The Family Doctor

Family Doctor Association Members' Newsletter Winter 2013/14

GP contract vindication. So what is next?

If you are 75+ you can soon have your personal doctor! We were right! This Association kept the flame of personal care alive when it was dead at the Department of Health, the BMA and the RCGP.

Suddenly they have rediscovered it. We can afford to be that little bit smug and self congratulatory, because no one else will thank us. If we are thought of as moral, industrious and half mad; so be it. We are right about continuity, always have been, and it has taken till now, well March 2014 for the others to catch up.

The College may choose to forget its Council's rejection of Sir Denis Pereira-Gray's submission on personal care. President Mike Pringle may remember though want to forget the drubbing he received from his own members when as Chair of Council he was soundly defeated in debate in Sheffield that "Personal care is dead". The Department of Health may also choose to forget the time when your Association (Small Practices Association as it was then) became "persona non-grata" for criticism of further erosion of personal care in health care policy.

Let's give thanks to the Heroes of Continuity. The late-and-greats **James McCormick and Barbara Starfield**, and the current **George Freeman** and **Richard Baker;** you were right too. Thanks too to our illustrious supporters including Mollie McBride, Lesley Southgate, David Colin-Thomé and Patricia Wilkie who never lost sight of what is truly important in medicine, people. Also known as patients.

The Heroes of Continuity

So what next? Holism and Generalism! No Cartesian duality of mind and body, no reverence for specialism like experts in DM2 CKD below 45ml/min.

But instead the hopes fears and aspirations of Joe and Jo Public. Holding their hand as they navigate the vicissitudes of life and the living of it. We will again watch our patients born, grow, love, parent and die, just as we do.

We can again become that most wonderful of professions, the family doctor.

So this is no time to relax. We have more work to do to ensure that this toe hold becomes the new reality of Primary Care.

Your National Conference #FDAsmile

National Conference 2014 | Learning & Fun | 6 September 2014 Nottingham

Editor's choice: Access & Triage e-cigarettes ... Buzzword Bingo Ben Dyson Glitteratum Interview

Glitteratum Interview

What makes you get up in the morning? All the interesting, resourceful and generous people I meet in the course of my work. Or my son needing to be driven to a football match.

Which team do you support and why? My son's Under 15 football team – I run the line for them on Sundays, which is a good way of taking my mind off work for a short while.

What is your pet hate? The invasion of the meaningless term "Going forward" into our speech and writing (or do we have to keep reminding ourselves we're not going backwards)? I also have a phobia of seaweed and acronyms.

What is your favourite book / film? Book - James Joyce's Ulysses. Film – Some Like It Hot.

What is your favourite app? I only have three on my phone – Twitter, Facebook and TheTrainLine. None of them has changed my life. What am I missing?

Your three predictions for the NHS in the next year? I'm not good at predictions. I'd like to see much greater integration of primary care, community health and social care teams; better community engagement to help people manage their own health; and a stop to needlessly polarised debates about the role of choice and competition.

Your three ideal guests at a dinner party? Alison Janney (The West Wing), Aaron Paul (Breaking Bad), Sofie Grabel (The Killing). They're only actors, I know, but I loved those three TV shows.

Your message to FDA members? I know everyone is feeling workload pressures like never before, but I hope we can find a way of breaking out of this vicious circle and working out how to make general practice sustainable for the future.

Ben is Director of Commissioning Policy & Primary Care at NHS England.

Stampede for Federation Factsheets!

Vice Chairman **Dr Claire Rushton's** federation talk at the recent Best Practice event caused a stampede at the FDA stand! 200+ delegates took the Federation factsheets. Authored by Andrew Lockhart-Mirams, the factsheets can be found on our website.

Author | Andrew Lockhart Mirams

Editor's choice

The fun of going to press is totally eclipsed by the sorrow at the death of our ages' most wonderful human, Nelson Mandela. May his humanity be forever remembered.

So were Madiba to be our Guest Editor what would he choose? Certainly the wise words of **Colin the FDA mascot** in this issue the article on **vapour cigarettes.** Sure you don't get to 95 years old by smoking. Always a bit of a rebel I am sure Nelson would be taken by the notion of grass roots revolution which is vapour cigarettes (page 5).

Finally back to Ed. I cannot help but wonder if Umar Tahir's article on GP triage is an important taste of the future. (page 3).

Get the most out of membership

- ✓ Use the FDA logo on your practice literature
- ✓ Free practice website listing Find a GP search
- ✓ Login and learn! Clinical and organisational topics in the members' website
- ✓ Need login details? Email gill@family-doctor.org.uk

Smarter Access: the Moss Side Model

The demands on general practice are ever increasing. Both patients and the government are demanding greater access, but at what cost? Are the proposed changes sustainable? What difference will they actually make? Will increasing the core hours actually result in greater patient satisfaction, or result in the same access issues, but during more hours of the day?

Moss Side Family Medical Practice in Manchester is probably not a great deal different from most city centre practices; a diverse population, busy, and challenging in more ways than one.

In order to cope with high demand, we ran an open surgery in the mornings, for two years. Not only did this dramatically reduce Accident and Emergency attendances, it also improved patient experience. However, as the patient list size increased and patient education was proving difficult, numbers and waiting times increased, as did the stress levels of the GPs.

The open access surgery had on occasions over 50 patients booked in. With the same kind of problems and requests coming to open surgery, it became clear that this service was not benefitting patients, or the GPs. Like at all GP surgeries, time and clinical staff as resources are limited, and cannot cope with continually growing numbers accessing a particular service.

The dynamics had to change, but the quandary was how to continue to provide unrivalled access, but with appropriateness and clinical need the priority. After discussion, we launched a new triage system. The open surgery became the urgent surgery, and the decision regarding when a patient needs to see a doctor was returned to the doctor.

So here is how it works. The patients book in with reception as usual during the allotted time, usually between 9 and 10 am, and is seen by the triaging GP. The triaging is in a room adjacent to the waiting area. The patient is called in and addressed by the GP, who remains standing. Triage notes are entered onto the patient record, either by the GP, or another member of the team. The GP decides what access is required.

The patient can be:

1. Asked to stay and is then seen in the urgent surgery the same morning, run by a second GP;
2. Asked to return later in the day;
3. Booked for a telephone or Skype consultation;
4. Offered a routine appointment with a GP or nurse;
5. Redirected to Pharmacy First; the red eye service; or reception for e.g. sick notes, prescriptions

The advantage over telephone triage, is that the patient can be "eyeballed", and basic triage tools can be used, like a temperature or pulse check. It should not go beyond that, or it becomes a full consultation. As with any clinical encounter, there is the possibility of making a mistake, but compared to telephone triage this is greatly reduced. The safest and most effective triage is done by the most qualified, which is why it works well with a GP on the front line. At the same time as delivering the most appropriate care, we are able to encourage self care, use all available services, and provide valuable patient education.

There are also added benefits for non clinical staff e.g. the decision is coming directly from the GP, rather than a receptionist. Patient satisfaction is higher, both with the speed with which a GP sees them, and the correct means for addressing the problem has been used. The immediate patient benefit was reduced waiting time.

We are in the first few weeks of the change, but already it has transformed both the patient and GP experience, as well as improved the access to the care that is needed. Numbers vary day to day. Less than 50% of the patients who book in are triaged to be seen immediately. We will have more robust data later this year.

As doctors we all welcome any attempts to improve care for patients, but greater access, I argue, will not necessarily achieve this. Again, extending the time for open surgery will not achieve significant results with better patient care, or happier patients, and neither will extending core GP hours.

The Moss Side Model proposes smarter access over greater access, based on clinical need, and guided by the GP. It seems to be working for us!

Dr. Umar Tahir, GP Moss Side

The safest and most effective triage is done by the most qualified person

Strengthening the GP voice in rehabilitation services

In September, Andrew Marr returned to our TV screens following a stroke earlier this year. This prompted a flurry of articles in the national press inviting us to reflect on the inadequacies of community rehabilitation. His wife, journalist Jackie Ashley, particularly criticized the inflexibility of services and the sudden step-down in intensity of rehabilitation on discharge from hospital.

Supporting people to regain their independence will always be a particular challenge, as the needs of patients vary so greatly. The patient's level of ability, their lifestyle and home circumstances all help to define what they as individuals need from a service. Perhaps this challenge goes some way to explaining why Andrew Marr and Jackie Ashley found what was available to them fell so far short of what they needed at the time.

The complexity and variety in the demands on rehabilitation services, mean that we are more likely to find effective solutions through a mix of different, overlapping organizations with different approaches. This would help rehabilitation to be tailored more closely to an individual's needs and preferences, while remaining as local as possible.

For GPs, however, this approach poses challenges. It can be difficult to keep track of large numbers of different providers and, as services evolve, remaining up-to-date becomes even harder. Consequently, there is a risk that as the variety of services available increases, patients will become less likely to reach the right service for them.

If we are to improve rehabilitation services, we cannot shy away from this tension between the complexity that patients need and the simplicity that facilitates referral. Finding a solution to this depends on the communication channels between providers and GPs and the development of simplified and streamlined referral processes. Most importantly of all, however, this will require a collaborative effort of all stakeholders, including referrers, commissioners, providers and service users.

As GPs, it is important that we are able to influence the commissioning decisions that affect our patients at a local level. To help us do this as effectively as possible, the **NHS Clinical Soft Intelligence Service** (formerly NHS Clinical Commissioning Community) has established an online forum where those who engage with rehabilitation services can share ideas nationally.

- What do you think excellent rehabilitation looks like?
- Have you identified barriers to progress?
- Do you have examples of success to share?

If so, then join this debate by logging in at **www.networks.nhs.uk/discussion/a-lifeboat-for-nhs-managers/370580099** and have your say.

It is essential for the sake of our patients that the voice of GPs is heard in this forum.

Dr Chris Longstaff, GP, Bassett Road Surgery, Leighton Buzzard

Latest Factsheets for Members

Common sense guides

At the FDA we try to make sense of the myriad of changes in the NHS. That's why our series of factsheets is so popular with members. Plain English guides written by GPs and Practice Managers doing the job not just talking about it!

Get the most out of your membership. Order the ones you've missed. Tell us ideas for new titles.

Free to all FDA members

1. QOF & Hypertension
2. QOF changes 2013—2014
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12. NHS England & your practice: what it means

Order : admin@family-doctor.org.uk

Jeremy Hunt vs. Vaping

Imagine this. In China 5 million people are going to die from eating a harmful plant. A UK pharmacist has developed a cheap substitute, which is readily available, which the population is starting to buy over the counter but now the Chinese Government is going to crack down on the new food-stuff. It will ban it completely except through official state channels. Mad, quite mad, but only what you would expect in China.

Except that for China read UK and for eating read smoking. So now you are bang up to date with the current situation about vapour cigarettes. Mad barking mad; and we think of ourselves as a civilised country! Oh and yes, it was invented by Chinese Pharmacist Hon Lik after his dad died of lung cancer.

Tobacco when smoked is highly addictive and of the UK's current 10 million smokers half will die directly from smoking diseases.

Nicotine, itself is neither highly addictive nor dangerous. The difference in addiction is probably due to the fact that tobacco also contains the active ingredient harmaline a naturally occurring MAO inhibitor. The danger of course is due to tar, carbon monoxide, acid smoke, and sharp micro-particles. So mix almost harmless nicotine with vegetable glycerine and propylene glycol both regulated as food stuffs and you have got an almost harmless product. Even NICE tells that we should tell our patients *"that these products are likely to be less harmful than cigarettes."*

The European Commission proposed a ban on e-cigarettes and vapour cigarettes, but for once, mirabile dictu, the European Parliament threw out the Commission's proposals and declined to have e-cigs labelled as a medicinal product. Whereupon our glorious coalition government announced that despite this outbreak of EU sanity the UK will press ahead with the legislation.

Guess what is happening to the prescription rates of current similar medicinal products nicotine replacement therapy? Yes you guessed, declining year on year for the past four years.

So don't wait for the nanny state, do as NICE tells you and start saving lives, by recommending vaping, which could well save in excess of 10% your total patient population!

Online learning. Download the FDA learning on e-cigarettes with the evidence so far plus ideas on talking to patients. **www.family-doctor.org.uk**

Contact: michael@family-doctor.org.uk

Recovery made easy | remember where you read it first

Soon, the mental health concept of "Recovery" will be as common as the ring tone Marimba. To most GPs the concept will be quite new; to the growing numbers of FDA members it will be common sense, for it is about people with diseases rather than the diseases people have.

So Recovery:

- Is about enabling people to build better lives on their own terms, with or without the symptoms of mental illness. That is clinical care should support individuals to get on with their lives instead of postponing personal goals while they 'get better'.
- Is about providing the opportunity to build full and satisfying lives, to integrate and contribute.
- Is about providing the support to enable people to live better and stay better.
- Delivers the outcomes that mean the most to each individual.
- Mobilises the rich 'natural resources' of the local community by empowering people to do things to support themselves and others e.g. by getting involved in peer mentoring, family support networks or mutual aid.

So, we are currently spending about 85% of our commissioning for mental health budget on symptoms. Austerity is forcing us to think.

So let's improve the patient focus, spend lots less and improve the quality of patients' lives. It is a bit of a no brainer really.

The Modern Family Doctor & the Future of General Practice

Dr Peter Swinyard was asked by health commentator Roy Lilley to give the Association's views on the state of general practice.

The seismic upheaval in health care in England following the Lansley reforms has put the focus firmly on delivery of health care in General Practice – from commissioning to provision – to the alarm of many and the satisfaction of a few. The underlying principle was that GPs are capable of understanding and managing risk in a way in which an administratively led health system was not and that these risk management skills could be applied to system design as well as to patient care.

There is a mantra developing that much work traditionally done in hospitals could and should be done in a primary care setting as being cheaper for the system and more convenient for the patient. However, no-one seems to have cracked the four hard facts: -

1. Hospitals have high fixed costs and high profile community support
2. It is political suicide for a local MP to advocate hospital closure in their patch.
3. Getting the cash out of the secondary care sector to invest in primary care is a real stumbling block.
4. Decommissioning services is hard.

General practice in its present form is at breaking point. There is just no slack in the system for GPs to take on more work. The funding of general practice is falling as a percentage of the overall health spend. 90% of health care is provided in General Practice and attracts a derisory 7.5% of the health budget (8.47% if you include prescribing costs).

The perfect storm of diminishing incomes, increasing pension costs and decreasing lifetime caps leading to earlier retirement and a poor career structure with threatens the whole future of general practice. General practice has ceased to be a great career choice for the new medical graduate – and we need the cream of the crop in GP-land. Not just those who can know everything there is to know about the left shoulder or the functioning of a nephron but those who can know pretty much everything about pretty much anything, can deal with unsorted illness presenting in its earliest guises and deal with the burden of chronic disease management as well as running their businesses in general practice.

So, how do we move from a system at breaking point to the "crown jewel" of the NHS that general practice could and should be?

Let's start with the most important person in any general practice. Nope, not the doctor but the patient. What does a patient look for in a modern general practice? I think there are two groupings of people here. They are not discrete groups as people move from one to the other freely.

The first group is those who have a simple self-limiting illness. On the whole, they are not too bothered about which doctor they see as long as the GP is affable, available and able. The second group is those who think that there is something mortal wrong with them. As one of my patients recently said "I know I can go to the Walk-in Centre, out of hours, or A&E to see someone but, when the chips are down I want to see you, my doctor, whom I have known for years. I know you will give me a straight answer and make sure I am looked after".

This Continuity of Care is an idea whose time has come. Goodness Gracious, even La-lite is using the phrase as part of his "wishlist" although I did ask him to put it at the top rather than the bottom. **Continuity of relationship medicine is proven to reduce health costs and increase patient satisfaction.** The doctor-patient mutual investment company is still one of the best underpinnings of cost-effective and patient-sensitive health care. **So how do we deliver this in the 21st century's 24 hour society?**

Continues on page 7

The Modern Family Doctor & the Future of General Practice

First, let's get rid of the notion that General Practice is a commodity like a trip to Tesco. Just because I can buy baked beans on a Sunday does not mean I need to have my GP at my beck and call and open all hours. The Darzi experiment has shown that this is a dreadfully expensive way of dealing with perceived wants, not needs and the NHS cannot be funded from general taxation to deal with this. .

What we must do is not to provide 7-day access but really good access for 5-6 days a week. There are various models of how to do this (again for discussion on another blog) but patient safety and satisfaction is best served by quick access to a GP. Yes a real GP, not a yan-ban (yet another nurse by another name) or other healthcare person but a GP. It is cheaper to employ a GP at the front end as they can make quick and safe decisions, more satisfying for the patient and more efficient for the system. Consultation rates which have risen from 3.1/patient per year in 1995 to 5.8 in 2008-9 (last official government figures) to about 9 now mean we have to work smarter. There are only so many hours in the day and the average GP principal works an 11-12 hour day already.

The corner shop model of general practice has served well for 60 years. Now we need to build on its strengths and deal with its weaknesses. I believe it is vital to retain health care local to patients, within a pram-push from their homes, especially in deprived communities who not only lack social mobility but mobility of any sort. However, lots of the backroom functions of practices can usefully be shared – payroll, HR, protocol development, cleaning contracts. The list is endless. We need a super-manager to cope with a group of practices and an administrator on site to deal with day-to-day things, leaving the GPs and clinical teams to do what they do best – the medicine.

Whether you call it federation or something else, closer co-operation is key. In many areas there is bad blood between practices for reasons almost lost to human memory. We must grow up and work in teams. We managed it in out-of-hours co-operatives, we need to use the same esprit-de-corps in-hours. Different models will work in different areas – from loose federations through partnerships to mergers and to super-practices with a few partners employing a lot of salaried GPs or even practices owned by commercial firms or Foundation Trusts – there is room for all. The workforce is also changing and no longer do most new graduates expect to work full time in the same practice for 30+ years. There is an increase in part time working and career mobility.

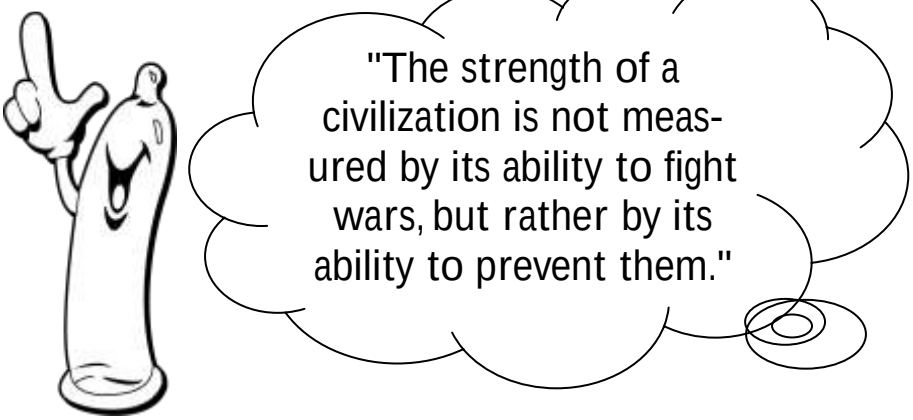
But let's remember who we are working for. Not a faceless foundation trust, not a PCT, a LAT or a CCG.

We are working for our patients as their doctor, their mentor, their friend, their advocate and their navigator through the health system. Keep our eye on this and General Practice will flourish.

Pictured is Dr Claire Rushton our Vice Chairman

Colin's Wise Words

Colin is the unofficial FDA mascot



Member Resources

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Opinion

#FDAsmile

family doctor.org.uk

Member news

Great Homer Street

Dr Clare Gerada visited FDA secretary Dr Simon Abrams' surgery in Everton, Liverpool on a fact finding visit about Shared Care Drug Misuse Services. Pictured from the left are Dr Gerada, Dr Simon Abrams, FDA member and Liverpool Addaction Medical Director Dr Sandra Oelbaum and their CEO Nick Evans

Patron's second term

We are delighted to announce that Professor David Colin Thomé O.B.E. has accepted a second term as Patron of the Family Doctor Association. A long time supporter since our Small Practice Association days, David became our Patron in 2008. This is an honorary post. David is currently an Independent Health Care Consultant and remains a lifelong Everton fan.

Good Fellows– now Official!

Dr Michael Taylor FRCGP
Founder member of the Family Doctor Association and immediate past Chairman **Dr Michael Taylor** recently received the award of FRCGP.

His citation said he is a family doctor who puts the patient's agenda first and foremost; he also works to improve the wellbeing of the town's population. Michael is also a Member of the Irish College of GPs.

Dr Alan Dow FRCGP
A founder member of the Family Doctor Association and current GPC member, **Dr Alan Dow** received the award of FRCGP. His citation highlighted he has been a Derbyshire GP for 18 years and is most proud of his contribution to reducing health inequalities.

Dr Ramesh Bhatt FRCGP
A founder member of the Small Practices Association, a pioneering GP educationalist and GP trainer.

Tell us your successes so we can share with members.

Heard at real NHS events

NHS BUZZWORD BINGO dare you try it?

Quality focus	A sense of togetherness	Fast turning circle	Adding value at each stage
Clear focus	Working under a different umbrella	Wider learning cycle	Establishing **…..anything!**
Structured focus	Issues logs	Does that chime with you?	Cornerstone of care
Blended learning	An Epiphany about anything	Socialise and embed a policy	Talent community

Buzzword Bingo is the perfect antidote to boring meetings where the air is full of NHS jargon. **How to play**
Simply tick off the words on the Bingo Card when you hear them at a meeting. The aim is to tick off all the words in a line (horizontal or vertical) and then yell "Bingo!" Dare you do it? **Tweet yours at #Buzzwordbingo**

Thanks to Johanne Shorrock, PM at Roman Road Practice, Blackburn for her fortitude in harvesting this Buzzword Bingo!