

Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE SEPTEMBER 2009 Edition

Dr. Andrew Seymour
LMC Chairman

Andrew.Seymour@GP-L84026.nhs.uk

Shelina Jetha
LMC Manager

shelina@gloslmc.com

Mike Forster
LMC Lay Secretary

mike@gloslmc.com

Sue O'Sullivan
Administration

sue@gloslmc.com

LMC Website: <http://www.gloslmc.com>

Tel: 01452 310706

Fax: 01452 386503

Forecasting the weather is an art; forecasting the incidence of swine flu is akin to a dark art. However, the boffins warn of a significant risk that there will be another wave, possibly more severe, peaking perhaps sometime in October. Now is the time to think about the consequences.

SWINE FLU VACCINATIONS

It will be a significant amount of extra work. For instance, if an average practice has to vaccinate only a quarter of its 6000 patients and each vaccination takes only 3 minutes and there are as many as 5 clinical staff available to do the work you are still looking at 5 working days spread, probably, over 3 weekends. (Spreadsheet sent to all practices 15 Sep.) Practices will be paid £5.25 per dose administered, but it is not yet clear whether one or 2 doses will be required per person.



CONSEQUENTIAL ARRANGEMENTS

- The collection date for data on childhood immunisations to be delayed by six weeks to mid February to allow practices time to carry out the swine flu vaccination programme.
- Local enhanced services (LES) funding will not be withdrawn to fund the vaccination programme.
- District nurses will vaccinate all the housebound in line with the seasonal flu arrangements. NHSE and DH have

agreed that there will be no charge from the PCT to practices for this. Please let us know if you receive any purported invoices for this service.

- Practices vaccinating a higher percentage of 'at risk' swine flu patients (a minimum of 3% increase), compared to the 2008/09 UK uptake of seasonal flu, will be granted a 10% drop in the upper and 20% drop in the lower thresholds of Quality and Outcomes Framework (QOF) indicators PE7 and PE8 in 2009/10.
- No change will be made to the QoF for 2010-2011.
- QoF indicators recommended by NICE for retirement (28 points) will be released in 2011-2012, to make room for new indicators to be piloted in the meantime.

COMMAND AND CONTROL (C2) ARRANGEMENTS

The joint GPC/NHSE guidance is at http://www.bma.org.uk/health_promotion_ethics/influenza/panflugp/flu_pandemic0508.jsp

This will be formalised in a pandemic flu SFE which has yet to be finalised. It might be introduced area by area by the DH as the situation demands. Local panels, including LMC membership, will

advise DH when to do so. The main change will be that the PCT will be responsible for engagement and deployment of locums across the county at the local Out Of Hours sessional rate on terms that would give them in-service death benefits. (Existing long-term locum contracts (e.g. to cover maternity leave) will remain the responsibility of practices.) The PCT will also have the right to request practices to open outside normal hours and to assist other practices.

ANTIVIRALS

A joint GPC/RCGP/DH letter regarding authorisation of supply of antivirals was sent to PCTs in England on 20 August. The letter advises GPs that antiviral vouchers must be used for all children under 13, and for patients over 13 years, the right-hand blank side of a normal FP10 prescription form should be used as if for a private prescription but with a clear anti-viral annotation as instructed, unless the GP is not at the GP premises, when vouchers should be used. This letter gives clear instructions:

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/DH_104491

NEW SWINE FLU PLANNING ASSUMPTIONS FOR PERIOD ENDING MID-MAY 2010
See <http://www.info4local.gov.uk/documents/publications/1324944> but in outline:

Potential effects of A(H1N1) infection for the general population		Implications
Clinical Attack Rate	up to 30% of population	Average figure: likely to be higher in those under 16. A further 30% may be infected but show no symptoms.
Peak Clinical Attack Rate	nationally, up to 6.5% of population per week	Peak estimated to take between 5 and 8 weeks to develop – but no one can predict when 'week 1' will be. Look for a busy month in October, though. Peak should not last more than a fortnight. Local and national peaks may not coincide.
	locally, 4.5%-8% of population per week	
Case Complication Ratio	up to 15% of clinical cases	Assumption is that the younger population will have fewer complications; the older will have more, but the clinical attack rate goes the other way, so overall 15% can be used for all age groups as a planning figure.
Case Hospitalisation Ratio	up to 1% of clinical cases, of whom up to 25% could require intensive care at any given time	Problem comes if there are inadequate facilities to take the surge.
Case Fatality Ratio	up to 0.1% of clinical cases	As a reasonable worst case that would result in about 20K deaths (about 1/30 th of the normal total annual deaths from all causes (600K))
Peak Absence Rate	up to 12% of workforce	Estimate based on half of those becoming ill recovering within 7 calendar days, a quarter of them needing up to 10 calendar days to recover, and a further quarter having symptoms for more than 10 days. A mean of 9 days. Closure of schools could take out a further 15% of the workforce as parents have to look after children. Effect of looking after other relatives has not been factored in.

The paper stresses that these are reasonable worst case scenarios; if we plan for them then we should not be caught out. They are not a prediction of what will happen.

SWINE FLU PATIENT LEAFLET

The BMJ group has published a patient leaflet on Swine Flu which practices can

print out and give to patients:

http://www.bma.org.uk/images/bmjpatientsummaryswineflu7august2009_tcm41-189637.pdf

CARE OF CRITICAL SWINE FLU CASES

The DH has issued a strategy for doubling the critical care capacity in hospitals to deal with a surge of severe swine flu cases. This may well involve cross-PCT and cross-SHA boundary cooperation and patient movement from worst affected areas to those with greater capacity. There will also be an impact on planned but non-urgent admissions so that life and death cases can be dealt with urgently and

appropriately. It is also very important to minimise the number of critically ill patients by curbing the spread and then the effect of the disease.

NATIONAL CONCERNS RAISED WITH GPC

You may be interested in reading at Annex B the various concerns about swine flu that LMCs around the country have raised to the GPC over the last few weeks.



Just to remind you, after the dust of summer has settled and before the autumn gets really busy, you may find helpful savings on offer from some or all of the firms listed below. No obligation to buy from them, but they may save you money.

Firm	Area of work	Contact	Address	Tel:	FAX	Mobile	email
MidMeds Ltd	Medical supplies, consumables and instruments	Mr David Roncs	Unit 71, Hillgrove Business Park, Nazeing Road, Nazeing EN9 2HB	0845 0 034 212	0845 2 805 800	07734 775 983	david@midmeds.co.uk
TAG Medical Ltd	Equipment calibration and testing	Mr James Dillon	1 The Triangle, ng2 Business Park, Nottingham, NG2 1AE	0845 0 707 800	0845 2 806 316		info@tagmedical.co.uk
Whittaker Office Supplies Ltd	Office solutions: stationery etc	Ms Lisa Perry	3 Weldon Road, Loughborough, Leicestershire, LE11 5TE	0150 9 235 888	0150 9 610 511		sales@whittaker-os.co.uk
Medical Insurance Advisory Bureau	Surgery and Locum Insurance	Mr Robert Lynch	1st Floor, 22 Basils Road, The Old Town, Stevenage, SG1 3PX	0143 8 730 210	0143 8 318 683		info@themiab.co.uk
Untied Utilities Ltd	Brokerage of utility savings	Mr Andrew Sutton	Whitworth Chambers, George Row, Northampton, NN1 1DF	0160 4 636 811	0160 4 628 936	07974 940201	andrew@untiedutilities.com

ACCESS

A series of workshops, supported by the RCGP and BMA, are being planned to support practices with access and responsiveness. You may wish to help shape them by clicking on the link below and completing the short survey.

http://www.surveymonkey.com/s.aspx?sm=WE4YIVrJDYgzEtCbQ7PCAw_3d_3d

COMPLAINTS

The GPC has produced further guidance to GPs about the complaints system, which can be used for the benefit of practices as well as patients. See:

http://www.bma.org.uk/employmentandcontracts/independent_contractors/managing_your_practice/NHScomplaintsproc.jsp

CERVICAL CYTOLOGY

The NHS Foundation Trust has acknowledged that the current system of Read codes is inadequate in that a single code is used for Cervical Cytology, which leads to two problems:

- It isn't recognised by the QoF software.
- It isn't stratified - i.e. you can't search for inadequate or abnormal results by read code.

Because of this the paper version will still be issued in due course. The electronic version gives the practice an immediate and useful alert if something adverse is found as a result of a smear analysis.

LOCAL INVOLVEMENT NETWORKS (LINK)

The BMA has produced useful questions and answers to guide practices on their relationships with the new LINKs

[They can also be found on the BMA website.](#) In outline: the local LINK is responsible for finding out what patients want from their health and social care services. They are entitled to visit GP practice premises, announced or unannounced, to observe and assess the delivery of service and collect the views of the people using the service. It is important that the authorised LINK representative produces evidence of their status before they are allowed to enter the GP premises. Guidance on how such visits can be organised in a positive rather than negative manner can be found at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_087285

Entry can be refused if the visit is '*not reasonable and proportionate or would compromise the privacy or dignity of patients.*'

The LINK, in writing, can request information from a practice. With some exceptions, which you should read. There is also a duty to:

- provide that information within 20 working days of receipt (if the information is not exempt)
- provide anonymised information within 20 working days of receipt (if the information is exempt.)
- provide an explanatory letter within 20 working days of receipt in cases where

the independent provider is not required to disclose the information requested.

BMA CONFERENCE FOR SALARIED AND LOCUM GPs

Many of you will have read of the move for salaried GPs to move away from the union services of the BMA to another. Below is a link to the BMA's conference for salaried and locum GPs entitled 'Recognise your Talents, Realise Opportunities'. It is taking place at BMA House on 13 November 2009. http://www.bma.org.uk/whats_on/SESSGP09.jsp?page=1

EUROPEAN WORKING TIME DIRECTIVE (EWTD)

The BMA has issued guidance for Registrar GPs about the EWTD. http://www.bma.org.uk/employmentandcontracts/working_arrangements/hours/ewtd/wokrtimeregs.jsp

POSSIBLE SCAMS

We would advise caution when getting involved with any 'directory service', no matter how plausible. Ask yourself: do the people you want to contact really read this directory, and find out from those people, not the directory author, before committing your practice.

BMJ GROUP AWARDS

You, or perhaps a colleague, might wish to submit nominations for the 2010 BMJ Group Awards. The categories include:

- * Research Paper of the Year
- * Getting Research into Practice
- * Primary Care Team of the Year
- * Junior Doctor of the Year
- * Excellence in Healthcare Education
- * Best Quality Improvement
- * Clinical Leadership
- * Corporate Social Responsibility
- * Health Communicator of the Year
- * BMJ Group Award for Lifetime Achievement

Entries for all nominations close on Sunday, 15th November, 2009. For further information see website: <http://groupawards.bmj.com/2010-awards/>

NHSE REVIEW OF EFFECTIVENESS OF CONTRACT FOR DOCTORS IN TRAINING

NHS Employers are undertaking a review of the effectiveness of contracts

for doctors in training, including GP training.

To say what you think about your current contractual arrangements, please visit the BMA website:

<http://www.bma.org.uk/employmentandcontracts/employmentcontracts/juniordoctors/jdcontracts/scopingcampaign.jsp>

MAX'S MUSINGS

I was delighted to find that hospitals (which originally developed from monastic infirmaries) are now borrowing another ecclesiastical idea by clothing their senior nursing staff in purple – until now the preserve of bishops and, in former times, of emperors.



In the ages before aniline dyes, twelve thousand *murex brandaris* snails when crushed yielded, I am told, no more than 1.4g of pure dye - enough to colour only the trim of a single garment. Purple is thus a traditional sign of wealth, and hence of power and authority. The latter two qualities may apply to nurses, but I doubt the first does. Let us also hope that the patient, seeing someone in purple, will not think that the time has come for a very senior administration of last rites.

'Top people take the Times; the rest of us buy it' goes the old joke, but going through my copy of the Thunderer I discovered that, 'The NHS, with its 1.5million employees, has become the largest employer in the world after Wal-Mart, Indian Railways and the Chinese People's Liberation Army'. And that

does not include GPs and their staff who, as we all know, are not NHS employees.

I can sympathise with, but am unable to emulate, the 'addicted' long-distance runner who gets so much physical pleasure from his self-generated endorphins that he goes on running long after his suffering knees beg him to stop. It is said that yesterday's runners are today's cyclists (i.e. when their knees give out). There must be other progressions, though. Take my case: over the years I probably have too often consumed too many of the good things in life in too great a quantity, even after my wife, my doctor and my reflection have told me to change the habit. But it was FUN, and, frankly, it still is. I know my sense of self-importance is expanding at a pace only matched by the increase in my BMI. But I would like to think that at my funeral my ten salaried doctors will gladly, even if not easily, carry my coffin to its last, rather large, resting place. I shall meanwhile have to bribe their personal physicians into prescribing them all a course of body-building beforehand. After all, my potential supporters should realise that this is a positive addiction and that the feel-good factor derived from beasting your body around the gymnasium relieves the stresses of working life and fits you for the unexpected. I shall look down on it all, reflecting that my arguably worthless existence has very much improved theirs.

And finally, from our collection of medical secretaries' howlers:

- Large brown stool ambulating in the hall.
- Patient has two teenage children, but no other abnormalities.
- When she fainted, her eyes rolled around the room.



This newsletter was prepared by Mike Forster, LMC Lay Secretary, & the LMC Office

HIGHLIGHTS OF THE LMC MEETING IN SEPTEMBER

LMC Membership. Dr Bob Hodges, a salaried doctor in the Barnwood Surgery, Gloucester, and Dr Emma Preston, a registrar GP in the Rosebank Surgery, have been co-opted onto the committee. Dr Hodges will be particularly responsible for maintaining contact with all GPs in the College Yard Surgery, the Kingsholm Surgery and the Rikenel Surgery, as well as his own. We will also be having practice manager representation at our monthly meetings.

Improved Access to Psychological Therapies (IAPT). IAPT is aimed at implementing NICE guidelines for those suffering from depression and anxiety disorders. It will go live on 28 Sep, from a free telephone number 0800 073 2200 most days except Sundays. The LMC asked the team to send a briefing letter to all GPs about it. The main points that arose were:

- IAPT will not be providing anger management as such, though it may be used to address the underlying cause of anger.
- It will provide psychological, not medical, treatment, and patients will be referred to their GP for medicinal assessment and treatment if necessary. GPs will also be kept informed of what is being done psychologically.
- Although the treatment is referred to as 'stepped', in suitable cases treatment can start at the appropriate rather than the first step.
- An important part of the roll-out of IAPT is the provision of space within practice premises to enable local treatment of patients. As we all know, space is at a premium in practices, so this requires further discussion.
- Not yet clear whether GPs can refer to IAPT using Choose and Book.

Cancer Audit. The LMC was invited by the 3-Counties Cancer Network to endorse a short-term agreement for practices to be paid to complete questionnaires. The aim of the exercise is ultimately to get patients in UK to present their cancers and have them diagnosed much earlier, thereby improving the chances of successful treatment. The work has to be completed before the end of the year. The LMC and PCT were in favour. If approached please would you give this your best shot? 'Garbage in, garbage out' is never truer than with this questionnaire – it will need accuracy and detail if it is to be successful.

Dementia. There are moves afoot, nationally and locally, to identify cases of dementia early on, and improve treatment. There is to be a GP study day on 24th November. Application forms are available from the LMC Office. The day should be interesting.

NHS Funding. Looking ahead to 2011, when the financial effects of the recession are likely to bite health budgets severely, the PCT believe that Practice Based Commissioning, if properly supported and led, could enable us all to do much more within a fixed and even reducing budget. They are determined to help practices do this. They suggest the grouping of clusters into not more than 5 confederations which will each have a named PCT director, with their staff, in support. Discussions along these lines are in progress, or about to start. Clinical lead is seen as really important, and confederations will be invited to be represented on the PEC.

Swine Flu. Anecdotally, few of those presenting to the national pandemic flu line are really suffering from swine flu – could be another form of flu or just a viral infection. There is now a degree of cynicism in the public at large about this pandemic.

POINTS RAISED ABOUT SWINE FLU BY VARIOUS LMCs TO THE GPC

Medical Indemnity. If a practice wants to increase the amount of work part-time doctors are doing (or employing part-time locums) beyond the number of sessions these GPs are telling their indemnity companies they are doing then theoretically they are not covered (as they receive proportional discounts on their premiums) and shouldn't, therefore, work these extra sessions despite the urgency. Likewise, there are retired doctors and nurses willing to lend a hand but aren't covered.

Sick Notes for more than 7 days. Patients who have suffered swine flu for more than seven days need to notify their employers. The problem is that many of these have been diagnosed via the help line and the practices have no direct evidence of the patient's original condition. A dilemma arises as to whether to bring a patient suffering from swine flu into the practice to obtain the sick note (risking the infection of staff) and the issue of whether the patient has in fact suffered a bout of flu, which is now ebbing and a sick note is appropriate. There is little communication it seems from the flu help lines to practices informing them that swine flu has been provisionally diagnosed. Patients are asking practices to issue sickness certificates without their attendance at the practice.

Flu Line.

- A patient used the web site and got as far as the authorisation number and pressed the back button by mistake; now can't get number again as system thinks she's been given it already, "help line said call your GP"
- Flu line not aware of rural antiviral distribution centre locations.
- Lack of access to swabs to confirm diagnosis. Labs refuse to analyse. Many diagnoses seem vague. One doesn't want to swab all, but it would be reassuring to know that some system of confirmation/observation of Flu Line accuracy in diagnosis was ongoing.
- Foreign-speaking (e.g. Urdu and Punjabi) patients have been told by the Flu Line to ring their surgery due to language problems.
- Some patients are being told by the Flu Line to inform their GP that they have been issued with antivirals.
- Patients not always being advised to take ID when collecting anti-virals.
- No way for practices to know when patients have been assessed by flu line so don't know if patient telling truth when asking for sick note beyond 7 days. (We don't want patients or flu buddies ringing up just to tell the practice!)
- Patients without flu friends in some instances have been advised to attend collection points themselves.
- Many instances of URN not being recognised on the system. With the lack of a search facility on the National Pandemic Flu Service this prevents PCTs (and the FluLine themselves) being able to determine if a simple error has occurred with the URN or patient / flu friend details. These patients are then advised to attend GP.
- Symptomatic patients contacting co-ordination centre regarding which site to attend as not advised by Flu Line.
- The positioning of Collection Point details at the front of the website makes this information freely available, so ACPs are taking general enquires.
- Incorrect dosing by national line.

Antiviral Distribution Centres. What happens when a patient who has swine flu is given a 12 digit code for Tamiflu but takes the number down incorrectly? In one case the chemist wouldn't issue tablets but told the patient to contact their GP.

Tamiflu Side effects. Some practices are spending most of their time treating side-effects of Tamiflu which the patient may not have needed anyway.

Foreign Travel. Foreign Embassies requesting 'free from Swine Flu' GP certification BEFORE they will issue Visas

Language. Ministers, doctors, health professionals and other educators should remember that 'pandemic' is a word to describe spread, NOT severity. Even when it is a pandemic (or epidemic, or even outbreak), the level of SEVERITY must be determined from the earliest possible time, with information being carefully managed until that point. It may be that we've got to the sad stage that the use of grades are required, to avoid everyone going on a military footing too soon, or at all. This pandemic would probably be graded as NO SEVERITY. If it mutated, the level can be raised.

Managing the Public. At best it has tested our plans for a Pandemic of Severe Flu. At worse, its embedded in the public psyche a fear of mild illness and a demand for unnecessary medication that will take a decade to turn around.

Support for Practices. Whether the pandemic is a high or low impact disease it is still possible for a GP Practice to be overwhelmed. Support should mean reduction in non-essential work in favour of managing the surge in Essential Services associated with flu. All non-flu related NHS bureaucracy should be suspended, with a recovery period implemented before Suspension is lifted. This could also apply to Appraisal and Revalidation.

Usefulness of LMCs. LMCs have proven invaluable already in helping PCOs through a huge mess. The term 'may consult with' should perhaps be changed throughout to 'shall agree with' on every regulation and direction and guidance document.

OOHs. Out of hours is commissioned with no reserve capacity and often forgotten despite being used as a safety valve / safety net by mainstream general practice.

Antiviral Vouchers for GPs are an additional workload, two sides to fax, and not compatible with the patients computerised notes. Vouchers not producible by computer / mail merger.