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SOUTH STAFFORDSHIRE LMC NEWS

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COMMISSIONING AND PATIENT CARE

Following previous discussions about commissioning and patient care the GPC carried the following motion:

'That GPC believes that compulsory practice membership of CCGs with statutory duties as defined by the Health and Social Care Act:

1. risks placing GP partners in a position of untenable conflict between their professional obligations to their patients and the statutory obligations of their practices as CCG members;
2. fundamentally changes the role and nature of general practices, and, in view of recent regulatory changes, risks forcing them to be integral agents of state rationing, cost control and privatisation, seriously threatening the trust between GPs and their patients and therefore posing a risk to the very integrity of NHS general practice;
3. places significant obstacles in the way of GPs and practices acting in accordance with the recommendations of the Francis report as they will be under inevitable pressure to comply with their CCGs' statutory obligations to stay within budgets and to achieve financially and managerially-driven targets which conflict with the needs of their patients;
4. adds to competing pressures on general practice, particularly following the recent contract imposition, and GPC recognises that practices must and will prioritise providing safe essential services to their patients and are therefore very likely to consider limiting their engagement with their CCG and its activities to their contractual obligations;
5. leads it to call upon the BMA and the LMCs to robustly support doctors who are placing the interests of their patients as their first concern and who may be unable to comply with obligations placed upon them by the constitution of their CCG where there is evidence that patient safety may be compromised by the requirements of CCG policy.'

FITNESS TO DRIVE REGULATIONS

The DVLA has amended the epilepsy and vision elements of the minimum medical standards for group two drivers (driving lorries and buses) in the UK. They have updated the form for doctors reporting on patients' fitness to drive and their information leaflet about the requirements. Because the visual standards now require a higher level of response from doctors, we advise GPs to refer patients requesting certification to optometrists for the vision section of the assessment, unless the patient has either 6/6 vision uncorrected or 6/6 vision corrected and with recent evidence of prescription strength.

BENEFITS SYSTEM CHANGES

You will be aware of the ATOS Work Capability Assessments that is going on at the moment and how this is impacting on GP practices. There are also a number of new changes to the benefits system from April 2013 onwards. These include:-

- Housing Benefit rules changed for council and housing association tenants which will take account of the size of each property and reduce benefit for those with extra rooms. The changes are a 14% reduction for 1 extra room and 25% reduction for 2 extra rooms.
- Benefits Cap to be introduced on the overall amount of benefits a household can receive.
- Phased replacement of Disability Living Allowance with a new Personal Independence Payment (PIP).
- Council Tax Benefit to be abolished and replaced with a Council Tax Reduction Scheme administered by local authorities.

These changes are likely to further impact on GP practices with patients affected by the changes looking for letters to confirm various care needs or medical conditions and general letters of support.

We have already seen Councils assessing Housing Benefit and sending patients to GP practices to "get a note from the doctor" confirming whether or not they need an overnight carer for extra bedrooms. We feel that this is totally inappropriate. GPs are not in a position to be assessing patients' requirements for overnight care. That responsibility lies with the Social Work department and the DWP.

The LMC has produced a draft letter (attached) which can either be given to patients, their carers or to the service that is asking for one of these notes. We feel that GPs need to have a consistent approach to this issue. Colleagues who provide these letters to patients ultimately make it more difficult for other GPs to resist and also it increases the number of requests from these authorities for GPs to provide this unfunded service.

CQC OUTCOME 18 - NOTIFICATION OF DEATH

This has been confusing but you need to refer to what the CQC is requesting and report deaths as highlighted (b) below.

Outcome 18

(2) Subject to paragraph 4, where the service provider is a health service body, the registered person must notify the Commission of the death of a service user where the death:-

a. occurred:-
   1. whilst services were being provided in the carrying on of a regulated activity, or
   2. as a consequence of the carrying on of a regulated activity; and
b. cannot, in the reasonable opinion of the registered person, be attributed to the course which that service user's illness or medical condition would naturally have taken if that service user was receiving appropriate care or treatment.

This is the information on death notifications from the CQC website:

All registered providers of primary medical services have to notify certain deaths to CQC from 1 April 2013. Notifications must be submitted directly to CQC. The law does not allow providers of primary medical services to notify CQC via the NHS National Reporting and Learning System (NRLS). However, not all deaths have to be notified.

The Health and Social Care Act (2008) requires that deaths must be notified if the death would not have happened if the person had been receiving appropriate care and treatment and either:

- the death occurred while a person was actually receiving a regulated activity from or at the GP practice (including in a person's own home, for example during a home visit).
- the death occurred, or may have occurred, as a result of regulated activity having been provided by your GP practice in the two weeks before the person died.

SUMMARY CARE RECORD IMPLEMENTATION

The LMC position remains that the decision whether to proceed with the summary care record uploads rests with the GP practice.

The LMC accepts that the core record, containing medications, allergies and adverse reactions is uploaded on the basis of implied consent. Additional information should only be added with explicit patient consent and should be information that is required to support patient care in an emergency or urgent situation. The SCR should only be viewed in emergency or urgent care settings with the explicit consent of the patient unless the patient is unable to give their consent for example, if they are unconscious.

NHS 111

Following the recent shambles with the introduction of NHS 111 it is the LMC advice that practices should inform their CCG about any untoward incidents.

Dr David Dickson
LMC Secretary

DATES OF NEXT MEETINGS

20 June	Edric House, Rugeley	**AT**
4 July	Edric House, Rugeley	**LMC**

The meetings with the **LMC** are for the full committee of LMC members without the AT.

The meetings with the **AT** are for the LMC Executive and the AT alone.

LMC MEMBERS

The following is a list of current members of the South Staffs LMC

Dr V Singh (Chairman)	01543 870580
Dr D Dickson (Secretary)	01283 564848
Dr P Gregory (Executive member)	01543 682611
Dr G Kaul (Executive member)	01543 414311
Dr P Needham (Executive member)	01283 565200
Dr T Scheel (Executive member)	01283 845555
Dr A Burlinson and Dr O Barron (job share)	01889 562145
Dr J Chandra	01543 870560
Dr J Eames	01785 815555
Dr A Elalfy	01785 252244
Dr C McKinlay (Treasurer)	01283 564848
Dr E Odber	08444 773012
Dr A Parkes	01827 68511
Dr A Selvam	01543 571650
Dr E Wilson	01922 415515
Dr A Yi	01543 870590
Dr H Zein-Elabdin	01922 702240

DR V SPLEEN

Dear reader

Dr Spleen is old enough to remember the days when prescriptions for Morphine had to be handwritten stating exactly the amounts in words and numbers that were intended to be used, because of the high addiction forming potential of strong opiates.

This made sense to her, because she was aware that other countries even used specialised separate prescription pads for this purpose, similar to the ones we still use for Methadone.

Drugs like Tramadol were later marketed very successfully, because they did not require such strict rules to be followed. Hence Dr Spleen is noticing with increasing surprise and astonishment how over the past years the attitude within the profession has changed and with what ease opiate prescriptions are being been issued for all kinds of pain; not just the terminal ones, for which it was initially largely intended.

Now we are prescribing Morphine in various applications and sometimes under different brand names to a point that Dr Spleen believes that patients often don't even know what they are getting.

Involved nurses in and out of care homes also now recommend Morphine containing products so frequently that Dr Spleen has even been approached by relatives, if "grandma can't also have such a lovely patch for her bad knee"?

However when pointed out that that "lovely patch" actually contains Morphine, the attitude changed.

At a recent meeting it had been suggested to Dr Spleen that the usage of Morphine is to be pushed up beyond 50% for certain types of pain as a measure of "good practice".

Dr Spleen does not really know, if all this is right or wrong. She is just surprised about the massive change in attitude that has taken place over time and sometimes wonders why on the other hand it still appears to be a sin to prescribe more than seven tablets of Diazepam when people are actually very anxious?

Dr Spleen can't help the feeling that in a few years' time a "new" study will suggest that there has been some "irresponsible and indiscriminate prescribing of strong opiates" and an "expert team" may recommend an increasing usage of alternative drugs instead; possibly even NSAID drugs, in which case everything might have gone full circle yet again.

Venture

The views expressed in this column are those of the author and not necessarily those of the LMC