THE PATIENT GROUP (PPG)

of Queen Edith Medical Practice (QEMP): Complementing the Work of the Practice

NEWSLETTER NO 20: December 2019

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Welcome to our fourth Newsletter of 2019.

Headlines

Much has happened this year in QEMP, in Cambridgeshire and in NHS England with new short and long-term plans. PCNs are due to become real quite soon and they are a step towards Integrated Care Systems – we will be reporting regularly on progress on this. Also, much has happened in QEMP itself.

Content

1. Over recent months, it has become very clear that the USA is seriously affected by the overuse of opioid painkillers and the consequent addiction of both patients and those who steal or "pirate" them, often leading to heroin (and worse). But, the USA is not unique; the problem exists in the UK and other countries as well and, closer to home, is significant in Cambridge.
2. We have a new section entitled "Healthcare Snippets". These are things in the news; we might explore some of them in more detail in the future.
3. Primary Care Networks (see Newsletter 19) are being developed. It is not yet completely clear what may be involved, both generally and for the PCN that QEMP will be part of.
4. Officially, Addenbrooke's Hospital is now part of the CUH Trust – see the update on Page 4.
5. Dr Hussey is retiring from QEMP after 26 years but will remain active medically as he explains.
6. We also have Practice News back again after completion of the main building work.

Note

Please feel free to pass this Newsletter on to friends and neighbours. Anyone registered as a patient at QEMP may become a member of the Patients Group and a (very short) note giving name, e-mail, phone number and signature is all we ask for. You can send an e-mail to me (see above) with these details (please note that the only reason we request a phone number is that a hand-written name or e-mail address might not be sufficiently clear and we would use the phone number just to check these points). All details are kept in one file, held by two committee members, and are not available to anyone else. If we have messages to send out that are aimed at more than one member, we use the Blind Copy system.

Our Talks are public events. We post notices about them and we welcome attendees from other practices – especially as the new PCN concept is being implemented.

We normally aim for six pages but there has been a lot of additional news including two separate items from the Practice itself (including several staff changes) – hence seven this time.

Painkillers And The Opioid Scandal In The USA

We are probably all familiar with the painkillers (analgesics) of old – aspirin has many uses (headaches, fever reduction and, in low doses, a blood-thinner used for patients who have had heart conditions), ibuprofen (originally and still sold under the trade name Nurofen) and paracetamol. Codeine was sometimes used as well and was somewhat stronger.

Even these drugs do have side effects in prolonged usage (aspirin can affect the lining of the stomach) and paracetamol can be difficult if the patient has liver damage. But, the real problem with them is that they can work very well in cases of short-lived pain (most headaches and bruises for example) but are much less effective in the face of chronic pain (prolonged such as arthritis) or very severe (for example where spinal nerves are trapped -- as with sciatica).

For use in very severe situations (extreme chronic pain, pre- and post-operative and end-of-life) opioid medications have been developed for 100 years or more. Properly used they clearly have a place in medicine. Examples of such pharmaceuticals include tramadol, fentanyl and oxycodon. They very in their strength but are much stronger than the more common codeine; fentanyl is assessed as about 100 times more powerful than morphine and some derivatives are thousands of times stronger still. However, some issues have become increasingly apparent in recent years and these can be summarised under the heading opioid scandal:

1. these drugs are addictive (they are all derived in some way from opium poppies)
2. they are not patented (any patents expired long ago) and there are many manufacturers around the world which inevitably means that supplies reach criminal channels
3. one version (known by the trade mark Oxycontin) of oxycodon was developed under patent protection (for the formulation invention); it is released more slowly into the blood than raw oxycodon and therefore lasts longer (around twelve hours versus one or two), which is convenient for the patient. The fact that it was marketed under a patent meant that it was worthwhile for the manufacturer to carry out an intensive marketing campaign.

This became a problem in the USA because its health system is not publicly funded for everyone; most are dependent on employment or personal insurance schemes but around 30-40 million people have no insurance at all. So, people with chronic pain would try and get the cheapest treatment from a doctor and, usually, that is just a few pills. Patients found Oxycontin helpful but tended to become addicted to it (as quickly as two-to-four weeks) and typically they wanted higher or more frequent doses; some died of an overdose. If their doctor refused to prescribe, patients turned to the illegal drugs, often heroin and obtaining that pulled them into crime to fund their habit. And, that led to more deaths (the available products not necessarily being subject to quality controlled manufacture).

In addition, younger people might “borrow” a tablet or two from older people (parents?) and like the effect (especially if they ground up the tablets, dissolved the powder and injected the result). Then they would seek to get their own supplies – which would also take them into heroin and criminality.

Recently the scale of the opioid epidemic in the USA has been declared a “national shame” and a public health emergency; it is estimated that tens of thousands of people die each year from overdoses with an increase of 30% in the last year.

But, it is not just in the USA. This is happening (so far on a smaller scale) in many other countries. Opioid prescriptions in the UK reached almost 24 million in 2017 – an increase of 10 million compared to 2007. Deaths of street sleepers are commonly from drug overdoses and the burgeoning demand has led to the “county lines” issue where criminal networks prey on quite young children as “mules”

(carriers), local sellers and potentially addicts themselves. Cambridge is not exempt from these problems.

The company that developed Oxycontin is Purdue Pharmaceuticals (which has nothing to do with the famous Purdue University in Indiana). The company is owned effectively (though indirectly) by the Sackler family which has been in the news recently because of their charitable activities (usually funding for museums and art galleries). The company has two subsidiaries in Cambridge - Napp Pharmaceuticals (operating in the UK market) and Mundipharma (which exports from UK to many other countries). After suffering several adverse rulings in cases in US courts where groups of States sued the company for billions of dollars, Purdue is effectively bankrupt and has entered special proceedings (known as Chapter 11 in the US legal system).

Those interested to know more could consult selected articles in The Sunday Times on: 10th March, 17th March and 19th May under the title "Britain's Opioid Crisis" or view websites such as: https://www.purduepharma.com and https://www.bbc.co.uk/news/health-43462975

Healthcare Snippets

This section is new and it is intended to give you a very quick commentary on some recent news items about health matters. If we hear from you that you would like to know more about one of these subjects, we will see if we can expand the item into a more detailed article (like the one in the previous section) for a future newsletter.

1. The health benefits of exercise are regularly in the news. This does not mean competitive rugby or long-distance running. In this context, regular brisk walking is considered to be valuable. One recent study suggested that people who always strolled in their middle years tended to live less long than those who walked faster.
2. A recent study suggested that successful rehabilitation of younger heart/stroke victims requires them to be pushed (in rehab) to walk at a speed of at least 3 feet/second (that's about 2 mph). My normal walking speed is about 3.5 mph but I find 4 mph is quite a push (at least for more than about 10/15 minutes) --- but I could easily do 5 mph when I was an older teenager (many years ago!).
3. Of course, the comments above relate back to our "Talk" in July 2019 by Dr Sally Pears (see Page 6 of our Newsletter #19).
4. When do you take your pills? A recent study suggested that blood pressure pills (ACE inhibitors like ramipril and beta-blockers like bisoprolol) perform much better if taken before bed rather than early in the morning. For more information see the article by Dr Mark Porter in The Times on 29th October 2019 (he referred to the study as "jaw-dropping") and ask your doctor when you are next visiting (please do not rush for a special appointment).
5. Brush teeth three times a day for a healthier heart. Reports are appearing on this subject; how "robust" the research results are is not yet clear – but an extra clean probably wouldn't do any harm.

Primary Care Networks

We have referred to PCNs in the recent past (see Newsletter 19). Progress is being made and doctors from the six practices are debating how this innovation will be implemented. At the same time, your

Patients Group is discussing with those in other practices what things we need to do together and what we expect to be continuing to do locally. The key messages are:

1. What can we learn from each other?
2. How do we jointly interact with the relevant patient groups - (some of which are less active than others)? What can we share from what we (separately) are already doing?

News From Cambridge University Hospital Trust (CUH Trust)

For many years, we have referred to our nearest hospital as Addenbrooke's: this is no longer appropriate. The Trust now includes Addenbrooke's itself, the Rosie Maternity Hospital and will also include the proposed/planned new Children's Hospital. Henceforth, we will use the CUH name.

The new (and recently re-opened) Royal Papworth Hospital is not part of CUH, but it is a world-leading heart/lung hospital and it is now established on the same "campus". Also, there are many research units and corporate organisations on the site (the new AstraZeneca world HQ for example).

Our Howard Sherriff will produce a periodic summary of major developments at CUH (most of you will know that he is a Governor of it); the first of these updates follows.

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In the last year the workload has been steadily increasing so on some days 400 patients are seen and at a peak nearly 500 per day (146,000 to 170,000 annually). To put this in context, departments such as Leicester (officially recognised as large) see 170,000 per annum. At times there can be 150 patients in the CUH Department at one time, and with relatives this can go up to 300 where there are only about 60 cubicles. This makes it impossible to achieve any sort of target, let alone the 4-hour target.

Various studies are looking at why this surge is happening when, for the last two years, the CCG (the Clinical Commissioning Group which manages the NHS budget for the County) planned that Primary Care would reduce the numbers attending A&E with various initiatives such as extended GP hours, improved 111, pharmacy consultations, and GPs in a Primary Care Unit in the hospital. Ambulatory Care provides a very good service but is only available for 10 hours each day on Mondays to Fridays. This differs from other Major Hospitals where this service is available 24 hours daily.

The Primary Care Unit is run by an outside provider (Herts Urgent Care) but they cannot always provide staff for the service, so by default A&E is used.

The current demand is not from the young and elderly, but from the working age population in the 25 to 60 group. Why this is happening is not understood. Various theories have been put forward, one of which is that workers cannot get time off if ill or injured, or cannot afford to be off in the working day especially if on zero-hour contracts. GPs surgeries still open for 50 hours each week, but patients are sick and injured over the whole 168 hours in a week.

Over the years the staff in A&E believe the service has been diluted by allowing specialty services to use A&E to see their patients, and some ask GPs and ambulance services to send patients to A&E using up what should be A&E space.

The Staff suggest that more space will not solve the problem. Linked to this is a real need to reduce the numbers attending (or build a new enlarged department with sufficient staff – my suggestion). In six months various trial projects elsewhere may come up with a solution - or not. The story is not complete so an update in six months may be needed.

Dr Hussey

As previously mentioned (Newsletter #19), Dr Andrew Hussey, Senior Partner, will be retiring from QEMP at the end of the year. We have invited him to send a valedictory message to you all. Here it is.

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My first involvement with The Queen Edith Medical Practice was not in fact as a doctor, but as a patient. In 1990, I moved with my heavily-pregnant wife from Kent to Cherry Hinton. We were anxious to arrange antenatal care as soon as possible. All our neighbours recommended registering at QEMP. This we duly did, although it was by no means the closest doctors` surgery. This was a wise choice; we were immediately struck by the friendly, family feel of the place and the excellent standard of doctors (Drs Scott, Calladine and Birch at the time).

Four years later I was fortunate indeed to be offered a partnership here, and started as a full-time junior partner in 1994. In those days the practice was very different – Laura Ashley wallpaper and curtains everywhere, carpets throughout! (CQC would have had a field day!) The building, although recently renovated, still felt like a domestic house rather than a doctors` surgery. The patient list was smaller-about 4200 compared to 8400 today- and there were far fewer admin staff and doctors. We had our own team of district nurses, inhabiting a small room upstairs which also contained the airing cupboard!

Over the years the practice has moved with the times and evolved into a much bigger organisation, delivering ever-more complex medical and nursing care. We have tried all the while to preserve the patient-centred ethos that my wife and I experienced as patients. I think is what sets us apart from many other practices. We are lucky to have just completed an extension of the premises. This will allow the practice to respond to future growth and yet continue to provide excellent care, as well as to become a training practice for new GPs.

I feel very privileged to have been part of Queen Edith Medical Practice over the last 26 years, working in an excellent team caring for a great group of patients. I am going to miss it very much, but I am looking forward to a better work-life balance! I would like to thank you for the many kind words, cards and gifts on my retirement, and wish you well for the future.

Practice News – From Claire Surridge, The Practice Manager

Staffing Update

As I reported in the last newsletter we have had several changes to staff over the last couple of months. The most important of these changes is that Dr Andrew Hussey, our Senior Partner, retires at the end of December – you will see his farewell article in this newsletter. We are of course very sad to see him go but wish him all the very best for this exciting new chapter of life. Dr Nidhi Sehgal joined us in October as Dr Hussey’s replacement so some of you will already have met her. From January, the Partnership will therefore be made up of Dr Jenny Clapham (who will take over the role of Senior Partner), Dr Mark Abbas and Dr Sehgal.

We are pleased to say that Dr Roger Petter will be returning to the practice in January working on Tuesday mornings.

There will be several changes to GP rotas in the New Year due to changes in working days and we will produce an updated list for patients in due course so that you know which GP is working when!

Sue Millard (our Office Manager) has now retired and 'escaped to the country' in a beautiful house in Suffolk, again she will be very sadly missed but we are sure she has lots of retirement adventures to look forward to! Miranda Hoad who joined us in September has taken over the Office Manager role.

We have been rather short staffed on the reception and administration team recently due to vacancies and staff sickness so appreciate this has meant longer waits when phoning and at the reception desk. This has also meant that some processes, for example typing of letters, processing of referrals etc has taken slightly longer than usual (although urgent items are always dealt with promptly). You will also have noticed we have several new members of staff who are in the process of being trained which takes some time as there is lots to learn, so please bear with them! We apologise for any inconvenience any of the above may have caused and appreciate your patience.

We are about to interview for further members of staff, so once they are also fully trained we should be back up to full speed!

Further Refurbishment Work to the Practice

Most of you will have now seen our lovely new extension! However, there are still some of the existing areas which need updating to bring them in line with the newer areas. Therefore, in the New Year we will be starting work on this additional decorating and flooring replacement, so hopefully by early spring all will look refreshed and bright. Whilst most of the work will be done out of hours, there may be some carried out when the practice is open, but we will try to keep disruption to a minimum.

Extended Access Service – Evening & Weekend Appointments

Did you know that we can offer evening and weekend appointments with a GP or nurse as part of Extended GP Opening hours. **These are for routine, non-urgent issues**. You can book your appointment through **our receptionist** who will give you a time, date and venue for your appointment. Our receptionist will also at be able to answer any questions you have about the service and how to cancel or change your booking.

If you would like to find out more please go to www.openlater.co.uk

PLEASE NOTE THAT THESE APPOINTMENTS WILL NOT BE AT QUEEN EDITH MEDICAL PRACTICE BUT WILL BE AT ONE OF THE 'HUBS' IN THE AREA (INCLUDING CORNFORD HOUSE SURGERY ON MON & FRI EVENINGS) AND YOU WILL SEE A DOCTOR/NURSE FROM A DIFFERENT SURGERY.

Don't swallow up your NHS - use it wisely this winter

Winter illnesses such as colds and coughs, sore throats, and upset stomachs can easily be treated at home with medicines available at low cost from your local pharmacy - no GP appointment or prescription required.

Be sure to stock up on the following winter self-care essentials to not only help save you time and help you to feel better quicker, but help save the NHS much needed resources.

- pain relief (paracetamol)
- cough and sore throat remedies
- first aid kit
- upset stomach treatment
- rehydration treatment
- heartburn and indigestion treatment

Your local pharmacist can also offer you advice and guidance on the best treatment for you – no appointment needed.

Pharmacists are available on every high street and in supermarkets with many open evenings and weekends.

Patients Group Annual General Meeting

This was held at the Queen Edith Chapel on 24th October. More than 20 people attended including some we had not seen before (they joined on the spot!). Dr Howard Sherriff and Michele Conway (our Secretary) were re-elected unanimously to the Committee. In addition, Professor David Bridges and Harry Ngatchu were elected for the first time. All four will serve for two years from 21st November (our anniversary date).

We heard (indirectly) from Dr Mark Abbas about the current state of development of the Cambridge 4 PCN – regrettably, Dr Abbas was unable to attend the meeting but he had thoroughly briefed your Chair in advance.

Coffee/tea and biscuits provided by the Practice and produced by our own Rose Barker were enjoyed by those present before and after the formal proceedings.

Talks To Be Organised By The Patients Group In 2020

We anticipate arranging three talks during 2020 and detailed planning for these is underway. We are aiming to hold them in the late spring/summer/early autumn (trying to avoid the cold dark evenings AND school half-terms). More details will follow. But, in the interest of the nascent PCN, we will be inviting people from the other practices to join us (it will be a good opportunity to learn from others). Watch out for further announcements.

Future Subjects For Our Newsletter

Articles under consideration for the next two editions (March and June) include:

- Stroke and heart conditions
- Obesity
- How does the NHS compare with healthcare systems in other countries?

If you have any other suggestions, let me know and we will see if we can get the relevant information and do something useful (but, of course, the more obscure something is the less appropriate it is for inclusion).

Season's Greetings and a Happy New Year to all our readers.

Please send comments on this Newsletter to me at the address shown on the first page.

Alan Williams, Chair