Somerset LMC Newsletter

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DEMAND & CAPACITY IN GENERAL PRACTICE

And what you should do about it

It's not been a great summer for general practice. But the weather has been pretty good, press criticism of general practice has reduced somewhat (even the most rabid journalists may be beginning to realise that if there aren't any more GPs left they will have to find someone else to blame for everything) and the news about the NHS is probably no worse than usual. There is a mood of weary fatalism about that: since it's going to collapse, please will it just get it over with so we can start building whatever comes next.

But GPs are tired. There seems to be no pleasure in the job, it's just a constant struggle to do the things that have to be done in a day that is so crowded that there is no space for everything that has to be done. It's a bit like those children's puzzles with sliding squares that you have to move around to make a picture. So long as there is one free space the puzzle can be solved, albeit with difficulty, but if the last square is occupied there is literally no room for manoeuvre, and everything jams solid. So that may be the first requirement – however busy it is, make sure you include some non-committed time in your day to deal with the urgent tasks that are going to crop up.

Changes in consultation patterns and skill mixing have made a big difference to the case mix that GPs see. If you deal with sore throats over the telephone, pill checks go to a contraception clinic and acute musculoskeletal problems are seen by the nurse practitioner, the weight of the consultations that the GPs undertake just gets heavier. Complex psychosocial problems, medically unexplained symptoms and potentially severe illness not only require more time – which few practices have been able to find – but also much more GP involvement and energy. Not only are GPs losing the precious moments of conversation we can have with patients with simple problems that help establish a relationship and build a picture of the family, but we run the risk of eventually filling our days struggling with problems that have no solution, which is not just soul destroying, it is also a complete waste of GP time and NHS resources. And that defines the next requirement. Make sure you have enough time for weighty consultations, and enough simpler ones to make the weight bearable.

But perhaps the biggest problem is the endless piling of task upon requirement upon expectation upon obligation. It seems there is nothing that someone, somewhere does not think should be done in general practice – so long, of course, that it is properly quality assured, regulated, inspected and compliance with diversity policies regularly reported. If we are going to make general practice tolerable for the current generation of GPs and practice managers, and sustainable enough for the next to want to join it, then the third message is to learn to say no: kindly to the patient with an insoluble problem, politely to a colleague who is seeking to transfer hospital work back to the practice outside of an agreed pathway, and very firmly to everyone else.

Doctors' capacity to deal with complex decisions at pace is, like all traits, spread along a normal distribution. Those of us scattered at the left side have struggled for years, but the demand line is now hitting the steepest part of the curve, so even a small increase takes a large number of GPs beyond their safe limits. We cannot change individual capacity, and even if we could, there is no time to do it. We need to take back control of GP workload now, and if that means some current tasks cannot be done, then that is the way it must be. When the balloon is sinking you throw out the ballast, and if, say, an enhanced service is too heavy, then over it must go. You may find it revealing to calculate just how few locum or out of hours sessions you would need to work to earn back the income.

FLU IMMUNISATION – WE NEED TO DO BETTER

Uncharacteristically, Somerset does badly at flu immunisation. Not only is the county the worst performing CCG in the Area Team, but we also fall below the national average for uptake. It is not at all clear why this is the case, but what actually matters is how we can do better. The reasons for that are self-evident, but perhaps worth repeating nonetheless.

The epidemiologists tell us we need about 75% coverage of the relevant cohort to reduce viral circulation during the flu season, and even amongst over 65s, uptake in Somerset actually fell from 73% in 2012 to 72.5% last year. This compares with 79.4% in South Gloucestershire. Even in a normal year, flu infection leads to significant morbidity and mortality, and statistically we are due for an epidemic season. With the NHS already on its knees, it does not take much imagination to see what would happen if it had to cope with a serious outbreak. Flu immunisation is also a valuable earner for practices, so as income continues to be cut it makes business sense to maximise this. And, of course, in the new world there is nothing to stop commissioners offering contracts to any number of other providers. Could you manage without the money from flu jabs?

It is especially worrying that immunisation uptake locally is particularly low amongst pregnant women (35.1%, 70.9% in South Glos) and practice staff (53.9% vs. 64.3%), for the former are at real risk from flu, and the problems of coping with an epidemic flu season in primary care would be simply unmanageable if practices lost GPs, nurses and admin staff to this preventable and sometimes prolonged illness. We suspect that practice returns on staff immunisation in previous years have not always been accurate, but we do ask practices to encourage staff to take up the offer of vaccination (and to make sure immunisations given outside the practice are logged), if only to reduce the risk that they themselves will pass on infection to vulnerable patients whilst incubating the disease.

The factor most likely to influence a patient to accept immunisation is a recommendation by a health professional that he or she should have one, and given the remarkable safety of the vaccine, the potential benefit to the patient, and the essential interest of the NHS in minimising the risk of an epidemic, it is important to encourage uptake. This is even more important for pregnant women, and as the vaccine is safe throughout pregnancy, it is worth making a point of offering immunisation as soon as a pregnancy is confirmed. Don't forget that pregnant women should be offered immunisation right up until the end of March.

Protection of the most vulnerable is not helped by the confusion over who is responsible for immunising patients unable to attend the surgery for vaccination. Older people in residential care are at high risk. In 2012 there were flu associated deaths in a home in the county that had an outbreak outside the normal flu season, and in 2013, a very quiet flu year, there were clusters of cases in residential care. Obtaining informed consent from the frail elderly can be difficult, but the patient's previous history of flu immunisation is usually a useful guide in making a best interests decision. It is particularly important that care home staff are immunised to prevent spread, and this is the responsibility of the home owner. The Flu Immunisation Enhanced Service specification encourages practices to immunise individual carers, but if a care home employee presents for an immunisation because her or his employer is not offering one through work, we suggest that the practice should go ahead and provide it but report the episode to the CCG through the Health Professionals reporting system so that the relevant health or social care commissioner can raise it with the owner as a quality matter.

Flu immunisation is a major task at a busy time of the year and just now may seem like just another chore, but it really matters. A local version of the PHE practice checklist can be found on the LMC website and at Link, we ask practices to have a look at it now and perhaps consider adjusting their systems a little to maximise uptake.

PATIENTS WHO NEED HELP FROM SOCIAL CARE TO TAKE THEIR MEDICATION

The CCG is working on plans to make it easier and safer for carers to help patients with medication but need to get a feel for the numbers. If you have such patients please try to remember to add a Read code .8BML (Needs domiciliary care worker to administer medication) to their notes.

SESSIONAL GP SUB COMMITTEE OF THE GPC

Update from your regional representative

The focus of the Sub Committee remains the lack of representation of Sessional GPs within CCGs or in federations and other GP networks. We will be exploring the impact of changes both at locality level and also upon career development opportunities, motivation and retention of the Sessional GP workforce.

Representation

Sessional GP representation remains a concern nationally. The LMC/Sessional GP guidance has been revised and should be available soon.

Commissioning

With the advent of Co-commissioning, it is even more important that Sessional GPs engage at all levels in commissioning. There are potential opportunities for Sessional GPs to become more involved especially given the potential conflicts of interest that GP principals may have in commissioning Primary Care services.

Workforce & Retainer/Returner Schemes

We want to ensure that working in General Practice remains a positive career choice, attracting the best candidates to build a strong General Practice for the future. The Sub Committee is committed to the Retainer and Returner schemes as essential workforce initiatives. At present there has been no commitment from Health Education England to fund these successful schemes.

Revalidation

We remain unsure that revalidation ready appraisal it is fit for purpose and will reflect what a doctor does, rather than a doctor having to change what they do to be revalidated. Isolation remains a significant issue for Sessional GPs and the we been working on support options, including chambers models and Sessional GP groups. Support for remediation, particularly for non-practice based GPs, remains a considerable concern.

Pensions

There are reports locally and nationally of problems with payments to the NHS pension scheme. Salaried GPs are urged to ensure that their employing practices are submitting a type 2 self assessment form before the end of the tax year, that includes all of their NHS earnings so that correct payments at the right percentage contribution tier can be made. Locums also need to ensure that practices are paying the employers' contribution in a timely way that is compliant with NHSPA regulations. It is also advisable to request an annual statement of contributions from the NHSPA to make sure contributions are being made. This can be done online.

The most recent A & B forms are now available here and information for members can be found here.

Other work streams

We are working with BMA regional services to monitor redundancies and/or changes in terms and conditions for Sessional GPs. This is a potential threat due to financial pressures on practices facing MPIG and PMS reviews. We are also monitoring the transfer of Salaried GPs to new service contract holders. The Salaried GP Handbook is to be updated and revised to reflect changes in advice regarding Terms and Conditions of employment of Salaried GPs. The Locum GP Handbook was published last year and is available online to BMA members. We are also working on the new Sessional GP webpage on the BMA website with improved access for Sessional GPs to their Sub Committee representatives and exploring communication via social media . We are still looking to extend the directory of Sessional GP groups to include LMC linkage.

HOSPITAL DISCHARGE REQUESTS FOR MDS PACKS

There is no evidence that it is safer for patients with dementia to have their medication in MDS packs . It is the responsibility of the discharging hospital ,in conjunction with social care, to decide what care package patients require on discharge, including help with medicines, and It is up to the dispensing pharmacy - whether in hospital or the community - to decide on any service adjustment to help patients take their medicines. It is not the responsibility of GP practices to 'sort out' MDS boxes for patients on discharge!

SMALL ADS… SMALL ADS… SMALL ADS

For current practice vacancies please see the adverts on our website at:

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

Dr Whimsy's Casebook: The Patient-Doctor Partnership

Prof. David Haslam, chair of the National Institute for Health and Care Excellence, said in a Daily Telegraph interview that British patients should learn from Americans to be more assertive and take a more active role in managing their health. They should not be refused drugs which are backed by NICE without good clinical reasons.

Scene: An extra urgent appointment in Dr Whimsy's Friday evening surgery.

Dr W: Come in, Ivor. Take a seat. You're looking well.

Mr N: Mr Nattitude to you, Dr Whimsy, but yes, the pregabalin, amitriptyline and duloxetine I persuaded you to prescribe for my chronic arthritic pain worked immediately, as I predicted.

Dr W: I'm so glad, although you only stubbed your toe, and I'm sure it would be better by now anyway.

Mr N: I'm sorry, doctor? Do you dispute my diagnosis?

Dr W: Heaven forbid, but I think we can probably tail off the neuropathic painkillers now.

Mr N: I'll be the judge of that if you don't mind, Whimsy.

Dr W: Of course. I do apologise. But how can I serve you today?

Mr N: I have severe psoriasis.

Dr W: I'm sorry to hear that. Where is the rash?

Mr N: On my chest. *[pulls up his shirt]*

Dr W: Your chest looks fine to me.

Mr N: Well, it would, wouldn't it, doctor? But somebody who knows what they're doing would see the psoriasis right there. *[points to the middle]*

Dr W: Let me get my microscope. Ah, I see what you mean. Yes, that's a small freckle.

Mr N: Excuse me, Dr Whimsy, I know my own body, and that's the start of gutted psoriasis. My only question is, what are you going to do about it?

Dr W: Er, nothing. I'd leave it alone. It's just a freck...

Mr N: I must stop you there, doctor. I don't wish to discuss the diagnosis, and I cannot wait until it's full-blown erythroderminal psoriasis. We must hit it hard now. It's also obvious that my arthritis is of the psoriatal sort, though I suppose that hasn't occurred to you.

Dr W: You've been on yourdoctorsapillock.com again, haven't you?

Mr N: I have decided to take a greater interest in my health, and I must tell you there are some deficiencies in your management that I'd like to go over once you've dealt with my psoriasis.

Dr W: I quiver with anticipation. But if you're adamant that it's psoriasis, I'm sure it won't harm the economy to give you a small tube of calcipotriol.

Mr N: Haven't we missed a step, doctor?

Dr W: Have we?

Mr N: Shouldn't you be enquiring about its impact on my physical, psychological and social wellbeing?

Dr W: OK. Tell me, Mr Nattitude, how has your, ah, frecklate psoriasis affected your physical, psych...

Mr N: Terribly. I can't sleep until I'm ready for bed, I'm a bag of nerves if I fall off a cliff, and I'd still be shouting at if my wife if she hadn't left me last year. That's why we must stamp on it this minute.

Dr W: Right. Not a moment to lose. Let's try the calcip...

Mr N: Three things, Dr Whimsy: first, vitamin D analogues on their own are no longer recommended in tropical therapy; second, the arthritis demands systolic treatment...

Dr W: I think you mean "systemic".

Mr N: *[raises eyebrows]* I beg your pardon, Dr Whimsy?

Dr W: Right, tropical and systolic therapy. Do continue.

Mr N: Thank you. And third, the NICE guidelines state that treatment and care should take into account the patient's needs and preferences.

Dr W: I know exactly what you need, Mr Nattitude, but what would you prefer?

Mr N: Stelara, if you wouldn't mind.

Dr W: OK, a small tube of Stelara, then.

Mr N: *[sighs]* Stelara is an injection, Dr Whimsy. Its generic name is ustekinumab.

Dr W: Isn't that somewhere in Russia?

Mr N: No, Dr Whimsy, it's a treatment recommended by NICE, and it's particularly appropriate in my case because the iridologist says my cytokines are crying out for modulation. Gagging for it, in her words.

Dr W: I'd better look this up. *[flips through BNF]* Holy Jerome! It's over £2,000 a dose!

Mr N: Professor Haslam says it cannot be refused on the grounds of cost if it's recommended by NICE.

Dr W: *[takes a deep breath]* Mr Nattitude, thirty years of experience tells me you do not have psoriasis. You have a harmless freckle, and even if you did have psoriasis I would not consider such expensive treatment before more conventional therapy.

Mr N: Dr Whimsy! Your manner is quite preposterous. You clearly have no intention of taking into account my ideas, concerns and expectations, and you insist on imposing your own prejudices upon my needs and preferences. Let's see what the GMC and the Daily Mail have to say about this.

DrW: The Daily Mail? *[shudders]* Er, look, I'm sorry, Mr Nattitude, it's been like this all week and I'm very tired. Forgive me. Here's your prescription. Please make an appointment with our nurse to inject it.

Mr N: Thank you, Dr Whimsy. *[stays in his seat]*

Dr W: Is there something else? Is my room tidy enough?

Mr N: Haven't we forgotten something, Dr Whimsy?

Dr W: Er, I think I'm doing what I'm told, aren't I? And this is an emergency appointment, after all.

Mr N: You haven't discussed all my comorbidities yet.

This column is written for humour and does not necessarily reflect the views of the author, his or her practice, or the LMC. Doctor Whimsy's Casebook is available on Amazon.

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