Somerset LMC Newsletter

January 2013

Issue 179

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ACCENTUATE THE POSITIVE?

Regular readers will be aware that for many years this publication has been encouraging GPs to start to say "no".

"No" to unresourced new work transferred from elsewhere in the NHS, "No" to useless bureaucratic tasks, and "No" to being the dumping ground of last resort for every health and social care function nobody else will accept. But we have to admit that this campaign has not been very successful, because it is inherent to the personality and working habits of most GPs to try and do their best for the people in front them, and that means "Just Doing It", whether the task is filling in someone's Attendance Allowance form or completing a MAR chart for a patient admitted to a community hospital with which the doctor has no contract. Both were acts of kindness (and you know who you are) that really helped the patient concerned, but which were nothing to do with the terms of the doctor's contract.

So we have decided to take a different approach. We now suggest that you should be saying "Yes".

Of course, that does not mean a grudging and defeated "Yes" to every bit of ill thought out and politically driven extra work that some adviser in the Department of Health dreams up, but rather an affirmative "yes" to the things that really make a difference to patients, colleagues and ourselves. This means, in consequence, an implied "No" to all the other stuff.

We suggest that this is also the best way of looking at the QOF imposition. The traditional GP approach of just absorbing the extra work is really not going to work this time – practices simply cannot accommodate anything more. Neither is the nihilistic alternative of simply walking away from the new indicators an option, as this is unaffordable. Practices need to take a long cool look at each of the new requirements and decide which are medically worthwhile, achievable and economic, and to aim for just those. In the words of Richard Vautrey, Deputy Chair of the GPC "Practices must start to become more business-like, assess the costs of delivery of a service, and question whether some targets are cost-effective or, indeed, in the best interests of their patients. The days when a practice could be proud of achieving maximum points in QOF could be over. We might start to question the wisdom of practices that strive to do this in the future."

Beyond this immediate requirement to make general practice sustainable, there is a more profound need for doctors to take back control of their professional lives before the tick box culture of management priorities overwhelms general practice completely. This is not going to be easy, for the counter-revolutionary forces are strong and their influence extends widely. This year, for instance, medical graduates are being matched to F1 posts using something called a "Situational Judgement Test". http://sjt.foundationprogramme.nhs.uk/sample) that asks candidates to rank several possible responses to a three or four sentence ethical or professional problem. Yet it seems to us that professional judgement should be about balancing all the information about a particular set of circumstances and that the right answer will differ accordingly. Can professionalism really be reduced to a rank order? If so, do we really need expensively trained doctors at all? However, it may be that your editor is a little tetchy about the subject as he did not score well himself: it appears that selecting "Just Do It" to resolve the problem is not an approach preferred by the examiners. We wonder what the patients would say?

NHS 111

Coming Soon to Somerset

Despite the sometimes alarmist press coverage of NHS111 the LMC thinks that progress towards implementation in Somerset is going smoothly so far. The formal launch date for us is 19th March, but from 19th February out of hours calls will be directed for triage to the new 111 provider, NHS Direct, to allow the service to bed in and build capacity before the public launch. SWAST UCS is already using the NHS Pathways triage system, so the operational change on 19th March should therefore be fairly small.

Unlike the UCS, 111 operates during the normal working day and some callers from 08.00 to 18.30 will be advised after triage to contact or speak to their GP practice. According to the perceived urgency, this will be within 1, 2, 6, 12 or 24 hours. How you respond to these contacts will be a practice decision, but for most such calls GP phone triage is likely to be the most effective response. Both in and out of hours the 111 call handler will be using the local "Directory of Services" that suggests a best solution, and, where possible, options, for each call. So, a caller with simple UTI symptoms may be directed to a pharmacist who is in the minor illness scheme, or someone with a red eye could be advised to contact an ACES optometrist. Our best guess is that the impact on general practices will be modest, but that on balance contacts should be more appropriate. One of the objectives of the system is to ensure that information about repeat callers is shared and evolving significant illness recognised. If a caller calls the service three times in four days he or she will be advised to contact their practice and request a call back within an hour. The call handler will contact the practice with all the relevant information and it is then up to the practice to deal with the call appropriately. This will have the incidental benefit of focussing minds on producing care plans for the small group of psychologically disturbed or personality disordered habitual callers who already persistently abuse urgent and emergency care services.

From 19th February we advise practices who currently transfer calls direct to UCS to stop using a divert, and everyone is advised to use an answering machine with the following message: "*XXXXX GP Surgery is now closed. Our opening hours are 8 am to 6.30 pm Monday to Friday. If you require urgent medical assistance which cannot wait until the surgery re-opens, please hang up and call 1-1-1. Calls to the NHS 111 service are free from both landlines and mobiles. If you have a life threatening emergency please dial 9-9-9.*"

MOTIONS FOR THE CONFERENCE OF LOCAL MEDICAL COMMITTEES – MAY 2013

Please send us your suggestions

The representative structure for GPs in the UK is unusual, but remarkably effective. It evolved out of the 1911 National Insurance Act which led to the establishment of a national committee – now the GPC – and later local committees of GPs who provided Panel medical services in a particular city or county. These grew into the modern LMCs, which are autonomous statutory bodies answerable to their members. Meanwhile, the national committee was absorbed into the BMA as one of its professional division ("craft") committees, but the work of the GPC is still funded directly by working GPs and it represents all doctors in family practice, not just BMA members. GPC policy is determined by the annual conference of LMCs to which the 100 or so LMCs in the country send delegates for two days of intense debate of some 500 motions. These are usually grouped together into composites covering 10 -20 separate motions so that there is a reasonable chance of getting to the end of the agenda by 5.00 pm the second day.

Somerset LMC has a good track record of submitting motions that are used to build the composite and our speakers are therefore often called. So, if there is something that you think needs to be discussed, reviewed or changed about any aspect of your career or life in general practice, please let us know by the end of February – we would be delighted to draft a motion, with your help, to put before the conference. Send your ideas to harry.yoxall@somersetlmc.nhs.uk

SUPPORT FOR GP REVALIDATION IN SOMERSET – PART 1

Help! What does my GMC Letter about "date of first revalidation" actually mean?

For a GP to remain licenced to practice, this is the date by which the GMC must have received a recommendation about that doctor's revalidation from the Responsible Officer for Somerset GPs. Technically this will be the "Medical Director of the Area Team of the NHS Commissioning Board", but in practice it will be Dr Kate Staveley who is a GP in Chard with lots of experience in appraisal, clinical governance and everyday general practice. GPs will have demonstrate to her that they are up to date and fit to practice so she can recommend to the GMC that "There is no reason known that this individual doctor should not be issued with a licence to practice." The GMC will then normally confirm that doctor's licence for a further 5 years.

So how can you demonstrate to her that you are up to date and fit to practice?

My own appraisal this year is due in June, a good time ahead of my revalidation date in September, and what Kate needs to see in the summary of that appraisal is clear evidence that I am:

- Keeping up to date through continuing professional development and applying my learning to patient care
- Routinely reviewing the quality of my work through, say, case discussion, monitoring of clinical outcomes or audit - and then making improvements
- Learning lessons from significant events, complaints and from compliments
- Getting feedback from colleagues and patients and then taking actions on my reflections

She also needs to know from the appraisal summary that I do enough clinical work, have had an appraisal every year and that I have made declarations in relation to probity and my health. Although the GMC does not require doctors to use any particular toolkit for collecting their evidence, Somerset will continue to fund your free use of the Severn Appraisal Toolkit (SAT). Using it will help you and your appraiser consider your appraisal evidence and then produce a summary that can be readily reviewed.

As an appraiser, a GP trainer and one of the SGPET educator team you might think that revalidation will hold no difficulties for me, but those of you who know me a bit more will know that organisation, deadlines, written reflection are not my strong suits! Yes, I do attend a lot of educational meetings and yes, we hit those QOF targets, but I am going to have to find some easy, practical ways of showing how my learning affects patient care, explaining my role in the care of long term conditions, and collecting feedback from colleagues and patients. There is clearly a bit to do and in subsequent newsletters I will be sharing my progress whilst going through the important sections of revalidation in more detail.

Although each cycle of revalidation is 5 years all GPs will have their first revalidation by March 2016, so even if you are not in the first cohort it is well worth starting to prepare now as everyone needs to have gathered all the required evidence before their first revalidation appraisal. To help with all this we are in the process of establishing a Revalidation section on the SGPET website. This will have links to all the important documents and resources provided on national, regional and local national sites. There will also be a FAQ section and practical ideas on audit, CPD and much more. The especially good news is that the LMC is now able to offer you excellent, good value tools for collecting feedback which have been developed by Wessex LMC and already have received very positive comments from almost 5,000 GP users

Dr Martyn Hughes

SGPET Revalidation Lead

THE LMC BARRY AWARD FOR INCOMPREHENSIBLE JARGON FOR 2013…

Is awarded to the Department of Health, the NHS Commissioning Board and The Queen's Nursing Institute for the following extract from "Care in local communities: A new vision and model for district nursing."

"There are currently a number of national levers to support implementation of the service offer including: emphasis on technology provides an opportunity to explore new ways of working, which will enhance and extend care that can be delivered at home (including with Tele-health support) and support mobile working enabling real time clinical information and reducing bureaucracy and increasing time to care and efficiency."

CCG AND OTHER NHS WORKING GROUPS

Be careful to make sure others understand you are giving a GP opinion and not a representative view

One difficulty with clinical commissioning is that to work effectively it needs a lot of clinicians to take part. With CCG delegates already overstretched, Commissioning Federations may well be asked to nominate GPs and others to provide clinical input to working groups designing patient pathways, referral templates, clinical management advice schedules and a host of other things.

Not everyone with whom we work understands the independent contractor status of GPs, and few appreciate the different roles that doctors have in commissioning and providing care, never mind the subtle differences between a COG delegate and a Federation GP - for many NHS managers a GP on the working group is a GP, and therefore represents all GPs. You can thus find yourself making suggestions in all innocence which are then incorporated into a set of guidelines and launched on an unsuspecting GP public only for some stroppy LMC secretary to start complaining that measuring hourly alpha-foeto-serum rhubarb is not part of the GMS contract and practices should certainly not do it!

It may therefore be wise - even in CCG groups where this is well understood and there are consultation stages built in – making sure that your role is clarified and minuted at the first meeting of the group.

GP TRAINEES' NEWSLETTER

The latest edition of the newsletter for GP trainees, including advice on expenses and information on the Junior Members Forum, is now available. http://bma.org.uk/about-the-bma/how-we-work/negotiating-committees/general-practitioners-committee/gp-trainees-subcommittee

PMRGCA – A CHARITY THAT SUPPORTS PATIENTS WITH POLYMYALGIA & RELATED CONDITIONS

This well regarded national charity (www.pmrgcauk.com) now has an active South West branch based in Taunton (01823 663911), pmrgca.southwest@yahoo.co.uk) that publishes a very helpful and informative newsletter for patients as well as running regular local meetings. Well worth recommending to sufferers.

SMALL ADS…SMALL ADS…SMALL ADS…

P/T TIME SALARIED GP: VINE SURGERY, STREET—DR WOLFE & PARTNERS

Details: Salaried GP required for 5-6 sessions p/w from March 2013.
Contact: Dr Carey Wolfe or Practice Manager Roger Harrison on 01458 841122 or email carey.wolfe@vinesurgery.nhs.uk or roger.harrison@vinesurgery.nhs.uk. Website www.vinesurgery.co.uk

LOCUM GP: THE PARK MEDICAL PARTNERSHIP, SHEPTON MALLET

Details: Up to 8 sessions p/w. Start mid-February for approximately 2 months.
Contact: Tracey Nicholls, Deputy Practice Manager on 01749 334383 or email tracey.nicholls@parkmedicalpractice.nhs.uk or Dr Louise Abson, GP Partner on the above number or email louise.abson@parkmedicalpractice.nhs.uk. www.theparkmedicalpractice.co.uk

LOCUMS REQUIRED: MENDIP COUNTRY PRACTICE, RADSTOCK

Details: Two locums required for commence early May. The first for 7 sessions p/w to cover 3 months sabbatical and the second for 5 sessions p/w to cover maternity.
Contact: Kaylyn Hudson, Practice Manager Kaylyn.hudson@mendipcp.nhs.uk or call 01373 812244. CV and covering letter via email or post to Mendip Country Practice. Further details at www.mendipcp.co.uk.

NOMINATIONS SOUGHT FOR THE LMC AWARD FOR THE MOST HELPFUL ORGANISATION OR PERSON FOR GPS IN 2012

Every so often somebody or some organisation provides a service that really helps GPs by willingly taking a burden from us. The LMC likes each year to thank these people in in public, and our winners in 2010 were Somerset Primary Link followed in 2011 by the Somerset Partnership Crisis teams. Nominations for 2012, please, to harry.yoxall@somersetlmc.nhs.uk.

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