Somerset LMC Newsletter

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A ONCE IN A LIFETIME CHANCE TO CHANGE THE NHS?

The inertia and complexity of the NHS means that most of the time effecting change is like steering a supertanker – it takes an awful lot of effort to shift course a few degrees. But very occasionally circumstances align in a way that means quantum change can be achieved with just a little pressure in the right direction. It seems we may be at just such a tipping point now. It is not an exaggeration to say that such an opportunity is likely to arise just once in a doctor's career. Your editor started GP training in the year Mrs Thatcher was elected, lived through the false dawn of the Labour victory of 1997 and finds that only now is there is the combination of political, organisational and financial circumstances that might allow the profession to persuade the NHS to do things differently.

The key to all this is the curiously unmemorably named "QIPP" (Quality, Innovation, Productivity & Prevention – doubtless to be relabelled before long) devised by the last government to deal with the steady 6% year on year growth of NHS activity in the face of static NHS funding. The drivers for this are our now familiar apocalyptic horsemen: demographic change, rising expectations and medical advance. Of course, at their head is not Death, but the abject failure of successive governments to put any real limits to the scope of the NHS. 6% compounded over 3 years comes to 19%, giving us an idea of the real funding shortfall we face. That sort of sum - perhaps £1.3 Billion for the Southwest alone – simply cannot be saved by traditional efficiency savings and cuts. We need to rethink the whole way in which patients regard their illnesses, responsibilities and treatment and thereby turn the current system on its head. The default assumption should not be hospital care, but self care. Patients who understand their conditions, who have their own specific plans for dealing with any deterioration, and whose problems are anticipated by the primary care team are less likely to need care from intermediate or secondary care services. We all know that the NHS still does far too much in hospitals, many of whose problems are caused by the sheer volume of work, and there are better ways of giving very many patients the care they need much closer to home.

Our Strategic Health Authority observed that if all PCTs operated in the top quartile for cost efficiency across the whole range of health provision, much of the deficit could be covered. Eight health communities have been instructed to prepare plans in a particular area (in Somerset this is long term conditions) and all PCTs must have plans in place for implementing all of these by the end of the year. Somerset PCT has four initial proposals concerning assistive technology (home monitoring to detect early signs of deterioration), end of life care, personalised care plans and enhanced care co-ordination for the most complex patients. Many others will follow. The plan is for these to be piloted in one GP Federation area and then quickly extended across the county. All of the proposals are evidence based, and although this was a scheme devised by the Department when Labour was in power, it seems inevitable that the current Government will wish to continue with something very similar.

There is no doubt that general practice could embrace all this and be a major force in bringing about the biggest improvement in the provision of

care since 1948. But we cannot do it without other changes in the NHS. The GP's day is now full from 08.00 to 18.30, and unlike the fundholding days of nearly 20 years ago this is not a "spare" time activity. Work of this magnitude must be resourced properly and it needs dedicated GP time, highly skilled management support and positive incentives for the weary troops in the surgery front line. We must unburden practices from the clutter of the 2004 contract and simplify relationships with the PCT, and, above all, change the persisting blame culture in the NHS that encourages clinicians to be risk averse because responding to even a simple complaint involves hours and hours of work and stress.

In the end resolving this is more about politics than management. Mr Lansley has responded to the assertion by GPs that we can do things better by offering us the chance to prove we can. We should take it.

IMPROVEMENTS IN THE OUT OF HOURS SERVICE

Will make working shifts for the Unscheduled Care Service more attractive

Significant changes are afoot in the Out of Hours Service following the appointment of a new Operations Director, Steve Frost, who was previously a modern matron in Emergency Services in Poole. Concerns voiced by GPs working for the service are already being addressed, starting with a detailed review of the current rota booking system to make it more user friendly – including an option for groups of GPs to manage parts of the rota amongst themselves. Drugs and equipment will be standardised and made more accessible, and communications with doctors working in the service will be improved. Clinical feedback is to be provided, starting with statistics on triage activity which compare each GP with the average performance. Maximum use will be made of local triage, but there will be a clinician working at the hub who can provide information and some help with case management. Rota gaps will be addressed and the use of Emergency Care Practitioners refined. All this is very encouraging, and we hope it may make local GPs more inclined to work some shifts. The UCS is offering a paid 3 hour induction course for new recruits, and returning doctors can get a briefer update on, for example, upgrades to the Adastra system. If you have general enquiries about working for the UCS you can contact them on 01202 851312, but if you would like to speak to Steve Frost about working sessions you can arrange this by speaking to his PA, Ellenor on 01202 851332 .

INITIATING DMARD TREATMENT IN PRIMARY CARE

As a rule.....don't!

Although there is an Enhanced Service under discussion between the PCT and the LMC for GPs to initiate some particular methotrexate treatments under the direction of a consultant, the LMC and PCT view is that under all other circumstances treatment should be initiated by the specialist.

For all DMARDs the consultant should prescribe (as a minimum) the first month's supply and appropriately advise the patient on the monitoring required and potential side effects to look for. When the patient is stable on treatment the consultant can then ask the GP to undertake shared care under the terms of the "Near Patient Testing" NES There has been considerable discussion as to whether "stable" refers to the disease or the dose, but the pragmatic position the PCT has adopted is that most of these patients prefer to have their routine blood monitoring point in primary care even when dose adjustments are being made by the specialist service.

Do remember that you do not have to accept responsibility for monitoring - GPs can decline to undertake shared care of a particular patient on clinical grounds and practices may decline to sign up to the DMARD commissioned service.

INTERIM SENIORITY FACTOR FOR 2010/11

The Technical Steering Committee has published an Interim Seniority Factor for 2010/11 of £95,802 for GMS GPs in England. You will remember that this is the number used to allocate GPs to the different seniority pay percentage bands for the year. A little surprisingly, given the perception that incomes have been falling, the 2010/11 figure is a higher than that for 2009/10 which was £94,723. The final figure for the most recent determined year, 2006/07, was £92,140 as against the interim of £95,355, so we anticipate that the final figure for the current may well be lower than the interim one. Further details are available on the NHS Information Centre website at www.ic.nhs.uk/tsc.

LETTERS PAGE

A true story

Dear Consultant

Thank you so much for the discharge summary for Mrs X, which she delivered on her way home from hospital. Although it was both legible and timely, it unfortunately did not contain any clinical information at all. Could I perhaps trouble you to enlighten me?

Yours sincerely

GP

Dear GP

Thank you for your kind letter concerning our new patient discharge summary. As you will understand, as part of the efficiency drive in the NHS these summaries are now generated by the doctor responsible for the case care.

May I draw your attention particularly to the line stating that "*unless specified this will be final communication to the GP".* I am not quite sure whether this a promise or a threat. However, I note that the summary contains considerable information about home addresses and discharge addresses and NHS numbers and things like that. I am slightly disappointed to find that any reference to the clinical event that the patient experienced is missing from the report, but I am sure that is in keeping with patient confidentiality or something similar. Actually, as far as I can ascertain from the notes (and it is not even completely clear there) the patient appears to have had a minor medical procedure.

This is a new system and I do hope we can make something of it. I think it probably makes me the highest qualified secretary employed by the trust – it is, of course, the cycling proficiency certificate that makes me stand out from my colleagues.

Yours sincerely

Consultant

SUMMARY CARE ROLL-OUT

Will continue in Somerset

Although the DoH is undertaking a review of the SCR public information process and the last government's accelerated implementation around London has been halted, it has now been announced that the rest of the programme is continuing - which means that practice uploads across the county will carry on. Recent EMIS connections seem to be going pretty smoothly, and the process now ensures that practice specific problems are identified and dealt with as they crop up. As a rising proportion of patients in the county have an SCR, the PCT is encouraging A&E Departments to start using them, and we understand that when the A&E module is added to the TST Cerner computer system there will be a quick link to the SCR making the whole process very easy. The LMC is also keen to see the SCR used for medicines reconciliation on admission. The evaluation of the SCR to date by University College researchers was fairly neutral but they did point out that benefits were most likely to be realised if stakeholders co-operate, and we hope that in Somerset the tradition of joint working will bear fruit.

DVT COMMUNITY PATHWAY

It is planned that practices using Yeovil Foundation Hospital Trust will be able to commence using this Pathway from the summer.

An education session is arranged for Thursday 15 July at Yeovil FC with 2 opportunities to attend; 12.00 or 13.00 hrs for a 45 minute presentation and finger lunch. Please book with rhian.lucas@leo-pharma.com. Further details will be circulated to all practices shortly.

SMALL ADS ..SMALL ADS.. SMALL ADS ..

ADMIN ASSISTANT: SOMERSET LMC

Details: Full time to provide admin support for Somerset LMC & Somerset GP Education Trust. More details on the website www.somersetlmc.co.uk.

Contact: Jill Hellens on 01823 331428 or jill.hellens@somerset.nhs.uk. Closing date 30.7.10.

PARTNER: CREWKERNE HEALTH CENTRE

Details: Full time or three quarter time.

Contact: Louise Walker, Practice Manager louise.walker@crewkernehc.nhs.uk or tel 01460 72435. Closing date 30.6.10.

SALARIED GP: EXMOOR MEDICAL CENTRE, DULVERTON

Details: 50% WTE. Start date flexible.

Contact: Kathryn Kyle, Practice Manager or Dr David Berger tel. 01398 323333 or email Kathryn.kyle@exmoormc.nhs.uk or daveberger@gmail.com. Closing date 31.7.10.

LOCUM: EXMOOR MEDICAL CENTRE, DULVERTON

Details: For holiday cover 16.8.10 to 3.9.10. Accommodation available.

Contact: Kathryn Kyle, Practice Manager on 01398 323333 or kathryn.kyle@exmoor mc.nhs.uk.

WANTED GPwSI ORTHOPAEDICS

Details: Up to 3 days a week in half day sessions at the EASe clinic Yeovil/Crewkerne.

Contact: Dr Steve Holden on 01935 470200 or Stephen.holden@hendfordlodgemc.nhs.uk.

JENNIFER'S JOURNAL

As a patient Jennifer is beginning to get used to attending hospital out-patients. She has had a few visits to the DGH and many visits to a very prestigious specialist hospital upcountry. Overall they both deliver a jolly good service but it is interesting that they both follow the same patient pathway.

When I see my GP I sit in the waiting room until my turn and then go straight from there into their consulting room. I like GP consulting rooms. They usually have a warm and friendly air about them. The decoration, pictures, tidiness or otherwise tell you something about the doctor and reinforces the idea that they are also human beings. They have a computer screen in front of them with all your details immediately available to them. Being invited into the doctor's 'lair' somehow reinforces a relationship.

Out-patients work differently. You start off in the big waiting area. This is busy and tightly packed with an electronic notice board that flashes up messages such as 'Dr Giant Brain is running 1 hr. behind'. (Useful to know, we never get enough information) though in the DGH you each get given little bleeps which go off when it is your turn. Presumably these are so that you can wander off while waiting, but since here you have no reason to know that Dr Brain is running late you don't really see the need to go anywhere. Bit of an expensive gimmick, if you ask me. Anyway, I digress. The moment arrives and you are summoned by a nurse. Not unreasonably, you might think that you were on your way to see Dr Brain himself - unfortunately not. You are directed to the next waiting area. Here, doors open and shut and medical personnel rush in and out continually. So you settle into your new environment and continue to wait. No clues at all on how long that might be.

Finally you are summoned again and nurse leads you on to your next destination. At last you will have your consultation with Dr Brain. Or so you thought. You are now shown into an empty examination room. There are two seats and an examination couch. You and spouse take the seats, the nurse leaves. There are no windows. No pictures. The room has no character: it belongs to no one. Eventually Dr Brain speeds through the door moving in a way to convey what a busy chap he is. He sits on the couch in a manner that clearly states he will not be stopping long. He is sitting close to you, but higher up and he smiles down. He may or may not have written notes with him but he won't look at them, hoping to wing it on the brief scan he gave them on his way to the room. He will be kind, caring, competent... and very soon gone, leaving you alone in your cold barren examination room. And then you go home.

Consultations in barren examination rooms with doctors too busy to sit down properly do not generate confidence. Written notes in which it takes ages to find anything are out-dated and even unsafe. Hospital doctors should work in consulting rooms with a desk and computer, they should arrange things so that the patient can at least try to believe the doctor has time for them. Herding patients into staged waiting zones is irritating and unnecessary. I did once see a consultant privately and this was in a very friendly beautifully decorated homely room. The trouble was that there was such an enormous desk between us that I almost felt I had to shout to communicate with him. Secondary care have probably never explored the dynamics of a consultation and think a transaction with a patient is how you cross the corridor from one examination room to another. They are such clever nice people, and could do so much better. But perhaps I complain too much. If you are getting the best treatment available what else really matters? With cancer we are all just fighting for survival, not niceties.

Jennifer

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

KEEPING LOCUMS INFORMED—PASS IT ON

Unfortunately Somerset PCT do not hold email addresses for GP locums and they do not have an overall prescribing lead to pass on Shaun Greene's newsletters and prescribing information. We would therefore encourage all locums to get in touch with Shaun in order for them to be added to his distribution list shaun.green@somerset.nhs.uk alternatively the newsletters and prescribing briefs can be found at http://nww.somersetpct.nhs.uk/pmm/default.aspx .

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