SOMERSET LMC

Newsletter

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DANCING THE NEXT QUADRILLE

Inside this issue

Just when you thought you knew who your dance partners were for the performance, the music starts again and we are back on the floor: the Somerset Together Tango whirls off into the Transformation Plan Pavanne. Meanwhile, something very strange and Alice in Wonderland-like is happening to the band. The woodwind section played by NHSE seems to have disappeared, leaving just its echo behind, and some of the CCG violins are starting to merge together into a cello. The specialist commissioners playing brass keep demanding more room on the bandstand, whilst Maestro Hunt at the front is waving a baton to his own rhythm, shouting "Faster! Louder!"

As always, the audience just cannot get enough.

Curiously, the choice that practices now face has something in common with Brexit. When the system is under pressure in every possible way – demand, resources, workforce, capacity and political imperative – the direction that we choose to take is ultimately determined by personal philosophy. Should we retrench, ditch everything that is not core primary care, and concentrate on maintaining traditional partnerships based on close relationships between GPs and their patients that last for a professional lifetime? Or is the answer the complete opposite: to scrap all the distinctions within the NHS and combine local providers in a properly integrated service that controls a fully capitated budget for half a million patients?

But unlike Brexit, this is not a wholly binary choice, and there are other elements to the decision. The argument for making patients more responsible for their own care is overwhelming, and this may even give the Government a way of starting to limit demand without having directly to introduce politically unacceptable demand side controls. Introducing health coaches/promoters/advisers into practices – whether locally employed or part of a larger organisation – has clear benefits in helping patients take more control of their own health (and, incidentally, in taking some of the burden of very dependent patients off GPs) although the number of different names for the role reveal the lack of certainty about their precise function.

There are some other changes that look as though they are helpful. Early experience suggests that paramedics can undertake the majority of on-the-day home visits significantly reducing the stress on a duty doctor trying to balance demand for visits, telephone calls and surgery consultations. Nurse practitioners can certainly manage many of the problems that are present in acute appointments, and practices that have access to other specialist clinicians such as physiotherapists and pharmacists quickly find them the right niche. Practices large enough to be able to employ a mental health worker report a dramatic improvement in the working day of front-line GPs when some long and sometimes worrying or challenging consultations can be moved out of normal surgery time.

Of course, none of these things changes the fundamental problem in the NHS of a mismatch between supply and demand, but they may just buy us enough time to make the right decisions, and perhaps to start to see the benefits of a change in the system from paying for interventions to one that looks how we can help our patients achieve the modest outcomes they usually seek.

SMALL ADS… SMALL ADS… SMALL ADS…

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

https://www.somersetlmc.co.uk/jobs/

iPhone and iPad app

Download on the App Store

Access all of the guidance on our website from your iPhone or iPad.

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LOOKING AFTER YOUR PRACTICE MANAGER

Look, we know GPs are busy and stressed and worried about the future. As the demands of the job have increased it is no longer just the most vulnerable at the tail end of the distribution curve who struggle, all but the very hardest-nosed are now challenged by the day job.

Understandably, that makes doctors tired, irritable, short sighted and less empathic. Never being able to do the job properly makes a typical, slightly obsessional GP an unhappy person. But there are some folk out there whose job is even more demanding, more complex and less manageable - our practice managers.

Some readers will remember that the 2004 Contract included, as Annex C, a "Competency Framework" for practice managers. At the time this defined a huge job, and one that very few people could span. Twelve years on the job has grown almost out of recognition with all kinds of new demands from commissioning to the CQC added in. How our dedicated band of managers keeps on top of this we just do not know, but somehow the payroll is done, returns are filed, staffing gaps filled and there is always milk in the fridge. Most of us have very little idea of how this magic is achieved.

All this takes its toll. Managers are even more stressed than GPs, and without the professional satisfaction of delivering patient care. They know that too much of their time is spent feeding the monster with information – much of which is probably never looked at or used – and not enough on strategic planning for a sustainable future. Just as with clinicians, sometimes surviving the day is as much as can be achieved.

It is therefore very disappointing when we hear from managers about the lack of understanding and apparent indifference with which they are too often treated by GP partners. Casual rudeness, unreasonable demands for immediate action, an assumption that what the doctor wants now is more important than anything else or an expectation that the practice manager will take sides in partnership disputes are not acceptable behaviour when dealing with a colleague, never mind an employee. There is still sometimes a wholly unwarranted feeling amongst doctors (and not just partners) that they are somehow more important than their professional colleagues. We need to remember that earning more money does not make one a better person or others less essential to the team.

Simple things make all the difference. A polite greeting in the morning (preferably cheerful) is a good start. And just offering a cup of coffee (the LMC Chair says accompanying this with a chocolate digestive triples the effect) shows that you are aware that your manager is working hard. But most important is the need for managers to know that their professionalism and skill is recognised and valued, and that the partners know full well that without them the practice would simply cease to exist.

IMPROVING HOW HOSPITALS WORK WITH GENERAL PRACTICE

NHSE has written to CCGs and Trusts reminding them of the requirements in their 2016-17 contracts to reduce unnecessary paperwork for practices. The key points are:

1. Hospitals cannot adopt blanket policies under which patients who do not attend an outpatient clinic appointment are automatically discharged back to their GP for re-referral.
2. Hospitals are required to send discharge summaries by direct electronic or email transmission for inpatient, day case or A&E care within 24 hours.
3. Outpatient letters to be sent promptly where there is information which the GP needs quickly in order to manage a patient's care, and certainly no later than 14 days after the appointment.
4. Unless a CCG requests otherwise, for a non-urgent condition directly related to the complaint or condition which caused the original referral, onward referral to and treatment by another professional within the same provider is permitted, and there is no need to refer back to the GP.
5. Providers to supply patients with medication following discharge from inpatient or day case care for the period established in local practice or protocols, but for a minimum of seven days.
6. A requirement for hospitals to notify patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner, for example, by telephoning the patient.

The LMC will be working with the CCG to try and make sure all this happens!

MALARIA IMPORTED INTO THE UK: 2015

The excellent Public Health England online "Health Protection Report" (you can subscribe at https://public.govdelivery.com/accounts/UKHPA/subscribers/new?preferences=true) has just published the following item on imported malaria:

In 2015, 1,400 cases of imported malaria were reported in the UK, 11.7% lower than reported in 2014 and 11.6% below the mean number of cases reported between 2005 and 2014. The majority of cases (76%) continue to be caused by the potentially -fatal Plasmodium falciparum parasite.

Of those with travel history/country of residence information available (976/1,400, 70%), the majority of malaria cases had travelled abroad from the UK (744/976, 76%), with most having travelled to visit friends and relatives in West Africa.

Six deaths were reported in 2015, compared to three in 2014, all from falciparum malaria acquired in Western Africa.

The latest report shows that malaria remains an important issue for UK travellers, particularly for those of African or Asian ethnicity who are non-UK born and going to visit friends and family in their country of origin. Failure to take chemoprophylaxis is associated with the majority of cases. Those providing advice should engage with these population groups wherever possible, including using potential opportunities to talk about future travel plans outside a specific health consultation, such as during new patient checks or childhood immunisation appointments [2].

The PHE Advisory Committee on Malaria Prevention Guidelines [3], and resources available from the National Travel Health Network and Centre, should assist clinicians in helping travellers to make rational decisions about protection against malaria.

Useful resources for travellers, including translated advice leaflets are available from the PHE website [4].

PHE (20 July 2016). Malaria imported into the United Kingdom (2015).

PHE website. Communicable Diseases: Migrant Health Guide.

PHE Advisory Committee on Malaria Prevention. Guidelines for malaria prevention in travellers from the United Kingdom.

PHE website. Malaria: guidance, data and analysis.

SSAFA – THE ARMED FORCES CHARITY

A valuable source of all sorts of help for military veterans

SSAFA was established in 1885 and since then, it has cared for our servicemen and women from their first day of duty and for the rest of their lives. SSAFA also remembers that it is not just the individual who joins the military: a commitment to duty is one shared by friends and family. Today it provides care to around 50,000 people each year through branches throughout the country that help veterans and their dependents. Volunteer Caseworkers help by offering guidance, financial help or supporting people through a crisis. A veteran can be young or old and have a wide range of problems. Some served many years ago and are dealing with the problems of old age. Other veterans have served more recently and may be struggling with, for example, physical injury, PTSD, or homelessness.

SSAFA was one of the first charities to recognise the importance of the family in the successful deployment of service personnel. SSAFA is there for the big and small problems that military life can bring. Most establishments have a SSAFA Service Committee to support the military community with everyday issues. For the times when a service career brings tragedy, SSAFA Support Groups exist for those families touched by bereavement or serious injury. SSAFA also provides two homes for families to stay in while visiting their family members who have been seriously injured when serving, one at Selly Oak, and one close to the rehabilitation centre at Headley Court in Surrey.

SSAFA operates a help line that can be accessed by anyone with a military connection - past or present - who feels that they need help. This service is completely confidential and is also accessible online. www.ssafa.org.uk or (for Somerset) call 01984 624564.

USEFUL RCGP MENTAL HEALTH TOOLKIT

Available for use by all practices

The RCGP has collated this set of useful documents and guidance related to mental health care in general practice and made it available to any practice. It is also accessible by patients.

http://www.rcgp.org.uk/clinical-and-research/toolkits/mental-health-toolkit.aspx

The section on "Suicide and Crisis Care" is particularly good, especially the short document on Suicide Mitigation in Primary Care.

Dr Whimsy's Casebook: Sunday Trading

Scene: It's 4:00 p.m. on Sunday. Dr Whimsy's room is as quiet as a grave except for the flutter of cards as he and Nurse Pherripy take turns to flick them into a vomit bowl.

Dr W: *[sighs]* I'm bored, Jean. It's six hours since the last patient, and that was to sign a passport form. I've had it with Sudoku. Isn't there anything else to do?

JP: Well, I've re-checked the drug cupboard and resus trolley, scrubbed the treatment rooms, made lunch and valeted your car, so I'm running out of ideas too. I know, here's a BNF. Let's start a book club.

Dr W: No thanks. You know we're paying you double time for this – any chance you'll consider piece rate?

[Suddenly a klaxon shatters the calm and the receptionist's voice crackles over the Tannoy.]

Rec: INCOMING!! WALK-IN ALERT!! ALL PERSONNEL TO YOUR STATIONS!!

Dr W: This is it, Jean. Scramble to your room and prepare for action. Crank up the ECG, prime the drip, and break out the defib – we're about to go in.

[A man with a shopping bag appears at Whimsy's door. It's Herbert Ditchmole, a patient of Dr Nott's.]

HD: Are you Dr Whimsy? My name's Ditchmole. The receptionist told me to come straight to your room.

Dr W: Good to see you, Mr Ditchmole. What's the problem? Chest pain? Sudden breathlessness? Weakness down one side?

HD: I'm perfectly well thank you, Dr Whimsy, but my wife sent me to Tescos for something to worm the parakeet, and on the way home I saw your door's open, so I thought I'd pop in on the off-chance.

Dr W: Very wise, Mr Ditchmole. You could have bird 'flu, or even psittacosis or campylobacter. Got the trots?

HD: Honestly, I'm fine, I just wanted a chat with Dr Nott about my prescription. I keep running out of Viagra.

Dr W: Your own doctor is certainly the best person to help with that sort of thing, but it's not his turn on the rota today. Couldn't you speak to him during the week?

HD: No appointments. Now that you're all working weekends as well, they've cut down the weekday appointments. Can't you just work longer hours?

Dr W: Er, no. I'd be asking my own doctor for a sick note if I did. It will be a lot better when Brexit's £350m a week kicks in and we have more doctors.

HD: You didn't really fall for that one, did you?

Dr W: Are you suggesting that our politicians were hiding the truth? Have faith, Mr Ditchmole. But for the time being have patience, as we're badly overstretched. Perhaps you could come on a weekend when Dr Nott's here.

HD: Actually, I don't want to come on a weekend at all.

Dr W: How strange. The Health Secretary says patients all want seven day access to a GP, so here we are.

HD: Well, he didn't ask me. Anyway, my mate Ron says they tried it up North somewhere and there was no demand so they gave up. Judging by your empty waiting room there's no call for it down here either.

Dr W: You may be right. In fact, we're seeing fewer people overall because of the poor uptake of weekend appointments. That's why you have to wait longer than ever to see your own doctor. But why don't you want to be seen on a weekend?

HD: Unless I'm really ill I have better things to do.

Dr W: Like what, if you don't mind me asking?

HD: Oh, having the grandchildren over, game of golf, pub lunch with Ron, day out at the beach, footie on the telly, cock-fighting in the Quantocks – there's always something happening at the weekends.

Dr W: Don't I know it. But surely you'd come to us if you had an urgent problem?

HD: In an emergency I don't need a doctor who knows about my, um, personal problem. We have Out-of-Hours GPs, the Minor Injuries Unit, or A&E in town. Besides, nobody with any sense would go to a doctor with a serious problem over the weekend.

Dr W: Why not?

HD: We might get admitted to hospital.

Dr W: What's wrong with that?

HD: Your Jeremy Hunt says we're more likely to die if we go to hospital over a weekend, so I'd rather stay at home and take my chance.

Dr W: Ah, the Hunt Effect.

HD: Isn't that the ability to talk your way back into a job you should have been fired from?

Dr W: No, the other Hunt Effect. Patients are scared by his weekend warning so they lie low until Monday.

HD: I don't blame them. He's right, isn't he?

Dr W: Rarely. He says there aren't enough hospital doctors at the weekend, so he's forcing them to work seven days like us, but it turns out that the standard of care is as good as during the week anyway.

HD: So why do the weekend figures look so bad?

Dr W: Confounding variables, Mr Ditchmole.

HD: Is that a fatal disease you only get at weekends?

Dr W: No, it's a statistical quirk that skews the data, such as fewer weekend admissions of people with problems that aren't life-threatening, terminally ill patients unable to get a hospice bed at weekends–

HD: OK, I get it. More doctors won't help that, but with this Hunt Effect, aren't people a lot more ill when they eventually turn up during the week?

Dr W: Of course, and the death rate for weekday hospital admissions is bound to rise.

HD: Ah yes, then the weekend figures won't look so bad, and it will seem as if his policy is working. That's clever. A doctor, is he?

Dr W: No, he couldn't sell marmalade to the Japanese and became a politician. But about your prescription…

HD: Oh, it can wait, doc. You have a rest.

This column is written for humour and does not necessarily represent the views of the author, his/her practice, or the LMC.

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