

HIPPOKRATES EXCHANGE PROGRAMME

THE LIME TREE SURGERY IN WORTHING - SUSSEX, UK

August 30 - September 10 2010

Overview

When I first met our national Hippocrates exchange coordinator in 2008 in Florence, I was absolutely enthusiastic about the chance of spending a fortnight abroad to visit other GP practices and observe how they were run. Thereafter I asked him to e-mail for an available place on the South coast of England and the first host who kindly replied was Dr. David Mannings from the Lime Tree Surgery in Worthing, West Sussex.

Really, it took me some time to find a suitable accommodation during summertime for a family of five people, but after some tries my English host and I could fix dates for the exchange. Although England is not at all new to me, I must confess I was really excited about this September period, which was supposed to be not only a working time for me, but also a seaside holiday for my family.

When I arrived at the surgery I received a very warm welcome from Dr. Mannings and all his both medical and nursing staff. Gradually, I was lead through the building structure and all its ongoing activities. While trying to explore this new world, I asked a great deal of questions and the answers I received slowly let me into the NHS system. As a whole, my stay at Lime Tree Surgery was a highly educative experience, both from the professional and the interpersonal point of view.

As far as my report is concerned, there are lots of very interesting issues I could deal with, but I would like to concentrate on GP specialty training in UK.

Its duration is of three years and consists of six, four month hospital placements over a period of two years. This allows for a wide range of specialties to be covered and there is some flexibility to cover any area of specific interest. GP training ends with a year as a GP registrar when a doctor works within a practice with his own patients and clinics. There are also regular meetings with the Educational Supervisor for an educational appraisal review and for future educational plans, while taking into account that the process of learning is a learner's led programme and where overall control and responsibility is taken by the trainee doctor himself. Within the third year the nMRCGP assessment has to be passed too which includes three components: AKT- Applied Knowledge Test: this is a summative assessment of the knowledge base that underpins independent general practice within UK; CSA- Clinical Skills Assessment: it assesses a doctor's ability to integrate and apply clinical, professional, communication and practical skills appropriate for general practice; WPBA- Work Place Based Assessment: it is defined as the process of evaluation of a doctor's progress over all three years of training through which evidence of competence in independent practice is

gathered in a structured and systematic framework. Satisfactory completion of this new assessment process will lead to a Certificate of Completion of Training (CCT) and with this award, the name of the doctor can be placed on the GP Register.

Finally, the doctor can practise as a General Practitioner. He will also be eligible to join the RCGP as a Member, and if he has previously been an Associate in Training, the membership category will be upgraded automatically. As a Member, the doctor is able to use the letters MRCGP after his name for as long as he remains a member of the College.

As for a concise comparison with our Italian GP training, I would only underline a single point that makes a great difference with the English learner's log: we do not submit a real WPBA during our one-year training in a GP surgery because we do not work on our own with patients and therefore cannot have a supervised case based discussion.

To sum up, I would definitely recommend this exchange to other GP trainees, although I must confess it is not a holiday time to be at leisure, but a worthwhile period to compare and to learn. Basically, I think that travelling abroad and observe different ways of doing things while broadening one's own horizons plays an essential part in a junior doctor's career towards General Practice.

Here is a concise grid to show GP career from medical degree to MRCGP.

Graduate from medical school						
F1 first year of foundation training in NHS hospital						
F2 during second year of foundation training apply to MTAS for a place to train as a GP. If successful, apply to Deanery for training arrangements. Apply to RCGP to start MRCGP						
Specialty Training (various routes)	GP 3 m	Hospital 12 mth	Gen Pr 6 mth	Inte- grated post 12 mth	Hospital 12 mth	Specialty Training 1
	Ho 3 m		Hospital 6 mth			
	Ho 3 m					
GP 3 m						
Minimum of 3 years. Must be completed in 7.						
Minimum of 12 months (18 in Scotland) full time employment, or equivalent, as a specialty trainee, under supervision of a GP trainer.	Integrtd 6 mth	Gen Pract 12 mth	Hospital 6 mth	Integrtd 6 mth	Integrtd 6 mth	Specialty Training 2
	Gen Prc 6 mth		Gen Pr 6 mth	Gen Pr 6 mth	Gen Pr 6 mth	
Minimum of 12 months full time employment, or equivalent, in hospital training posts approved for GP training.						
Have current CPR and AED certificates and pass AKT, CSA and	Gen Pract 12 mth	Gen Pract 12 mth	Gen Pract 12 mth	Gen Pract 12 mth	Gen Pract 12 mth	Specialty Training 3

final review of WPBA.

Apply to GMC for Certificate of Completion of Training and entry onto GMC GP Register and be entitled to work as an independent GP and be eligible to be Member of the Royal College of General Practitioners

Reflections

While following Hippocrates Coordinator advice to add some reflections on my experience, I have to consider my learner's log first and then think about my actual outcomes carefully. Really, I bear so many ideas in mind that it can be difficult to write an integrated essay as I looked more like a journalist than a doctor, when I wandered all over the place to discover and to learn.



Before leaving Italy, I had some expectations as to patients and doctors, but they ended to be irrelevant, because both doctors and nurses have to face the same medical conditions. Generally speaking, health professionals are competent and well trained to face any unselected medical situations, but I must also underline their ability to deal with all psychological aspects of personalities with deep insight, in order to distinguish signs and symptoms of patients. As a matter of fact, in General Practice a great and unavoidable job must be done with many patients with psychological problems.

Basically, the enormous difference I found is within work organisation and the keystone of this healthcare model is team working.

First of all, let me consider that General Practice assistance does not always demand medical involvement, but also nursing or administrative issues that can be taken on by specific professionals. For example, at Lime Tree Surgery repeat prescriptions can be made either via telephone or re-order paper form or even via e-mail; after that a paper bag with the requested drugs can be collected after

three working days in the in-house Pharmacy. To this purpose secretaries and a patient services manager are well trained and equipped.

Secondly, let me discuss about patient accessibility to doctors. Both in Italy and in England, medical needs are increasing due to population aging, so that every patient would like to talk to or see a doctor within a few hours; on the other hand medical graduates are numerically less now than in past years, so that the workload is rapidly increasing. To this problem many solutions can be found, while bearing in mind that a surgery session cannot be interrupted every ten minutes by a patient phone call. At Lime Tree a new appointment system has been recently introduced to increase the number of services, whose aim is facilitating improved access for all patients, promoting continuity of care for on-going problems and offering a same-day-appointment when requested. Every phone call is answered by an information desk receptionist, who will give general advice over the phone, book an appointment with the usual doctor or arrange a home visit. Thus GPs spend a specific length on the telephone every day to answer patients' questions and in case of need, they will give a same-day-appointment. Definitely, there is no queuing or direct access to the doctor's door for supposed urgent problems.

Third, moving to medical staff organisation, an extremely important aspect of healthcare assistance is the list of patients: in this respect Italian General Practice is at crossroads. Adopting a single GP patient list model implies a much heavier workload and this isolated job cannot lead to team working or assistance sharing. To be honest, collaboration is crucial nowadays, to stand up to increasing medical requests, and there is no need to work with a list of patients who only refer to and trust a single (father) GP. The usual objection is that a GP-patient relationship cannot be safeguarded otherwise.

A well-tried method is the patient registration within the practice and the doctors' working model as a non-limited partnership. At Lime Tree Surgery there is a group of ten General Practitioners, seven of which form the fixed team and share the Practice income, whereas the other three ones work as associates and are salaried by the GP practice manager. They overall share the workload: on one side there is the booked group of patients that are visited every day according to the appointment list without interruption, on the other side the urgent problems are taken on by a book-on-the-day-surgery-team of three doctors and one nurse practitioner per session. In this way an extra amount of 60-70 patients with urgent problems are visited every day. It is not to be forgotten that children and babies belong to the workload of GPs too.

Moreover, in General Practice an important role is now played by nurses as practice nurses and nurse practitioners. They are registered with the Royal College of Nurses at different levels: they study to gain different professional qualifications and work in different medical settings, so that they are provided with many auxiliary both nursing and medical competences up to the highest grade of independent nurse prescribing. This type of diploma is a high grade of nurse qualification that helps GPs greatly at a much lower cost. Within this new nursing educational framework a number of other caregiver roles is possible and this results in a lot of competences of health professionals at different levels.

For example, health care assistants belong to the lowest grades of nursing careers and work under indirect supervision of the practice nurse team leader, while undertaking many tasks and duties. They work collaboratively with the general practice team to meet the needs of patients, following policy and procedures of infection control, while providing supervision to more junior staff too. Clinical and assistance skills include duties like measuring and recording physiological measurements in routine presentations: for example they register blood pressure, pulse rate and rhythm, temperature, height and weight - body mass index, visual acuity, phlebotomy, ECG. Apart from this basic competences of HCAs, qualified nurses can work as practice nurses, district nurses and nurse practitioners. The competences are numerous and cannot be briefly summarised: they include the delivery of basic practice nursing services to the independent nurse prescribing level .

What I would strongly underline is the role of practice nurses in cooperative work with GPs as far as assistance and nursing competences is concerned, such as leg ulcer dressings or ear irrigations; on the side of nurse practitioners, the sharing of the same responsibility is essential to work collaboration with GPs for surgery visiting and prescribing. Committing some duties to different nursing health professionals reinforces and improves medical assistance, because many more requests can be met and patients with chronic diseases can be frequently and regularly reviewed. To make some examples I would like to list pathologic conditions like diabetes, hypertension, COPD and asthma for which there is a dedicated nurse at Lime Tree Surgery that has her own specific workload. To tell the truth, this kind of work organisation is strictly related to the Surgery income too, as a bigger sum of money is given by the State if the specific QOFs for each pathologic condition are met and thus the principles of equality and integration of care are well kept within General Practice.

As a consequence of nurse collaboration, GPs can dedicate their time to patient consultations without interruption and without endless queues for minor questions. It deals only with better work organisation, as older patients with chronic diseases are rapidly increasing. While bearing this situation in mind, I must also point out that clinical aspects of chronic diseases reveal their major importance as far as management is concerned, that is to say that hospital referrals are involved to a far lesser degree.

Finally, a short word about care for the elderly. Since the Worthing area population is old, many services are well developed and equipped, ranging from the basic needs of having a shower and doing daily shopping to the highest grade of assistance for the bed bound. Social services for routine activities of daily life are provided by private companies, whereas home nursing assistance is organised by the PCT by district nurses. Home urgent visits are organised within the surgery and can be carried out either by GPs or even paramedic nurses. In the Worthing area there is also a country hospital for the admission of outpatients with particular needs or for a rehabilitation short stay after hospital discharge.

To sum up, I would like to underline the enormous potential of General Practice that must be developed by GPs themselves who should organise a sort of tailored assistance to the local needs of the surgery population in accordance with general supervision of PCTs.

For this and many other reasons I would recommend the Hippocrates exchange to all GP trainees.

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