Letters

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Editor's choice

Multimorbidity: what next?

Your editorial by Mair and Gallacher draws attention to the importance of comorbidity.[1] We have extracted data from NHS Digital, relating to the changes in some mental health indicators of the Quality and Outcomes Framework (QOF). In 2014–2015, indicators for the measurement of BMI, blood glucose or HbA1c, and cholesterol:HDL ratio were all retired. The indicator for blood pressure was retained. The measurement of HbA1c and cholesterol has fallen from around 90% in 2014, when it was included in QOF, to around 50% when it was no longer included. This is important, as the mortality of this group is much greater (they die 15–20 years earlier than people without a severe mental illness, and from diabetic and cardiovascular disease). It also highlights the impact of removing items from QOF.

The *Five-Year Forward View for Mental Health* states that *'current incentive schemes for GPs to encourage monitoring of physical health should continue'*.[2] The data show that the retirement of QOF indicators has led to a reduction in screening for diabetes and dyslipidaemia — in a population significantly at risk.

Does this reflect a health force now more influenced by financially incentivised practice than clinical need? Or does it reflect a continuing lack of awareness of the premature morbidity and mortality experienced by patients with SMI?

The physical health of the severely mentally ill (those included in the inappropriately labelled 'mental health' domain) remains a source of inequality. It is Department of Health (DH) policy that the physical health of this group should be addressed so that there is 'parity of esteem' between physical and mental health patients. Yet, in the same year that the DH introduced a CQUIN for mental health trusts to measure some physical health processes of care, they removed from the QOF those same indicators

We believe that the DH should heed the recommendations of the recent Academy of Medical Royal Colleges report,[3] and address the lack of planning, coordination, and leadership in this area.

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When the words 'handover' and 'prioritise' are overused

We often hear about jobs being inappropriately dumped over from secondary to primary care.[1,2] There are suggestions on how GPs can fight back, such as refusing to make referrals on behalf of hospital consultants.[3] However, as a counterargument, hospital doctors can claim they must 'prioritise' the serious cases in secondary care, and, thus, have to 'hand over' these administrative duties to GPs. Also, it costs the NHS more money to manage patients in secondary than primary care.

It is evident that the stress and workload in the NHS are turning primary and secondary care doctors against each other. For instance, junior doctors in hospital often face time pressures to finish patients' discharge summaries. When they try to be good doctors who facilitate detailed communications with GPs, they can receive criticisms such as *'you're not typing an essay'*, *'just ask the GPs'*, and *'poor time management'*. This could explain why we frequently see errors in discharge summaries.[1]

Although it does not justify dumping jobs, the reality is that everyone is stretched in the NHS. If we have to constantly say *'I've handed over'* and *'I must prioritise'* to defend ourselves for not getting jobs done, it suggests our workplace has serious work coverage issues. Perhaps, it is time to raise this issue with Members of Parliament, rather than directing the anger at our colleagues.[4] Our real enemies are not our colleagues, but those who control the staff funding. Handover hostility is an ongoing problem in the NHS and detrimental to both patient care and doctors' wellbeing.[5,6]

This letter is not meant to demand doctors constantly work overtime to finish their jobs. It is a gentle reminder to revisit some key bioethics concepts — act in the patient's best interest and do no harm. Patients are the sufferers of this political battle between primary and secondary care. They are being passed back and forth; their illness may not be proactively managed until it snowballs into bigger problems. Is that the service we want to receive if we were patients ourselves?

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