Somerset LMC Newsletter

October 2012

Issue 177

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PRACTICE MANAGERS: FIT TO DROP?

When it comes to primary care who would argue that the volume, range and complexity of tasks have all increased with the shift of work from secondary care? And that many are working long hours, probably unsustainable in the long term? Or that many feel unsupported by colleagues who appear to be insensitive to their problems, partners who seem to lack insight, and understanding, and who do not provide clear leadership, leading to a feeling of isolation? There is no competition about who is more stressed but these are just some of the complaints expressed by practice managers (PMs) in Somerset.

After a recent study day for PMs organised by the LMC we asked the County PM Group to summarise the things they would like to stop doing . There were three main headings: communications; being the single point of access for alerts and the general stress experienced by many in the job. These were discussed by the County LMC at its meeting on October 11th.

As far as the first is concerned the LMC has always done its best to rationalise communications: it makes no sense to add 20 attachments to an email – shades of Sir Humphrey in "Yes, Minister" burying the important document at the bottom of Jim Hacker's red box. The weekly PCT bulletin was singled out for praise and we hope that the CCG will adopt a similar, simple format to make a good start in the right direction. Annoying though PCT emails requiring instant attention may be, the PCT genuinely tries to help practices achieve contract payments. Whether the more remote NHSCB Local Area Team will be so considerate in future is open to doubt.

Similarly, we have strived over the years to rationalise the numerous alerts, trying to weed out the irrelevant. Unfortunately the issuing authorities are increasingly unwilling to risk allowing filtering, "just in case." Hence only the other day the author promised his manager not to perform any tracheostomies with a dodgy batch of tubes. The group felt that the Datix website might provide a better single portal for all alerts but, importantly, many PMs are the common point of access so what happens when he or she is away?

When it came to the stresses of the work there were complaints about doctors who expect the rights of partners but without the attendant responsibilities: those who act more like employees. Paradoxically this may well be an unexpected consequence of phenomena like wider part time working, greater emphasis on work-life balance, importance of child care arrangements and GP training no longer involving prolonged out of hours experience; all changes in modern practice applauded by many brought up in the "old school." Many PMs, in contrast, still carry huge burdens but are not partners in the business. Indeed, we hear that requests for help are often refused owing to lack of funding or the shortage of suitable staff with the right skills. Divisions within partnerships were also cited as adding problems for managers ,as was having to deal with stress in GPs. Everyone has their head down dealing with the clinical work, assuming that somehow everything will just carry on. Requests for clinical input are refused: "Just get on with it!" Too many GPs are too busy to help and support their managers.

The LMC has been shocked by the number of calls it has received from PMs and the numbers taking sick leave or even resigning. The lack of support

and sense of isolation can even mean that PMs feel unable to attend group and county meetings where assistance for some of these problems can be found: one example being collaborative working to achieve CQC inspection requirements. Why reinvent the wheel? Other examples of good practice are appointing deputy PMs and appointing an executive partner with protected time to work with the manager — but these require investment.

But, none of this applies to your practice...or does it? Stress in PMs appears invisible to many partners. One suggestion raised at the county meeting was to devise a diagnostic tool to make an examination. Once the diagnosis is made, the treatment will be up to you. Support is available through the LMC safe-house SuCceSS scheme which is now open to PMs, but mutual support at an early stage is much more important. As the chairman of Bridgwater Bay Federation recently asked, when did you last sit down with your PM (perhaps having first made time or her a cup of tea) and, rather than talking about how stressed and busy you are, asked how things are for them? The survival of your practice may depend upon it.

CONTRACTS FOR PRIVATE CARE SERVICES BEYOND GMS

Should be considered with great care

The Serious Care Review into the events at Winterbourne View Hospital Link makes for depressing reading: an all too familiar tale of fragmentation of care and a lack of clarity about who was taking responsibility. The role of the GPs who provided a privately contracted service to the hospital is touched upon in the report, and has implications for all practices that provide similar services for complex patients in a hospital setting.

In June 2012 the GPC published guidance on *"Identifying services that should not be provided by GPs as primary medical services"* Link. . This should be your starting point when deciding whether a service requested by an institution falls within your GMS/PMS contract. Although GPs are not required to provide care for patients in hospitals, there are likely to be a growing number of occasions when a care institution is registered as a hospital but normally behaves more like a nursing home, except in one or specialist areas. These cases are more difficult, and the practice needs to have a very clear understanding of what services are required under GMS and those that require a private agreement. You then need to decide whether you are prepared to provide the extra services, and under what form of contract. Few GPs will have the requisite level of skill to provide specialist psychiatric care or to manage ventilated patients, and even if there is theoretically consultant support available, will you be able to get it at 6.30 on Friday evening? And even then, unless the relationship is formalised within your contract, liability is likely to rest with the GP. It is therefore imperative that all the clinicians who are involved in any potential contract know what they are required to provide and are confident they are competent to do so. Do not let the practice be drawn into a contract by one enthusiast, however tempting the remuneration!

Before entering into any agreement you need to talk to your medical indemnity providers as they may have an additional subscription for GPs working in extended roles. Will the contract be with the practice, or with named GPs? If the latter, what cover arrangements are required? How does the practice prioritise the hospital work, and what response is required in an emergency? Who decides if the matter is urgent? How does the practice terminate the contract if the hospital starts to accept cases of greater complexity or in a different area than those originally admitted? Who will be providing the necessary specialist care and how is liaison between the consultants and the practice included in the contract? This should be an integral part of the service and not left for the GP to try and arrange whenever there is a problem. And perhaps most important of all, do not accept any restrictive contract clause that could clash with your GMC and ethical obligations to report and act upon evidence of poor practice or abuse.

The LMC would like to hear from practices that are providing "non-primary" services so that we can collate and share experiences, good or bad. Please contact harry.yoxall@somersetlmc.nhs.uk.

CONTINUING MEDICAL EDUCATION FOR REVALIDATION

An update from Somerset GP Education Trust

A key part of the revalidation information that all doctors will need to provide in the next three years is evidence both of learning and also of its validity - that it is reflective and not superficial.

SGPET has evolved in anticipation of the changes to make such learning easy and interesting.

When I arrived in Somerset in 2005 there was no coordinated postgraduate educational provision in the county, apart from a yearly update in the form of 'Fresh Looks'. I struggled to feel involved and in touch with what was going on. Since SGPET was set up in 2008 the situation has improved immeasurably. We now have a number of dedicated educators, based across the county, who meet regularly to plan and co-ordinate a 3 year revolving programme of curriculum-linked educational events relevant to the primary care team, including:

Six study days a year: Diabetes and Respiratory days annually, other topics such as Women's Health and Mental Health in rotation. Coming up: Rheumatology and Musculoskeletal including Osteoporosis update).

Half day study events: Next year these will include "Personality Disorder and the Difficult Patient" and a Men's Health update.

Regular locality evening meetings around Somerset arranged by SGPET local educators: Dr Elisabeth Gillies (West Somerset), Dr Helen Cotton (Yeovil), Dr Tony Wright (Bridgwater and Wells & Taunton) and Dr Martyn Hughes (Chard).

Sectional GP groups: *'First Five'* groups for trainees in their last 6 months and GPs in their first five years (Drs Tim Horlock and Laura Taylor). *Sessional GPs* group (Dr Hilary Allen) and *'20+'* Practical Management skills for experienced doctors (Dr Harry Yoxall).

Subject specific events including consultation skills, telephone work and out of hours.

Practice Manager sessions on employment law.

Practice Nurses and HCAs. Extensive rolling programme of training from basic ear care to a professional nurse appraisal pilot.

Updating Courses over a week: Fresh Looks in Taunton (November) and Yeovil GP Update week (May).

Future Plans include videoconference lunchtime presentations with live Q&A for practices to dial into.

We also keep a diary of other educational events so that everything available county wide is visible on our website. Events are colour-coded by area so you can find out what you can easily get to.

Membership of SGPET is available to individuals or to GP practices. If your practice joins, your whole team can attend events. Trainees have automatic membership. We provide a log of attendance over the year as evidence of your involvement and we also provide tools help show you have reflected on our events for revalidation.

We strive to make our education relevant to practice and we want and need your involvement and feedback to build on. If you don't know who represents your area or how to contact them, do get in touch. Your ideas and contribution are welcome, so let us know what you want, and indeed, what you have to offer. Do you want to get involved?

sgpet@somersetlmc.nhs.uk We are also on Twitter https://twitter.com/SGPET

Dr Lizzie Gillies

TREATMENT FOR OVERSEAS VISITORS

Despite the abuses elsewhere exposed by Panorama on 3rd October, deliberate defrauding of the NHS by non-eligible patients appears to be rare in Somerset. There is no requirement for practices to check that patients presenting for registration are eligible, and, indeed, even if they are not automatically entitled to care, the practice can choose to treat them as NHS patients anyway. If you do have a checking process it must be non-discriminatory, and must comply with your ICO registration under the Data Protection Act: keeping copies of documents to prove identity could fall outside this. If you are concerned that a person may be attempting to obtain treatment by deceit contact the NHS Counter Fraud Service via the PCT

Link

SOMERSET LMC MEDIATION SERVICE

A Better Solution for Partnership Difficulties

As life gets busier, medical; practice more demanding and the way in which we work ever more prescribed, it is perhaps not surprising that the differences within practices that used to be minor niggles may now quickly escalate into significant irritations and then on to serious disputes. There seems to be no room to tolerate difference any more. The LMC pastoral service and SuCceSS are mainly to help individuals, albeit often within the practice setting, and the LMC has a formal role in dispute resolution in many partnership deeds, but for years we have had a gap in our ability to help practices with internal relationship problems at a stage before the partnership deed is being invoked and lawyers instructed.

The LMC now plans to set up a mediation service to help practices with dispute resolution.

The free service will be provided by an accredited mediator with experience of general practice and is intended to help with workplace problems and partnership disputes. It is absolutely confidential.

Mediation helps parties to find their own solutions to problems. It is not directive in the way that arbitration and legal processes are. In mediation the parties make their own decisions and find ways of managing any further conflicts. The focus is on the future and (where possible) rebuilding relationships rather than apportioning blame. It avoids the cost and much of the personal stress associated with litigation and is much quicker. The process usually involves the mediator meeting each party separately and then arranging a meeting which is attended by the mediator and both parties accompanied by a supporter if they wish.

If you think that this service could be useful to your practice please contact the LMC secretary Harry.yoxall@somersetlmc.nhs.uk or 07796267510 anytime.

LMC PRACTICE NURSE ADVISOR

It's now just over a year since I took the post of a Nurse Advisor to the LMC. Several things have been accomplished including a rolling, structured education programme, a mentorship structure for inexperienced nurses and a list of locum practice nurses available for practices. We are now in negotiations with SCAT to provide QCF (formerly called NVQ) modules for HCAs.

As part of my remit I am also available in a pastoral role and I am more than happy to help nurses and practices where I can. It is a difficult time all round for and as a result of the many changes much stress and pressure is being experienced by almost everyone, including nursing teams.

If you think I may be able to help please don't hesitate to contact me at marion.baker@somersetlmc.nhs.uk or on 07557 494320.

Marion Baker

PERTUSSIS IMMUNISATION OF PREGNANT WOMEN

Change to the Data Collection Requirement

The LMC strongly supports this campaign and we are aware that practices have already started to offer pertussis immunisation to pregnant and some recently delivered women. We believe that this is an area in which prompt action really will save babies' lives. However, because of the need for rapid implementation the details of the programme are still being worked out. The PCT has just been informed of a change in the national data collection requirement, which now asks that immunisations for pregnant women and those who have recently delivered are counted separately, and the PCT will be contacting practices with details of the new arrangements. There may be further small adjustments to the programme in the future, but we do not anticipate any more major changes

FLEXIBLE HEALTH CARE UROLOGY PATHWAYS

Will be a "test bed" for innovation

FHC was the title given to the PCT project to take a radical look at where, how, and by whom health interventions should be offered. Since then the group has developed the growing number of pathways to be found on your Navigator desktop app. Up to now this has been a process worked out around a committee table and involving only a relatively few clinicians, but the CCG is now keen to test both the principles and the practicalities of the pathway model for clinical referral. The Urology pathway group has been working on a male Lower Urinary Tract Symptoms (LUTS) pathway and believes that the number of patients who need to be seen in clinic could be dramatically reduced if referrals were accompanied by a standard set of information, much of which is often missed out at present. But we don't know whether this is omitted because GPs don't think it is relevant, have chosen not to do it, or just did not know it was helpful. At the other end of the process, correspondence coming out of hospital does not always contain the information that the GP needs. If the recommended treatment does not work, what is the next step? What symptoms should prompt a re-referral? Are any regular checks likely to be helpful? Is repeating the PSA worse than useless for this patient?

This pathway was chosen because of the very good working relationship that has built up in the group between the primary and secondary care clinicians involved and the good and evolving evidence for what dictates the most effective interventions.

You may therefore start to see requests from the Group for information about either your referral, or the letter you had from the clinic, or both. The intention is not to criticise any clinician, but to try to get a thorough understanding of what is valuable in the correspondence between primary and secondary care, and to try and tease out if making small changes will affect the workload for either party, or whether getting the pathway just right actually saves time all round.

More information can be had from matthew.dolman@somersetccg.nhs.uk

SMALL ADS…SMALL ADS…SMALL ADS…

GP PARTNER: THE PARK MEDICAL PRACTICE, SHEPTON MALLET

Details: Up to 8 sessions per week. More information can be found at www.theparkmedicalpractice.co.uk.

Contact: If you are interested in the post or want to visit the practice please contact Andy Dorgan, Practice Manager on 01749 334383 or email Andrew.dorgan@parkmedicalpractice.nhs.uk. Please apply with CV and covering letter to Andy Dorgan, Practice Manager at The Park Medical Practice, Cannards Grave Road, Shepton Mallet BA4 5RT. Closing date for applications 9th November.

GP: VICTORIA GATE SURGERY, TAUNTON

Details: GP required as soon as possible. Flexible about the model of employment and would be willing to offer a salaried or partnership post. Number of sessions to be worked is completely negotiable.

Contact: If interested please come along and see us. Information pack can be supplied. Contact Mrs Linda Willis, Practice Manager, Victoria Gate Surgery, East Reach, Taunton TA1 3EX or phone 01823 275656 or email linda.willis@victoriagate.nhs.uk.

HALF TIME LOCUM GP: CHEDDAR MEDICAL CENTRE

Details: Half time, 4.5 sessions over 3 days, Tues am, Thurs and Fri all day. Period from Tues 18th December to end of March 2013..

Contact: Pauline Drummond, Practice Manager, Cheddar Medical Centre, Roynon Way, Cheddar BS27 3NZ or email Pauline.drummond@chedmed.nhs.uk. Closing date 26th October.

NURSE PRACTITIONER: VICTORIA GATE SURGERY, TAUNTON

Details: 25.5 hours per week to be worked Monday to Wednesday, although flexibility will be required to provide holiday cover.

Contact: For further details and information pack please contact Linda Willis, Practice Manager on 01823 275656 or email linda.willis@victoriagate.nhs.uk. Closing date 26th October.

THE VIEW FROM THE HIGH COMMAND?

The constant struggle by the NHS to provide good and appropriate care whilst under inexorable and growing pressure is often compared to waging war. Perhaps the best military analogy is with the Western Front in 1916. The front line troops are bogged down in a mire of bureaucracy and regulation desperately fighting the old enemies of disease and ignorance, whilst our now familiar apocalyptic horsemen (rising expectations, demographic change and technical advances) add chaos and confusion to the battlefield. Of course, we must not push the analogy too far: the million plus army of NHS workers fortunately has a lot less than the 13% daily attrition of front line regiments during the Somme offensive.

But from time to time something happens to make the comparison seem particularly apposite. If you happened to glance at the Appointments section of the Sunday papers at the beginning of last month you may have seen the advertisement seeking applicants for Director posts at the NHS Commissioning Board. "Join the Patient Revolution in the NHS!" declares the headline, and the text goes on to talk about "a passionate commitment to secure the best possible outcomes for patients" and a wish to "ensure everything we do is informed by the needs and views of patient and the public". That all sounds great, you may say. We need some passion and commitment to energise the service. Perhaps a couple of generals with swords drawn ready to lead the charge?

But reading on, some doubts begin to rise. The Director of Intelligence will "lead on the modernisation of the infrastructure…so that patients, public and clinicians and service providers have the intelligence the need to make informed decisions and choices." A slightly unfortunate turn of phrase there, but we know what they mean. Meanwhile, the Director of Open Information will "work with partner organisations to stimulate a vibrant market to unleash the power of data." A little more tricky, but we can just about follow that one as well. It gets harder with the Director of Customer Relations. He or she will "lead on the NHS brand so the public has a strong and clear offer to patient and the public." Doubtless this means something to the congnoscenti, but not to the average clinician. However, the real problems is with the job summary of the Director of Insight, which is worth quoting in full. "World class leader in customer insight sought to develop and implement leading edge and comprehensive insight strategies for the NHS to support the improvement in quality of services to patients. You will educate and inspire your peers as to the value of insight in enabling all business-critical decision making to be truly grounded on patient and public voice and evidence."

We eventually found a medical MBA who was able to translate this. Insight, it appears, is about marketing.

A comparison between the leaders of the NHS and remote army headquarters staff sitting in a chateau way behind the lines is easy to make. Waves of ultimately futile NHS reorganisation expend resources for no useful gain and the tactics, as in the battlefields of 1916, fail to improve with experience. It is worrying that the NHS CB seems to be locked in to a market and consumer based model when clinicians almost invariably believe that an operational one based on evidence, clinical cost benefit and public health information offers the only sustainable solution. We may be fighting our war in entirely the wrong way.

ADVANCE WARNING – CHANGE IN UNITS FOR HAEMOGLOBIN REPORTING

As part of a national scheme to ensure that there is consistency across the whole NHS in the units used for reporting laboratory results, from early in 2012 haemoglobin reporting units will change from g/dl to g/l. An Hb of 10 will therefore become an Hb of 100. Because of the tenfold difference the risk of confusion should be slight: if an Hb is reported as 20 presumably most of us could decide if the patient is critically anaemic or has gross polycythaemia!

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Somerset Local Medical Committee, Crown Medical Centre, Venture Way, Taunton TA2 8QY

Tel No: 01823 331428 Fax No: 01823 338561 E-mail: lmcoffice@somersetlmc.nhs.uk
LMC Website: http://www.somersetlmc.co.uk