Letters

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GP training

I would like to thank Dr Brettell for eloquently raising the demoralising discrimination we face as GP trainees within hospital.[1] It is all too frequent that the moment a senior member of the team realises that we are GP trainees, after a sigh, we are relegated to service monkey role to the extent that even our weekly teaching is often not protected.

In view of this I would also like to mention that our GP trainers should be more understanding of our reduced clinical exposure and for many of the trainees that I have spoken to, the service element of our training is not unique to hospital medicine. In two separate GP placements, both small practices, I have felt pressured to reduce my consulting time before I was ready, and met with brusque 'I'm busy' replies during times that I have requested my trainer to help me with a clinical question. This is despite clear trainee supervision slots marked out, and they have been busy either because of managing their own personal administration or that of the practice, hardly ever because they are consulting from their own list. Meanwhile, I have struggled as I have been given patients from other lists, all as an FY2 and ST1, which you will agree is quite early on in my training.

Luckily this has not been a deterrent, and when I have struggled I have asked for help no matter what the 'mood' of the trainer has been, but I can imagine this being a problem for the less confident or timid GP trainee and potentially compromising patient safety.

I feel that the extended training can only be a good thing given the difficulty in changing historical attitudes and egos faced both in hospital and GP settings and the increasing pressures on GPs leading to greater administrative duties that appear to take precedence over effective training that they are remunerated for.

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Out-of-hours care

Confused, as have many, by the Out of Hours section of the *BJGP*, it was good to see a piece that actually was about out-of-hours (OOH) care.[1]

In many ways, it was the patient and secondary care views that best summed up the problems we face in OOHs. Because of the lack of shared care record access, we are 'blind' in OOHs and this significantly raises risk, encourages defensive medicine, increases costs, and prevents us giving the best service possible. Despite what is often said, it is not the IT that is the problem but management and primary care involvement that is at fault.

Professor Mason rightly raises the issue of the large numbers of patients who inappropriately attend A&E. Most of these do need medical care but not necessarily of a secondary care nature and around 40% of those turning up at A&E would be best managed by a primary care practitioner be they a nurse, GP, or paramedic. Collocation is a far better answer than the ineffectual NHS exhortations to attend A&E appropriately. Numerous pilots and ongoing facilities have proved this time and time again.

Among the hype and hysteria on both sides regarding primary care 'taking back OOH care' is a kernel of truth. Primary care does need to get more involved, at least, in making sure that the service that is provided is up to their own and their patients' standards. It has to be remembered that the service pre 2004 did not have any of the developments, both in provision and governance, we have now, and we are all the better for that. The dewy-eyed picture of GPs visiting their own patients only, hardly ever existed pre 2004.

The work in OOHs is different when compared to the daytime chronic disease management demands but many of the skills needed are interchangeable. I do think Dr Greenhow has a point in sharing best practice and striving to achieve the highest standards and, as members of Urgent Health UK, we work hard at doing just that. As for the buddy system, I am not sure how that would work and would be, I would imagine, prohibitively expensive.

OOHs will always need better funding but better primary care involvement and innovative ways of working, based on good evidence, would help to give the high standard of service we all want to provide.

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Young people's health

Sir Al Aynsley-Green, in his recent text based on the Inaugural Ann McPherson lecture: *Young People's Health Today — the inconvenient truths for primary care*,[1] suggested that personal, social, health, and economic (PSHE) education in schools may not be giving the youngsters the answers they need. There is also evidence in the literature[2] that there is a negative perception by young people regarding the role of schools and health information. Sir Al Aynsley-Green also commented that it should be of real concern to GPs that so many young people refuse to attend routine surgeries.

I am GP in the North East of England and in 2011 we started working with young people registered at practices within our health centre and Investing in Children, a local young people's rights organisation.

From this a young persons' group (Teen Talk) was formed. While working with them it became clear that many of the young people had a limited knowledge of what general practice offers them. Specifically, few of them understood what a GP does, what problems we see, knew when they could come to see a GP, at what age we would see them on their own, or knew their rights in relation to consent and confidentiality. These findings are sadly not new.[2]

However the young people did identify that PSHE could be a good opportunity to learn about health-related issues. Working together we developed a lesson plan. We delivered the lesson in a local school to year 8 pupils, using practice staff (GPs, nurses and administrative staff) alongside Teen Talk and Investing in Children.

We were able to discuss the issues that pupils raised and so addressed concerns that were important to them. We specifically addressed areas such as when young people can be seen, confidentiality, and how we can help to support them with emotional as well as physical problems. We discussed how general practice can support young carers as well as how GPs can help with the more common health issues for young people such as smoking, weight management, and keeping healthy.

We believe this basic health information is vital for young people, enabling and empowering them to access health care appropriately and responsibly.

But perhaps building relationships and improving trust between young people and health professionals in this way may also help to overcome some of the barriers young people face when accessing services?

The RCGP Adolescent Health Group (AHG) is producing a patient leaflet which summarises the key areas which might be covered in a consultation between a young person and their GP, and specifically addresses confidentiality. The leaflet should be available to all practices via the RCGP CIRC AHG webpage in January 2014.

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The iSurgery

General practice is leading the way in terms of incorporating the advances of information technology (IT) into day-to-day medicine. Currently, most GP surgeries share information about patients across an interconnected network and this information is available on an intranet. Patient information is computerised and their notes, blood tests, and clinic letters are accessible at the touch of a button. Moreover, telephone consultations enable GPs to triage patients and give clinical advice successfully. This is a far cry from hospital medicine where there is hardly any integration of patient information across different software programs. For example, it is not uncommon to find patient blood tests results, imaging results, and clinic letters on separate programs and their notes in giant folders in the corner of hospital wards. It is clear who is keeping pace with technology and who is falling behind.

But why not extend the gap further? The next logical step seems to be the use of social media to share and communicate information with patients. One study showed increased patient satisfaction when using email with patients to book appointments, order repeat prescriptions, and consult GPs without increasing their workload.[1] This has been further evidenced in other publications and has also been replicated with short-message services (SMS) on mobile phones.[2,3] SMS exchanges with patients has also been used to successfully manage patients with uncontrolled hypertension in primary care.[4] These practices have been carried out safely and are widely accepted by those GPs involved. Ongoing efforts are targeting smoking cessation, controlling asthma, and reducing missed appointments. There also seems to be great scope for health promotion via these methods and others such as Facebook and YouTube whereby reminders for events and videos previewing classes and services at GP surgeries can be shown to patients. Anticipating these changes, the Royal College of General Practitioners has published a 'Highway Code' as a guide for doctors to social media appropriately.[5]

We may be closer to the iSurgery than we realise. A large randomised controlled trial of telehealth and telecare, the Whole System Demonstrator, showed that it can substantially reduce mortality, admissions to hospital, and cost of beds in hospital and A&E.[6] The Secretary of State of Health, Jeremy Hunt, has also pledged millions of pounds to help make the NHS 'paperless' by 2018 and connect the fragmented IT services which store patient information.[7] The future of healthcare could truly be online.

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The Worcestershire Prostate Cancer Survivorship Programme

Two million people in the UK have had a cancer diagnosis and, due to improvements in diagnosis and treatment, the numbers of survivors are increasing. According to the National Cancer Institute, cancer survivorship encompasses the 'physical, psychosocial, and economic issues of cancer from diagnosis until the end of life.'[1] Hospital clinics are often overbooked with follow-up of survivorship patients, with little time available for each patient. Involvement of community-based care in survivorship has been shown to be beneficial. Follow-up for prostate cancer survivors through the UK varies, with some being discharged back to their GP and others remaining under secondary care. Cancer survivors may present to their GP after surgery and hospital discharge with a range of problems.

At Worcestershire Acute Hospitals, prostate cancer patients are offered entry to our new Survivorship programme, set up in 2009. Patients who have initial therapy with curative intent for organ confined-disease (surgery, external beam radiotherapy, or brachytherapy) are invited to join. Patients must have survived 2 years after radical

prostatectomy, with an unrecordable PSA reading, 3 years after external beam radiotherapy with no metabolic relapse, or brachytherapy with no metabolic relapse. Recurrence is monitored by PSA measurements. After being discharged their details, including PSA measurements, are entered into a password-protected database by a specialist nurse, who acts as the patients' keyworker. This database can generate alerts if the PSA is elevated so that patients can be brought back to the clinic by the specialist nurse who can also respond to symptoms or signs of recurrence, adverse effects of treatment or a patient's request. We have over 500 patients on this programme.

When we investigated GPs' views of this programme we detected low confidence levels in managing relapsing/hormone resistant breast and prostate cancer, and in the management of side effects. Half of the GPs were not fully informed about the survivorship programme, which is designed to remove this burden of care from general practice, and many had misconceptions about the programme: 25% thought it was a programme to empower patients who are cured, and 15% thought it simply offered a holistic approach. The purpose of this programme is, of course, to keep patients under surveillance in the community while under the clinical governance umbrella of secondary care.

We aim to promote this programme among the general practice community and to involve patients with active disease being treated in the community.

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A strategic plan

Who is to lead the large strategic changes to general practice that are required to deliver 21st century health services that can respond to the increasing health needs of the population?

In his editorial Chris Drinkwater proposes that we should re-think the provision of primary care in the light of the needs of our 21st century population. Certainly a strategic plan is required. General practice has been allowed to 'evolve' without any clear vision over the last 50 years. It has migrated from being a service that mainly responded to the presenting needs of patients to one driven by QOF. Now a third strand is emerging around co-productive care planning for long-term conditions and older people.

Over the same period other community services have hardly changed, links with primary care teams have been undermined as they have oscillated from one corporate managerial home to another, and organisational and professional interests have undermined the systematic integration of services.

Bearing in mind that GPs have moved from having one job (reactive care for a registered list) to two jobs (reactive and now proactive care with QOF targets) and are likely to be vested with a third (care planning) it is no wonder that GPs feel overwhelmed. Over the same period there have been additional demands as a consequence of clinical workload that has 'moved from secondary to primary care', and additional organisational workload including supporting CCGs.

There is adequate evidence to make the systematic implementation of targeted, multidisciplinary care planning for long-term conditions desirable. Surely this must be led by general practice, with its long-term knowledge and relationship with patients, practice lists and disease registers. However if this new service model is to be established, we will need horizontal integration of general practice with community services, including social care. This will require investment, and the rationalisation of reactive care, including out of hours, at local level using whole systems approaches.

So who is to lead these changes? Drinkwater suggests a 'Chief GP'. I believe that it is unlikely that the substantial changes required can be led from within the bureaucracy of government. Even if they could, the credibility and acceptability of 'managerially' led change is now long past. Surely now is the time for the RCGP and the BMA to take concerted action to effect change as they did in the 50s and 60s. Now, as then, there is a need for action driven by energetic colleagues from the front line, who are supported by professional bodies with a wide understanding of the issues. However this time we must also engage and enlist the voice of the patients who we serve. They are our strongest allies. The co-production of the new service model jointly with our patients will ensure that we remain focused and not blown off course by political or professional vested interests.

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