Somerset LMC Newsletter

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THE NHS IS BROKE – SHOULD WE FIX IT?

Your editor took his much loved and battered old car to the garage recently. There was much tutting and indrawing of breath before the mechanic pronounced. "Frankly, it is going to cost twice as much to fix as its worth. And anyway, another rusty bit will fall off next week." So there is now a shiny new red car outside the house. All the wheels go round at the same time, fuel consumption is substantially better, and driving is almost a pleasure. Sometimes you have to let go of what you love and move on.

As funding for the NHS remain static whilst the workload continues to increase and patient expectation rises – often stoked by opportunistic politicians - it is inevitable that bits are going to start to fall off this as well. According to the always fascinating Kings Fund quarterly report one in four trusts is already predicting an overspend for the financial year, which, in theory ought to bring down the wrath of Monitor upon them (so it is hardly surprising that this organisation is expecting a mere £11.7M or 26% increase in its budget this year – an urgent priority for public funds, as I am sure readers will agree) but as an accelerating number of lights go red on the NHS England trust dashboard, that may be impractical. Meanwhile, primary care is melting. Practices cannot recruit partners, community providers struggle to find nurses, and training schemes are not even turning out replacement numbers of new GPs.

And the media barrage continues. On 19th July The Times carried an interview with Sir Stuart Rose (formerly of Marks & Spencer) in which he said that GPs should be more prepared to work weekends and in the evenings, drawing comparison with the retail sector. But retailers open at weekends because people want to *buy* goods. There is a direct transaction between provider and purchaser – and you can get almost any service at any time if you are prepared to pay for it. So is it time to think the unthinkable? Anuerin Bevan reputedly said of the NHS that "we promise the people everything on the understanding that they take nothing" - which worked, for in 1948 health care was precious and special. But that generation is going, and it seems that under 40s are increasingly likely to turn up at A&E or a Walk-in Centre for minor conditions rather than contact a GP or the out of hours service. Is the "free at the point of delivery and funded by general taxation" model simply unsustainable, and should we seek to control the torrent of demand by putting a price on healthcare? Every other Western European country has some kind of social insurance based system – are we really the only ones in step? A wise Continental GP working in Somerset recently said " It sometimes seems as if you have never even heard of Bismarck" and it is sadly true that the founder of the first social insurance scheme in 1889 is sadly neglected in UK health planning circles.

If there are pricing levers, regulating demand becomes a practical proposition. So, if calls to 111 are free and an OOH GP appointment costs the insurer, say £25, whilst an attendance at A&E for a minor illness is priced at £50, patients will quickly learn how to use the system. Health outcomes are no worse (and in some cases may be significantly better) in social insurance healthcare systems but there will be new problems of access and equity to be ironed out, and administration costs will be higher in a system where remuneration is actually linked to the work done.

Will anything change? If left to the politicians, no, of course not. (continued……..)

Their political advisers are telling them that changing the NHS is political suicide, so each administration patches up the old model, squirts in a bit of oil, and prays that it does not blow up until the opposition is in power. But we may have gone beyond that, and if the fabric of the NHS starts to really come apart, things could change very fast indeed.

We would welcome any comments or contributions to this debate for our next edition.

VIOLENT PATIENTS SCHEME IN SOMERSET

It is a little ironic that because Somerset practices are usually very good at meeting the needs of challenging patients there have never been many referrals to the VPS, and consequently it has never been economic to set up a formal structure in the county. With the transfer of responsibility for this from the PCT to the Area Team arrangements have become a little fuzzy and we are grateful for the following clarification from them:

"The process that we have adopted locally to assess such cases, particularly those where the decision to allocate to the VPS may not be clear cut (the degree of abusive behaviour can vary and may not always be appropriate for VPS referral), is as follows:

Practices should contact the Area Team within 24 hours of the incident, and also send confirmation in writing. We will then discuss the incident with the practice and:

For clear cut cases agree to a referral to the VPS service.

For lesser incident agree with the practice alternative actions such as a formal warning to be provided to the patient, or in some cases that a more formal behavioural contract should be entered into between the practice and the patient. The Area Team has an outline template to assist in this process if needed.

Agree a further assessment of the incident involving the local Security Management Service (SMS).

For the last of these we contact the SMS to undertake a review of the incident, liaising with the practice and other agencies. This will often involve contact with the Police, Somerset Partnership and others so that a fuller picture of the patient can be established, including any history of incidents or other matters which may have a bearing.

The SMS then makes a recommendation to the Area Team based its findings. We then take this into consideration on deciding what action is appropriate.

No incident of violence or abusive behaviour is acceptable, but not all cases are judged to be of a nature sufficient for allocation to the VPS. A patient demonstrating any form of abusive behaviour should be sent an appropriate letter - this is often the practice's responsibility, although on a number of occasions the Area Team also sent such letters to patients, often jointly with the SMS. We also sometimes ask the SMS to provide advice/training to a practice on how such incidents may be handled. This helps prevent or defuse similar events in the future. The SMS can also assist the practice if any further action such as a criminal prosecution is required.

The Area Team does monitor and restrict the registration of patients who are formally registered on the VPS scheme. Indeed, we have experienced a number of cases where VPS patients have tried to register with other local practices; such patients are contacted to remind them of the registration restrictions that have been imposed upon them. Patients remain on the VPS until such time as it is agreed by the treating GP that can be registered with 'normal practices'. Details of VPS patients who relocate outside of our area are sent to appropriate NHS England colleagues so that they can make any necessary local arrangements.

VPS patients are allocated to a number of different providers and in some instances such providers are supported with security guard support for patients considered to present the greatest risk."

DR JAMES HICKMAN MBE

Congratulations to Somerset GP Dr James Hickman who has been awarded an MBE for services to healthcare, and in particular emergency medical care in Somerset and abroad.

APPEARANCE IN A CORONER'S COURT.

Under the 2013 Performers List Regulation 9(2)(h), GPs who are "*involved in any inquest as a person who falls within rule 20(2)(d) (entitlement to examine witnesses) or rule 24 (notice to person whose conduct is likely to be called into question) of the Coroners Rules 1984* are required to inform the Area Team.

So, if you think that any part of your conduct relating to a case before a coroner may be subject to criticism, let the AT know.

SOMERSET GP EDUCATION TRUST ACTIVITY IN SOUTH SOMERSET - ADDRESSED TO ALL SOMERSET ST3S

So you're approaching the end of your vocational training? Three years of structured training (longer if you're LTFT), timetabled for you and top quality speakers laid on almost weekly to help populate every nook and cranny of the e-portfolio. So a big problem lies before you, how will you fill those long evenings now that the CSA, WPBA and other abbreviations you will be pleased to see the back of are behind you?

Well the truth of it is that the fun is just beginning. Wouldn't it be great if instead of having a prescribed programme laid on for you, you could attend a group once a month, and have a major input into the topics chosen to address your own individual learning needs. You could even have the chance to present yourself every now and again to your small supportive group (double your appraisal points if you reflect on how it all went!) So for those in the first 5 years since VTS, the Yeovil First 5 Group meets once a month, usually on the first Monday of the month, 7.30-9.30pm at The Brewers Arms, South Petherton. A topic is chosen and presented by a member of the group, often focusing on recent guidelines. Recent sessions have covered men's health, headaches and childhood behaviour problems. Occasionally an outside speaker is brought in if there is a learning need to fill. And the whole evening is lined with some nice pub grub so you don't have to worry about dinner after a busy day.

For those who prefer more of a "meet the specialist" style of session, the South Somerset GP Education Group meets once a month from 7.30-9.30pm at Lanes, High Street, West Coker, usually on the third Thursday of the month. A hot supper is also provided.

There is usually a local specialist as speaker and an opportunity for an interactive discussion on a clinical topic. Topics are very much generated from local needs and requests so if there is something you feel would be useful please do get in touch. Recent sessions have been on hips & knees, radiology and irritable bowel syndrome.

If you would like more information on the South Somerset meetings then please contact Andy Eaton at andy.eaton@martocksurgery.nhs.uk, Christian Stanley for First 5 at Christian.Stanley@prestongrovemc.nhs.uk or Erica Baily at SGPET@somersetlmc.nhs.uk.

For information on other sessions that are held in Somerset please visit the SGPET website: www.somersetgpeducationtrust.co.uk. The next First 5 meeting will be Monday 1 September on Appraisal & Revalidation which Christian Stanley will be leading on. To book a place please email SGPET@somersetlmc.nhs.uk or book online at the above website.

PAYMENTS TO LOCUMS

Must be made promptly!

As small businesses, practices are sometimes subject to unacceptably long delays in payment for work they have done for large organisations, and the LMC therefore believes it is particularly important to ensure that we are all scrupulous in promptly settling bills from other small businesses and individuals, especially locums.

Locums have a 10 week window to submit their Forms A & B, and the accompanying payment, to the Area Team for it to be pensionable. Documentation and payment related to work in month 1 has to be received by the AT by 7th of month 3, which means that locums need to be paid, at the very latest, at the end of the month following the one in which they have worked.

Although there may be odd occasions where this may not happen, we are saddened to report that there are some Practices that persistently make late payments to locums. If this situation continues those Practices will be identified and that information shared between the LMC, the Sessional GP Group and the Taunton GP Locum Agency.

To speed up and facilitate payments we would also expect practices to offer settlement by BACS transfer as an alternative to a cheque.

2014-15 PRACTICE FUNDING READY RECKONER

NHS England has produced this for practices to use as a rough guide to estimate how their funding will change for the current year, both as a result of the phasing out of MPIG and the negotiated changes to the GP contract for 2014/15. See LINK.

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

For current practice vacancies please see the adverts on our website at:

http://www.somersetlmc.co.uk/classified.php

Dr Whimsy's Casebook: Early Diagnosis

The Health Secretary announced plans to name and shame GPs who are "slower than average" to recognise cancer.

Scene: the Decision Room at the Department of Health. The Secretary of State, The Far Right Honourable Wattup Wratte, is in the bath. His Permanent Secretary is straightening the towels.

WW: I say, Jenkins, have we humiliated any GPs yet?

PS: We're working on it, sir, but there is a small hitch.

WW: We don't have hitches in my department, Jenkins, only fools who don't know what they're doing.

PS: My very thought, sir. But I'm wondering if you, er, we, have properly thought this one through?

WW: That's never hindered us in the past, Jenkins.

PS: Indeed not, sir, with frequent embarrassment.

WW: [crossly] What do you mean by that, Jenkins?

PS: I'm rather spoiled for examples, sir, but recently you reported that a quarter of A&E patients are there because GPs are too lazy to see them.

WW: [sheepishly squeezes his rubber frog] Oh, that.

PS: Quite, sir. It transpired that, ahem, somebody was being a trifle parsimonious with la vérité.

WW: Just my luck some truth junky dug out the real figures. But won't we get GPs on cancer referrals?

PS: Well, sir, apparently you can't diagnose a nasty disease simply because somebody has a symptom.

WW: Oh, fiddlesticks, Jenkins. Any dunce can do it. Let me show you – pick a horrible illness.

PS: I disdain being frivolous about these things, sir, but if you insist, how about lung cancer?

WW: Easy. What's the main symptom?

PS: A cough, sir?

WW: Exactly. Chap has a cough, must be lung cancer. What's so hard about that?

PS: The fact is, sir, that it's much more likely to be a cold, a chest infection, hay fever, asthma...

WW: Oh, stop going on, Jenkins. Very well, all the GP has to do is make sure it's not one of those conditions, then – Voilà! – it's lung cancer.

PS: I gather that's one of the difficulties, sir.

WW: What is?

PS: Estimating the probability of serious illness before referring the patient for expensive tests.

WW: [horrified, grips the sides of the bath] Did you say "expensive"? What sort of "expensive"?

PS: Things like endoscopies, special scans, biopsies, and so on, all under the supervision of highly paid hospital specialists. It costs thousands of pounds.

WW: Oh, my word. Well then, the GP must test for all those common things before doing something expensive. Just so long as the patient is sorted within two weeks of developing the symptoms.

PS: That's another problem, sir.

WW: Dammit, Jenkins, how many problems are there?

PS: Cancer can take time to reveal itself, sir. It depends a lot on the circumstances, but the current wisdom is that lung cancer is more likely if the patient has symptoms for three weeks. With bowel cancer it's six weeks, three weeks for mouth cancer...

WW: Let's make it quicker, then. Just shorten those intervals to, say, a week. There you go! Job done.

PS: What an excellent idea, sir. Most insightful.

WW: Thank you, Jenkins. That's why I'm here.

PS: In all your glory. Um... just a small point, sir.

WW: What is it now, Jenkins?

PS: Your splendid idea will lead to an exponential rise in referrals, sir. We'll need more specialists, nurses, diagnostic equipment, buildings...

WW: Are you being deliberately awkward, Jenkins?

PS: Forgive me, sir, I was just trying to introduce a fact.

WW: Well, I'm not going to let it spoil a good idea.

PS: Of course not, sir, that would be inconsistent. But might I mention just one more thing?

WW: For Heaven's sake, Jenkins, WHAT?

PS: Word has it, sir, that these illnesses can have unexpected symptoms, or there may be other conditions that, ah, muddy the waters.

WW: Jenkins, are you trying to tell me that it can be difficult to diagnose cancer, or even to suspect it?

PS: Perhaps these are things to bear in mind before we rush to apportion blame, sir.

WW: [peers at Jenkins] Jenkins, you've gone soft, haven't you? You're turning native. Are you hiding a stethoscope and a golf club under that penguin suit? Sounds like you're actually defending GPs.

PS: [confidingly] Well, sir, strictly entre nous, it turns out that most GPs are honest, hard-working doctors who strive to do the best for their patients while trying to be efficient with resources that are rationed by our relentless budgetary restraints.

WW: Jenkins! That's heresy, and I won't have it. They're a money-grabbing bunch of nine-to-fivers. And what I really hate about them is... is...

PS: Yes, sir?

WW: [fiddles with plastic duck] Er, nothing.

PS: Come on, sir. You can tell Uncle Jenkins.

WW: Well, have you seen the latest polls? 92% are happy with their GP, but only 6% are satisfied with my performance. [sniffs] There's an election next year – what more can I do to appear competent?

PS: A formidable challenge, sir, but somehow you survived the reshuffle so I'm sure you'll keep trying.

This column is written for humour and does not necessarily reflect the views of the author, his or her practice, or the LMC. Doctor Whimsy's Casebook is available on Amazon.

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