

Somerset LMC Newsletter



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FLEXIBLE OPENING HOURS

Don't do anything in a rush

It is intriguing that the Government campaign to persuade practices to open outside of the contracted opening hours has so far been entirely indirect. Indeed, until this month we understand that the GPC had not had a single approach from the Department of Health on this matter – not one letter, phone call, or email. Instead there has been a lot of political rhetoric, mainly from the Prime Minister himself, and now, of course, we have Lord Darzi's curiously insubstantial interim report, perhaps best described as a pamphlet for the election that never was. Yet even so, his section on "flexible" opening for practices is hardly draconian. The plan is that half of practices will offer either an evening or Saturday morning opening within the next three years. There is no stipulation as to how long that opening time should be or that it should cover urgent work as well as routine appointments.

We also need to be aware that it is very much focused on London, and, to a lesser extent, the other large cities. For instance, it is hard to feel that Somerset needs an 08.00 to 20.00 extended opening hours APMS provider. So, whilst it is clear that there is a great deal of pressure on Health Authorities and PCTs to tick the political boxes, we also know that if PCTs and LMCs can reach their own sensible local arrangements to improve access the national "solution" is unlikely to be imposed.

The LMC strongly believes that such joint action to produce a realistic and workable plan is more likely to succeed if practices continue to work together on this. The GPC has said that "*local GPs should not feel pressured into accepting any local arrangements that they do not feel are satisfactory. We will continue to discuss options for central arrangements but would stress that any centrally negotiated outcome should not preclude the operation of more favourable local solutions where these are available.*" We are therefore starting discussions with the PCT on a whole host of matters related to flexible opening including practitioner working hours, staff and practitioner safety, access to support services, prescribing and dispensing, cost reimbursement and locality planning and the complexities of the impact of on the Out of Hours service – notably the potential loss of GPs able to work sessions for them.

If we ignore the political point scoring, this whole discussion should be about how practices offer patients timely and appropriate access to the right clinician according to their needs. Ensuring that patients can be seen, on at least some weekdays, for routine matters between 8.00 am and 9.00 am, and between 5.30 and 6.30 pm would seem to be a good start. Combined with novel appointment systems like total telephone triage ("intelligent access") we are confident that neither the need nor the demand for longer opening will be significant.

All this will in theory present a greater challenge to smaller practices than larger ones but patient satisfaction with, and loyalty to, small practices with fewer team members tends to be very strong which may have some interesting lessons for all of us.

PALLIATIVE CARE DEVELOPMENTS IN SOMERSET

Gold Standards Framework

This is a practice-based system to improve the organisation and quality of care for all patients reaching the end of their life, regardless of diagnosis or care setting. Within Somerset, 47 practices are already GSF registered and the PCT is encouraging others to adopt this initiative with its proven benefits for patient care. The essential elements are a rolling palliative care register, regular multi-disciplinary meetings, a formal patient needs assessment, anticipatory planning, an emphasis on good communication, support and information for carers, and the use of an integrated pathway for the last few days of life. A local audit has emphasised the need to ensure that the OOHS is aware of such patients and that patients dying from non-cancer illnesses are considered for inclusion.

The Liverpool Care Pathway

This multi-professional document brings hospice best practice in caring for the dying into the community. It emphasises the need for shared decision-making and lists evidence based care goals. The pathway includes control guidelines for the common symptoms and technical information like opioid conversion chart. It should be particularly valuable for staff in care homes in which 22% of deaths in Somerset occur.

Out of Hours Access to Palliative Care Drugs

The PCT is considering the idea of a "Just-in-Case" box. Clinicians will be encouraged to anticipate their palliative care patients' needs for drugs to manage potential symptoms which can then be prescribed and left in the patient's home - maybe some weeks before they are needed - with the aim of averting a crisis and possibly an unscheduled admission. They will be stored in a blue, labelled box containing the LCP symptom control guidelines and the community prescription for administration. Some 90% of patients require palliative care drugs in the lead up to their death and the costs and risks of the scheme do seem to be outweighed by the benefits. The PCT is also exploring contracts with several extended opening hours community pharmacies across the

county to hold an agreed stock of palliative care drugs and there is a pilot in the OOH treatment centre in Shaftsbury where palliative care drugs will be held in a cupboard accessed through a keypad system. If the system works this could be extended. Finally, discussions continue on 'in extremis' access to palliative care drugs from the hospital pharmacies in Taunton and Yeovil.

A full version of this update has already been circulated to GPs but if you have questions regarding any palliative care issue contact:

Julie Vale, (Palliative Care Lead Nurse) julie.vale@somersetpct.nhs.uk or Dr Chris Absolon chris.absolon@somersetpct.nhs.uk or on 01935 384092.

PCT PROPOSALS FOR MUSCULOSKELETAL AND ORTHOPAEDIC REFERRALS

Intermediate assessment proposed for all referrals

Over the next few months the PCT is moving towards meeting the national 18 week referral to treatment target, and hopes to reach this well ahead of most other areas. Experience shows that one helpful way of sorting out musculoskeletal referrals is to have patients assessed and triaged at an intermediate care level, either by a GPSI or an extended scope physiotherapist. A large proportion of new orthopaedic referrals can be quickly, effectively, and safely managed at this level which is obviously of benefit to everyone. However, there is a wide variation in the proportion of patients presently referred to intermediate care services by different GPs and the PCT is therefore suggesting that in future all referrals should be reviewed at this level. The LMC view is that this is reasonable, provided that a GP referral made to a specific consultant for a particular reason is allowed to pass straight through the system. Furthermore, If a patient is seen by the interface service and onward referral for a surgical opinion is required, we anticipate that the "choice" discussion will be between the patient and the interface clinician although the actual booking process has yet to be agreed.

WHAT FUTURE FOR THE PCT?

Provider Services Review under way

Although the original national plan that PCTs were to divest themselves of provider services has been deferred, it still seems likely that at some time community services including district nursing and health visiting will be separated from the performance management and contracting functions of the PCT. As a first step the PCT is reviewing all of its clinical provision with a view to drawing together all the facilities and staff from the four old PCTs into a common management and service structure. Linked to this are some service developments that are in turn associated with PBC, including, amongst others a nurse consultant in unscheduled care and a consultant physiotherapist for musculoskeletal services. The new management structure is out for consultation until 10th December and can be found at <http://nww.somersetpct.nhs.uk/default.aspx>.

MRSA IN THE COMMUNITY

Comprehensive guidance from the PCT

You may have seen the recent coverage in the medical press of a DH programme to set up a surveillance system for MRSA in primary care - it will, of course, be "robust and comprehensive". We gather a sample of patients will be contacted either by post or through contact with general practice to see what the community incidence of MRSA actually is. Given that a significant proportion of healthy people carry Staph. aureus nasally, I don't think we will be surprised if quite a lot of MRSA is uncovered.

Meanwhile, although our local microbiologists are happy to offer advice and guidance on the need for treatment for patients with symptomatic MRSA, it is also worth keeping a link to the PCT's very helpful paper on the subject to be found at

(<http://nww.somersetpct.nhs.uk/InfectionControl/Shared%20Documents/J3%20MRSA%20Policy.pdf>)

For really authoritative guidance the British Society for Antimicrobial Chemotherapy (BSAC) has a comprehensive draft paper at:

http://www.bsac.org.uk/content_display.cfm?cit_id=933

EARLY DEMENTIA IN PATIENTS WITH LEARNING DISABILITY

The development in Somerset of supported living and better involvement of patients with Learning Disability (LD) in their own care has made more apparent the increased risk of presenile dementia in such patients. Because of their existing problems, the signs may be hard to spot at an early stage, but health and social care staff working for Somerset Partnership (who provide care for about 1600 of the roughly 2000 adults with diagnosed LD in the county) have been trained to pick up early evidence. If the diagnosis is suspected, the GP will be sent a letter requesting some basic screening investigations to exclude alternative general diagnoses, but the Partnership itself will be responsible for considering neuropsychiatric explanations as these may require particular clinical skills and/or access to specialist investigations. If the diagnosis is then confirmed the GP will be notified so the patient can be added to the practice Dementia Register and the usual annual check undertaken. We will also be notified of any treatment and care plans. You can get further advice on this or any other aspect of LD care from your locality LD Community Nurse: mel.axon@sompar.nhs.uk (TD), judi.crossman@sompar.nhs.uk (SC), terry.neal@sompar.nhs.uk (SS), bridget.unwin@sompar.nhs.uk (M)

PARTNERSHIPS FOR OLDER PEOPLE

18 months into this two year centrally funded pilot, there are now 41 volunteer run Active Living Centres across the county catering offering people over 50 a whole range of activities based on regular sessions in village or community halls. An initial assessment shows encouraging quality of life improvements for participants, most of whom are between 65 and 79, and typically living within 10 minutes walk of the venue. Involvement of local services is generally good, though NHS participation is patchy. Do note that several centres offer falls prevention advice amongst the activities and we would encourage you to point suitable people towards your local centre. More details at

<http://www.somerset.gov.uk/somerset/communityliving/popp/index.cfm> or from Emily.ruthven@ageconcernsomerset.org.uk

NOTES FROM SOMERSET IMMUNISATION GROUP

Primary Immunisation Rates

Have risen in 2 years olds during the first quarter of 07/08 to 96% for HiB/DTP&P and 88% for MMR - both a little above the UK average. Provisional figures for pneumococcal immunisation suggest we are exceeding the 80% targets

HPV immunisation

The DH has announced that the campaign will start next September with girls aged 12 and 13. Three injections are required over a 6 month period, meaning that in the first year something like 24,000 will need to be given. The PCT is looking at how this will best be arranged, but giving the immunisation in schools does look like being the best option. Catch up immunisation will be offered in subsequent years to girls up to 18 and the LMC will be discussing with the PCT a suitable LES for this.

Yellow Fever

Yellow Fever Centres must now change to the new style forms and stamps as the existing ones will not be accepted after 16th December. Further information from NaTHNaC (<http://www.nathnac.org/pro/news/YellowFeverCertificates161007.htm>). It is now recognised that the risk of severe or fatal adverse reactions to the vaccine is five times greater in the over 60's, so it is especially important to discuss the risks and benefits of yellow fever immunisation with this age group. For example, patients on a sea cruise through endemic areas may be at low risk if they do not plan to disembark.

Hepatitis A & B immunisation for travellers

The group looked again at the benefits of joint Hepatitis A&B immunisation for travellers. The proportion of patients contracting hepatitis B directly through travel is apparently falling, so the PCT and LMC advice remains that the two immunisations should be given separately, with the hepatitis B component remaining a chargeable private service. Travellers should continue to be warned about risk factors for hepatitis B, such as sexual activity.

Hepatitis B Immunisation for Health Care Students

The group confirmed their view that hepatitis immunisation should be offered by the education institution concerned after an appropriate risk assessment has been undertaken.

TB in Somerset

The HPU reports a slow rise in the number of confirmed human TB cases to about 15-20 per year in Somerset. Migrant workers are known to be at greater risk, and are more likely to have multi-drug resistant strains of infection. BCG immunisation is now only routinely offered to children and grandchildren of people born in a country with a high TB incidence (http://www.hpa.org.uk/infections/topics_az/tb/epidemiology/who_table2.htm) and the arrangements for this are still being finalised by the PCT. Enquiries from farm residents and workers about the risk to humans when bovine TB has been identified should be referred to the Somerset Health Protection Unit (01823 287817). Generally no special precautions are required unless TB of the udder has been diagnosed, and unpasteurised milk is being consumed by children under 16.

“NOVACHANNEL AG” – BEWARE!

We have had reports that this Swiss based organisation is targeting practices. Their letter says that if you fill in the form you are “helping keep the ‘Medical Directory’ (sic) up to date”, and you get to be listed on their website for free. However, if you carelessly then *sign* the form you are signing up to a three year contract to have an advert on the site - at cost of 2949 Euro, or about 2 Grand to you and me!

LETTERS TO THE EDITOR

Dear Editor,

An excellent editorial in the September Newsletter. What the health technocrats seem signally unable to appreciate is that by turning obesity into a medical diagnosis they take the responsibility for it away from the patient, who is then free to utter the refrain of the terminally useless: "I asked for help, but no-one gave it to me." What are we supposed to do -- go round Tesco with them and nick the junk out of their shopping trolleys?!

It's not our fault if the nation is turning into a bunch of dough balls and, most critically, it doesn't do those people any good whatsoever to suggest that the responsibility might not be theirs.

David Berger, Dulverton

SMALL ADS SMALL ADS.....

Practice Manager Required for growing practice in a brand new purpose built surgery close to Bridgwater town centre. We are a 3 partner practice evolving from a well established and very popular existing practice. The position will be available in March / April 2008 when our current part-time practice manager retires.

We are looking for an enthusiastic person with good management skills for what will effectively be a new post. Hours 30 per week (flexible) Salary c. 33k pro-rata

Please see our website www.vpmc.co.uk for more information about the practice.

For further information, or to apply with a copy of your CV, contact :

Sandy Jones Victoria Park Medical Centre, Victoria Park Drive, Bridgwater, TA6 7AS, 01278 437100 Sandy.Jones@victoriaparkmc.nhs.uk

Closing Date for Applications - 15th December 2007

PRIMARY CARE CLINICAL IT LEAD FOR SOMERSET PRIMARY CARE TRUST

Somerset Primary Care Trust has identified the need for a Clinical IT lead to support the new structure for IT development in Primary Care.

The core role will be to lead the engagement of primary care in the local development and implementation of both the National Programme for IT and other local IT initiatives.

The individual will need;-

- An understanding of and enthusiasm for the National Programme for IT
- Credibility with primary care clinicians
- Good communication skills
- Change management skills
- An understanding of project management issues and processes

The post is not restricted to General Practitioners but is open to any professional working in primary care who can demonstrate credibility. The post is funded at 4 sessions per month

Please contact Neville Roberts Director of Information Technology or David Slack Director of Primary Care Development at Somerset Primary Care Trust, Wynford House, Yeovil for a copy of the role profile and person specification, or for an informal discussion. Tel: 01934 384000

Closing Date for Applications 21st November

FOOTNOTE

Following on from the recent DH publications "*Your NHS, Your Say*" and "*Your Weight, Your Health*" we eagerly anticipate that the title of their alcohol policy paper will be "*Your Drinking, Your Round.*"

JENNIFER'S JOURNAL

Is the GPs life going to be better with Boredom Gordon or Dave the Rave? Not much to pick between them since they both plan to meddle with the NHS. At least Dave isn't running a propaganda campaign against us. Presumably Labour will stick with their chum Kamikaze Darzi. He has just produced the interim report for '**Our NHS, Our Future**'. He must be an amazing chap what with being a Lord, a Professor, a working surgeon and Parliamentary Under Secretary of State. No doubt he finds time for quality time with his family as well. The thing is, is a chum of Tony Blair's, who happens to be a surgeon, (and a Lord and a Professor), the right man to design the future of the NHS? He might know something about hospitals but what does he know about General Practice?

His opening line is "As you know, I'm a doctor not a politician." Wrong- he is now! Assuming that he wrote the summary himself, it is the language of politicians alright. He has four key words for his vision for the NHS: Fair, Personalised, Effective and Safe. Could this be the breakthrough we were looking for?

Not that he holds a political view.... but he uses the summary to say how successful changes to the NHS have been under Labour so far, which Jennifer found a little sycophantic. But try and stay calm with this: "Back in 1997.....although many patients enjoyed good care, many more experienced the trauma of poor access to primary care". Trauma!!!! In 1997 we provided a service with evening and Saturday morning surgeries. We provided our own OOH emergency cover which was much higher quality than alternative providers are offering now. We had routine and urgent appointments during the day. Any one who needed it could be seen the same day or within the hour if necessary. Before this Government started interfering with new contracts and ridiculous targets for everything the patients had a good deal. This Government have raised patient expectation and trashed and demoralized the service. Lord Darzi and I have different experiences of primary care – well that is, I have an experience and he doesn't.



So what does he recommend for Primary Care in his "Immediate Steps"? He wants patients to be able to attend health centres where they are not registered with a GP. He wants "PCTs to introduce new measures to develop greater flexibility in GP opening hours, including the introduction of new providers..... extending hours into evenings and weekends". The same Government that only recently contracted GPs to work 8-6.30, now either wants us back ,or to replace us with yet more second-rate alternative providers.

When it comes to 'immediate steps' for hospitals Darzi's ideas are very different. We hear the surgeon protecting his own: I quote – "ensure that any major change.... is clinically led. Change should only be initiated when there is a clear and strong clinical basis for doing so. Resources are made available to open new facilities alongside old ones closing" . I think 'clinical' means consultant. He wants consultants to be in charge of hospitals (funny that) and they will only co-operate if given extra money; but GPs are left to the whim of politicians and managers, undergo huge turmoil, compete with alternative providers and all on the basis of no evidence at all except the government's 11 million pound survey that said 84% of patients were happy with access to their GP.

Incidentally, the summary makes no mention of the Government's role in Public Health. There is no mention of Health Promotion or disease prevention. No mention of working with employers and schools.

This could go down as one of the most disappointing DOH documents yet; certainly no 'vision' and not a clue about primary care. So try again Lord Darzi – it's not really a part-time job planning the future of the NHS. Give up the day job or give up politics. I suggest you stick to surgery - could be safer for all of us.

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

Jennifer