THE PATIENT GROUP (PPG)

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

NEWSLETTER NO 18: June 2019

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Welcome to our second Newsletter of 2019.

Headlines

Many of you will have observed that the building work at the surgery is progressing and the external outline is becoming clear; and you can sort of see where the additional consulting rooms will be. But, for many of us who have been inside, the temporary impact on space is obvious and a lot of people find the waiting area short of space (and the noticeboards are not there to look at or to display things which may interest us). For example, the two folders about the Patients Group are now both in Waiting Room 2 (not everyone gets that far!).

The key question of course is "how much longer".
The short answer appears to be that the target of end-July ought to be achievable

One of our members (Howard Sherriff – who organises our talks/events) has been elected as a Governor of Addenbrooke's representing the Patients Constituency. **Well done, Howard**!

Content

Note

Please do not hesitate 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); if you cannot do this, you could also leave a note, addressed to the Patients Group at the surgery. All details are kept in one file, held by two committee members, and are not available to anyone else.

Additionally, please note that our Talks are public events. We post notices about them and cannot realistically object to patients from other practices coming along; nor do we want to.

Vaccination

As a child I received some vaccines (diptheria etc which are no longer scourges) but I did not have those for measles, mumps and German measles (rubella) – they had not been invented! I had all three diseases as well as chicken-pox but measles was much the nastiest of them; I was off school for about two weeks with that, much of the time in a darkened room running a high temperature. Many people just do not realise how serious measles can be. It can and does kill and a not uncommon side effect is deafness (I have a relative who is totally deaf in one ear as a result); eye damage (sometimes blindness) can happen and inflammation of the brain (encephalitis) occurs in one child out of a thousand and can lead to permanent brain damage.

When there were no vaccines for rubella and mumps in the 1950s parents sometimes hoped that their children would get these diseases as children. The reason they did so was that that they would become immune and not get these diseases as adults when they would be even more unpleasant and also might have devastating effects on their futures. Mumps can cause seriously swollen testicles and occasionally render young men infertile. Rubella can cause a significant range of serious conditions in a baby if an unprotected mother is exposed to the disease in the early stages of pregnancy (including when the pregnancy itself may not even have been noticed).

Vaccinations (nowadays MMR) against these diseases started in the late 1960s and incidence of these conditions has been rare for many years (and total eradication was thought to be a possibility) but they are now making a big comeback world-wide because of low vaccination rates. When 95% of the population has either had the diseases (as I did) or has been vaccinated a situation known as herd immunity applies. If this is achieved, the disease does not spread rapidly because those who are infected and contagious do not meet enough unvaccinated people. At lower levels of cover, the disease spreads faster and can even become epidemic.

In the UK at the moment, approximately 89% of people are immune and at this level the disease spreads, albeit not very rapidly. Worryingly, the number is falling and infection is quickening. Even more worrying is the fact that in Cambridge (including at our practice) the proportion of immune people is falling (the latest score is around 83% at QEMP). And, very importantly, the UK is not alone. France and Italy are just two European countries with even bigger problems (so UK unvaccinated travellers can bring them home and infect others who have not been vaccinated). In the USA (especially in New York State but also elsewhere) the incidence of measles, in particular, has leapt.

Doctors blame false statements made and spread though mechanisms such as social media and there are suggestions that a Russian Government disinformation campaign has been involved (see The Times of 24th October 2018). Many of these statements are rooted in the allegations made by Andrew Wakefield some 20 years ago that the MMR vaccine causes autism. Based on a sample of just 12 children, he made this suggestion. This is a serious example of bad science where a coincidental association is confused with causation. This was such bad science that his original article was withdrawn from scientific journals and he was banned from practising medicine. His wrong statements have led to the deaths of hundreds, and probably thousands, of people (mostly children) with also huge costs in hospital care in the more serious cases.

If parents do not have their children vaccinated it is possible that compulsory measures will be taken. For example, in Italy, the Government is prohibiting unvaccinated children from schools and may fine the parents up to €500. In part of New York State, for a period of 30 days unvaccinated children were banned from public places.

The Charlemagne column in The Economist of 19th January 2019 is a useful overview. In April, the Victoria Derbyshire programme investigated "vaccination myths" from the standpoint of sceptical parents being taken to talk to experts - see www.bbc.co.uk/news/health-47787908

It is worth remembering that a terrible disease (with a very high death rate) like smallpox was eradicated from the world's population by vaccination that was started in 1796 by the visionary Edward Jenner. He observed that milk maids did not contract smallpox although the cows they milked suffered from cowpox (a milder but related disease); cowpox became the basis for the first smallpox vaccinations given by Jenner. Polio (a literally crippling disease which was often observed, even in the UK, when I was a child) has been almost eradicated from the world. Tuberculosis, which killed my great-grandfather at age 28, is much less common than it used to be but is now making a comeback as parents avoid their children being given the vaccine. A vaccine to control the very dangerous Ebola, which is fatal in as many as 90% of people, has been developed by Canadian researchers and is going into use in many African countries – but there is an outbreak, amongst unvaccinated people, currently in the news. Vaccination against yellow-fever is compulsory in many countries and travellers need to be able to show a valid certificate before being admitted to those countries.

To summarise, vaccination is vital to public health in general and saves countless numbers of lives; the New England Journal of Medicine reports, 17th April 2019, that measles vaccination has prevented an estimated 21 million deaths worldwide since 2000.

The same journal (6th June edition) contains three articles on the subject including one entitled "Mandatory Measles Vaccination in New York City"; those refusing were subject to a fine of $1,000.

If you know parents of young children, you might wish to show them this article and/or recommend that they contact the surgery for more information about the vaccines recommended, their benefits and when they should be given.

The NHS Long Term Plan

In February Simon Stevens (the CEO) launched the Long-term Plan of NHS England. This is a ten year plan said to fit the service for the 21st Century (or at least the next bit of it). The plan is set out in a complex document covering some 140 pages and is available at www.longtermplan.nhs.uk In this short review, we will focus on Chapters 1 and 7 passing quickly, for now, over the others in between.

Chapter 1 describes a new service model with five key statements which are explained in more detail in the plan. These are:

A. We will boost "out-of-hospital" care and finally dissolve the historic divide between primary and community health services
B. The NHS will reduce pressure on emergency hospital services
C. People will get more control over their own health and more personalised care when they need it
D. Digitally-enabled primary and outpatient care will go mainstream across the NHS
E. Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems (ICSs) everywhere.

Fundamentally, the aim seems to be to develop systems which keep people out of hospitals by doing more things in the community – not to put too fine a point on it, hospital treatment is very much more expensive than primary care on a per patient basis. Points D and E are about integrated and digital systems which should avoid things falling through gaps and will include a greater focus on prevention

(eg, as discussed in detail in *Chapter 2*, action on smoking, obesity, alcohol, air pollution and antimicrobial resistance).

Chapter 7 entitled Next Steps is about a new way of working. Key points are:

A. NHS England and NHS Improvement will implement a new shared operating model designed to support delivery of the Long Term Plan.
B. The establishment of ICSs everywhere from 2021 will be built on strong and effective providers and commissioners, underpinned by clear accountabilities.

This is where the idea of five year plans raises its head. The judgement is that the effective delivery of the ten year (long-term) plan requires some intermediate steps and that those have to be in process soon. You will note the statement in B above - ICSs are Integrated Care Systems and a key step in developing them is the concept of Primary Care Networks (PCNs) which need to be created in the next two years.

PCNs are envisaged to be formed by a degree of cooperation between existing General Practices covering 30,000 or more patients (QEMP currently has about 8,500) so that additional services (perhaps a pharmacist or a physiotherapist) can be provided in all surgeries and some more specialised services can be provided in at least one place in each network. PCNs will receive additional funding (depending on patient numbers) to support these developments.

A lot of background work is going on thinking through what the implications of all this are and how the ideas can be implemented. As a Patients Group we are not directly involved and necessarily much of the planning will be happening on a confidential basis. Nevertheless, we will be keeping our eyes and ears open through talking to our Practice and also learning from our networks (including the Cambridge Area Patient Group and the Patient Representation Group of the Cambridgeshire-wide Clinical Commissioning Group).

Our expectation is that over time we will have more to say – sometimes snippets of information and, when possible, we will be able to comment on formal plans as they are announced and being implemented.

Change is inevitable; nothing stays the same for long and new technology (especially) can create different ways of doing things. The older of us will recall how General Practices worked 50 or 60 years ago; now is very different from then and the future is bound to be very different from now.

Local Performance (mostly Addenbrooke's) vs National Targets

Against the national target of 95% for the four hour turn-round in A&E, the hospital achieved almost 84% in April (the last date currently available) but this was a marked improvement on the same time the previous year (just under 79%). Please note that this figure will not be reported publicly by Addenbrooke's in the next few months – the NHS has decided to trial a new approach to assessing A&E performance which, it seems, will involve increasing effort with the more urgent cases and so less urgent cases may have to wait longer. Addenbrooke's is one of a small number of hospitals testing the new proposed measurement system. Presumably, results will be announced later when the trial has been completed.

Performance against the other most important targets was reported for March/April this year as follows:

Patients starting cancer treatment within 62 days of urgent GP referral was still below the target 85% at 81% (vs 80% nationally) but Addenbrooke's has indicated that a significant proportion of the "breaches" occurred when patients had been in other hospitals before coming to Cambridge.

Planned Operations and care within 18 weeks of referral ---- Target is 92%, Addenbrooke's was at 89% and nationally 87% was achieved).

Mental Health therapy starting within 6 weeks of referral. For us (Cambridgeshire and Peterborough) this was 80% vs target of 75% and national achievement of 89%.

Practice News

In and amongst the building development of the surgery the workloads of many of the employees has increased. Coupled with staff sickness and holidays, the remaining staff have been under considerable pressure in the last few weeks. As a result, we have felt that it is inappropriate to request someone to set time aside to provide an "official" version for us on this subject. We hope to be able to issue a full update before too long, perhaps in our September issue.

Future Subjects

Articles under consideration for the rest of this year (we plan two more editions before Christmas) could include:

- How does the NHS compare with healthcare in other countries?
- We will review health screening later in the year with stories linked to subjects such as cervical screening, mammography, prostate cancer and bowel cancer; where appropriate, vaccination will also be touched upon again.
- We are sure that much will become clearer about the NHS long-term plan in the next few months – perhaps we can find out even more about the key points, and what that means for us, as implementation proceeds.

If you have any ideas or 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).

Our Last Talk

This took place on 10th April and was focused on emergencies in the home. Very regrettably, our original speaker, Michele Conway, was unable to give her planned talk. We had to make a late speaker change and the Easter celebrations made getting a room difficult. As a result there were fewer attendees than we hoped for. Nevertheless, Howard Sherriff stepped in and Roger Crabtree (our former Newsletter Editor) has provided the following comments.

> *Our speaker, on the subject "**What to do in an Emergency at Home**" was our own Howard Sherriff, who is one of the Patient Group stalwarts. Howard is now retired but was previously Accident and Emergency Consultant at Addenbrooke's.*

Rather than give a formal talk, Howard asked us to list the possible emergencies we might face at home. We came up with a list of some 10 topics, such as burns, insect stings, strokes, and heart attacks. He then discussed each of these, giving advice and the medical background, interspersed with anecdotes and amusing stories from his experience.

The whole session was very interactive and Howard kept us interested throughout. A 'tour de force', I thought. Such a pity that only 14 of us turned up. The rest of you missed an informative, and stimulating evening. Thank you, Howard.

Thank you Howard for the event and thank you Roger for the report.

Our Next Talk

St James Church in Wulfstan Way, 6.30-8.00 pm on July 3rd

"Joy in Movement - The Mental Health Benefits of Physical Activity"
Led by Dr Sally Pears, PhD Counsellor and Physical Trainer

The Poster about this talk is attached for your information. It has been placed in various sites around the neighbourhood and is being highlighted by the Queen Edith Community Forum in its Weekly Events bulletin (see http://queen-ediths.info/).

One more talk is planned this year. This is likely to be in September/October and we will confirm the date and details as soon as possible

Watch out for the announcements.

Final Thought

NAPP (the National Association of Patient Participation) held its Annual Conference just a few days ago. Although this group is a Member of NAPP, we were unable to take a direct part. However, NAPP has now produced a YouTube video of the main parts of the day. This can be accessed at:

https://www.youtube.com/user/PPGGroups/live

Perhaps the most relevant item will be the presentation headed "Integrated Care" presented by Zephan Trent of NHS England.

If you have any comments on this Newsletter please send them to me at the address shown on the first page.

Alan Williams, Chair