Somerset LMC Newsletter

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Issue 182

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UNSCHEDULED CARE IN SOMERSET

Can we unweave the tangled web?

By the time you read this the Conference of LMCs will have concluded, Jeremy Hunt will have made his speech about GP responsibility for Out of Hours, and right-wing press will have moved on to chew over some other victim. Of course, none of this will have made any difference to the problems of the patients who need out of hours care, and the spaghetti of services, pathways and organisations involved in it will be just the same. And things are, frankly, a mess. So, this month we lead with two sorry tales from GPs providing unscheduled care in different capacities.

"Yesterday an old lady fell again and a paramedic was summoned by the warden of her housing scheme. He found not much wrong but contacted the GP who said that she was demented, tended to fall and really needed to be somewhere more protected - which was being put in hand. Later she stumbled again so another crew brought her to A&E "for assessment" but not without criticising the colleague who'd left her at home earlier. She arrived in A&E about 14.30. It was heaving. Her entry on the computer list was "unwell-collapse" with the suggestion that she'd need an acute medical bed. I noted she has been admitted four times, once in each month since January, on the revolving door principle, but now she was well and wanted to go home. She could stand and walk unaided, if a bit wobbly, but her stick has been left at home. The surgery told me she'd used her Piper line 49 times this month. I could not contact her daughter but, after four more calls, I spoke to the warden who was "just going off duty" but did give me the patient's son's number. It appeared there was a dispute in the family about mother's future and he could not help other than to provide his sister's mobile number. Meanwhile, in A&E, there is a team of OTs and physios who can help get elderly people home by making an assessment on the spot. When I rang I was told that as it was now after 16.00 they could not take the referral as they finish at half past. However the lady was recalled as having had "no rehabilitation potential" on her last admission. I next tried to arrange a community bed near to where she lived. The SPL operator was not keen to speak to me as I really ought to contact the "in reach co-ordinator" at the hospital so I was put through to be told that if the lady had "no rehabilitation potential" then she was not suitable for the community hospital which did, by the way, have a female bed available. Perhaps I should speak to the duty social worker? She told me she also was now going off duty, and as indeed it was now 17.02 the hospital social worker had also gone home so I was directed to the county emergency duty team. After an initial testy "what do you want me to do about it?" we were able to agree that some additional home care that night would be useful if we could get her home. I spoke to the casualty staff - all we needed now was someone to get her there. The hospital might pay for a taxi but she was unsteady (no stick!) and we needed to coordinate the home care with her arrival. A relative would be best and, lo and behold, the daughter phoned me at that point but the family couldn't help until the next day. Hospital transport could not guarantee an ETA to mesh with the homecare and so after three hours I threw in the towel and she was admitted to an acute general hospital bed. I still have a headache and believe it or not I have left out a few stages in the soul-destroying process.

"Last Tuesday I was called out to an urgent visit to see a man whose wife reported him as having confused speech and being unsteady on his feet. She though he might have had a stroke. To me it sounded more like an acute confusional state, but I thought I ought to go and have a look. Examination was unremarkable but there had been recent changes to his medication which I thought might relevant. Anyway, he had difficulty getting out of his chair and could not stand without the support of two adults, and his wife was clearly unable to cope with him alone. I rang SPL to discuss the options. They advised that the nearest Community Hospital probably would not accept him as they were " running down their beds." The patient was very anxious to avoid going into to the DGH, so I asked SPL at least to speak to with the hospital. The message came back that they had indeed declined him although several empty male beds were showing. SPL then tried a second community hospital (the SPL nurse had previously worked there and thought he might be suitable) but they also refused. I then rang the nurse directly to be told they could not accept the patient without a diagnosis and because he was unsteady on his feet: " if he had a fall here we would just dial 999 and send him to the DGH". This all took place between 15.00 and 17.30 hours in the middle of a "sit and wait" duty surgery with just two doctors covering a large practice so it caused total chaos. Next time I will simply tell the receptionist "Oh dear, it sounds like a stroke, tell the patient to dial 999" which is what we are accused of doing anyway. I have previously done an Acute Care of the Elderly job, including community hospital work, and also worked as a GPED so I think I have a reasonably good idea of what is an appropriate admission . Livid is an understatement for the way I feel about this!"

These narratives illustrate the growing problem of the many frail elderly people whose ability to live at home is becoming compromised unpredictably but with increasing frequency. Existing services are just not set up to deal with this – each organisation works in its own silo and without reference to the others . GPs are trying to find the best path through this mess, but is it really a good use of their time to spend an afternoon looking for the "least bad" answer, if most of the time the patient ends up in the DGH anyway? It is clear that the politicians are not going to help find a solution – with the Government in disarray, an unstable new NHS landscape, and substantial QIPP savings still to be made, we cannot expect any help from the centre. But perhaps that is for the best, for this is a problem best solved locally by everyone involved working together to produce a system that provides a safe and cost effective solution to these problems. That solution will not be perfect, and it will not be without some risks, but we think that it can be done, at least in Somerset. So the LMC offers its full support to the CCG who are responsible for achieving this, because if it they can pull this off it will be the most important single achievement in NHS care since 1948. No pressure then!

SIGNIFICANT EVENTS

Please consider continuing to report these to the CCG

Although the QOF changes mean that since 1st April 2013 there is no longer a requirement to report significant events, SEAs and learning from incidents are still an important part of improving healthcare, and the Francis Inquiry has also made recommendations about the importance of reviewing serious incidents and sharing that learning from these to improve safety.

Somerset CCG would like to continue to receive copies of practice's SEA reports that relate to patient safety or patient experience (includingnear misses) via significantevents@somersetccg.nhs.uk

The CCG Patient Safety Directorate will continue to review SEAs and to share both lessons learned and positive examples to promote best practice. It would help them if you could submit SEAs throughout the year as they are considered in the practice, so the CCG can ensure they are reviewed promptly and, if of particular interest and importance, anonymised and included in the SafetyNet Newsletter.

Contact liz.jagelman@somersetccg.nhs.uk or 01935 384185

TADALAFIL FOR BPH

Currently non-formulary in Somerset

Although tadalafil (Cialis) now has a licence for the treatment of BPH and has been recommended by secondary care specialists for GP prescription, there is a regulatory problem that has not so far been resolved. NHS prescriptions for PDE-5 Inhibitors must be endorsed "SLS" to be allowed. However, this new indication is not covered by the SLS rules for these products and therefore if a GP did endorse a prescription in this way he or she would, technically at least, be in breach of the terms of service.

Until the DH has resolved this, the LMC advises that you refer these requests back to the specialist concerned.

NEW TREATMENT OPTIONS FOR MANAGING IBS IN SOMERSET

introduction of the first dietetic led primary care gastroenterology clinic in the UK

After the success of an award winning pilot, a new service has been set up to manage adult patients with irritable bowel syndrome (IBS) and gastrointestinal allergy in Somerset. This new dietetic service has been available throughout the county since March 2013, with clinics run by community dietitians in South Petherton, Shepton Mallet, Burnham on Sea and Taunton. Referrals can be made by Somerset GPs and Somerset Community Dietitians. As this is a specialist service, first line advice for both IBS and allergy patients will continue to be provided by the dietitians using the GP in-house dietetic service; however patients with intractable symptoms can be referred on to the new service if required. In the words of the consultant lead for the project:

"IBS is a chronic debilitating disorder affecting up to 10% of the population each year. Most patients are managed very effectively in general practice with a combination of diet and lifestyle advice, however a significant minority are referred to secondary care. This is despite a low probability of finding significant pathology in those of 16 to 45 years with no alarm symptoms—who make up 14% of all new referrals to GI departments in Taunton and Yeovil. These patients often undergo uncomfortable and unnecessary investigations before the diagnosis of IBS is confirmed and a basic management plan is set up. We know that at least 10% of these patients are re-referred within the next 3 years so it has not been of benefit to them."

For the majority of patients with IBS, where you are confident of the diagnosis you should continue to manage them in primary care. The new pathway should be used if you are considering a secondary care referral for patients between 16 and 45 years, with suspected IBS, diagnosed using the Rome criteria, and who have with no red flag symptoms. For this group, you can request a faecal calprotectin. A low result of < 50 effectively excludes inflammatory gut conditions such as ulcerative colitis and Crohn's disease and makes the diagnosis of IBS highly likely. (These are the predominant differential diagnoses in this group of patients.) Faecal calprotectin is available using OrderComms and for the first few months, this will run this as a pilot so you will be asked to fill out a short pop-up audit form to obtain the test. For those patients with a result of < 50, initial referral to your practice dietitian will provide basic diet and lifestyle advice, and for those with more intractable problems, the new dietetic clinic will help minimise symptoms in the longer term. If the reading is > 50, then the patient should be referred to a Gastroenterology department for assessment as usual.

In the Somerset pilot, new dietary approaches, such as the low FODMAP Diet, have shown a 78% success rate with IBS patients. These results show the same benefits as those from primary research studies. Capitalising on this this will significantly reduce the need for secondary care referrals, expensive investigations and medication , and GP consultations. It may also prevent the long-term and costly 'revolving door' hospital attendance which is so prevalent in this patient cohort.

For more information, contact Emma Greig (emma.greig@tst.nhs.uk) Consultant Gastroenterologist or Marianne Williams, Specialist Gastroenterology Dietitian (Marianne.Williams@sompar.nhs.uk)

TREATMENT OF ANAEMIA IN PREGNANCY

Haemoglobin still matters!

Analysis of a case of severe post-partum haemorrhage at MPH that needed HDU care found the woman had been anaemic antenatally but she had not had an iron supplement prescribed. NICE guideline CG62 suggests that an Hb of <110g /l (11g/dl) at booking, or <105g/l (10.5g/dl) at 28 weeks merits investigation and consideration of iron supplementation. Local Obstetric consultant advice is that ferritin and folate should be checked with the aim of giving a specific treatment rather than automatically selecting an old-fashioned iron & folate combination. Note that B12 tends to be spuriously low and difficult to interpret in pregnancy. If the clinical circumstances and blood indices are highly suggestive of one kind of anaemia (e.g. hypochromic microcytic) it may be reasonable to treat without investigation.

It most cases the blood testing will be done by a midwife, but generally she or he will need to discuss abnormal results with the GP to arrange suitable treatment.

LOCUM GP SUPERANNUATION

A little more clarity, but still no news for PMS practices

The BMA has been in discussion with the NHS Pension Agency about the expenses element of locum GP earnings, and they have advised that sessional GPs have two choices. Whatever is entered as income in Box 1 on Locum Form A (which locums must fill in for each contract worked in order to pension the income) is used to calculate the employer's contribution. The locum can choose either to treat mileage as part of the fee from which an averaged deduction of 10% is made, which will increase his or her pensionable income, or alternatively or it can be charged for separately and not included in Box 1 on the form.

If you charge mileage separately you can then claim tax relief on it (generally sessional GPs who work in multiple localities are treated by HMRC as working from home so mileage is a legitimate expense), and that may make more sense financially. We certainly recommend that you obtain accountancy advice about this!

It is important to note that practices shouldn't be acting differently simply because they now have to pay the employer's contributions. Employers SPA will be due on 90% of the total in Box 1, whether or not mileage is included in it.

THE SOMERSET ELECTRONIC PALLIATIVE CARE COORDINATION SYSTEM (EPACCS)

(previously known as the End of Life Register) has recently been upgraded

Primary care Clinicians who are users with editing rights are now able to send an electronic Special Message direct to the ambulance service, thus replacing the current fax arrangement. Examples would be patients who are particularly vulnerable or where there is a risk of violence or where access is difficult. This can be done using the "Special Msg" (not "EOL") button. Please don't use this for end of life patients, but continue to use the EOL tab as before. The current faxing system will continue to be available for a while, but the CCG would like to encourage you to use this special message feature as it will be easier and more reliable.

A specific tab has also been added so users can include patients under the age of 18. The questions on this tab have been developed alongside the Bristol Children's Hospital, local children's hospices and local trust paediatric consultants. This is, of course, a very sensitive area for parents, and it would be good to discuss such a proposed addition to EPaCCS with the child's paediatric team.

For general queries, please contact Julie Brooks Julie.brooks@somersetccg.nhs.uk
For user account queries, please contact Somerset Health Informatics

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

SALARIED GP: VINE SURGERY, STREET DR WOLFE & PARTNERS
Details: Salaried GP required for up to 6 sessions a week to start ASAP. Further details on request. www.vinesurgery.co.uk
Contact: Dr Carey Wolfe or Practice Manager Roger Harrison on 01458 841122, email carey.wolfe@vinesurgery.nhs.uk or roger.harrison@vinesurgery.nhs.uk.

GP PARTNER: LUSON SURGERY, WELLINGTON
Details: Due to impending retirement we are looking for a GP Partner (4 sessions).
Contact: Full practice information pack available from Martin Ellacott, Practice Manager 01823 662836 or email martin.ellacott@luson.nhs.uk. Informal visits welcome. Closing date 14/6/13, interviews w/c 26/6/13. www.lusonsurgery.co.uk.

GP PARTNER: BLACKBROOK SURGERY, TAUNTON
Details: GP Partner required due to retirement from October 2013. 8 sessions per week, whole time position, part time or job share an option.
Contact: Apply in writing with CV to Gale Berryman, Practice Manager, 01823 250240, email gale.berryman@blackbrooksurgery.nhs.uk. Closing date 30/6/13. www.blackbrooksurgery.co.uk

GP: TAMAR VALLEY HEALTH, CORNWALL
Details: Prospective partner or salaried, full or part time required due to the forthcoming retirement of senior partner. Start date flexible.
Contact: Kathie Applebee, Strategic Management Partner at Kathie.applebee@call-gunn.cornwall.nhs.uk, 01822 832641. www.tamarvalleyhealth.org.uk.

PRACTICE MANAGER: VINE SURGERY
Details: Full time Practice Manager required. NHS experience desirable. Salary according to experience—circa £45K. www.vinesurgery.co.uk
Contact: Enquiries/email applications to roger.harrison@vinesurgery.nhs.uk (by attached letter and CV). Closing date 7/6/13, interviews 19/6/13 and second interview 2/7/13.

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