No 47 Spring 2017

# BARGOOSE

**Dr Simon P Hughes and Partners**
**Patient Participation Group**

**Newsletter No 47 Spring 2017**

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## THE CARE QUALITY COMMISSION REPORT

The CQC report on the Practice inspection at Barton on 17 May 2016 presents a picture of a technically excellent and well equipped team, devoted to the welfare of the patients, who were treated with kindness, dignity, compassion and respect. Information on the services available to patients was available and easily understood. Appointments with a named doctor and continuing contact with that doctor were possible. There were emergency appointments available for those needing same-day help. Older people and those with long-term conditions had special provision, and a register of carers, and contact with them, was developing well. Nursing staff took lead rolls in chronic disease management and patients at risk of hospital admission were identified for special care.

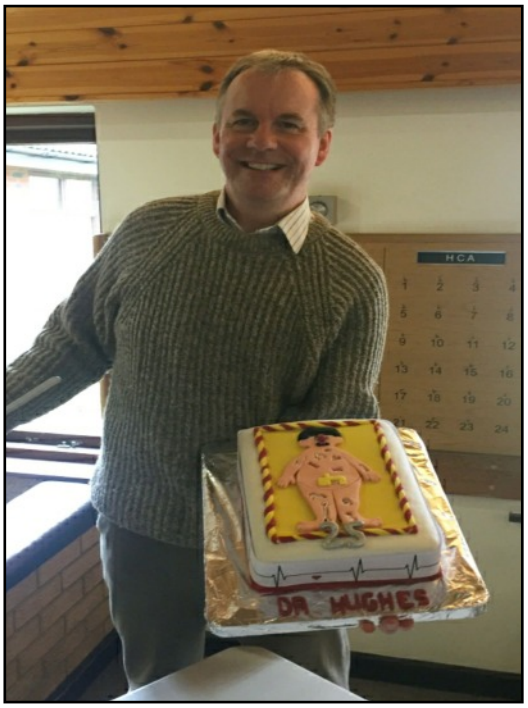
The leadership and management of the Practice was highly rated. The partners had demonstrated that they had the experience, capacity and capability to run the Practice and deliver high quality care. They prioritised safe, high quality and compassionate care. Staff said that the partners were approachable and always took time to listen to all members of staff. Staff felt respected, valued and supported, particularly by the partners. They were encouraged to take part in discussions about how to run and develop the practice. Feed back from patients, the public and staff was encouraged. The Patient Participation Group (Bargoose) was part of this. *For an account of the actual inspection day see page 8*

**Staff were not mentioned by name in the report, but clearly the leadership provided by Dr Hughes and colleagues, and the involvement of all staff, was seen to be critical to the success of and patient satisfaction with the practice.**

## CHRIS PORTER 1935 - 2016

We have to report the sad news of the passing on 11th December of Chris Porter, one of our committed and able Bargoose members.
He was born and spent his early years in Liverpool, and retained his affection for the city and Anfield throughout his life. He served a 5-year apprenticeship in design and draughtsmanship in Kent and became a teacher, eventually teaching engineering drawing and mathematics at Harlington School.

Chris was a football and cricket enthusiast, a devoted father and grandfather, a life-long church member and supporter of community projects. He belonged in this district, having been married in Silsoe church and lived in Greenfield and Barton for many years. Pulloxhill church was packed for the memorial service on 5th January.




## The Practice of Dr Simon Hughes and Partners, Barton le Clay, is part of the West Mid Beds Locality. This is what it means.

All 55 GP practices in Bedfordshire are members of the Clinical Commissioning Group (CCG). The CCG divides itself into five areas or 'localities'. Bedford Locality covers roughly the same area as Bedford Borough Council. The other four localities cover the area of Central Bedfordshire Council.

- Bedford Locality is a group of 26 GP Practices covering the towns of Bedford and Kempston and some north-Bedfordshire villages.
- Chiltern Vale Locality is a group of 10 GP practices in the south of Bedfordshire covering Toddington, Houghton Regis, Dunstable and the surrounding villages.
- Ivel Vale is a group of 7 GP practices covering Sandy, Potton, Biggleswade, Shefford and Stotfold.
- Leighton Buzzard is a group of 3 GP practices in the south of Bedfordshire.
- **West Mid Beds is a group of 6 GP practices covering a population of 58,790 in Ampthill, Flitwick, Barton le Clay, and Woburn Sands**

On 5th February **Dr Hughes** completed 25 years service with the Practice. We give thanks for all the help and support he has given us, patients and staff alike, over those years, and beg him to continue the good work for many years to come.

# A PLAN AIMED AT GREATER EFFICIENCY THROUGH COOPERATION AND JOINT WORKING WITH OTHER LOCAL PRACTICES, CHANGES IN WORKING METHODS AND THE RELEASE OF MORE DOCTOR AND NURSE TIME FOR DIRECT CONTACT WITH PATIENTS

## PRIMARY CARE DEVELOPMENT IN WEST MID BEDS LOCALITY

**Primary care**, the service provided by doctors, nurses and others at our local surgeries, is under severe pressure. We have more patients, older patients with multiple problems needing more attention, a Government demand for complete out of hours and weekend services, and more administrative duties. Funding for General Practice has declined by 30% since 2010. Government has promised 5000 additional General Practitioners within a few years, but there is widespread doubt that this can be achieved. The work is less attractive to new doctors and recruitment is difficult. Unless some action is taken General Practice as we know it will collapse.

**The Bedfordshire Clinical Commissioning Group** has asked each locality to produce a 2-year plan to alleviate some of the present problems. Our **West Mid Beds Locality** has produced the following proposals, the development of each section of which has been allocated to one or more of the surgeries. Overall management of the plan is by Gill Hiscox, our Practice Manager.

**Miriam Coffee, working with the Locality Group, has played a leading part in the preparation of this plan.**

**The plan** is based on national guidance which emphasises the need for practices to work together, not to make further demands on already overstretched GP's, to accept that evening and weekend access to primary care is mandatory but not necessarily depending on GP's, and to make more extensive use of digital technology. The main proposals are as follows:

- **A Locality website** providing information, advice, eventually on-line consultations and possibly shared phone lines.
- **Further training of administrative staff** to enable them to take over more of the paper work at present overwhelming GP's.
- **Urgent home visiting service**
- **Inclusion of pharmacists** in the Practice team for minor illness clinics, medication reviews for complex patients, care home ward rounds and joint working with other professionals.
- **Improvements in working premises** to include joint Health and Social Care premises in the Ampthill or Flitwick area to house health and social care staff which could provide services such as physiotherapy to all patients within the locality

**Gill Hiscox**

**Gill Hiscox** will be the overall manager of the programme, with each Practice taking the lead on one of the projects under the direction of their Practice Manager and one of the clinical staff. We will be kept informed of progress over the next two years.

# MORE OF THE QUESTIONS PUT TO THE DOCTORS, AND THE REPLIES, AT THE OPEN EVENING IN SEPTEMBER

**Question: Are the Health Checks for the 40-74 year olds useful and how many of the patients (percentage wise) need treatment for conditions that they were not aware of?**

**Dr Sulakshana replied:** 664 invitations were issued and 400 were accepted. 66% were counselled on diet, exercise and lifestyle choices. 2% were diagnosed with blood pressure, 2% were advised to take statins to reduce cholesterol, 15% had blood sugar levels higher than ideal and 1% had diabetes.

**Question: What plans have been put in place to combat the increasing number of patients joining the Practice due to the ever increasing developments in both areas?**

**Dr Westgarth replied:** The Practice is not restricted by the number of patients but more by the complexity of their conditions. The income of the Practice, which has a direct bearing on the services that are provided for the patients, rises with patient numbers.
Government recently introduced a central audit group to look at practice patient registers and delete any patients who had not made an appointment in the last 5 years. These so called 'phantom patient' records were archived in a centre at Warrington. **Dr Hughes** made the point that many of our younger and fitter patients did not require any treatment over very long periods and it may be unreasonable for them to be de-registered.

**Question: There was a pilot scheme at the L&D aimed at ensuring that elderly patients being discharged from the hospital obtained all the relevant services they needed at home. Was this a success?**

**Dr Gurram replied:** The pilot has finished and was found to be generally useful, but no funding was available for it to become a permanent feature.

**Question: Why hasn't the path to the entrance to Barton Surgery been repaired for a long time?**
**Able bodied people occasionally park close up to the surgery door, taking spaces that would otherwise be used by others who have difficulty in walking from the main car-park. Perhaps a sign, or signs, encouraging able bodied people to park elsewhere, would help.**

**Gill Hiscox, Practice Manager, replied:** We are aware that some areas of tarmac are in poor condition. Three bodies are responsible for the relative roads and paths – The Parish Council, the Village Hall, and the Practice. Recently we paid £800 to repair a 6 metre section of the tarmac, and the Parish Council replaced many paving slabs after three elderly people suffered falls on them. More tarmac improvements have been scheduled for the near future. *Continued on the opposite page*

# QUESTIONS AND ANSWERS CONTINUED

Gill Hiscox

A sign or signs about parking near the front door are a problem. It is not possible to mark the gravel parking spaces, and any signs we install are quickly vandalised. We plan to tarmac two of the bays and have them marked with yellow paint for disabled use. It would be helpful if able bodied patients did not use any of the front spaces and let those with restricted mobility, but not necessarily having a disabled card, use them.

Dr Randall

**Question: What, in the doctors' opinions, are the greatest challenges facing the Practice, and what gives them the greatest satisfaction or enjoyment in their work?**

The replies: Dr Sulakshana – the love of the job, Dr Westgarth – the love of the job, the challenges being workload and budgets, Dr Randall – continuity of care and patient relationships, Dr Hughes – getting a laugh from patients and helping their situation ( not always able to cure, just help), training registrars. The main challenge – getting registrars to become practice GP's rather than do locum work or going abroad. The job has to be made much more attractive, with pride in it restored and a good work-life balance.

## When stroke strikes ACT F.A.S.T.

F. FACE - has it fallen on one side? Can they smile?

A. ARMS - can they raise both arms and keep them there?

S. SPEECH - is it slurred?

T. TIME - to call 999 if you see any single one of these signs of a stroke

There are other symptoms that may occasionally be due to a stroke:

- Sudden loss of vision or blurred vision
- Sudden weakness or numbness on one side of the body
- Sudden memory loss or confusion
- Sudden dizziness, unsteadiness, or a sudden fall, especially with any of the other symptoms

( F.A.S.T. is a national campaign aimed at raising awareness of strokes)

# LASTING POWER OF ATTORNEY - it's often too late, seldom too early

Lasting Power of Attorney, formerly known as Enduring Power of Attorney, is a means of authorising chosen and trusted people, the Attorneys, to act on our behalf in the event of our being disabled or incapable of managing our own affairs. There are two types of LPA:

LPA for financial decisions
The Attorney can use the LPA for financial decisions while you still have mental capacity, or you can state that you only want it to come into force if you lose capacity. If you lose mental capacity and do not have an LPA in place your family or friends will not be able to make financial decisions on your behalf.

LPA for health and care decisions
This can only be used when you no longer have mental capacity. It covers all kinds of health and care decisions. Without this LPA the final decision on health and care matters rests with the medical advisers.

There is no need to be losing mental capacity before making a Lasting Power of Attorney. It can be done at any early stage and treated like an insurance policy. You hope you will never need it, but if you do your family will be grateful that you took the trouble to make dealing with your affairs as simple as possible. Problems can come on very quickly, and the Power of Attorney needs to be in place.

The role of attorney involves a great deal of power and responsibility so that it is important that you trust the person or people you choose. This is usually a family member but could be a spouse or friend, and may be a solicitor. The attorney must be over 18 and will receive no payment for the time involved unless they are a professional such as a solicitor. It is usual to have more the one attorney, and it has to decided whether they will act separately or jointly, or very often separately for everyday transactions and jointly for property deals. When you choose your attorneys give them a few days to think about the responsibility before the final decision.

To apply for a Lasting Power of Attorney you get in touch with the Office of the Public Guardian who will provide an information pack and the Lasting Power of Attorney forms online. Contact: https://www.gov.uk/power-of-attorney

You can fill in the forms yourself or it can be done for you. You don't need a solicitor or local advice agency, but accepting professional advice can save problems later on. The LPA must be signed by a certificate provider, any responsible person, who confirms that you have not been put under any pressure to sign it. Finally, the LPA must be registered with the Office of the Public Guardian before it can be used. There is a fee to be paid but this can be reduced or dropped if there are financial problems. The Public Guardian will provide help and guidance throughout the process.
We last printed advice on Power of Attorney five years ago. Since that time the arrangements have been simplified and made more user-friendly.

# THE YEARS BETWEEN THE TWO WORLD WARS

**In World War II** the highest casualty rate was in Bomber Command. In World War I it was unsurprisingly among the Infantry, and in the infantry the highest casualty rate was among the officers who went over the top with their men. They were easily picked out by virtue of their different uniforms and the fact that they carried pistols rather than rifles. Officers were almost exclusively the educated sons of the middle classes so that although the 'Top Brass' were usually commanding from cosy headquarters miles from the front, there was considerable mixing of the social classes lower down. The officer class came to have the utmost admiration for the endurance, stamina and good humour of the average British 'Tommy' in the face of such terrible conditions, deprivation and daily encounters with death. How did men survive such hardship? The truth was that life in the trenches was, for many, not much worse than life at home in squalid slums, dead end jobs, with low pay, poor diets and few educational opportunities! And yet they were fighting and dying 'for King and Country' by the hundreds of thousands!

**The terrible conditions on the Somme battlefield, 1916. The junior officer is second in the file.**

Such was the terrible cost of this war that afterwards there was a frantic search for some good reasons to explain why it had been fought. One idea that emerged in Britain was that life for ordinary people had to be made a lot better. It is interesting to note that throughout the 1920's and 30's income tax never fell below 5/- in the £ (25p.) and few complained. In those times most ordinary people earned less than £150 per annum which was below the lowest tax level that the tax was levied at, so income tax was just something for the middle and upper classes to settle twice a year between the tax office and their accountants! (PAYE for the masses only really got going during World War II when inflation and vast amounts of overtime for the War effort brought many more in to the tax net.) So there was a general feeling among the better off in Britain that taxation at 4 or 5 times the level of the pre-war, Edwardian period had to be accepted to improve the lives of ordinary people who had sacrificed so much. (The contrast with today's thinking is surely most marked!)

Sadly, of course, the effects of successive governments attempts to raise living standards in the 1920's and 30's were largely masked by the massive world-wide Economic Depression that set in in 1924 as World Trade completely failed to recover from the massive disruption caused by 4 years of global war. There was massive unemployment (twice as high in Germany as in the UK.) Unemployment levels varied from area to area. In Merthyr Tydfil at the height of the Depression in the early 1930's the level was 70%! The birth rate plummeted to it's lowest level ever in this country in 1932. However, the school leaving age was raised to 14, National Insurance was extended to cover many more jobs and some Health improvements were made. But perhaps the biggest strides were in Housing, following on from Lloyd George's 1918 slogan about ' building homes fit for Heroes'. All Local Authorities were required to purchase land and commence a programme of building houses to rent which ordinary people could afford. The age of the ‘Council House’ had arrived to house a third of the population.

*The second part of this article by Ivan Jones will appear in the next Newsletter*

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**PRACTICE WEBSITE**

**www.bartongroupsurgeries.co.uk**

## EUROPEAN HEALTH INSURANCE CARD (EHIC)

A valid European Health Insurance Card (EHIC) gives the card holder the right to access state-provided healthcare on a temporary basis as it would be to a resident of that country in the European Economic Area (EEA) This covers treatment necessary before the card holder returns home and includes treatment for pre-existing medical conditions.

This is not an alternative to travel insurance which is still vital for those travelling within Europe.

The card is provided free of charge. Initial contact:

www.ehic.org.uk

# THE CARE QUALITY COMMISSION IS THE INDEPENDENT REGULATOR OF HEALTH AND SOCIAL CARE IN ENGLAND



**The Practice** were given two weeks' notice of a CQC (Care Quality Commission) Inspection to take place on the 17 May 2016. One inspector and three 'specialists' arrived just after 8.00 a.m. Prior to the visit we had had to send a forest of paperwork to the CQC including protocols, surveys, staffing information, reports, statistics etc.

The 'specialists' were a GP, a Pharmacist and an Administrator who had knowledge of Practice Management. The day was planned for the GP to spend the morning with Dr Hughes and the afternoon with Dr Westgarth. The Lead Inspector would be with Liz, our Lead Nurse and the Pharmacist with Naomi, Dispensary Manager whilst the Administrator spent the day with me, the Practice Manager.

During the course of the day the Lead Inspector also interviewed a number of staff including Kate, Reception Manager and our Chair of the Patient Group and his wife Bill and Christine Holes.

The inspection covers 5 areas :

Safe
Caring and Responsive
Well Led
Effective
Utilities

Each area has to be evidenced with numerous systems, procedures and safety certificates. The Administrator sat in my office surrounded with almost every piece of paper I have! Some areas covered were checking staff files for references, contracts, training certificates etc; electric safety checks; complaints processes; significant event records and so on and so on!

Even though we consider that we are a good Practice, actually being inspected is an extremely stressful experience for the whole Practice.

The day ended at 5.00 pm with a meeting of all Partners, Departmental Heads and myself with the CQC Inspectors feeding back on their findings. They were very generous with their comments and were obviously very impressed with us which was a huge relief.

The final report was received on the 1st December (six months after the inspection) and can be read on the website www.bartongroupsurgeries.co.uk

**Gill Hiscox, Practice Manager**