

Somerset LMC Newsletter



Feb 2009

PROVIDER SERVICES - AN OPPORTUNITY WE CAN GRASP

Issue 147

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The NHS is going to be in for some hard times. After years of generous growth the money is running out, but the factors driving demand – ageing, expectation and medical advance – are set to accelerate, and far from controlling expectation the government seems determined to drive it ever higher. Gordon Brown's "NHS Constitution" seems likely to have about the same impact as John Major's "Patients Charter" but is still heavy on rights and light on responsibilities. So, if the NHS now can ration neither by waiting time nor availability of services, a financial meltdown seems inevitable. Perhaps the NHS Bank can ask for a £360 billion guarantee?

Meanwhile, we have to make our own services as efficient as we can. Once there was a time when I looked after patients with COPD until I needed help, at which point I referred them to a consultant. He kept them in clinic until they were sorted, and then sent them back. Now, of course, things are much better. We have a COPD nurse, a community COPD service, the THREADS outreach team, specialist respiratory nurses and an oxygen assessment programme. But does all this represent good value for money? And how joined up is it all?

There is a strong *a priori* argument that organisational simplicity should be preferred, but how do we match this to an increasingly complicated health system? We think that the answer is real integrated working between providers who have a common purpose, a shared philosophy and culture, and sufficient overlap in services to leave no gaps for patients to fall into. Services should be geographical and provided by people who know and trust one another and who accept shared responsibility for a common patient pathway. In a nutshell, localism not pluralism.

We have perhaps a year to get such an arrangement solidly in place before the financial storm hits, and we have the nascent structures that could allow us to do it. The establishment of Somerset Community Health as the arm's length provider arm of the PCT coincides with the coalescence of groups of practices into provider bodies – so far in Yeovil, Bridgwater and Taunton, but doubtless elsewhere as well before long. At the same time the two Somerset Foundation Trusts are reviewing their own service provision to see what work is really core, and what could be done elsewhere.

Add to this the growing experience of Wyvern Health and the clear willingness of PCT commissioners to make bold moves there is the chance of making sweeping agreements across the local NHS to provide the best possible service for the money available, whilst keeping resources within Somerset and sustaining local providers.

This will not be easy, not least because the day job just gets busier and busier, and the constant flood of unhelpful directives and queries from the DH is a huge drag on us all, but a little vision and energy could catalyse some very interesting reactions. For most of us, the most important task is to support our colleagues in general practice and elsewhere who are working hard to make things happen – if ever there was a time for consideration and co-operation, this is it.

PARTNERSHIP AGREEMENTS

What? Still not got one??

The LMC is concerned that a number of practices still do not have a current and up to date practice agreement – technically better described as a “Partnership Deed”.

Getting round to doing this is a tedious and moderately expensive task, but it really is important that you do so. Working as an NHS contractor in 2009 is immeasurably different to the way things were 20 years ago, but a worrying number of agreements are of that vintage, and many have not been signed by all the partners. If you are in this position any partner, even if newly appointed, can dissolve the partnership at will – thereby possibly putting your PMS or GMS contract at risk. On the other hand, you may find yourself unable to sanction a partner who is underperforming, or even expel one who has been suspended by the GMC. And how do you deal with retirement when age discrimination is outlawed?

A good modern Deed that covers all eventualities may run to 100 pages, and you will need to be prepared to spend a couple of evenings with the partners going through it to check all the clauses: it is vital that everyone read it properly so they know what they are signing.

The LMC strongly advises that you consult a solicitor who is an expert in this field as medical partnerships are complex. We have particular experience of the Lockharts Deed which has coped well when tested. Until the end of March they are offering Somerset practices a discounted rate of £1400 +VAT for preparing a deed up to a first draft (rap@lockharts.co.uk). BMA Law also offers a competitive rate for this work, currently £1500 + VAT up to second/final draft, but note that the contact GP must be a BMA member (info.pds@bma.org.uk).

Please contact the LMC office if you would like a copy of our full list of solicitors recommended by LMCs as having special expertise in this area.

THE LIVERPOOL CARE PATHWAY FOR THE DYING PATIENT

Time for us all to adopt this very useful tool

The Liverpool Care Pathway for the Dying Patient (LCP) was developed in the late 1990's to promote excellence in the care of the dying patient. It is written framework for use by all

involved professionals that provides evidence based end of life care. The LCP provides guidance on all elements of care, including comfort measures, anticipatory prescribing of medicines and discontinuation of inappropriate interventions as well as psychological and spiritual care and family support. It is also a key recommendation in the NICE guidance for supportive and palliative care and it is applicable in any care setting: at home, in residential care, or in a community hospital

The current use of the LCP in Somerset is varied. The teams that are using the LCP believe it ensures the dying patient receives care of a very high standard and that nothing is forgotten - one of the benefits of the LCP is that it is a comprehensive checklist.

To promote the uptake and use of the LCP the PCT has appointed a lead, Gaynor Woodland, on a temporary basis until 31 March 2009. Gaynor will be looking at uptake of the LCP and providing updating and/or training where required. Training sessions will be arranged across the county for GPs, hospital and community staff: these can be booked through the PCT training department and all staff are very welcome to attend.

If you have any queries or would like some help or support in using the LCP please contact Gaynor on 07833 295372 or e-mail gaynor.woodland@somerset.nhs.uk. Additional information on the LCP is also located on the PCT intranet in the palliative care section.

POLICE DEMANDS

There has recently been considerable discussion on police demands for the disclosure of patient information. Any information about identifiable patients is confidential, including the name of the patient's doctor or when he or she attended the practice. A practice should always find out more from the police about why they are asking for the information before deciding whether it is appropriate to release anything. You will certainly want to know:

- Is it possible to obtain the patient's consent to disclosure? If not:
- What is the crime and is it sufficiently serious for the public interest to prevail?
- Is the patient, or are others, at risk of death or serious harm?
- Would the task of preventing or detecting the crime be seriously prejudiced by

refusing access to the medical record?

- Is the information sought available from another source that would not necessitate a breach of doctor-patient confidentiality?

If it is not possible to obtain consent, and the doctor is not satisfied that a public interest disclosure is justified, the police may need to seek a court order requiring release

For further information regarding confidentiality, please see the BMA Ethics department guidance at:

www.bma.org.uk/health_promotion_ethics/confidentiality/ConfToolKit08.jsp

The GMC guidelines on the disclosure of patient information can be found at:

www.gmc-uk.org/guidance/current/library/confidentiality.asp#Disclosures%20required%20by%20law

ANDROLOGY – FERTILITY INVESTIGATIONS

Somerset Pathology (Covering Taunton and Yeovil labs) have asked us to remind requesters that laboratory advisory comments on repeating andrology tests tend to be regarded as a requirement so automatic second appointments are being made. They point out that abnormalities in semen analysis should be interpreted in the context of all other investigations, including those for the partner, and repeat testing may not be a clinical necessity. The laboratory is no longer automatically recalling patients for repeat testing and if you are unsure of the need for a retest it is best to discuss this with a consultant urologist or gynaecologist with an interest in fertility.

BLOOD BORNE VIRUS TESTING FOR PATIENTS UNDER TURNING POINT CARE

Turning point are about to start a screening and immunisation programme for BBVs for patients using their service who may be at risk. They emphasise that this should not mean more work for practices. but we will be kept informed of results and any consequent referrals. The PCT has agreed that Hepatitis C positive patients can be referred directly by Turning Point to gastroenterology at YDH or TST, and any HIV positive patients will be referred immediately to GUM and escorted to their appointment. Turning Point will need to know if patients have already had HAV or HBV immunisations, so we ask that practices respond promptly to requests for information about this

DRUG TARIFF – HARD COPIES

You may be aware that the PCT still supplies a hard copy of the Drug Tariff to practices on an occasional basis. However, this tends to be out of date even before it is published and the paper copies are expensive in both trees and money. Given that up to date information is readily available on the NHS Prescription Service website

www.ppa.org.uk/ppa/edt_intro.htm we suspect that most practices would now be prepared to stop having the paper version. If you have strong feelings about this, please let us know, otherwise the March 2009 edition will be the last paper copy circulated.

“WHO” SURGICAL SAFETY CHECKLIST AND MINOR PROCEDURES IN PRIMARY CARE

The LMC position

Practices will have recently had the NPSA edition of the WHO “Surgical Safety Checklist” cascaded to them from the PCT. Whilst, of course, patient safety must be of paramount importance this particular piece of work is designed for secondary care use and in the LMC view has no place in the provision of primary care minor surgical services, for which use it was quite clearly never intended. Requiring GPs to fill out a fairly lengthy form where the answer to almost every question is "not applicable" does not in any way contribute to patient safety (in fact it may well be an unwelcome distraction). The various strictures regarding consent, operative equipment, resuscitation, infection control, audit etc are already present in considerable detail within the contractual requirements of the Minor Surgery DES.

The LMC believes that Primary Care minor surgical services have a very high degree of safety and patient acceptability already. We have asked the PCT if there is any evidence that the data sets on "surgical errors" that prompted this advice (and the attendant press coverage) included figures from primary care. If not then this advice is itself "not applicable".

We should be careful to ensure that any changes to the provision of minor surgical services in Primary Care are genuine enhancements, or measured responses to proven problems, neither of which is the case here. If it is felt necessary that additional safety measures are needed then they need to be tailored to the service, not simply "cut and pasted" from secondary care.

ARE YOU A “GLUTAMATE SURFER”?

Dr Gordon Morse, Medical Director, Turning Point Somerset

Many professional people, along with 40% of the UK adult population, drink a good deal more alcohol than what authorities deem to be “safe” (21u per week for a woman and 28u per week for a man). It is perfectly possible to drink considerably more than these amounts, daily, for many years – everyone knows that, and because everyone knows that, and sees others around them doing the same thing, that seemingly discredits official advice.

Indeed, many of these people are busy, hard working professionals who I describe as “glutamate surfers”: The body is amazingly effective at self regulation, and if we insert a large bolus of sedative in the evening such as a bottle of wine, our brains attempt to combat the sedation by liberating large amounts of an endogenous stimulant known as glutamate. The half life of glutamate is hours longer than that of alcohol, which is why very heavy drinkers wake with huge cardiovascular overstimulation in the form of tremors, tachycardias and so forth, after the sedation of alcohol has worn off. Lesser (but still excessive) doses of alcohol liberate lesser amounts of glutamate that wake us early and leave us charging in to work in the mornings, apparently being very effective and busy, if a little grumpy and short tempered. Colleagues might even describe us as being very hard working and, indeed, good at what we do. By the end of the day the glutamate has gone, the body is exhausted and the hard work is over – so the weary worker trudges home for a “well-earned” drink. And so the cycle is repeated – sedation-stimulation-sedation, day after day.

Does this matter? This is probably not dependant drinking – it could be stopped at any time with no ill effect, although in most cases it would not be stopped for long and the pattern repeated soon after. And if, as is the case with most professional people, the diet is good, then many of the physically damaging effects of alcohol on the liver are to an extent reduced. But it is still problematic: aside from the weight gain, the tendency toward stress, dyspepsia and reduced libido to name but three, this sort of chronic stimulation considerably aggravates the risk of cardiovascular disease: hypertension and atrial fibrillation are commonplace in this drinking pattern, as well as a reduced life expectancy from heart disease and stroke, and gastrointestinal cancer, that compares with smoking 20 cigarettes a day.

It used to be said that the definition of an alcoholic was someone who drank more than his doctor – an unfair caricature perhaps, but many doctors do fit the “glutamate surfer” pattern: from medical students onwards there is a group denial that is partly excused by our own scientific knowledge that we are not dependant and are still doing a good day’s work. And so we are, and as long as we are happy to indulge in a habit that compares with smoking 20 cigarettes a day and even greater risks on mood, then that is of course the right to choice of the individual. But maybe we should be more honest with ourselves.

If you are concerned about your alcohol use you may find the following organisations useful:

The Sick Doctor’s Trust

www.sick-doctors-trust.co.uk or the BMA Counselling Service 0645 200169. You can contact the LMC Medical Secretary at any time on 07796267510

VOLUNTEER MEDICAL ADVISER NEEDED FOR BIBIC

The British Institute for Brain Injured Children (bibic) is a nationally important charity based just outside Bridgwater that provides help and support for children with neurodisability and their families.

Their usual medical adviser is away for at least the next six months, and they are seeking a replacement for at least that time, though they may need someone in the longer term

The role is mainly to look at the medical history and notes of children coming to bibic to make sure that there are no medical contraindications to the proposed therapies. The medical advisor is not expected to make diagnoses, issue prescriptions or recommend treatments, although around 20% of children presenting to bibic have no formal diagnosis, particularly in cases of global development delay or certain Autistic Spectrum Disorder conditions. Bibic do not expect their advisor to evaluate their core activity but rather to flag up any concerns before they commence work with the family and child.

The role might suit someone recently retired from full-time practice, although we are not yet clear whether GMC registration and medical indemnity cover are required. The time commitment required is pretty modest, so if you think you might be able to help do contact John Bennett, bibic CEO, at john.bennett@bibic.org.uk or on 01278 684060

Small Ads Small Ads Small Ads.....**WARWICK HOUSE MEDICAL CENTRE
PART-TIME RECEPTIONIST VACANCY
(to cover maternity leave)**

We are looking for an enthusiastic, motivated and flexible Receptionist for a one-year fixed term contract to cover maternity leave from February 2009. The successful applicant will have previous reception and administrative experience in a medical/clinical or similar environment be computer-literate with a sound knowledge of the EMIS clinical computer system have excellent communication skills and be able to work under pressure.

This position involves varying shifts between 8:30am and 4:00pm but it is essential that this Receptionist is able to offer holiday and sickness cover for the rest of our Reception staff who work a range of morning and afternoon shifts between 8:00am and 7:00pm weekdays.

A full job description and person specification for the vacancy can be found on our website www.warwickhouse.org.uk. If you would like to know more please contact

Jane Watts on 01823 447374 or email jane.watts@warwickhousemc.nhs.uk

Applications should be addressed to

Mrs Jane Watts Office Manager Warwick House
Medical Centre Upper Holway Road Taunton,
TA1 2QA

Closing Date : 23rd January 2009

**QUANTOCK VALE SURGERY, BISHOPS
LYDEARD****PART-TIME PRACTICE NURSE REQUIRED**

Due to retirement, we are looking for an enthusiastic part-time respiratory specialist practice nurse to join our small friendly rural practice in April 2009.

We need you to offer three respiratory clinics per week, totalling 13 - 14 hours per week, at times to be mutually agreed. Ideally, you will be an experienced practice nurse and you will already have the Education for Health Diplomas in Asthma and COPD, or be working towards these. Our nursing team comprises a nurse practitioner, two practice nurses and a health care assistant. We offer a full range of nursing services to our 5300 patients and there will be the opportunity to undertake some treatment room duties as well as the respiratory chronic disease management clinics.

FOOTNOTE

Readers will be interested to hear that the PCT is running a "Plain English " course for their staff in February.

For an informal discussion about the post, please contact the Practice Manager, Dorothy King, on 01823 433400, or by email to Dorothy.king@quantockvalesurgery.nhs.uk

To apply for the post, please send your CV with a covering letter to the Practice Manager, either by email, or to:- Quantock Vale Surgery, Bishops Lydeard, Taunton, Somerset TA4 3LH. Closing date 20 February 2009

Dr Victoria Lanary MRCP DRCOG MRCGP

I completed Plymouth VTS 3 years ago, after hospital jobs in the Region

Since 2006 I've worked as a Locum GP in Plymouth and Torbay, and also spent a year in Western Australia, where I worked in A&E, and made time for some great adventures!

Now returning to Taunton as my husband has a Consultant post at Musgrove Park.

I will be looking for locum work in the short term with a view to partnership when the right opportunity arises. I'm cheerful, hard working, motivated, patient centred, yet QOF aware!

Familiar with EMIS, INPS & microtest
drvlanary@yahoo.co.uk or 07968 827629

ST JAMES MEDICAL CENTRE**Salaried GP – 4 sessions per week**

We need an enthusiastic, forward-thinking Salaried GP with lots of initiative. You will work at our Main Site and at our Branch Surgery. This post offers the potential for extra sessions and possible further career development due to our expansion and relocation plans. Interested?

For an information pack contact Guy Patey, Practice Manager, St James Medical Centre, Coal Orchard, Taunton, TA1 1JP. Tel 01823 285414, email guy.patey@stjamesmc.nhs.uk.

Closing date 12th February 2009.

HIGHBRIDGE MEDICAL CENTRE**1 YR Fixed Term Contract Salaried GP**

We are an EMIS LV PMS practice with 14000 patients. 6 partners, 2 part time salaried GP's, and a large team of experienced Nurses. We need an experienced GP to provide maternity leave cover for one of our salaried GP's who works 6 sessions over 3 days. To start 1st April.

Closing date for applications 20 February.

Please send CV and covering letter to Chris Edwards, Practice Manager, Highbridge Medical Centre, Pepperall Rd, Highbridge TA9 3YA or email chris.edwards@highbridgemic.nhs.uk

JENNIFER'S JOURNAL

The lunchtime meeting with the counsellor is usually an escape from protocols, guidelines and targets. We discuss the human side of medicine... but things are changing. I knew about CBT (Cognitive Behavioural Therapy) but suddenly they were talking about CAT (Cognitive Analytical Therapy). No doubt there is a CCT (Cognitive Crackpot Therapy?) and a CDT – or is that something they do in school these days? CET is a form of backward ECT where you electrocute the therapist and not the patient and CFT is Cleverdick Effing Therapy.

The NHS is forgetting it is the people that count, not the therapy. A good therapist will get good results whatever letter they insert in their CT. A bad therapist will fail regardless of what tool they use. Rapport, kindness, good listening, empathy and allowing your own emotions to be engaged will do more good than all the CTs in the world. And this is something that GPs are usually pretty good at. We also have the advantage of already knowing the patient, their background and their family. Which brings me to a horror draft flow diagram circulated at the end of last year by Wyvern Health:

Outline Care Pathway – Somerset Emotional Health & Well Being Service.

In English bureaucracy there is a tradition of writing write the opposite of what is meant. So, we have a Mental Health Team which is really a Mental Illness Team; and, of course, we now have Teams instead of individuals. We also have lots of different Teams who pass patients on from one to another. I am sure the patients just want to work with someone that they can get to know and trust and not be shuffled about.

But back to the Emotional Health and Well Being (yuck) Pathway. The GP gets one little mention in a box at the beginning, which is shared with “Community NHS, Social Care, Self, Probation and Other”. An arrow goes from this box to a box called “Referral Management” which does “Triage, Assessment, Care Plan and Allocate Therapist”. Arrows lead on from this box to various treatment options but one arrow leads back to Referral Box and says “No action needed but referred back to GP for observation and support”. It is irritating enough to think that this triage person (who will have never met your patient before) can just send them back – Triage(computer) says “....no” – but what is really upsetting is the value given to GPs. They are recognized only as Referrers and the best they can do is “observation and support”. 90% of the emotionally wounded and vulnerable are supported by GPs every day in their surgeries. It is the biggest part of their job. They are experts at relating to people and therapeutic transactions and if we send the odd one on, it is not T for “Triage” we are after, but T for “Treatment”. The trouble is once your poor patient (sorry – Service User) has braved revealing all their inner secrets to the triager and impressed them with a sufficient level of misery they then have to be referred on to another individual and start a relationship all over again. The options include “High Intensity Individual Therapy”, “Low Intensity Individual Therapy”, (Just how intense would you like your therapist?) “Group work” (cheaper) or “Supported Self Help”. The latter includes Bibliotherapy (i.e.get a book on it), and Exercise (healthy body, healthy mind ...)



There was a time when a GP had the support and help of a Psychiatrist and a CPN for the really ill and otherwise managed on their own. I think we did OK. In those days it was thought wise to minimize disease-seeking behaviour but now it seems we are meant to seek it out and encourage it, so that we can let unknown therapists loose on them. Jobs for the boys if you ask me.

Jennifer

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

Sickness Absence Certificates for School Children

We have noticed a steep rise in the number of requests from schools for a range of certificates and letters about individual students. There seem to be several reasons for this, but the bottom line is that unless there is a child safety concern you should not share information without consent and that in the majority of cases providing it is not an NHS service. We are very grateful to Wessex LMCs for providing the majority of the text of the attached letter which we hope you will find useful. Please do continue to let us know about any difficulties you have in this area.