Somerset LMC Newsletter

Feb 2011

Issue 163

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LMC BROAD SHOULDERS AWARD FOR 2010

The nominations are in, and the pretty lady in the posh frock hands an envelope to that chap in a dinner jacket....

....and the winner is...

Somerset Primary Link!

A box of chocolates is winging its way to Wells as a thank you to Sophie and her team for all the help and support they have given GPs in the last year.

MANAGING THE WORKLOAD—WHEN TO CALL A HALT?

Although the 2004 contract tried to specify what GPs were expected to do, the very nature of a generalist job means that it is hard to define firm edges to the commitment. There have always been differences both between individual doctors and between practices: GPs do more or less in certain areas depending on their experience, clinical skills, practice organisation and political philosophy. Up to now, this has been a decision for each to make for him or herself, but the great tide of commissioning changes and the demands of QIPP are starting to impose a new set of expectation on the profession.

There has been a wrong but worrying presumption amongst some NHS managers that general practice is a "free good". In other words, any work transferred from secondary to primary care will be done at no cost because GP practices can simply absorb it all. This is far from the case. The typical GP's day is now full from 8.00 am to 6.30 pm, and beyond. Altering a patient pathway to prevent an admission thereby changing what might be a 20 minute job into one taking perhaps an hour simply will not work in a day made up of 10 minute appointment blocks – even if you work 40 minutes later at night, everyone you see for the rest of the day will have had to wait the extra time, which is clearly not acceptable.

There is certainly a strand of senior civil service opinion which says that GPs earn too much and that more work should be squeezed out of us. Putting aside the fact that it was they who agreed the contract, the reality is that making changes in practice configuration is not easy: more doctors need more space and bringing in new partners or salaried GPs is complicated in all sorts of ways, assuming that there is someone suitable around in the first place. Reducing list size does not seem to help much either, and anyway that will start to cause problems with registration and access that nobody is likely to want to commission more expensive 8 to 8 centres to provide for!

So, whilst primary care will have to face some QIPP savings that does not mean we do extra work for nothing. At the very least practices should expect their marginal costs to be covered. We accept that if QIPP does lead to better pathways and efficiency savings, some of these may actually benefit practices. Indeed, some of the admission prevention schemes introduced by Wyvern and the PCT have already done so. Having SPL to do the organising for an admission certainly saves time, and the Acute Care GP service helpfully bridges the gap between patients who can be investigated in the practice and those who definitely need admission. But on the other side of the equation there is a steady stream of extra work that threatens to become a torrent as new schemes evolve. Methylphenidate monitoring, the DVT pathway and the End of Life Centre and are just some local examples, and on top of the ever increasing regulatory and "patient safety" requirements we have to make it clear to commissioners at all levels that general practice is not bottomless pit into which an ever increasing proportion of hospital work can be chucked and forgotten.

PATHOLOGY MODERNISATION PROGRAMME IN SOMERSET

Following the publication of the Carter Report which recommended the consolidation of pathology services, Somerset Pathology, which provides services at TST and YDH for most of the county, is looking to further develop its position as a national leader. The current plan is to join with a new partner organisation to establish a new processing centre in Taunton to deal with GP and other "cold" samples thereby freeing space in the hospital laboratories for dealing with more acute work.

GP users should notice no change in the service, requesting and reporting will carry on as at present, and clinical advice will continue to be available as before. The database will still be available via your web browser.

In the longer term the service anticipates being able to offer more services to practices, including point of care testing and support for outreach clinics. Potentially we could be offered sample tracking so users could check at a glance where in the system a specimen had reached.

In the medium term it is likely that GP consortia will contract directly with pathology providers rather than indirectly via an acute trust, and the proposed change should allow the development of accurate and dynamic reporting of the use of laboratory services to support this.

LAUNCH OF THE COLORECTAL ENHANCED RECOVERY PROGRAMME AT TST

Aimed at improving patient outcomes following colorectal surgery

Enhanced Recovery is the implementation of an evidenced based, "multi-modal" approach for patients undergoing Colorectal Surgery. There are three components:

1. The preoperative assessment, planning and preparation before admission.
2. Reducing the physiological stress preoperatively.
3. A structured approach to the immediate postoperative management, including pain relief, dietary intake and mobilisation targets.

To achieve these goals, patients will be given clear guidance on what is expected of them in the lead up to surgery, and during the immediate days afterwards. This will be done by the Preoperative Assessment Team and also the three Enhanced Recovery Nurses the Trust has now appointed. The ERNs are available from 8am to 8pm Monday to Friday and 8am to 2pm on Saturday and Sunday on 07500 029151. Patients and GPs will have direct access to the enhanced recovery team so that any concerns can be addressed and acted upon. If necessary, urgent clinical assessment is available. The whole process will undergo ongoing rolling evaluation, so that the pathway can be tweaked and improved with time.

Although this has been done in an ad hoc way over the last couple of years, the team are now able to formalise a more structured pathway from the end of January.

Mr Paul Mackey, Consultant Colorectal Surgeon would value any feedback or suggestions on 01823 343831, or Paul.Mackey@tst.nhs.uk.

CALLING ALL SESSIONAL DOCTORS!

Please consider joining the LMC Sessional Doctors eGroup

With the impending upheavals in NHS commissioning and other major changes in primary care delivery likely, the LMC recognises that the committee needs to set up better communications with GPs who are not based in a single practice, or whose job profile means they are not in touch with what is going on in the wider medico political world.

We need your input to the LMC's decision making processes and we want to make sure all GPs are kept up to date with important decisions. To help with this we are setting up two email groups. The first is a simple distribution list for sending out information and canvassing opinions – we guarantee that you will get no more than one message a week. The second is a discussion forum to encourage debate and information sharing.

If you can find the time join either group please do let us know: harry.yoxall@somerset.nhs.uk

Sessional GPs Newsletter

A new issue of the sessional GPs newsletter was published this week, and is available at:

http://www.bma.org.

This issue covers the following topics:

- GPC Sessional GPs Subcommittee Election
- The NHS White Paper and Sessional GPs
- Revalidation
- Contacting the Sessional GPs Subcommittee
- Sessional GPs: Your Pathway to Success

AND ANOTHER THING.. REFERRAL FORMS!

There was an excellent letter in the BMJ this week bemoaning the plethora of referral forms that the GP author was expected to use, and commending a return to a universal standard referral form – a sheet of practice headed paper. The GMS contract requirement is simply to refer appropriately, and we like to think that this means the medium used is up to the GP. Rather like the old stories about a cheque written on the side of a cow being valid so long as all the information was there and the cow duly signed, there seems no absolute obligation to use a referral form. It is interesting that SMTC started out with a suite of referral forms that some GPs never used, and they now appear perfectly happy to accept traditional written referrals, whilst the 2 week cancer referral forms in use by TST and YDH are increasingly prescriptive – a difference perhaps dictated by a wish either to attract or to reduce referral numbers.

Referral forms can be valuable in helping the recipient prioritise work or direct referral appropriately, but sometimes they seem to be more about the bureaucratic convenience of the provider than the care of the patient. The LMC view is that all referral forms should be agreed by the commissioner after consultation with representative GPs, and they should only be accepted if there are definite benefits for the patient. There should be a central on-line repository of forms from which the practice can pull them down as needed. Forms should all revised at the same time and only once a year, so we avoid the nonsense of referral being rejected just because it is submitted on a previous version of a form which has been marginally changed.

GPs must continue to reserve the right to send a traditional letter if that is what is needed to make a safe and comprehensive referral.

NHS SPORT & PHYSICAL ACTIVITY CHALLENGE

Calling all couch potatoes....

Go on, admit it, you don't take as much exercise as you should. Although we advise patients to exercise more, it is not easy to crowbar our own exercise time into a frenetic week in general practice. But as work pressure ever rises we all need to take time to look after our own health. At a formal launch at MPH on 26th January the PCT joined other NHS bodies in signing up to an NHS challenge to get 2012 staff members involved in regular physical activity by 2012.. There are four strands to the initiative, details are on the website:

- Have A Go" taster sessions for those unused to regular exercise
- Join A Team" opportunities to form or join workplace based teams in various sports
- Go Fat Go", a weight loss challenge
- Go for Green" an initiative to encourage walking or cycling to work

Anyone who works for the NHS in Somerset can register as an individual. If you don't have a ".nhs.uk" email address you can ask for a verification code to do this. You will be asked to complete a brief health questionnaire and then log your activity. GPs can register as part of the Primary Care Services team, along with the other contractor professions, and we will be encouraged to host, encourage and fund physical activity within our practices. A lot of other activities on the website calendar will be free or discounted.

See www.teamsomersetnhs.co.uk for details or contact elaine.harris@somerset.nhs.uk

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

SALARIED GP (PART TIME): AXBRIDGE & WEDMORE MEDICAL PRACTICE

Details: 4 sessions pw, initial 6 month contract with potential to extend. April start date. Closing date 23rd February 2011.

Contact: For a full job description email maria.allen@axbridgewedmoredoctors.nhs.uk stating "Re: Salaried GP" in the subject.

LOCUM : CANNINGTON HEALTH CENTRE, BRIDGWATER

Details: Locum required 5-7 sessions from 21st March to cover one months Sabbatical.

Contact: Secretary on 01278 652335.

PRACTICE NURSES: HENDFORD LODGE MEDICAL CENTRE, YEOVIL

Post 1: Treatment Room Practice Nurse, 24 hrs pw permanent contract.

Post 2: Chronic Disease Management Practice Nurse, 28 hrs pw maternity cover leave. To be worked over 5 days.

Also Bank Practice Nurses required. Closing date 4th February 2011. Interviews 14/15th February 2011.

Contact: Nicola Hardwill, Senior Nurse Lead on 01935 470200 or request an application pack from the surgery.

COMMUNITY COPD SPECIALIST NURSES: BUPA HOME HEALTHCARE LTD

Details: Full and part time vacancies. Car owner/driver is essential. COPD Diploma or other relevant qualification essential. Closing date 1st February 2011.

Contact: Julie Excel, Lead Nurse for informal enquiries on 07983 453673 or for an application pack contact Jill Allen on 07957 125281 or jillallen@bupahomehealthcare.com.

DR WHIMSY'S CASEBOOK **QOF: A User's Guide. No.73 – Diabetes**

Our video series on the Oriental Art of Tick Boxing continues:* *[*East of Barnstable]*

GP: Good morning Mrs Globulin, what can I do for you today?
Mrs G: I've come for my diabetes check, doctor. You wanted it before the end of March.
GP: Ah, yes. Tell me, Mrs Globulin, in the last month have you been bothered by feeling down, depressed or hopeless?
Mrs G: Er, what's that got to do with my diabetes, doctor?
GP: We'll take that as a No, then.
Mrs G: But since you mention it…
GP: Let's press on, Mrs Globulin. I need to check your blood pressure… Damn, your systolic's 146. I'm going to take it again, but this time I'd like you to bear down as if you're giving birth to twins.
Mrs G: If I must, doctor…NNgggnnphh…Oh, doctor, I'm feeling really dizzy. I think I'm going to…
GP: Hang in there, Mrs Globulin… 40… 35… 30… Result!!
Mrs G: …ugh…
GP: Now, your cholesterol is still 5.1. Have you cut out red meat?
Mrs G: As God is my witn…
GP: And poultry, eggs, bread, sweets, nuts, crisps, biscuits, cakes, dairy and chips?
Mrs G: Completely, doctor. Although I don't enjoy food so much nowa…
GP: And you're still taking the statin?
Mrs G: The one that makes my legs ache? Yes, doctor.
GP: Hmm. We'll have to add ezetimibe.
Mrs G: Is that another tablet, doctor? The lady at Boots says they won't be able to shut the lid on my Nomad if I have any more.
GP: All in a good cause, Mrs Globulin. Now, I'm afraid your HbA1c is 7.5%.
Mrs G: Ooh – is that bad, doctor?
GP: It's fine for *you*, Mrs Globulin, but the government pays me to get it below 7.
Mrs G: That must be better for me then, doctor.
GP: Well, apparently it's not: you're more likely to have a heart attack, but at least you'll snuff it with less than 7% of your haemoglobin glycosylated. Think of it as having a car crash in clean underwear.
Mrs G: …er…
GP: So we'll have to add metformin to your gliclazide, pioglitazone, sitagliptin, exenatide, repaglinide, acarbose and insulin.
Mrs G: But, doctor, didn't you tell me I can't have metformalin because of my kidneys?
GP: *[Tetchily]* Listen, Mrs Globulin, what do you want to do – cooperate, or live longer?
Mrs G: Sorry, doctor. You know best. As you say, it's all in a good cause.

In tribute to Jennifer, our first Newsletter Back Page columnist, whose diary is sadly now closed. We hope he would have enjoyed this contribution from Dr Whimsy, submitted in his memory

DR RICHARD EVE 1953-2011

We are very sorry to have to report the recent death of Richard Eve, until recently senior partner at Crown Medical Centre in Taunton. Richard was an outstanding and outspoken GP, and for many years the back page columnist for the LMC Newsletter under the pen name of "Jennifer". Few things made his eye twinkle more than the frothings of rage his articles occasionally generated in a certain kind of NHS manager, and more than once he started a valuable debate by expressing a trenchant (sometimes tongue in cheek) view of a currently fashionable NHS development.

Richard started in practice in Taunton in 1982 and was a founder member of the first Young GPs Group in the county. He had a wide range of interests from country sports and polo at one end to medical education at the other, where his idea of "PUNs and DENs" (Patients' Unmet Needs leading to Doctors' Educational Needs) gained national currency. He also led the complex negotiations for the development of the Medical Centre, and it was his foresight that ensured it was built large enough to accommodate other healthcare providers, and, incidentally, the LMC.

Richard was lucid and direct, a loyal friend and great company – he would have been a brilliant commissioner. We will miss him greatly.

Editor Dr Harry Yoxall
Somerset Local Medical Committee, Crown Medical Centre, Venture Way, Taunton TA2 8QY **Somerset LMC**
Tel No: 01823 331428 Fax No: 01823 338561 E-mail: lmcoffice@somerset.nhs.uk
LMC Website: http://www.somersetlmc.co.uk