# Somerset LMC Newsletter

**January 2012**

**Issue 172**

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## RISK AND REGULATION

High in the Italian Dolomites at the turn of the year there was a New Year celebration that included a night time display on one of the pistes leading into the village. A platoon of Alpini skied down the mountain and through a flaming hoop carrying flares in the colours of the Italian flag, followed by the local Carabinieri and ski school instructors with flaming torches. They all lined up along the piste in front of the crowd, patiently assembled behind a piece of string, leaving a space about 20 metres wide. Out of the night sky appeared a group of paragliders who spiralled down to land in the gap, followed by two hang gliders with flares hanging beneath them, which swooped low over the town before dropping their flares, and, with some slightly frantic last minute steering adjustments, landing perfectly in the middle of the piste to much applause.

For a native of this country where one cannot even get insurance to have a bouncy castle at the church fete this was a remarkable sight, and had the gliders missed and ploughed into the crowd in a catastrophe of burning nylon we would all now be shaking our heads at Italian recklessness. But the point is that they didn't. The lead aircraft was flown by a four times world champion pilot, who was trusted to make a professional judgement about the safety of the display.

We have commented before about the consequences of over-regulation and the huge cost burden that this brings. Unfortunately, there is little evidence of change for the better. Regulation of practices and GP groups by the PCT is to be replaced by the three regulators, Monitor, CQC and the National Commissioning Board, and already our own professional regulator, the GMC, is itself overseen by the Council for the Healthcare Regulatory Excellence.

Apart from the expense and inherent inefficiency of such a system, the opportunity cost is huge. Time spend completing the paperwork and ticking boxes is not spent on more productive work, and as the demands on practices rises it cannot be afforded. Our back page column touches on a difference between British and French general practice, where primary care clinicians often work on their own. This is barely acceptable in the UK now, but French healthcare consistently scores amongst the best in the world, so they must be doing something right.

But if external regulation is costly and of dubious effectiveness, what is the alternative? Given that GPs will increasingly be looking at the details of their clinical work in both practices and localities, performance review within federations will become inevitable. This does not need to be threatening, and so long as we are able to recognise and accept differences, offer positive and useful support for colleagues who are struggling, and supply targeted education and training wherever it is needed then difficulties and problems should be detected early and the risks to patients reduced.

Meanwhile, those charged with setting up the structures of the new NHS need to do so with one question always at the front of their minds, and that is: "How will this post or function *directly* improve the health of patients?" If they have to struggle for an answer, that is a job that we should not be trying to fill in these austere times.

We accept that in the modern world patients rightly expect a safe and efficient service, but there is no such thing as perfect safety. Co-operative self regulation is not a licence for recklessness, but it encourages us all to be aware of the risks we have to take in day to day practice and ensure that these are understood by both clinicians and patients.

## COMMUNITY DIETETIC SERVICE REFERRALS PATHWAY

*Move to an opt-in arrangement for appointments proposed*

Most practices currently make the appointments for clinics run by their attached community dietitian. CHS aims to see 95% of dietetic referrals within 8 weeks and currently they achieve around 87%. DNA rates between practices are very variable, from 0-25%, and it is these that are preventing the service reaching its target.

CHS are therefore proposing that patients should "opt-in" to an appointment. At the time of referral the patient is given a letter inviting them to make an appointment themselves – it is not done by the clinician. The referral process will therefore be:

1. Clinician discusses and agrees need for dietetic advice with the patient.
2. Clinician makes the appropriate clinical note or generates a referral letter according to preference.
3. Clinician prints off from Pathway Navigator an information leaflet with a food diary and also the "opt-in" letter for patient to book their own appointment. (Some practices prefer to post letters later, but that is at their own expense).

Although technically all that is required of the GP is to make the referral and that responsibility for arranging appointments rests with CHS as the provider, the dispersed nature of the service and the small numbers involved make it difficult for them to do so.

The LMC recommends that practices use this pathway, unless there are particular local difficulties that mean they prefer not to.

Please note that requests for domiciliary visits should be sent to the service, fax to 01278 431384 or post to Somerset Community Dieticians, East Quay Medical Centre, Bridgwater, TA6 4GP.

## CHANGES TO ANTIMICROBIAL SUSCEPTIBILITY TESTING AT TST & YDH

From Monday 16th January 2012 The Microbiology laboratory will be changing the method used for antimicrobial susceptibility testing to the "EUCAST" methodology, (European Committee on Antimicrobial Susceptibility Testing). Which accredited laboratories within the UK are adopting. Mostly you will not notice any difference to reports, except they will no longer report **clarithromycin** for *Haemophilus influenzae*, as there is no "interpretive guideline" for this antibiotic.

**From Monday 20th February 2012** they will no longer be performing a direct antibiotic susceptibility test on urine which is "positive" by microscopy. It will still be cultured (overnight). The next day, any "significant growth" will have antibiotic susceptibility tests performed. This will increase the turnaround time to 48 hr for all urines that **do** have a significant growth of an organism. At present a large proportion of direct susceptibility tests have to be repeated, so the turnaround time is already 24–48 hr. In addition performing susceptibility tests from an isolate, rather than the urine, will give a more reliable result. Any urine that is "negative" by automated microscopy will still be reported the same day. Any microscopy-positive urine that is cultured, but does not have a significant growth will still be reported within 24 hr.

## ZING SOMERSET

*A new website designed to encourage people of all ages to get and stay physically active*.

It will both allow people to record their activity minutes at a low, medium or high intensity and also allows people to browse what is on offer in Somerset through leisure centres, sports clubs and one off events and, we hope, motivate them to try new activities.

Zing is very simple to register on and use. It will send messages and reminders to all its members to either 'keep up the good work' or 'to get going again' and to help motivate members to set some short term goals, Zing will have a number of challenges for people to sign up to and record their minutes towards. These challenges might be to train and run a Sport Relief mile, to try out an activity they haven't logged before, or to introduce a friend to physical activity and Zing. It will also have a number of video clips of the sports and challenges available to increase confidence and motivation to try something new regardless of age or fitness.

Recording of weight loss targets for individuals will be introduced in the summer 2012, an application for smartphones is also planned for 2012/13.

Zing is commissioned by NHS Somerset to the Somerset Activity and Sports Partnership. However it will not display NHS logos or any advertising. Zing Somerset is due to launch on 4th February 2012 in the Taunton area. Public Health plan to use the data from Zing to find out if this approach does increase physical activity.

See www.zingsomerset.co.uk

## ABDOMINAL AORTIC ANEURYSM SCREENING PROGRAMME

*A quiet success story*

Uptake amongst 65 years olds invited for screening across the county remains good, and nearly all patients can be screened at their own practice or nearby. As of December the top five for coverage are as follows and detection rates continue to be close to the expected numbers

1. HMP Shepton Mallet – (unsurprisingly!) - 100%
2. Quantock Vale Surgery, Bishops Lydeard - 89%
3. Church Street Surgery, Martock - 88%
4. Vine Surgery, Street – 87 %
5. Joint place Williton & Watchet and College Way, Taunton – 86%

For more information on the programme see link.

Men over 65 can request a screening examination by contacting the service direct on 01823 344567.

## HEALTH COMMUNITY WORK ON STOPPING SMOKING

*Don't forget to offer stop smoking help when referring for surgery*

Public Health has been leading a series of projects to continue to help and encourage people not to smoke. In December the Musgrove Park site became completely smoke free. Highly visible signs have been installed throughout the site, so no one can be in any doubt that smoking is not allowed anywhere in the grounds, and also providing a text number to call for support. This is part of a wider programme to include smoking cessation in care pathways and to support staff to quit, which in turn will provide health and productivity benefits by eliminating smoking breaks for staff, reducing staff sickness and post-surgery complications, improving wound healing, and reducing post -operative length of stay. It should also encourage many more smokers into stop smoking services in primary care and the wider community. The other Trusts in the region are all working on similar plans.

GPs are asked to warn smokers who are being referred for a condition that may require admission that no smoking at all is allowed on the MPH site, and to use this as an encouragement for them to accept stop smoking help. For those who still do not wish to quit, you may wish to offer NRT for control of withdrawal symptoms during the hospital stay. Recent evidence suggests that intended temporary abstinence may go on to produce a successful quit attempt.

## LMC AWARDS FOR 2011

*Stiff competition for the most helpful organisation of the year*

Thank you to all our readers who have submitted nominations for the person or organisation that has done most in the course of the year to make GPs' professional lives easier. Last year the clear winner was Somerset Primary Link for taking so much of the hassle out of arranging admissions – we can all remember hanging on the phone for ages waiting to speak to the admitting doctor or the ambulance service until they took on those responsibilities.

This year we had three nominees battling it out for top spot. The **Imaging Department at Musgrove Park** was mentioned for the ease of access to senior medical advice and their willingness to suggest and then arrange appropriate investigations and also for the dramatic improvement in reporting times, with reports sometimes available on PACS on the same day that the patient attends for their X-Ray. The new **Reablement Service** in Taunton has only been going a few months but has been a breath of fresh air with team members from health and social care working together to support patients with complex needs in the community in co-operative and innovative ways, marked by a willingness to take on a problem and then work out how to solve it, rather than the other way round.

But the winners for 2011 are the **Community Mental Health Crisis Teams** across the county for seeing patients with acute mental distress promptly and willingly, even on Friday afternoons! Few things stress a GP more than trying to risk assess a potentially suicidal patient in the middle of a busy duty day, so being able to hand over this task is much appreciated.

Thanks to all of them and a modest gift will be on its way to the four locality Crisis Teams shortly.

## MEDICAL EXAMINATIONS IN EARLY PREGNANCY

*Should be offered to women at higher risk of having undiagnosed illness*

One consequence of the increasing professional autonomy of midwives and the progressive exclusion of GPs from maternity care is that the traditional medical examination of women in early pregnancy has largely disappeared. As women can arrange all their maternity care with the midwifery service and, in theory at least, the GP practice may know nothing about the pregnancy at all, it is also possible that even if a potential problem is known about, that information never gets passed on

Although these examinations rarely picked up anything, occasionally an unexpected heart murmur or other problem came to light, and now that routine physical checks for preschool children have also disappeared there is a cohort of young women growing towards childbearing age who may not have had their hearts listened to since infancy.

At the same time, a significant number of women presenting for pregnancy care are from outside the UK, and we know that the incidence of significant cardiac and respiratory problems is greater for those who come from developing countries.

If you have signed up to provide the Maternity medical services additional service under the GMS contract (or a PMS agreement), then the practice should (Clause 79.1) *"provide to female patients who have been diagnosed as pregnant all necessary maternity medical services throughout the antenatal period".* There is no definition of "necessary services" but if the consensus of expert opinion is that this includes an examination of the heart and lungs for women for whom this would be appropriate, which includes those who are migrants.

To try and improve communication between practices and the midwifery service the Somerset Medical Services Liaison Committee has agreed a communication form that allows you quickly to pass on any key information to your community midwife. We hope that this will shortly be available on the new Pathway Navigator and that both GPs and midwives will find it helpful.

## SMALL ADS ..... SMALL ADS.....

### GP PARTNER: ESSEX HOUSE MEDICAL CENTRE, CHARD

**Details:** Partner required for 4/5 sessions per week. Starting April 2012 but prepared to wait for the right candidate.

**Contact:** Enquiries to April Jefferson at April.Jefferson@essexhouse.nhs.uk or telephone 01460 260220. Formal applications with CV and covering letter to April Jefferson Essex House Medical Centre 59 Fore St Chard, Somerset, TA20 1QA.
www.essexhousemedicalcentre.co.uk.

### PARTNER: SOMERTON SURGERY

**Details:** Opportunity for a salaried GP wishing to move to full partnership following a period of mutual assessment.

**Contact**: Len Chapman for applications or informal chat on 01935 470816 or email len.chapman@pennhillsurgery.nhs.uk.
www.somertonsurgery.nhs.uk

### SALARIED GP WITH GYNAECOLOGY EXPERIENCE: THE PARK MEDICAL PRACTICE, SHEPTON MALLET

**Details:** 4 sessions/week. Further details at www.theparkmedicalpractice.co.uk.

**Contact:** Tracey Nicholls, Deputy Practice Manager at tracey.nicholls@parkmedicalpractice.nhs.uk or Dr Louise Abson at louise.abson@parkmedicalpractice.nhs.uk or telephone 01749 334383 for informal enquiries. Please forward CV by post or email to Tracey Nicholls. Closing date 15th February 2012 with interviews to be held end February/early March.

### PRACTICE NURSE: THE PARK MEDICAL PRACTICE, SHEPTON MALLET

**Details:** Part time position, 20 hours per week (plus additional holiday/sickness cover).

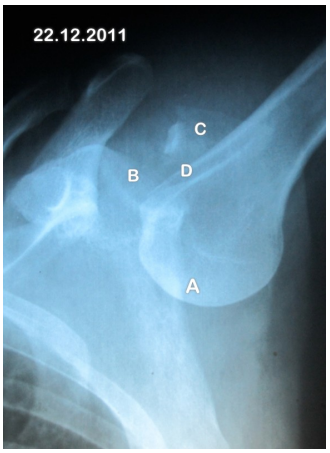
**Contact:** Tracey Nicholl for a job description and application form at tracey.nicholls@parkmedicalpractice.nhs.uk or telephone 01749 334383. Closing date 31st January 2012.
www.theparkmedicalpractice.co.uk

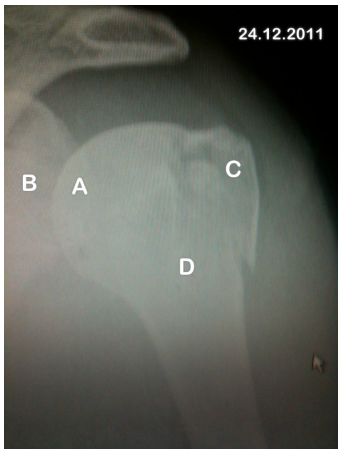
**QUASIMODO: A CAUTIONARY CHRISTMAS TALE OF CATASTROPHE, CROISSANTS AND CLINICAL COMMISSIONING**

***"I'm off to test the early Alpine snow and the French orthopaedic pathways."***

So ended my Federation Chairman's premonitory Christmas message to the troops. Seven days later, after a spectacular, but ultimately doomed high speed cartwheel, my left shoulder hit a French Alp, and I found myself on my back in the snow, in a state of "Luxatio Erecta Humeri". It's not nearly as much fun as it sounds. Somewhat dazed, I was aware of my left arm stretched up alongside my head with the elbow flexed. Any attempt to move it by well-intentioned ski-Samaritans resulted in a stream of Anglo-Saxon invective, the gist of which appeared to be universally understood. My shoulder had dislocated inferiorly.

Here's the crouton of CME floating in the potage of self-pity: the vast majority of shoulder dislocations (95%) are anterior, 4% are posterior, and only 0.5-1% are inferior.




Above are two of the pictures from my personalised advent calendar for this year. (For the benefit of non-medics and London graduates, A normally sits snugly against B, and the floaty lump C is more traditionally found attached to D.)

Partly due to their rarity, but also because often bizarre accidents are implicated in the "hyperabduction-with-knobs-on" needed to propel the humeral head through the inferior capsule, individual cases have been written up, and tend to have the ring of contenders for The Darwin Awards. Chinese authors detailed a case where the patient was jettisoned over his handlebars, having carelessly poked an umbrella through the front wheel of his bicycle. Another paper from the alarmingly named General Hospital of Drama in Greece cites two cases of falls from height with the arms abducted. An Indian paper describes a walnut farmer desperately clinging onto a branch as he fell out a tree whilst harvesting his nuts. To achieve the same injury somersaulting down a mountain with planks on your feet starts to feel a little more acceptable. Inferior dislocations are associated with a greater incidence of complications than other varieties, and these can be serious. 80% are associated with various fractures (in my case the greater tuberosity of the humerus) or rotator cuff rupture, and 60% with neurovascular complications - my thumb and index finger are still numb three weeks later. An additional, but thankfully rare complication here was that a small French boy had managed to evade the crossed skis and other warnings, skied into my prone figure, and my daughters were busy trying to extricate his skis from under my back.

As I lay motionless staring up into a cloudless sky, I could sense that my clinical outcome was "suboptimal", and what I really needed was an orthopaedic pathway to plug myself into. My

colleagues pointed out that we were actually in the Haute Savoie CCG region, and perhaps we should check out their locally commissioned services. After all, Anglo-French relations are going so well at the moment. Cameron and Sarkozy are bosom pals, Lady Ashton is wowing them in the European parliament and as a proud sea-faring nation, we have seen fit to rely on French aircraft carriers for the foreseeable future. What could possibly go wrong? What follows is a breakdown of the recovery and treatment process. If it sounds like a MasterCard advert, well- I suppose it is:

1. **Mountain Rescue by skidoo:** The accident happened 150 metres from the bottom of the piste, where an ambulance could pick me up. 4 highly-trained (and toned) French first-responders packaged me into the sled, whilst Caroline was more than happy to provide full details of our apartment address to all 4 of them. The fare for 150 metres? **€350**
2. **Ambulance Transfer to Allemont:** The ambulance appeared to double as the boulangerie van (having "pain" written on the side was particularly apposite). I was accompanied in the back, still very much luxatio erecta humeri, by a female technician well equipped with studs and shrugs but alas, no analgesics. The bill for 6 miles lurching down the mountain amongst the croissant crumbs? **€250**
3. **Doctor/Clinic Services:** Despite it being Thursday lunchtime, the clinic was locked and deserted. We waited for the kindly Dr Thoret ("GP omnipraticien") to arrive and let us in. No receptionists, practice managers, nurses, health visitors, midwives, secretaries, admin assistants, audit clerks, patient participation groups, cleaners, or indeed other patients, in evidence anywhere (how do they cope?). I was laid on a kitchen table whilst he took and developed several X-rays himself. Eventually, some 90 minutes after the accident, by which time it was beginning to smart a bit, I was given some serious opiates and diazepam. After 3 unsuccessful tugs, he elected to phone a friend in Grenoble - to where transfer was to be the next step on the pathway. The advice and guidance he received from his orthopod colleague presumably went something along the lines of: *"Pah! Tirez PLUS fort!",* as the next, heftier heave produced the required and welcome "clunk". My recollection of this final tractive episode, clouded as it was through a haze of Class A drugs, is of my wife on one side, hanging on to my chest, whilst my new best friend, Jean-Yves, hauled on my opposite arm with his foot intimately deep in my axilla, as if we were involved in some bizarre Gallic love triangle. This fuzzy memory may yet lead me to give counselling a go at some stage in the future, but for now I'm coping with it. The good doctor also thoughtfully provided me with a letter for those nice people at Sleazyjet to say that I was fit to fly, and had as much right to be treated like cattle as anybody else booked to fly into Gatwick on Christmas Eve. The bill for Dr Thoret's expert services? **€84.19**
4. **Drugs and Appliances:** Fizzy co-codamol **€5.44,** orthopaedic gilet **€99**
5. **Christmas at home trussed up like a turkey: Priceless.**

It has become clear to me over the past few weeks that we have a significant gap in our local services here in Somerset, and that we should put in a commissioning proposal to the CCG to provide an equivalent service for the Quantocks in case we get another harsh winter. Just off the top of my head, how about something like Quantock Snow Injury Medical Officers Delivering Orthopaedics - *QUASIMODO*?
But at the above rates, and because I thought of it, I get to drive the skidoo.

**Nick Bray, Chair BBHF**

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



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