



LMC NEWS

Cornwall & Isles of Scilly Local Medical Committee

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No. 192 December 2006

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LOCAL MEDICAL COMMITTEE ELECTIONS 2007

The LMC Chairman has invited me to act as Returning Officer for the Triennial LMC Elections which will take place next Spring. I am currently preparing a provisional Schedule of Electors, to be finalised when the PCT publishes its latest Performers' List for Cornwall and the Isles of Scilly on 1 January 2007.

At the beginning of December I wrote to all GPs in Cornwall and IoS, Principal and Non-Principal, to confirm whether or not their names appear on the provisional Schedule of Electors. (All GP Principals qualify as Electors, as they automatically pay the Statutory Levy. GP Non-Principals only qualify if they pay the LMC Levy, currently £100). If you did not hear from me by mid-December, this means that we do not have your current address. In that case, if you wish to receive election communications you should contact me no later than 31 December 2006 with your current address.

I am working mainly from home, so to avoid delays over the holiday period, please contact me either on rosalindwinter@mevweb.com, or at my home address:

Spindrift, Bodrugan Hill, Mevagissey, ST AUSTELL PL26 6PS.

Dr Rosalind Winter



There has been only one Christmas - the rest are anniversaries
- W J Cameron

Christmas Greetings

Just a short note to wish all our readers a very Happy Christmas, I won't tempt fate by hoping for a restful one because we all know that it won't be, at least for those on duty. Lets hope that 2007 is a successful year for us all.

We have tried to improve the quality of medical care by sending Basil down under, but it seems to have back fired as it seems as if he has been advising the cricket team, No doubt he will be back soon. Nationally things are hotting up between our negotiators and the Department, and locally we can see the pressure on the faces of people at the PCT as they are told to deliver the impossible, with impossible resources within impossible timescales. Our best wishes go to you.
David and Dawn at the Office.



Recruiting Patients for Clinical Skills Teaching

The Peninsula Medical School and the Royal Cornwall Hospital are committed to providing the highest quality teaching for both medical students and junior doctors.

We are actively recruiting new patient volunteers to our database and would greatly appreciate the involvement of primary care practitioners in this process. Posters and flyers are being sent out to all practices to invite patients directly or through their doctor or practice nurse to become a volunteer. They do not need to have rare or difficult to diagnose conditions. Patients with asthma, COPD, diabetes, arthritis dermatological conditions or any neurological signs are equally valuable as a teaching and learning resource.

If you know of any patients who may be willing to volunteer, please contact Anne Davidson, The Knowledge Spa, Royal Cornwall Hospital, Truro, TR1 3HD, Tel 01872 256453 or email Anne.Davidson@pms.ac.uk.

All patients will receive travel expenses and a small gratuity.

Thank you for your help.

Patient Experience Survey

Nationally things went awry on the Patient Experience Survey; not only did we end up with questions that the GPC had not agreed on, and the Department of Health insisted on, but that the statements were embargoed until the Monday, so all the media ran it on the Sunday. The GPC and its spokespeople had already got statements out, and quickly fielded people to be questioned but it does appear little is trustworthy

High earnings GPs-the truth

Within days of the patient experience survey mess, the GPC was defending the pay rises that GPs had earned because they had actually done what the new contract required of them. Now whilst I am disappointed that nationally the Department should be so used to its contractors never delivering, that it should have been surprised when a new contract actually delivers what it wanted. I am still disappointed how quickly they have forgotten the reasons for it.

Lest you forget and patients ask, remember the crisis of recruitment in many of our cities, the lack of people going into general practice, the need to modernise the contract, the fact that it really is now the most monitored part of NHS expenditure and the most heavily weighted towards quality output. There should have been a celebration of the earnings because they showed the work that had been put in.

They also did not acknowledge that many practices were seeing what income the new contract really brought before making decisions about investing in more staff, and in fact practices are still nervous because of uncertainty about QOF, MPIG, enhanced services, PCT policy on primary care. Perhaps the investment that Lord Warner seeks will only come about when general practice feels more confident about its future.

We now understand that further to this mess, it is likely that the national statistics used are wrong in that they included the employers superannuation contributions. This would of course falsely inflate the amount considerably.

Pensions

Nationally it looks as though the gloves are coming off on the topic of pensions, and more specifically the pension dynamising factor, of huge interest to all those just retired or just wondering about it. The GPC understand the importance of this issue, but there are other national issues and wonders about the amount of sympathy the public would give to GPs on £100k a year when many of their pension schemes have been going under. The BMA is seriously considering a legal challenge. It does not help as Lord Warner is using incorrect figures on GP's earnings to set their arguments, I don't know whether that will stop them. We will keep you posted on the news as we hear it.



The New national spine and patients registrations

Practices are starting to receive letters from patients requesting that their records are not included in the national spine. This has been started by a campaign by the Guardian newspaper, and now compounded by the letter from the CMO requesting GPs to forward any letters they receive to the DoH. The national view is that, you cannot forward the letters onwards because you have not received the permission from the patient to do so. The GPC is in discussion with the DoH (where have you heard that before) and will be contacting practices soon. All practices should be provided with posters informing patients about the national spine, what to do if they want to opt out, and a leaflet threatening them with a poorer service if they do, and instructions for practices, soon.

Excessive Prescribing

The PCT has produced a paper for consideration by the LMC, and it is also taking it to locality groups on the subject of excessive prescribing. There are concerns, at the PCT, that some practices, especially dispensing ones, are making decisions based on profit gained rather than clinical need.

The BMA and the LMC both recognise the contractual and moral obligations to use resources efficiently and avoid "excessive drug costs". The contract contains a clause relating to excessive prescribing.

The draft document we have been asked to scrutinise, and which prescribing groups have been shown, is unacceptable in its tone and some of the detail. We are currently discussing a new version of this with the PCT.

We have BMA guidance on this and are mindful of the fact that dispensing practices look after over 60% of patients (not all of whom are dispensed to, but whose care would be substantially threatened if practices were severely penalised).

We need to achieve a balance and will keep you informed.

Conference Call 27 / 28 February 2007

The LMC is organising a conference for next spring, something to look forward to after the long and dark winter nights. It will be held over 2 days at the Crantock Bay Hotel.

First of all, why there? Well it's large enough for us to get a reasonable number of delegates accommodated, and we are uncertain of the level of interest, but small enough for us to take over the whole hotel, which means we have their full attention.

The first half day, starting at lunchtime, is more aimed at GPs with a national flavour about where general practice is heading and then understanding from the PCT where the NHS is going. We are hoping to get Dr Fay Wilson from the GPC and Dr David Jenner from the NHS Alliance to give that national perspective.

There will be a dinner that evening, and some may wish to stay over.

Day 2 dawns bright and early with part two, which we are trying to aim more squarely at practice managers. There will be sessions looking at Practice Staff training, appraisal, managing stress in a surgery, PBC, employment law, the national IT strategy and making sense of it all and starting with Dr Fay Wilson on what practice managers need to be doing to get themselves prepared to meet the challenges of the future.

Last year the LMC ran its first conference, just to make certain we learn from history, we have a new team organising this one. However we hope that it will be better than last year and if it is, we will organise another one.

The conference is being supported by various drug companies, however the venue and speaker costs are such that we are having to ask a fee for the half day, and for the whole day.

You will have received details of this event separately from Dawn. Please contact Dawn with any enquires, and we look forward to seeing many of you next February.



Choose and Book

The LMC has been asked to be supportive of the PCT by encouraging practices to achieve the 90% target. This has placed the LMC in a difficult position, partly because the decisions about choose and book are individual practice ones, and secondly because it was initially so badly implemented by the PCT and RCHT. Over the early months there were two project managers who left after a very short time because they could not stand it any more, huge confusion about the directory from RCHT, constant changes. Practices have also had problems with the system being slow and sometimes not working at all. Exactly you cry, so let's leave it alone.

Recently however it has been well managed and supported. Then we have the bigger picture, which is that the Choose and Book target is being regarded by the SHA as being really important, a key target. We also keep being advised that choose and book is not going away, and many practices, when it is operating well find it quite a good system. We also think that it would do general practice no harm to show a degree of flexibility and behaving corporately within the NHS, because that is what's going to be expected of us in the future.

The LMC recognises that for some GPs there is a fundamental issue in using the system, and the links to choice,- indeed some practices have decided not to be involved at all. However for choose and book, there has been some resources applied to it, it is national policy and is clearly going to be implemented, and not to continue to try to implement it does therefore seem counter intuitive to many.



" I just want a blinking Ambulance"

An article by South Western Ambulance Service NHS Trust

Many of you will have noticed since April 2006, changes in Ambulance Control when you ring up to request an ambulance to take patients to hospital. We are aware that on some occasions this has led to somewhat fraught conversations between GPs and Ambulance Control Assistants. The purpose of this article is to try and clarify, and inform you, about the new systems.

Ambulance Control have the difficult task of dealing with all emergency calls, and in a very short space of time, identifying the appropriate priority of that condition, to determine the urgency of an ambulance response. The staff taking the calls are not, by and large, trained ambulance clinicians. It is therefore important that the call takers are taught a reliable, reproducible and quick method to assess, over the 'phone, the urgency of a call.

Worldwide the most commonly used package is called AMPDS (which stands for Advanced Medical Priority Dispatch System). In the UK most ambulance services use this. It consists of an algorithm of standard questions which can be followed by the Control Assistant, ending up with a priority being assigned to that particular call. In it's simplest form, this results in one of three levels of priority – 'Red' category, life threatening emergencies when the aim is to get an ambulance to the patient within 8 minutes on at least 75% of occasions. 'Amber' category emergencies, when the target is 19 minutes, and 'Green' category emergencies when there is a 60 minute target.

Clearly as with any fairly rigid triage system, there are occasions when it appears to produce slightly unexpected results, but overall ambulance services are very happy with the results of this system. the questions are and how it generates a coding.



“I JUST WANT A BLINKING AMBULANCE!” contd

So how does this affect you as a GP? If you ring '999' for an emergency ambulance response, even though you are a doctor, the Control Assistants will go through the same series of questions using the same AMPDS algorithms as they would do if you were a member of the public. This has the potential to be somewhat frustrating to you, as you already have an expert idea of how urgent the problem is. It is, however, important to ensure there is a consistent, reproducible way of dealing with all emergency calls coming into Ambulance Control. This then allows for the appropriate deployment of ambulance resources to the patient with most need. So, if you do ring, please don't be surprised if you are asked a series of up to half a dozen questions about the condition of the patient – it is not that the call taker is questioning your clinical expertise, merely that they need to input the data into the AMPDS system to ensure the appropriate response. If you are interested in finding out more about AMPDS, feel free to arrange a visit to Ambulance Control in Sowton, Exeter; where they will be more than happy to allow you to watch them using the system, and talk you through what the questions are and how this generates a coding.

The other issue that is at times causing frustration, is the booking of non-emergency but urgent transport often for hospital admissions. There are about 140 such requests every day. As you may be aware, it is now standard practice for ambulance call takers to initially offer a 3 hour response, i.e. they will ensure that the ambulance reaches the patient within 3 hours from the time of your call. It should be remembered that the 3 hours is the absolute maximum time it will take the ambulance to get there and very often a crew will be there considerably before that time. If you feel that a response within two hours is best then the Ambulance Control Assistants can and will arrange this for

you. However if you feel that one hour is needed then it is best that the call gets put through the AMPDS system (as for a '999' call) so that it can be prioritised against other '999' calls. This will not necessarily result in a 'blue light' response as it may be prioritised as 'green' call allowing a 60 min non 'blue light' response. For patients that in your opinion need a response between one & three hours, it is best to discuss this with the call taker who have been told that it is entirely appropriate to take a booking for the ambulance to be with the patient within two hours.

There are also occasions when the reasons for not waiting 3 hours are not directly related to the patients clinical condition, e.g. the patient who requires transport to a community hospital for admission to that unit before the duty doctor's shift finishes. If they don't reach the hospital within that time there will be no-one available to admit them to the ward without sending an out of hours doctor, often from some distance away. Ambulance control will do their best to accommodate such requests, whilst ensuring adequate emergency response cover.

As with all things, if we have a better understanding of how each other needs to work, we will work better together. We all share the same fundamental purpose of trying to deliver high quality healthcare to the population.

The ambulance service is very keen to hear feedback on the service provided. This is especially the case if you feel dissatisfied with arrangements.
Contacts;

Steve Pryor, Director of Operations
on Steve.Pryor@swast.nhs.uk
or

Andy Smith on, DDOC Chairman
on andy.smith@GP-L83092.nhs.uk



BASIL'S CHRISTMAS LETTER FROM OZ

G'day you wingeing poms –this is your old cobbler Baz signing in from downunder where I have been on a fact finding mission on behalf of the Local Meddo Committo and I have to tell you it's been an absolutely ripper experience. The only blot on the antipodean horizon has been the insistence of the locals to keep asking me what the bloody score is in the Ashes test series, firstly at the Gabba in Bris and then at the Yobba cricket ground in Addo. Let me tell you dear readers that there is only one thing more obnoxious than a full-of-himself aussie when our cricketers are getting a bashing and that is a whole country full of the blighters. Strewth mate, I was forced to sink a few crates of tinnies to deaden the pain and with the aid of the odd barbed roadkill managed to fan the flames of the old hiatus hernia to such an extent that even a whole packet of Losick failed to douse the furnace. Given the severe drought and high fire risk in Oz at the presso, my belching smoke was not the best idea but a gallon of Muddy Pond Reisling followed by six pints of Armpit Creek Sheeraz and a watering can full of Traffic Island Chardonnay was a passable and far more pleasurable alternative to the UK's unpalatable NHS version of triple therapy and at a fraction of the cost- PCTs please look and learn.

This is certainly a strange and wonderful country. Despite temperatures that would fry your undies to a crisp they insist on banging on endlessly about Christmas and exchanging cards with snow and robins on them! No wonder they banished the buggers to the colonies.

But they are undoubtedly ahead of the game in the world of Primary Care in some significant respects. For starters they had out-of-hours GP services up and running when we were still living in caves and doing it all ourselves. They are old hands at competing with each other for business too, something that our dearly beloved Sec of State for Health would like us to do. I

passed one establishment in the steamy suburbs of Melbourne that advertised family doctor, dental, pharmacy, physiotherapy, acupuncturist, and fortune telling services all under one roof in conjunction with a café and tyre and exhaust business thrown in for good measure. Now that's what I call a one-stop shop.

However the lucky so-and-sos do not seem to have been inflicted with the obsessive compulsive madness of targets, at least not yet. I have to agree with the sentiments of one Raymond Tallis in the London Times recently who said that when politicians set targets they are infused with a sense of being in control. Meantime we medics feel less in control and more stressed out as a result so the old job satisfaction goes down the pan. Politicians conveniently forget that for each activity that is "prioritised" another one has to be "posteriorised". As Tallis puts it so well: *"when priorities are determined by the discomfort of a minister at the dispatch box rather than by local clinical knowledge, dangerous things happen."* Jolly well said, old fruit!

334 in-patients went down with infectious diarrhoea in a well known hospital recently, 33 of them dying. According to the Healthcare Commission report managers chasing targets overrode the advice of doctors and admitted A&E patients to open wards instead of to isolation facilities. And now HM Gov wants to strip the GMC of its adjudication powers and transfer them to some government quango to decide what is good or bad doctoring. To be truthful cobbles I'd rather be sitting on the dunny in a bushfire than submit my professional future to that cockeyed malarkey.

A Very Happy Christmas to One and All, and may all your targets be little ones!