SOMERSET LMC

Newsletter

SPRING 2017 **PEERING THROUGH THE MURK** **Issue 206**

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PEERING THROUGH THE MURK

For as long as your editor can remember – roughly since 1955 - the role of GPs has been pretty obvious. The likely development of the profession has been reasonably clear through good times - (like the Robinson reforms) and bad (the 1990 contract), but whatever the problems of the day succession and continuity could be assumed.

Now the world is a different place, and none of the traditional assumptions can safely be made. Too much is changing too quickly for the future to be predictable; the fog thickens just a few weeks ahead, and it's hard to say what any of us will be doing in a year's time. But are there any landmarks left to guide us? Is anything fixed in the primary care landscape?

It's not hard to identify the roots of our problems: the familiar triad of workload, workforce and resources aggravated by a covert organisational change programme that will be by far the largest the NHS has ever seen, that itself set against a background of increasing austerity and political prioritisation of NHS activity. That's a pretty toxic mixture. After 10 years of effectively flat funding and evidence that the GP workforce is actually contracting, the welcome proposals in the GP Forward View may have come too late for some practices. As the fabric of general practice gets thinner, holes will become increasingly difficult to repair.

Workforce planning in the NHS is notoriously difficult because of the long lead times, but the latest workforce figures suggest that after years of steady increase consultant numbers are still rising whilst the GP figure has apparently dropped by 400 in the quarter to December. Recruitment to training places is up, but it will be some years before they complete training. Young doctors trained in shift working and protocol driven medicine who anticipate a retirement age of 68 are understandably less likely to accept the work intensity and risk management required of a full time partner, so an apparent rise in GP numbers may not translate into a real increase in the medical workforce.

Meanwhile, system demand for GPs is growing. As well as practice work, GPs are needed to provide community specialist services like dermatology, a growing volume of "extensivist" complex care work, Out of Hours cover, 999 car shifts, involvement in service development such as the STP, clinical supervision during Improved Access hours and now Emergency Department primary care from 08.00 to 23.00 365 days of the year. The lack of coherent system planning is frankly astonishing, and the latest assumption that there is capacity in the system to find the equivalent of at least 8 WTE GPs per ED - with 139 Trusts having a "Type 1" A&E that adds up to 1,112 GPs – is alarming, even if some already have "GPED" doctors in place. Yet if one 10,000 patient practice implodes because it cannot recruit enough doctors that could, in theory, double attendance at the nearest A&E, and empirical evidence suggests that when a practice does fold the GPs often do not return to full time work, leading to yet more workforce attrition. What price continuity of care?

But the situation is not inexorably gloomy, and although profound change in the way general practice works is inevitable, practices still have the considerable asset of a GMS/PMS contract, the flexibility to implement new ideas quickly, increasingly sophisticated and integrated IT and a growing acceptance of collaborative working. Embracing Enhanced General Practice and the recruitment of health coaches is making life dramatically better in some practices and this points the way to a GP working pattern that could be not only sustainable, but enjoyable as well.

The other requirement for stability in the NHS is for us to be able to concentrate on preventative care and the management of serious illness. We have often criticised the failure of successive governments to address NHS demand, but the current financial position of the NHS – Somerset is about £10m in the red means that consumers will have to accept the healthcare they need, not what they want. It is time for us all to be more honest with our patients about what the system can no longer provide, and to direct those who are unhappy to those who are responsible for decision making, our MPs.

SMALL ADS… SMALL ADS… SMALL ADS…

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ELIGIBILITY OF NON-UK RESIDENTS FOR NHS TREATMENT

Indicating on referral letters if a patient is not a UK resident will make it easier for Trusts to implement the new rules

Readers will be aware that from 1st April trusts are expected to charge patients who are not eligible for NHS secondary care before providing non-urgent treatments, and also to make sure that the social security system of the home nation of patients seeking secondary care under the EHIC arrangements is billed for their NHS care. Even for an average sized provincial DGH like Musgrove, the latter has amounted to over £225,000 in the current year so these are not trivial sums.

Primary Care

At the moment *anyone* can register with a GP practice, whether or not they are "ordinarily resident", and then receive UK primary care on the same basis as UK residents. The DH is investigating the possibility of charging some non-resident patients for prescriptions and other items, but there is no current proposal that GP clinical services will attract a payment to either the practice or the Government.

The 2017-2018 GMS Contract amendments include the introduction of a slightly amended version of the GMS1 registration form that will ask the patient to provide additional information to help determine his or her eligibility for NHS secondary care. Practices will then need to extract this and send on details of non-UK EHIC card carriers and S1 form holders. Detail on this is promised in the full contract guidance, and, of course, we have no idea whether and how Brexit will affect this.

Many practices seek evidence of identity when registering new patients, but this is of little value in determining NHS eligibility as identity/nationality and residence are not related unless patients self-declare that they are visitors.

Secondary Care

There are over 120 pages of regulations and guidance for hospital trusts on charging overseas visitors, and it is trusts' responsibility to determine who they should or should not charge. Practices are not involved with this. However, it is very helpful if referrers can indicate on letters if the patient is a visitor or new arrival overseas, whether or not he or she is a UK citizen. In brief, visitors from an EEA country carrying an EHIC card can be treated, but the card issuing country will be charged. UK pensioners resident in the EU are eligible for treatment whether or not they have an EHIC card. As a rule non-EU visitors in the UK for less than 3 month will be charged (so they should have insurance for non-urgent secondary care even if they are UK citizens). After 3 months those who have "indefinite leave to remain" need to produce evidence that they are settled in the UK (e.g. payslip, tenancy agreement, school enrolment details) and will usually then be eligible for full NHS care. There is currently a loophole in the Regulations which allows an applicant for a UK visa to pay an extra £200 "health surcharge" for immediate NHS access which is a pretty good bargain for, say, an operative delivery of twins! There are still some reciprocal arrangements with other non-EU countries but they are limited in scope. Don't forget that the Channel Islands are not within the NHS so visitors from there will have to pay hospital charges. Emergency care and treatment under the Mental Health Act is available to all as are some public health services including treatment for STIs and TB. Maternity care is chargeable, but payment is not required in advance.

You are not required to warn patients about possible charges, but it would be helpful to do so, if only because some will choose not to proceed.

All trusts are now required to have an Overseas Patient Manager and Sarah Porter at TST is happy to be contacted if practices have any questions sarah.porter@tst.nhs.uk.

INFORMATION SHARING FOR BETTER HEALTH CARE

The recent tribulations of TPP over concerns that SystmOne allows too much information sharing is reminder that although the balance between maintaining strict confidentiality and allowing wider access to patient data for safe and effective care is shifting we still need to consider both aspects as we move towards a more integrated NHS information network.

Somerset practices are fortunate in having had excellent support from CCG and Commissioning Support informatics teams with the right combination of vision and sound planning which has put this health & social care community at the head of developments. With all practices now either using EMIS or likely to switch to it in the next few months the opportunity of using single system solutions means that we can progress even further, whilst always making sure that developments are supervised by sound information governance policies.

The CCG has recently circulated a "level two" IG agreement for practices that wish to share clinical record access for the provision of Improved Access. The key to this, as always, is making sure that proper consent is obtained before any patient information is shared, but the LMC contributed to the final version and we are happy that it is safe and appropriate for practices to sign it. The technical process for linking practices to allow them remote access to one another's clinical notes is then fairly simple, but the timetable for

that will rests with EMIS, once practices have signed up. We have not yet discussed the position of practices that are not participating in Improved Access, but you will have to allow at least notes access.

Meanwhile, Phase 1 of the EMIS Viewer project has been a definite success. Although uptake by the different urgent and emergency care providers included has been variable, the acute care physicians at Musgrove have found it hugely useful in saving time, improving safety and informing care decisions. The last LMC County meeting agreed unanimously to support the extension of the project to include access by registered clinicians in non-urgent settings as well (Phase 2) and we hope this can be implemented early in May. At the moment consultation and free text notes are not visible because of LMC concerns – confirmed by the CCG's lawyers – about inadvertent release of third party data. Practices in some other parts of the country are allowing the full record to be viewed without, so far as we know, any problems, and we have now heard anecdotal evidence that a case is being brought against an NHS provider that centres on harm that followed a failure to share information. The picture is therefore far from clear. The LMC preferred solution of opening access to consultation records only from a particular date onwards is apparently not technically possible, so the Committee will be seeking further information over the next couple of months before making any further recommendations.

MACMILLAN CANCER LEAD FOR SOMERSET

After four years as Macmillan GP Cancer Lead for Somerset I am leaving this role to become the clinical lead for the SWGAG Cancer Alliance. I have very much enjoyed working as Cancer Lead in Somerset and I've learned a huge amount about primary care, vising many GP practices and working with practice nurses across the county to support them in dealing with cancer patients. The job has also involved working with CLICK federation on an Early Diagnosis of Lung Cancer project as Part of NHS England's ACE (Accelerate Communicate Evaluate) programme as well as helping Mendip practices with a joint QI project on a proactive approach to smokers who are infrequent GP attenders. Amongst other projects I've also worked with volunteers in South Somerset and Mendip on a community support advocacy project and organised an early diagnosis of cancer speed dating event that I hope will be the first of many.

But there is still a much to do. From 2013-15 the rate of premature death in Somerset per 100,000 population was 44.4 for lung cancer, 33.6 for heart disease, 19.4 for breast cancer and 13.1 for colorectal cancer - but just 11.9 for stroke. Cancer accounts for 63% of premature deaths reported by Public Health England.

As cancer plays a small part in QOF there is a perception in the wider health community that GPs don't do much about it. The reality is that, particularly in rural communities, GPs play an essential holistic role in the care of cancer patients at a dark time in their lives, often having known them before their diagnosis. As we struggle with rising workload and increasing complexity this work is ever more vulnerable.

Meanwhile, the GP Forward View anticipates a diversification of the primary care workforce. Somerset's STP document suggest that the percentage of same day patients seen by GPs will fall from 70% to 35% over the next 5 years with the rest being seen by other clinicians will often have received training in self-limiting illness, but not in the subtler clinical skills such as recognizing the early presentation of cancers.

In my new role I will still be working closely with Somerset CCG on three large transformation projects; the early diagnosis of Lung cancer, implementation of faecal immunochemical testing for suspected colorectal cancer and the implementation of the recovery package. GP input will be crucial to the success of these projects for which we have applied for £10m in funding.

The Macmillan Cancer Clinical Lead post is currently being advertised. If you would like to discuss the role please get in touch amelia.randle@somersetccg.nhs.uk. An interest in cancer is more important than specific experience as it you will be well supported by the Cancer Alliance and the Cancer SRO for the STP.
The CCG contact for the GP lead role is rachael.rowe@somersetccg.nhs.uk.

Dr Amelia Randle

COLUMNIST SOUGHT

Due to a retirement the position of Backpage Columnist for the LMC Newsletter has become vacant. If you would like to write an occasional or regular one page humorous or insightful piece for the Newsletter (which is now quarterly) and follow in the illustrious footsteps of Jennifer, the Urban Doctor, the Country GP and, of course, the inimitable Dr Whimsy please contact the Editor. Harry.yoxall@somersetlmc.nhs.uk

RECRUITED A GP?

If you have been successful in attracting a partner or salaried GP we would very much like to know about it in the LMC office. There are various recruitment initiatives under way and at the moment it is hard to know which are yielding results and it would be a great help to know so that we can focus our efforts. Please contact Jill. Jill.hellens@somersetlmc.nhs.uk. www.gpinsomerset.com

Dr Whimsy's Casebook: The Performers List

Scene: It's 11:30 on a warm Friday morning in Spring, and Whimsy is lounging on his patio with a coffee and the Guardian crossword. The intro to "When I'm 64" starts playing: it's his cell phone, a call from Sebastian Asiasist.

WW: *[licks flakes of buttered croissant and apricot jam from fingertips]* Mmmm… Hello?

SA: Good morning, my name's–

WW: *[suddenly angry]* Listen, I do NOT suffer from whiplash. The accident was five years ago and it only damaged a wing mirror, so you and your fellow ambulance-chasers can jolly well lay off me.

SA: Accident?

WW: Oh, it's PPI then, is it? I've settled with my bank, and if I get one more call from you bottom-feeders I'll sue you for harassment.

SA: No, it's not about PPI, I'm from–

WW: In that case, foam freak, we already have so much loft insulation that we get in-house global warming, so thank you, and good day.

SA: Hold on, sir. Am I speaking to Doctor Whimsy?

WW: Nope. He doesn't exist any more.

SA: Oh. Has he, um… passed away?

WW: Let me check… *[takes his own pulse]* No, still alive. But it's plain "Mister" now. Who's asking?

SA: Sebastian. Seb for short.

WW: And whence do you hail, Seb?

SA: Uhh?

WW: *[slowly]* Where - are - you - call - ing - from?

SA: Right. I deal with the Performers List at NHS GP Support, and the Clinical Director for the South West Division of NHS England asked me to call you about information from the Revalidation and Appraisal Department concerning your registration with the Responsible Officer.

WW: Strewth! How many of you *are* there?

SA: More than you can ever know, Dr Whimsy.

WW: I told you, it's Mister. I'm four months retired, and wild nurses couldn't drag me back.

SA: You're currently licensed with the GMC, so technically you are still a doctor.

WW: Very well, but please don't spread it around. I've had thirty years of people telling me about their bad backs, bad thoughts, and bad children, and that's quite enough. I'm breeding daffodils now, and I've already forgotten what Aricept is for.

SA: OK. Forgive me if I address you as Doctor, but I have to observe the formalities.

WW: If you insist, but I'll hang up if you mention anything medical. So what seems to be the problem, Seb?

SA: We've been informed that you have retired.

WW: What Stasi infiltrator has been spying on me?

SA: You were offered an appraisal, and you declined.

WW: You have no idea how much I enjoyed that moment, but what's it got to do with you?

SA: You didn't tell us.

WW: Why should I? I don't even know who you are, and I certainly don't harbour an overwhelming urge to inform you every time I brush my teeth.

SA: You can't just retire, Dr Whimsy. You need our permission.

WW: The only permission I needed was my wife's. She wasn't sure she'd want me around this much.

SA: How's that going?

WW: I'll get back to you.

SA: Well, I'm afraid you can't stay on the Performers List unless you have an annual appraisal and do GP work at least once a year.

WW: Let me simplify it for you, Seb. I have moved on. I have finished being a GP. I certainly don't want another appraisal – all those last-minute fictions, apart from the complaints, of course.

SA: But you're still on the Performers List.

WW: Then take me off. I have stopped performing.

SA: I can't do that unless you ask me to.

WW: Have I missed something? Tell you what: got a pen?

SA: Yes.

WW: Guide the tip of it down your list until you reach "W", then put a horizontal line through my name.

SA: I can't do that. You have to apply in writing to have your name removed.

WW: OK. Still got your pen? Write this down: Dear Seb, I've retired, have a nice day, lots of love, William Whimsy.

SA: You have to sign it. Anyway, there's a form called NPL3 with a series of questions.

WW: What sort of questions?

SA: GMC number, your address, your practice…

WW: And what if I don't fill it in?

SA: Your name will be removed from the list when the Responsible Officer informs us that you didn't take your appraisal. Unless you ask us to do it first.

WW: Seb, I'll be honest with you. There are some things about being a GP that I miss more than I can say: the challenge, the colleagues, the patients – well, some of them – but not the stress, the politics, the bureaucracy, the misconceived directives from apparatchiks in windowless offices…

SA: [hurt] I'm only doing my job, Dr Whimsy.

WW: I know. I'm sorry, Seb. Send me your form.

SA: Thank you. Anything else I can help you with?

WW: There is, actually. 6 down: "Had another go, confused, but getting well-earned rest." Something E, something I, something something D.

This column is written for humour and does not necessarily represent the views of the author or the LMC.

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