THE GP PRACTICE MANUAL: How does your Practice Work?

GP Hours and Groups

Those of you familiar with the famous Haynes Manuals for motor cars may be aware that you can now purchase a Haynes Manual for just about anything: The Flying Scotsman, The Space Shuttle, The London Underground, Sheep and even Running the Country. There is, however, no such manual for General Practice, which just proves that running a GP surgery is much more complicated that getting a man onto the moon!

In this brief article we will focus on just one aspect of our complex operation: the working day of GPs. Of course, the doctors could not carry out all of their tasks without the excellent support of the practice's teams of nurses, receptionists, administrators and our practice manager. In subsequent newsletters, we will be pleased to 'look under the bonnet' of those areas which are of interest to the PPL members; the editor will be delighted to receive your requests *(lae@ianellisassociates.com).*

The GP Day

Currently there are 9 regular GPs working at PMG. 5 of these doctors are partners (Drs Fooks, Mitchell, Ghazanfar, Tooley and Campbell) and 4 are salaried doctors (Drs Scahill, Bascombe, Murphy and Bedi). At present we also have two qualified doctors who are either training for a career in general practice, or are with us as part of their first two (Foundation) years as a NHS medic. GP Partners and salaried doctors carry out similar levels of clinical work, but the partners have the additional responsibility to ensure that the practice is well-led and functions safely and effectively in every department. At PMG, we have expanded our partnership to include both our practice manager, Alan Bolt, and our senior Nurse, Anna Harrison.

GPs are by definition medical generalists, trained to be able to assess and treat patients with problems that can arise in any part of the body. To achieve this we can arrange tests, prescribe and administer treatments and, where necessary, follow up with our patients to ensure they are making progress in the right direction. However, we are also trained to understand our clinical limitations and to discuss those cases where we are not certain of the best course of action. Our current GPs have such a wide range of additional expertise that often we can resolve a difficult medical issue through a discussion within our team. However, we are also able to refer to our local hospitals for a specialist opinion. On average, GPs will refer only 10% of patients to local hospitals.

Each working day, doctors run morning and afternoon clinics during which time they will consult, in all, about 30-35 patients. On three days a week, the practice starts some doctor and nursing clinics at 7am and on Mon - Friday PMG closes at 6.30pm. Most of the appointments are only 10 mins and it is frequently a challenge for both GP and patient to conclude all their business within this time-frame. Appointments can be booked in person, by phone or on-line, but it is difficult to arrange to see a specific GP unless arranged some way ahead. However, every weekday PMG has one or two doctors available so that every patient who contacts the practice, needing an appointment that day, will be spoken to or seen by a GP or our Nurse Partner (NP). Each of these duty clinics will involve 30-50 consultations in person or on the phone.

Between the morning and afternoon clinics, GPs, and our NP, visit patients who are housebound. PMG makes about 1,000 home visits a year and each can take up to an hour of the GP's day due to the large geographical area we cover, approx 175 square miles.

Receptionists may also message doctors with requests to speak to patients. These are called tasks and may number 10-20 a day. GPs are also sent about 30 prescription requests a day to check against the patient's medical record before they can be approved and issued.

The practice can receive several hundred letters from specialists and a similar number of reports and results from the blood tests and x-rays ordered. Each letter and result is checked for new diagnoses and changes in clinical management; these are highlighted by the scanning team and then scanned into the patient's 'SystmOne' clinical record and passed on to the GPs for interpretation and action. Often this requires the patient to be contacted to ensure the new plans are put in place safely. Each GP can receive up to 30-50 letters in a day.

Those of you with a mathematical inclination will realise that each GP has a large burden of very important 'paperwork' to process every day. This must be done on top of their more familiar role of patient-centred consultation in booked clinics. For some, this component of the work can take up several hours, making 10-12 hour days in the practice, or on a secure connection from home, not unusual. Many GPs have other important commitments at home and elsewhere and several of us will work a 40+ hour week spread over less than 5 days.

it can be difficult, in such a busy environment, to ensure a) patients can follow through their problems with the same doctor and also b) that there is no delay in processing potentially critically important clinical information; letters and actions that sit around awaiting the return of a GP from leave or days-off are prone to be overlooked.

NEWSLETTER NUMBER 38 SEPT '17

Pulborough Patient Link

pulborough patient link - your voice in local health

Pulborough Patient Link invites you to a Public Meeting in Pulborough Village Hall on

Monday 2 October

when

Dr Peter West MA MSc FRCP FRCS

Consultant Audiovestibular Physician

President of the British Association of Audiovestibular Physicians

will give a talk entitled

What Every Patient Needs to Know about

Dizziness and Imbalance

7.00 pm Talk – approx. 8.30 pm

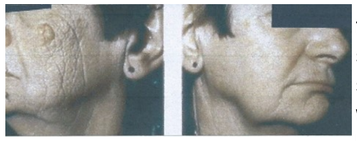
We are most grateful to our advertisers for sponsoring our newsletters.

SKIN CANCER

Our July public meeting was attended by 96 of us, all keen to hear what Dr Bav Shergill, consultant dermatologist working in Sussex, had to say about this emotive subject. Apart from seeing NHS patients at hospitals in East Grinstead and Worthing, he consults privately at three centres and holds community dermatology clinics at PMG.

Dr Shergill's specialist area of interest is the treatment of skin cancer and he also gave us guidance on the use of sunscreens and, from his talk, his hope is that we 'communicate the message and appreciate the scale of skin cancer in the UK'.

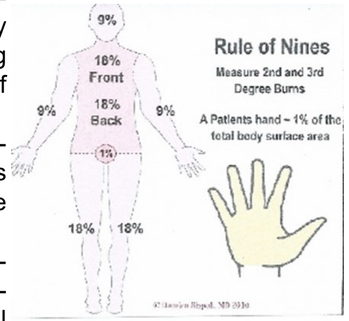
Light is wonderful, but ultraviolet light both A and B, which we cannot see, damages living tissue and our DNA is broken by excessive amounts of sunburn. The sun induces ageing as the exposure to the sun causes cell damage. These photos clearly show the effect of sitting at the same window facing the same way for 15 years as windows block ultraviolet B but not A.



There are six skin types and we have to be particularly careful to protect very fair and red-haired children as they are the most vulnerable, with darker skins much less so; the fairest will always burn whilst the darkest hardly ever burn (deeply pigmented dark brown to black skin). If you are a smoker more sun damage will result than for those who are not.

Treatment of sunburn includes:
Antihistamines
Steroid creams
Aloe vera, moisturisers, cold water
Non-steroidal anti-inflammatory drugs (NSAIDS) and
Knowing when to seek help (cont'd on back page)

Help is required when – more than 20-25% of the body is burnt – using the Rule of Nines there are severe blisters (2nd degree burn) there is pain, fever, chills, nausea and general feeling of being unwell *or* blood pressure is low and there is fluid loss



The incidence of skin cancer has doubled locally in the last 10 years, with there being 15,000 cases of melanoma, 30,000 of squamous cell carcinomas (SCCs) and up to 200,000 of basal cell carcinomas (BCCs) diagnosed in the UK each year. Australia has 10 times greater incidence of skin cancer than we do. If a spot keeps improving and getting worse again 'you will cause less drama to yourself' if you get it looked at early as a BCC can go deep and damage bone. There are several possible treatments for pre-cancerous lesions (the medical term) including cream (Efudix), cryotherapy (freezing), scraping and cutting, with cancerous lesions needing more radical therapy such as surgery and radiotherapy.

It is important to remember the ABCs of what are melanocytic naevi (what we call a mole) which are only dangerous if they change; it could be a problem if:

A – it is asymmetric; one half does not match the other in shape
B – the border is irregular, ragged or blurred
C – the colour is non-uniform pigmentation throughout, often varying shades of black and brown
D – the diameter is more than 6mm
E – it is evolving, ie changing, itching, bleeding, growing, blurring, darkening, lightening. It is a good idea to photograph any mole that you are worried about with a coin next to it so that you can gauge whether it is growing.

Frederick Mohs developed a type of surgery whereby a layer of skin is removed and, while the patient waits, that tissue is tested to see whether another layer also needs removing, thus ensuring the problem is solved with one treatment.

Dr Shergill stressed how vital sun protection is, although we do need some sun to make vitamin D which is important for our bones – even 15-20 minutes a day on the forearm is sufficient, as is including oily fish in our diet. The first sunscreen products were available in 1900, but it was not until the 1970s they were much improved, with more efficacy and more choice of product, which is why many of us have problems now as it takes many, many years for damage to show. There are two types of sunscreen – inorganic and organic. Inorganic are usually known as sunblocks or physical blockers and scatter (or deflect) the protons, whereas organic are known as sunscreens or chemical absorbers and absorb the protons. Without sunscreen 100% of protons can do damage; with SPF15+ only 7% enter the skin and with SPF30+ only 3%. It is possible to be allergic to suncreams, usually caused by the fragrance or the preservative.

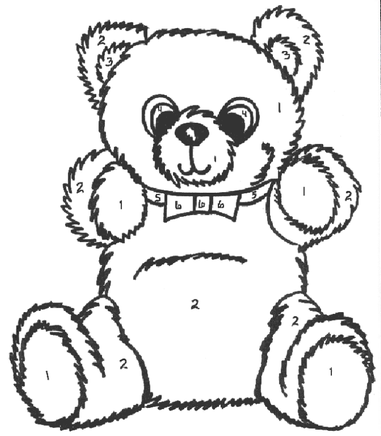
The advice is :
to check moles regularly using the ABCDE rule and take any concerns to your GP
apply a high factor sunscreen - SPF30+ (we normally use only about half the recommended amount which results in SPF15) using one that also includes UVA protection (shown either by 4-5 star rating or by the letters UVA encircled)
reapply regularly, particularly after swimming
seek shade between 11am and 3pm
wear tightly-woven clothing
invest in a wide-brimmed hat (much preferable to a baseball cap)
wear UV protection sunglasses

In other words **be sunsafe**, with the take home message

Please tell your children and grandchildren.

PLEASE COLOUR ME

1 Light brown 2 Brown 3 Pink
4 Light blue 5 Green 6 Red



DENTAL PAIN?

Please remember, if you have a dental problem, this is something which needs to be addressed by a dentist, ***not a doctor***. British Medical Association advice is that doctors do not have the expert knowledge required to diagnose and solve dental pain, etc..

If your problem arises outside your dentist's normal hours, please contact an emergency dentist. Worthing area is covered on 01903 230 364, with Chichester 01243 831 790; failing these and in an emergency go to an A & E Department.

To resolve these important concerns, over the past 3 years, we have organised our doctors into teams of three: we call these GP Groups. Each group is supported by a named administrative assistant and takes on the responsibility for handling the correspondence and results for roughly a third of our 13,000 patients.

In addition, wherever possible, when a GP is on leave and a regular patient needs medical attention, it will be one of the doctors from the same GP team who will provide the additional support.

In summary, the role of a GP is an enviable one: we spend every day in clinic ensuring our patients are safe and able to understand and cope with whatever health problems have afflicted them. We are general medical problem-solvers and we count ourselves privileged to be involved in such a fascinating, worthwhile and rewarding role. However, as we have seen, the working day of a GP is often long and always involves intense and complex decision-making. At PMG, therefore, we are concerned to ensure that all our GPs keep themselves well and we encourage them to find a balance of work and home-life which enables them to stay 'on the ball' and enjoy every day they are working with you, our patients.
However, times in the health service are a-changing yet again, and the NHS is committed to increasing the hours GP surgeries are open and to shifting more work from a hospital setting into general practice. PMG whole-heartedly supports these initiatives in principle but we wait, with great interest, for the announcement from the NHS which will explain how this can be achieved in a way that will be successful for both our patients and all those that are proud to serve them.

Dr Tim Fooks

PMG UPDATE

We have appointed another new salaried GP – Dr Lucy Oxley – Lucy will be joining us towards the end of October and will be working Mondays, Tuesdays and Thursdays.

Dr Oliver Brown, an FY2 trainee joined the Practice for 4 months in August and is under the clinical supervision of Dr Ray Ghazanfar. Dr Tim Fooks will continue to mentor Dr Rosanna De Cata, our ST3 GP trainee, until she completes her training in January 2018. It is unlikely we will have another GP trainee as there is a shortage of trainees coming through the system and most trainers will have a year without a GP trainee. In view of this we are looking at the possibility of having year 5 medical students for training attachments.

PMG continue to meet and work with the other Practices in our Group, regarding future developments in Primary Care within our locality and CCG.

The Practice will close for **Encircle training on the afternoon of Tuesday 10th October,** with the next one being on **Wednesday 22nd November.** As is the case on these afternoons, we will be closed for routine clinics/appointments from 12 noon. Those attending non-PMG clinics are asked to sit in the waiting room until called.

Alan Bolt