The Family Doctor

Family Doctor Association Members' Newsletter | Spring 2016

The GP Forward View: Promises... Promises ...

Bruised and battered by five years of financial torment, GPs can be forgiven for thinking that the three most worrying phrases are:
1 "Darling, I love you"
2 "Your cheque is in the post"
3 "Trust me I'm an NHS Strategist".

If you want a recap of what has been promised you can find the short term and long term lists on page 2. If you want an FDA opinion read on.

Of course we're pleased with the GP Forward View proposals; this is welcome and much needed investment. Yet, we are pleased in the same way as a man thrown a lifebelt, "We're saved!" but then the niggle "I wonder where we are being taken?" So immediate survival is assured but do we approve of the direction of travel, do we approve of "the promised land." How will we judge?

"When the dust settles will this help me do my job better, better for me and better for my patients".

By this yard stick there are promises which are hopeful, some less so, and some which are worrying. One which has been unheralded by the media is the pilot of a new medical assistant role. How many times have we wished for a personal assistant, someone who would look at the at the 2 week wait referrals to check for DNAs, that the upper GI'ologist didn't simply 'scope and discharge, that the patient returned home was phoned on our behalf to ensure that all was well, that could navigate the patient to the appropriate service, that could back up consultations with a quick call later etc.? Compare this with the promise of pharmacists and mental health workers; the worry here is that these are promised simply because they are available and seem about right.

Growth funding is to be split between core funding and incentivising multi-speciality community provider contract, but what is the split? This is not the same as the long promised aim of combining core general practice with responsibility for wider services; this we wait for.

Transformation is to be at "scale and pace", which translated means "bigger quickly" to gain the presumed economies of scale.

Economies of scale are presumed, even promised, but are uncertain. Such economies are best delivered by large organisations behaving uniformly throughout. Accountability and control are at the system level. So for *Devo-Somewhere* it will be at that Somewhere regional level.

To the greatest possible extent clinical procedures will become standardised. Overlap of services will be aggressively minimised. Performance will be analysed at a whole system level. This is scale at pace working well; is it this we want?

There is however one cherished immutable component, the doctor-patient relationship. It is this which makes our job, our lives enjoyable. It is this which will sustain any excellent modern health system; would we want less? So what should our future look like from a patient (aka taxpayer') perspective; what do our patients tell us they want? First and foremost is access. We GPs are so downtrodden with escalating health service demand we have not been able to provide this. *(What percentage of out of hours demand is fuelled by in hours lack of access? Ed.)*

Other than access:

- "see me as a whole person, not a condition";
- "See me as a partner in my care; inform me, empower me"
- "don't desert me when specialist treatment is finished"

So to the FDA, who treat the patient by knowing the person, the yard-stick by which we judge the coming reforms will be, access, holism, patient empowerment, and continuity.

Now where have we heard this before? Let's make sure that no one forgets it!

Dr Michael Taylor, Editor

Editor's choice: **GP Appraisal: What's New?**
Crowdfunding to Save Surgery? **Indemnity Woes?**

NEW factsheets available online
Appraisal Update | Social Media & GP Practices
Safeguarding at Your Surgery | Medical Indemnity

The GP Forward View: Quick Guide

The Family Doctor

Short term

- New £½ billion Sustainability and Transformation Fund over the next five years, starting 2016/17
- Introduction of a new four-year practice resilience programme from 2016, worth £16m in year one and £40m altogether over four years. A further £10m investment to support the most vulnerable GP practices.
- GP burnout & stress support with £16m extra investment in a new specialist mental health service, starting in December 2016
- New financial support (May 2016) for doctors returning to work in areas that have been struggling to recruit.
- Increases in current funding for the GP retainer scheme from May 2016.
- Roll out of 250 post CCT fellowships by summer 2017 to bolster recruitment in areas of GP shortage.
- IT funding. Practices can bid through CCGs for new IT funding in 2016/17 to help improve patient access and reduce GP workload.
- Practice nurses. Launch of a return to nursing programme to deliver new practice nurses from 2016/17.
- A new programme of mental health workers from 2016/17 to give an extra 3,000 mental health therapists working in general practice by 2020.
- A new £112m offer to enable every practice to access a clinical pharmacist, to deliver 640 additional pharmacists in general practice by April 2017 and 1,500 by 2020.
- A five-year £45m national training programme 2016/17, for reception and clerical staff, to play a greater role in the navigation of patients and handling clinical paperwork. Pilot of a new medical assistant role.
- An investment of £30m in a 'Releasing Time for Patients' programme 2016/17 to help release capacity within general practice, plus measures to tackle bureaucracy.

Longer term

- A guarantee by NHS England that general practice will receive a minimum of 'over 10%' of NHS budget - or £2.4bn of additional recurrent funding each year by 2020 (this means of the additional £8bn committed by the Government to the NHS each year up to 2020, around 30% will be going to general practice by end of 2020.
- By 2020 overall spending on general practice *could* increase to up to 10.7% of the total NHS budget
- 14% real terms funding increase, approximately double the increase for CCG-funded services.
- Medical indemnity proposals July 16
- Further additional funding from CCGs to build community services and develop new models of care.
- Reduction in the number of CQC inspections for 'good' and 'outstanding' practices to 1 every 5 years - 2017.
- £206m on expanding the general practice workforce by 5,000 doctors and 5,000 other practice members.
- A guarantee that no GP or GP practice will be forced to offer routine seven-day access to their services; an assurance that the level of capacity required on different days of the week will be a matter for local decision makers.

Editor's choice

If you come to each issue of your newsletter in search of escapism this issue may disappoint as contributors have certainly responded to the GP Forward View. There is however realism in approaching the difficulties of our times. There is an article from the MDU on page 3 exploring the difficulties of indemnity. This is timely considering that Simon Stevens tells that there is to be a review of this issue in July. Our Chairman Peter Swinyard has written survival tips, and Peter is to meet with GPSurvival and Resilient GP Chairs within the month, so look out for our next issue in July.

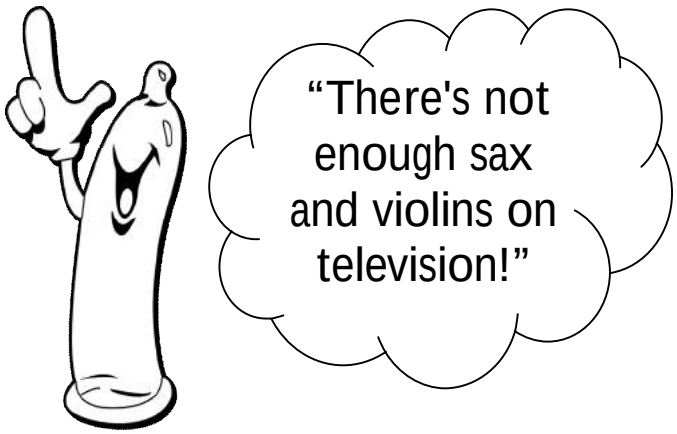
GP appraisal changes are demystified by our Vice Chairman Claire Rushton. Thank goodness too! See p 3.

The first rule of Harry Hardnose the archetypal journalist is well known: "Don't let the facts get in the way of a good story". What isn't so well known is the second rule "If there's something you want printing, that's advertising, if there's something you don't want printing that's news". Why do I mention this? See page 7 on the Five Year Mental Health Forward View. To lighten the mood, visit page 8 for our series of collective nouns for medics. Plus perennial favourite, NHS Buzzword Bingo!

Dr Michael Taylor

Colin's Wise Words

Colin is the unofficial FDA mascot



2 Minute GP Update

'A useful weapon in the GP armoury of keeping up to date.'

Don't miss out! Sign up for your monthly GP bulletin:

☑ **moira@family-doctor.org.uk**

Recommend a friend too!

Medical indemnity & GPs.

Why costs are rising and how you can help.

You don't have to look too hard in the GP press to find mention of the increasing cost of medical indemnity. And if you look at national media coverage you could be forgiven for thinking it's all your fault. It's not and here's three reasons why.

1. Medical indemnity costs are rising because of the spiralling cost of claims. The MDU has seen the number and size of claims rising at a steady rate of 10% per year, outstripping other forms of inflation. Paying £5million in damages in a claim against a GP is no longer unusual. The MDU's highest GP payment was £8.5million for a missed diagnosis of subarachnoid haemorrhage. MDU members' subscriptions must reflect increasing claims payments.

2. **Despite relentless increases in compensation payments, there's no evidence to suggest that it's because of a deterioration in GPs' practice or clinical standards.** Take, as an example, GMC complaints. Despite the increase in the number of doctors on the GMC register since 2006, and an increase in the number of complaints, over the same period there's been a 22% decrease in referrals to MPTS tribunals which look at fitness to practise. There are many factors driving claims; legal changes play a big part and as medicine advances so do expectations and standards which also redefine success upwards.

3. It is suggested that the solution to the spiralling cost of claims is to make medicine safer. Logically, that makes sense: safer medicine should lead to less avoidable harm and in turn fewer claims. But the evidence to support such a proposition is scant. Some studies in the US in highly technical specialities such as obstetrics and anaesthetics have shown that certain safety initiatives reduced claims payments and frequencies, but most did not. We haven't seen any research showing that patient safety interventions reduce claims in primary care. This is not to suggest that safety initiatives should be ignored; practise safe medicine for its own sake, just don't expect it to reduce what you pay for indemnity.

MDU

The last point is an important one, because it goes right to the heart of the only effective solution, which is reform of the law. There is evidence from many other jurisdictions, such as the USA, that law reform does reduce the cost of claims. The MDU is calling for UK reforms, in particular repeal of a 1948 Act that allows damages to be calculated on the basis that all future care will be provided in the private sector. We also want caps on the cost of future care to be introduced. Go to www.themdu.com/faircomp to find out more, and get involved in the campaign.

Dr Michael Devlin, *MDU Head of Professional Standards & Liaison*

GP appraisal: what's new?

What you really need to know and then get on with the day job!

Changes in "Impact" credits

Previously credit points were doubled for "impact." However a lot of doctors did not properly qualify what that impact was. A vague plan of 'I will use this in practice, I have told my partner about this' was not enough! "Impact" is in fact the most use that can be made out of learning in our professions. Now if your learning has had "impact" this can still be used to increase credits. You need to demonstrate:
it changes the way you do your job
has been "applied" to patient care or shared with colleagues

Practical note: 1 hour = 1 credit demonstrated by reflective note on lessons learnt and changes made. Impact is to be recorded as a separate CPD item. So any changes in practice resulting from CPD, QIA (quality improvement activities) feedback, complaints or compliments, are to be recorded as a separate reflective entry. You need to allocate accurately the time taken.

New! Quality Improvement Activity (QIA). Previously two Significant Event Audits (SEAs) and / or case reviews each year were recommended, and one audit every five years. It has been recognised that this may be difficult for locums, so the criteria have changed.

Just make sure that some form of Q.I.A. every five years covers the scope of your work. Q.I.A. activity is now credit worthy (this was previously not the case apparently, but we all did it!) You do not have to "number crunch" yourself but reflect on personally relevant outcomes.

Q.I.A. includes:

- ✓Audit
- ✓Review of personal outcomes data (e.g. did I refer to the right person, was my diagnosis correct, audit of infection rate in minor surgery)
- ✓Information collection and analysis (search and do)
- ✓PDSA (Plan, Do, Study, Act) cycles
- ✓SEAs
- ✓Multi Source Feedback (MSF)

Continued in FDA Factsheet no.46. At www.*family-doctor.org.uk*

Dr Claire Rushton
GP Appraiser, Trainer, Vice Chairman
Family Doctor Association

Uncertain future ahead for GPs?

For the last five years ,Lloyds Bank has undertaken a business confidence survey amongst primary care professionals – the Healthcare Confidence Index. Some FDA members have contributed to this, for which I am very grateful.

The 2016 report was published in March and once again highlights the lack of confidence amongst doctors. Ranked on a dispersement index scale of -100 to +100, short-term confidence (the next 12 months) amongst GPs is -20 and longer term (5 years) is -76. This is a slight improvement on the 2015 figures but still in the 'very pessimistic' zone.

One of the interesting findings was confirmation of recent experiences with Federations. There has been a significant increase in the formation and membership of Federations, with nearly three quarters (73 per cent) of those surveyed now in a Federation or planning to join one. However, with 48 per cent actually signed up, only a quarter say the Federation is active. From my experience there appear to be cases where the Federation was perhaps created in haste and without a proper business plan or agreement over what it would actually do - the alternative view of course is that there is now enough funding or time to make them work.

There is much industry talk and activity around practice mergers. Our latest Index shows that the majority of GPs expect the average practice patient numbers to at least double but few (seven per cent) expect the numbers to increase to the NAPCs Primary Care Home model levels currently being piloted of between 35,000 and 50,000. Demands for longer surgery opening times, restrictions to budgets, new services and potential contract changes are all moving practices towards larger structures seeking benefits of scale. To some extent the Federation is one way of potentially achieving scale without the need for a full or formal merger, but a lack of resource, both financial and management time, and focus could be leaving many to wither on the vine. Federations are also usually separate legal entities, typically a limited company, and this can lead to issues around VAT and some contracts.

I am also unsure if everyone has the same view or understanding of the objectives of a Federation versus a larger merger or super-partnership, for which incidentally there is no separate legal definition. Larger partnerships should give the required economies of scale and the size to allow flexibility of access and working; they can also pull together admin functions and the capacity and expertise to bid for additional services, whilst the downside is loss of independence and the intimacy of a small local practice.

A new model being seen is attempting to have the best of both worlds: a super-partnership with local practice autonomy and management. Effectively the partnerships do merge and share many back-office functions, but each separate surgery operates as a profit centre. As with any business model, the devil is in the detail and clear partnership agreements need to be in place, with accountants' advice taken over profit allocation and tax.

The Five Year Forward View gives no detailed direction on which business model to follow or structure to use. Over time one model will undoubtedly become the common standard but for now it remains uncertain. Lloyds Bank will work closely with practitioners to support whichever format is chosen, and recommend GPs turn to trustee advisors to explore the pros and cons of each and make sure all parties to any changes are clearly aligned on their understanding of what they are signing up to.

Ian J Crompton ACIB
UK Head of HealthCare Banking Services SME Banking

LLOYDS BANK

Events, online learning and using our logo!

@FamilyDoctorUK

Did you know that all presentations and resources from our study days across the country are available online for you to download?

CPD events

- 9 July Accrington Lancashire 'The Digestion Question'
- 20 July Liverpool Lace Centre Worried Mums: Paediatric Update
- 1 Oct Bury Village Hotel GP Hot Topics

Book online or call HQ

Follow us on Twitter

- ✓ Use the FDA logo on your practice literature
- ✓ Need login details? Email gill@family-doctor.org.uk

family-doctor.org.uk & click the learning tab

Practice survival matters: five tips

Dr Peter Swinyard advises on some steps you can take if you're a vulnerable practice.

The increased pressures on general practice mean that practices are closing at an ever-increasing rate with over 200 closures reported in the last year alone.

Plus around 10% of GP practices in England are becoming vulnerable. But what can you do if you think that your practice is in danger?

1. Watch the pennies

Do you know what your cashflow is like? Do you have any financial projections? Make sure you have all this information to hand. If you realise that you are in fact skint, look at what caused this. Is there one particular partner or indeed the practice manager who has not managed things properly? If so, get the blame game over quickly and try and sort things out.

Have a forensic look at all your expenses. Staff first – they are your biggest outgoing. Are you getting the best for them and, on the principle of subsidiarity, are they taking as much workload and responsibility as their training allows, from receptionist to salaried doctor?

Look at all the outgoings. It's amazing what you may save on energy supplies, insurance cover, paper and toner and medical supplies. It may be worth joining a buying organisation for long-term savings. Don't forget to check that your partners and practice MDO cover is correct – that all the sessions you do are covered and, as important, that you are not paying to cover work you don't do.

2. Talk to people

Call the NHS England local office, your CCG and your LMC. No-one wants to see practices failing. They can offer advice and support to help you get back on track. You may be amazed at how the goodwill you have built up with employees that have moved around from Health Authorities to PCGs to PCTs to CCGs can be monetised. Bank managers can also help. See if they can advise you on managing your cashflow or if you are in deep trouble, offer a loan to tide you over.

3. Involve your staff

It's up to you how much you share with your staff about your financial situation but they can help.

Reassure them that they will still get paid, but tell them that you need all hands on deck to try and keep the practice viable. I always find that management by lunch works exceptionally well. A trip to Pizza Hut for lunch at £6 per head is an excellent and cost-effective way of boosting staff productivity.

4. Mobilise your patients

Do you have an effective Patient Participation Group? If so, get them on side. If not, you can still mobilise your patients to help you. Patients are happy to help if you encourage them – when I was starting my practice in 1995 a patient did a midnight bike ride to raise money for me to buy the equipment I needed. The spirit is still there if you can tap into it. Get your patients writing to local councillors, the local paper and their MPs. Put up notices in the waiting room encouraging patients to do this and telling them how. They can help get the message out that general practice needs help and raise the money and/or political will to save the practice.

5. Sort out your premises

There is a limit to what you can do when finances are tight, but **look critically at your building and mystery shop your telephones** to avoid patients walking away at the worst possible time. I ask a friend to phone up and listen in on speakerphone. How are the phones answered? Is it all negatives *('no we haven't any appointments and you can't be seen')*? Or is it positive *('yes, we are busy today and the first routine appointment is on the 31st and if you are ill enough that you must be seen today for your health, Dr X could fit you in for a brief consultation for this emergency item at 12.34')*?

Look at the waiting room. A couple of leather sofas from DFS do wonders. And you won't even have to start paying for them for a year.

When patients hear that a practice is vulnerable, they walk away. Making sure the practice still looks nice can go some way to keeping patients with you when times are tough.

Above all, keep to your practice ethos of offering excellence of clinical care with continuity of care of 60% or more for patients with ongoing problems. Your reputation will spread.

Dr Swinyard is a GP in Swindon and national chairman of the Family Doctor Association. The article is based on his talk at Pulse Live London.

Evidence Based Idleness: Mid Life MOTs

The Family Doctor

Kenneth Clarke was the man what got it. When KC was Secretary of State for Health he knew the importance of a) the GPs wallet and b) the importance of sticking needles in kids. So Public Health Doctors with immunisation rates commonly below 50% were replaced by giving GPs and teams a bob or two and lo! **immunisation rates doubled**.

There was some evidence around even then (1990) that financial incentives worked well when there was good evidence of benefit. but when applied to procedures / practices for which there was no evidence of benefit, led to frustration. The first bit has been remembered but the second appears to be utterly forgotten.

We know that the QOF for three years was a great innovation, a great leap forward, and an aspiration to lessen the health inequalities gap. Now the evidence tells it is scratching around to demonstrate additional benefit in subsequent years and it's becoming a bit of a drag increasing to the soaring work load. **Personal Care Plans in primary care have a) no evidence of benefit and b) there is some evidence of no benefit.**

To these financial teases can now be added "mid-life MOT's". In a new report published in the Journal of Public Health It said, including several reviews examining all the available evidence. The report's authors including Professor Simon Capewell, of the University of Liverpool and Professor Walter Holland, from the London School of Economics, said **'Health checks have been repeatedly shown to be ineffective'**

'In spite of austerity policies, they (GP teams) are required to commit time and scarce resources to activities of debatable effectiveness and cost-effectiveness,'.

'This saps morale, particularly considering the substantial opportunity costs of failing to invest those scarce resources in alternative, more effective interventions.' The authors said the money could be better spent in areas such as child health or promoting healthy food, which could halve early deaths for heart disease.

The mention of child health brings me back to the beginning. Have you thought what happened to all the customary middle ear infections and glue ears in the past few years. The incidence appears to have reduced as the uptake of meningitis vaccine has increased. Ah, the joys of EBI so watch this space!

CQC Fees: Appeals?

Several members have contacted HQ to ask about an appeal mechanism following the imposition of raised CQC fees for general practices. The Association did submit a robust response from its membership to the CQC fee consultation however the fee hike on general practice was imposed. We remain concerned about the disproportionate impact on smaller GP practices, many of whom are in a precarious financial situation. We checked with the BMA a few weeks ago:

FDA: *Several member practices have asked whether they can appeal the new fees imposed by CQC? I wondered if the GPC has any information on this or whether other practices have done so? My hunch is that there is no right of appeal and it's a done deal..... can you let me know?*

BMA: *We sympathise very much over the fees and made our views plain in response to the consultation. Sadly, however, you are correct that there is no right of appeal.*

Chairman's Diary

One week in May!

- **Shadow Secretary of State for Health Heidi Alexander.** Peter met with Ms. Alexander at the House of Commons to discuss all things primary care.
- **NHS England** regular teleconference.

Speaker engagements:

- **AISMA Annual Conference** on the Future for General Practice
- **Practice Manager Conference,** Essex on Marketing and Future Proofing your Practice.

Chief Exec's Diary

April and May have been busy months on Mr Branson's mobile office (a.k.a. Virgin trains!) between Manchester and London! I've taken the voice of grassroots general practice to:

- National Primary Care Network
- GP Bureaucracy Roadshow
- BMA Patient Liaison Group
- CQC GP Co-Production Group
- HSJ Leaders' Summit on Modernising Healthcare
- National Association for Patient Participation *(I'm a Trustee)*
- FDA Council meeting

Events run for our members:

- Rochdale GP Hot Topics
- East Lancashire Death Update
- Liverpool Hot Topics (with RCGP)

Did you know?

As a member of the Family Doctor Association you can speak directly with your Chairman, Peter and Chief Executive, Moira to discuss any family doctor matter. *Confidentiality and a friendly 'listening ear' guaranteed.* Call 01706 620 920 or email moira@family-doctor.org.uk

Moira Auchterlonie, Chief Executive

Five Year Forward Mental Health View

If the Five Year Forward View was such a success why not repeat the exercise? I don't know if this was on Simons Stevens' mind when he commissioned the a report from the Independent Mental Health Taskforce; it reported to the NHS in England February 2016. There was the customary fanfare of publicity and then the report disappeared. My steam driven NHS computer can no longer find it on the web. Here at HQ we read it, liked it, wrote a relevant precis about it but foolishly didn't keep a downloaded copy!

Here are some very abridged GP-centric notes about the report. This independent report of the Mental Health Taskforce sets out the start of a ten year journey for the transformation of mental health services. A most attractive part of the review is the admission that *"hundreds of thousands of people go untreated each year at a cost of billions of pounds to our society and the economy."* The authors focus in particular on those non-psychotic cases of severe and enduring illness, ADHD, Bipolar Disorder and Personality Disorder. "There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder". (Page 15)

Here are some more snippets.

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men. Suicide is now the leading cause of death for men aged 15–49. However, within Community Mental Health Services there are very long waits for some of the key interventions recommended by NICE, e.g. psychological therapy, and many people never have access to these interventions. (Page8)

Currently needs are addressed in isolation, if at all, which is not effective or efficient. CCGs need to ensure people with multiple needs do not fall through service gaps e.g. the commissioning of alcohol and substance misuse services has been transferred from the NHS to local authorities, leading to the closure of specialist NHS addiction inpatient units. Referral pathways have become more complex and many people with mental health and substance misuse problems no longer receive planned, holistic care. (Page 23)

Waiting times, for first appointments and for the right follow-on support, are unacceptably long. (Page 30)

Recommendation 36: The Department of Health and NHS England should work with the Royal College of GPs and HEE **to ensure that by 2020 all GPs,** including the 5,000 joining the workforce by 2020/21, **receive core mental health training, and to develop a new role of GPs with an extended Scope of Practice (GPwER) in Mental Health,** with at least 700 in practice within 5 years.

Here at HQ we suspect that the three little words "one billion pounds" which was the Taskforce's recommendation for investment for improvement are the reason why the site has disappeared. Perhaps the Treasury don't want you to read the report. Without this additional investment the unnecessary wastage of lives will continue, with the GP the one part of the system left to try to manage the pieces of shattered lives if not end up in the Coroners Court!

Review by Dr Michael Taylor
FDA Executive, GP Heywood

Essex Surgery Harnesses Crowdfunding to Keep it Open

The Patient Participation Group (PPG) at Greenwood Surgery in South Woodham Ferrers, Essex has taken patient power to a whole new level! It has successfully secured over £5,000 by crowdsourcing, to keep the surgery open. *And there's more planned!*

The practice is run by single handed GP and FDA Founder Member, **Dr John Cormack.** He has become known as 'the doctor who works for the NHS for free.' He regularly pays his own money into the practice to keep it running. The PPG said, *'To continue to treat his 4410 patients in the excellent manner they have become accustomed to, we need your help as the surgery is in desperate need of cash, not to pay Dr Cormack, but to go towards the surgeries basic running costs: electricity, heating, equipment upkeep etc.'*

Read more about the campaign:
www.facebook.com/Greenwood-Surgery-183768308322626

Member news

Small is still beautiful!

Outstanding CQC rating for member practice! **Dr Mushkoor Sheikh's** single handed training practice in Doncaster has been judged outstanding following CQC inspection.

Dr Claire Rushton FDA Vice Chairman commented, *'It just goes to show that small is beautiful.'* This is significant as it busts the myth that Quality and Innovation are the preserve of the larger units. And all this without significant investment into primary care.

The single handed practice is justifiably proud of its strong patient-centred culture. The CQC report commented on:
Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. The practice also sent birthday cards to those patients celebrating milestone birthdays and cards to patients who were seriously ill in hospital.
We found positive examples of staff going that extra mile to provide a caring service. For example, staff would contact patient's to check everything was alright if they did not see them pass the surgery or exercise their pets as part of their normal daily routine.
Congratulations to the team!

Well Being Charter Awarded

Great Homer Street Medical Centre in Liverpool was recently awarded the Workplace Well Being Charter .

Practice Manager, **Margaret Slavin-Shaw** said, '*This award means that the practice is considered to be an employer who looks after the health and wellbeing of its staff. When staff members feel looked after, and are happy, they are more productive and able to focus their attention on their patients.'*

Collective Nouns for Medics

Thanks to Dr Claire Parsons, Oakhill Medical Practice, Derbyshire for the latest collection.

A sprinkling of Urologists;
A sighting of Ophthalmologists;
A bloodgroup of Haematologists;
A footnote of Podiatrists;
A fortitude of Family Doctors
And, in the current climate: An ignorance of Politicians and A dysphoria of Doctors

Do send yours to michael@family-doctor.org.uk A used tenner for any we print!

As heard at 'real' NHS events!

NHS BUZZWORD BINGO

dare you try it?

Contemplating conglomerates	**Over the horizon**	**Going forward in the future**	**At scale (anything)**
Deviation from the median	**Well-led**	**7 Day Services**	**Portfolio (anything)**
Deeper dives ***Trumps deep dives***	**Involving**	**Economies of scope**	**Targeted & tailored**
Interface	**Golden threads**	**Silver bullets**	**High trust High confidence**

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 #Buzzwordbingo**