

SOMERSET LMC

NEWSLETTER



Dec 2008

Issue 146

Inside this issue:

Lesson from America	1
Zambian E Diary	2
Changes to Cremation Regs	3
Buying Group	4
Treatment in Nursing Homes	4
Safety Alerts	4
Small Ads	4
Jennifer	6
Flexible Health Care	6
SGPET AGM	6

Somerset Local Medical Committee and all their Secretariat Staff would like to wish all constituents and their readers a Very Merry Christmas and a Happy New Year



The LMC Office will be closed from Wednesday 24th December and will reopen on Monday 5th January 2009

LESSON FROM AMERICA?

Your editor is a little embarrassed that shortly after returning from a long spell of sick leave he pushed off on a sabbatical for most of November. But the trip was booked and the flights paid for, so there was no turning back, and now I have to justify the trip. Costa Rica is a beautiful place, and the "Ticos" charming and polite. They are rightly proud of their country and society. Intriguingly, the army was abolished in 1948 and much of the saving invested in social and health care. Consequently medical treatment is free at the point of delivery, being paid for out of a social fund derived from a 9.5% levy on all salaries and wages, along with a 20% employers contribution. Everything up to DGH level is provided within the country but complex tertiary care is purchased abroad: one of our guides had a grandchild with a congenital heart condition flown out to Johns Hopkins for definitive surgery on the day of delivery – all free. Primary care is largely provided by a contract between the social security fund and a co-operative called "COOPESALUD" whose provision ranges from large primary care centres to small local clinics open perhaps once a week. Where all this gets interesting is in the WHO ranking and cost of the Costa Rican service. WHO ranks it at 36, just ahead of the USA who are at 37. The UK is 18th, but Costa Rica spends only US\$450 per head per year on health, whereas the NHS costs nearly ten times as much! Part of the answer seems to be their very simple structure which seems to be almost completely devoid of bureaucracy and targets.

Anyway, there I was jammed into the front seat of a minibus with a very ample but charming American health informatician whilst we waited for the best part of an hour at some roadworks. I mentioned that the UK Government was rather taken with the US idea of Healthcare Maintenance Organisations. "For the love of God" came the reply "don't touch them with a bargepole! Half the employees are there to watch and count what the half actually doing the job are achieving."

Does this mean anything for us? Well, we know that PCT funding will grow at 5.5% next year, but with "very substantial efficiency savings" expected from 2010 onwards, money is going to be tight. National enthusiasm for HMOs appears to have waned, and DH interest in integrated care is focusing on Integrated Care Organisations based on practice populations rather than complete integration of primary and secondary care. Wholesale commercialisation of primary care services seems a less likely direction than social enterprise schemes linking different local community providers.

So whilst we cannot assume that the Government has lost its urge to privatise, this does give us an opportunity to look at different ways of developing services whilst they are busy on more pressing matters. The recommendation to the PCT Board to accept the GP Consortium bid for the Yeovil GPLHC is a good start, and the PCT is also supporting joint working amongst Bridgwater and Taunton practices to look at how GPs can produce real improvements in the care of our patients. If we can develop costed and resourced plans that involve practices, community services, social care and specialised private sector services (such as Clinovia's for the delivery prepacked injectable DMARDs) we may at last be able not only to improve care but keep the cost of such improvements manageable.

Practices need to be thinking again about how to co-operate with their neighbours whilst accepting that there will always be an element of competition. In the end good local working with one another and the PCT has to be in the best interests of our patients.

A local co-operative working with a commissioning agency? Why, one day we may even catch up with Costa Rica.

SIMON'S ZAMBIAN E DIARY

Simon Bonnington has been off on sabbatical, working for the past six weeks at Mpongwe Mission Hospital in rural Zambia. Here are some extracts from his e-diary

"I started work properly with a Ward Round with Dr Okoko. 19 patients on Female Ward, 6 have known HIV. One had had a hysterectomy 3days ago and now looks septic. We can do an FBC and differential, also ESR and Blood Film for malaria. ALT is available but K⁺ and Na⁺ are not. There are plain film XRs and USS, but no ECG. I asked Dr Okoko if it would be helpful to have one, knowing that Yeovil Surgeries replace old equipment. Yes, he said, but then we would need to know what to do with the findings! Blood transfusions are given below Hb of 5, or 6 if symptomatic. There appears to be a reasonable supply of needles, fluids etc, but few Nurses. Notes are somewhat disorganised, as are X-rays, which are stored in one pile, but eventually you can locate the right pieces for each patient."

"Wednesday was a particularly heavy day – I saw 75 patients but no electricity and then no water in the evening. The next day three cases for theatre. One was a revision of a debridement of an infected foot in a very poorly controlled insulin dependent diabetic. Should have been Nil By Mouth but had felt hungry, so he ate a bowl of nsima (ground maize porridge). The procedure needed doing, so I did it, necessarily without much sedation. It hurt. I asked the Student Clinical officer assisting me to explain to him that a Below Knee Amputation would be the inevitable result if we did not attend to the wound properly. The patient gritted his teeth.

"Surgical sets are devoid of drapes to establish a sterile field and the I&D set has no scalpel handle. So I am becoming proficient at requesting exactly what I need from the Theatre Orderly who runs the autoclave. I am therefore scrub nurse, anaesthetist, ODA, surgeon and then recovery nurse whilst the ward nurse finds a trolley to take the patient back to the ward.

Transferring the patient from the table to the trolley involves a heave on the patient's clothing. The impact tends to help to wake them up a bit!"

"Tuesday is Theatre Day. We have a pulse oximeter, though it is not always used. Anaesthetic is again Diazepam, Atropine and Ketamine. The first case was climbing on the table when I arrived -- a bilateral tubal ligation. Dr Okoko was taking his time to arrive but the medical licenciate was all set to administer the anaesthetic. All that was required was a surgeon. Blow it! I've done this loads of times before, albeit thirteen years ago, let's crack on. Transverse lower abdominal incision, through the rectus sheath, blunt dissection of the peritoneum, find the left tube, clamp, clamp, catgut to tie & tie, cut and cut to resect the mid section - Manchester technique. Or is it Pomeroy? Or is that something totally different? Anyway, who cares what it is called. Same for the other side. Then out again, peritoneum, non-absorbable for the rectus sheath, interrupted silk to skin, one wet, one dry, et voila!"

"Next Dr Okoko and I tackle a very tricky hysterectomy. We continue with the aspiration of a large ovarian cyst and finally a repeat laparotomy for post-op peritonitis and sepsis following a C-section two weeks ago. No lunch, but Dr Okoko assured me that if he stopped he would never be able to get the list restarted again! We use the same room for Pre-op and Recovery, so the next patient knows what is coming."

"On Female Ward we have a steady stream of odd infections that turn out to be HIV +ve. On Thursday the Clinical Officer admitted a lady with a two week history body wide eruption of small lumps. It looked like Von Recklinghausen's but with barely any gaps between lesions now discharging pus and blood I gave her a trial of Cloxacillin and sent her for Pre-Test Counselling for HIV. Yesterday she was no different, and she was found to be "reactive" (the euphemism here for HIV +ve). I scratched my head. In my recent CME study notes I had come across a question about a woman with skin lumps and a positive Acid-Fast stain of a skin smear. Could it be? I checked in the Oxford Handbook of Tropical Medicine... and the lab can do the test. "Doctor, you are very clever!" comes the reply No, it was just a very fortunate guess: leprosy. With a 6 month course of medication, it should come under control."

"Jungle Doctor meets Scrapheap Challenge. On

Saturday I see a girl of seven who had a fractured midshaft left femur. The X-ray showed very obvious displacement. I remember being taught that you should never see an X-ray of a fractured femur that isn't already in a Thomas splint. Mpongwe has no such appliance. Because of her age I wasn't happy to simply consider weeks of traction leaving her with an inevitably shortened leg, and thought that internal fixation to the proper length at Ndola Hospital was required. Dr Okoko agreed, but there was no transport to take her and no Thomas splint. We could provide her mother with funds to transfer her to Ndola (presumably by bus!) but what to do in the meantime? Dennis and a colleague were stripping some sort of engine down and a pile of scrap metal lay behind the carpentry shop. Broken beds, wheelchairs, bits of bicycle and obscure antediluvian medical devices were heaped up. Half an hour later, after a nifty bit of scavenging, using an angle grinder, two bolts, assorted washers, a hefty hammer and the vice, I was finished. Proper job! Padded with cotton wool gamgee and bandages from Theatres, a rope from a dusty cupboard, copious amounts of sticky strapping tape and the limb was immobilised and in traction. Possibly the most useful thing I have done here. After this, the resetting of the forearm was a bit of an anticlimax."

"The medical work is challenging and stimulating; without paperwork, meetings, budgets or endless diktats from local or national control. If you can do it, you do, if you can't, you don't, or you 'make a plan' to try to do it differently. Very simple, with no space for argument and a population that accepts the status quo without grumbling. Every day I have had the opportunity to really improve health and even directly save lives – not rely upon statistical significance to probably affect an outcome. I fear that as a result returning to work in the NHS will be even more challenging for me. On the other hand I have also found it far too easy to drift into the accepted standards and sub-standard (from a European perspective) practices at Mpongwe. Initially horrified that a heavily sedated patient under Ketamine with an unsecured airway is neither monitored nor necessarily watched whilst a minor surgical procedure is undertaken, I am now very happy to knock them out and crack on, glancing occasionally at the chest to make sure it is still moving. The UK Government want more procedures done in GP surgeries and fewer in Hospitals; I've now got some rather good ideas..."

CHANGES TO CREMATION REGULATIONS IN THE NEW YEAR

As yet another fallout from the Shipman Enquiry there are to be some minor alterations in the procedure for cremation from 1st January, notably a change in the appearance of the paperwork. Parts B and C are renamed 4 and 5 and the layout has been modernised. A doctor completing the forms is no longer expected to have "seen and" questioned anyone, which legitimises the normal practice of discussing things over the phone.

Form 4 now asks the date and time you saw the body rather than when the patient died and there are some extra questions that probe for any suspicious circumstances:

- (13) If an operation has taken place "Do you have any reason to believe that the operation(s) shortened the life of the deceased?"
- (15) If anyone was present at the time of death "whether you have spoken to them about the death" .
- (16) "If there were persons present at the moment of death, did those persons have any concern regarding the cause of death?"
- (21) "Has there been any discussion with the *coroner's office* about the death of the deceased?"

Form 5 now requires confirmation of the name, address and occupation of the deceased, and allows the doctor to disagree with the cause of death or clarify it. Presumably in such cases the medical referee will be unlikely to allow the cremation to proceed!

The person applying for cremation will have the right to see Forms 4 and 5 (or to ask someone to view them on his or her behalf) within 48 hours of being told by the cremation authority that they are completed. The applicant then has another 24 hours to contact the medical referee with any concerns. Since this could in theory delay the process by 72 hours, there may be a little more pressure from funeral directors for signatories to complete the forms quickly if a cremation date has been fixed.

Details of the Regulations are at:

http://www.opsi.gov.uk/si/si2008/pdf/uksi_20082841_en.pdf.

SOMERSET LMC BUYING GROUP

Somerset LMC has recently joined a multi-LMC buying group which will give Somerset Practices the opportunity to obtain bulk buy discounts at no extra cost to the practice. This group was originally developed by Trent LMCs in the mid 1990's and has grown over the years, currently covering 11 LMCs and has the power to negotiate on behalf of nearly 2,000 practices. The purpose of the Group is to save its member practices money by negotiating discounts with approved suppliers of goods and services which GPs regularly purchase.

Through its considerable purchasing power agreements currently available include:

- Flu and travel vaccines
- Medical consumables, including a special deal on single-use instruments
- Office stationery and furniture
- Medical equipment calibration and testing
- Insurance products, including Locum insurance
- Gas, electricity and telephone discount negotiation
- Practice website design packages
- Car purchase and leasing

This service will be available to all Somerset practices and you are free to take up or decline any of the deals negotiated, or continue with your existing local arrangements. New services are being added all the time, and a dedicated national web site is currently being developed.

This service will go live in the New Year and if you wish to take advantage of it you will need to pre-register with the LMC. This will authorise us to pass your details to members of the group, who will then send you information about what is available and offer you a bespoke purchasing service.

If you would like to join please email a designated contact name and practice details to: lmcoffice@somerset.nhs.uk

RECORDING TREATMENT IN NURSING HOMES

Whilst GPs are not required to record normal prescriptions in care home records we are asked, for patient safety reasons, to make sure that staff are informed about any injected or other personally administered treatment that you give. We have had cases when staff were unable to tell a subsequently attending doctor whether a patient had had an opiate, an antibiotic, or a B12 injection, and this is obviously not good!

SAFETY ALERTS – FINDING THE ONES THAT REALLY MATTER

Amongst the notifications about paediatric ventilator tubes and mislabelled chemotherapy infusions, there is some very important stuff for primary care being disseminated. An excellent source of key information and audit topics can be found at:

<http://www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/general-practice/patient-safety-alerts-and-guidance-for-general-practice/>



SMALL

ADS

SMALL ADS

**Police Surgeon/
Medical Officer Vacancies**

Forensic

Medacs Managed Healthcare are seeking Doctors to participate in a rota (on a full or part time basis). You should have an A&E or General Practice background, a broad range of experience, and an interest in forensic work.

Duties will include examinations of detainees and victims of crime, attendance at scenes of sudden/suspicious deaths and preparing statements for legal proceedings.

There are also specific vacancies for female Doctors with the above and/or Gynaecology experience who are interested in supporting us to meet 'gender specific' requests from the Constabulary to provide an on-call forensic service for victims of sexual assault.

Medacs will provide specialist training and continuing professional development

For an informal discussion please contact Katie Sloggett on 07912 406

202 or email katie.sloggett@medacs.com

SALARIED GP REQUIRED AT FROME MEDICAL PRACTICE

This high quality training Practice can offer you:

- One of the highest salaries in the area
- Comprehensive education programme
- Mentoring scheme
- Opportunities to work full or part time
- Support of individual career development including speciality training

If you are seeking to develop yourself as a GP please apply with CV and covering letter to Deborah Hyde, Frome Medical Practice, Park Road, Frome, Somerset BA11 1EZ or by email to deborah.hyde@fromemedicalpractice.nhs.uk

All applicants need to be committed to working extended hours in line with the latest government plans.

FULL TIME PARTNER TO FILL A RETIREMENT VACANCY IN TAUNTON from 1ST JUNE 2009

We are a friendly, well established GMS training Practice in purpose built accommodation located near to the centre of Taunton with a mixed urban and rural list of 15,500 patients

- 8 Partner practice with GP registrar(s)
- Nursing team of 4 RGNs and 2 HCAs
- Core and enhanced services provided
- Consistently high QOF achievement
- Paper light EMIS LV Practice
- No out of hours on call

For more information visit our website at www.frenchweirhealth.co.uk or contact:

Mr P M Taylor ,Manager, French Weir Health Centre, French Weir Avenue, Taunton, TA1 1NW
peter.taylor@frenchweirhealth.nhs.uk

Full time or a job share arrangement considered. Please forward your CV, including the names and contact details for two referees, by post or e-mail to Mr P M Taylor by no later than the closing date of the **15th February 2009**. Interviews are planned for Mid March 2009.

NURSE PRACTITIONER AND INDEPENDENT PRESCRIBER

I am looking for part-time work in a GP surgery following a move from Kent to the Bridgwater area. I have 7yrs experience in Open Access, home visits, admissions, referrals, ordering/acting on investigations, monitoring chronic disease, medication reviews. Main experience with EMIS system.

Please contact Heather Hawley - 07887684245 / 01278 734624 / mummyhawley@hotmail.com

THE ONE DAY MBA: A BUSINESS PRIMER FOR GPs AND PRACTICE MANAGERS

Thursday, February 12th 2009, Padbrook Park, Cullompton, Devon

The economy's in trouble and there are no free lunches for GPs. This course, lead by Dr. David Berger of Dulverton Medical Practice, will help you...

- **Diversify** your income
- **Maximise** your existing practice income
- **Plan** a new venture
- **Think** like an entrepreneur (and know your limits)
- **Analyse** the economics of a pharmacy
- **Make** the most of NHS opportunities to enhance income

Full booking details and more information online at www.davidberger.co.uk

For queries, call Dr David Berger on 07812 191843 or email daveberger@gmail.com



GP PARTNER REQUIRED IN TAUNTON, SOMERSET

Full time (9 session) partner required to replace retiring partner. We are seeking an enthusiastic and motivated person to join our friendly team who is committed to first class patient care and keen to be involved in the further development of the practice.

- Large 8 partner (6.25 WTE) practice, 12000+ patients (nGMS)
- Suburban/semi-rural practice area with practice owned, purpose built premises
- Consistently high QOF achievement
- Core, enhanced and GPSi services provided
- GP Training practice
- Isoft (Synergy) with Front Desk
- Website www.collegewaysurgery.co.uk with prescription request facility

Closing date for applications 17 January 2009

Interviews 7 & 8 February 2009, Start date 1 May 2009. Please send CV and covering letter to Mr John Parkinson, Practice Manager, College Way Surgery, Comeytrowe Centre, Taunton TA1 4TY. For more details or to arrange an informal visit, please contact John Parkinson on john.parkinson@collegewaysurgery.nhs.uk

JENNIFER'S JOURNAL

There is a place for humour in medicine and Christmas gives one opportunities to live somewhat more dangerously. But perhaps remarks to the terminally ill that they had better make the best of Christmas "because this is definitely their last" are not wise. An elderly gentleman did say to me this week "Have I got to take these pills then for the rest of my life, doctor?" Yes. "I replied "but don't worry, it won't be for long!". Luckily he and his wife shared the joke and our laughter could be heard all the way to Santa's Grotto next door.

Some surgeries do next to nothing festive, and others turn the place into a Lapland world of fantasy. With the piped Christmas music you could be in a department store. There's a thought: we are meant to treat patients like customers these days so we should try and make a few bob out of it?. But what can we sell that is appealing? Doctors are meant to be sombre and sensible – advocating moderation in all things and a balanced diet (for the punters that is, not themselves). "Roll up for low fat chocolates and the Christmas diet sheet. Get the free Royal College leaflet on the evils of drink....Have a bonus BMI and obesity scare sheet with your holiday jabs...." But it just isn't going to sell. We might do better with raffle tickets and vouchers: we could sell vouchers that guarantee an appointment with the doctor of your choice instead of always getting the locum. Or an opportunity to upgrade your drugs to the best ones instead of the cheap stuff that we hand put these days.

The only thing that would have them flocking through the doors is to give up the Health Message altogether. Kick out the Pharmacy and have a discounted Off-licence, medically-endorsed discounted cigarettes, private massages in a bath of chocolate, pole dancers on the reception desk and lap dancers in the waiting room; free alcopops for the kiddies and a weeks sick-note for every £50 spent! The only exit would be through the fast food take-away where you could get a fat coke and a greasy burger. We would advertise appointments with Doctor Death and promote binge-drinking parties.....I digress; back to Christmas.



Reception staff with reindeer earrings is one thing but those with red noses and deer antlers are probably over the top. No doubt the odd senior partner will still dress up as Father Christmas but by far the best costume is to dress as Jesus, with the long hair, beard and flowing robes. It does no harm to remember that Christmas is about the birth of Christ and not just a mammoth consumer orgy. Take a slow stately walk around the waiting room before surgery and then they would be queuing up outside your consulting room door. If any get too demanding during the consultation you are set up for "What exactly do you want from me – a Miracle?"

Happy Christmas to all.

Jennifer

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

FLEXIBLE HEALTHCARE

Expect to hear more about this concept which will be taking over from waiting lists as the main focus for patient referral improvements. There are three main elements – any waiting period for treatment should suit the patient, "one-stop shop" treatment wherever possible, and delivery of care close to home. The PCT will be asking for clinicians to help with pathway development, so watch this space

SOMERSET GP EDUCATION TRUST

The Annual General Meeting of SGPET will be held in the LMC Office at **13.00 on Wednesday 18th February**. This meeting will elect a formal committee to replace the current steering group, discuss our expansion plans for 2009/10 and agree the annual subscription. Please contact SGPET@somerset.nhs.uk for more details, especially if you are interested in joining the committee!