

Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

APRIL 2010 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>

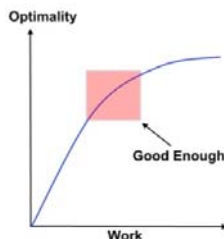
Tel: 01452 310706

Fax: 01452 386503

With effect from 1 April 2010 there are only 5 PMS practices in the county. All the others have moved across to nGMS. This strengthens the hand of the GPC when negotiating for doctors in this county. The LMC will, of course, continue to support PMS practices as strongly as GMS practices, as occasion demands.

THE GENERAL ELECTION

Thursday 6th May. Whoever gains power will strive to keep us healthy so that we can continue to work and pay our taxes. But beware of the '80:20' rule – also referred to as the law of diminishing returns. This can be simply stated as 'enough is as good as a feast' or 'the best is the enemy of the good'. With greater complexity:



'Eighty percent of what you want can be had for 20% of the full potential cost, but to get closer to the full requirement will cost exponentially more than that.'

The NHS already costs the UK just over £1,500 a year for every man, woman and child in the country. Sixty percent of that goes on staff costs. Just under half of those staff are clinically qualified. The really expensive bit of the NHS is at secondary care and above; primary care is already highly cost-effective but may still come in for some pruning. The instrument which will be used for this pruning is called, in short, QIPP. This stands for Quality, Innovation, Productivity and Prevention and will probably be wielded by whichever party wins the election. QIPP is divided into

eleven heads, of which eight can apply to GP practices. Details at the moment are sketchy and we will let you know more as soon as we have details. In the meantime let us hope the pruning will be more of a reshaping and a cutting out of dead wood rather than a brutal pollarding.



Mind you, the LMC is not bigoted. The LMC just supports GPs, and we will argue their case with anybody.

2010-11 DIRECTED ENHANCED SERVICES

For the Alcohol, Osteoporosis and Ethnicity and First Language Recording DESs the format is slightly different to last year. The 2010 Directions require practices to provide the PCT with written proposals within 42 days in



order for PCTs to consider and reach a decision as to whether or not to enter into an arrangement with a practice to provide the DES. **This means that if a practice wishes to take part in any or all of the above DESs, written**

proposals should be returned to the PCT by 12th May 2010.

SWINE FLU VACCINATION

The Director of Immunisation, Prof Salisbury, wrote on 18 Mar 10:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_114372.pdf

that 'Vaccination should continue to be offered to all those in designated risk groups: it remains the best way to reduce the risks of serious complications of H1N1 pandemic flu in the future.'

The BMA confirms that the H1N1 DES will not be continuing in its full form. However, GPs can opportunistically vaccinate at-risk patients, and receive £5.25 for doing so, but they won't get any other DES concessions.

Note that Prof Salisbury has also authorised the use of the vaccine as a travel vaccine for those going to the southern hemisphere this summer (c.f. the World Cup in South Africa). No charge for the vaccine itself can be made to the patient.

Any reasonable commercial charge for administering the vaccine will be subject to a private agreement between practices and their individual patients except that no charge can be made to:

- Patients in the priority groups defined in the Swine Flu directed enhanced service (since a fee of £5.25 is payable through the NHS); or
- Patients who are in a group covered by any local scheme under which the contractor is paid for administering the H1N1 vaccine.

Patients in these groups should receive the vaccination free of charge in accordance with the directed enhanced service or in accordance with the local agreement even if their request is related to travel abroad.

FIT NOTES

GPs need to be careful they are not drawn into making comments they are not qualified to make, because, unlike occupational health doctors, they are not often in a position to know the details of the patient's working conditions, neither do they have specialist knowledge of workplace

hazards. Occupational health doctors have a central role in helping people back to work, but, unfortunately, only one worker in eight has access to an occupational health doctor. Employers have a responsibility to provide adequate occupational health services and the government must encourage them to provide that if the overall plan to help more people back to work is to be truly effective.

HELPING VETERANS

A veteran is one who has served in Her Majesty's armed forces for at least one day (not just the Chelsea Pensioners). Veterans are entitled to priority treatment in hospitals for service-related conditions, so long as there is no



more urgent clinical case waiting. All that GPs have to do is to document that the patient is a veteran; the secondary care clinicians will decide from the referral letter whether the condition is related to their service, and thus

entitling them to priority treatment. Coding of veterans can be a problem on GP systems but, as communicated in the guidance, veterans should be coded when receiving their medical records e.g. using 'history relating to military service' code **Xa8Da**.

The Reservists Mental Health Programme offers assessment and treatment for demobilised reservists and can be referred to by GPs: (Help line no 0800 032 658). Many veterans would also be suitable candidates for help from IAPT.

Advice and support can be accessed via Veterans UK (www.veterans-uk.info) or charitable bodies e.g.

The Royal British Legion

(www.britishlegion.org.uk)

Combat Stress

(www.combatstress.org.uk.)

ALBUMIN:CREATININE RATIO (ACR) SPECIMEN BOTTLING

Practices have been asked by the Lab to divide ACR urine samples into 2 little

pots rather than using the current one, and the little pots and instructions have been sent out to practices. The PCT supports the Trust on the grounds that it is not a lot of extra work – they calculate that on average there are 3 samples per surgery per working day, and the new procedure only takes a few more seconds per sample; furthermore, all additional costs for equipment are met by the Trust and the practice benefits from QOF payments. Indeed it may be no big deal, but the LMC cannot support the change wholeheartedly: the work is laboratory work and should be done by the laboratory; three of the 8 practices which trialled the system replied to a survey from the LMC – two were strongly against the new system and only one was for it; there is no flexibility on when to do the work, and it tends to be at the busiest times of the day, and the work probably takes more than the extra few seconds suggested. Even if the PCT's figures are right as an average, there will be practices at the extreme end of the sample that may be worse affected.

It is your choice, but if you refuse to change the way you send ACR samples to the laboratory the LMC will support you.

ZOLADEX PRESCRIPTIONS

There have been instances of our colleagues at secondary care requesting GPs to prescribe Zoladex prior to their patients undergoing gynaecological operations. The LMC view, shared by the PCT, is that this work is part of secondary care and the hospitals should be prescribing this drug if it is necessary. If you receive such a request you may feel it sensible to bring this to their attention.

REVALIDATION CONSULTATION

Practices may wish to discuss internally the issues involved in Revalidation. If so you may find the GMC's toolkit at www.gmc-uk.org/thewayahead/toolkit helpful. The GMC is looking for doctors views and responses to the consultation at www.gmc-uk.org/thewayahead by 4th June 2010

CALDICOTT GUARDIANS

The DH has issued an updated Caldicott Guardian Manual. The intention is that this new Caldicott Guardian guidance will be reviewed annually and updated as required. Where necessary, updates will be published on the Caldicott web pages at:

<http://www.connectingforhealth.nhs.uk/syst/emsandservices/infogov/caldicott>

The Manual should be read alongside the e-learning module "The Role of the Caldicott Guardian: NHS and Social Care", which provides more detailed information on all aspects of the Caldicott Guardian role. The module is available at:

<http://www.connectingforhealth.nhs.uk/igtra/iningtool>

Individual general medical practices do not need to appoint a Caldicott Guardian, but do need to have an Information Governance lead (sometimes referred to as a Caldicott lead) who, if they are not a clinician, will need support from a clinically qualified individual.

COMMUNITY PHARMACY: A GUIDE FOR GPs AND GP PRACTICE STAFF

NHS Employers, the General Practitioners Committee (GPC) and the Pharmaceutical Services Negotiating Committee (PSNC) have jointly issued a guide to increase awareness of the work of community pharmacies and to encourage joint working. You may also



find it beneficial in educating trainee GPs about community pharmacy. In parallel a guide on GP practice has been prepared for community pharmacists. Both guides can be accessed via the NHS Employers website at www.nhsemployers.org, along with details on the work of the Professional Relationships Group. The GPC encourages all practices to meet local pharmacy colleagues to discuss working together to enhance patient care. We commend this guide and hope you will find it useful. If you have any comments about the guide, please email pharmacy@nhsemployers.org.

ATOS HEALTHCARE

Atos Healthcare provides medical services to the Department for Work and Pensions (DWP).



Their main role is to give medical advice to help DWP decision-makers reach an appropriate decision on entitlement to benefit. The regulations state that the claimant is required to attend for an examination by Atos Healthcare when requested and if he does not he loses his benefit. If, however, he can show good cause for not having attended, his benefit may be continued. Reasons constituting good cause include the state of the claimant's health. A claimant who has not attended may ask his GP to confirm that he was unable to attend due to his state of health, but there is no obligation on a GP to respond to such a request and if he does so, he may charge. The patient can appeal against a decision that he did not have good cause not to attend. A tribunal hearing the appeal may decide that a report from the GP would be helpful. If so, the tribunal service would pay for a report; but there is still no obligation on the GP to provide it.

INCIDENT REPORTING

The electronic incident reporting system



'Datix' is available on the NHS Gloucestershire

Intranet Site to report incidents very quickly after they have happened. Delay allows the trail to run cold – the follow-up can be less effective. Obviously its main use is for serious incidents (e.g. suicides and child deaths), but non-serious incidents can be taken seriously if there are enough of them reported (e.g. inadequate or late discharge summaries.) The PCT will feed back on incidents deemed to be moderately serious or very serious, but cannot reply to all. So:

- If it caused harm or had potential to cause harm (near miss), report it.
- If it is persistent but not necessarily harmful, report it.
- If in doubt, report it.
- Unsure if it is relevant to incident reporting – call Nicky Lane (see below) or report it anyway.

More and more surgeries are using the system. If you would like any assistance with incident reporting, training and access to electronic reporting please contact:

Nicky Lane

Governance Officer (Commissioning)

NHS Gloucestershire

Tel: 08454 221506

Email: nicky.lane@glos.nhs.uk

There is also a demonstration site available on this link:

<https://pctdatix.glos.nhs.uk/datix/demo/index.php>

SUMMARY CARE RECORDS

The BMA have issued a statement saying the CfH have postponed the uploads of SCRs, but this is not strictly speaking the case. If a practice thinks that patients and practitioners have not had sufficient time or information to make up their minds then uploading can be postponed whilst the PCT and the practice work out what needs to be done to rectify the situation. The PCT will be consulting practices on a one to one basis after the election.

PREMISES

The GPC practice finance subcommittee wishes to collect evidence of the problems being experienced by GP practices with regard to premises funding and contracts. They would like to be able to discuss this information at the Practice Finance subcommittee meeting on the 20 May; I would therefore be very grateful if you could send your responses to the LMC office by **Tuesday 11th May**. Apologies for the short notice!

MAX'S MUSINGS

The hallmarks of Christmas are that the carols are sung and the seasonal musak is played for weeks beforehand until you long for it to cease, you don't know what you are going to get on the day, and may not care either, and afterwards you have to eat leftovers for a long time and clear away the debris. However, the event is traditional and generally deemed to be a good thing. A General Election is thus very like Christmas, but without the public holiday, and it doesn't cost so much – at the time.

Senility has not struck, but deafness has. I discover that the colour code for hearing aids is 'Red right, blue left'. Pity, then, the poor sailors and all others who from their earliest years are taught that starboard ('right' for you landlubbers) is green by learning the mantra, 'Have you any Red Port Left?'

The headline the other day 'Candidates united against sale of port' intrigued me. Why should the sale of port wine, in whatever quantity, be an election issue? I later discovered that the port in question was Dover, not the 1896 Vintage, much to my relief. It is a while since the Government sold off so much of our gold reserves at what now seems a ridiculously low



price, but the fear still haunts me that they will order the sale of other national treasures, of which port (of the right vintage, *nota bene*,) is one.

Talking of port, I often fancy a bit of mature Stilton cheese after dinner. I had always assumed that it came from Stilton. If you are a cheesemaker and you live in Stilton and want, quite reasonably, to call your cheese 'Stilton' you may not. Stilton is in Cambridgeshire. By law Stilton Cheese not only has to be made from a fixed recipe but can also only be made in the three counties of Derbyshire, Nottinghamshire and Leicestershire. I suppose you could try to wheedle a licence from someone in the EU. But it would be easier just to call your cheese 'Bloated Politician' or some such ear-catching title.

PRESS CUTTING – Daily Telegraph – 15th April 2010

'Previous research has suggested that premature hair loss is linked to good health. According to scientists from the University of Washington's School of Medicine in Seattle, men whose hairlines start to recede at a young age are 45 per cent less likely to fall victim to prostate cancer.'

Some comfort then!

And finally:

- 'In this area we have a ... LES which I believe will be the first causality of cut backs.'
- 'Patient was released to outpatient department without dressing.'



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