Somerset LMC Newsletter

February 2013

Issue 180

Inside this issue:

GETTING IT RIGHT

At the beginning of November your editor's elderly father in law was discharged after a spell in Musgrove CCU. His wise cardiologist quietly warned us that he probably only had a couple of months to live and that oxygen and opiates could as well be given at home as in hospital when things deteriorated. From being highly independent he now needed a lot of care – and we both had jobs to do as well as his house near London to clear ready for sale at the end of the month.

"What you need", said the district nurse, "is the Independent Living Team", who were duly contacted. Within 48 hours they arrived: the social work team leader patient, respectful and compassionate, and his OT and physiotherapist colleagues thoughtful and efficient. We accepted, slightly diffidently, the six week supportive care package that was offered whilst we got things sorted out. The simple practical suggestions from the ILT were invaluable – and the next day some bathroom grab rails arrived, and the day after that, the fitter arrived and put them up. Terry was now able to resume his much loved long soaks in the bath. We enquired about the bill. "There isn't one" came the reply "The service is fully funded". He was less keen on mobilisation exercises until the physio quietly suggested these were to help get him back to his piano; that, of course, was an entirely different matter!

A few weeks later things took an inevitable turn for the worse. We rang his GP for advice, who decided to come and see him anyway. We had no idea until being on the receiving end how reassuring that would be. The doctor visited again the next day, came out of his room looking sombre and an oxygen concentrator was ordered and delivered the same day.

A ripple mattress and other aids also appeared, the district nurse completed the Continuing Health Care funding application and the End of Life Care Co-ordination Centre was notified. They rang the next day. Did we need additional care? Was there anything else they could do to help? Well, we had just decided to buy some night sitting care from another agency….. that's fine, came the reply, that can be funded from the CHC money, and the EOLCC will sort it all out for you.

A couple of days later another evening call to the GP – could we give the medication written up, or should we call the district nurse? Again, calm reassurance from the doctor. Yes, it was OK for one of us to give the injection.

The next day Terry died peacefully on his 92nd birthday. He had been playing his piano just a few days beforehand.

What made everything work so well? To begin with, his care was joined up. One phone call was enough to get the whole package set up and running. Furthermore, there was no need for long negotiations about whether, where and when a service would be provided, and no gaps were left for things to fall through. Just as important was the continuity of care. Yes, of course we got special attention from the GP - but not having to explain the situation afresh with every contact and having trust in the professionals providing care made us much more comfortable and confident in. But the thing that

was most striking was the considerate care from everyone. Time, thought and respect for the patient were evident in every contact we had with the services.

What should we learn from this? First, the way that community services are now configured in Somerset for seriously ill elderly people at home really works, especially where an ILT is involved. Secondly, that the failings of the NHS in Stafford and elsewhere are far from universal, there are places where it delivers everything, and more, that Bevan could have wanted. But most of all it should remind us that patients do not recall the fact that their GP asked about how much exercise they took for their blood pressure, or make a mental note of how often the nurse measured their cholesterol, but they do remember - forever - how the doctor cared for their dying relatives. And that is something to remember when you are planning how to respond to the contract imposition.

NEW TEST FOR HELICOBACTER PYLORI

The Microbiology department of Southwest Pathology Service (TST & YDH) has introduced a new test for the diagnosis of Helicobacter pylori in patients with dyspepsia. This is the **Helicobacter faecal antigen test**, which is much more specific for active infection, compared to serology. The specimen required is faeces – this will be indicated in OrderComms. However, if you still submit blood samples for Helicobacter serology, they will still be processed for a month or so.

We strongly recommend the guidance on "test & treat" of Helicobacter pylori, produced for primary care by the Health Protection Agency. This can be found at http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947419406 and also in Microbiology's "Clinical Investigation Guidance" section of the SPS website (lab handbook) http://intranet.tsft.nhs.uk/pathology/Microbiology/ClinicalInvestigationGuidance/tabid/1420/language/en-GB/Default.aspx.

Dr Mike Smith
Consultant Microbiologist

PARTNERSHIP DEEDS

It is essential to keep yours up to date

The traditional approach to Partnership Deeds (practice agreements) is to draw up a new one when a new GP joins the practice, and then chuck it in a drawer and forget about it. All too often it does not even get signed!

But in the modern world that really will not do. You need to take it out every two or three years and make sure that it matches the needs of the rapidly changing professional environment in which we work. At the very least you *must* have signed the current Deed as without this your GMS or PMS contract could be at risk. Lockharts (one of the LMC recommended specialist solicitors in this field) write:

"If your deed has not been reviewed in the last 3 or 4 years it certainly needs to be to cover:

- *CQC responsibilities*
- *Commissioning responsibilities and the interface with CCGs*
- *Claw-back of seniority or other reimbursement payments*
- *Updated GMC and Performers List suspension provisions, and*
- *Updated 24 hour retirement provisions*

Additional to the "stitch in time" principle, a proper Partnership Deed now can potentially save enormous legal and accountancy costs if there is dispute in a partnership at will: and particularly if the PCT, in due course the NHSCB, seek to terminate the contract and put the practice out to tender."

Please do not delay. Check *now* that your Deed is current and comprehensive. If not, do contact the LMC office for our list of recommended partnership lawyers.

GOOD NEWS SECTION

Doctors still most trusted Profession

The annual Ipsos Mori "Veracity Index" for 2012 shows that doctors are still trusted to be truthful by 89% of respondents. The profession has consistently been at the top of the surveys results with about the same level of trust, with 82% when the poll started in 1983 and a peak of 92% in 2004. Meanwhile, politicians manage a mere 18%. These figures may be worth remembering for the future, we suspect.

APPRAISAL & REVALIDATION

GPC/RCGP Statements on Safeguarding Children & Quality Improvement Activity

The GPC and RCGP have agreed the following statements that were written in conjunction with COGPED. The statements were agreed following numerous reports of PCOs requiring all GPs to attend training on child safeguarding and young people, and to clarify the revalidation evidence requirements for quality improvement activity.

Safeguarding Children and Young People

In 2010 the revised Intercollegiate Guidance on Safeguarding Children and Young People was published. This is intended to provide guidance about safeguarding competences for different staff groups and at different levels, and to emphasise a flexible approach to knowledge and skill acquisition.

This framework identifies six levels of competence, and gives examples of groups that fall within each of these. GPs practise at level 3:

- **Clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/ child protection concerns**

For the purpose of revalidation, GPs need to demonstrate that they are up to date and fit to practise in all aspects of their work. Level 3 describes the scope of work of GPs in relation to safeguarding of children and young people. It is the responsibility of GPs to demonstrate that they maintain their competence. A GP may keep up to date in a variety of ways, for instance completing an e-learning module, attending a training session in or out of the practice or reading appropriate local guidelines. There should not be a defined frequency of updates; the important point is that it is the responsibility of the GP, in their appraisal, to demonstrate they are competent and up to date. Case reviews can be used to show how knowledge and skills are used in practise. We believe that there may have been some confusion over the appropriate level for general practitioners as different levels were used in previous guidance and so we hope that this statement will clarify that under the 2010 Intercollegiate Guidance level 3 is the minimum level required.

Quality Improvement Activity

The GMC state that quality improvement activities "could take many forms" depending on the role a doctor undertakes and the work that they do. The RCGP has defined the significant event audit and clinical audit as the core information for GPs to include under Review of Practice. GPs would, in most circumstances, be expected to provide evidence of these. It is recognised, however, that clinical audit may be challenging for GPs in different working circumstances, for example locum and salaried GPs, and those who work in out-of-hours, walk-in-centres or similar environments. GPs who feel that it would not be feasible for them to participate in clinical audit activity should produce alternative evidence of quality improvement and discuss this with their appraiser. For such GPs, the RCGP has identified a range of alternative approaches to enable them to demonstrate evidence of quality improvement If conducted properly, and with sufficient evidence of reflection, these alternative approaches should not be considered of any less value to conventional clinical audit activity.

WANT TO GATHER INFORMATION FOR REVALIDATION?

Go to www.mylmc.co.uk !

Somerset LMC has joined the revalidation and appraisal support service run by Wessex LMCs that provides the tools you need to collect the evidence and information you will need for your revalidation appraisal all in one place. We have already had good reports of the Multisource Feedback survey that will email out requests to your identified colleagues, collate their responses, and pass the final anonymised report to one of the Somerset LMC moderators for checking. We think that moderation is an essential part of the scheme as it helps ensure that colleagues see negative remarks in context and can use them as constructive criticism. There is now a patient survey available as well.

This service is inexpensive, secure, and independent of any official NHS body. We can thoroughly recommend it to colleagues.

GP SURVEYS – 1964 & 2013

Rien ne change?

The Chairman of Somerset contacted all the GPs in the county asking for their views on "the causes of the present discontent in general practice...I do ask you, both as a matter of vital interest to yourself and to the profession as a whole, to complete and return the questionnaire." Two hundred and ninety Somerset GPs responded by post - compared with 248 completing the recent online survey about the QOF imposition: this was 1964 and general practice was in crisis. Just 16 years after the foundation of the NHS incomes were falling, demand was rising and there was inadequate reimbursement of expenses. General practice was once again what you did when you failed in hospital medicine.

It is fascinating to look at the opinions expressed by our predecessors 50 years ago. The past is another country and things certainly were done differently but the seeds of change were there: 63% wanted to get away from 24 hour a day, 365 days a year, responsibility. Other sentiments still remain to be satisfied: 75% wanted a statutory minimum annual leave entitlement and 72% wanted a "national locum service." As 84% also rejected the concept of salaried employment critics might have thought then as they do now that GPs were in favour of having cakes and eating them too. But there are also unexpected findings. Modern mythology has it that hardly any patients complained in those halcyon days but clearly not few enough for 1960s GPs as 84% agreed that financial barriers should be raised against the making of "frivolous complaints."

Seventy-one percent wanted more part-time paid hospital jobs for GPs and 83% wanted to look after their own patients in hospitals. In those far off days of "Call the Midwife" 258 practised obstetrics and 184 did so because "they liked it" while 234 considered it part of being a family doctor. A sad reflection on modern times is that 83% were in favour of the then exciting prospect of district nurses, midwives and health visitors being attached to their practices. We all know hardly anyone lived to old age in those days: strange then that 87% wanted more help looking after elderly patients. Other modern expectations are met: only 45 doctors had heard of a new-fangled thing called a telephone answering machine and 53% used no appointments system. Only 56 of the respondents had had any formal GP training. One of my favourite findings was that 283 were in favour of regular refresher courses for GPs but of these six said they would not attend themselves: presumably these were a good idea "for other people."

Unlike our recent survey there were no questions about intentions to retire or the viability of their practices. Nevertheless after this consultation thousands of undated letters of resignation were sent to the Ministry of Health. The minister, Sir Kenneth Robinson, the son of a doctor, was sympathetic and the new prime minister Harold Wilson was desperate to keep GPs inside the NHS. One commentator wrote that, "Kenneth brought to this crisis a mind that was well prepared and the calmness, consideration and personality which we all have known." He quickly sought to reach agreement with practitioners and change the organization, funding, and nature of practice in the system. He agreed the *1966 General Practitioner's Charter* negotiated with Dr. James Cameron of the BMA which led to the system of fees and allowances set out in the Red Book. There was a renaissance in general practice which arguably continued until Kenneth Clarke's first imposed contract in 1990 since when independent contractor status has been continually eroded and power given to managers. *Si monumentum requiris circumspice:* the results we see all around us. The regional LMCs' press release on the 2013 survey stated that the general practice system valued by patients and repeatedly shown to give excellent value for tax-payers money is under serious threat. It is sad to reflect that in Mr Jeremy Hunt we do not have today's Kenneth Robinson.

SESSIONAL GPS SUBCOMMITTEE ELECTIONS

Nominations for election to GPC's Sessional GPs Subcommittee have just opened. The subcommittee, which represents all salaried and locum GPs, has 16 elected members from across the UK. You can find out more about the election and download a nomination form on the BMA website: http://bma.org.uk/sessionalGPselections

LMC AWARD FOR THE MOST HELPFUL ORGANISATION OF 2012

Many thanks to everyone who submitted nominations for the group or organisation that they felt had been of the most help in making GPs' lives easier during last year.

Somerset Primary Link was nominated again for their invariably patient and polite acceptance of admission requests. **Somerset GP Education Trust** was suggested because of the range and quality of their events which helps GPs organise their continuing education. The **LMC Pastoral Service** also had an honourable mention. But the runaway winners for 2012 were the **Independent Living Teams** which are currently being rolled out across the county. The nominations particularly mentioned their accessibility, speed of response and willingness to say "yes" to requests whenever possible. Our congratulations to these worthy winners.

GP GOVERNOR SOUGHT BY TST

Taunton & Somerset NHS Foundation Trust would like to recruit a current (or possibly recently retired) GP to be a governor on its Members' Council. The governance arrangements of Foundation Trusts are fairly complicated, but one of the main roles of the governors is to appoint and be responsible for the Non-executive Directors of the Trust Board. The existing governors are very keen to have a GP on the board who can offer them a primary care perspective of the Trust and its services. The basic commitment is fairly modest, about five meetings a year. More details from the TST Governor Support Manager:

kerry.laugharne@tst.nhs.uk 01823 342051.

SMALL ADS…. SMALL ADS……

PARTNER: ST JAMES MEDICAL CENTRE, TAUNTON

Details: ¾ time (6 sessions) partner required owing to retirement to start from July 2013.

Contact: Guy Patey, Practice Manager at guy.patey@stjamesmc.nhs.uk or call 01823 285400. www.stjamesmedicalcentre.co.uk.

SALARIED GP: GLASTONBURY HEALTH CENTRE

Details: Required for 4 sessions + initially for 12 months but with potential to develop the position in the long term/further sessions on an ad hoc basis. Salary negotiable.

Contact: Applications and expressions of interest to Mrs Sandie Sealey, Business Manager 01458 834100 or email sandie.sealey@glastonburyhc.nhs.uk. Closing date 29th March.

SALARIED GP: CHURCH STREET SURGERY, MARTOCK

Details: 9 month fixed term contract, 5 session per week initially. Salary circa £43,000. Closing date 5 April, interviews 12 April.

Contact: Dr James Buckle for informal discussion on 01460 240707. CV and covering letter to Karen Harley, Business Manager by post or to karen.harley@martocksurgery.nhs.uk. www.martocksurgery.co.uk.

DEPUTY PRACTICE MANAGER: TAWSTOCK MEDICAL CENTRE, CHARD

Details: To oversee the reception and admin functions, 21 hours per week worked over 3 days.

Contact: Linda Bickerton, Practice Manager for further details/application pack by email linda.bickerton@tawstockmedicalcentre.nhs.uk. Closing date Friday 8th March 2013. www.tawstockmc.co.uk

SALARIED NURSE PRACTITIONER: PENN HILL SURGERY, YEOVIL

Details: Up to 8 sessions available from May 2013.

Contact: For informal contact or applications contact Len Chapman at len.chapman@pennhillsurgery.nhs.uk or call 01935 470816. Closing date 29th March 2013. www.pennhillsurgery.nhs.uk

NURSES, HCA & RECEPTIONISTS: TAUNTON ROAD MEDICAL CENTRE

Details: Vacancies available for a number of positions, full and part time. Further details can be found under vacancies at www.trmc.co.uk.

Contact: Apply in writing with current CV, see website for details.

The new partner at the Yeowaterton practice tells us that his unusual surname was chosen by his mother after she fell for a Madrid football player she met at the Institute of Scientific and Technical Information of China. The following helpful suggestion was submitted by the same Dr Real-Istic:

Yeowaterton Medical Centre: Standard Communication Form

After many minutes of internal discussion this practice has concluded that our lives would be substantially easier if all communications about our patients were received on a "Standard Communication Form". After due consideration we have also decided that there is no need to discuss this with organisations that may contact us. If letters or reports are received on a non-standard form then they will be returned to the sender.

We understand that other local practices are in the process of developing their own versions of this form and fully expect they will be completely different to our own form for perfectly justifiable internal reasons. Undoubtedly they will also reject letters received inappropriately.

Please find attached our new standard form which will come into full use on **1st April 2013**. A digital copy may or may not be available on request. Your software supplier may be able to help you to mail merge many of the details from your own computer system. However, if the fonts and/or colours are unacceptable to us then your letter will be returned.

Should you have any comments or questions then please contact the surgery for a copy of our "Comments and Questions Communication Form" on which we are happy to receive your thoughts.

P Blackadder, Practice Manager.

Yeowaterton Medical Centre

Standard Communication Form

Please note: All boxes must be completed before sending or this form will be rejected

Patient Surname		Planned treatment	
Telephone number		Date patient seen	
1st Line of address		READ code of diagnosis	
Postcode		Follow-up arrangements	
Title		Diagnosis or problem	
Date of Birth		Next of kin name	
2nd line of address		Date initial completion of this form	
Patient Middle Name		Communicating Organisation Name In Full	
Mobile telephone number		Department	
NHS Number		Date form corrected	
Next of kin postcode		What has patient been told?	
Next of kin religion		Head of Department date of birth	
Next of kin telephone number		Cost per QALY of new medication	
Monthly cost of medication started	[if it is a "special" please arrange for it to be dispensed regularly by the hospital pharmacy at a cost of a few pence instead of by a community pharmacy at a cost of several hundred pounds; if it is an appliance or other non-medicine , please give mother's maiden name]		

Continued on p 94.....

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