before. Currently there are 462 TST staff authorised to view the SCR (primarily in A&E, POAC and medical specialties) , including 79 consultants, 62 Associate Specialists, 180 specialist registrars, 97 nurses and 18 pharmacy staff.

INTERESTED IN HEALTH SCREENING PROGRAMMES?

If you have ever wondered why some screening makes it to become a national programme and other suggestions do not? Or do you want to find out how the national schemes are really doing? If so there is a huge amount of information available via the National Screening Portal. They publish regular newsletters which are a good place to start http://www.screening.nhs.uk/screeningmatters-issue16

SMALL ADS…. SMALL ADS…. SMALL ADS….

For current practice vacancies please see the adverts on our website at:

http://www.somersetlmc.co.uk/classified.php

Dr Whimsy's Casebook: Pharmaceutical Company Promotions

Dr Whimsy doesn't normally see drug reps, but it's two o'clock, he's exhausted and hungry at the end of a long morning surgery, and the Banoffee rep, Paul Tutherlegg, has turned up with a sandwich. Dr Whimsy is only human...

PT: Hello Dr Whimsy, thanks for seeing me. Here's your sandwich...

Dr W: I'm very grateful.

PT: ...and some crisps, peacock in aspic, Lafite '61...

Dr W: The sandwich is fine, thanks. What are you selling?

PT: SodoFix. It's a great treatment for a new category of severe psychiatric illness described in DSM-6.

Dr W: There's more than a dozen of those. Is it this cluster of symptoms we're supposed to treat our kids for: Periodic Intoxication at Saturday Sports Events Disorder, Argumentation Syndrome in Adolescents, and Naughty Exclamatory Word Trait? Let me see, what's the acronym? PI...

PT: No, no, they'll soon have their own remedies. I'm talking about a condition that affects all of us when we're waiting for our computers to boot up, called Software-Oriented Dyspatience Irritability Trait.

Dr W: Oh, SODIT.

PT: Exactly. A daily dose of SodoFix prevents it.

Dr W: What's the generic name?

PT: It's howtheheckarewegonnasellthisjunkimab.

Dr W: I'll go with SodoFix for now. But isn't the generic the same stuff you peddle at wildly different prices for obesity, athlete's foot and wind? I think you call them FattoFix, FootoFix and Far...

PT: Well, those are all different licences. To help you remember SodoFix, here's a nice pen.

Dr W: Thanks. *[presses the button; the top breaks off]*

PT: And this is a note to remind you as well .

Dr W: Thank you *[turns the note over]*, but it doesn't mention SodoFix. All I can see is a picture of the Queen and the words "Fifty Pounds".

PT: Yes, it's to remind you that a trial of SodoFix showed that fifty percent of those who continued treatment had a lower than average risk of SODIT.

Dr W: No kidding? Where was the trial published?

PT: Acta Rejecta Podunkia.

Dr W: Oh, yes, they're kept afloat by support from Banoffee, I believe. Who wrote the paper?

PT: The authors were...

Dr W: No, not the names at the top: who *wrote* it?

PT: Er, Banoffee's technical writers, but...

Dr W: And who funded the work?

PT: Well, Banoffee... oh, I get it – you've been reading Ben Goldacre, haven't you? He is just *so wrong*.

Dr W: Then why don't the drug companies sue him?

PT: The moment he makes a mistake, we pounce.

Dr W: Hmm. But you mentioned "those who continued treatment". Some of them stopped it, did they?

PT: Technically, yes, but just a nominal number.

Dr W: Why did they stop?

PT: Mostly because of cardiovascular complications.

Dr W: What sort of complications?

PT: They, um, ceased to continue to be alive.

Dr W: You mean SodoFix *killed* them?

PT: Good Lord, no. Just that their global loss of vital functions was statistically linked to SodoFix.

Dr W: So how many lost their "vital functions"?

PT: You're not really asking the right questions.

Dr W: Come on, how many?

PT: Oh, about five... ten... um, seventy percent.

Dr W: *Seventy percent?!*

PT: But many consider that the benefits of SodoFix far outweigh the risks.

Dr W: Many *patients* think that?

PT: Er, no, many Banoffee executives. But SODIT can have quite severe consequences, you know.

Dr W: A terminal episode of tut-tutting, perhaps?

PT: You're being a little sceptical, Dr Whimsy, but have you never sat through a Windows update?

Dr W: Point taken. Now, let me get this clear: if I use SodoFix it will probably kill me, but if it doesn't, my risk of becoming irritable remains average.

PT: Oh, much better than that. More than fewer than 50% have a lower than average risk of SODIT.

Dr W: In other words, half. Overall, only 15% of those on SodoFix will benefit, and that's purely by chance.

PT: Precisely. It's non-inferior, which is excellent.

Dr W: It's also non-superior. Anyway, what's the cost?

PT: Twenty-eight pence a month.

Dr W: *[surprised]* I'm impressed - I thought you'd be greedy. At least it won't hurt my drug budget.

PT: Er, that's the hospital price. It's £5,496 to Primary Care.

Dr W: Ah, the old loss leader trick. You know, I can't put my finger on it, but there's something about SodoFix that I don't find entirely persuasive. Are you promoting anything a little more convincing?

PT: Absolutely. Do you know about HiccoFix?

This column is written for humour and does not necessarily reflect the views of the author, his or her practice, or the LMC. The complete Doctor Whimsy's Casebook is available on Amazon.

Somerset Local Medical Committee, Crown Medical Centre, Venture Way, Taunton TA2 8QY

Tel No: 01823 331428 Fax No: 01823 338561 E-mail: lmcoffice@somersetlmc.nhs.uk

LMC Website: http://www.somersetlmc.co.uk