Somerset LMC Newsletter

Jan 2010

Issue 154

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WHY BOTHER WITH THE LMC?

We accept that it may not be the very best time of year to be asking you this question, but bear with us. It may be the worst January weather for years, with queues of slightly poorly patients right out into the car park, every DGH bursting at the seams and half your staff snowed in somewhere on Exmoor, but we are pretty confident spring will eventually come. And with spring will come the election, and doubtless a resumption of hostilities between the GPC and the Government – whatever colour it turns out to be. The Conservative health manifesto is a bit of a curate's egg with some sensible things like more attention to public health, but also some rather alarming stuff about *"unleashing an information revolution in the NHS by making detailed data about the performance of hospitals… (and) GPs… available to the public online"* and introducing *" a single number for every kind of urgent care to run in parallel with the 999 emergency number",* never mind *"linking GPs pay to the quality of the results they deliver"* However, the proposals to *"scrap all the politically motivated process targets"* and to *"cut the cost of NHS administration by 1/3"* may strike a chord with GPs.

What is perfectly clear is that the profession will need to maintain the political and philosophical coherence that has stood us in such good stead in the past. It is remarkable how the economic and political pressures on general practice have even driven together the BMA and the Royal College, who now have very similar views on just about everything. But the number of problems we face is growing all the time, and to maintain a strong GPC we need strong local representation to support it. The LMC's strength lies in its geographical constituencies, which ensure that all the disparate parts of the county are represented. Although we recognise that some organisational change is needed to reflect the changing GP workforce, constituency members remain the bedrock of the LMC. Elections for the next four year term will be held in March, and we urge all GPs – partners, salaried and retained doctors, or sessional GPs to consider standing and certainly to vote in the election. The committee meets on the afternoon of the second Thursday of the month in Taunton, and an attendance allowance and travel expenses are paid. Members are encouraged to develop expertise and experience in the particular areas that interest, but the basic commitment is modest.

The work of the LMC covers a wide range from administering the Benevolent Fund and providing pastoral support to GPs and practices to undertaking detailed negotiations with the PCT on local contracts and representing general practice to the wider public. There are plenty of opportunities for members to become involved in all aspects of the committee's activities

We believe that the good relationships that a strong LMC has been able to maintain with practices, the PCT, hospital trusts and other organisations working in health and social care has helped our members, our patients, and the profession. Please help us to continue to do the same in the future.

CHILD DEATH OVERVIEW PANEL RECOMMENDATIONS: NEED FOR A LOCAL PAEDIATRICIAN AND RISKS OF NON-ATTENDANCE IN CHRONIC DISEASE

You may recall from previous Newsletters that the circumstances surrounding the death of any child is now considered by the Child Death Overview Panel for the local authority area in which the child died. The intention is that any lessons can be shared with other professionals, and we have been asked to pass on two recommendations from recent events in the South west. First, it has been noted that not all children with chronic illness cared for by tertiary specialists have a local DGH paediatrician. That child therefore does not have local notes, and if admitted unexpectedly there may not be enough information to assess and treat him or her adequately. In the case in question this may have potentially contributed towards a death. If you do have any children in this position please can you make sure they are referred to a local consultant. This will not necessarily add to the clinic load for the parents as they can simply maintain a paper involvement unless clinical review would be necessary or helpful. All our local DGHs and Bristol Children's Hospital have agreed to this

The second case concerns a 12 year old child who died of diabetic ketoacidosis. The main carer had complex personal problems and the child frequently missed appointments. There had been no contact with the GP for 5 years despite invitations being sent. The report noted that each agency concerned had tended to concentrate only on their own area of interest, and the GP record was the only place where all the problems of the family were brought together. The key message is that just sending out invitations is not enough – if a vulnerable child is not being seen, then this should trigger consideration of a referral to social services. We may be the only people who have the whole picture.

Use of NHS Logo

If you are want to use the blue NHS logo on practice notepaper etc there is GP-specific guidance at:
http://www.nhsidentity.nhs.uk/all-guidelines/guidelines/general-practitioner/introduction

THE COST OF DH PUBLICATIONS – WE SUGGEST YOU READ THIS SITTING DOWN

Our thanks to Gloucestershire LMC who made a Freedom of Information request to the Department of Health about the production costs of two of their recent publications '*Let's Get Moving'* and '*Putting Patients at the Heart of Care: a vision for patient and public engagement in health and social care'.*
The Departmental response makes interesting reading: it revealed that the first cost £59,232. The design and print cost of the second was just £5,243, but it was the culmination of 'an extensive process' which at £113,385.90 + VAT seems to us to us to be an 'expensive process' You may perhaps wonder, when you read the documents in your copious spare time, whether they were worth it.

PRESCRIPTION DRUGS AND DRIVING

The DH and Boots have this week launched a pilot "Think" campaign to remind patients about the effects of various prescription drugs on driving. Although medication packaging contains information, and this is reinforced by the dispensing pharmacist, it is always worth bearing in mind the possible effect on driving when you write a prescription. Research has identified the following medicines as the most risky:
Neuroleptics Tricyclic antidepressants Benzodiazepine anxiolytics Compounds used to treat Parkinson's Disease (e.g. L-dopa, dopamine agonists) Some hypnotics and sedating anti-histamines may also be problematic.

"HEALTH TALK ONLINE" WEBSITE

The well respected charity DIPEx has set up two websites at www.healthtalkonline.org and www.youthhealthtalk.org that contain interviews, narrative and discussion about various health problems and conditions from the patient perspective. The sites can be visited by the general public as well as health professionals, and cover both specific conditions and more general topics such as participating in medical research and experiences of intensive care. Well worth a look.

EMPLOYMENT AND SUPPORT ALLOWANCE APPEALS.

Information from GPC Member Dr John Grenville

The criteria for ESA are much stricter than for Incapacity Benefit which it replaces. Although the Department for Work and Pensions talks about the test defining the claimants ability to work, they have to score 15 points on the test to get the benefit, otherwise they must claim Job Seekers Allowance. This does not necessarily mean that they are fit for work or Employable.

It is likely that many applicants will appeal as they continue to get ESA until their appeal is determined. If the appeal panel hears a case and thinks it would be helped by further medical evidence it can adjourn the case and ask for a GP report or for a copy of the records. The Tribunals Service will pay for these, not a very high rate but better than nothing. The practice does not, therefore, disadvantage a patient if it declines to do a report for at the patient's request before the appeal.

SMALL ADS SMALL ADS SMALL ADS…….

PRACTICE NURSE :
WELLINGTON MEDICAL CENTRE

Enthusiastic and motivated practice nurse sought to join our primary care team. Experience of chronic disease management and general practice nursing desirable, but not essential. Hours and salary negotiable depending upon experience. Please contact: Lydia Daniel-Baker, Wellington Medical Centre, Bulford ,Wellington TA21 8PW 01823663551

Closing date Friday 29th January 2010.

MEDICAL SECRETARY: WARWICK HOUSE, TAUNTON Part-time Medical Secretary 10 hours a week, worked over 2 days. Duties include coding of medical information on to the EMIS, system. The work is highly confidential and attention to detail is of great importance. Ideally you will have previous secretarial and administrative experience, preferably within a GP Practice or similar, and be computer literate with a sound knowledge of EMIS and MS Office

Salary dependant on experience. Full job description atwww.warwickhouse.org or for details please contact Jane watts 01823 447374 jane.watts@warwickhousemc.nhs.uk

PART TIME PARTNER: WEST SOMERSET HEALTH CARE

Enthusiastic and motivated GP with an interest in women's health to join our dynamic team in twin site practice of just over 10,000 patients, excellent QoF achievement, special interests and personal development supported, 12 Months mutual assessment.

Applications welcomed for a minimum of 4 sessions per week, CV and applications to/or further information from: Mrs Alison Foulkes, west Somerset Healthcare, The surgery, Robert Street, Williton, Taunton, Somerset, TA4 4QE. Tel: 01984 632701 E mail:

Alison.foulkes@willitonsurgery.nhs.uk

Closing Date 15/01/10 Interviews 28/01/10

GP PATIENT SAFETY LEAD/ NAMED GP FOR SAFEGUARDING CHILDREN : NHS SOMERSET

GP with knowledge and experience of working with children and young people needed to take on the role of Named GP for Safeguarding Children and GP Patient Safety lead within the Nursing and Patient Safety Directorate at NHS Somerset. This role involves providing advice and guidance to general practitioners on child protection, working with the Designated Doctor and Nurse for Safeguarding Children and the Local Safeguarding Children Board to provide GP education in child protection and support audit and case review in general practice. The post holder may also take on other responsibilities for patient safety and clinical governance matters in the Directorate in respect of primary care. Training and development can be provided

Contact Lucy Watson, on 01935 384033 or email: lucy.watson@somerset.nhs.uk.

Closing date : 29 January 2010

ACCOUNTS & ADMIN ASSISTANT:
SOMERSET LMC

Part time Accounts and Admin assistant required for 30 hrs per week to provide finance and administrative support to Somerset Local Medical Committee. The LMC team provides support, advice and information to General Practice as well as liaising and negotiating with Primary Care Organisations You should be familiar with MS Office, have a good all round knowledge of accounts' and ideally have experience of Sage instant accounts or similar. Previous experience of working within a health care setting would be an advantage.

For a job description please contact Jill Hellens jill.hellens@somerset.nhs.uk or phone the LMC office 01823 331428.

Closing Date: Friday 22 January 2010

TXT FROM AN URBAN DOCTOR

Ah the winter season is upon us. A layer of snow is on the ground grinding the country to a standstill, and an avalanche of emails are hitting our inbox explaining the increasing panic and despair that is in secondary care.

Each email seems to be trying to outdo the previous one in order to put across to us GPs the gravity of the situation. They used to use a simple traffic light system. Musgrove Park Hospital is on amber alert. Yeovil Hospital is on red alert. But that was not scary enough. Now we have *black alert*. Wow! Now that does sound bad. Throw in various "situations" such as the weather situation, the diarrhoea situation, the economic situation, and we begin to get a cataclysmic picture.

The general gist of the emails go along the lines of, "Stop admitting patients you dastardly lot. Please accept any increased risk of keeping the patient at home, but please note our disclaimer on page 73 paragraph 18 of the Word Document attachment on this email that states: Should any harm come to the patient as a result of you failing to arrange an appropriate admission, you are entirely to blame and will be held accountable faster than you can say GMC complaint."

The problem that I've got is not so much the content of the emails or even the assumption that we really are just admitting patients for a laugh, but more this amber, red, black malarkey. It's not snazzy enough. I think we need to take a leaf out of the book of our American cousins and give the whole thing some Hollywood Bling.

You can just imagine how much fun they would be having in a meeting at the Pentagon Care Trust Headquarters in Wynford House. All the joint-chiefs-of-staff from the primary care directorate sitting in on Operation Cobra talking in a Deep-South drawl.

"We have a situation here Sir. All facilities are currently operating at capacity. We have packed 'em, racked 'em and stacked 'em and there are still patients in the corridors. There has been a virus attack at Musgrove that has shut down four units. We have a Black Hawk Ambulance Copter down, and a detachment of mobile transport ambulances holed up on the Mendips. Staffing levels are critical and supply lines are stretched. Four hour breaches in the field hospitals are threatening our star rating and still the patients come. It's like a war zone out there sir!"

"Get me the SHA president on the line. I'm taking us to DEFCON ONE!"

The views expressed in this column are those of the author and not necessarily those of the LMC

PRIVATE HEALTH SCREENING – ADVICE FOR PATIENTS

It is clear that a growing number of organisations nationally and locally are seeing commercial opportunities in selling various health screening tests directly to the general public. Some of these are familiar, like the provision of cholesterol testing, but others are more recent such as the offer of vascular scanning or even a "whole body check". Although it seems likely that few of these offers will meet Wilson's criteria, in a free market there is nothing to stop providers offering a service to people and trying to persuade them to buy it. Unfortunately the advertising material rarely allows people to make a full objective assessment of their personal risk and likelihood of benefit from undergoing screening.

Although the NHS is – very sensibly – rather slow to adopt new screening proposals, at least we can be confident that the evidence has been carefully weighted before public money is invested. It will be interesting to see when and how Abdominal Aortic Aneurysm ultrasound examination makes the grade. But the need for proof of cost benefit does not apply to private providers who have no need to think of the tail of consequences for the NHS if an "abnormal" result turns up.

The LMC has prepared some information for patients that we hope you may find useful if asked about screening tests, and a copy is attached to this Newsletter. Please feel free to use and adapt it as you please: it is a first draft and we would welcome any suggestions for amendments.

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