Somerset LMC Newsletter

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Issue 190

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SOMERSET PRACTICE QUALITY SCHEME - OFF THE GROUND AT LAST

It will not have escaped your notice that readers are receiving the May edition of this Newsletter almost at the end of June. Thereby hangs a tale.

You will recall that following the decision in December that the LMC, the CCG and the Area Team would commit to working flat out to produce an optional quality scheme that would focus on integration and sustainability rather than box ticking, the Steering Group finalised SPQS at the beginning of April.

The Group understood that NHS England centrally supported the idea, and that obtaining their approval would be a formality. We were also aware that the GPC had reservations about the scheme, but it had been somewhat reassured to hear that it was optional, with practices free to continue with QOF if they preferred, and also that it was a one year pilot with practice remuneration still being linked to the nationally negotiated contract. The Steering Group agreed that two other concerns - the continued national reporting of Somerset practice data on CQRS and the risk that practices would end up doing a lot of QOF work as well as contributing to SPQS – would need to be watched closely.

Obtaining formal approval proved to be a rather more complicated process than we had expected, and by the end of May the LMC felt that it was no longer reasonable to expect practices to carry on waiting indefinitely, but fortunately word arrived just in time from NHS England that the scheme could go ahead as proposed.

The LMC is well aware that there is still significant opposition to SPQS, and a GPC spokesman has been reported as saying "Patients will suffer – that's undoubtedly the case". Obviously we hope this concern is not borne out, and we are confident that practices will not compromise the essential elements of patient care, but we are aware that Somerset is not representative of England as a whole and that our experience locally is not necessarily going to be transferable.

We are also clear that SPQS is not about co-commissioning. Whilst there are benefits for everyone to be gained from joining up Area Teams and CCGs rather better (we could even call them Primary Care Trusts…) it is essential that practices' core GMS/PMS contracts continue to be held by a third party. Although our objectives of ensuring the sustainability of general practice and improving integration of health and social care will require funding flexibility, it is imperative that the unique funding pattern of general practice is not disrupted – no other professionals involved are risking their own salaries by their involvement in shared developments.

Despite the delays and concerns, a substantial majority of practices have elected to join SPQS, and the LMC believes that this support means it will be possible to produce results within the remainder of the financial year that will indicate whether this is the right route to take. Pioneers may strike out in the wrong direction, but expecting that doing more of the same will deal with the fundamental structural problems of general practice seems defeatist. We hope that SPQS may at least provide a signpost for the future.

REPORT ON 2014 CONFERENCE OF LMCS

Sue Roberts, Berge Balian, Nick Bray, Barry Moyse, Jill Hellens and Harry Yoxall represented Somerset LMC at this year's conference and there was no doubting the change in the GPC approach. Apart from the new Chair (Chaand Nagpaul), the Committee itself was freshly elected and their intentions were signalled in a slimmed down agenda. At first it felt as though the number of our motions which were accepted was a bit disappointing, but on reflection we did figure quite noticeably in debates, speaking in five out of a possible seven. This compared well with other LMCs in our region. The GPC was reacting to quite vehement criticism of their approach to Conference last year and there was much more true debate this year.

Discussion was lively on day one and the shortened agenda gave more time for varying views to be aired. The GPC Chair started proceedings off with a very impressive and determined speech – a side of Chaand (as our Deputy Medical Director said) that we have not seen before. He is clearly no pushover and demonstrated that he understands the pressures we are under at the frontline. He spoke from the heart and said that he would not let traditional General Practice be dismantled on his watch, and got a well-deserved standing ovation.

We moved on to some motions that were bound to be passed which is the pattern for Conference: for example the first debate was on excessive workload. Shortly after Barry Moyse was our first speaker opposing a motion against all co-commissioning by Area Teams and CCGs. His argument, essentially 'Could local CCGs really do any worse than distant Area Teams on enhanced service contracting" was unfortunately misquoted in a PULSE report as appearing to criticise Area Teams as being ill informed. There was an overwhelming vote against CCGs holding core GMS/PMS contracts. Berge Balian later spoke in support of a motion expressing concern about the CQC by recounting the labyrinthine bureaucracy he had had to negotiate when his Practice appointed a new partner. Conference took no prisoners in condemning the current CQC approach to Practice inspections and risks of over interpretation of requirements.

Motion 20 was on whether primary care should provide an 8-8 service seven days a week and resulted in a split vote (depending on whether it was resourced to the 'satisfaction of the profession'). In essence, the GPC has a clear steer from Conference that this will not be done unless funded adequately and even then we need the workforce and time to do it. To be fair to the GPC, they knew this, but the message got home to the media present.

Conference later voted against charges to patients for core work, against the current reduction in MPIG and also the planned PMS reviews (which will inevitably cause a reduction in funding). It also opposed Pension changes and supported investment in premises development (we remain indebted to Somerset PCT who got this sorted before they disbanded – it really IS awful in other areas). Later it was resolved to explore whether the GPC should continue to engage with the DDRB and were unanimously in favour of opposing publishing GP pay unless it is clearly explained and put into context. There was a slightly confused debate about Federations which some delegates mixed up with GP Provider companies, emphasising that perhaps Somerset is more developed in this respect than some other localities. At the end of the day Barry Moyse proposed a Somerset motion against the massive merger and likely privatisation of Primary Care Support Services planned by NHS England. He spoke about 'Sally' in Patient & Practitioner Support and the value of her local knowledge that will be lost if it goes ahead and asked Conference to consider that, although this may be inevitable, it should at least be adequately monitored.

Day two started with Chris Ham from the Kings Fund giving the guest speech - saying much that he has before about collaborative working, and that the NHS has to work differently, but also producing graphs of research that supported our impressions of excessive GP workload and the reduction in funding and GP numbers. He was followed by the official launch of the GPCs 'Your GP Cares' campaign that we hope all practices will be involved in over the coming months. Conference went on to demand that the government prioritise the workforce crisis, oppose a PBR system of payment for General Practice, assert that the demands of patients fuelled by media and government are unrealistic and the system can only work on the basis of they need and not of want. We went on to agree that we must be honest to patients about rationing – or at least the government should be. It was also agreed that there would be a trial change in the format of the conference so that there will be 2 hours put aside for small group work so that GPC can better gauge the opinion of all representatives – especially the view of new GPs who may be intimidated by the current formal structure of Conference. This session ended with votes against setting up a national LMC body and for patients opting in to Care.data.

In the 'Ask the negotiators' session the

redoubtable Peter Holden staunchly defended the principle that 'If it ain't in our contract, we don't do it!' which was encouraging.

There was a tense moment for us when alternative QOF schemes were mentioned. Conference felt the GPC had done well to reverse the imposed changes of last year and reduce the QOF burden, and effort should focus on taking this further. The risks of locally negotiated schemes were highlighted but your representatives were happy to vote in favour of the motion as SPQS has been designed to avoid the risks mentioned. Nick Bray proposed a very lengthy composite motion (a speaker for the Agenda Committee later apologised for this) on the Summary Care Record. Nick was recalled to the podium to respond to GPC comments but did not give way to a proposal to accept a sub clause as a 'reference' (when it is taken in spirit and effectively buried), so whilst the whole motion was not passed, sections regarding digitisation of patient notes and compensation for practice costs incurred in dealing with the CQRS failures were.

Near the end of the day Berge again impressed Conference by describing his experience with a violent patient and the handling of the matter by the Area Team. The GPC will be using his information to emphasise that more needs to be done to support practices in such circumstances.

So in conclusion, we had a successful Conference in speaking terms but also in Twitter terms since we gained 10 new followers.

But perhaps the most remarkable feat of the conference was the ability of Jill, the LMC Executive Manager to appear before a bedraggled group of GPs standing helplessly in the rain with a 6 seater taxi apparently summoned out of thin air….

CONTROLLED DRUGS FOR DOCTOR'S BAGS

Will now have to be ordered from a wholesale pharmacy – if you really need them?

The Department of Health has recently issued a letter confirming that controlled drugs can only be supplied by a pharmacy with a wholesale licence, which means that if you carry CDs or hold a stock in the practice you can no longer replenish this at a local pharmacy. We raised this with the GPC who replied: *"This is not something that we have been consulted on, but we don't think that this will affect the ability of GPs to carry any drugs - CDs or otherwise - in their bags (providing they can get them in the first place as it is no longer possible to acquire them via community pharmacies). Stock medicine supply requires a wholesales licence, so therefore local pharmacies will no longer be able to supply. Apparently this is part of the measures to control drug shortages and trading drugs for export, although some continue to abuse the market and create shortages despite this. Specifically for CDs they will need the additional level of paperwork and licensing so legitimate supplies and uses will be hit hard.*

As you are probably aware, there already are clear requirements for the way practices store and record their CDs and in many practices, particularly in urban areas, GPs don't carry CDs any more as the paramedics can get to the patient so quickly it is no longer necessary."

FERTILITY (ANDROLOGY) INVESTIGATIONS AT MPH AND YDH CHANGING FROM 23RD JUNE

Message from Dr David James

Over the past few months we have been able to offer additional appointments in andrology for fertility investigations, and patients who had been waiting for appointments have now either been seen, or have been offered an appointment within the next few weeks. We have also taken the opportunity to re-engineer how the investigations are organised so as to maximise the availability of the service. This includes changing how appointments can be requested.

As of **Monday 23rd June 2014,** all appointment requests will have to be made using order comms [request item is "GP Fertility Screen"]. On requesting, you will be asked to confirm where the patient would like to deliver the sample to [MPH or YDH], and where possible, provide a contact number for the patient. The request once made will generate labels, but these are not required by the laboratory and can be discarded, or kept for your records.

The process is already available through order comms, and we would encourage users to start to make requests through this as of now.

From 23rd June, the telephone number on which patients contact the laboratory will no longer be in use, and will direct callers back to the referring clinician.

Once the request is within the system, we will arrange an appointment for the patient, and send this together with an information/instruction sheet, which incorporates the request form and sample container directly to the patient. Please do not give "old" information leaflets to patients as it may cause confusion.

Dr Whimsy's Casebook: Wider Societal Benefits

The Department of Health asked the National Institute for Health and Care Excellence to make judgments on the "wider societal benefit" of treatments before recommending them for NHS use. Currently the NHS would pay for the first £20,000 per Quality-Adjusted Life Year, but in the not-too-distant future...

Scene: Mrs Forth has an urgent appointment with Dr Whimsy.

Dr W: Come in and take a seat, Sally. How are you?

Mrs F: I've had indigestion for a couple of weeks, doctor, and it's worse today. I even got it sat in the waiting room, a crushing feeling in my chest and pain in my left shoulder, made me feel sweaty and sick.

Dr W: Oh dear. We spoke about your heart risk only a few weeks ago, and I'm afraid it looks as if your chickens have come home to roost.

Mrs F: Er, I don't keep chickens, doctor.

Dr W: I mean you almost certainly have unstable angina. You ought to be in hospital.

Mrs F: If you say so, doc.

Dr W: First things first, though. Do you normally work?

Mrs F: Yes, but I don't feel well enough today.

Dr W: I'm not surprised, but if you work you must have a P60 tax declaration. Did you bring it with you?

Mrs F: Yes, the receptionists remind us every time now. Here it is, doc, but why do you need it?

Dr W: Oh, just working out whether you're worth treating. Hmm... I don't think you pay enough tax to cover this kind of heart trouble.

Mrs F: Surely that doesn't matter in the NHS, doctor?

Dr W: A quaint thought, Sally, but rather old-fashioned.

Mrs F: But isn't treatment "free at the point of delivery"?

Dr W: My word, that little gem bit the dust over sixty years ago when they introduced prescription charges. No, you can have treatment as long as it doesn't cost more than your value to society, in other words, what you pay to the State.

Mrs F: So what treatment can I get for what I pay?

Dr W: Well, let's tot up the cost. There's the ambulance, Coronary Care admission, blood tests, ECG, angiography, cardiology and radiology consultants and their teams, a stent or two, nurses, drugs, bed and board and so on. Even if you don't need a by-pass it still leaves the government out of pocket.

Mrs F: So what about going into hospital, doc?

Dr W: Sorry, no can do. Let me help you to the door.

Mrs F: But, doc... ooh, that pain's coming on again.

Dr W: OK, I'll give you a couple of puffs of GTN on the house, but I'll have to start a tab with the aspirin. Here we go: open wide.

Mrs F: Thanks, doc... It's a bit better now. But won't it keep doing this until I get hospital treatment?

Dr W: Too right. Let's see what we can do. Now, the ambulance is £300 – can you take the bus?

Mrs F: If somebody will carry me to the bus stop.

Dr W: And we can admit you to a psychiatric unit rather than CCU, and skip the consultants – I'm sure their F2s will have seen all this on Casualty.

Mrs F: Anything that will help, doc.

Dr W: Bare metal rather than drug-eluting stents of course; that saves £600, and they won't rust for months.

Mrs F: Whatever's cheapest, doc.

Dr W: Good, but still some way to go.

Mrs F: What about the tax I'll pay when I'm back at work?

Dr W: Well, the longer this takes, the more myocardium you'll lose and the less likely you are to return to work, so don't bank on it. Do you claim any benefits – child allowance, that sort of thing?

Mrs F: No, and my bedroom allowance has been stopped, so money's tight at the moment.

Dr W: But at least you're less of a burden on the State. Any savings, or alimony from your husband?

Mrs F: You're joking, doc. But what about the taxes I've been paying for the last thirty years, and all that National Insurance?

Dr W: Not hypothecated, I'm afraid.

Mrs F: Uhh?

Dr W: It wasn't ring-fenced.

Mrs F: Are you back to chickens again, doc?

Dr W: No, I mean your contributions paid for other essentials like military invasions, MPs' second homes, corporate tax avoidance and sweetheart deals, National Programme for IT, HS2, my income... Tell you what, though...

Mrs F: Yes?

Dr W: We could start you on the proper treatment pathway then just stop when the money runs out.

Mrs F: At what point will that be, doc?

Dr W: Let's look at your P60 again... Yes, they could pop in the coronary catheter but they won't get as far as inserting a stent. If you take a hat with you, you can hold it out after the dye's gone in.

Mrs F: What, beg for money?

Dr W: Sure. You've got a good voice haven't you? A couple of verses of "Don't go breaking my heart" might get you enough for the Angio-Seal.

Mrs F: Blimey. What if I was a pensioner or a housewife?

Dr W: I'd tuck you up in bed with a good book. Short stories, of course.

Mrs F: Well, please do what you can for me, doc.

Dr W: Right, I'll phone for an ambulance. Have you got the 20p on you?

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.

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