

LMC NEWS

Cornwall & Isles of Scilly Local Medical Committee

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Items for the Newsletter are always welcome, and should be sent to the Editor, Rosalind Winter, at The Sedgemoor Centre, Priory Road, St Austell PL25 5AS (Tel 01726 627978, Fax 01726 76247, e-mail ros@kernow-lmc.demon.co.uk). See also our website at www.kernow-lmc.co.uk

REFERRAL MANAGEMENT: INTERIM ADVICE

The LMC remains very concerned about the medico-legal implications of the interception of referrals by PCT management and their diversion sometimes to non-doctors who by definition cannot take over clinical responsibility from the GP as happens with a normal consultant referral.

The LMC is also deeply concerned about issues of patient confidentiality and patient consent, where the patient is not aware that his or her medical details, divulged to the GP for the purposes of referral to a consultant, are in fact being scrutinised by lay staff. The LMC has raised these concerns with the PCTs and until they have been dealt with satisfactorily its advice is ALWAYS to refer to *The Consultant* or to a named consultant. If a lay member of PCT or other trust staff then diverts your referral elsewhere, then any breach of patient confidentiality/consent will be theirs, not yours; the legal position on clinical responsibility is, unfortunately, less clear-cut.

OUT OF HOURS SURVEY

At their first meeting of the new year, LMC members expressed a number of concerns about the future of out of hours care in Cornwall when Serco takes over from KernowDoc in April. These concerns are compounded by the lack of any information about the sort of service Serco will be providing: we understand that contractual details are still under discussion. The LMC is particularly concerned about the "Top and Tail" arrangements and will be following this up with the PCTs.

There have been suggestions that the over all service provided by Serco may not match KernowDoc's. To test whether or not this is the case, the LMC is conducting a survey between February and June of quantifiable items such as next-day referral back to the GP, and hospital admissions. Ten practices throughout the county have "volunteered" to take part, and results will be published in due course. The LMC would also welcome subjective impressions from practices of whether or not there is an increase in daytime GP workload after April.

ELECTION OF LMC NON-PRINCIPALS' REPRESENTATIVES

The first election of representatives to the new GP Non-Principals' constituency of the LMC will take place in March/April 2006. We will be writing shortly to every GP Non-Principal in Cornwall and Isles of Scilly for whom we have an address, indicating whether or not they are eligible to be nominated and to vote in the election, and if not how to become eligible (by paying the Non-Principals' Levy of £50 no later than 12 noon on Thursday 23 March).

If you are a GP Non-Principal and did not receive a letter from the LMC Chairman in January, it means we do not have your address, so if you would like to participate in the election, please send your name and address to the LMC Office as soon as possible.

Please draw this notice to the attention of any GP Non-Principals who you think may not be on the LMC's contact list.

BODMIN NHS DAY-CASE TREATMENT CENTRE

From the Bodmin NHS Treatment Centre,
Boundary Road, Bodmin PL31 2QT

This brand new, State of the Art, Day Case Treatment Centre, located adjacent to the Bodmin Community Hospital, has now opened its doors and begun treating patients. The Treatment Centre, owned and operated by Capio Healthcare, is now fully operational and an open day has been arranged for Wednesday 1st February, with sessions at 12 noon, 3pm and 6pm. Anyone who is interested in looking round should contact the Treatment Centre direct on 01208 262520

The Treatment Centre is able to accept direct referrals from GPs and Optometrists and the range of procedures currently available are:-

Ophthalmics Phako extraction of lens and lens implant
Non phako extraction of lens and lens implant
Removal of lens – not replaced
Replacement of prosthetic lens with prosthetic lens
Minor ops around the eye

GI Tract Diagnostic Osophagoscopy

Gastroscopy
Colonoscopy
Sigmoidoscopy
Proctoscopy

Minor therapeutic endoscopic

Osophagoscopy
Gastroscopy
Colonoscopy
Sigmoidoscopy
Proctoscopy

Gen Surgery

Simple haemorrhoidectomy
Simple anal procedures not needing overnight accommodation.
Hernia repair – inguinal
Femoral
Umbilical
Simple incisional
Non plastic minor skin procedures

Gynae

Minor lower Gynae procedures
Minor upper gynae procedures not requiring open abdominal surgery or an over night stay in hospital.

Further Gynaecology procedures will be added, including Termination of Pregnancy, in the near future. Details will be sent out when these are available.

CHLAMYDIA SCREENING PROGRAMME

A reminder to all practices involved in the Chlamydia Screening Programme:

TREATMENT SHEETS

Could all practitioners who are prescribing or treating patients with a positive chlamydia test as part of the Cornwall Chlamydia Screening Programme please remember to send completed treatment sheets back to the Chlamydia Screening Office (CSO) at Camborne and Redruth Community Hospital.

Without these sheets the CSO cannot complete the data required for the Department of Health, which is mandatory.

Thank you for your help and time in ensuring the continued success of the programme. Any queries should be directed to the CSO on 01209 881727.

FALMOUTH - GP PARTNER VACANCY

TRESCOBEAS SURGERY, FALMOUTH

We are looking for a new PARTNER to commence July 2006

- **8 sessions per week, 10 weeks holiday/study leave**
- **9,125 patients**
- **Purpose built premises**
- **Community Hospital next door**
- **GMS, No OOH, 1000 + QOF points**
- **Paperless**

Applications with CV to –

**Simon Fox, Practice Manager,
Trescobeas Surgery, Trescobeas Road,
Falmouth TR11 2UN.
Tel: 01326-434876**

Email: simon.fox@trescobeas.cornwall.nhs.uk

Closing date for applications – 31st March 2006

ISTCs: PRE-OPERATIVE ASSESSMENT OF PATIENTS

A GP surgery was contacted recently by the Plymouth Nuffield in respect of a patient about to undergo an NHS procedure two weeks later. The Nuffield wanted the surgery to carry out all the necessary pre-operative ECG and blood tests, as the patient claimed to be too unwell to travel for the pre-op assessment that was booked for later in the week. By chance the patient attended the surgery on the same day as she was supposed to attend the pre-op clinic, from which it transpired that she was fit enough to travel but was unwilling to do so because of the inconvenience of the distance involved, and hence wanted the tests done locally.

The surgery quite properly refused to carry out the pre-operative tests on the grounds that this was a secondary care procedure which the Nuffield is funded to carry it out as part of its contract with the PCT. There was no suggestion from the Nuffield that the cost of the pre-operative assessment be transferred to the surgery.

The LMC will be meeting PCT representatives in February and has added this to the agenda for discussion. It is important that GPs make it clear from the outset to patients who exercise their choice to have their treatment at distant venues that the total treatment package will be carried out there, and the patient will be expected to attend there for all appointments applicable to that procedure.

Meanwhile the Nuffield patient's PCT has responded:

"Thank you for making us aware of this. Our contract with the Nuffield does include all pre-op assessment and all patients should be aware that this will require a trip to Plymouth."

This is good, but not good enough: *"patients should be aware"* - but patients are clearly not aware, and the ISTCs aren't telling them. We suspect that when it comes to shedding workload whilst retaining the payment for it, the ISTCs are likely to prove just as savvy as the acute trusts have always been, because they know there will always be GPs soft-hearted enough to do their work for them rather than inconvenience the patient in any way.

SALARIED GP - STRATTON MEDICAL CENTRE

We are a seven partner, friendly, motivated, GMS practice in the attractive seaside resort of Bude seeking a Salaried GP to work 4 – 6 sessions per week.

- 14,300 patients
- High achieving QOF
- Paperlight, EMIS LV system
- Nurse Practitioner, strong Nursing & Admin team
- Six weeks annual leave plus study leave
- Cottage Hospital

Practice Profile on request

Apply with CV and covering letter to:
Kathryn Pengelly Practice Manager
Stratton Medical Centre, Hospital Road,
Stratton, Bude. Cornwall EX23 9BP

Email:

kathryn.pengelly@strattonmed.cornwall.nhs.uk

Telephone: 01288 352133

EXCESSIVE WORKING HOURS

At the January LMC meeting a member asked for advice on a potentially dangerous situation which had arisen at his practice. A doctor had worked a full night shift with KernowDoc, and then worked all the next day in the practice, before a long drive home.

The LMC agreed that GPs should be reminded through this Newsletter that it is their own responsibility to ensure that they are fit to work, and that there is powerful evidence that working such very hours may well be unsafe. If anything were to go wrong, either in the surgery or on the road, and it became known that the doctor had been working for such a long period without a break for sleep, the doctor could well find him/herself facing a GMC hearing.

CAMBORNE - FULL TIME GP VACANCY**Full time dynamic computerphilic doctor to replace retiring third partner in July 2006.**

- All usual staff, paperfree, recently extended refurbished premises.
- Opportunity to develop own interests.
- High QOF payments.

Informal approaches/visits welcome.
Please contact Joy Adamson, Practice Manager,
at Clinton Road Surgery, Redruth
on 01209 218686 or email
joy.adamson@clintonroad.cornwall.nhs.uk

PENINSULA MEDICAL SCHOOL NEWS**GP Conference – 12 October 2005**

We had an excellent turnout for the joint Peninsula Medical School and SW Peninsula Deanery GP Medical Education Conference on Wednesday 12 October 2005. There was enthusiasm and keenness to be involved from those who attended. It was good working jointly with the deanery. A summary report has been sent to the delegates but the full joint report is available on the website:

www.peninsuladeanery.nhs.uk (Foundation – What is it? – Foundation News.)

Year 5 students

In Year 5 the students will spend five weeks in General Practice running their own surgery etc in preparation for their Foundation Years. Further information is currently being sent out by the Localities to Practices who expressed an interest in having Year 5 students. For further information, please contact the Locality Offices:

Exeter - Rachel.blake@pms.ac.uk
Plymouth - Jodene.melville@pms.ac.uk
Truro -
Claire.newland@centralpct.cornwall.nhs.uk

ENHANCED SERVICES FLOORS

Enhanced Services Floors remain a constant issue nationwide, particularly in terms of how PCTs can be encouraged to spend up to the Floor before the end of the 2005/06 year. Concerns have been raised regarding their status and whether, and by whom, they are enforceable. This has been heightened by examples of PCTs elsewhere in the country stating that they will not spend up to their floor, but instead will use underspends to help offset their deficits.

Current opinion is that PCTs can be instructed to spend up to their ESF, although such instructions are not legally enforceable. The same applies for PCTs being instructed to manage their budgets. Inevitably there is a conflict between these two obligations, particularly given the financial position of the NHS.

The GPC negotiators' position has remained consistent – that the ES Floor should be spent on contestable Enhanced Services as a minimum – and they have and will continue to press the Department of Health to instruct, encourage and performance-manage PCTs to spend up to the Floor.

LMC representatives will meet in February with representatives of all three PCTs in

LOCUM GPs - PENSION ARRANGEMENTS

It has been confirmed that the employers' superannuation contribution for locum GPs remains with the PCTs "for the foreseeable future". The regulations for locum GP pensions have not changed and locum GPs should continue to claim for this in the normal way.

Please note that locums should check that the organisation that engages them as a locum is an approved NHS pension scheme employing authority to ensure that pay will be superannuable under the NHS scheme.

TRAINING AND MENTORING OF COMMUNITY MATRONS

Many thanks to Ms Helen Lyndon, Professional Lead for Community Matrons in Cornwall for the following response to a letter from the LMC Chairman following complaints from a number of practices that GPs were being asked to provide extensive on-the-job training and mentoring for their newly-appointed Community Matrons. In some cases there has been a lack of communication between the PCTs and GPs when Community Matrons have been appointed, and clearly there needs to be clarification over the issue of training, which practices maintain they have been asked to provide, and have provided, and over the issue of funding for training and mentoring, which practices say they have not been offered. The LMC will pursue these matters with the PCTs.

Meanwhile it is important to repeat that all practices that have commented to us on the issues have been unanimous in their welcome for the Community Matrons themselves, and in praise of the excellent work that they are doing.

From Helen Lyndon:

Training

Training of the new CMs (Community Matrons) is provided by the PCT through a Partnership Course with the University of Plymouth for which I am Module Leader. It has never been suggested that training is the responsibility of GPs. During training, the CMs require support from a mentor to enable them to put the skills they have learnt into practice.

There is also a formal element of competency assessment which the mentor is asked to participate in. The CMs are encouraged to use a wide variety of professionals for mentorship - GPs are just one suggested group. If a GP does agree to provide mentorship then there is a small amount of funding available to support this - although we acknowledge that this does not cover the full cost. There is no expectation that a GP alone will provide mentorship. There are Mentor's Handbooks which are given out to all mentors which details what is expected and my contact number is in the handbook to contact if

there are any problems. To date, I have only been contacted by one GP to express concerns. It would have been helpful to be made aware of these issues at an earlier stage in the course, so that we could have looked at alternatives. Now that the taught element of the course is complete I plan to send a letter to all mentors to thank them for their participation, but also to get their views on how we could improve this for the next course.

Medico-legal Responsibility

It is my understanding that once the CM has completed and passed the training course that if she is acting within the policies and procedures of the PCT, then the PCT accepts full vicarious liability for her actions. There is also professional regulation within the NMC Code of Conduct that nurses work within their sphere of competence and are responsible for their own actions within this regulation. GPs would not be held liable for any error the CM makes.

Future training of CMs

For this course I was heavily influenced by the University to use the competency/mentorship method of training. I am planning at the end of the course to write to all mentors to thank them for their efforts, but also to get formal feedback as to the impact of this on their workload and suggestions for future courses. It is my feeling this method needs to be reviewed for the next course and an alternative e.g. OSCE examination trialed. This is a new course and we are still learning the best ways to deliver.

Communication

Personally, I believe communication about the commitment of practices and the introduction of the CM role could have been better in some cases prior to the appointment of the CMs. However, since all 3 PCTs chose to implement the role in a slightly different way, there was not the consistency of communication which was apparent when the first CMs came into post (through the EPIC project). I would propose we do this differently for the next tranche of CMs.

GREEN PAPER ON WELFARE REFORM

At the end of January the Government published its Green Paper on welfare reform with the aim of removing one million people from Incapacity Benefit by 2010. It is clear that they are pushing for a major culture change to encourage people off benefit and into work, with General Practice playing a significant role. One of the ideas floated was that of Employment Advisors sitting in on GP surgeries to offer help and support. GPC Chairman Dr Hamish Meldrum said that although he had no problems with this in principle, there were many questions about the practical implications of doing so that would need to be answered.

Another idea, floated in the media at the end of January, was that GPs might be financially incentivised to write fewer Med 3 certificates. Following some robust comments and representations from the GPC and BMA, the Government seems to have dropped that particular idea, certainly for the foreseeable future.

**PNEUMOCOCCAL VACCINE:
LETTER TO THE GPC CHAIRMAN**

Dear Dr Meldrum,

Philip Leech spoke to you this morning about the leaked story in today's Independent about pneumococcal vaccine and other changes to the routine immunisation programme. I understand he confirmed that the information reported was not accurate, did not come from us and he expressed his regret about the situation. I would also like to offer our apologies.

It has been our intention that CMO would be in contact with you as soon as we were able to share the information, as far as possible in advance of any announcement. We are currently in the process of finalising a mandate for NHS Employers to take forward discussions with you around the complete immunisation schedule, including issues that you yourselves have previously raised. We do recognise there have been issues around communications in this area and we will ensure that NHS Employers are mandated to discuss a communications strategy with you as part of this work.

We deeply regret when information is leaked and the Profession learns about it either through their patients or from the media.

Thank you again for your assistance (and patience!) on this matter.

Yours sincerely,
David Salisbury

Immunisation Policy, Monitoring and Surveillance Department of Health Wellington House
133 - 155 Waterloo Road
London SE1 8UG

**PENSIONS: EMPLOYERS'
CONTRIBUTIONS AND TAX**

Some accountants have raised the question of GP clients who have paid PP contributions in respect of NHSPS earnings in 2004-05 and 2005-06 intending to use the ESC A9 to waive relief on the NHSPS contributions and claim it instead on their PP contributions. If they do so, the relief waived is 20% (or up to 29% if the GP is paying added years contributions, NHS AVCs or FSACVs), GPs have often paid the PP contributions on the assumption that the NHSPS relief to be waived would only be 6% (as was the case before 1 April 2004), particularly as the tax position has only been clarified very recently.

In such cases, there is nothing in ESC A9 to say that an election to waive relief on NHSPS contributions is irrevocable. So, if their income tax liability has not been finalised yet, a GP may revoke their election for 2004-05 and claim relief on what is now the 20% (6% employee and 14% employer) contribution to NHSPS. HMRC has confirmed that it would have no objection to the PP contributions being refunded in such cases.

ADVICE FROM THE GPC - ALLERGY RECORDING IN GP CLINICAL SYSTEMS

Introduction

In September we published an advice note regarding the handling of allergies in preparation for the electronic transfer of GP records. This guidance supersedes and formalises that advice. It has been developed after further discussion and consultation with the GP2GP team, users groups, suppliers and the GPC's legal advisor.

The context

The context of this advice is that we are all going to be moving from an environment where we just create records for ourselves, to one where records will be routinely transferred between practices and shared with other clinicians. The consequence of this is that new responsibilities arise.

The problem

Transfers of allergy information between same GP systems generally work well but transfers between different GP systems may not always result in all the allergy information being transferred because allergies are handled in different ways in different systems. Not all systems use Read codes to record allergy information, some use other code sets and others may use bespoke codes. Qualifiers that exist in one system may not have an equivalent in another. Translation arrangements are therefore needed. The GP2GP team has developed import mechanisms designed to recognize incoming system specific allergy information that presents this information to the user and then prompts for action. If the incoming allergy codes cannot be safely mapped to the receiving system they will be degraded and may appear as text alone or as text associated with less specific codes.

Another issue is that system specific recording of allergies can be limited to prescribable items, thus omitting some extremely important non drug allergies.

Our Advice

GPs should continue in all cases to use their system-specific mechanism for recording allergies. It is essential that allergy information is properly recorded on your own system to ensure it can be recognised and dealt with during GP2GP transfer. Receiving systems will have any incoming allergy information that has been entered using the sending system's specific mechanism presented to them as part of a receipt workflow (for detailed advice see references below). This workflow should facilitate appropriate translation into the receiving system's allergy alerting mechanism.

For systems that use Read code(s) as part of their system specific process no additional entries are required for drug related allergies. The Read code(s) will be unequivocally recognizable by the receiving system although some system specific qualifiers may not be.

However if your clinical system's allergy recording mechanism **does not** use Read Codes to record allergies, then you should **in addition** double enter all allergies as Read coded data, as well as via any system specific mechanism.

This will have the effect of providing a backup to any system specific entries, adding another level of patient safety and mitigating any possible liability in respect of the clinician. We hope that most GPs will see this as a worthwhile duplication to enhance patient safety.

All of the double entered read codes will be reliably transferred between systems via GP2GP and it will be possible to search for any such codes in the receiving system. Care will have to be taken in interpreting the context around these codes such as certainty and severity.

Please check with your supplier or your users group for precise advice as to how this applies to the system you use. They will know whether your current system's allergy recording uses Read codes.

The Read codes available are not exhaustive and may need expanding but where they exist they should be used. They do change from time to time and GPs should keep themselves up to date.

GP2GP import mechanisms will evolve over time and GPs should keep themselves up to date.

All GPs are reminded of the Good Practice Guidelines for GP electronic patient records <http://www.dh.gov.uk/assetRoot/04/11/67/07/04116707.pdf> which contain detailed guidance on the use of electronic records in General Practice. Chapter 5 and appendix 2 deal with G2GP record transfer. Updates to this guidance will be prepared and published by the GP2GP team as further supplements available from the GP2GP website <http://www.connectingforhealth.nhs.uk/delivery/programmes/gp2gp>.

Dr Paul Cundy, Chairman, GPC IT Committee

We have been asked which codes GPs might use. The following are examples from the 5 byte Read Codes;

Chapter title	Read codes beginning with
Drug – Adverse reaction – AR	TJ...
H/O Drug allergy	14L..
H/O Non drug allergy	14M..
Allergy unspecified	SN53.
Anaphylactic shock	SN50.
Food allergy	SN58.
Personal history of drug allergy	ZV14.

Equivalents exist in the Clinical Terms Version 3 and SNOMED code sets.

DR BASIL BILE WRITES ...

“Striking Doctors On The March” thundered The Times, *“50,000 surgeries closed as GPs threaten to desert”*. Whoopee thought I, our negotiators have finally decided to stand up to HM Gov and its bullying “you screwed us over the new contract so we’re out for revenge” posturing. Sadly not. On reading on it became clear the headlines relate to our saxon cousins. A third of German doctors earn less than £1,400 per month, while the many that fly over here to do weekend moonlighting can pocket £2,000 each trip. Small surprise then that thousands of Jerry Docs have announced they are going to abandon Europe’s most modern health system to work in Britain. Ironically what is also upsetting them is that their own government is seeking to restrain them from prescribing expensive medicines as well as capping the individual budgets of Practices. So they should feel perfectly at home here then. Willkommen.

Tony and his cronies are presumably rubbing their hands in glee as if we turn bally bolshie he can replace us wholesale with the German invasion. It might therefore be a judicious time in the Grand Duchy to consider reviving the spirit of Dad’s Army in our LMC Cabinet. With Captain Mainwaring Dommet at the helm, Rabid Rob in the role of the spiv selling dodgy blackmarket stockings and bananas, Dr Bumbleton dashing around in “Don’t panic Mr Mainwaring” and “They don’t like it up them” Corporal Johnson mode, Ashtray Rooster as the John Laurie gloomy pessimist and The Absent Abbott as the Ian Lavender “Silly Boy” I feel sure we can sleep easy in our beds when the air raid siren sounds and the sky is full of parachute canopies supporting stethoscope wielding Berliners. Just in case Plan One flounders I will describe a typical working day for a Tommy Doc in the hope that it can be used in a leaflet drop over enemy territory.

8.59: Arrive at desk allowing 60 seconds to deal with queries.

9.00: Computer crashes.

Practice IT Lead Dr Hilda Bunnytunnel phones

to tell me it is due to the wrong type of leaves on the line and will be fixed Monday week.

9.01: Told by receptionist that we have no appointments left today.

9.02: Computer comes back on, announces on the screen that my password is out of date and I cannot have access.

9.03: Password changed to Hatepatients7

9.04: Message from reception - Mrs Purbright has cancelled as I am running 4 minutes late and she will writing to the PCT to complain.

9.05: Buzz for second patient

9.05.30: Message from reception - Mrs Highorse has cancelled as I am running early and she will be writing to the PCT to complain.

9.06: Computer crashes - IT lead Dr Hilda Bunnytunnel phones me to explain it is due to Mars being in conjunction with Venus and it will be fixed on Tuesday week.

9.07: Request for urgent visit from a mother who has run out of Calpol and her car has been stolen by her estranged husband so she can’t possibly come in to the surgery. If I don’t visit she will report me to the PCT. Give her PCT phone number.

9.08: Computer crackles in to life and I call in next patient who has received a letter asking her to come in urgently to discuss her recent test results. Haven’t a clue what it is all about but luckily all is safely recorded on the computer.

9.09: Computer crashes. Unable to give her results. She tells me in the midst of hysterical weeping that her husband, an out of work all-in wrestler, will be round to see me shortly to discuss the shortcomings of the service I offer. Meanwhile she is going to report me to the PCT.

9.10: Post card arrives from Dr Hilda Bunnytunnel, from Brazil, from where she has been phoning me all morning, reversed charge calls of course. Hopes to be back Wednesday week.

9.11: I telephone the German Embassy asking if they could send a German doctor to replace me A.S.A.P.

9.12: Smash up computer with sledgehammer. Feel a lot better. Phone PCT to report myself....