

Somerset LMC Newsletter



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PATIENT CLINICAL QUERIES

May be a useful clinical governance tool

The LMC is not infrequently approached by practices who have become concerned about the clinical performance of a GP or practice nurse. Often this concern is not enough to trigger a formal clinical governance investigation or a report to the PCT, but is more a feeling of unease about some aspects of a particular clinician's practice. By definition, these things are rather nebulous; so how do you capture the information that helps the practice decide whether this is just part of the natural difference between people in the way that they work or a sign of a significant performance issue?

You may find it useful to adopt a system we describe as "*Patient Clinical Queries*". Whenever a clinician notices something that bothers them – for instance, a missed referral, an abnormal test not acted upon, or the prescription of interacting medication, he or she sends a simple email to the person concerned : "*Re: Joe Bloggs. Potassium 3.0 in April. No action recorded?*" with a copy to an email address called "*PCQ*"

The clinician concerned replies to the sender, again with a copy to PCQ "*Whoops! Missed that – thanks for letting me know, I will sort it.*" or perhaps "*He has congenital hypokalaemia and hospital says anything above 2.5 is OK*" or even "*So what?*"

From time to time someone checks the PCQ mailbox to see what is in there. Do the messages just reflect random noise generated by normal practice ? Do they point to a system problem - maybe your lab link software is not reporting low potassiums? Is there a learning need "*Oh, is 3.0 a problem?*" or is there actually a pattern of events that may point to a performance issue for a particular doctor?

For this to work and be blame free a few conditions have to be met.

- Someone needs to be appointed by the practice as the moderator to keep an eye on the correspondence.
- Although all clinicians should be able to look at the correspondence, nothing should be deleted without this being formally agreed
- You need to remember that some emails may need to be released if a Freedom of Information Act application is made to the practice or in the event of legal action pertaining to patient care
- *Everyone* should be encouraged to report *all* incidents using the system so that it is not seen as either a tool for witch hunting or a pastime for obsessives
- There needs to be designated time in practice meetings to discuss and reflect on the correspondence using the Pendleton Rules.

We think this is one way of ensuring that the practice can pick up small things before they have a chance to grow into bigger ones, and at a time before the emotional temperature rises. You might like to give it a go?.

THE “PROACTIVE” REFERRAL SCHEME FOR COMMUNITY PHYSICAL ACTIVITY

Also includes falls prevention and Phase IV Cardiac Rehabilitation

There are perhaps a few GPs who are still unaware of ProActive, which is a countywide scheme designed to provide a safe introduction to physical activity for people who have specific health problems and have previously led an inactive lifestyle. It welcomes referrals for clients who would benefit from a **structured** approach to increasing their activity levels, and it aims to provide safe and effective exercise within the knowledge base and experience of the instructors, all of whom have been assessed as having the required skills. The scheme is primarily designed for patients who will be able to exercise independently once they have completed the scheme. There are currently about 2000 referrals a year and more would be welcome. It's obviously the referrer's responsibility to clinically assess the patient and make sure he or she is suitable for an exerciser programme. But we know that premature mortality in people who take regular exercise are reduced by 20-30% and there are relatively few contraindications to referral. Most of these are pretty obvious:

Cardiac

Unstable angina, uncontrolled cardiac arrhythmias causing symptoms or haemodynamic compromise, severe symptomatic aortic stenosis, uncontrolled symptomatic heart failure, acute pulmonary embolus, acute myocarditis or pericarditis, suspected or known dissecting aneurysm tachycardia of >100 bpm at rest, **Uncontrolled** Hypertension (i.e. resting systolic > 180 or diastolic >100).

Metabolic

Uncontrolled metabolic disease (e.g. diabetes, thyrotoxicosis, or myxoedema)

Muscular

Neuromuscular, musculoskeletal, or rheumatoid disorders that are **exacerbated** by exercise

Other

Acute infections/illness/fever

Uncontrolled mental health condition

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Significantly impaired cognition (unable to follow simple movement instructions)

Clients who require continuous one to one supervision or help with undressing can be accepted if a carer is in attendance.

The referral process is straightforward. You need to complete a short form which the patient must also sign. Give the patient a ProActive leaflet and send the form to Irina Kweatkowski, Health Promotion Manager for CHD. (01823 344223) or e-mail on irina.kweatkowski@somerset.nhs.uk (from whom you can also order referral pads).

PCT staff from the Scheme contact clients by telephone and the most suitable of the 25 current providers can be chosen. The patient's details are passed on to the provider who makes contact to arrange the first appointment. There are a range of activities available on the scheme including gym work, walking, swimming, and Pilates. Activity is set at the patient's pace and the instructors can also offer advice and support on other lifestyle issues, such as healthy eating, drinking alcohol, and managing stress.

Most of the involved leisure providers have set up a special discounted rate for people who are on the ProActive scheme. Costs vary and depend on the activity concerned: clients will be given information on prices during the introductory phone call. Work is in hand to expand the range of activities on offer to include more community options, and activities that are free, such as Health Walks.

Occasionally scheme staff may have a query about a patient, such as a particularly high blood pressure reading. They may then contact you, or refer the patient back to you for additional checks before beginning exercise. This is to help ensure patients will be safe, and to meet national guidance for the scheme. The scheme is well liked by patients and reports many success stories including increased confidence in daily activities, losing weight, reducing blood pressure, better control of diabetes, and improved mood. Patients are sometimes able to reduce medication or learn to manage long term conditions better. Some people say the scheme has helped them to change their lives!

“CHOOSE AND BOOK” AT T&S TRUST

Information from Dr Peter Cavanagh, Medical Director at T&S

Choose and Book (CAB) is becoming an essential part of the way that the acute and primary sectors work together. We are very aware of the additional work it creates for busy GPs and the difficulties that we have all faced with the system so far. We are doing everything we can to make the process more straightforward.

When a practice refers a patient a unique reference number (UBN) is generated in the CAB software. When the patient calls the Booking Management Centre (BMC) the latter will go through the list of providers that they can choose from. The patient can either then be booked directly (see below) or be put through to the hospital by the BMC or phone the hospital to book an appointment themselves.

We know that our directory of services (DOS) is complicated. We want to improve this and would welcome your views on what needs to improve. To help you navigate it we have:

- Created a shortcut guide to the directory – call us if you do not have one
- Set up a helpline at Musgrove Park (07778523830)
- Set up a helpline at the booking management centre (01278 727422)

Where appropriate generic referring will allow us to be more flexible. But if you want more information about which is the right service, call the helpline.

We also know that getting through to use the system is difficult. Only 30% of calls to the CAB line at the hospital are being picked up first time and we are looking at ways to improve this. 90% of calls to the BMC are answered within 30 seconds and a patient can ask the BMC to contact the hospital for them.

The solution to this is direct booking, so that the BMC can book appointments without patients needing to call the hospital. We are currently operating direct booking for five specialties at Musgrove Park (Dermatology, ENT, Cardiology, Gastro Entorology and Urology) and we are planning to have all specialties fully booked by the end of the year.

Even with the frustrations above, the Choose and Book system is gradually having an effect.

- In a survey of patients who had used the system earlier this year, 90% said that it was an improvement.
- 55% of all referrals to Musgrove Park are now made using choose and book

We need you to:

- Make use of the helplines listed above
- Bear with us as we continue to improve the system
- Tell us where things are going wrong so we can try and make it better

Choose and Book is here to stay, and by working together we can make it a better system for patients.

PARTNERSHIPS FOR OLDER PEOPLE PROJECT

A innovative plan for developing Active Living Centres across the county

As the population grows older it becomes more and more important to maintain the health and well being of ageing people, not only for their own sake, but also to reduce the demand for expensive health and social care services. Somerset has obtained £M1.3 of central funds to set up a partnership with Age Concern that seeks to establish a network of 50 Active Living Centres across the county. These will be located in natural communities and be based on an informal café-style service run regularly in a suitable venue such as a community centre. This will link in to existing preventative health and social care services, local groups and societies including churches, the voluntary sector, continuing education and other services like transport and libraries. The idea is that each centre should evolve according to local needs and desires, but always with an eye to maintaining health and independence through physical, mental, and social activity. As far as possible centres will be volunteer run, and it is hoped that they can act as a focus for wider community development and empowerment. One particular project is the development of a screening tool to identify older people at risk of falling – something that will be of interest to practice based commissioners. The first five centres should be established by the end of 2006, and we will keep you informed of progress.

THE NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT

If you have not come across a medical website called Univadis, may we suggest that you have a look at it? (www.univadis.co.uk) Dr Phil Hammond has a regular column on it, and in August he wrote about the CFISSA programme, which is the central government allocation that funds the NHS plan. Apparently, the budget set for 2005/06 was £10.4 billion whereas the actual expenditure was £18.3 billion – an 80% deficit. Compare the silence on this with the furore about the 1.5% hospital trust overspend for last year! One reason for the overspend must be the cost of endless reorganisation including the merger of 3 recently formed bodies into something called “The NHS Institute for Innovation and Improvement”. We asked an LMC member to review its prospectus.

This reviewer gets to read a lot of documents that emanate from the growing bloc of NHS management. But a new organisation has come to my attention that really got the blood pressure up. “Then felt I like some watcher of the skies/ When a new planet swims into his ken.” Never mind, Milton, Wordsworth or Keats, it would need an Orwell to do justice to this new group of managers managing managers that will cost the taxpayer £70.7 million in 2006/7.

And what will the NHS be getting for this investment? Well, if the Institute’s document “Delivering on Quality & Value – focus on productivity and efficiency” is any guide, a lot of bar charts, impenetrable management jargon and innumerate, wishful thinking about everyone being “as good as the average.” Your reviewer was reminded of Mr Blunkett, when Education Secretary, claiming the aim of “Excellence for all!”

You will not be surprised to learn that there is variation in the NHS. Just as with prescribing in General Practice, to the managerial mind variation means only one thing: inefficiency. Never mind that health care is a complex, multifactorial entity where real people make individual decisions about when, where and to whom to present problems and other individual people make decisions about how to respond.

Of course, there are practices hard to defend. Progress is made and we are second to none

in adapting to it. When did a patient of yours last have a “D&C”? Tonsillectomy goes in and out of fashion but people still get sore throats. Money is wasted in shed loads on agency nursing staff by hard pressed Trusts trying to “meet” targets while many of their overloaded, unappreciated staff go off sick. Patients are admitted for surgery and sent home disappointed.

But, would you believe that, on average 3,000 fewer patients are discharged from hospital on Saturdays and Sundays than on weekdays? The Institute deplors this and mutters pieties about patients being discharged “when they are ready, not when the system is ready.” If every Trust was “average” fantastic sums of money on bed days could be saved. Never mind that these patients are probably mostly elderly and in need of social services that are not available at weekends. Or, God forbid, that they might require old fashioned “care.” Just get them out of hospital. Can someone explain to me what money is saved when a 20 bed ward has 19 patients in it? We worked out that only the food is saved and that costs pennies, Jamie Oliver notwithstanding.

Reading the paper I realised what Patricia Hewitt thought she was on about when she spoke about patients with angina and heart failure being treated at home. These are both examples of 19 “Ambulatory care sensitive” conditions, which I think means the patient can still walk. Since gangrene is listed as one of these I suppose it all depends which part is going black. COPD is said to cost the NHS £253m in emergency admissions, CCF £211m, hence the need to be “developing and targeting community services for ACS conditions...” to reduce admissions by 25%. Similarly we must have more day surgery, fewer elderly people admitted the day before surgery, more early discharges and more stroke patients sent home at weekends.

Naturally, there is much in this wish list that is as unarguable against as motherhood and apple pie. But the figures given for savings seem to be plucked out of the air with the usual insouciance of the manager who always knows other people’s jobs better than they do themselves.

GPs have seen this and, surprisingly, largely accepted interference in their right to prescribe as they see fit. Expect more of the

same in every aspect of the NHS. The day of the manager and “Clinical Government” (*sic*) is upon us.

Suffice it to say that inefficiencies abound – except for in the Institute, of course. After all, as the Strategic and Business Plan states, of the £70.7m budget, “£52.9m are (*sic*) dedicated to delivery on (*sic*) priorities. Corporate Services supporting efficient delivery of the priorities represent £16.9m.” You might think dear reader that this means a small proportion is going on wages. I think that we are meant to believe this but a convenient table shows that of the £52.9m no less than £31.8m is going in pay, plus over £5m of the £16.9m. That is £37m – more than half the budget. Nice work if you can get it – inside and no heavy lifting.

NATIONAL REPRESENTATION OF GP TRAINERS

Please register with the GPC Database

The GPC is well aware that trainers are not properly rewarded for their educational work, partly because the DH has not submitted any evidence on training to the DDRB who have therefore not been able to make any recommendations on an increase to the trainers grant. In order to pursue this the GPC wants to ensure that its list of trainers is current and comprehensive so if you have not done so we encourage all trainers to email the GFPC office with your details. jgoodway@bma.org.uk putting “GP Trainers Database” in the subject field and your name, practice address, and preferred email address in the body of the message.

“HAVING IT ALL? CPD AND THE SESSIONAL GP” - FIFTH NATIONAL CONFERENCE

Friday 6th October 2006

A GPC/ London Deanery conference for those interested in continuing medical education and professional development for sessional GPs is being held at BMA House next month. Discounted fee (£76.38) for sessional doctors not funded by a deanery or PCT. Details from BMA Conferences 020 7383 6137/6605 or

www.bma.org.uk/conferences

Small Ads Small Ads.....

WELLS CITY PRACTICE PART TIME SALARIED GP

The Practice is in the beautiful cathedral city of Wells in purpose built new premises with excellent facilities. We require an enthusiastic doctor to join our small friendly team to do 5 sessions a week.

3.5 Partners, 6750 patients, EMIS system Paper light, GMS, High QOF achievement, Excellent nursing and support staff No OOH/weekends.

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Carol Judd, Practice Manager, Wells City Practice Priory Health Park, Glastonbury Road, Wells BA5 1XJ or

email: carol.judd@wells-city-practice.nhs.uk

Telephone: 01749 836652

Informal visits welcome by arrangement

Closing date: 29th September 2006

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Associate GP needed for friendly practice of six partners and two associates.

New well equipped premises with full support staff. Fully computerised (EMIS LV).

Up to 5 sessions a week available.

Please contact Dr. Roger Ashman (Senior Partner) or Mr. Mark Burton (Practice Manager) for further information.

Telephone 01749 672137 or e-mail Roger.Ashman@wells-hc.nhs.uk

FootNote

“Doctor, doctor I cannot stop singing “The Green, Green Grass of Home!”

“Aha! That is because you have developed Tom Jones Syndrome.”

“Is that common?”

“Well, it’s not unusual”

JENNIFER'S JOURNAL

Freed from Holloway on the latest Early Release Scheme after serving 6 ½ minutes of her 20 year sentence, Jennifer has attached her electronic tag to a passing pigeon and returned to her desk. Now read on...

THE REVOLUTION

Dr. Zhivago, with Omar Sharif and Julie Christie, was a great film. I remember the doctor's support for the ideals of justice, fairness and equality; but how it all broke down when humanity was destroyed. The system before the people; the people before the individual - utilitarianism with personal suffering for the common good. This tale of the Russian revolution reminds me of the changes in the NHS being forced upon us...

"Comrades- from now on you must all provide an equally crap service! Specialist opinion is an unnecessary extravagance when the patient can see a GPs with a special interest (GPSI) or an Allied Health Professional (AHP). And why do you refer to a British trained surgeon keen to build a reputation when we can use one from Eastern Europe on a temporary contract? Why should you use a quality drug designed and produced by a responsible reliable company when we can use a cheap imitation from a generic house? Why have an MRI scanner in your local hospital when you can have one in a van outside? Why have an ultrasound in your DGH when patients can struggle to a cheaper location? Why should we support your local hospital when we can buy care from little temporary ones further away? We will plan to do everything in primary care even though we have no capital investment strategy or space to do things!"



It seems that we are set on a path to destroy what we have and then see what comes out of the rubble. Is it safe to tailor care to individual patients when we can now be sued for failing to follow guidelines? Why spend money on training doctors to understand the complexities of the transaction when their decisions are already decided by protocol? Why use doctors at all? Primary Care can be run by nurses and HCAs following protocols written by managers in committee. Anything beyond the protocol that needs doing out of primary care can be done in a crumbling cottage hospital by the few remaining GPs (with a special interest) and the last bits left can be done by third world specialists on the cheap. In fact, doctors are the expensive part of the equation. GPs and specialists are now too expensive, elite and bourgeois. Better to have cheap staff who perform according to contract and are not allowed to have ideas of their own.

The world must be laughing at us: we down-size and down skill – and down quality and down cost. We are one of the richest countries in the world and yet we choose to do everything as cheaply as possible. I hope that most GPs will ignore bribes and Government policy; will ignore protocols and guideline; will ignore administrators and NHS management and will ignore unrealistic budgets. Let us all hope that they knuckle down and provide quality personal care to their patients. Ironically, it is by ignoring the Government that we will survive. At the end of the day, the patients are voters and enough of them will want a doctor that they trust and that offers personal care.

So, Comrades, it is time for our own revolution; let's spend some money and return humanity to the NHS. Let's offer personal quality care- the best drugs at highest cost and referral to the best specialist who can provide the best care in the world. If we spend enough money we might yet save the NHS from becoming a crumbling mediocrity.....so let's get to it, squash the Revolution and spend, spend, spend!

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

Jennifer