SOMERSET LMC NEWSLETTER

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Issue 178

Inside this issue:

We wish all our readers a very Merry Christmas and a Happy New Year

The LMC office will be closed from Friday 21st December and will re open on Wednesday 2nd January 2013

GOLF BALLS AND THE FUTURE OF GENERAL PRACTICE

As a grim wet autumn turns into a cold and bleak winter, it is easy to draw a parallel between the state of the weather and the state of the NHS. It is hard to find much Christmas cheer about, and even the most optimistic observers are struggling to find positive things to say about the immediate future. We are all well aware that the country has been living beyond its means and that a period of austerity is inevitable, and also that this will be prolonged by the slowdown in the global economy. What galls is the mismatch between the self-evident need for financial restraint and the political presumption that the NHS can deliver more for less whilst public demand and expectations are stoked ever higher. The GMS contract imposition which was dropped like a bombshell into the annual round of negotiation between the GPC and NHS Employers has Treasury fingerprints all over it and represents an astonishing misjudgement by the Government, the long term costs of which will far outweigh the short term financial savings.

General practice will respond to this challenge, as it has to all the others over the years, but the consequence will be an irrevocable change in the profession, particularly the way in which GPs relate to their patients. For many years maintaining a personal list and a family doctor relationship with the patients on that list has become ever harder if the GP was also going to do all the other things now required. By the time your editor left practice earlier in the year, he and his job sharing partner/wife were working a total of some 80 hours a week looking after a list of 1650 patients. It was unsustainable then, and would be simply impossible in the new world.

Many of our readers will be familiar with the analogy that life is like a large glass jar into which you need to pack as much as you can. Start by putting in the important stuff – partner, children, long walks on the Quantocks and your tuba practice. These are like golf balls in the jar. There is room between the golf balls for other stuff like going to work, doing a postgraduate diploma or becoming a training practice. They can go in as marbles. That leaves small gaps that can be filled with the sand of life – washing up, worming the dog and doing your tax return. (Interestingly, even when the jar appears to be completely full there is room for a glass of red wine…)

The point of all this is that GPs must now take a long, hard look at what they are doing and how they do it. In hard times a wise company will retrench to its core activity rather than risk expanding into unfamiliar and risky markets, and with austerity set to last for many years that means practices must be sure that *everything* they do is not only medically effective, but also sustainable and profitable. With the number of "must do's" ever rising, and the effective resource base falling, we have already started to lose some of our best and most empathic GPs. That is a trend we have to stop, and we can only do that by practices individually and collectively establishing their own limits to the services they are prepared to provide.

Withdrawing from commissioning may appear tempting, both as a protest and also to reduce non-core work, but this is something that both the LMC and the GPC suggest that you do not do. Apart from wrecking all the work that many GPs, practice managers, and others have done to bring our CCG

to its successful authorisation, we still believe that clinical commissioning can help shape the NHS into a higher quality, more effective and better integrated service, never mind protecting the position of general practice as the hub around which patient care rotates.

And our Christmas Message? Why, one of goodwill, of course. And by that we mean the time has come for practices to start talking seriously with their neighbours and in federations about how joint working may be at least part of the solution to many of our problems. Meanwhile, make sure you spend enough time with your golf balls!

WORK TRANSFERRED FROM SECONDARY CARE: CAN WE SAY NO?

Although the job of a GP is still impossible to define, the 2004 contract did set some boundaries around the core "essential services". In essence this requires the practice to *" …provide services required for the management of its patients who are, or believe themselves to be, ill with conditions from which recovery is generally expected, terminally ill, or suffering from chronic disease..."*. What is included in this definition is broadly taken to be the things that the practice was doing within its old contract at the time of the change.

It's also worth remembering the last sentence of Clause 15 of the GMS contract, which is that these services will be "***delivered in the manner determined by the practice*** *in discussion with the patient"*. With some exceptions, it is not within the power of the PCT or the NHS Commissioning Board to dictate how you deliver essential services during normal opening hours.

Everything outside core GMS/PMS that you are asked to do for patients should be covered by another contract. This could be as an additional service, an enhanced service, an item of service arrangement, a private fee, or whatever.

So, when you are asked to undertake work that was previously done in some other way by someone else it should always come with the necessary resources including a reasonable profit element - GPs can no longer afford to do new things at cost. So, however good a new pathway may be, and however much it may save money for the broader NHS, the answer should always be "no" to new work that is not properly funded.

THE CAMERON FUND CHRISTMAS APPEAL

Many readers will know of the Cameron Fund, the national charity that supports GPs, (including those who have retired) and their dependants. In Somerset we are very fortunate in having the Local Medical Benevolent Fund which has a broadly similar remit to help GPs within the county, but we do sometimes call on the Cameron Fund for technical help, and they can also offer interest free loans to GPs who face financial hardship because they have been required to undergo re-training. However, for most of the country there is no local resource, and the Cameron Fund struggles to meet the growing need amongst GPs in difficulty. Donations are always needed and invariably gratefully received and acknowledged – see www.cameronfund.org.uk

SAFEGUARDING ADULTS AT RISK IN SOMERSET

New multi-agency guidance for the county

A new policy document and accompanying guidance has been published on the Somerset County Council website.

The main things to note are:

- A change of terminology from 'Vulnerable Adult' to 'Adult at Risk' in line with the proposed Care and Support Bill, but without a change in the definition of who safeguarding is for.
- Emphasis on the importance of understanding the mental capacity of the adult at risk in all decision-making.
- Emphasis on the need to ensure that victims are supported to contribute to the assessment and decision-making processes.
- A re-statement of the Safeguarding Adults Board's decision to use safeguarding procedures in serious cases of self neglect and clarification about when this will be appropriate.

Link

The North Pole practice sent their new GP registrar to do the outreach clinic at Santa's Cave. She brought back some notes for her trainer

Problem: Santa's little helper HY presented with poor sleep and anxiety.
Diagnosis: Low elf esteem.
Problem: Helper JH complained of being unfit. **Treatment:** Advised a week at an elf farm. **Problem:** Helper EB reported being scared of Father Christmas **Diagnosis:** Claus-trophobia.
Problem: Elderly male FC presented with concern about gender dysphoria. **Evidence:** Knows how to pack a bag, wears red velvet, and has an interest in stockings.

ACETAZOLAMIDE (DIAMOX) AND TRAVEL TO HIGH ALTITUDES

Some interesting observations from a Devon GP

I came to the Khumbu Valley three years ago as the medic to a small party to climb Island Peak. At that time I knew much less about altitude than I do now. However I was surprised to see how a drug such as acetazolamide was the source of so much confusion. Some of the worst culprits are GPs from the UK. Only yesterday I chatted to a man who had been denied Diamox by his GP, I think on the basis that the doctor didn't know how to recommend its use and was unsure of the dose. All you need to do is to go to NHS Choices website and scroll to A for altitude, the evidence, dosage side effects are clearly written. Please do not deny people this very useful aid to acclimatisation. There will never be a product licence for this indication because the return on investment for a drug company is too small. It is an old drug - as I am sure most of you know - and was used in glaucoma before drops were used.

What's the evidence? The best paper is the Prevention of High Altitude Illness trial (PHAIT) which was a double blind placebo controlled trial of Gingko biloba and acetazolamide done here at Pheriche. The incidence of acute mountain sickness in the placebo group was 34% whilst in the acetazolamide group it was 12%. Gingko was no better than placebo. So, please, if asked for Diamox consider doing a private prescription. The drug is as cheap as chips and you will not be sued, just thanked by a grateful patient for being up to date and ensuring that the trip of a lifetime is not ruined by GP ignorance. More information on acetazolamide at

Link

Neil Rushton (neil.rushton@nhs.net)

SMALL ADS…SMALL ADS…SMALL ADS…

PART TIME SALARIED GP – BECKINGTON FAMILY PRACTICE FROME

Details: 4-6 sessions a week from February 2013; ideally to include Mondays and Tuesdays but flexibility may be possible.

Contact: Dr John Beaven on 07719 534996/ 01373 830316 or Practice Manager Robert Slade on 01373 867989 or email john.beaven@beckingtonfamilypractice.nhs.uk. http://www.beckington.org.uk/amenities/surgery.htm

SALARIED GP: GLASTONBURY SURGERY

Details: Maternity cover required from March 2013, up to 4 sessions per week.

Contact: Applications with CV to Andrea Ball, Practice Manager, Glastonbury Surgery, Feversham Lane, Glastonbury BA6 9LP or to andrea.ball@glastonburysurgery.nhs.uk. Tel 01458 836109.
www.glastonburysurgery.co.uk

RETAINED GP: NORTH CURRY HEALTH CENTRE

Details: 3 sessions per week (Tuesday and Thursday morning & Thursday afternoon).

Contact: Applications in writing enclosing CV to Lisa Wallis, Practice Manager, North Curry Health Centre, Greenway, North Curry, Taunton TA3 6NQ. Email reception@northcurryhc.nhs.uk. www.northcurryhealthcentre.co.uk. Telephone 01823 490505. Closing date Friday 18th January 2013.

LOCUM COVER REQUIRED: SHEPTON MALLET PRISON

Details: To provide GP support for the on-call nursing service. Emergencies are referred to the 999 service and historically there is little demand for actual attendance (4 visits in 7 months), and on-call availability can be via mobile telephone. Retainer: £105/24 hours. Visit fee: £50 plus mileage allowance.

Dates of cover required: 14th/15th/16th/17th/ 21st/22nd/23rd/24th/25th/26th December 2012.

3 hour clinic required on: 14th/17th/21st December (morning or afternoon to suit) £200.

Contact: If interested in any or all of the above dates please contact Lucy Hornshaw, HMP Shepton Mallet on 01749 823314.

PRACTICE NURSE: VINE SURGERY, STREET

Details: Part time practice nurse required. Experience in wound care/cervical cytology/ travel health/childhood imms desirable and training will be offered. Approx. 16-20 hours per week, salary dependent on experience.

Contact: For informal discussion contact Karen Goodwin, Lead Practice Nurse 01458 841122. Letter of application to: Roger Harrison, Practice Manager, Vine Surgery, Hindhayes Lane, Street BA16 0ET. Roger.harrison@vinesurgery.nhs.uk. Closing date Tuesday 15 January 2013.

TXT FROM AN URBAN DOCTOR

So, another familiarly depressing letter from Dr Lawrence Buckman. As we get used to the fact that the government has raided our pensions, it has decided that it is going to change our working contract, not through negotiation, but by simply imposing a new one.

It's been a bitter pill to swallow the pension changes, but we have to admire our enemy for the way they have gone about it. Firstly, they win the propaganda war by painting a picture of lazy overpaid GPs who have a gold plated pension that most people can only dream of. Next they say these overpaid GPs need to fund their own pension instead of depending on taxpayers. Then they quietly siphon off the extra revenue into the national deficit reduction programme. A de facto income tax!

Having put that one to bed, they now wish to grind away our day to day income. The core GMS contract is very cost-effective for the government, but what about all these DES & LES things? Strategy two is to start paying GPs to do non-GMS work until they are used to doing it – and secondary care is used to not doing it. In couple of years they quietly remove the DES or LES, advise GPs they don't HAVE to do, knowing that momentum is such practices are probably just going to do it anyway. A de facto pay cut!

Next, what about this QOF business? The government are clearly not used to public sector bodies delivering on contracts, but we GPs are rather good at meeting performance indicators. We get paid for this, but it appears the government would rather we didn't. Each year they keep tweaking the QOF markers, focusing less and less on real quality and more and more on what is harder to achieve safely. The classic example being the ridiculously low Hb1ac target that we all knew would cause an epidemic of hypoglycaemia. Still, we delivered. Still, we found ways around the difficulties, and, still, the government had to pay the bill. Strategy 3 is therefore to do away with existing QOF and replace it with the NICE guidelines. After all, these are the markers of excellence in medicine. But the problem is that they are written specifically to deliver the best possible care for the condition they refer to, as if that condition was the only one in existence, and as if medicine did not have to deal with any other conditions. If you pour all your resources into treating CKD, how you are going to find the time to deal with diabetes or depression?

So what can GPs do other than emigrate? It appears the fight for our pensions is lost. With the LES and DES erosion, you will have to ask yourself will you do this work for nothing, or will you tell your patients the government is no longer funding this service and refer patients back to secondary care?

But what of the NICE guidelines? Clearly we must follow them religiously. Let's look at what we will be doing regularly now:

CG73 - Refer to a renal physician all patients whose eGFR falls by more than 10 in the last 5 years. So that's basically all of them isn't it? And let's not forget, anybody with an eGFR of less than 90 has CKD.

CG27 - Referral for CXR anybody with an unexplained cough longer than 3 weeks. A heavily irradiated society then.

CG127 - Consider specialist referral anybody under the age of 40 with a BP greater than 135/85 on home readings. Ok, I've considered it and referred them. If on 4 drugs and BP not controlled - regardless of age - then seek a specialist opinion. Yes sir, 250 letters winging their way as I speak.

CG90 - Offer psychodynamic therapy to all patients with mild to moderate depression as an alternative to medication. For all people with mild to moderate depression having short-term psychodynamic psychotherapy, the duration of treatment should typically be in the range of 16 to 20 sessions over 4 to 6 months. Right Steps WILL be delighted, and I WILL be demanding my minimum of 16 sessions for my 90 patients with mild to moderate depression - as will you I'm sure.

NICE is full of wonderful advice on patient care: these examples are just snippets from the first four I opened. However they are not a reflection of real life. If the government want to impose this alternative reality upon primary care, they better get ready for having the whole NHS sucked into this delusional world. I guess only then will they will go back to the drawing board.

This column does not necessarily reflect the views of the author, his or her practice, or the LMC

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