Somerset LMC Newsletter

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SUSTAINABILITY: IS IT THE KEY TO FUTURE HEALTHCARE?

As budgets are cut and demand spirals, GPs have been handed the reins to the NHS. Commissioning groups scratch their heads and think "How on earth are we going to do this?" Perhaps 'Sustainability' can help.

Sustainability is meeting the needs of today without compromising the resources of tomorrow. In the context of the NHS it aims to maintain the current quality of healthcare within the constraints of the planet and its ecosystems, and also within current social and economic conditions, without detriment to the future.

Repeatedly, and quite rightly, we are urged to reduce our destruction of the natural world and tackle climate change, both to preserve our resources and also to curtail pollution. As doctors, we, more than most, should appreciate the importance of this as human health depends so much on a healthy environment. We need clean air and water, sustainable food production and green space. And what's good for the environment is often good for health. For example, choosing to walk or cycle rather than drive benefits both the environment and individual health. Eating mainly fresh vegetarian foods and less red meat has a lower carbon footprint and at the same time brings multiple health benefits. Sustainable living has been said to reduce heart disease, cancer, obesity, diabetes, mental health problems, road deaths and diseases from air pollution.

How do you see medicine in the future? Do you think the NHS is sustainable? The NHS has a huge environmental impact and it is the threat of climate change that has triggered the introduction of targets for NHS greenhouse gas (GHG) emission reduction. The government has stipulated an ambitious target of 80% reduction in GHG emissions by 2050. A massive undertaking, but the NHS Sustainable Development Unit (www.sdu.nhs.uk) is helping the NHS move towards a sustainable and low carbon healthcare service.

Sustainable healthcare could be central to the survival of the NHS. It is about delivering healthcare today without inadvertently compromising the health of current or future generations. It should focus on preventative medicine and health promotion, giving patients responsibility for their own health and educating them about self-care. It advocates streamlined, efficient, referral pathways and services, lean service design and delivery, evidence based medicine and low carbon technologies. A move towards Sustainability forces us to debate seriously the ethical dilemmas about resource allocation and to rethink what healthcare should be.

In 2008, the Climate and Health Council and the Health and Sustainability Network proposed *Ten Practical Actions for Doctors to Combat Climate Change* (BMJ2008; 336:1507). We now know that the principles of sustainable healthcare have the potential to improve patient care, whilst reducing its environmental impact and also increase cost-efficiency. Important financial savings can be made through Sustainable Action Planning (SAP). SAP (link) is a programme to support clinical teams in taking action for sustainability. It identifies opportunities for change by using various tools such as thinking of the bigger picture, looking at inputs and outputs, process flows and involving the 'team on the ground'. Through a process similar to an audit cycle, changes are made and improvements are measured.

This really works in both hospital and practice settings. Examples of cost savings achieved in SAP pilots include £250,000 per year (across a number of units) saved on waste disposal after recycling was introduced and the proportion of non-clinical waste entering yellow bags was reduced; £4,250 per year by reducing unnecessary items in birthing unit maternity packs, plus £1,525 by improving storage to reduce instrument loss. An estimated £6,000 was saved on electricity in one unit by removing alternate fluorescent lighting tubes in a main corridor. Through improving processes across departmental boundaries further cost savings are possible: for example £300,000 savings were reported by a main hospital after it improved its system for pharmaceutical returns and cut waste. In fact, it is estimated that £1000 could be saved per employee if everyone engaged in SAP. And it's not all about switching to energy saving light bulbs!

We face great challenges but the principles of sustainability, sustainable healthcare and sustainable action planning may help us address them at work as well as at home, and at the same time relieve a little if the inexorable financial pressure. Do give SAP a go, and please share your experiences with the LMC so we can pass them on.

Dr Sally Aston
Severn Deanery Sustainability Scholar

NATIONAL CONFERENCE OF LMCS 2011

This year's conference was held for the first time at the Mermaid Centre, Blackfriars. Somerset LMC was represented by the chairman together with Drs Nick Bray of North Petherton, Andrew Dayani of Williton and Chris Hunt of Street.

Last year we had a newly minted coalition and there were strong hopes that, after the breakdown in relations with the previous government, things could only improve. With the novelty of a Health Secretary who knew the NHS, to the extent that some rightwing newspapers accused him of being "in the BMA's pocket," there was even some hope for the future. What a difference a year makes.

Lawrence Buckman opened the conference with a typically pugnacious speech. He said that the government could have solved its problems by listening to the profession and we would soon see if they really had taken any notice. He was not interested in putting "sticking plasters on a bad bill." He condemned the proposed quality premium for successful GP commissioning consortia saying it would be unethical for GPs to be rewarded for cutting services to patients. Practices had nothing left to cut but "whole limbs" were being amputated from the NHS. The government should not confuse membership of consortia with support for NHS reform. "Getting into the lifeboats is not the same as supporting the sinking of the Titanic." However he reminded delegates that GPs being involved in commissioning was potentially still a great prize for improving services. He went on to attack CQC registration as a pointless "tax" on GPs and said that threats to the NHS pension fund (which is in surplus) would not be forgiven.

In the subsequent debate on the Health & Social Care Bill the antis had it all their own way with support for motions condemning it as the "greatest threat to the NHS since its inception" and rejection of one saying it had potential to improve patient care. However a ballot to ask if GPs were "happy" to be part of consortia was rejected after the treasurer said it would cost £25,000 and Dr Buckman said that the answer to any question asking if GPs were "happy" about anything was bound to be a foregone conclusion.

- Later there was unanimous support to enshrine in the Health Bill the role of LMCs to represent GPs, with negotiating rights over their role in consortia, calls for Monitor to encourage cooperation rather than cooperation and certainly not to attempt to do both.
- The all party policy of abolishing practice boundaries was roundly condemned but the GPC view was that the DH had put this into the "too difficult pile" for the time being.
- A call to abolish the RCGP's allegedly sluggish registrar e-portfolio was passed after a lively if unbalanced debate. The biggest laughs and cheers went to the opponents.
- A string of motions criticizing the "contamination" of the doctor-patient relationship by financial inducement to reduce referrals was passed but not unanimously. There was a view that thresholds and targets might not be all bad but that these must be set by ordinary working GPs, not by "enthusiasts."
- The first day closed with the rejection of a motion from Cumbria to strengthen gun

licensing with a proposed "HGV-type" medical and mandatory psychological assessment judged to lack any evidence to justify them.

- The CQC also lacked evidence to back up its existence Conference decided and although it was guided by the GPC against making it BMA policy not to register – that would be against the law – it voted overwhelmingly for the CQC to be abolished. This came at the end of an emergency debate called by Avon LMC after the Winterbourne View scandal.
- An interesting discussion followed on the need for new QOF domains to have evidence to back them. A move to condemn some for encouraging polypharmacy and iatrogenic illness was unexpectedly defeated after two QOF assessors reminded practices to exempt suitable patients despite PCT managers' frequent scepticism.
- A call for all GPs to do out of hours work at some time in their careers (registrars these days doing so little in training) was rejected after GPs working in OOH said they did not want pressed men but volunteers and older delegates reminded us of the horrors of the past. Conference also narrowly supported the concept of a minimum price per patient for OOH contracts.
- GPC was instructed to get back payments for patients found to be unfairly removed in "list cleaning" exercises by PCTs. Some London practices had "lost" a third of their patients in one quarter!
- A Somerset LMC motion warning of the threat to GP manpower, despite ever increasing workloads, from changes to pension regulation and the well-intended extension of registrar training was backed *nem con*.
- There was strong support from the platform and the hall for the retention of a UK-wide primary care contract.
- A call to campaign for the abolition of revalidation was rejected after "Beware of what you wish for" seemed to be the winning argument.
- In an impassioned debate Conference agreed that the NHS pension scheme was affordable but heavily rejected a call for industrial action to defend it from Cornwall. The GPC reminded us what the "Daily Mail would say" and, in Churchillian mood, that "Jaw-jaw was better than war-war."

NHS SOMERSET HEATWAVE PLAN

Please do have a look at it

Although the arrival of the PCT Heatwave Plan tends to trigger a wry smile and an apparent instant return to winter weather, it does merit proper consideration. The 2003 European heatwave caused a significant increase in premature deaths – 2,000 in the UK, but some 15,000 in France where temperatures were over 40 C for 7 days in some Northern towns. Climate change means the risk of a recurrence is considerable. The French found that it was frail elderly people living alone who were most vulnerable. Although it may seem obvious that moving to a room on the north of the house, keeping blinds closed but air moving and drinking plenty of fluid are sensible steps, older people, particularly if they have any cognitive impairment, may find it hard to change their habits.

Because this group is also at risk from all kinds of adverse weather, including prolonged cold, it is worth having at least a mental check list of vulnerable patients about whose welfare you would be concerned during extreme weather. Better still, spend a little time with your community nurses and get it down in writing.

Patients on anti-psychotics, and some other medication, may have disturbed thermoregulation and reduced sweating. In combination with their mental or physical health problems this group may also be at particular risk.

Where possible vulnerable people need to stay at or below 26 C which is usually achievable in the UK. The DH produces a good guide for the public, see link and for professionals at link

WAITING TIMES FOR "RIGHT STEPS" APPOINTMENTS

Congratulations to the Emotional Health & Wellbeing Service (and the PCT and iGPCC commissioners) for producing a remarkable and sustained improvement in the waiting time for assessment and treatment. The number of patients waiting fell by 75 (6.9%) between 31 May and 15 June 2011, representing the sixth consecutive month during which the total number had fallen. As at 15 June 2011, the total number of patients waiting was at its lowest since reporting began. The number of patients awaiting assessment has fallen from a peak of 610 in September last year to just 104 in June. Although on the front-line you may be still experiencing long waits for your patients, it seems that a real and noticeable improvement is finally on the horizon.

iGPCC REPORT

What a difference a month makes! The Transition Group completed their remit, following election of federation delegates to the interim GPCC. The new organisation has met and elected a Chairman and Vice-Chair: congratulations to David Rooke and Matthew Dolman respectively. The iGPCC has been formally adopted as a sub-committee of the PCT and we have a Managing Director in Jan Hull, who is on partial secondment from her post as Deputy Chief Executive of the PCT.

Of course, in the NHS nothing happens in isolation and alongside the progress in Somerset, the 'Pausing, Listening and Reflecting' has been going on at national level. For us in Somerset the impact appears to be minimal, largely a name change from GPCC to ClCG (Clinically-led Commissioning Group) and a few extra seats needed at the table.

So how's it going? Having attended two meetings so far, I have to say that I am cheerfully optimistic. (Those of you who know me may be surprised!) The new team gelled well. There was opportunity and willingness to participate, and a feeling of shared purpose. Obviously there is also a background of political and financial imperatives of which you (do not?) have to be reminded, but make no bones about it, General Practice - via GP Federations - is being offered a huge opportunity to be the engineers of change in the NHS. The PCT representation on the GPCC board is supportive and of the calibre to ensure that we have expert local commissioning, finance and strategy skills available. Time is being appropriately spent training and developing the personal and corporate skills to enable board members to work efficiently in a new and, for many, foreign working environment.

I appreciate that for some there may be a degree of scepticism, that we have either been given Wyvern re-incarnated, or that the PCT is still making all the decisions. But although there is some sensible continuity in personnel, this *feels* like a different body. It will remain to be seen how grassroots General Practice is encouraged to engage, and how the evolution of Federations from the loose local assemblies into working, fully functional organisations is facilitated and funded. Good communication is essential, and I have repeatedly emphasised that two-way channels must be opened, and suggestions and concerns from primary care responded to, if General Practice is going to take ownership and responsibility for the decisions made.

Without doubt, these are exciting times for the future of healthcare and the way in which it is delivered. We have made a good start locally, which I hope will be built upon by strong GP engagement. I shall keep you informed of developments.

Andrew Dayani

LMC Representative on Somerset iGPCC Board

DO I REALLY NEED A....

Henry Schein Finger Pulse Oximeter

At just £49 (£63 with VAT and P&P) this little gadget is an affordable addition to your medical bag, but how useful is it?

Like all these devices it gives a pulse reading and saturation level from a finger within a few seconds, though nail varnish is a problem, and if the arterioles are shut down due to cold or shock you won't get a reading. The one we tried reads a little lower than larger and more expensive devices – most fit patients seem to show 98% rather than 99% saturation - but otherwise it correlates well.

For patients with no respiratory history, a low value is a pretty reliable indicator that something is amiss. Although other observations are almost invariably abnormal in such cases, a low saturation may, for example, point to a respiratory rather than a urinary cause of non-specific infective symptoms in an older patient, and knowing the saturation value can be helpful in deciding how aggressively a respiratory tract infection needs to be treated.

Patients who have a history of chest problems are more tricky as some with COPD will always have a significantly low reading. It is really helpful to have a baseline for such folk recorded in the notes as a falling saturation is an important marker of an evolving problem that may need hospital care, whilst if it is maintained normal community management may be more appropriate.

In summary, an oximeter is of limited value for a GP as a diagnostic tool in its own right, but in managing patients with chronic respiratory illness or others for whom you are trying to make an informed decision about the best management option it is a useful addition to the diagnostic armoury.

Available from ***www.porternash.co.uk***

FREUDIAN SLIP FOR OUR TIME?

A genuine message from a GP to the Senior Partner

'I wrote in the patient's note that she thought "QOF was unacceptable and she might as well be dead". I did mean Quality of Life, but I suppose other things have a way of working their way into the brain!'

BLUE BADGE SCHEME

We would like to draw your attention to this correction from the May 2011 DH GP and Practice Team bulletin: Link

It clarifies that local authorities can still currently ask GPs to carry out eligibility assessments for the Blue Badge (Disabled Parking) Scheme. However, this will change from 2012, when local authorities will have to use mobility assessments that are undertaken by professionals who are independent of an applicant's care. Under the new system, GPs may still be asked to provide factual information to be used in these assessments.

The intention of this change is to move from a system where GPs are perceived to make these decisions about patients to one where, when necessary, GPs only provide facts for the local authority to use in their assessment. Providing factual information for a local authority is a collaborative arrangement function and is fee paid by the PCT at the practice's rate. The BMA Professional Fees Committee guidance may help in relation to charging such fees: Link

DERMATOLOGY GPwSIS

Somerset PCT invites expressions of interest from GPs with an interest in Dermatology who would like to provide a specialist service through an Enhanced Service arrangement with their practice. You will need to have the Diploma in Dermatology and to be available for at least one session a week as well as being able to meet the national accreditation criteria.
Contact Chrispher.breens@somerset.nhs.uk before 29th July 2011

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

SALARIED GP: PENN HILL SURGERY, YEOVIL
Details: Maternity cover, up to 6 sessions from August 2011. Closing date 30th July.
Contact: Len Chapman for applications/ informal chat on 01935 470816 or len.chapman@pennhillsurgery.nhs.uk.

PARTNER: WESTLAKE SURGERY, YEOVIL
Details: 7 sessions per week in view of taking over practice in 3-5 years time. Closing date 22nd July 2011.
Contact: Applications by email to marcus.pawson@westlakesurgery.nhs.uk or Dr J Cox, Westlake Surgery, High St, West Coker, Yeovil BA22 9AH. Informal enquiries and visits welcome. Tel 01935 862212.

SALARIED GP: WINCANTON HEALTH CENTRE
Details: 6/7 sessions, will consider part time combinations. Salary negotiable, Aug/Sep start date.
Contact: janet.loe@wincantonhc.nhs.uk or tel 01963 435703. Further details www.wincantonhealth.co.uk.

GP MATERNITY COVER: LANGPORT SURGERY
Details: Commencing 22 August for approx 9 months. Special interest in family planning desirable. 4 sessions p/w; Mon & Thurs afternoon and all day Tues (negotiable). Closing date 15 July.
Contact: Applications to Brig Teuber, Practice Manager, tel 01458 254100. www.langportsurgery.co.uk

SALARIED GP: MID DEVON MEDICAL PRACTICE
Details: 3 sessions p/w at the Witheridge Surgery (Tues pm & Wed all day) with opportunity to cover annual leave in all 3 surgeries. Autumn start date. Closing date 31 August.
Contact: Jane Hunt on 01884 860205 janehunt@nhs.net.

PRACTICE MANAGER: AXBRIDGE & WEDMORE MEDICAL PRACTICE
Details:
Full time post located in Axbridge with some travel to Wedmore surgery. Salary negotiable up to £40K. Closing date 8th July.
Contact: Written applications with covering letter and CV to Di Hill, The Surgery, Houlgate Way, Axbridge, BS26 2BJ, or email at di.hill@axbridgewedmoredoctors.nhs.uk

CEO: STENNACK SURGERY. ST IVES
Details: Individual required to take the management lead. NHS experience desirable but not essential. 25-30 hrs p/w negotiable. £50 -70,000 pro rata. Closing date 18th July.
Contact: Dr Colin Philip colin.philip@stennack.cornwall.nhs.uk for job description/further info.

TXT FROM THE URBAN DOCTOR

I decided to go for a drive in my new car yesterday. It was a bright sunny day and I was full of good cheer. The car had just arrived, and I was keen to try it out. It was a new Coalition model, the Optimism - a type not seen in the UK for a long time. People criticised me saying they often broke down and the depreciation would be horrendous, but what did they know?

I was going for a long drive to a place called Healthcare Reforms. I knew how to get there because I had spent 6 long years chatting with friends about the best route to take, where to stop for breaks and how to save money on the way. I had studied the map and was sure that by evening I would be sipping Pimm's and receiving envious looks from other users as well as congratulatory slaps on the back.

So off I went, complete with picnic. This journey would not need any expensive and pointless PCTs or SHAs for power. Pah! Once this baby caught on, there would be hundreds of those dinosaurs redundant all around the country. No, I was using some eco-friendly, elbow patched GPs under the bonnet to get me to my destination. Just a couple of stops to plug the GPs into the grid at a GPCC and you could move the project forward at a tenth of the previous cost. As a matter of fact, I had plans to move all of my running costs bills across to these new GPCC power stations. If I could persuade everybody to do the same we could use the money saved to build a new motorway extension that would mean that Care Users could actually drive to Shepton Mallet instead of having to fly there.

The journey proceeded smoothly enough to begin with, but then I started hitting a few snags. I had heard on the radio that there were not going to be enough GPCC stations, and the lobby of self-interest groups had decided they felt left out and wanted to join the party. The trouble was that the replacement CCG fuel just didn't have the octanes. I couldn't believe it: barely 2 hours into my journey, and the energy level of my Coalition Optimism was getting dangerously low. I came off the road and called into one of those depressingly huge Secondary Care Stations that always seem to serve you up a 3 day admission for £2000 and you leave feeling that nothing has been sorted. While there they gave me a rollicking because I dared to wear long sleeves! Can you credit it?

Anyway £2000 and 3 days later I finally left the Secondary Care Station and had to head back home. My trip to paradise via GPCCs just did not work. So now I'm eating humble pie and trading in my Optimism Economy for the new Senate that has just been launched.

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

PASSING ON RECORDS WHEN A PATIENT LEAVES THE PRACTICE

You still must send the full record when a patient is deducted.

Please can we remind you again that when you return records to the PCT after a patient is deducted you have a contractual and medico legal obligation to send the whole of their records to be passed on to the new practice. Whilst GP2GP is developing fast as more primary care systems are able to use it, it does not yet replace the requirement to return the full record, and the present limit of 99 attachments can now be reached surprisingly easily for patients with complex medical histories stretching back over some 20 years. Please note that printing out a summary and sticking a letter in the Lloyd George envelope inviting the receiving practice to contact you if they need more information is not an acceptable solution: tedious and wasteful as it may seem, for the moment you need to send paper copies of everything when the patient leaves.

RADIOLOGY REQUESTING AT TST

Please note that if you use web requesting for imaging investigations at TST, it is important to make sure you are asking for the right thing so the patient is given the correct appointment. If what you want is not listed under "Common Orderable" examinations, the "search" button below this takes you into a full list of what can be requested, including ultrasound and some other more complex investigations. You also do need to fill in enough detail in the "Clinical History" field so that the department can confirm that the investigation is warranted: apart from the obvious cost and time involved they are under an ethical obligation to satisfy themselves that any exposure to radiation is appropriate and proportionate.

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