SOMERSET LMC

Newsletter

AUTUMN 2017

Issue 208

SWIMMING WITH THE TIDE

Primary Care Home and Practice "At Scale"

Inside this issue

If you can spare a moment from the demands of the day job, grab a balloon and float up to look down on the primary care landscape in Somerset. You'll see that it is distinctly patchy. Most of the larger urban training practices with a good mix of GP ages are looking pretty healthy, but out in our towns and villages smaller practices with predominantly older GPs are sometimes beginning to look a bit wilted. Thanks to initiatives like "GP in Somerset" the flow of new recruits into the county is better than last year, but still not enough to provide like for like replacement for all the retiring GPs, and understandably new arrivals are choosing to work in practices that appear to be the most stable. Many practices are going to have to find a different solution.

Although no other clinicians are a complete substitute for GPs, there is now plenty of experience that they can free up remaining doctors to do the things that only GPs can do. But practices need to have enough people in each professional group to make sustainable teams, and for many that will require some sort of collaborative arrangement with their neighbours. Nick Robinson, the new Chief Officer of the CCG, has a clear vision that primary care - not just general practice - needs to be provided "at scale" (your editor has admitted linguistic defeat and no longer insists that this ought to be "at large scale") and we agree that this is now the right way to go. It's important to say that there is no one configuration that has all the answers, and the LMC foresees a mixed economy of independent practices, collaborative networks, and directly managed primary care sites - notably those run by Symphony Healthcare Services. Yet we do need to start with a framework for development, and preferably that should be flexible enough to accommodate all the different elements of primary care provision in a particular locality.

The Primary Care Home model (link), developed by the National Association of Primary Care, looks like a good candidate. There are now nearly 200 PCH test sites across the country, all built on list based practice, and all recognising that a 21st century GP needs to work in an integrated team, with an integrated record, agreed system protocols and a common culture. There is plenty of introductory information on the website that should give you a feel for the principles, but one of the strengths of PCH is that it starts with a natural group of primary care providers and builds by progressively tackling constraints before looking at form, rather than taking a more formal and contract driven MCP approach. PCH shares the now widely agreed assumption that a population size of about 30-50,000 works best for a new model of care as this is big enough to support population health management whilst still allowing personalised care by a team small enough for everyone to know one another. It's also clear that the model has been developed from the ground up by primary care professionals and not theoreticians: it's also pretty radical, suggesting we should be looking outside traditional health and social care relationships and talking to schools, churches, businesses and other community organisations, which fits well with the parallel development of preventative and anticipatory care. It is said that 30% of NHS spend could be being lost due to duplication, inefficiency and waste so there is an awful lot of money we could re-invest in promoting healthy lifestyles if only a fraction of that can be saved. But perhaps the most important thing about PCH that James Kingsland, president of NAPC, said at a meeting at the CCG in August was "We need to bring the joy back into the job". That is a guiding principle we would thoroughly endorse.

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

Follow us on Twitter

GP In Somerset

PALLIATIVE CARE UPDATE

From Dr Charlie Davis, Somerset Palliative Care Consultant

Living well until we die comfortably in a safe place is important. As Dame Cicely Saunders explained; 'How we die remains in the memory of those that live on'.

Since 2014 Somerset has had a consortium palliative care consultant team, aiming to improve care for all, not just those with specialist needs. The consortium includes all the Somerset trusts, St Margaret's Hospice (who also have their own consultant) and the CCG. There are six consultants (4WTE) working across the whole county. Three years into the new system there are a number of developments under way:

SOMPAR Verification of expected death policy now uses a decision support tool to allow district nursing teams to proceed with verification if a DNAR form and a clear understanding that the patient is reaching the end of life are present. Training of nursing teams is ongoing and GPs may still be needed at times to help during the key early bereavement period.
See link

EMIS has an essential role in future developments and there is a budget for further integration of the primary care record with specialist palliative care information. An exciting aspect of this is anticipatory (just in case) prescribing. The team are planning to adapt an existing EMIS template to allow pre-printing of a SOMPAR drug chart for anticipatory prescribing. This will also facilitate safe prescribing of defined ranges for syringe drivers in keeping with the recent Somerset 'Just in Case' medications policy update.
See link

Prescription Stickers on MAR Charts. Using stickers is now considered too unsafe. Please make sure prescriptions are handwritten, clear and unambiguous, especially for all 'just in case' drugs.

A new life limiting illness discharge summary produced at Taunton and Somerset Trust is being sent out to practices to help with advance care planning and readmission decisions. It gives key information for out of hours colleagues to improve personalised care and reduce inappropriate admissions.

The County wide advisory group on treatment escalation planning. This currently has limited primary care involvement but includes all other NHS providers in Somerset. Please contact charlie.davis@sompar.nhs.uk if you would be interested in helping develop a paper and electronic community TEP for the county.

Further support needed for CCG developments in end of life care. The CCG are looking for an experienced GP who is passionate about; and has experience of, delivering palliative and end of life care in a community setting. Enquiries to deborah.rigby@nhs.net. This is a paid role.

Approachable consultants are available to attend practices. The consultant team all have community time in their job plans and cover federation based geography. They work closely with the local hospice community nursing teams and would be delighted to attend palliative care meetings in practices or educational events.

Remember: 24/7 palliative care advice is available, supported by the consultants, on 0845 070 8910 (within the St Margaret's footprint).

A SUSTAINABLE WAY OF IMPROVING HEALTHCARE IN THE THIRD WORLD

A request from retired Somerset GP, Andrew Quayle

After six months of working in a large rural hospital in Zambia two years ago, we came to the conclusion that funding local clinicians to upgrade their medical qualifications was often a much better use of resources than getting expats to work in the developing world for short stretches. Recently, Mpongwe Hospital, where former Somerset GPs Ant Webb and Simon Bonnington worked many years ago, has requested financial support for one of their medical licentiates, (a sort of physician's assistant), to upgrade to become a doctor. He has already paid for his first 3 years of training himself, but needs to raise the money for his final 2 years. If we can help him, he is willing to commit to Mpongwe for 6 years after he qualifies. This would bring a much needed stability to the hospital, especially as his family are local, and it is very likely that he would stay long term.

If you feel this is something that strikes a chord, please would you consider supporting us in raising his fees? To donate and for further information please go to mydonate.bt.com/charities/mpongwespeople

We can be contacted on antwebb2@yahoo.co.uk and ajmquayle@doctors.org.uk. And we would be delighted also to have you join us on one of our work parties if you fancied a trip to Zambia as well!

Footnote

The LMC Benevolent Fund trustees have for some years supported a charity called AMREF to train Clinical Officers in South Sudan, which has one the lowest number of doctors per head of population in the world.

SOMERSET LOCAL MEDICAL BENEVOLENT FUND

Sometime in the first half of the last century GPs in Somerset agreed to set up a mutual insurance fund under the auspices of the LMC. Subscribers paid something like a penny a patient into the fund, and in times of trouble they could apply for financial support from it. When most doctors were single handed and there was no income protection during illness, this was a sensible arrangement, but with the advent of the NHS and the pension and other benefits that brought, the need for a local fund gradually declined. We don't know when the scheme was actually started, but in 1949 it was formalised into a charitable trust, presumably for legal reasons. The Vesting Deed allows the trustees to use the resources of the trust in three ways: to provide "relief and assistance" in a time of need to any doctor who has practised as a GP in Somerset, or their dependants; to contribute towards the higher education costs of the dependants of a current or former Somerset GP; or to make donations to medical charities.

Over the next fifty years the number of contributing GPs gradually fell, but calls on the charity were few. In 1996 contributions were finally stopped as the capital assets of the fund were sufficient to generate enough income to meet demand, but all Somerset GPs remain lifelong members of the scheme, and, thanks to the foresight of their predecessors, you do not need to pay any premiums. As with military charities, a doctor just needs to have served for one day as a Somerset GP in one capacity or another to be eligible.

The Fund currently has assets of about £590,000 and the trustees spend some £28,000 a year on services for GPs and usually £2,000 on charitable donations. Local spending includes the LMC Clinical Psychology service (the fund pays for any GP to have up to six sessions with a counsellor experienced at working with health professionals), some of the work of the LMC pastoral service, and a number of direct payments to GPs. The criterion the trustees apply is that the doctor has suffered a significant drop in income, not that he or she is in desperate financial straits, and that covers all sorts of circumstances from personal illness, or the need to take time off to care for a sick dependant, or family breakdown to suspension from the Performers List or by the GMC. Payments are usually one-off but can be repeated and are typically between £1000 and £4000. As with any other insurance payout, there are no strings attached though the trustees will sometimes make a gentle suggestion, which is usually that the doctor should spend it on themselves, perhaps by taking a holiday.

In recent years the trustees have made regular donations to the Cameron Fund (the national BMA GP charity) in recognition that we are very fortunate to still have our own significant local resource, to the Sick Doctors Trust who do great work particularly with doctors who have addiction problems, and finally to support the training of clinical medical officers in South Sudan by the development charity AMREF.

Enquiries and applications can be made by the potential recipient themselves, or, with that person's consent, by someone else acting for them and they should be made to LMC Medical Director who is *ex officio* the Fund Secretary.

NOOKS AND CRANNIES OF THE NHS REGULATIONS

Readers may enjoy the following slightly edited extract from a letter received by the LMC about an application from an appliance contractor to set up business in Somerset

"**Regulation 24(2): relocation to a neighbouring Health & Wellbeing Board (HWB) area.**

The Committee noted the wording of Regulation 24(2) which is as follows (emphasis added): *…an application from a person already included in a pharmaceutical list for the area of a HWB (HWB2) for inclusion in the pharmaceutical list for the area of a* ***neighbouring HWB*** *(HWB3)…* The Committee also noted that in Regulation 2 it states (emphasis added): *"neighbouring HWB", in relation to a HWB (HWB1), means the HWB of an area* ***that borders any part*** *of the area of HWB1…*

Given the definition in regulation 2, the Committee was of the view that Essex (HWB2) cannot be considered as neighbouring Somerset (HWB3) – there are a number of counties separating them."

CONVERSATION IN THE SUPERMARKET

A GP reported this chance encounter with a bright 19 year old on the Tesco checkout

"Would you like any bags Madam?"

"Yes please, just the cheapie 5p ones." (I'm still hopeless about bringing my own bags)

"Sorry Madam, they are 10p now."

"*Right,"* I said, *"I'm going to have make more of an effort."*

We both agreed they would be a £1 bag soon.

"Yes" I said *"that is when it is really going to hurt and things will change."*

She then volunteered, without any prompting or knowing that I was a doctor, that she had been hearing from her own GP that his surgery was starting to think about charging.

"I want to be a GP" she said.

I found myself telling her that I had just spent an afternoon with GPs who had chosen to leave employed general practice but who were still passionate about doing the job well.

"Yes" she said *"It is just so inefficiently run, isn't it."*

I gave her a big smile, told her to work hard and that being a GP was one of the best jobs one could do.

There is hope for the future!

Dr Whimsy's Casebook: Doctoring by numbers

Advice from the SW GP Performance Advisory Group: "Make sure that you give the numerical value or a specific comment rather than just recording 'normal' as this is such a nebulous term."

Scene: a busy Monday morning surgery. The duty doctor is on an urgent visit, and Whimsy has been asked to squeeze in one of her patients, Mr Baldy. But first there's an urgent phone call from Mr Elpew, the Clinical Standards inspector.

Dr W: Hello, Evan. I'm up to my eyeballs. Can it wait?

EE: Absolutely not. I'm reviewing your consultation records and there's a significant risk of somebody coming to serious harm because of your laxity.

Dr W: And what did you manage to dig up this time?

EE: Please dial up Mrs Fayshant on your computer.

Dr W: Ruby? She's alright, isn't she?

EE: As far as I know.

Dr W: Then what's the problem? She's a frequent attender, but I always take her concerns seriously.

EE: You saw her a week ago and diagnosed laryngitis.

Dr W: That's right. She's a bingo caller with a deaf husband and teenage kids, so she shouts a lot. Seeing Harvey Weinstein on the TV tipped her over the edge.

EE: That's fine, but under "Examination" you put "apyrexial". Did you really take her temperature?

Dr W: Yes. It was normal.

EE: That's the point. You won't have a leg to stand on in front of the GMC because you didn't write down the exact temperature. You also wrote, "LNs OK". Normal lymph nodes, I suppose?

Dr W: Precisely.

EE : Did you measure them?

Dr W: Of course. After sterilising her neck with 30 mls of 2% chlorhexidine in 70% isopropyl alcohol and injecting 7.45 ml of 1% lignocaine containing 1:200,000 adrenaline through a 21 gauge needle on a sterile disposable polypropylene syringe with a silicone-greased latex rubber plunger, I made a 23 cm skin incision with a number 15 blade–

EE: So why on Earth didn't you write that in the rec– Ah... You're teasing me, aren't you?

Dr W: Yes. She had no swollen glands. I used my clinical judgement. You knew exactly what I meant, and so would any other clinician who sees her record. It's shorthand. It saves time, which we don't have in the same luxurious abundance as some other people.

EE: So you regard your record as adequate?

Dr W: A bit wordy maybe, but I think it caught the gist.

EE: I regret to say that I don't agree–

Dr W: Sorry to cut you off there, Evan, but I have an overbooked surgery to get through. I'll bear in mind what you said, and I'll try not to abbreviate anyone to death before lunchtime. [hangs up, opens door; a man in overalls is standing outside]

Dr W: Ah, come in Mr Baldy. May I call you Gary? You came straight from work, I see. It must be urgent.

Man: Actually, I–

Dr W: No time for chit-chat, Gary. How can I help?

Man: Well, I'm bleeding–

Dr W: That's not very nice for you. [typing verbatim into the computer] And where are you bleeding?

Man: Er, the ground floor, but I–

Dr W: The ground floor..? Oh, I understand. [backspaces over "ground floor", types "PR"] No need to be coy, Gary. It saves time if you speak plainly.

Man: But doctor, I–

Dr W: How long has this been going on for?

Man: All morning, but–

Dr W: What time did it start? Please be exact, now.

Man: Nine o'clock sharp. Look, Dr Whimsy–

Dr W: [types "started 09:00 BST"] OK, take off your lower things and hop up on the couch, please.

Man: Listen, doctor, I–

Dr W: Mr Baldy, we don't have time to discuss this. You have a serious symptom. I'm already running late, I need to examine you thoroughly, and it's going to take me ten minutes to write it all up because I have to record everything down to the last decimal place, then I'll probably take blood and refer you to a specialist. So let's get on with it. And since I don't know you I suppose I ought to record your consent to being examined in as many words as possible. Are you happy for me to continue? [poises finger over "Y" on the keyboard]

Man: No, doctor. And I must tell you–

Dr W: [crestfallen; looks at clock] Oh, great. Look, I know it's not nice to be examined by a strange doctor, but I need to sort you out. You must have known what it involves, so why come to my room if you don't want to be examined?

Man: Because you're next on my list.

Dr W: You mean you've seen other doctors about this?

Man: Yes. I was with Dr Groinstrangler just now, and before her it was Dr Takenout.

Dr W: That's not on your record yet; they must still be typing in your hair colour. But why didn't you let Adam deal with your problem in the first place? [The phone rings. It's a receptionist, Ms Nutherthinge] What is it, Anna? I'm busy.

AN: Sorry to disturb you, Dr Whimsy, but Mr Baldy is asking when you're going to see him.

Dr W: He's with me right now, Anna.

AN: Um, actually he's in front of me in reception.

Dr W: [Covers the mouthpiece, speaks to the man in overalls] Aren't you Mr Baldy?

Man: No, doctor. That's what I'm trying to tell you, but you're too busy typing on your computer to listen. I'm the plumber. I came to bleed your radiator.

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: www.somersetlmc.co.uk