SOMERSET LMC

Newsletter

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SOMERSET TOGETHER – WITH OR WITHOUT GPs?

Inside this issue

The case for change in general practice is now hard to resist. Indeed, of the 133 GPs and practice managers who attended the LMC evening meeting on 9th February to discuss outcome based commissioning, just two believed we should carry on as we are. But in the maelstrom of initiatives, pilots, revolutions and restructuring that blows all around us, how do we pick out those that will help us achieve a sustainable future whilst avoiding the ones that are just distractions doomed to failure?

The principles behind Outcome Based Commissioning are appealing, and – if we can make it work – it is perhaps the only initiative that will allow the Somerset health economy to become significantly more efficient, simultaneously allowing us to control primary care workload whilst accommodating the growing care needs of an ageing population. But the road map to those sunlit uplands is not clear, and although the proportion of practices' budgets that is at risk is small to begin with, it is essential that the promised benefits are realised early on. A promise of "jam tomorrow" will not do for the majority of GPs who are running at or beyond their safe working capacity.

Participation in OBC is not compulsory, though it is heavily incentivised. The requirement for the first year is modest, essentially that the practice commits to participation in your local implementation group. Other parts of the country are pursuing integration without overt adoption of OBC, but it is interesting that some of the apparently most successful models seem to be incorporating at least the principles. OBC does not absolutely require GPs, but it makes little sense not to include the primary care foundation of the system where a substantial majority of health interactions take place.

Every health system in the developed world is grappling with the same challenges that we face, and for once having a national system, albeit one that is now disjointed, may make embracing change easier. Even so, the differences of culture and clinical approach between general practice, acute services, mental health and community services are considerable – and that is before we even think about social care. OBC may be the only lever that commissioners have to motivate providers to work collaboratively and really change their set ways.

But GPs are pragmatists, and with businesses to run they need to see how the transition is going to work. How will patient care be different? Do we have a plan for a shared health record? How will monthly cash flow change? And, most importantly, how is front line demand going to be managed better? If all the routine appointments are still gone by 8.35 on Monday morning, wonderfully efficient pathways for one or two patients with complex conditions will make precious little difference to the 12 hour day.

The LMC is therefore pressing the CCG for a more detail, particularly as to how the timing of the new Locality Enhanced Service links to formal participation in OBC, and just how the LES is going to facilitate early engagement, support integration, and demonstrate some early wins for practices.

OBC does not, of itself, provide answers to the urgent problem of practice instability caused by demand, resource and workforce pressures. We hope that other national, regional and local initiatives may help address these. But if we can work through the details of the process and the timeline, it could still be a powerful tool with which to rebuild our ailing NHS.

SOMERSET PRACTICE QUALITY SCHEME FOR 2016-17

The SPQS Working Group at the CCG, which includes practice manager and LMC representatives as well as CCG, NHSE and Public Health managers, and a lay member, has been deep in deliberation about the possible content of the scheme for 2016-17. The changes in the political and organisational landscape of the NHS since we first started this project two years ago have been considerable, but the Group still believes that we have much to learn from exploring alternative ways of measuring practice quality, and the underlying objectives of SPQS fit well with many of the other developments and initiatives currently under way in the NHS.

Subject to approval by NHSE centrally, the Group is proposing to re-focus SPQS a little. The question of vertical integration is now being considered in others ways – notably the Better Care Fund LIGs and the Somerset Vanguard project – so this element of the scheme will be re-focussed on developing patient centred care. Some of the numerical targets, such as the number of patients who have had a Patient Activation Measure score recorded, are being funded in other ways, but with growing evidence that patient engagement improves outcomes and reduces costs, this area is well worth further exploration.

Sustainability of general practice remains the main focus, for without a solid foundation of primary care the rest of the NHS rests on very shaky ground. The LMC has long advised that practices need to have rolling forward plans for at least the next two years, and this could be included in this part of the scheme.

There is still a need to capture some activity and diagnostic data. Whilst SPQS has deliberately moved away from recording QOF data for the sake of it the Group recognises that prevalence information is essential for health care planning, and also very important for patients moving between practices. It is suggested that rather than requiring specific four character coded entries, SPQS should use a template system that will capture a range of read codes that all indicate the same diagnosis. We are looking at options about how to do this.

The important new element for the year will be a requirement to engage with the Institute for Health Improvement programme currently under way across the Somerset health economy. This is likely to involve sending a practice representative to an IHI training day and participating in an IHI project or audit. These programmes have already been very successful in secondary care and participating clinicians are enthusiastic. They are designed to empower local clinicians to improve care in their own workplaces, and participation is very helpful for both CQC and Revalidation purposes.

The final specification of the scheme is now awaiting national guidance document which is expected imminently, and we hope that the full version will be available in good time for practices to make a decision on participation by mid-March.

NATIONAL CHILD MEASUREMENT PROGRAMME

Offers valuable early warning of future health problems

Every year children in Reception and Year 6 have their height and weight measured at school, and they are categorised as underweight, normal, overweight or very overweight, according to the WHO reference charts. This year practices will be sent, for the record, a copy of the results letter to parents. A small number of whom are likely to contact the practice to discuss concerns about their children. It would be helpful if practices could flag an individual child's record with their result, to inform clinical decision making. Brief intervention at this point are likely to pay far greater health dividends than most of what we do, as there is good evidence that this can be effective in increasing physical activity and promoting a healthy diet among children.

In Somerset 9% of Reception and 27% of Year 6 children are obese, so a recommendation from a GP or practice nurse that the family should contact Zing Somerset (the children and families new healthy weight provider for Somerset www.zingsomerset.co.uk) or download the excellent resources from Change 4 Life www.nhs.uk/change4life - which, incidentally, includes the brilliant "Sugar App" to help people identify and track their sugar consumption – will be a simple but effective step.

JOBS??

Can you help????

There are a number of experienced (soon to be) ex PPS members of staff who, are looking to remain in the Primary Care sector of the NHS. They bring with them a wealth of knowledge, which would be an asset to any practice brave enough to take any of them on ☺.

If you have any potentially suitable vacancies that anybody may apply for, please send the information to ppsjoboffers@hotmail.com.

SMALL ADS… SMALL ADS… SMALL ADS...

For current practice vacancies please see the adverts on our website at:

https://www.somersetlmc.co.uk/jobs/

ROLLOUT OF EMIS VIEWER

Providers of Urgent and Immediate Care to have access to practice EMIS records

After a long gestation period the CCG is nearly ready to launch a scheme to allow other NHS providers, should practices agree, to view patients' EMIS records remotely, within the next few months. Discussions continue about possible access to INPS and Microtest records.

EMIS viewer allows approved users to look at defined parts of the GP patient record, but not download or print off any of it. Nor can they write in the record. Each practice has to approve a list of other providers who will be able to have access, and the LMC is suggesting that in the first instance this should be those that are providing urgent or immediate care - which might include local acute Trusts, the ambulance service, and Somerset Doctors Urgent Care. RUH at Bath has a similar scheme and it should be possible for practices to participate in either or both. Access will be restricted to particular clinical users (who will be role defined) and these could include, for example, the clinical supervisor in the local 111 service, but not the call handlers. Practices can specify which categories of notes they are prepared to share, but our general feeling is that it is better to share more information with a small number of other clinicians rather than less information with a larger group of people. Practices are able to look at who has accessed their records, and which patient files have been viewed.

The technical process is fairly straightforward and it does not affect practice systems directly as access is via the EMIS servers. All participants will have to sign up to a specific second level information sharing protocol that will sit beneath the existing Somerset Information Sharing Agreement, and permission to see the notes will be obtained by the relevant clinician at the time of patient care being delivered. Practices will need to put up information about the scheme in the Waiting Room and add a piece to their websites and brochures, but individual patient consent is not required in advance. There will be an exclusion code that prevents access to the records of patients who want to block access completely, and guidance on how to ensure your practice is complying with all the relevant data protection guidance will be circulated in due course.

We see the scheme as being particularly valuable in A&E – especially where there are GPs working in the Department – but also in Medical Assessment Units, Out of Hours GP Centres and 999 ambulances. If all goes well it could then be extended to include other clinicians and providers.

'FEEL BETTER WITH A BOOK' PROJECT

A simple non-clinical intervention to improve mental health

Public Health at the County Council is funding the establishment of reading groups across the county to support people who are isolated or who have mental health difficulties. "The Reader" delivers an innovative intervention called Shared Reading that over 10 years has helped thousands of people with a wide range of conditions: those with mental health problems in the community, on wards and in high secure units, and people with chronic pain, in recovery, or living isolated lives.

Shared Reading relates to the person rather than his or her problem. It is run in small groups or one to one. A story or poem is read aloud that the group then discusses. There is no need to for group members themselves to read aloud, speak or even stay awake, so the groups can work with anyone. The model works because it offers continuity and structure in chaotic and lonely lives. It is inclusive - all are welcome and can take part regardless of their literacy level, status, state of health, education, age or cultural background. Readers control their own involvement, contributing as much or as little as they like according to mood and confidence levels, and it offers a supportive place with a difference**:** A long term community of peers where the focus is on the book rather than a particular health condition or status. Wherever possible it tackles quality literature which members might not read alone, giving a real confidence boost and pleasure of achievement.

Shared reading has been nationally lauded as a positive health and social care intervention and a recent study showed a statistically significant improvement in the mental health of depressed patients during the 12-month period in which they had attended. http://www.thereader.org.uk/what-we-do-and-why/health-wellbeing.aspx.

The Somerset group also has a Facebook page: https://www.facebook.com/SharedReadingSomerset/?ref=aymt_homepage_panel+

Yeovil Library Memory Group (for those with memory loss and their carers) Thursdays 2-3:30pm.

Yeovil Library Mental Health Group Wednesdays 11am-12:30pm.

Burnham on Sea Library Mental Health Group Mondays 2pm-4pm.

Taunton Library Memory Group (starts 11th January) Mondays 11am-12:30pm.

Taunton Library Mental Health Group (starts 18th January) Mondays 2-3:30pm.

Wells Library Mental Health Group (to start end of February).

Dr Whimsy's Casebook: NHS Policymakers in Action (No. 67)

Scene: the Decision Room at the Department of Health. The Secretary of State, The Far Right Honourable Wattup Wratte, is in the bath. His Permanent Secretary is straightening the towels.

WW: Look at this, Jenkins. The Prince of Wells has given me a bottle of his homeopathic bubble bath.

PS: *[inspects the bottle and shakes it]* It's water, sir.

WW: Don't be a dunce, Jenkins, it's his highest strength bath foam, frightfully expensive. Heaven knows how many dilutions.

PS: Precisely, sir. It means there isn't a single active molecule within a billion light years of Whitehall, hence the total absence of bubbles in the bath.

WW: But look how clean it's made the bath water, Jenkins. I can see my toesies.

PS: I believe that's how it came out of the tap, sir.

WW: Oh, loosen up, Jenkins. I want you to tell the Medicines Regulatory Agency to include homeopathic remedies in the NHS formulary.

PS: As you wish, sir.

WW: You see, Jenkins, doctors are too obsessed with evidence – they should learn to have some faith.

PS: You mean 'faith' defined as the belief in something for which there is no proof?

WW: Exactly. Let's bring back a bit of imagination to the NHS, instead of this slavish dependence on data.

PS: Well, we're not doing badly, sir. The Ultimate Drug Fund spends millions on treatments which were hyped in the Press but rejected by NICE.

WW: Yes, I'm very proud of that, Jenkins...

PS: Though word has it that the Fund has been soaking resources from proven NHS treatments.

WW: The money's got to come from somewhere, Jenkins. It doesn't grow on trees, you know.

PS: Really, sir? With a bit of faith, surely...

WW: Now you're being silly, Jenkins. Let me show you what I really mean. See this thing in my hand?

PS: The toy pistol with a metal stick for a barrel, sir?

WW: It's not a toy, Jenkins, it's a cunning device for detecting bombs, invented by a chap in Somerset.

PS: Surely, sir, that was a fraud and he's in jail.

WW: A misunderstanding, Jenkins, and to prove it he's developed an electronic parole tag which he's testing for the Home Office right now. Anyway, he modified his bomb detector so that it can also identify things like liverishness and socialism.

PS: Unicorns and phlogiston too, I daresay, sir?

WW: I didn't ask, but I don't see why not. Look, I'll switch it to "Water"... see the stick trembling?

PS: It was trembling before you turned the switch, sir. You have an overactive thyroid gland, remember? You take His Highness's *Gullibalaticum* for it.

WW: With remarkable effect, I can tell you.

PS: You think so, sir? You're still shaking like an electrocuted stoat.

WW: No, Jenkins, it's the detector that's shaking. See – it can tell there's water here.

PS: So can I, sir. You're sitting in 50 gallons of it.

WW: All right, Smarty Pants, I'll switch it to something else... There, what do you think of that?

PS: It says one of us has rhubarb wilt, sir.

WW: Well, it isn't me, Jenkins, so you'd better get yourself treated.

PS: Very well, sir. But do I take it that you're going to distribute this device to GPs?

WW: Further than that, Jenkins. It's called the Divinary Care Diagnosticator, and I want it to *replace* GPs.

PS: Are you quite serious about this, sir?

WW: You know it's been one of my goals, Jenkins. GPs are a useless expense, but this clever little machine never makes a mistake, as you have seen.

PS: A remarkable device indeed, sir. And I suppose it can arrange treatment for the diagnosis it makes?

WW: Oh, you just connect it to a computer that can look up the treatment and issue a prescription.

PS: And will it tailor the treatment to the individual?

WW: What do you mean, 'tailor'? You have pneumonia, you get the antibiotic. It doesn't take a genius to work that one out, and it's all done automatically.

PS: Well, I was thinking how GPs know their patients and can take into account age, allergies and so on.

WW: You just program that into the computer, Jenkins. You don't need a GP for that.

PS: Will it deal with the patients' emotional concerns?

WW: No need. It'll print out a leaflet.

PS: And how is it with safety netting, sir?

WW: These are patients, Jenkins, not circus acrobats.

PS: Of course, sir, and let's hope they can still get the comfort and care their GP provides when they're grief-stricken or terminally ill. What's the word..?

WW: Meddlesome busy-bodies?

PS: No, um ... *compassion*, that's the word.

WW: Pah! An obsolete quality, Jenkins. Patients want measureable outcomes, not patronising homilies.

PS: Really, sir? Is that a fact or is it your extraordinary intuition at work again?

[tinkling noise of a mobile phone playing "Jerusalem"]

PS: It's your cellphone, sir. Let me get that for you.

WW: No, no, Jenkins, it's all right, please leave it...

PS: No trouble at all, sir... Yes, it's a message from an agency called RevolvingDoor.com. They want to know if you're still interested in the offer from the Divinary Care division of Hair-Of-The-Dog PLC... I say, sir, you've gone frightfully pink. Perhaps there *is* something in the royal bath foam after all.

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