

LMC Secretariat Newsletter (November 2005) (Oxon Supplement)

Contents

Click to hyperlink)

Un-communicated alterations to 2 week wait process in Oxfordshire	1
CLAG and CALS.....	1
Single Assessment Process for Elderly Mental Health Referrals.....	2
LMC Liaison with Secondary Care Trusts.....	2
GP view of Oxon hernia decision	2
Antenatal Screening for Haemoglobinopathy	4

Un-communicated alterations to 2 week wait process in Oxfordshire

It now seems that for some specialities, GPs phoning up cannot get an immediate date and time on the phone. This is because some departments in the John Radcliffe now require sight of the referral letter and assessment by a specialist nurse. The aim of this is to ensure that the patient, as far as possible, goes straight to diagnostics. The change appears to have been instigated unilaterally without any reference to commissioners or the LMC and without the new process being formally written down. The John Radcliffe has apologised for these omissions and promised corrections.

CLAG and CALS

Two months ago Oxfordshire PCTs set up the Clinical Leaders Action Group (CLAG) to formulate ways for the Oxfordshire NHS to live within budget. This committee of very senior representatives from PCTs, ORH, NOC and Social Services meets fortnightly with the LMC Secretary and Chair also attending.

Outcomes so far are:

- Lavender statement for inguinal and umbilical hernia surgery. Now low priority.
- Revised Lavender statement for Varicose vein surgery which will be applied retrospectively to those listed but not yet dated for surgery
- CALS (Clinical Advice and Liaison Service).

A CALS Steering Group, attended by the LMC Secretary is developing the service which will be sited in the RI.

CALS' aims are to lessen the gap between spend and budget in secondary care by having experienced clinicians give telephone advice to GPs and also vet referral letters.

I have mixed views on CALS. I support clinically intelligent assessment of referrals together with advice on referring differently, but would prefer if this took place at practice level. This is what I understand to be one of the components of PBC. Such a system could quickly deliver some reduction in referral rates. I envisage a system of financial incentives for practices that commit to peer review of all referrals from the practice.

CALS may not deliver in the right timescale.

Any altered pattern of referral from practices would be made a lot easier if there were financial pump priming to develop alternative referral pathways in the community, very likely using GPs as providers.

Single Assessment Process for Elderly Mental Health Referrals

(Text of email from Secretariat to Jonathan Coombes, Lead at North Oxon PCT)

Thank you for talking on the phone yesterday.

I have just been sent a copy of the proposed form GPs are expected to use as part of the Single Assessment Process.

Like other GPs I was amazed at how unusable it was as a GP referral form.

It is long and cluttered so that identifying the questions that GPs might reasonably be expected to have answers to, involves major expenditure of time that we just do not have.

The opportunity cost is too great and it just won't be used.

I understand why receiving the organisation has to have a template defining the dataset that it wants to collect on all clients, but the task of bringing this dataset together cannot fall on the referrer.

An urgent rethink involving LMC as the statutory representative of GPs is needed.

The alternative is total rebellion and non co-operation which I think we would all like to avoid

LMC Liaison with Secondary Care Trusts

Since the Oxfordshire LMC meeting on 29th September, I have received the following self nominations.

Trust	Self Nominee
NOC	Neil Bryson
OMHT	Bettina Rand
OMHT	Rob Mather

Could LMC reps please let me know by email who they would like to represent them with the OMHT.

The self nominee with the highest support from reps will be asked to take on the role.

Do we need to have a rep for the Royal berks Hospital?

GP view of Oxon hernia decision

(text of letter received about this issue)

I am writing to you on behalf of one of my patients who has been told that his bilateral inguinal hernia operation has been cancelled because his condition is now not considered to be a "priority".

In fact he was one of 4 of my patients who received similar letters on 14th November, all of whom were dismayed by the news.

I had originally referred my patient to Miss Linda Hands Consultant Surgeon at the John Radcliffe Hospital on 23rd September 2005 because he had significant pain from his hernias with the expectation that he would be put on the waiting list for surgery.

I find it deeply disturbing that a non-medical person (Mr A Murphy, Associate Director of Access at the Radcliffe Infirmary) should be writing to my patient, whom he knows nothing about, telling him in that his NHS operation is to be cancelled. What, I wonder, is the patient or the GP supposed to do next?

The fact that this management decision was based on a policy statement from the Priorities Forum seems little excuse for ignoring the human suffering which will inevitably result.

I do not know a single surgeon or GP who supports this policy and I wish to express a vote of no confidence in the system which arrived at this perverse decision.

Is there anything you can do to bring some sense back to the situation and get my patient his operation?

You might like to consider the following points:

From the medical perspective the evidence quoted by the Priorities Forum seems to be out of date and inaccurate. I quote the current Clinical Evidence chapter on Inguinal hernias which says, in essence, that the only beneficial treatments are surgical and that there are no systematic reviews, RCTs, or cohort studies of sufficient quality supporting expectant (ie. non surgical) management (ref BMJ Clinical Evidence 12 Dec 2004 118-122). Why, one wonders, were non operative treatments not more widely advocated in the past if they were such a good idea?

GPs are quite well aware that not all patients require surgery, and we already act as a filtering system by not referring patients who would not benefit from an operation. Conversely we are likely to refer patients whose symptoms demand a surgical solution, and it is illogical to say that they should only be allowed treatment if they develop a complication such as strangulation when this could be prevented by elective surgery.

If this sort of policy is deemed acceptable then what other treatments will become unavailable in the future? What ever happened to patient choice? How many hernia sufferers were consulted by the committee who produced this policy? As a GP I feel a sense of hollow irony when I watch one set of NHS administrators spend £6.2 billion on an infra-structure to increase patient choice (Choose & Book), whilst my patients are being told by another set of bureaucrats that they have no choice at all and no treatment.

Antenatal Screening for Haemoglobinopathy

Oxfordshire planning universal antenatal Haemoglobinopathy screening and needs GP rep for group. PCTs have suggested approach to LMC

Current selective screen has problems: delay in getting sample affecting prenatal diagnosis.

Proposal to cut out GP and use screening co-ordinator