SOMERSET LMC

Newsletter

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TRANSFORMATION: MAKING QUALITY CARE EASIER

SOMERSET LMC/SCEPN STUDY DAY 13 NOVEMBER 2018

For some time now the NHS has been moving towards commissioning not so much specific services as for health outcomes designed for the needs of specific populations. The latest incarnation of this is found in the proposals for Neighbourhoods of some 30-50,000, or even larger in some cases. The National Association of Primary Care believes that these are small enough for the team to know each other but large enough to be resilient. We hope that you will forgive the hackneyed expression, but primary care is "well placed" to lead on this because it has always been based on defined, registered population lists.

Primary care networks have been evolving to meet this pattern whether we call them federations, clusters, localities, neighbourhoods or primary care homes. The ideal is for health and social care teams to work together locally and so breaking down the contractual barriers which have heard so much about over the years but, so far, with only patchy success: for all the talk about "wrapping care around patients" money talks and contracts win. As Dr Nigel Watson of Wessex LMCs (presently conducting a long overdue review on partnership for the Secretary of State) has said, "If the NHS is serious about trying to address the challenges of an ageing population, growing numbers of people with one or more long term conditions and more and more people with preventable disease, it cannot achieve this by simply focusing on investing more and more resource in hospital-based care. The greater benefit for the NHS will be seen by developing and expanding services in the community."

Practices vary many ways, not least in size and primary care networks are not only about practices working together but also about supporting smaller practices. In the words of the Somerset GP Board the recommendations of working at scale include "greater workforce resilience; economies of scale in both business and clinical matters; better use of specialist skills; more management capacity; potential to provide wider range of contracts/services; greater influence on other NHS commissioners and providers; synergy of development and planning ideas; better use of premises and resources; ability to move to new contractual or organisational structures and in the current climate we should add: stronger recruitment presence and potentially a more robust business model. But none of these presumes any particular model, and SGPB believes that given the great variation in practices' characteristics, significantly different locality cultures, patient requirements and the spectrum of GP partner opinions, it would at best be foolhardy to pursue a single solution. We need a menu of options that will best allow individual groups of practices to reach the best local solution."

But there are many potential solutions from which practices can choose. Somerset LMC has been running work on the 10 High Impact Changes identified by NHSE and the BMA as part of the GP Five Year Forward View Project at no cost to practices. An LMC team with extensive practice managerial and nursing experience that can advise practices on better working in practice support visits. At least one practice which was seeking integration with a larger provider changed its mind after a radical review of its ways of working and appointments system. Practices have transitioned from working together to merging and there are now 66 rather than the historical 74 practices in Somerset. We should be proud that no practice has closed in Somerset involuntarily and compare this with the situation in, say, Plymouth where over 25,000 people have no regular GP. Others have been very positive about practices working within the Symphony project,

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GP In Somerset

engaging in new models of care or fully integrating with SHS. The Alliance Trust is seeking to build on work that its predecessors, the Taunton & Somerset and Somerset Partnership Trusts, have done with the practices each of them were running. Somerset LMC has also led on attracting people to work here with its GP in Somerset Campaign and the GP Careers Plus has seen not a single participant give up clinical work. Somerset Primary Health is a limited company wholly owned by the practices of Somerset and as such is able to hold contracts and better manage risk, enabling practices to create economies of scale and to work more collaboratively. And where, exactly, will the government's policy on Urgent Care Hubs, open every day from 8am to 8pm fit in all of this?

To make sense of this bewildering range of options – few of which are mutually exclusive – Somerset LMC is organising another of its highly successful study days at Taunton Racecourse on Tuesday 13th November. To reserve your place please book at www.somersetlmc.co.uk/events/7647.

RAPID RESPONSE SERVICE

An alternative to an admission you really did not want to make

Every GP knows the feeling: you are seeing a patient at home who normally manages but something simple has knocked them sideways. It is often a UTI, a simple fall or loss of mobility. You think that with a bit of support she will probably be back to baseline in a day or two but there is no one to help. Social Care can rarely swing into action quickly, especially in these straitened days. There is a niece in Lincoln. Somerset Primary Link (SPL) tells you there are no community hospital beds. With a heavy heart you send her in to a District General Hospital bed that she really does not need. With the best will in the world patients like that cannot be expected to do well in the unfamiliar circumstances and routines of hospitals which can quickly lead to the loss not only of independence but even of muscle mass as well. And that is if things go well…you know all this but what can you do?

There is a new service which aims to keep patients at home when they do not need to go to hospital for assessment, and they need some care support to keep them at home. It seeks to support primary care teams and SWASFT with a credible alternative to admission for the frail elderly, in the latter case often to A&E, and it will start from November 1st. Referrals can be made between 9am and 9pm via SPL on the usual 01749 836 700. West Somerset services will follow on December 1st.

The service intends to respond within two hours from bases set up around the county putting in intensive support for up to three days so that more people can stay in their own homes, rather than be admitted. The teams of HCAs will be supervised by a clinical supervisor. The HCAs will work seven days a week from 8am to 11pm with overnight cover if needed from 9.45pm to 8.15am with district nursing telephone back up. Patients and their families will help the team make a plan which might involve help with washing, dressing, personal care and supervising medication. The three days can be used to coordinate other support if any is needed.

This is not intended to replace adult social care for those who are "just about managing" all the time but for those on the cusp of admission. It is not for cases when you really do not know what is going on – those patients probably need hospital assessment. If patients deteriorate during the maximum three day period then a rethink will also be necessary. The team will keep in touch with the GP after discussion with the clinical supervisor in that case. Of course, having as many patients as possible with a Treatment Escalation Plan will help make sure they get the right level of intervention too.

We think that this scheme, together with the various care home outreach schemes also being devised as part of the A&E Delivery Board plans to reduce winter pressures, has a real chance of "striking at the root" of some "unnecessary" admissions. Because, as the man said, "It's not unnecessary if there's no alternative."

GP RECRUITMENT/SPEED DATING EVENING 17TH OCTOBER AT DILLINGTON HOUSE

Are you an GP or GP Trainee looking for the right practice/employer to meet your career aspirations? If you're thinking about partnership, salaried or retainer posts but not sure where to begin and aren't sure what your next steps are then help is at hand. Your questions can be answered by attending this unique event where practices from across the county and GPs and GP Trainees can come together and be introduced to each to other to explore options and hear about the innovations that are happening in Somerset Primary Care. Please book online at www.somersetlmc.co.uk/events/7340.

DR NIGEL WATSON'S GP PARTNERSHIP REVIEW

At the September South West Regional LMC Meeting Dr Nigel Watson of Wessex LMC discussed progress on his review of GP partnership which he was leading on instructions of the Secretary of State. He had visited various hot spots where primary care was just about holding its head above water such as the Isle of Wight, Bridlington, Folkestone and Plymouth. Workload remained the greatest problem leading to stress, burnout, early retirement and which was no incentive to new recruits. The elastic nature of our contracts, as seen by NHSE, meant that the funding put in to deal with hospital workloads was not made to primary care. General practice was still not valued enough in any sense. Far from increasing the number of GPs there were now some 750 fewer over the last few years. Some GPs in the hard-pressed areas were angry about locums earning up to £1000 a day and there was a sense that this bonanza could not continue. Premises were a barrier to younger doctors joining practices as they no longer tended to expect to stay in the same place for 20-30 years. Some agonised about the risk of being liable for staff redundancy payments in the event of practice failure. Fear of litigation and overregulation with micromanagement (by CCGs, NHSE, CQC and so on) were perpetual worries too with a sense of being beset on all sides, including the media. It had been noted that Scotland had set a minimum remuneration for partners. The limits on pension contributions and the lifetime limit were not helpful and, as the Treasury was unlikely to make any changes to something which affected only the top one percent of earners. It was thought perhaps being able to select strands of income for superannuation was a way forward? The NHS pension scheme remained outstanding value however.

The strengths of the partnership model were undoubted but not well understood by the powers that be. Unfortunately London, which contained vastly more locums and single handed practices than the rest of the country, skewed the statistics seen by politicians and so their opinions and prejudices. NHSE was soon to publish intentions for the spending of the £20b promised by the prime minister. Workforce and workload in primary care had to be priorities despite secondary care deficits. Technological improvements should not be side tracked by GP In Hand.

Medical students should spend more time in general practice. Young doctors could be encouraged by portfolio working with mentorship across primary and secondary care. Services for the frail, mental health and community nursing could be more efficiently run if firmly embedded in primary care. Pharmacists and physiotherapists working in practices would save the wider system work and so should be funded and not paid for by practices as benefiting only them as NHSE argues. Sorting out Capita's PCSE would be a great help to practice managers. The Treasury would never take on practice leases. Corporate mortgages could be taken out removing some personal liability but forming limited liability partnerships would not. Indeed the indications were that LLPs, although still being considered as an option, were not the panacea some hoped.

On morale some areas had seen consultant-GP swaps leading to changing working relationships. The idea of changing our name to "Consultants in Primary Care" was being discussed but others said that "GP" was a massively recognised and trusted brand that should be retained. The GMC recognising general practice as a separate speciality could be helpful.

Radical thinking might include setting a clinical session at four hours, as consultants do now, with a definition of what could realistically expected to be done in that time. Telling new recruits they would start before 8am and not get home until after 8pm was not attractive. It might also stop the "lazy part time GP" slur favoured by the Daily Mail. GPs working three days a week mostly did more than 40 hours. This would have to wait until after the state-backed indemnity scheme however.

Working at scale in primary care networks (for which read "clusters," federations, neighbourhoods or Primary Care Homes) must be led by practices despite the NHSE focus on the impact on hospitals. Community teams such as specialist nurses, mental health workers, pharmacists etc. should be working in practices using practice records and not separate systems. This should all improve workload and job satisfaction. Networks could take on extended and improved access funding and the mandated urgent care hubs if given the funding and trusted to find local solutions.

Implementing the partnership review to improve recruitment and retention would be more efficient than trawling the world to find overseas GPs. Dr Watson was well aware of the heavy responsibility riding on his report: some practices in less favoured areas had even put plans to hand back contracts off in anticipation of a good outcome. But the report would be challenging to the government and also to the BMA. The interim report can be found at www.somersetlmc.co.uk/gppartnershipreview and the final report will be published by the end of the year.

The Intermittent Diary of a Mature GP (aged 56 and ¾)

Last week I received my best hospital letter yet. It reads "She has a very noticeable long saphenous asparagus vein in her right leg". It conjured up images of bright green tortuous leg veins, with tempting spears poking through at every incompetent valve. Thank goodness it isn't the asparagus season – it might have put me off! The next document I opened described a patient drinking a bottle of mild in the waiting room. They are becoming liberal in the ED department I thought, until I spotted that the patient was only six months and it was just a typo.

Of course I am mercilessly teased by my junior partners for being such a ridiculous pedant. My "Secret Santa" gift was a mug bearing the message "I am silently correcting you're (crossed out and corrected) grammar!" I use it daily and am delighted with it, especially the reference to silence, which has never been applied to me in my life before.

In consultations I do try very hard to listen. On Monday afternoon a lady several years younger than me poured her heart out regarding her menopausal symptoms. I could only sit and nod. It was the "hot flusters" which really bothered her; I carried on nodding. Eventually we looked at some treatment options, printed a mountain of blurb and I have arranged to follow her up soon. It is easier dealing with medical issues we have been through ourselves. Yes, I am over 55 and have had my screening flexi-sigmoidoscopy at Bridgwater Hospital. It was much less unpleasant than I had anticipated and the process most efficient. I have personal experience of coils and smears and mammograms, not to mention childbirth. I can empathise with the parents of girls through every stage, but on foreskins I remain a bit vague.

Tuesday turned out to be the day of the difficult home visit. How do you help somebody who has at least a PhD in the game "Yes, but…"? I have a housebound patient whose medical records were delivered in their own personal lorry when he joined us a few years ago. A major issue has been housing problems, along with difficult to manage pain. But he can't get to the pain clinic (or any other clinic), even with hospital transport, although he can manage a trip to the pub. The flat he has recently been allocated is the wrong shape, too warm, and he doesn't like the taps. So far nobody has been able to help him with any of these features. My second visit was to a nursing home, where a frail old lady had been receiving end of life care for 3 weeks. The family were wondering just when was she going to die, as they had holidays planned and so on. I hedged my bets and waffled a bit, but in the event she died peacefully that same evening, with sighs of relief all round.

There are some real benefits to hanging on in the same practice for decades and Wednesday afternoon reached a new high for me. I found myself doing a six week postnatal check on a mother and baby, when I personally had performed the mother's baby check 22 years ago. Not only did I recognise her name, but she looked so like her Mum did then that it was quite uncanny. I caught up with family news and cooed over the baby. It was all quite emotional, for me that is – the young woman was oddly unmoved.

I can only think of one family where I have cared for four generations, although the great grandma is long gone now. It is a privilege to get to know a family and their history, and to understand how individuals fit into the jigsaw. I may not know the latest NICE guidelines on pseudo-pseudo-gout but I do know that Mrs X used to be married to Mr Y, and that her brother is the chap who stole a couple of chairs from the waiting room in our old surgery. Don't ask me why, they were stained and dilapidated in the extreme, but we were positioned in a less upmarket part of town in those days!

I was "duty doctor" on Thursday, and the emergency cases I attended to included a wart on a child's hand, a "massive" swelling on someone's back (which was actually just a small spot) and a child with fever who roared around my room with every appearance of excellent health. I made several urgent telephone calls, including one to a nursing home who needed to know (urgently you understand) whether a patient's dietician referral had been done. There were no cardiac arrests, asthma attacks or anaphylactic episodes - and trust me I am truly grateful for that. Give me an emergency crop of molluscum any day!

So to Friday, and (whisper it!) a day off for me. I spent much of it in the garden, until my neighbour started telling me about her varicose veins. Yes, images of asparagus before my eyes again! I rushed around Sainsbury's in disguise, then went to the pub with my husband. In the ladies' somebody I did not recognise started chatting to me as though we were long lost friends. I just did the nodding and smiling routine and hoped for the best.

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