SOMERSET LMC

Newsletter

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LIFESTYLE MEDICINE

A seismic shift in Healthcare thinking is coming

Inside this issue

The last few years have not been great for general practice. More work, relatively fewer resources and an evaporating workforce mean that the primary care front line has become perilously thin. But there is more to the problem than these familiar challenges. We sense a growing conviction amongst clinicians that the health service has been going down the wrong path for several decades and we are now standing at the end of a box canyon looking up at a cliff that we simply cannot scale using the tools we have to hand. Although pharmaceutical and technical medicine is dramatically effective for acute illness and injury it has not proved to be the panacea for the growing number long term conditions and the complex psychosocial and existential distress that generates so many of our most difficult consultations may actually be worsened by the use of medication. As the list of long term pharmaceutical treatments that patients are prescribed - but rarely take as advised - has increased, so have wastage, unpredictable interactions, and pharmaceutical company turnover.

Some visionary thinkers, and we would particularly mention Matthew Dolman and Trudi Grant, the Director of Public Health at the County Council, have been warning that we needed to "flip the system" and stop waiting until patients develop a specific condition before we intervene. It now seems extraordinary that for years we have been effectively telling people with slightly abnormal blood glucose to go away and come back when they have diabetes, at which point we deploy a whole panoply of healthcare interventions well after the horse has bolted. It feels as though we may have been under the same sort of collective delusion that made so many builders in the 1960s appear to think that flat roofs and softwood cladding were suitable design features for the wet British climate.

Our approach to evidence and where to look for information has been too selective. There is plenty of published information from other scientific fields, such as nutrition, that the medical profession rarely considers. We have, perhaps, spent too long thinking about familiar fields such as pharmacology rather than taking a whole patient view . Lifestyle and Functional medicine approaches which were once regarded as peripheral are increasingly recognised as offering important insights into the causes of disease, and, much more significantly, how it should best be treated.

The benefits of lifestyle medicine are obvious and immediate. Patients regain control of their own care and much of the help they need does not have to come from a regulated health professional. There will be a saving in direct drug costs, the indirect costs of prescribing, supplying and monitoring these, and, of course, a reduction in drug related adverse events. Furthermore, each lifestyle change will be helpful for a range of conditions and in enhancing wellbeing generally, not just in treating a specific medical problem.

In particular, the potential to manage Type 2 diabetes differently is creating a lot of interest, and the approach taken by Campbell Murdoch at Wells Health Centre (Campbell is also the CCG Person Centred Care Lead) is well worth a close look. Link . If that whets your appetite you may wish to join the new Lifestyle Medicine Discussion Forum he has set up. You just need to email campbell.murdoch@nhs.net with "Somerset Lifestyle Medicine group" in the subject heading.

But the very best thing about taking this new approach is that it offers real hope for the future of primary care and positive route out of the endless cycle of doom laden discussion about the NHS. It's the good news we wanted, and just in time.

SMALL ADS… SMALL ADS… SMALL ADS…

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GUIDANCE FOR PRIMARY CARE: TRANSITIONING* FROM READ TO SNOMED CT VERSION 1

The clinical coding system for primary care is being planned

In December 2016 NHS Digital published introductory guidance about the impending switch from Read to SNOMED for clinical coding in practices. Our LMC reviewer writes:

"Read codes came in in 1985, the year I qualified and so we have been through a great deal together. Frankly I do not relish the prospect of change, not just for change's sake but also because I could not see the point or a smooth transition. Read is only used in the UK and so, once again, I was tempted to think perhaps the rest of the world should change instead. It was like "you say furosemide, I say frusemide" all over again. This paper did offer some reassurance and also some insights into the less clear meanings of some Read codes. SNOMED does seem to offer some more logic about what words actually mean.

Read codes cannot be retired and the "children" of any term can only amount to 62 in number leading to over spills requiring a separate parent code. SNOMED has no such limits.

SNOMED will also allow more precision. For example I had no idea that "Constipation" in Read coding encompasses "not constipated" too. In order to be clear that this is not included one must stipulate "Constipated" which hardly anyone does, apparently. That might be important for research data but SNOMED is also less generally ambiguous, and a fascinating example is given with the word "dressing" which can mean "the covering applied to a wound", "the act of covering a wound", or "the ability to put on clothing". Doubtless many readers will know exactly what the suffixes NOS, NEC and the prefixes [X], [SO] and [M] signify, but apart from the first one, I must admit to being hazy. In fact all of these relate to International Classification of Diseases (ICD) and Office of Population Censuses and Surveys (OPCS) classification of surgical operations and procedures. Hence "not otherwise specified" and "not otherwise classified" means something highly technical and so our adding "NOS" to "otitis media" adds very little but potential coding confusion, and SNOMED will do away with this. [SO] refers to anatomical site ("site only") which enables an OPCS code to be annotated to allow more precision about what part of the body was operated upon. SO codes are rarely appropriate for primary care in that case. Similarly, codes starting with [M] originated from ICD codes referring to a histopathological morphological term not recorded as disorders in themselves unless linked to a specific anatomical site. You can still record "carcinoma metastatic" or "malignant lymphoma" (instead of "[M]Lymphoma NOS") if the exact origin or type remains unknown.

Mental health terms beginning [E-] are derived from ICD-9 whereas [Eu] (the latter also being prefixed X) come from ICD-10. SNOMED has transposed those across, although losing the X, which should help those still doing QOF. T and U codes refer to causes of injury and poisoning and come from ICD-9 and -10 respectively, as the former cannot be retired we can have both "TE60 00 Dog bite" and "U124. 11 [X] Bite from dog", "U6000 14 [X] Adverse reaction to flucloxacillin" and "TJ002 00 Adverse reaction to flucloxacillin" are the same but mutually exclusive on searches. In SNOMED "adverse reaction to penicillins" is a concept description allowing specifics to be coded reliably.

Chapter R of Dr Read's codes are much beloved by General Practitioners, especially by your correspondent, who after 30 years' experience is still relieved to be able to use R021. 00 "[D] Rash and other nonspecific skin eruption" as well as the surprisingly useful [D] Musculoskeletal chest pain [D] Raised blood pressure reading and [D] Abdominal pain. The authors of the paper do concede that there is an argument for these (especially the latter) in patients with recurring symptoms for which no underlying cause can be found or for which investigation is continuing i.e. the symptom is the disorder and admit that ultimately these imprecise codes may be the best available.

It appears then that SNOMED may offer an improvement in practice allowing more precision in coding, cutting out inconsistencies, redundancies and unnecessary confusions inherent in Read. However it will be sad to be unable to trade amusing and arcane Read codes such as those specifying the injuries caused to occupants of spacecraft that wiled away an idle hour in the days when we had them. However it appears that the most profound Read code located by searching under "knows" will be retained. Xa7wA will be mapped to concept ID 301327002. Thank God for that!

THE SOMERSET GENERAL PRACTICE BOARD

Somerset Primary Healthcare, the STP GP Provider representative and the LMC are joining forces to advocate for general practice within the STP. This is the text of the letter the new Board has sent to interested parties

We are writing to inform you of recent developments that we believe will ensure both better representation of Primary Care in discussions with other organisations involved with the development of the Somerset STP (Sustainability and Transformation Partnership - note the change from "Plan"), and improve communication with practices about what the implications might be for them.

There have been discussions recently between the LMC, Somerset Primary Healthcare Ltd (SPH) and Dr Rosie Benneyworth, who acts as the Primary Care advisor to the STP, as to how we can present a more united front and ensure consistency and rigour when discussing any changes that might have an impact on Primary Care. The very nature of the way that General Practice has developed into such a variety of differing sizes, locations, and contract types over the years has enabled individual practices to flourish, but hindered collaborative working as a group with other organisations. We believe there are good reasons why neither the LMC nor SPH can act in isolation as the voice of Primary Care in the STP process.

In addition, the STP process itself has become immensely complex, both in terms of the workstreams, and the governance structures. All this against a background of severe financial pressure and increasing workloads across the system has meant that we must use our small number of experienced and knowledgeable executive team members in the most effective way possible. The LMC has the statutory representative function for all GPs, and all practices are shareholders with SPH. Rosie Benneyworth has extensive experience and built up a wealth of knowledge working for other health bodies (such as the Academic Health Sciences Network) that will be invaluable.

There is far more that unites us than divides us, and we have decided to form the Somerset General Practice Board (informally known as Team GP), as a body that will represent the interests of Somerset practices, and act as a "go-to" group for other organisations in the STP who wish to consult with Primary Care. We can coordinate attendance at meetings where we need to be, and an important function of the group will be to ensure that the impact of every decision that has any impact on Primary Care will be clearly quantified in a transparent and consistent manner. The Board will also liaise with GPs working in other roles within both provider and commissioning organisations. It is important to recognise that the constituent bodies will still retain their independence (the LMC will still need to act to represent an individual practice that might find itself in disagreement with other organisations, for example).

We have agreed our terms of reference and reporting structures within our own organisations, and we are seeking an early meeting with Niall Dickson and Pat Flaherty, who are leading the local STP, to introduce the new Board. We will also report on a regular basis to practices to outline and explain important developments as they occur.

You may be aware that there have been significant leadership changes at senior levels of the CCG, Taunton and Somerset Trust, and Somerset Partnership, and this feels the right time to be presenting a cohesive and consistent voice that we believe will best serve the interests of all Somerset practices and their patients.

Monday started well, or so I thought; the significant cock-up I made that day did not come back to haunt me until Wednesday. On arrival I learnt that my end of life patient had died over the weekend. I had done the DNAR form and the Treatment Escalation Plan and there were Just In Case meds in the home. I had visited the previous Thursday. Tick, tick, tick, tick! Her family did an excellent job and there were only 6 Out Of Hours contacts duplicating information about district nurses popping in and out. One of them Read "blocked catheter, 'phone does not reach" which conjured up a bizarre combination of tubes and wires. I spoke to the patient's exhausted daughter, tackled the paperwork in the usual way and rushed in and out of the undertaker's at 12.55 to see the body. We have a lunchtime meeting at 1pm so there is always a scramble. A health visitor was scheduled to attend that meeting but did not turn up. I would not have recognised her if she had; she resides in a mysterious and distant planet known as a "hub".

During the afternoon I supervised our GP registrar. In the past three weeks I have had two registrars, two fifth year medical students and a paramedic sitting in at different times. The consultations are always a little stilted with third parties present ,but most of my patients behaved impeccably and did not let on that my examinations are not always quite so textbook thorough!

I had all Tuesday off, which is how it looks on my timetable but it rarely happens that way. A coastal walk was exactly what I needed and very much enjoyed.

Wednesday started early. Doctors on hols, staff on hols and some off sick, patients queueing at the door… and it was a lovely day, didn't they have anywhere else to go? I ploughed through letters and lab results as carefully as I could. Requests for phone calls (please could the doctor explain why the pills are pink this time and usually they are white?) trickled in as I embarked on morning surgery. I saw a mother with twin babies and a two year old for a postnatal/six week check, and realised that her job is infinitely more exhausting and demanding than mine. Trying to rescue all my medical equipment from the hands of the oldest child, juggling the babies and making sure I put the correct info in each of the red books was quite a challenge. Then there were home visits to a local EMI nursing home, later in the day followed by a call from the home saying the man with a cold for whom I had prescribed nothing was worse and very chesty, and couldn't he have some antibiotics after all as the family was very worried? I often wonder what we are doing prolonging the lives of people who no longer have any understanding of the world. During afternoon surgery something went well with a middle aged patient I have known for years and she gave me a spontaneous and heartfelt hug. I felt warmed and successful for five minutes. Then one of my admin staff popped in with the cremation form I had written on Monday, which the undertaker had returned for a few "amendments". Hmm … first there was the final page which I had left completely blank, then there were the comments written in and underlined by the part 2 doctor, clearly describing the pacemaker he had identified in the left infraclavicular region and how he had removed it. You know that hot and cold sinking feeling you get when you know you have done something really stupid…? I had once been aware that this lady had a pacemaker, but her medical problems and hospital admissions had piled up recently in such a way as to shift the relevant problem title a long way down the list. And the truth is I had forgotten about it, and had been doing everything in a rush. So there's a significant event for my appraisal and a learning point - always use a really conscientious and reliable doctor for the second part of your crem forms as they will definitely sort out the mistakes and omissions you have made yourself. That night I had fitful sleep and dreamt of a massive explosion at the crematorium.

I was Duty Doctor on Thursday, which gave the day a different rhythm and a predictable set of presentations. Many consultations involved gaggles of children on school holidays accompanying whichever friend or family member needed to see the doctor. They were all planning trips to Crealy Park, Legoland or Tropiquaria. "Lovely! Lovely!" I enthused, handing out stickers to all and sundry, while inwardly thanking my lucky stars that I was at work instead. I am clearly becoming Dr Old and Grumpy!

On Friday the old man in the nursing home died. I don't think it was his cold which killed him, I think he had just given up. I had succumbed to pressure and prescribed an antibiotic on Wednesday but it had not prevented the inevitable. So there were deaths at both ends of this week, with everything else sandwiched in between. I will triple check that patient's notes for any mention of a pacemaker or other hazardous implanted device. RIP.

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