Somerset LMC Newsletter

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ALL CHANGE IN THE NHS

It is extraordinary to feel the tectonic plates of the NHS start to shift. Although storms of change have blown around us with growing ferocity for many years, it now appears that rather than the wind blowing down some dying old institution to reveal an interesting new perspective, the whole landscape is heaving. And for once this is driven not by political whim, but by necessity. Whilst successive governments have been paralysed by the impossibility of providing an unlimited service that is free at the point of delivery - which their political advisors say it would be electoral suicide to alter - within a fixed budget, the colossal evolving funding gap means that we have to make practical changes *now* for the NHS to survive. Wrapping it up in layers of institutional brown paper and sticky tape in the form of CQC, Healthwatch, Monitor, NHS England, the TDA and Uncle Tom Cobley will not stop large bits falling off if unchecked demand is allowed to continue to run free. Meanwhile, the 20% of the maternity budget that is spent on negligence cases suggests that political and public expectation of care far exceeds that which the NHS is actually able to provide. This is not a good place to start.

But fellowship in adversity may sometimes lead to lasting relationship and hence real improvements in the way things are done. The Somerset GP federations are beginning to develop distinct identities and to look at closer joint working, including sharing specialist management skills between practices. The share offer for Somerset Primary Healthcare has been issued (practices should receive their packs by 21st November with a return deadline of 3rd December) and the LMC has kept a watching brief on its progress to ensure that the interests of all practices are protected and balanced so SPH can seek to help us through these difficult times. Meantime, the national 2014 contract proposals are a welcome recognition that QOF was leading us down a blind alley, and that a return to concentrating on real patient care was overdue. The LMC believes that more progress along these lines can be made locally.

Of course, we still have plenty of problems. Recruiting and retaining GP partners in Somerset is challenging. Falling incomes, concern about the host of pension changes and sheer exhaustion is leading to a steady loss from partnerships of GPs in their 50s, and younger doctors are hesitant for many reasons about committing to becoming partners. We cannot afford to unwind the partnership model of independent contractor primary care delivery until we can work out if there is something more fitted to the 21st century to replace it, but that should not stop practices working together in networks and localities to make the best use of scarce resources. Certainly if we are to provide intermediate level care in general practice, that will mean sharing expertise, and having two or three really expert diabetes nurses in a federation area may be a better solution than every practice having one person trying to cover a whole range of long term conditions. Add in a community specialist diabetes service with consultants and a couple of nurse practitioners, and who needs hospital diabetic clinics?

So our message is that we can – and must – design our own local solutions to the universal problems of the NHS, and that these solutions should offer not only better health for our patients, but also a more sustainable job for all primary care workers. We have to concentrate on achieving both.

MULTISOURCE & PATIENT FEEDBACK – WHAT SHOULD YOU EXPECT?

LMC advice from our experience of moderating responses

A good number of Somerset GPs have used the Wessex feedback tools that the LMC recommends, and the LMC moderators have now reviewed enough responses to give other potential users a feeling for what to expect. Early users have been at something of a disadvantage, as the first GPs to be revalidated were our professional leaders, so to begin with the initial denominator group really was made up of Professors of General Practice! It is perhaps reassuring that they all scored so highly, and more humble users should not feel disappointed if their own patient scores were, relatively, not so good. Remember that only half of us can be above average, and there are many reasons - that are nothing to do with the quality of care that you offer - why your patient feedback scores may be low. Indeed, there is sometimes an inverse relationship – if the GP is very good, patients will sometimes punish her (or, just occasionally, him) in these surveys for not being available all the time.

The professional feedback that we moderate is tending to follow a pattern. Most GPs will, very sensibly, choose colleagues for their MSF with whom they are in sympathy, although the most excoriatingly honest will just pick sixteen contacts at random. In either case most respondents will be kind and cautious, with any criticisms generally carefully veiled so it is usually very obvious when the subject GP has just had a row with one of the respondents! Numerical scores typically cluster around "good" with some "excellent", some "satisfactory" and one or two "unsatisfactory". It is unusual not to have any negative remarks, because you cannot please all of the people all of the time. These reflect the main dimensions of clinical practice, so it is either "works efficiently but sometimes brusque and notes are scanty, some patients don't want to see him" or "patients love this GP but surgeries are chaotic and patients complain about long waits", depending on the kind of doctor that you are. Try to see negative comments as coming from a critical friend: After all, the whole point of MSF is to help improve practice, and if everyone was just nice all the time the whole exercise would be a monumental waste of time. MSF is not a "pass/fail" test – there is no minimum acceptable score – but it should help you to reflect on what you are doing and add some value to your next appraisal.

Of course, GPs do not work in a vacuum and both patient and professional feedback are influenced by how people view the practice as a whole – in particular how they perceive access, whether as a patient booking an appointment or a colleague trying to ring to talk to someone. Inevitably some criticisms will really be about things outside your control, and whilst they may be informative, do not spend time ruminating about them. Don't forget that genuinely hurtful comments say much more about the critic than they do about you. Such behaviour suggests that either the individual is struggling him or herself, or that there is an important dysfunction within the practice: either way, it may not be your personal problem, but you do need to address it.

Please do not be alarmed or concerned if an LMC moderator rings to arrange to discuss your MSF results. This does not mean that they are abnormal, it is just that during this initial stage we like to be sure that they are not misinterpreted. If you are concerned about any part of your feedback, please do contact the LMC secretary harry.yoxall@somersetlmc.nhs.uk or by text or call to 07796267510.

NHSMAIL FOR SESSIONAL GPS

Essential for the secure exchange of data

If you are a sessional/locum/salaried GP and require an NHSmail account to securely exchange data, please contact the NHSmail Administrator in the GP practice for which you carry out most work. The Administrator will need to liaise with the Local Organisation Administrator (LOA) at South West Commissioning Support (CSU) to ask that an account is hosted and administered via the GP Practice on your behalf.

If you work across several GP practices, it may be more appropriate to have your account hosted and administered directly by the CSU. If this is the case, please contact Primary Care IT Support at somersetservicedesk@swcsu.nhs.uk who can arrange this for you. If you have any problems with registering for NHSmail contact feedback@nhs.net

RELOCATION, RELOCATION, RELOCATION*?*

An email about federation nursing from a concerned GP:

"Our DNs are still resident in the building, perhaps because it has been unseasonably mild. Even the clocks changing does not seem to have triggered their migration to hub or spoke. Maybe the North Atlantic blocking has changed the direction of the jet stream so they cannot fly that far?...But will there be enough food for them to forage on during the long winter months if they leave it too late?"

SMALL ADS…. SMALL ADS…… SMALL ADS….
For current practice vacancies please go to:
http://www.somersetlmc.co.uk/classified.php

SOUTH WEST CLINICAL SENATE

A Strategic Advisory Body that needs GP involvement

The South West Clinical Senate is hosted by the BNSSSG Area Team but covers the whole of the Southwest with a huge geographical area and a population of around 5 million. It's purpose is to '*bring together a range of professionals to take an overview of health and healthcare for local populations and provide a source of strategic, independent advice and leadership on how services should be designed to provide the best overall care and outcomes for patients'.*

As the commissioners of most services, CCGs are the main clients, although the Senate does not restrict itself to services commissioned by CCGS and may also make recommendations on specialised services. As a new entity, crossing professional boundaries and sitting above the existing geographic and organisational borders, the Senate's role is to ensure that quality and efficiency in the commissioning of patient services are firmly prioritised.

The Senate consists of its Council, a small group of senior clinicians and managers with a breadth of experience across local healthcare provision, whose role is to oversee the work plan, and agree and ensure adherence to operating principles. This will be supported by the larger Assembly, of indeterminate size (but likely to be in the region of 250), drawn from the wider health community, to include representation across all health professions and Patient and Public involvement. The Assembly will meet only occasionally to deliberate (probably 2-3 times/year). The Senate can also draw on specialist expertise.

The Senate management team is led by the Senate Chair, Dr Vaughan Lewis, a paediatrician in Exeter, and Shelagh McCormick, a GP from Cornwall, in the Deputy Chair. It is important that GPs are involved with the Clinical Senate to provide a grassroots, generalist view with a focus on patient advocacy. From time to time the Senate will be seeking new members and that hope that GPs across the region will consider getting involved. If you are interested please contact the Senate administrator: sarah.redka@nhs.net.

LETTER TO THE EDITOR

Dear Editor

I read with concern the suggestion in your September newsletter that Primary Care should "sideline" or "abandon" the NHS Health Checks programme as it "does not meet genuine and urgent priority needs".

In highlighting the issue of capacity in primary and acute care, I would argue that you have made the case for the NHS Health Check programme. Pressures on the acute hospitals, falling funding and demographic change indicates that efforts must be increased to raise public awareness of the link between lifestyle choices and health, and the value of preventing ill health. Currently 28% of people aged 40 to 74 are not eligible for a NHS Health Check, due to a pre-existing condition. 26% of those aged 55 to 59 are ineligible, rising to 37% aged 60-64, 49% aged 65-69 and 61% aged 70-74.

The evidence to support the NHS Health Checks programme is developing. However, there are a number of significant facts that we know already about diabetes alone:

- Levels of obesity are of major concern and are linked to development of Type 2 diabetes. As of 2012 it was estimated that 25.9% of Somerset adults were obese which is above the national average.
- In 2010/11 there were 24,405 people aged 17 years and older diagnosed with diabetes in Somerset. It is estimated there are 10,200 adults in Somerset with undiagnosed diabetes.
- Diabetes significantly increases the risk of heart attacks, strokes, blindness, kidney failure and amputation.
- Hospital lengths of stay are on average 20% higher for those with diabetes than for those patients without diabetes. Life expectancy for someone with Type 2 diabetes can be reduced by up to 10 years.
- It is estimated that £10 billion (10% of 2010/2011 NHS budget) is spent by the NHS on diabetes.

In Somerset, 10,280 NHS Health checks were delivered during 2012/13. Of these:

- 2,933 (29%) individuals had elevated glucose levels (≥6mmol/L).
- 1,486 (14%) people had a Qrisk of 20% or greater.
- 334 (3%) individuals indicated chest/calf pain on exertion (presumably previously undetected); 90 (27%) of whom were aged between 40 and 49.
- 3,100 (30%) of the checks delivered were for people residing in high deprivation areas (Somerset quintiles 1 and 2), of which 442 (14%) had a Qrisk score of 20% or greater.

We know that 90% of the causes of premature cardiovascular disease are due to lifestyle choices and therefore preventable. The value of the NHS Health Check programme is the opportunity it provides to engage with individuals, highlight their personal 1 risk and advise each how small changes in lifestyle can help to reduce their long term risk. It is a step in the right direction to educate people and empower them to begin to take control of their own health. I would ask you to reconsider your position. **Sharon Ashton, Public Health Programme Manager, Somerset County Council**

Dr Whimsy's Casebook: Dealing with The Press

It's 7:00 p.m. A patient has failed to keep an urgent appointment to discuss the multidisciplinary management plan for his verruca, and Dr Whimsy takes the opportunity to catch up on an essential newspaper article. It's a well argued, meticulously researched and scrupulously balanced exposition of primary care by a highly qualified expert in the field: http://tinyURL.com/DailyMail-GPs. The phone rings. A jobbing reporter, would like to conduct a brief interview over the phone for the Morning Moan. Dr Whimsy accepts the call.

Interview

EV: Hello, Dr Whimsy. Can you give me a couple of minutes to answer a few questions?

Dr W: I do have a moment to spare so I'd be glad to help. It's probably a good idea to keep it anonymous in case my patients read it.

EV: That's fine. Now, how do you decide whether or not to visit a patient at home, and how quickly?

Dr W: If they need to be seen, and they are unable to leave the house because of illness or disability, I'll gladly visit them as soon as necessary.

EV: Suppose it's an emergency, like a heart attack?

Dr W: If that seems likely from the patient's symptoms, then we may call an ambulance so that the patient is taken to hospital as quickly as possible. A house call could delay their access to life-saving treatment.

EV: Why can't you see all your patients at home?

Dr W: In the time it takes to make one home visit we can see several patients at the surgery, so it's not an efficient use of our time when the patient is able to leave their house. And, of course, we can't take along most of our equipment, our nurses, and so on.

EV: In your busy schedule what do you do to relax?

Dr W: It's exhausting work, often more than 12 hours a day, and when I get home I'm afraid I often fall asleep watching the TV. I have a break in the middle of the week to recharge my batteries, and I might play a round of golf then.

EV: Do you do any out of hours work?

Dr W: No. My daytime job is far too demanding, and I simply wouldn't be able to do both. I was so glad when we were given the opportunity to hand the out of hours work to a dedicated service.

EV: But isn't it be better for patients to see their own GP if they have a problem out of hours?

Dr W: With the evolution of group practices and co-ops patients didn't usually see their own GP at night anyway, and it's not necessary in a genuine emergency. A doctor doesn't have to know the patient personally to diagnoses a stroke.

EV: Patients say they sometimes can't get an appointment with their GP for several days. What do you say to them?

Dr W: Patients expect much more from their GPs nowadays, so demand is high, and you may have to plan ahead to see your doctor about a non-urgent or long standing problem. But if it's urgent we'll always see you on the same half-day. If it's a real emergency it might be better to dial 999.

EV: Well, thanks for taking the time to talk to me.

Dr W: You're very welcome. Goodbye. [hangs up]

Article in the next morning's Morning Moan

Doctors are always lying about their pressure of work. In a probing telephone interview by our Senior Health Correspondent, a GP who was enjoying a long afternoon break admitted that they have plenty of time to relax during their easy surgeries.

The GP, who refused point-blank to give his name, confessed that you have to be at death's door to get a home visit, and then he'll wander over to your house in his own good time, however urgent you think your condition may be.

Or he might just decide that he can't be bothered to visit you at all, even if you're having a heart attack. He'll simply tell you to travel miles to an overcrowded A&E department, where you'll probably die while you wait for 12 hours on a trolley.

Doctors regard their time as being far more valuable than their patients'. You can get your groceries delivered, but rich GPs think they're too important to offer even a Tesco level of service at home. Desperately ill patients will just have to struggle through the blizzards to get to their doctor's surgery.

Despite the needs of their patients, doctors take plenty of time off to lounge around on the golf course, and they like nothing more than putting their feet up while we're all suffering from pain, disease, broken bones, and mental illness.

And watch out if you have a problem at night or over the weekend - you'll be seen by a doctor who doesn't know you and is only doing it for the money. Badly paid junior A&E doctors can sort you out with little or no sleep, so why can't your own well paid GP?

The Health Secretary supports our call to bring back the old days, when you were seen at night by the doctor who knew you best. They would sort out your corns, or tell you whether you're the kind of person who should be having a stroke, or discuss how your haemorrhaging aneurysm will affect your daughter's gerbil.

When I challenged him about how impossible it is to get an appointment for weeks ahead, the GP owned up, admitting that he has no intention of working hard enough to see his patients when they want. He says you'd be better off calling an ambulance and bothering the hospital instead of him. We pay them a fortune, but GPs simply don't care about us.

This doctor could see he was losing the argument, and he just hung up the phone.

This column is written for humour and does not necessarily represent the views of the author, his/her practice, or the LMC.

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