Somerset LMC Newsletter

August 2012

Issue 176

Inside this issue:

INFLUENCING PATIENT EXPECTATIONS : ACCESS

It is still surprising when someone within the NHS gets cross because patients are "not using services properly": folk have the effrontery to go to A&E rather than call the out of hours service if their GP practice is closed, or walk past several community pharmacies to go to a GP practice to get an emergency prescription because they have left their pills behind on the kitchen table when going on holiday. Yet it is easy to forget after a few years inside the system how complex and daunting it can be to get help. The current menu of options open to patients may include contacting any of NHS Direct by phone or online, a GP surgery, out of hours GP services, a walk in centre, A&E or a minor injury unit , a pharmacy, a dentist or an optometrist, a 999 ambulance or even their open access to the outpatient departments. Add in Turning Point, the hospice, the district nurse, the health visitor, you can suddenly see why a young mum with her feverish child at 6pm might just go to the "wrong place"

We can make every effort to direct patients to the right service for their needs. We can provide information to them on the best way to access the most suitable professional help, but we must also accept that patients will make their own way into the service and design access arrangements accordingly, the so called "no wrong door" policy.

But that in turn means we must ensure that once contact with the service is made, patients are quickly allocated to the right pathway. The ambulance service already has protocols that seek to ensure patients with urgent problems are taken promptly to hospital, so if a patient with a long-term condition takes themselves to A&E there should be a simple and safe system for them to be directed back to their GP or the relevant specialist community service. Of course, all this requires considerable intelligence within the system and a sensible balance between safety and practicality. We await with interest the arrival of the 111 service in the Southwest as this has the laudable aim of triaging patients into the most appropriate care first time round. Anecdotal evidence from places where it is in use suggests a modest effect on primary care (that can probably be reduced further if practices set up phone triaging of 111 appointment requests) but a more worrying impact on ambulance activity and A&E attendances.

If the system is designed to offer broadly open access with filtering and triage as the next step, this means the number of patient contacts is likely to grow at all levels. With the need to keep tight control on costs we will have to hold as many patients as we can at the lowest level of safe care - ideally, of course, that is self care – only taking them up a level for the shortest possible time and wherever possible as a planned move. So, for example, if telemedicine lives up to its promise, more patients with long term conditions will be able to look after themselves, supported by planned attendances at their GP practice or chronic disease service.

At the more intense end of the spectrum, patients needing emergency secondary care should increasingly be attending an assessment unit for diagnosis and a treatment plan before being discharged home rather than

being admitted. A lot of changes are occurring in secondary care "under the bonnet" that we GPs don't get to see. These include rapid access scans, MAU consultant clinics, same-day invasive diagnostics, and outreach treatment initiation protocols with. This will be a big change for some patients, and especially some relatives, who pack a holiday suitcase for their hospital rest only to be told they are going home the same day. It is the therefore important that we manage these expectations at the point where we are sending them into hospital.

We all know what it is like when a patient is comes to see the GP expecting to get antibiotics a their sore throat. Please spare a thought for our secondary care colleagues who have patients coming to them anticipating a week in a hospital bed, when the intention is to give them an MRI scan and send them straight home again.

POINT OF CARE TESTING

Have you got your quality controls right?

As the technology improves and more work is shifted out of hospitals, it is increasingly tempting to start using portable equipment in the surgery to undertake a range of tests. We've been using glucometers for years, nearly all practices now use Coaguchek machines, and the roll out of NHS Health checks mean many are measuring cholesterol as a "near patient test". And there are a lot more tests we might adopt that could speed diagnosis and improve care - for example, D -dimer measurements for suspected DVT.

As the test processes are made very simple, it is easy to forget how complex and sensitive the underlying chemistry may be, so although the manufacturers of machines and reagents try to make them self checking as far as they can, there is still a need for quality control, not least because the manufacturer has no idea about the environment you keep the equipment in, or the training and skill of the operator.

Equipment should be stored and operated according to the instructions (and before you say that of course you do that, are you sure you know the operating temperature range of that device, and are you confident that it is *always* operated within it?) and the results that it gives need to be validated. This is a two part process. Internal Quality Control means checking the device calibration using standard samples with known acceptable limits, and run at least daily when the device is to be used, whilst External Quality Assurance means testing material provided by an independent third party and meeting an acceptable standard of accuracy in comparison to other users. Sending periodic parallel samples for testing by the local NHS laboratory is a form of EQA, but not sufficient in itself as the sampling procedure, handling and processing may all be very different. Venous glucose results will, for example, usually be lower than capillary ones.

All equipment, including pocket glucometers, should be subject to Quality Control processes, which includes specifying the required device performance before purchase/commissioning and ensuring quality control is embedded in all contracts. With some devices, low accuracy may be required, e.g. when an on-call GP is using a glucometer to determine if a patient's blood glucose is very low or very high, but with other devices an accurate result is very important, and none more so than the INR when determining warfarin dose.

It is easy to be awed by the sophistication and apparent accuracy of POCT machines, and to assume that the results are invariably correct. But through human error, biological variables, confounding factors and technical problems things can go very wrong. If the result is unexpected, be prepared to check it with some other method. As your editor once discovered, capillary blood glucose should not be tested immediately after eating a doughnut….unless the patient washes her hands!

[Suggested reading; Management and Use of IVD Point of Care Test Devices MDA DB2002 (03), and Management and Use of IVD Point of Care Test Devices DB2010(02) which give guidance on operation and responsibilities with regard to commissioning and operation of Point of Care Devices]

EQUIPMENT TESTING

Medical Electronics at TST offer a very good and moderately priced arrangement to service and recalibrate your clinical equipment. For information contact Paul Derrick on 01823 342486 or medical.electronics@tst.nhs.uk

OCCUPATIONAL HEALTH ADVICE FOR GPS

New Pathway agreed

Since the winding up of the consultant led service at TST for Occupational Health in Somerset, whenever a GP has needed to obtain OH advice for him or herself this has been arranged informally by the PCT or the LMC directly with Somerset Partnership, who are now responsible for OH services to primary care. As they do not directly employ any specialist occupational health physicians, provision of this expert resource is contracted out. The contract for this is currently held by Serco, who provide OH services for a number of NHS Trusts and other organisations across the South West.

Because of the nature of the contract, and the fact that there are now two extra tiers in the system, we have had to replace the old self-referral arrangement with a specific pathway for GPs who wish to obtain personal OH advice. Full details can be found at www.somersetlmc.co.uk (hot topics)

In brief, the GP patient can contact either their own GP or a SuCceSS advocate. An online referral form is then completed and sent with an email consent slip to a secure mailbox at Somerset Partnership. From there it will be passed to the OH provider within 2 working days for assessment by the OH specialist doctor who will normally arrange an appointment, but may suggest an alternative route or ask for more information.

After the appointment a report is sent within 14 days to the GP patient and such other people as he or she has asked to be included on the consent slip.

Although it may seem a little complicated, we have now trialled the pathway and the LMC is happy that it is secure, and that the OH advice obtained is of a high quality.

A PLAGUE OF MACROCYTOSIS?

More likely a change in equipment calibration

MCV is one of the most variable tests that GPs order, and many patients with a high value will have no pathological cause found - though do remember that it can the very first sign of myelodysplasia.

In recent months the proportion of results reported to primary care with a raised MCV has risen, and following queries from several practices Somerset Pathology looked at all their internal and external quality control results which revealed no problems. However, there did seem to be an upwards shift in values. Discussions with the equipment manufacturer suggested that the shift is related to the introduction of a new calibrator, and after a review of the new distribution of results produced, the lab will be adjusting the reference interval quoted to match the 2.5th and 95th centile of the truncated distribution, which equates to a reference interval of 82-104 fL. Put simply, 95% of results from "a normal population" will be less than 104 fL.

For more information contact david.james@tst.nhs.uk or simon.davies@tst.nhs.uk.

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

GP PARTNER Victoria Gate Surgery Taunton

Details: Full time partner to work 8 sessions over 4 days (flexible)

Contact: Mrs Linda Willis, Practice Manager, Victoria Gate Surgery, East Reach, Taunton, TA1 3EX, telephone 01823 275656 or e-mail Linda.Willis@victoriagate.nhs.uk

Closing Date: Friday 14 September 2012

GP Part Time Partner: Ryalls Park Surgery Yeovil

Details: Part time partner to work minimum 6 sessions per week

Contact: Rowena Turner Practice Manager 01935 446812 or e mail Rowena.turner@ryallsparkmc.nhs.uk

Closing Date: 31st August 2012

Salaried GP up to 8 sessions The locality Health Centre Weston Super Mare

Details: 2 salaried GPs required, one to cover maternity leave.

Contact: for informal discussion please contact Shirley Smith (Practice Manager)

0345 350 3973

Shirley.smith@gp-L81670.nhs.uk

DR WHIMSY'S CASEBOOK: QUALITY CARE

Dr W: Come and heave yourself into this chair Mrs Bottlenose. I'm sorry to have kept you waiting.

Mrs B: That's all right doctor, I know how busy you are in these emergency surgeries.

Dr W: What's the problem?

Mrs B: My cystitis has come back.

Dr W: I'm sorry to hear that. What sort of symptoms are you getting?

Mrs B: What do you think? It stings when I pass water. I can't explain it. I'm very hygienic and my husband doesn't do you-know-what to me any more.

Dr W: I'm surprised to hear that. Anyway, how long has it been going on for?

Mrs B: Forty-two years.

Dr W: Right. And what's made you come about it now?

Mrs B: I'm not bothered about that, I've come about the cystitis.

Dr W: OK, how long has the cystitis been going on?

Mrs B: Three weeks. I've also come about my back: it's been playing up again for months and the painkillers my own doctor gave me aren't working but if I take the stronger ones I get constipated so she told me to mix them with parametasol but that doesn't seem to work either and those iburofins don't do a thing but at least they don't upset my stomach like she warned me but that may be because I'm taking the ompromazon although...

Dr W: Sorry to interrupt, Mrs Bottlenose, but did you bring a specimen by any chance?

Mrs B: *[rummages in Tesco bag]* I knew you'd ask me for one, doctor. Here you are.

Dr W: Ah, thank you. That's a big jar, isn't it?

Mrs B: I rinsed the onions out first.

Dr W: Very wise... **WOW!**

Mrs B: What's the matter, doctor?

Dr W: My fault, I shouldn't have been standing over it when I took the lid off.

Mrs B: Are you all right, doctor?

Dr W: I'll be fine when I've had some air, thank you. When did you produce this sample, by the way?

Mrs B: Six o'clock.

Dr W: Oh, just now?

Mrs B: No, in the morning.

Dr W: Ah, this morning.

Mrs B: No, Monday morning. I know you like an Early Monday Specimen.

Dr W: A small misunderstanding I think, but it explains why the stick's buckled. We'd better have a fresh sample - would you mind?

Mrs B: Well, what about my back? I've been to the chiropath and he gave me some acutincture but I don't think it works and he charges me £25 a session so do you think I should keep going there after all this has been going on for years but nothing seems to work and I...

Dr W: Let's sort out your cystitis first. Would you mind popping to the loo with this pot and getting a fresh specimen?

Mrs B: Oh, very well, but I wish somebody would do something about my back.

10 minutes later urinalysis indicates a UTI and a prescription for nitrofurantoin is handed to the patient.

Dr W: There you go, Mrs Bottlenose, take one of these four times a day and that should sort out your cystitis. If it doesn't seem to be getting better...

Mrs B: What are you going to do about my back, doctor? I think I should have another X-ray and go and see Mr Foster.

Dr W: Well, I think something going on that long should really be dealt with by your own doctor rather than at an urgent appointment with a doctor who doesn't know you. Let me...

Mrs B: But you know me from when I came to you with my rash in 1987.

Dr W: Well, that's not quite the same thing. Let me try to help with the painkillers to keep you going until you can see your own doctor. Now, since you're taking the omeprazole I thought we could try some naproxen, which might work better than the ibuprofen. Here's a prescription, and you can...

Mrs B: Won't that make my stomach bleed?

Dr W: Your omeprazole should protect your stomach.

Mrs B: But I still get indigestion even with twice the usual dose of ompromazon.

Dr W: *[tears up prescription and sinks further into chair]* Oh. Have you told your doctor that?

Mrs B: I've got an appointment next week and I was going to tell her then. But perhaps you can help me with it doctor you see this has been going on for some while now and...

This column is written for humour and does not necessarily reflect the views of the author, his or her practice, or the LMC

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: http://www.somersetlmc.co.uk