Between the lines

'Analysis and explanation of things that matter to Nottinghamshire GPs'

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Five Year Forward View offers daunting prospect for GPs

GPs may be forgiven for being unfamiliar with the NHS Five Year Forward View published a few months ago by the newly ensconced Chief Executive of NHS England, Simon Stevens. Many may not even of heard of it. However this document represents a blueprint for the most radical changes the NHS has seen in decades. Andrew Lansley's reforms in 2010 were hailed as revolutionary but were in many ways merely an extension of existing policies (though taken perhaps to an extreme). The FYFV (as it is known as brevity's sake) is potentially much more far reaching as it affects the whole of NHS in England and potentially other parts of the UK.

Without any preceding fanfare it has introduced a major shift in NHS policy, moving it away from competition between providers orchestrated by commissioners as market managers intent on tightening purse strings, towards mandatory collaboration between providers which is seen as a more effective way to deliver efficiencies and service improvements within a single accountability framework. This is to be overseen by a simpler, more clearly defined and, arguably, more laissez faire commissioning structure. But it is predicated on attitude of 'no more bail outs'. Providers are being told that there is one pot of money to be shared by primary and secondary care (and in some cases social care) and providers must manage the system with what they've got and work out or themselves how to deliver 'more for less'. Accountability will thereby have shifted from commissioners to providers, along with the ability to innovate and supersede organisational barriers to integrated care. The sting in the tail is that all of this is focused on delivering £30 billion worth of savings from the NHS over the next 5 years.

So how will this affect GPs? This is a conundrum with which the profession's representatives are currently grappling. On the one hand, the idea of collaboration involving commissioning primary and secondary care working together to re design patient pathways and services without organisational interference it is an enticing and welcome prospect – better than the current war of attrition between of opposing camps. But against a background of cuts in spending and rising demand it may be seen as a poisoned chalice. Many GPs may prefer to disengage from such considerations – they have enough to do already – but the pressures they face, with the 'perfect storm' of falling practicing income, increased regulation, rising patient demand and falling recruitment, is already forcing them to look at collaborating with other practices in one form or another as a means of survival. The FYFV takes this as read and postulates two new models of care in which large scale GP practice organisations are expected to want to participate. The first, the Primary and Integrated Community services (PACS) model involves a pooling of primary and secondary care budgets and services in to a single accountability framework. Some fear that if GPs are not vigilant this will lead to a takeover of primary care by large secondary care Trusts. The second, the Multi-Speciality Community Provider (MCP) model, involves integration between primary and community service organisations and budgets and is seen by some as a means by which GPs can take over all community service provision. Both these scenarios are not beyond the realms of possibility and are likely to be tested out in local pilots (see page 4).

But the acid test for GPs will be the extent which they are prepared to hazard the security of their own core practice income in a game of chance which offers potentially greater rewards for the successful, i.e. will they allow their core practice income, rather than just that related to services by commissioned by CCGs, to be pooled with secondary care spending? While few will immediately be that brave (or foolish?) it is likely that carrots and sticks will be employed in due course to persuade them. We expect the local 'vanguard' sites to test the limits, and reveal the limitations of, this 'grand plan'.

Chris Locke, Chief Executive, Nottinghamshire LMC Ltd

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Upcoming changes to Parental Leave

NOTTINGHAMSHIRE
LOCAL MEDICAL COMMITTEE (LIMITED)
LMC
REPRESENTING AND SUPPORTING GPs

Chairman's Message

It's funny, but it seems that Spring has come round again. It only seems the other day that I wrote an article entitled "Spring is here", and I've got to do it all over again. I will admit that I was tempted to recycle the original document. After all who really reads some of the documents that we churn out using "copy and paste" technology. Well I can tell you that CQC do as they have just been to see us... coffee, croissants, and Danish pastries didn't really work to soften them up, and picolax has nothing on the way that they went through our Practice, looking eagerly in every nook and crevice for protocols, significant events and other unmentionables. And then we had interviews. I remember vivas being easier than this process. So be warned. And they are really keen on care plans as well.

Winter pressures have spilled into all other seasons so successfully that someone will now have to invent a new term for this. Perhaps that will distract someone at the CCGs so they will stop informing us of the latest red/black/grey alert at our local hospitals (have you ever been tempted so send a snappy email back reminding them of the pressure we're under too?). Our contracts are now going to be looked at by the CCGs as we have granted them levels 3 commissioning powers. Local QOF? Contract variation? A Manchester model? And have you tried to find a locum/partner/new pair of hands recently?

So there's a lot of stress around. Nevertheless this is still the best job in Medicine; nothing else I suspect provides so much job satisfaction, and how to encourage our younger colleagues to enter General Practice is something that should task all of us over the next few years. Why not get involved with medical students; contact the Medical School office, and rekindle some of the enthusiasm we all had at their age?

My children tell me I getting old. I remind them that I'm a lot closer to retirement than they are. But I'd do it all again even knowing how I got here in the first place. Perhaps I am becoming a grumpy old man but I still love being a GP. So a happy new NHS year to all in General Practice.

Dr Greg Place

Using green care for self-care

By Dr Jill Naidoo

GPs are stressed. You know it, we know it and the LMC knows it because they have just completed a survey of local GPs, which confirms this. Out of the 100 responses analysed so far, only 25% of GPs reported feeling happy. Of those wanting help, the second most common request was for peer and psychological support including alternative/holistic therapies.

If most of us are stressed, what can we do about it?

It's hard to look after ourselves. There's an abundance of complex mechanisms that can prevent doctors looking after themselves. However, underlying all these is the grim reality of accepting that we may have stress and might have difficulty coping. Those of us who cope well can probably find time for activities to keep us sane. The rest of us who have a pressing need to find personal space perhaps find it harder to do so. Therein lies the paradox of looking after ourselves.

What's the most effective way of helping our stress levels?

No one wants to participate in activities or take treatments that have no or little beneficial effects. Ideally, as doctors we would like the same for ourselves as for our patients i.e. any intervention of value should be not only helpful in making us feel better but also be safe with minimal side-effects.

We all like to be evidence-based, so here's some evidence concerning physical exercise. You all know about the physical benefits of walking and may prescribe the Healthy Walks programme to patients. In 2011 the chief medical officers developed guidelines that 150 minutes/week of moderate activity is all that is needed to help prevent a variety of diseases. Physical conditions include heart disease, type 2 diabetes and breast cancer. Mental health conditions include improvement in depression and a 40% reduction in development of dementia.[1]

Why not just go to the gym?

Clearly the gym provides an ideal setting for physical activities, which can be stepped up as one's fitness improves.

In 2014, Marselle, Irvine and Warber[2] found significant reductions in both depression and perceived stress with an associated enhancement of mental well-being for people attending outdoor walking groups. This suggests that there are added benefits from walking with one's peers over walking alone. Also, there is a view that being disconnected with nature can be linked with poor mental health as well as poor physical health.[3]

So, moderate exercise can also be achieved by walking outside. What better way is there to share experiences, gain mutual support and experience the benefits from exercise all at the same time?

One of the initiatives of the soon to be launched LMC/Primary Care Development Centre's GP wellbeing project is to start walking groups. The plan is quite simple. It is to get together a group of GPs who might fell they would benefit from going on local walks together. The walks would be planned, not too challenging and easily accessible. Planning would be dictated by test-running the walks to know how long they take. They would be not too challenging so as to be accessible for all fitness levels. Accessibility is crucial to minimise travel time.

This walking project would be an exciting, innovative way to provide one component of the new GP Wellbeing Service. Walking and talking with peers whilst in an outside sensory environment may give you a greater sense of wellbeing.

1. http://learning.bmj.com/learning/module-intro/.httm?locale=en_GB&moduleId=10051859&
2. Marelle, M., Irvine, K., Warber, S. (2014) 'Examining Group Walks in Nature and Multiple Aspects of Well-being: A Large -Scale Study' Ecopsychology 6 (3)134-147
3. Sempik, J, Hine, R., Wilcox, D. (2010) Green Care: A Conceptual Framework A Report on the Health Benefits of Green Care COST 866, Green Care in Agriculture, Loughborough University
4. Wright, M. (2015) 'GP Wellbeing survey' Nottinghamshire Local Medical Committee (Limited)

Upcoming changes to Parental Leave

Guidance from Lockharts Solicitors

On 5 April 2015, two very important changes will come into force in respect of parents and adoptive parents' rights to parental leave.

1) Age Limit Increase

First, the age limit for children in respect of whom parental leave can be taken, will increase from 5 to 18 years of age. This entitles parents up to 18 weeks unpaid leave for the purpose of looking after their child at any point up until the child's 18th birthday. For small professional practices, this will impose a very substantial burden on resources.

2) New Shared Parental Leave System

Second, a new system of shared parental leave will be introduced and this is the main subject of this article.

Please be aware of the difference between Shared Parental Leave and Parental Leave. Parental Leave is unpaid leave that a parent is entitled to up to the 18th birthday of the child. Shared Parental Leave is a separate scheme which allows parents to share the statutory maternity leave in the year following the birth of the child.

Shared Parental Leave is a system which allows eligible parents (including adoptive parents) to share the maternity/adoption leave allowance between them. They can take the leave together or separately; intermittently or continuously; between the date of birth of the child and 52 weeks thereafter. Both parents can therefore share the leave entitlement and pay following the birth of their new-born.

The eligibility criteria for Shared Parental Leave are as follows:

- They must be entitled to maternity/adoption leave;
- They must share the primary responsibility of caring for the child;
- One parent must satisfy the continuity of employment test;
- The other partner must satisfy the employment and earnings test;

and

- They must notify their employer of their intention to use Shared Parental Leave at least 8 weeks before the start of the period of Shared Parental Leave. The notice must include their leave entitlements and their intentions for taking it.

Employment Test

The parent has been employed by the same employer for at least 26 weeks at the end of 15th week in which the child is due (or in the case of adoption, at the week in which they are notified of having been matched with a child).

They must also still be employed in the first week that the Shared Parental Leave is to be taken.

Employment and Earning Test

The other parent/partner must have worked for at least 26 weeks in the 66 weeks prior to the due date and earned over £30 a week in 13 of those 66 weeks.

The leave must be taken in complete weeks but note that the employer is entitled to refuse a request for leave in a discontinuous period. Parents can instead ask that the leave be taken in a continuous block. The parent is entitled to submit 3 separate notices to book leave but they must each be submitted at least 8 weeks before the intended period.

If a parent gives notice to end adoption or maternity leave early, then this entitles them to shared parental leave and pay. The remainder of the 39 weeks maternity pay (up to 37 weeks as there is a two week compulsory period of leave) can be taken as Statutory Shared Parental Pay. From 5 April 2015, the statutory shared parental pay will be £139.58 per week or 90% of the parents average weekly earnings (whichever is lower).

Shared Parental Leave is intended to provide more flexibility for growing families and to assist in the struggle of balancing work and home life. It is advised that employees and employers discuss the options together as far in advance as possible, so that they can plan the best way to accommodate the periods of leave. Employers should ensure that all employees are aware of their statutory rights and should consider developing a policy and procedure to follow when considering parental leave.

For further information, please contact Ron Cheriyan, who is a Dispute Resolution Solicitor at Lockharts Solicitors. Ron can be contacted directly at rc@lockharts.co.uk.

All general Employment Law enquiries should be directed to csd@lockharts.co.uk. Alternatively, please contact us on 0207 383 7111 or by visiting our website www.lockharts.co.uk

‘Once more into the breach’ (Notts in FYFV vanguards)

All NHS organisations are prone to suffer from pilotitus, a condition characterised by desire to be first to try out anything new and in favour with the ‘powers that be’ (and likely to be implemented whether or not the pilots show the initiative to be successful or not).

Being first ensures your organisation is seen as ‘leading edge’ and offers bragging rights over other hopefuls, and ensures that you will get your noses first in the trough of any innovation funds on offer. (The extent to which this influenced our local CCGs’ desire to opt for full devolved responsibility under co commissioning is debatable, as no extra funding was offer. All Notts CCGs opted for this except, surprisingly, Bassetlaw, which opted for level two only).

However pilotitus was certainly manifested in local bids to become FYFV vanguard sites of which Nottinghamshire, on a population basis, has the largest concentration in the country (with 3 out of 63). These involve a PACS model in the mid Notts transformation ‘Better Together’ programme, an MCP model led by Rushcliffe Principia partners in health and supported (and led?) by its CCG, and an integrated care homes model in Nottingham City, also instigated by its CCG. Whatever the enthusiasm to embrace Simon Stevens’ challenge it remains to be seen how involved GPs will feel in each of these models and what they make of the prospects they offer. Just occasionally it proves to be wise to let others be first into the breach in order to learn from the mistakes they inevitably make. As one wag put it, “when the train is leaving the station it is sometimes more comfortable to be in the guards’ van than in the vanguard”. (!)

LMC levies frozen for fifth year running

The LMC has once again decided to refrain from increasing the LMC levy which will now have been frozen at its present level (37p per patient) for six years. Most LMCs now charge in excess of 40p per patient.

New LMC Member

I qualified from St Mary’s Hospital Medical School London in 2000 and moved to Nottingham to undertake Histopathology training in 2002. After deciding this was not the speciality for me, I commenced basic surgical training in Nottingham and Derby, but eventually saw the light and began my GP VTS in Nottingham in 2006!

In 2009, after eighteen months as a qualified GP, I acted upon my enduring interest in medical law and ethics and started work as a medicolegal advisor for the MDU. While undertaking this role, I decided to take my legal interests further, commencing my legal studies at Nottingham Law School in 2011. I obtained my law degree and qualified as a barrister in 2014.

I now work as a part-time locum GP, an out of hours GP for NEMS, a GP Fitness to Practice Case Investigator for NHS England, an advocate / advisor for the LMC, a tutor on the ‘Professionalism, Ethics and Law’ course for first year clinical students at the University of Cambridge School of Medicine, and an expert GP witness; additionally, I am currently studying for a MA in Healthcare Ethics and Law.

I enjoy spending my spare time with my wife and daughter and family and friends. I also like watching films and stand-up comedy.

Dr Adam Harrison

The Last Word

In their desperate attempts to dispel any notion that the new administrative units to which the NHS has now organised bear any resemblance to what has gone before, NHS mandarins keep finding ever more ridiculous descriptions for the remaining organisations. The Area Teams are now classified as Sub-Regions. Ours, the ‘North Midlands Sub-Region’ extends as far south as Telford and the boundaries of our neighbours, the ‘South Midlands Sub-Region’, extend from the fringes of London to Humberside! Health Education England meanwhile has abandoned talk of regions, while bringing the LETBs together under centralised management structures and prefers instead to them as ‘geographies’ (Ugh! Was ever our language so misused?)

The LMC has over many years supported the running of the violent patient schemes which protect GPs and their staff. Would that the courts were quite so supportive! We learnt recently that when one particularly troublesome customer on the Nottingham scheme was taken to court for breaching an injunction a Court functionary, whether deliberately or by accident, negated any chance of the police taking action for further breaches by striking out their “power to arrest” from court documents. To add insult to injury (literally!!) they then made a mockery of the fine imposed by allowing the said miscreant to pay his £6000 fine at the rate of £1 per week!!

There were red faces in Nottingham a month or so ago when bailiffs turned up at GP surgeries over non-payment of business rates traditionally paid directly to the City Council on practices’ behalf. GPs’ faces were red with anger and Area Team finance colleagues’ faces were red with embarrassment as it emerged that no one had instituted payments following the demise of the PCTs two years previously. The LMC wondered why in the intervening period during which the City Council had failed to receive any of the money owed and they kept sending invoices to a redundant address with no reply, no one had bothered to pick up the phone and find out who was actually responsible. (So much for integrated working!)

And finally, here is a classic from the “dumb questions asked of the NHS” folder. EMAS reported recently that a patient had rung 999 to ask “what’s the number for this new 111 service?”.

Happy Easter

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