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Cornwall & Isles of Scilly LMC Newsletter

NMC Registration

As result of an incident in Kent where an unqualified HCA fraudulently obtained the NMC pin number of a qualified nurse and worked for a number of practices, all practices in Kent have been asked to check their nurses NMC registration. This individual who no longer works in Kent is likely to face criminal charges in due course.

This exercise has thrown up a (so far) small number of qualified nurses who had failed to keep up their registration. It does not appear that legal action is going to be taken against these nurses even though it is an offence. However the practices now have to deal with the nurses. One without registration for some 20 years will not be able realistically to retrain, another without registration for 9 years will be able to retrain but at considerable cost and delay. The final nurse with less than a year off the register will probably get registration back without too much difficulty but will have to face a NMC panel hearing.

The NMC and the SHA are likely to be writing to all PCTs to ensure that all practices check registration of all practice nurses and put procedures in place to ensure periodic checks take place. The NMC website has 2 separate means of checking registration, a simple pin number check that is open to the public and an employers check. It is important that practices register as employers and undertake the enhanced employers check as this gives additional information including the employment history of the nurse.

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- *e-mail dawn@kernowlmc.org.uk*

Your Chairman writes……

The Health and Social Care Bill has made it through the House of Lords and is a step closer to its final form. In Cornwall, the LMC has been monitoring the progress of the three existing Clinical Commissioning Groups and having overseen the initial elections to mandate a delegate from every Practice in Cornwall, it is now time to consider how the shadow CCGs will achieve democratic representational validity. The LMC and KCCG have had initial discussions and will be working together to develop a Constitution , and as part of this we will have a role in the electoral process once more information becomes available from the Department of Health. It is still unclear whether Chief Officers of CCGs will be appointed or elected and if the former, against what competencies?

It is essential that all GPs are engaged with understanding this process and we encourage questions and queries from any GP working anywhere in Cornwall either to the LMC Office, or to Joy Youart(Chief Development Officer) or Colin Philip(Chair of shadow KCCG). You can also liaise with your locality lead (of all the CCGs) and we will be publishing their details elsewhere in this newsletter.

The LMC hopes to be similarly involved with the other CCGs in due course, and has already run an election earlier this year for ECCG's Chair and Vice-Chair.

Now is the time to take more interest in what your GP colleagues are doing - this will affect you, the way you practice, and your capacity to continue to offer services from your Practice. Sessional GPs - this includes you. The LMC is aware of the difficulties that Sessional non-Practice based GPs experience in keeping up with what is happening with the CCGs and intends to see that this group of doctors is not excluded.

There have been concerns about CQC registration and I wish to reassure GPs and their Practice managers that there is no need to do anything about this at the present time. The earliest you can start the application process is summer 2012 with full registration from April 2013. The annual registration fee is yet to be decided.

Apart from QIPP which is the main issue being driven by the PCT-even, it seems, at the expense of developing the CCGs-there are two other issues of significance to GPs at the moment.

The first involves the transfer of those services provided by the FHS-backroom functions but essential nonetheless and including Performers List management and payments to GP practices - to another provider. I have written about SBS (Shared Business Services) before and you will know by now that this hybrid company (part-owned by the NHS) has secured the contract in the South West to take over these functions. The LMC has been vocal in its opposition to this, as have other regional LMCs but the deal is all but signed. The LMC now will concentrate on being involved in the contract details to ensure that General Practices can hold the company to its Key Performance Indicators.

The other issue is 111 - this is still in development and is being managed regionally with input from all PCTs - the final picture has yet to be decided but the LMC anticipates that the flexibility we hoped for might yet be deliverable. It has not yet reached the stage of procurement. One wish of the DoH is that GP appointments could be directly accessed via the 111 triage. Fortunately this is something that is not in the PCT's gift. I'm sure you don't need the LMC to advise you on this one!!

Information Sharing Protocol

The PCT has offered Practices the option of signing up to their Information Sharing Protocol. This document has already had sign-up by the Acute Trusts, Community Services, and SWAST, and is designed to outline the signatory's responsibilities with regard to sharing information about safeguarding issues in specific cases.

The LMC's view is that Practices can choose to sign up to this if they wish, but that it is not necessary to do so as the obligations outlined therein are already enshrined in the responsibilities of a doctor and Good Medical Practice as outlined by the GMC.

An Introduction to Registration with CQC

CQC have issued a really helpful short guide for General Practice. It includes a number of myth busting facts including the phrase " the majority of practices will already be meeting the essential standards of quality and safety", practices are able to declare non-compliance providing they show how they plan to become compliant and it also refutes the need for practices to remove all carpets and toys using the phrase proportionate !

With thanks to Wessex LMC.

http://www.cqc.org.uk/sites/default/files/media/documents/20110825_4b_introductory_guide_v_4_final_for_print.pdf

Vacancy - Probus Surgical Centre

EXCITING OPPORTUNITY FOR A DYNAMIC EXPERIENCED HEALTH SERVICE MANAGER,

PROBUS SURGICAL CENTRE is seeking a Senior Surgical Manager to maintain and expand surgical services based at Probus Surgery, Cornwall

Currently we are providing day case surgery under local anaesthetic for hernias, carpal tunnels, hand surgery, vasectomies and dermatology procedures.

We have an "Any Willing Provider Contract" covering Cornwall and are CQC registered.

The successful applicant will be responsible for managing a team of surgeons, nurses and admin staff and is expected to assume the role as CQC registered manager.

Salary depending on experience.

For more details please phone Mr Guy Lin, Clinical Director on 01726 885104 for an informal conversation or
E-mail debbie.barnicoat@probus.cornwall.nhs.uk for a job description, person specification and application form.

Closing date for applications: Friday 4th November 2011

Interviews and presentations will be held on Wednesday 16th November 2011

A safety message from the SW Peninsula Child Death Overview Panel Office

Tragically there has been a toddler death in the peninsula this year due to an accident involving a blind cord.

There is a blind cord safety leaflet, endorsed by ROSPA and CAPT, which can be downloaded from the British Blind and Shutter Association website on: http://www.bbsa.org.uk/domestic/child-safety/26 .

Please would your GP surgeries consider posting this safety leaflet on one of your notice boards or printing a few to put with the reading material in your surgery waiting room?

Thank you most sincerely,

The Peninsula Child Death Review Team

Full Time GP Partner
Lander Medical Practice, Truro, Cornwall.

Lander Medical Practice is a friendly 8 partner (7 WTE) PMS practice. We are based in purpose-built modern premises (opened 2010), and with a practice-owned branch surgery serve a patient population of 15,700 in the City of Truro and immediate surrounding countryside. Due to retirement, we are looking for a dynamic, forward thinking full time partner (9 sessions) to provide a full complement of services to our patients, and to assist the practice in its plans for the provision of new services.

VISION clinical system

Supportive multidisciplinary team including in-house physiotherapy.

Dedicated minor surgery suite

High QOF achievement

Website: www.landermedicalpractice.co.uk

Working collaboratively with Kernow Clinical Commissioning Group

The City of Truro is located in the centre of Cornwall, but only 15 minutes drive from both the South and North Coasts, has excellent leisure, retail and education facilities.

CV and application in writing to Liz Wilson, Practice Manager, Lander Medical Practice, Truro Health Park, Infirmary Hill, Truro TR1 2JA

Closing date for applications: 18 November

Interview to be held on: Week beginning 6 December 2011.

Part Time Salaried GP Post

Manor Surgery, Redruth

Initial contract January – June 2012

GMS training practice | Consistent high QOF achievement

List size 12,100

Long-established and well organised practice. We run a telephone triage on call system and are looking for flexibility, good attitude and willingness to participate in full.

To the right person we can offer support, commitment and a relaxed, welcoming atmosphere in addition to an attractive salary package and your own PA.

Contact Julie Campbell on 01209 313313 or e-mail: Julie.Campbell@manor.cornwall.nhs.uk

Manor Surgery, Forth Noweth, Redruth, TR15 1AU

Closing date: 20th November 2011

Camelford, North Cornwall

Partnership

Partner required to join existing F/T Partner, leading to a 2 Partner

Partnership GMS practice in the rural North Cornwall town of Camelford close to Bodmin Moor. Situated close to the beautiful North Cornwall coastline with many leisure activities within easy reach.

The main surgery is in Camelford with two outlying branch surgeries, one of which is dispensing. It is a friendly, well-organised, progressive and forward thinking practice.

List Size approximately 3,200

Nurse-led clinics with excellent and well organised support

Phlebotomy Clinic | High QOF Achiever

Computerised Microtest system in all surgeries, full supporting admin team

Opportunity for Partnership at one year | Proposed new LIFT building for practice

This is a first class opportunity to become part of a friendly and hardworking team working in a rural community in a beautiful part of Cornwall

Please send expressions of interest and a copy of your current CV to:

Mrs N Sherry, Practice Manager, The Medical Centre, Churchfield, Camelford, PL32 9YT. 01840 213893

Or, email: nicky.sherry@camelford1.cornwall.nhs.uk

RCGP Events

RCGP Tamar Faculty McConaghey Lecture 2011

7 pm, Thursday, 10 November

The Arundell Arms Hotel, Lifton, Devon PL16 OAA

Speaker: Baroness Judith Jolly

'The Health and Social Care Bill 2012 – A View from the Red Benches'

Health & Work in General Practice Workshop

7 December 2011, 12.30 – 4.30 pm

Duchy Hospital, Truro TR1 3UP

Book online at www.rcgp.org.uk/healthandwork

Full details and application forms are also on the website: http://www.rcgp.org.uk/tamar_events

Locum Agreements

The locum agreements guidance is for both locum GPs and the practices who engage them. It is aimed at locum GPs to help them put together written agreements with the practices for which they work, and should also be of interest to practices who engage locums. It assumes that the arrangements made will reflect the locum's status as a self employed GP, and that the agreement will be a contract for services, rather than a contract of service, which would apply to an employee.

This guidance is available on the BMA website, but please note that it is restricted to BMA members and LMCs.

http://www.bma.org.uk/employmentandcontracts/employmentcontracts/sessional_gps/locumagreements.jsp

NHS Reforms

It is now only six months until Clinical Commissioning Groups (CCGs) are expected to be up and running in shadow form. While there are good things happening in some areas – GPs, supported by managers, are becoming more involved in the planning and delivery of healthcare and there is greater working with our consultant colleagues - I am becoming increasingly alarmed by the manner in which some CCGs are being established and are operating. There is a limited window of opportunity left for us, as your national representatives, and you, as practising GPs, to influence the development of CCGs, and that is why I am writing to you now.

The BMA continues to have major concerns about the Health and Social Care Bill, but we recognise that the changes set in motion simply by its proposition are already having a huge impact on the NHS. We are therefore trying, as far as possible, to influence this process so that GPs' interests are best represented. That is why the GPC has been involved in Department of Health groups developing policy on the new structures. However, I am very concerned by reports I am getting from GPs who do not feel engaged with the changes happening in their area, or feel they have not been given opportunity to be involved; it is vital in the early days of a new NHS in England that it is the many and not the few who influence important formative decisions.

NHS Reforms

The changes to health services in your area are happening now, regardless of the Bill's passage through parliament. I have set out our primary concerns below and would urge you to make sure your voice is heard locally, not just if you have concerns, but so you can help shape the future of healthcare in your area. More information about how you can do this is set out at the bottom of this email.

The GPC's main areas of concern about the development of CCGs are:

- In areas of good practice, board members are being properly nominated and elected, but we have heard of places where there has not been any adequate democratic opportunity or where not all GPs have been included in the process.

- In some cases CCG board members have put in place untried and unacceptable measures to micro-manage practices, irrespective of the views of local GPs.

- Local medical committees (LMCs) represent GPs and practices locally and they must be engaged with CCGs and primary care trusts (PCTs); where this is happening, positive developments are being made, but in some areas the LMC is being side-lined and ignored which is not acceptable. CCG authorisation requires the demonstration of engagement of local practices and the LMC is best placed to assist with this.

- It is appearing increasingly likely that the authorisation process, while trying to ensure that these newly formed statutory bodies (CCGs) will be fit for purpose, will only authorise organisations that bear a remarkable resemblance to PCT. It means many GPs trying to build their groups will have wasted a lot of time, energy, and resources and are now having to reorganise for a second time.

- In terms of government health policy and its impact on GPs:

- The greater focus on competition, particularly through the enforced roll-out of the 'any qualified provider' policy, will make it harder for primary and secondary care providers to collaborate for the benefit of patients.

- Although the government has amended its proposal to make clearer the link between any reward and commissioner performance in relation to quality and healthcare outcomes, we remain seriously concerned that potential incentives or financial reward associated with commissioning will adversely affect the doctor-patient relationship.

More detail about our many other concerns surrounding the Health and Social Care Bill and what the BMA is doing to address these can be found on the BMA website.

However, when it comes to the development of CCGs, we believe democratic accountability and collaborative working with constituent GP practices, including all sessional and salaried GPs, is vital. We must learn the lessons from Practice Based Commissioning: where there has been active engagement of grassroots GPs greater positive change has been achieved; where it has not it has failed to deliver and, in some cases, has damaged existing services.

Your LMC, working with the BMA, has a long history of representing GPs' interests, having been in existence through 100 years of NHS reforms; its organisational memory and role, both statutory and none statutory, is even more important today than it has ever been. But it needs to know your views. More information about how to contact your LMC can be found on the BMA website.

No matter what happens with the Health and Social Care Bill, for our patients' sake we need efficient and effective services. Vested interests need to be removed as do actions which do not improve patient outcomes. CCGs and PCTs need to work with LMCs, following the example we have seen in areas where there is constructive working. This is the only way that positive changes will be made.

Yours sincerely,

Dr Laurence Buckman

New Medicines Service. A New Advanced Service from Community Pharmacy.

As from the 1st October the Pharmacy contract that governs the activity of Community Pharmacies has had a new advanced service added. This service is called the "New Medicines Service" (NMS). It allows Pharmacists to offer patients starting a new medicine for some specified conditions, extra help to ensure concordance and adherence to the new medicine and the best ways of taking it.

Appropriate Patients may be recruited to the new service either be prescriber referral or opportunistically by the community Pharmacy. When a patient presents with a prescription with an item that is new for that patient for COPD and asthma, diabetes, hypertension or anticoagulation, the pharmacist will dispense the medicine and then at an initial consultation provide initial advice about the medicine as they have always done and then offer further support to the patient. If the patient agrees they would like the new service, then the Pharmacist discusses with the patient whether they would like this support face to face at the Pharmacy or by telephone and agree an appropriate time within the next 7 to 14 days.

The Pharmacist will use an interview schedule to help assess the patient's adherence, identify problems and the patients need for further support. The Pharmacist will then provide advice and answer patient's questions and agree a time and method for a further conversation within the next 14 to 21 days. At this third consultation, again either face to face or by telephone, the Pharmacist will discuss how the patient is getting on with the medication and again provide advice, help and support, to ensure the patient is getting the maximum benefit from the medication.

At both these follow up interventions, the Pharmacist may identify a problem which requires the prescriber to review the prescription. The Pharmacist will talk to the patient about the best way to achieve this. This is an area where it would be useful to have local conversations between GP practices and Community Pharmacies as to how this feedback could be best achieved. An NMS feedback form has been designed by the Professional Relationships Working Group, which is made up of NHS Employers, the GPC and the Pharmaceutical Services Negotiating Committee. The aim of the service is for the Pharmacist to help patients with their issues and problems, not refer issues back to the prescriber, unless really necessary.

The NMS is designed to provide early support to patients to maximise the benefits of their new medication. Proof of concept research was used in its development which shows that an intervention by a pharmacist can help to improve patient's adherence to their medicine. In the research patients who used the service experienced fewer medicines problems and made less use of other NHS services, saving money and GP time.

It would be helpful to Pharmacists if GPs could highlight this service to patients when they prescribe a new medicine in the specified categories. It would be great if GPs could mark new by such items. A list of the medicines covered is on the PSNC website at www.psnc.org.uk and follow the quick link to NMS. Further information is also available on the BMA website at www.bma.org.uk/healthpromotionethics , then click on Drugs and Prescribing and go to the Community Pharmacy section and click on Changes to the Community Pharmacy Contractual Framework in England.

If you have any queries please talk to your local pharmacy or contact the Local Pharmaceutical committee on 07734056305, who would be very happy to help.

Kernow Clinical Commissioning Group
Localities/Practices/Locality Leads

North Cornwall

Lead – Dr Malcolm McKendrick

Carnewater Practice, Port Isaac Surgery

Stillmoor House Surgery, Stratton Medical Centre

Wadebridge & Camelford, Lostwithiel Surgery

Bottreaux Surgery, Dr Garrod's Surgery Camelford

Dr Nash/Roland Camelford, Bude Surgery

North Kerrier

Lead – Dr Tom Edmunds

Manor Surgery, Veor Surgery

Phoenix Surgery, Homecroft Surgery

Pool Health Centre, Trevithick Surgery

Harris Memorial Surgery. Praze-an-Beeble Surgery

Clinton Road Surgery

South Kerrier

Lead – Dr Francis Old

Mullion Health Centre,

Helston Medical Centre

Meneage Street Surgery,

St Keverne Health Centre

Penwith

Lead – Dr Neil Walden

Bodriggy Health Centre, The Alverton Practice

Marazion Surgery, Penalverne Surgery

Rosmellyn Surgery, Sunnyside Surgery

Morrab Surgery, Cape Cornwall Surgery

Isles Of Scilly Health Centre, Stennack Surgery

Truro

Lead – Dr Andy May

Lander Surgery (Upper Lemon St)

Three Spires (18 Lemon St)

Falmouth & Penryn

Lead – Dr Nick Rogers

Penryn Surgery

Falmouth Health Centre

Trescobeas Surgery

Westover Surgery

Coastal Cluster

Lead – Dr Natalie Dawes

Perranporth Surgery

St Agnes Surgery

Chacewater Surgery

Carnon Downs Surgery

Restormel & Roseland

Lead – Dr Howard Ball (& Dr Mike Ellis - Carrick)

Clays Practice

Woodland Road Surgery

The Park Medical Centre

Probus Surgery

Brannel Surgery

Roseland Surgery

Newquay

Lead – Dr Tamsyn Anderson

Narrowcliff Surgery

Newquay Health Centre

Dalton House

Tamar Valley

Lead – Dr Shelagh McCormick

Tamar Valley Health Centre

PRACTICE IMPERFECT - Chapter Two

Dr Bathsheba Bungler stood up and touched all four corners of her consulting room desk at the Soddem Health Centre, tapping twice each time. She then made her way to the sink in the corner of the immaculately tidy room and washed her hands for the tenth time in as many minutes. She felt the tension easing away. She glanced in the mirror over the wash basin and regarded her reflection with the usual distaste. “Poor Old Pudding” was what Daddy called her, but at least it was an affectionate epithet. Her mother was less forgiving. “My Ugly Duckling” and “The Runt of The Litter” where two of the more gentle descriptive references she used for her eldest daughter.

Her younger by two years Sister Belinda was a different kettle of fish, universally adored by all she encountered. Lonely Bathsheba had endured Friday evenings of her late teens listening through the thin adjoining bedroom wall to Belinda entertaining a succession of the Sixth Form’s best looking boys. Fridays were her father’s weekly evening meeting of The Railway Modellers’ Club and her mother’s night for visiting Gran in the nursing home.

When Bathsheba had got a place at medical school she thought that at last her parents would begin to feel proud of her, but predictably Belinda entered medical school two years later, met and fell in love with Beautiful Ben The Brain Surgeon, and indecently shortly after their spectacularly lavish wedding gave birth to the world’s most beautiful twins. Bathsheba’s mother couldn’t make her mind up who to drool and simper over the most, the Beautiful Twins or the Beautiful Ben.

At least her patients gave Bathsheba their unquestioning and unconditional respect and gratitude; that was until the Letter of Complaint arrived.

Occupational Health Assessors – initial thoughts on Dr Bungler

Most doctors’ worst nightmare; The Complaint.

And it has happened to someone with very few personal resources with which to cope with it.
Once again, as with the previous doctor in difficulty, she seems to have succeeded in concealing her problems from her colleagues and the cost to herself is enormous.
Bathsheba has striven all her life for approval and a sense of self-worth and has found it in her work and, specifically, in the regard of her patients. In her view, she is a failure in all the other areas of her life. She is enormously vulnerable.
Her colleagues may be unaware of her hand washing and her low self-esteem or they may be aware of her fragility and unsure of how to approach her and wary of precipitating an emotional response that they feel unable to deal with.
Bathsheba certainly lacks the confidence that a request from her for help or advice would be met with kindness and support and we have no indication in the story that this might or might not be the case.

She needs 2 stages of input:

1. *A sympathetic and supportive approach by a Partner colleague to enable her to manage the Complaints process without breaking down and to feel that she is not condemned by her colleagues. Indeed it is likely that at least some of them will have experience of the process themselves, but Bathsheba will almost certainly not have imagined this for herself. She will need on-going support while the Complaint is addressed and encouragement in obtaining the necessary input from her Defence organisation.*

2. *She also needs clear and non-judgmental recognition of her psychological issues with reassurance that they do not lower her in the esteem of her colleagues and with the re-assurance that they can be addressed and resolved.*
   For this, she needs referral to Occupational Health Service for Primary Care through the use of her Green Card – she does have one, doesn’t she? Or at least are they available in the surgery?
   Bathsheba requires crisis support from the Practice, although this may be difficult to obtain it is something that should have appeared at Appraisal with a sensitive appraisal, and she will be difficult to engage as she does feel shamed and terrified. Also, she is only used to conditional approval and can rarely even get that. Therefore, the process of initial assessment/engagement will have to be managed with considerable sensit ivity otherwise there is a serious risk that her defences will break down and she will be seriously at risk.

PRACTICE IMPERFECT - Chapter Two

This is the type of case that needs to be identified if possible at a very early stage through networks of support in Primary Health Care and good education so that vulnerable doctors like the above can be engaged safely without it becoming catastrophic and receive therapy from an appropriately trained intervention. Given the very poor attachments described it is unlikely she will engage in any significant cognitive work and although she might have a flight into health with some symptom resolution, fundamentally she needs to address the very difficult attachment issues that she has experienced.

In summary

1. The Practice would benefit from a review of its in-house processes for dealing with colleagues in difficulty. And does it have a system in place for dealing with complaints?
2. Bathsheba requires crisis support and input both from the Practice and from OH as she is extremely vulnerable; her GP may need to be involved and she will need to be helped to trust the confidentiality of the process as she is likely to be feeling extremely exposed and shamed, as well as terrified.
She also needs to engage in the therapeutic programme offered by OH Service for Primary Care with financial assistance in paying for it offered through that system should she need it.

Drs Ben Charnaud, Anne Read, and Andy Stewart
GP Occupational Health Service

Flu Season

Please help to fight the spread of seasonal flu this year by making information on your vaccine clinics readily available to at risk groups.

Last year in Cornwall and IOS the flu virus was circulating in the community at the same time as Norovirus; making a huge impact on the NHS. This year we hope to urge all those who are eligible to have the flu vaccine to help control and prevent the spread of infection.

Printed materials including posters, surgery screen savers, leaflets and stickers have been produced, along with a template patient letter sent via GP bulletin so please

It is best to encourage your at risk patients to get the seasonal flu vaccination in the autumn before any outbreaks of the virus begin. It is also important to remind people that the vaccination is required every year, and not to assume that they don't need another vaccination because they had one last year.

Patients eligible for the flu vaccination are those who...

- Are 65 years or over;
- Are the main carer of an older or disabled person; or
- Live in a residential or nursing home;
- Are pregnant.

…Or have the following conditions:

- Heart problems; A kidney disease; Liver disease; Diabetes.
- Chest complaint or breathing difficulties, including bronchitis or emphysema;
- Lowered immunity due to disease or treatment (such as steroid medication or cancer treatment);

Children with any of these conditions or who have previously been admitted to hospital with a serious chest or respiratory condition should also be vaccinated.

Is there anyone who shouldn't have the vaccination?

Almost everybody can have the vaccine. Egg-free vaccines are available for those who are allergic to hen's eggs. There are some fairly common but mild side effects to the vaccine. Some people get a slight temperature and aching muscles for a couple of days afterwards. Any other reactions are very rare.

Flu season is here!

More information from your local NHS at **http://tinyurl.com/6xjbsqd**

DR BASIL BILE WRITES…..

When times are tough one get inspiration from wherever one can, so it was with a surge of opportunistic arousal that I excitedly noted a headline in the Daily Torygraph last week.

“Patients need GPs to act like local priest”.

Apparently we family docs are not providing a broad enough range of care and support for our ever whinge-ing clientele and should adopt the role once taken by the local priest. This humdinger of a report hails from none other than our highly esteemed Royal College of Garrulous Practitioners, once of Princes Gate and now conducting business from a caravan parked off the Euston Road. The report, jointly commissioned with an organisation called The Health Foundation, said the GP should be a respected figure who could be turned to for non-judgmental advice on a range of issues including, but not limited to, health care. I thought that was exactly what I had already been bally well doing every Friday Night for the last 30 years propped up at the bar in our local hostelry, “The Stirrups and Speculum”.

I sat and pondered this superficially ludicrous proposition for a while, and then following an exhilarating eure-ka moment sprang into action by firstly phoning my plumber who is forever indebted to me for sorting out his piles prior to his honeymoon. Admittedly it was 20 years ago, but it is never too late to call in a debt in our line of business.

Thus it was that over the weekend whilst the prying eyes of my less innovative colleagues at the Abandon-hope Surgery were otherwise safely engaged in bailing out their numerous dysfunctional teenaged offspring from local police stations, my plumber converted the sink in my consulting room into a rather fetching font.

The local glazier (genital warts 15 years ago) replaced my grimy consulting room window by running up a jolly impressive stained glass jobby in a mere 48 hours, the memory of podophyllin paint still burning fresh in his mind spurring him on.

I am now in a position to carry out the wishes of our College by performing christenings, weddings and funer-als, which you have to admit fits in very neatly with an existing portfolio of special interests which includes contraception, antenatal care and care of the elderly. Admittedly fees earned in this manner are likely to be on a modest scale, but when NICE Guidelines on Christenings are published I will have a head start over those of you of a more sluggish disposition, commissioning groups please note. I am afraid any out of hours ceremonies will have to be provided by SERCO.

Meanwhile, that other Royal College, namely the one for Nurses, Midwives and GP’s Handmaidens, has sid-ed with our very own Dr Ford Granada of RCGP fame, in helpfully suggesting that patients’ relatives should be caring for inpatients on the wards rather than hospital staff, who are apparently far too busy having lunch. At least that is what I have gathered from Dr Peter Carter, RCN Chief Exec, who said (and I quote from the London Evening Standard 26th September 2011): “ If you have a 24-bed ward and 5 nurses, and everybody is having lunch at the same time, it becomes difficult to get it done. If someone is sitting with their loved one they are going to have focused dedicated time.”

Not to be outdone Dr Granada chimed in:“ Can we afford to have someone sitting by an elderly person and feeding them which might take 2 to 3 hours? Don’t relatives have responsibilities?”

I have to say that I agree wholeheartedly with this common sense approach, which clearly needs to be adapted for the Primary Care environment. Forthwith patients attending the Abandonhope Surgery around midday will be expected to bring with them a relative who can serve lunch to the GPs in our dining room…