Somerset LMC Newsletter

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COMING APART AT THE SEAMS?

No, not you this time – the NHS.

Once upon a time, in a land that may never have existed, occasionally when patients came out of hospital it often did not matter too much that the discharge summary took a month to arrive because they would have stayed on the ward until they could care for themselves, there would be an outpatient appointment booked, and the one or two discharge medications would be solemnly handed over in a paper bag as they left, bearing with them an illegible note from the houseman.

Now, of course, acute hospitals provide acute care and once the sutures are tied or the IVI down patients are on their way – skilfully treated, but often with a lot of loose ends to be tidied up. That is no criticism of our hospital colleagues, for as the number and turnover of admissions rises inexorably year on year with patients living longer and developing more and more complex disease, there may just be no time for absolutely everything to be completed.

But it does mean that although we all talk about integrated and flexible care pathways, the reality for many patients is that each transition is sudden and jerky. Instead of the GP on call for the practice visiting a sick patient at night and talking to the house officer who admits the patient straight to a ward, we now have an out of hours service that despatches an ECP who calls an ambulance that takes the patient to the clangour of A&E and thence to the frenetic environment of MAU.

Of course, this dislocation is not intended – each contributory change has been made for very good reasons. We do not want patients in expensive hospital beds if they do not need to be there, it is obviously sensible for prescribing to be co-ordinated by the GP wherever possible, and the removal of GPs' OOH responsibility in the 2004 contract was a vital response to the frankly desperate recruitment crisis in some parts of the country. But making the NHS more technically and financially efficient risks stripping out the time for compassion, and the further that decisions are made from everyday clinical practice the greater the likelihood that this will occur.

For many years the oil that lubricated the wheels of the NHS was the goodwill of the staff – the nurse who always worked on at the end of her shift, the ward orderly who skipped her break to take a patient a cup of tea, and the A&E consultant who popped in "just to check things were alright", but, like North Sea oil, that supply may be running out. Changes in working practices, increasing regulation and the sheer intensity of the work mean we have to design a better engine rather than just chuck in lots of oil.

But as everyone gets busier and busier we all retreat into our core work – we look at the contract and not the patient. Going the extra mile is sometimes just more than one can manage, and, very slowly, gaps appear in the service; areas where nobody has a contract obligation but

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the patient has a need.

We cannot – and should not – go backwards, so we need to find another way of doing things, and that has to be clinical commissioning. This is one thing that we think Mr Lansley has got right, and if the early promise of the Somerset CCG leads to a genuinely flexible and clinically led commissioner there may be a way out.

We recently had in the county a chaotic patient with complex infectious disease who declined to stay in hospital for treatment. It rapidly became apparent in the community that nobody actually had a contract obligation to provide key elements of the necessary care. Some rapid work by public health and PCT commissioners - all of whom were clinicians – produced a patient specific treatment contract and an entirely satisfactory outcome.

So we know it can be done. And doing it right should free that little bit of time that is needed for the kind word or non-clinical smile, which makes everyone feel better.

SAFEGUARDING CHILDREN - A GOOD NEWS STORY!

A baby is well because people thought about the possibility of abuse, acted promptly and followed the local protocols

A 4 week old infant attended a routine Health Visitor clinic. The HV noticed some facial bruising for which the baby's mother did not have any explanation. The mother also volunteered the information that the baby had had some bruising the previous week. The family were known to the practice but no previous concerns had been raised about the baby or older child. The HV spoke to the GP and an urgent appointment was arranged, which was not attended. The GP informed the health visitor, who contacted the mother and made sure that the baby was brought in later the same day.

Although the bruising was very slight, the GP referred the baby urgently to paediatrics where a comprehensive assessment was carried that included a skeletal survey that revealed fractured ribs and long bones. A child protection plan was agreed, under the category of physical abuse, and the baby has been placed with foster carers.

Good Practice points:

- Recognition of bruising with appropriate referral by the Health Visitor.
- Follow up of DNA by GP and prompt action by the Health Visitor.
- Appropriate urgent paediatric referral by the GP.
- Comprehensive and well documented assessment by the Paediatric team.
- The skeletal survey was completed according to national and local protocols, enabling defence claims of rough handling by the radiographers to be easily refuted.

GREEN BAGS FOR PATIENT MEDICATION

It's worth encouraging patients to use them

Although use is still patchy, there is anecdotal evidence that encouraging patients to use a green bag to take all their medications to hospital is valuable. Whilst the repeat prescription counterfoil lists all the tablets we *think* the patient is taking, what they actually consume may be very different and it really does help the admitting hospital reconcile medication if the patient brings all of their pills in with them. It also reduces the risk that he or she will just go back to their old ones on discharge.

Somerset hospitals will in future be giving or sending a bag to patients who are being admitted electively and it is worth carrying a couple in your own bag to use when you admit a patient from home. Care homes now have a supply, and the PCT is encouraging SWAST to put them on ambulances as well.

PLEASE DO NOT SEND ROUTINELY REMOVED IUCDS FOR MICROBIOLOGICAL CULTURE

Request from Dr Mike Smith, Lead Consultant Microbiologist, Somerset Pathology

Every year Microbiology receive a small number of requests to culture Intrauterine Contraceptive Devices taken out at "routine change". There is no indication to send these devices for culture unless there are clinical indicators of pelvic inflammatory disease, or other inflammation. If PID/infection is suspected, please state this on the request. IUCDs will no longer be cultured if there is no relevant information.

CCG AUGUST REPORT

This past month has seen some important progress in the development of a functional Clinical Commissioning Group with the delegation from the PCT of the budget for Primary Care prescribing.

Although, historically we all now feel as if we own our prescribing budgets, this is a demonstrable change that has taken place in both ethos and management. Large sums of money are involved and the SCCG must grasp the opportunity to engage with primary care via federations to meet its responsibilities. Shortly further contracts are to be delegated, including the newly merged Somerset Partnership and Somerset Community Health.

At least two potential problems exist. The first, arguably is the lack of experience that the new board has in managing and policing such contracts and the finances that accompany them, although training is being provided via the NHS Institute for Innovation and Improvement. The quality of support to the board from PCT directors is excellent and there exists a high level of collaborative interaction in a non-judgmental atmosphere. Team dynamics are still being established, whilst work is being distributed, which whilst not ideal, is necessary.

The second problem I feel must be addressed is that of Federation development. These loose collections of practices have largely no formal standing or organisational status and yet are being seen as the mechanism for GP and Primary Care involvement. Financial and administrative support is essential if work is to be delivered willingly by these emerging bodies, accompanied by closer links to the board through their Federation delegates.

Ultimately it is primary care through the Federation that will make the CCG succeed, but that will only happen if the members of a Federation understand what value arises from their involvement.

WANTED! BNF EDITIONS 60 & 61 & BNF FOR CHILDREN

The Commonwealth Pharmacists Association sends them to developing countries

PharmAid is the annual re-distribution of recently outdated copies of the BNF to clinicians in over 45 Commonwealth developing countries with links to CPA. The books are collected by AAH Pharmaceuticals from community and hospital pharmacies during a specified week in November each year and the company's network of distribution points allow the books to be returned to London – at no charge to CPA.

Between 7,000-10,000 copies of the BNF are sent abroad each year which can make a real difference to the quality of therapeutic care in developing countries. If you would like to donate copies of the BNF to the Scheme please take them to any community pharmacy whose wholesale supplies come from AAH, which includes all branches of Lloyds and Co-op pharmacies. They will be collected between **7–11 November**. To make a donation to the costs of shipping the books overseas please go to Paypal. Donate on the Pharmaid page of the CPA site Link

HINTS AND TIPS ON BIOCHEMISTRY INVESTIGATIONS

Some recommendations from Dr David James

HbA1c is now only being reported as mmol/mol in line with national guidance. For a conversion chart to % see: .Link

- For routine monitoring of hypertensives and patients on ACEI/ARBs "E+C" (Electrolytes and creatinine) will suffice.
- CA 125 levels are raised during menstruation or after bimanual pelvic examination.
- Please don't forget that all the following should be marked on the request are private:
  Court & solicitor requests, drug screens for schools & employers, patient requests for testing for non-clinical reasons.
- Patients under consultant investigation for infertility should have this arranged by the relevant trust or private hospital. Somerset Pathology only provides testing for patients under TST or YDH care.

Authoritative advice on a range of tests can be found at www.bettertesting.org.uk – pin it to your desktop!

Over next few weeks, major analyser replacement at MPH is taking place in chemistry. This may cause temporary delays in turn around times of non-urgent samples.

HELPING YOUR LOCUM HELP YOU

Complaints

On the rare occasion that a patient complains after seeing a locum GP, please can practices make sure that the locum is sent a copy of the complaint and is invited to contribute to the practice response? Occasionally we hear that a locum has not been involved until well into the process, or sometimes not at all, and this is likely to be a breach of the practice complaints procedure as well as denying the locum an important source of feedback. It is also kind to pass on any compliments!

Room facilities

To work effectively your locum obviously needs access to some basic facilities and equipment, and it is surprising how often sessional doctors say this is not the case. Please try to make sure that sample containers, syringes, speculae and proctoscopes are somewhere obvious, along with some practice notepaper, envelopes and a supply of Med3 forms. A recent BNF is also handy. The LMC is considering developing a web-based "locum pack" that would cover general information and link in to PCT and CCG information on prescribing, referral documents and so on, but especially if you regularly use locums it is worth making sure that your intranet has local and practice specific information readily to hand. It is also very helpful to have a specific member of staff tasked to support the locum so he or she knows who to ring first if there is a query. As the availability of locums gets less, apart from being sensible about what you are asking the doctor to do, a few cheerful smiles and a good supply of chocolate biscuits may also help persuade sessional doctors to come back another time.

VACCINE INFORMATION SITE

Useful new service from Pfizer

Look on this site for a suite of management tools and information including:

- A text message reminder service so patients don't miss appointments.
- Childhood immunisation schedules in an easy look up format.
- Posters and other materials to publicise vaccination clinics.
- Risk profiles for vaccine-preventable diseases.
- Symptom checkers.
- Information downloads you can print out for patients & parents.

www.pfizervaccines.co.uk

"NEW MEDICINES" SERVICE FROM COMMUNITY PHARMACISTS

Evidence based support for patients starting new medications

As from 1st October the Pharmacy contract has been extended to allow pharmacists to offer patients starting medication for some specified conditions extra help to ensure concordance. If a patient presents a new prescription for COPD & asthma, diabetes, hypertension or anticoagulation the pharmacist may offer an initial consultation about the medication and how to use it, and then further follow up by phone or in person during the initial month of treatment. There is strong evidence that this improves medication usage.

Unfortunately the number of patients who will be able to have this support is fairly small, and it is up to the pharmacist to decide to whom it should be offered. However, the LMC has agreed with the LPC (Local Pharmaceutical Committee) that if the GP writes "New" next to the appropriate item that will identify the patient as one for whom the GP thinks the extra help would be valuable. Recent research suggests that many patients do not use their MDIs very well and this is one of the PCT priority areas. Anticoagulation, of course, is always risky and reinforcing advice about warfarin usage is potentially life saving.

Please make contact with your local pharmacies to discuss how the new service can work most effectively and how the practice and the pharmacy can exchange information. This is a great opportunity for closer working, which will benefit everybody. More about the New Medicines Service at: Link

PRESCRIBING GUIDANCE FOR "SPECIALS"

Although Somerset is amongst the lowest PCTs for use of Specials (unlicensed made-to-measure medications) they are still a significant cost burden. The National Prescribing Centre has recently published guidance at Link

Appendix 2, *Prescribing Specials: a quick checklist for prescribers* is very helpful. As a rule of thumb, if it is not listed in the BNF as a licensed product, your prescription may be dispensed as a Special. You can always check with Medicines Management if in doubt.

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

PARTNER OR SALARIED GP: LUSON SURGERY, WELLINGTON

Details: 6 sessions per week with the opportunity to increase to 8 sessions within 12 months.

Contact: Martin Ellacott, Practice Manager telephone 01823 662836 or martin.ellacott@luson.nhs.uk. Closing date 4th November 2011. www.lusonsurgery.co.uk

SALARIED GP: GP-LED HEALTH CENTRE, YEOVIL

Details: Opportunities for part/full/flexi GPs with future partnership opportunities in the GP consortium practices for ambitious candidates. Opening hours 8-8 Monday to Sunday.

Contact: For an informal chat ring Daniel Vincent, Practice Manager on 01935 709269. Applications by CV with a covering letter, referees and details of current salary to Daniel Vincent, Practice Manager, Yeovil Health Centre, 37 Middle Street, Yeovil BA20 1LS or by email danielvincent@nhs.net.

GPwSI ORTHOPAEDICS WANTED: OASIS CLINIC, YEOVIL

Want to add some variety to your practice? Wondering if there is medicine beyond QOF? Why no become a GPwSI in Orthopaedics.

Details: Up to 3 days a week available in ½ day sessions to join a team of 5 doctors and 3 ESPs. Training provided.

Contact: For an informal chat telephone Dr Steve Holden on 01935 470200 or email Stephen.holden@hendfordlodgemc.nhs.uk

CIVILIAN MEDICAL PRACTITIONER: 40 COMMANDO ROYAL MARINES, TAUNTON

Details: Full time position working at the Medical Centre, Norton Manor Camp, Taunton, TA2 6PF. For full details please see job vacancy reference 1191727 (from 21st Oct) at https://atsv7.wcn.co.uk/company/nghr/jobs.cgi. Closing date 25th November 2011.

PRACTICE MANAGER: VINE SURGERY, STREET

Details: Full time post for a practice manager, NHS experience not essential. Salary according to experience—circa £40K.

Contact: For enquiries and/or email applications (with covering letter and CV) to Practice Consultancy Services at recruitment@practiceservices.co.uk. Closing date 4th November, 1st interview 22nd November & 2nd interview on 2nd December www.vinesurgery.co.uk

LEAD PRACTICE NURSE: VINE SURGERY, STREET

Details: Experienced lead practice nurse required for approximately 20 hours per week to cover all aspects of practice nursing. Diabetes and respiratory disease experience desirable. Salary dependant on experience.

Contact: For further information please call Louise Marriott on 01458 841122. Letters of application with a CV to Liz Seekings, Vine Surgery, Hindhayes Lane, Street BA16 0ET or email liz.seekings@vinesurgery.nhs.uk. Closing date 28th October & interviews 8th November. www.vinesurgery.co.uk

HEALTHCARE ASSISTANT: EXMOOR MEDICAL CENTRE, DULVERTON

Details: Healthcare assistant required for 22 hours per week, experience essential.

Contact: Kathryn Kyle or Dr Andrea Trill on 01398 323333 for enquiries. Applications with CV and covering letter to Kathryn Kyle, Practice Manager, Exmoor Medical Centre, Oldberry House, Fishers Mead, Dulverton TA22 9EN. Closing date 21st October 2011.

SAVES GRAND DINNER AND FUNDRAISING AUCTION

Raising funds for this charity that equips medical emergency responders working in support of the ambulance service

This event will now be held at Somerset County Cricket Club at 7.30pm on Friday 18th November 2011. Music from "Ultrasound" the remarkably good band made up of Musgrove clinicians, and lots of good auction items. Tickets £30 from www.saves.org.uk or call Jackie on 07886630388.

Dr Whimsy's Casebook

Dr Whimsy is always keen to demonstrate his telephone triage technique. The following conversation is adapted from a real case in the days of the local out-of-hours co-operative, when GPs on the evening shift particularly cherished the calls that came in at 9:57 pm. This is the low-carbon model, obviating prescription costs, consultation time and travel.

Dr W: [weary after a 15 hour working day] Hello, is that Stacey Thugg? This is Dr Whimsy returning your call. What's the problem?

Ms T: [sounding quite jolly] Yes, I'd like a visit, please. [long pause] Hello?

Dr W: [looks at clock] Yes, I'm here. I was waiting for you to tell me why you want a visit.

Ms T: Oh, my ear hurts.

Dr W: Your... ear... hurts.

Ms T: Yes.

Dr W: And how long has this been going on for?

Ms T: All day.

Dr W: The... whole... day... long.

Ms T: Are you taking the Mick?

Dr W: No, just typing it in. Did you call your own doctor?

Ms T: No. I thought it would get better, but it's got worse and now I'm in absolutely 'scruciating agony.

Dr W: Just let me get this down... agony... excruciating... and... absolute. Is that completely absolute?

Ms T: Yes.

Dr W: As in the most total pain you can possibly imagine and still be alive, sort of 18 out of 10?

Ms T: That's right. Terrible.

Dr W: ... terrible... Is your hearing O.K.?

Ms T: Yes.

Dr W: Is there any discharge?

Ms T: No.

Dr W: Have you taken a painkiller?

Ms T: No, I haven't got any.

Dr W: Do you think you could borrow some?

Ms T: I don't know anyone who's got any. Anyway, I'm getting really worried and I need to see a doctor.

Dr W: Well, it sounds like some inflammation of the ear canal. I probably wouldn't be able to do much about it tonight, but if you could take some painkillers they would keep you going until you see your own doctor in the morning.

Ms T: I want to see a doctor now.

Dr W: Very well, but you'll need to come to the GP Centre and we'll see you here.

Ms T: No, I want a doctor to come out here.

Dr W: I'm afraid we can't make house calls for things like earache which don't make you housebound.

Ms T: Well, I've got no way of coming to the hospital.

Dr W: No car?

Ms T: It doesn't work.

Dr W: Can you get a lift or a taxi?

Ms T: We don't know nobody with a car and we can't afford a taxi.

Dr W: You don't know anybody with a car. There is absolutely nobody you know who has a car.

Ms T: That's right, nobody. Anyway, I've paid my taxes since I was sixteen, and I've earned a visit. You visit all those other people who don't pay taxes, so I think I should have a visit too.

Dr W: We visit anyone who is unable to travel because of their illness, but—

Ms T: I can't travel.

Dr W: But that's not because of your illness. I suggest you call a taxi.

Ms T: I can't afford one 'cos I'm still on the dole.

Dr W: I see. On… dole… pays… taxes. Now, Mrs Thugg—

Ms T: Miss, if you don't mind.

Dr W: Sorry, I should have guessed. Mzz Thugg, I'm afraid I really can't justify sending our mobile doctor on a home visit for this, but I'm sure that if you take—

Ms T: That's bloody typical. My feller had a stroke last week because his doctor refused to come out. He had to go to hospital.

Dr W: I'm sorry to hear that. How is he now?

Ms T: He's wallpapering the bedroom.

Dr W: I'm glad he's got over his stroke, but I don't think you're having a stroke.

Ms T: How do you know if you won't come and look?

Dr W: Well, you're rather young, and—

Ms T: My feller's younger than me and he's had a stroke. He wouldn't've had a stroke if his doctor had come out.

Dr W: I think we should talk about you rather than your partner. It just doesn't sound like a stroke.

Ms T: So what would sound like a stroke?

Dr W: Well, collapse, slurred speech, weakn—

Ms T: I've collapshed.

Dr W: What, just now, when I said the word "collapse"?

Ms T: Yesh, my legsh have gone weak and I'm completely collapshed.

Dr W: I don't think you're being entirely straight with me, Miss Thugg.

Ms T: How do you know if you won't come and see me?

Dr W: Well, you don't sound collapsed, nor in absolute agony for that matter.

Ms T: Are you calling me a liar?

Dr W: Well, not in those words. I would like to help and we'd be glad to see you down here, but I don't think you need a visit and I expect some painki—

Ms T: So you're not going to come out, then. What's your name again?

Dr W: I'm Dr Whimsy, but I really don't think—

Ms T: You're refusing to come out and you're going to leave me to have a stroke just like my feller when his doctor wouldn't come out.

Dr W: I don't think it—

Ms T: Well, **** off then, "doctor". [hangs up]

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

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