

Somerset LMC Newsletter



Sept 2008

Issue 144

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LETTER FROM THE EDITOR

REPORTS OF MY DEATH ARE GREATLY EXAGGERATED

I have been very touched to receive so many messages, cards and gifts from friends, colleagues and patients during my recent indisposition due to a subdural haematoma. I especially enjoyed the chocolates and the splendid book of 50 great philosophical ideas summarised in 2 pages each – just about as much as my brain could cope with for a while. I am looking forward to enjoying the champagne, and there was even a bunch of flowers from the PCT who have been extraordinarily helpful throughout. Thank you all very much.

It is often a valuable experience to be on the other side of the medical equation, but this episode was particularly revealing. Dealing promptly with important problems is one of the things the NHS generally does well, but I was struck by how many people went out of their way to smooth my passage. My GP fitted me in instantly at the end of surgery, she and the consultant arranged a CT scan, and the next day the Musgrove neurologist cycled into work to start clinic half an hour early to see me and arrange admission. You might argue that this was all just because I am a high profile local doctor, but the care at Frenchay was equally good. Despite the tattiness of the buildings the ward was immaculately clean, thanks to two ladies of mature years who relentlessly cleaned everything that didn't move and quite a lot that did. The nursing care was also first class – and just as good for one far from easy patient who was also in the ward. All the staff tried hard to make sure we were treated as individuals, from the receptionist making sure they knew by what name each patient would like to be known, to a sister who spent a lot of time (unmasked) trying to rearrange my CT appointment so I could go to a service in the hospital chapel.

Two things struck me about all this. First, the treatment was seamless. I moved easily between NHS organisations with no more than a phone call or a letter at each transition. Secondly, everyone with whom I dealt considered themselves as part of the NHS and shared in its culture. You try hard, sometimes in difficult circumstances, to do the best for the patient in front of you and to hand them onto the next person in the chain ready for the next phase of their treatment. Individuals show initiative, bend the rules a bit, and go the extra mile.

As I went through the system I asked people what they thought of working for the NHS. Their answers were strikingly similar. "I love my job, but I hate the politics." Not the management, not the bureaucracy, but the politics. The politics of arbitrary targets, of documents of vapid and jargon-ridden rhetoric, the encouragement of consumerism for political advantage and the selling out of a comprehensive health service to a corporate philosophy that has no interest in the things that make the NHS what it is. At the moment health care workers all still products of the NHS, whether as independent contractors, managers, or employees but things can change very fast. It seems that in future we will all just have to follow the protocols, tick the boxes, and salute whichever flag happens to be at the top of the flagpole that week.

The NHS has educated me, employed me, paid for most of my pension fund and now saved my life. I for one am not prepared to let politicians whose involvement with healthcare may last for just a few scant months destroy it. The unique NHS model of integrated, state funded personal health care based on social consensus must be protected from cynical party political meddling. That is something we owe our patients, ourselves and everyone else who has worked so hard over the years for a principled service that they actually believed in.

MEDICAL REVALIDATION – PRINCIPLES AND NEXT STEPS

The Report of the Chief Medical Officer for England's Working Group.

If it does what it says on the tin there should be nothing to worry us.

Towards the end of July the newspapers were full of stories about doctors "facing "annual checks" in order to be allowed to carry on working. As usual the impression was that this would start tomorrow but reading the actual report gives quite a different picture: a "preliminary indicative timetable for roll out in England...envisaging the component parts of the system being put in place over the next 18 months to two years, with piloted initiation in early adopter sites, specialities and sectors in late 2009...and gathering pace in subsequent years."

Readers will have spotted the familiar vocabulary but should be reassured that there are some very good aspects to this document. Surprising though it may seem, some of the views expressed in the prior consultation have actually been listened to and incorporated, notably recognition that the process could be seen as threatening to practitioners. Instead, it should be a positive process adding "further focus and energy" to doctors' acknowledged desire to keep up to date and improve as well as to provide support to those who may discover deficiencies. It is not intended to be a disciplinary mechanism to deal with the "small proportion of doctors who may cause concern", nor, we are promised, should it be used to weed out the "managerially awkward" which will come as a relief to some. After the unmitigated disaster of "Modernising Medical Careers" the plan to pilot schemes comes as welcome relief.

There is much further planned work, really only dealt with here in a list of outline good intentions but which will involve the Royal Colleges, the GMC and the BMA. Although it is stated that appraisal as currently practised in the NHS is "too patchy" to be used as a general model for revalidation (as a doctor) and recertification (as a specialist or GP) it is planned that the best practices will be used to avoid duplication and bureaucracy. It is to be hoped that Somerset primary care can lead here as in so many other fields. Readers will not be surprised to discover that public involvement is vital and there will be exploration of methods of "360 degree assessment" which will be interesting. The GMC "will be consulting on principles to guide delivery of the 360 [degree] approach later in

2008." Your LMC expects to be giving suitable robust advice on this matter. Responsible Officers for each organisation will be appointed and the still shadowy role of the "GMC Affiliate" made flesh. The first concrete step is that doctors on the medical register will be invited to apply for a licence to practice in 2009 and in doing so will be taken as implying the intention of taking part in the annual review process, whatever it turns out to be, starting in 2010. Retired doctors are clearly expected to consider whether or not it is worthwhile applying but the implications for the NHS work force is not discussed.

The report concludes that, "Revalidation will provide rigorous and evidence based assurance to patients that their positive view of their doctors is firmly based. It will provide more effective support to doctors in reflecting on their practice and developing their talents. It will help a small number of doctors improve on those areas where they need help to meet the standards of their peers... It will cement further the trust that the people of the UK have in the medical profession, and give doctors the... means to sustain that trust." If all that is achieved by the proposed scheme then we only need to add, "Amen...but watch this space very carefully."

WEIGHT LOSS PROGRAMMES – PATIENT REQUESTS

GPC Advice

GPs themselves should be primarily responsible for providing appropriate advice and treatment for a patient's obesity, rather than encouraging the patient to participate in a private programme.

However, if the GP does choose to provide this information, a medical form of this type falls under the BMA's fee guidance schedule 11, section B, which covers instances where there is no agreement in place. The doctor can therefore charge for the initial medical and completion of the certificate at his/her own rate. However, the doctor would not be able to charge for follow-up appointments as it is not acceptable to charge for providing an ongoing course of treatment, as stated under Paragraph 24(2a) of the National Health Service (General Medical Services Contracts) Regulations 2004, and equivalent PMS Regulations.

Responsibility for the fee (i.e. whether the patient or the company) will depend on the arrangements the company have agreed with their members.

CARERS.....UNPAID AND INVISIBLE?

10% of your patients may be Carers

There are at least 55,000 carers in Somerset, and despite the best endeavours of our carer support workers, some 50,000 of them remain unknown to health and social services. This represents some 10% of the typical GP list, a proportion that is expected to rise to 15% by 2030.

Research carried out by St John Ambulance shows that many carers suffer from isolation, stress and back pain. Over the past three years St John has trained and supported nearly 400 Carers in a their Carer Support Programme that helps carers to gain confidence in their caring role and also to realise the importance of looking after their own health.

The Programme has had very positive outcomes. Simple measures like peer support, education, learning practical skills and help with obtaining the best products and equipment are crucial to keeping carers fit and well, which has a knock-on effect for the 'cared-for' as their carers are better able to cope.

Carers may be unrecognised for many reasons, but often it is because they do not see themselves as "carers": the parents of a child with a chronic illness see themselves as parents not as carers, and the wife of a physically disabled man sees herself as a wife not as a carer. But helping these people identify themselves as carers and register on the Carers Register at their practice ensures they can get access to services, including the Carer Support Programme. All too often that help only kicks in once the carer reaches crisis point, and time and money can be saved by preventing this.

Don't forget that carers can be offered flu immunisation as part of your annual recall.

Information about the CSP is at www.somerset.sja.org.uk/carersupport or call Jude Glide on 01823 345920

SOMERSET BOOK PRESCRIPTION SCHEME: HELPING PEOPLE HELP THEMSELVES

A surprisingly effective form of treatment for some patients

The roll-out of the "Book Prescription Scheme" for Somerset will take place this autumn to tie in with World Mental Health Day 10th October following a successful pilot that has run since November 2006. The scheme essentially gives clinicians a list of recommended titles, some explanatory leaflets for patients and a brief

"prescription" form that allows the patient to borrow the books from a County Council library without charge.

The PCT has produced a list of 32 titles covering a range of mental health problems including anger, anxiety, depression, relationship problems and stress. All are recommended by psychiatrists, clinical psychologists and counsellors based on national research and clinical experience. The full range is now stocked by larger libraries and can be ordered from smaller ones.

During the pilot Over 600 "prescriptions" were written and over 2000 self-help books taken out, and the scheme has been a popular and useful adjunct to traditional treatment options amongst both practitioners and patients alike. Experience suggests a surprising number of patients take to this form of help - especially if you have a few copies of frequently used titles to loan patients in a consultation or via a patient lending library in the practice.

Full details will be sent to all GPs in the course of the next few weeks but if you want to know more prior to the launch please contact Dan Marshall on 01823 346143 or dan.marshall@somersetpct.nhs.uk. Alternatively contact Emily Dodd on 01278 458178 07864 708519 or Emily.dodd@somersetpct.nhs.uk.

IMMUNISATION NOTES

Recommendations from Somerset Immunisation Group

MMR: Children with an egg allergy no longer need to be referred to a paediatrician to have MMR in hospital. (See page 168 of the latest Green Book page 41)

BCG for Travel: Travellers only need BCG if they are visiting a high risk area for more than three months, so gap year students and volunteers working in developing countries for less than this time do not need BCG. Adults over 18 who need BCG for travel should be referred to your local chest clinic, under this age to the paediatric service. The patient will usually be charged by the hospital for this.

BCG for Farm workers: With the rising number of farmers losing their TB free status there have been a number of inquiries about the need for BCG for farm workers and their families. We are advised that this is only needed if they are drinking raw (unpasteurised) milk from the farm.

**PHARMACY IN ENGLAND: BUILDING ON STRENGTHS – DELIVERING THE FUTURE
A WHITE PAPER APRIL 2008 – A THREAT TO ONE IN THREE PRACTICES IN SOMERSET.**

The consultation period on this document has now opened and the LMC urges all practices to look at the Pharmacy White Paper and to submit comments. It may have grave consequences for up to a third of all practices in Somerset. The greatest part deals with a vision of the future of pharmacies as part of the wider provision of health care, advice, preventative measures and screening in line with government thinking as originally expressed in the Wanless Report. There are also assessments of current programmes, such as pharmacist medication use reviews which are not thought to have delivered value for money, repeat dispensing and electronic transmission of prescriptions from practices to pharmacists.

The largest area of contention is the small section (eight out of 77 paragraphs) in Chapter Eight “Structural enablers and levers” concerning dispensing doctors which, if implemented will have major impact for the provision of general medical services in rural areas of Somerset where a third of the 76 practices dispense to at least some of their patients.

The government has two concerns. The first is that, because of the “one mile rule,” it is where the *patient* lives that determines whether he can receive “convenient dispensing services” from his GP. The White Paper acknowledges for the first time that this leads to inequity where patients living on opposite sides of the same street are treated differently and also that this rule takes no account of how far patients might actually have to travel to collect their medicines.

The second is about the proximity of dispensing practices to community pharmacies. “Some people who receive dispensing services from their GP surgery walk past a community pharmacy...especially in market towns.” A “logical solution” is new control of entry rules for dispensing practices – a single condition relating to the distance from the *surgery* to the nearest pharmacy instead of where the *patient* resides. If this rule were satisfied then the surgery could dispense to *all* the patients on its list and a dispensing practice would also be allowed to sell over-the-counter medicines in order to improve the availability of these products in areas without a convenient local pharmacy. It might appear that this might be only for new applications but it is not. “Transitional rules would be required ... to consider the financial impact on the GP practice of losing the right to dispense as well as the impact on pharmacy provision. Practices meeting the new criteria could find they dispense to more patients but...those who do not...**will have to accept that they will need to wind down their dispensing role.**”

The LMC believes it is vital that the potential impact of these plans on rural areas of Somerset is acknowledged and resisted. The national LMC conference this year unanimously backed a call that all practices be able to dispense to their patients if they chose to, thus providing the opportunity to “level up” services to patients as well as allowing real competition in this field which might even be really made into the proverbial “level playing” one. Dispensing practices in Somerset rely on dispensing income to employ staff and not just in the Dispensary. Reduced practice income will have grave implications for rural communities who are rapidly losing amenities including post offices, schools, shops and pubs. The general practice and certainly the branch surgery, could be next.

Please see www.dh.gov.uk/en/Consultations/Liveconsultations/DH_087324 to register your views
Responses should be sent no later than **Thursday 20 November 2008**

STOP PRESS.....STOP PRESS.....STOP PRESS

The PCT have just announced that the ‘GP-led Health Centre’ will be based in Yeovil

There are some GPs in Somerset who believe that the establishment of such centres is a ‘good thing’. A lot of us will be relieved that it is not in our area and hope that we can now be left alone to get on with the job we trained to do without yet more changes and interference. As our campaign earlier this year showed, there are strong feelings in the County against this latest Government initiative and these remain despite the relative quiet of recent times.

With this announcement, the main challenge at present is how GPs in that area and in Somerset as a whole can support their colleagues who may feel threatened by this outcome, the effect it will have on the doctor patient relationship and ultimately patient care.

The GPC have not given up on attempts to change the Government’s mind about the Darzi centres and we expect to hear more on this soon.

SMALL ADS SMALL ADS**WARWICK HOUSE MEDICAL CENTRE
PART-TIME MEDICAL RECEPTIONIST**

If you have previous medical reception experience we would like to hear from you.

Our immediate need is for cover on a Friday and some Saturday mornings, but it is essential that this Receptionist is also able to offer holiday and sickness cover, over variable shift patterns between 8.00am-6.30pm, at other times.

A full description of the vacancy can be found at www.warwickhouse.org.uk.

For more details please contact Jane Watts on 01823 447374 or e-mail jane.watts@warwickhousemc.nhs.uk

Applications to: Mrs Jane Watts, Warwick House Medical Centre, Upper Holway Road, Taunton, TA1 2QA Closing Date : 12th September 2008

**PRACTICE MANAGER VACANCY -
PRELIMINARY ANNOUNCEMENT.**

Crewkerne Health Centre is looking for a new practice manager to commence work in January 2009. This vacancy will exist following the retirement of our long serving current manager. Formal advertisements and job descriptions will be available in September but the practice would be pleased to receive notification of any interest from potential applicants. This can be sent in complete confidence to Dr Gilson, Crewkerne Health Centre, Middle Path, Crewkerne, TA18 8BX

PART TIME PRACTICE NURSE REQUIRED

We are looking for an enthusiastic and flexible Nurse to join our friendly team at our Practice in the City of Wells.

Total hours required: 13 per week as follows:
Tuesdays 2.30 – 6.30pm
Fridays 8.30am – 1.30pm & 2.30-6.30pm
(Some holiday/sickness cover for colleagues will be required).

The Practice is located in new purpose built, well-equipped premises and looks after just under 7000 patients. We are fully computerised using EMIS and offer a full range nursing support including asthma, diabetes, and coronary heart disease, Stroke, Foreign Travel etc. Experience in Practice Nursing desirable, particularly in the area of Asthma/respiratory monitoring, but not essential as training can be arranged for the right candidate.

Applications in writing with CV to: Mrs C Judd, Practice Manager, Wells City Practice, Priory Medical Centre, Glastonbury Road, Wells BA5 1XJ

Closing date: 8th October 2008

AGA Cooker for Sale

2 door oil fired AGA in racing green, for further details please contact Jill in the LMC office.

Mobile 07887566510

YOUR CHANCE TO GET INVOLVED**IN THE SUCCESS OF THE ACUTE CARE GP (ACGP) SERVICE IN SOMERSET**

The ACGP service has been operating successfully this year at Yeovil and Taunton hospitals, and sees referrals from GPs, Somerset Primary Link and from within each hospital. We offer community based GPs another choice for the management of their patients, including another peer opinion, access to simple diagnostics and the arrangement of community support to enable the patient to remain at home.

It is a pilot service contracted by the Primary Care Trust and managed by Devon Doctors. We see a wide variety of patients, ranging from query chest pain to pneumonia, appendicitis, abdominal pain and shortness of breath. We have access to simple blood tests, ECGs, plain film X-rays and with close links to Somerset Primary Link and the community hospitals, we have the ability to facilitate admissions or home management as required.

In the first seven months of the pilot in Yeovil we have had 465 patients referred and, of these, 320 were successfully sent home after the appropriate tests and treatment. In the first three months at Taunton, we have seen 269 patients, with 193 returned home.

Due to this success, and with an eye on future plans and development, we are looking to recruit more local and experienced GPs to work in this growing service.

The work is challenging but extremely rewarding. We offer ECG and X-ray teaching to all GPs working within the service, along with clinical review meetings and a good rate of pay.

If you are interested in joining this vital service, and would like more information, please contact:

For clinical queries: Sara Frost, GP clinical lead, on dafandsara@btinternet.com

For operational queries: Martin Shaw, Project Lead on martin.shaw@devondoctors.nhs.uk or telephone 07792639996

JENNIFER'S JOURNAL

In the June newsletter Jennifer expressed disappointment at the SHA document 'NHS South West- Our NHS Our Future' and was particularly concerned by the statement "96% of people at a listening event in the South West said they wanted extended opening hours at their local GP surgery....". Jennifer's friend did some research. The event took place in 2007 and was held in North Bristol and all participants came from the same area of North Bristol. There were 40 'patients' and 40 'members of the public'. They did press button voting to projected questions. The relevant question was "If General Practice's opening hours were to change, what would you change, if anything (pick as many as you want)?"

The results were

Open later in the evening on weekdays – 39%

Open on Saturdays – 39%

The hours are fine as they are – 4%.



The Director of Strategic Development interpreted this result as "This showed that 96% of people present didn't think the hours were fine, in other words, they wanted change". Using his logic he could have said 61% didn't want evening opening and 61% didn't want Saturday opening, i.e. happy as they are, but this would not give him the message he wanted to invent.

I suspect you have noticed that the question was leading in that it assumed change to start with. If people picked both the first choices then 57% didn't answer at all, if they picked just one each (despite 'pick as many as you want') then 18% didn't vote. The Director of Strategic Development elected to assume that non-voters all wanted change, took 4 from 100 and came up with 96%.

This is somewhat at variance with the Government's own survey of 7 million patients which concluded 84% were happy with present opening hours. Nevertheless, the Strategic Health Authority stuck to printing the incorrect figure and implying that it referred to the South West (and not to an area of North Bristol). It is somewhat worrying that a Director of Strategic Development doesn't understand or is poorly advised regarding statistics.

Jennifer's friend explained it to the Director and wrote "In summary the sample is not representative of the South West and it is not statistically significant. The question was biased and to interpret the result (39%, 39%, 4%) as '96% of people present.....wanted change' is just not true". He looked forward to a reply, perhaps, including an apology for being so misleading and a promise of a correction. The Director declined to reply but passed it to someone else to acknowledge the letter and to say little more than "Your comments will be taken into account in producing the final version.....".

Jennifer's friend is left feeling he has been banging his head against a brick wall and that the SHA have no interest in listening to GPs and simply want to follow Government directives and publish political propaganda. It is all very disappointing.

Jennifer

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

D-DIMER AND TROPONIN LABORATORY REQUESTS

MUST be confirmed by phone

As we try to manage more patients in the community without running into problems with missed diagnoses, GPs have started to request "acute" diagnostic investigations, notably D-dimer for DVT and PE, and troponin for myocardial infarction. Taunton and Yeovil laboratories are able to offer a limited number of such tests but you **MUST** telephone the laboratory to arrange them, and also give a contact telephone number on the request. Results will not be phoned through to practices unless this has been arranged.