Referral management: cost before patient care?
Dermatology for GPs

The College has launched an online Dermatology GP library as a one-stop shop packed full of the latest dermatology e-learning resources, national guidelines, and RCGP accredited courses relevant to GPs and other primary healthcare professionals.

The free resource has been developed in collaboration with the British Association of Dermatologists (BAD) and the Primary Care Dermatology Society (PCDS). It follows the launch of the Women’s Health GP library last year.

A comprehensive series of clinical and non-clinical GP educational libraries will be released over the next year as part of RCGP’s new CPD strategy and to support the GPs with Extended Role (GPWER) programme. Access the library via elearning.rcgp.org.uk.

New College Vice Chair appointed

Dr Mike Holmes has been elected as the new RCGP Vice Chair (Membership), following a ballot of Council Members.

Mike is a practising GP in York and Hull where he has been a partner at the Haxby Group since 2002. He formally took up his new position at Council on 23 February.

“T I look forward to working with the rest of the Officer team to ensure we are listening to and engaging with members in the most effective way possible,” he said.

New laws on data protection – make sure you opt in

New legislation – General Data Protection Regulation (GDPR) – comes into force in May and you must opt in if you wish to carry on receiving emails from the College about GP learning, services and member benefits.

The legislation aims to better protect data privacy. As a result, the College will no longer be able to email you based on what you have previously told us you want to receive – and what you do not.

If you would like to continue receiving College e-communications, please visit https://rcgp-news.com/p/49/LX/232/update-email-preferences or see the front page of the College website www.rcgp.org.uk.

3 before GP: new RCGP ‘mantra’ for patients

In response to winter pressures and escalating demand facing GPs and practice teams, the College launched a three-step ‘mantra’ for patients with acute illness to consider before booking a GP appointment.

Patients are being encouraged to think about whether they need to see a GP by asking themselves three simple questions: Can I self-care? Can I use NHS Choices or a similar reputable website or resource? Can I seek advice or treatment from a pharmacist?

Following extensive media coverage, including on BBC Breakfast Radio 4’s World at One, and the front page of the Daily Telegraph, the College has also developed downloadable posters for each of the four UK nations.

RCGP Chair, Prof Helen Stokes-Lampard, said: ‘3 before GP is a simple and easy way to help reduce the strain on general practice, and we hope it will enable GPs to spend more time with patients who have complex health issues and are most in need of our expert help.’

Download your poster here: www.rcgp.org.uk/campaign-home/uploads.aspx

Council Elections – use your vote!

Elections open on 30 April for the six seats on College Council that will become vacant from November 2018. Every member eligible to vote will be sent a ballot pack with instructions and you can vote by post or online.

Find out more about the candidates here: https://pre.ukvote.rcgp Closing date is 1 June.
Fielding the critics

Former RCGP Chair Professor Steve Field CBE on courting controversy and why regulation is a good thing for patients – and GPs.

Steve Field didn’t put a foot wrong during his three years as College Chair from 2007-2010. Widely credited with putting the RCGP on the media map, he wrote and introduced the GP specialty training curriculum, and the MRCGP also became the compulsory entry standard for general practice during his term of office. His current role as the Chief Inspector of General Practice at the Care Quality Commission has proved somewhat more controversial with College members. His motivation for accepting the job was, he says, to ensure that ‘general practices were inspected by people who knew about general practice’ and encourage improvement in the quality of general practice, but also to celebrate what he understood general practice, and delayed transfers.

“We want to encourage innovation and new models of care – and I remember saying to Jeremy Hunt (Secretary of State for Health and Social Care in England) that this role is not just about general medical practice, but new models of joined-up care,” said Steve.

“We’ve created the reviews from scratch and will be going into 20 areas talking to GPs, Clinical Commissioning Groups, hospital chief executives, and local government and it’s the first time we’ve done that.”

“General practice and hospitals are just part of a bigger system, and by the time I finish, I want to have the CQC focusing on the system as a whole, but you can only do that once you’ve got a baseline for GPs, hospitals, dentists, and social care.”

A GP for over 30 years, Steve, 58, says his inspiration was his own family doctor as he was growing up in Stockport.

He did his medical training at Birmingham University and worked in Droitwich, Worcestershire, for 10 years before taking up a partnership at the Bellevue Medical Centre, an academic and training practice in Edgbaston, in 1997. He has been involved with the College all of his professional life and was an MRCGP examiner for many years as well as leading many of its education and professional development boards. He also worked with the College as a Postgraduate Dean for the West Midlands through his work on summative assessment.

After demitting office as RCGP Chair, Steve was appointed by former Prime Minister David Cameron to lead the NHS Future Forum, responsible for reviewing and recommending changes to the modernisation plans (subsequently the Health and Social Care Act) proposed by the then Health Secretary for England Andrew Lansley. He then continued this work by chairing the advisory board on the NHS Constitution. He was NHS England’s Deputy National Medical Director from 2012-13, before the CQC came calling.

Throughout his career, he has had a personal as well as professional interest in the health needs of the most vulnerable in society, and previously chaired the government’s National Inclusion Health Board looking at homeless care.

He is now taking forward this work at the CQC, which last November launched a report looking specifically at end of life care for the homeless and how better to support GPs in addressing the healthcare issues these patients face. “I’m a human being and a GP, and my entire career has been about promoting general practice because the academic evidence is strong, but also about making sure we get the best care for the disadvantaged.”

“It’s been a joy to see that most practices caring for the homeless rate as outstanding, but we wanted to say something about the high quality of care that is provided for the homeless by many surgeries because they often suffer from many illnesses and the average age of death in that community, in London, is somewhere between 43 and 47.”

“Some homeless people are turned away from some surgeries, so behind the scenes we’ve been working on making sure that doesn’t happen and started some training for receptionists.”

He cites several examples of how effective this kind of care can be, including Inclusion Health in Leicester.

“It’s an interesting town where they don’t like to see people drinking on the streets, so they have a wet centre where people can drink instead. The practice teams then go and do a surgery in the wet centre because they know that’s where these patients will be.”

Recently widowed with twin daughters both at university in London, Steve managed to combine his CQC role with his Bellevue commitments until last summer.

“I am a GP and am going through revitalisation, but the amount of work we’ve been doing on Local System Reviews and other things meant that I didn’t feel as though I could give patients the care I wanted to.”

“The question is whether I go back and do more this year, or maybe the next, but I haven’t decided how to do it yet.”

“I think there’s a limit to how long you can do these roles and this year I’ll decide what I want to do and where I want to go, but at the moment I’m enjoying this role at CQC more than I’ve ever done.”
When the Computer Says No!

New RCGP report criticises 'ethically questionable' schemes for managing GP patient referrals to hospital

Policy focus

Grainge Photography

6 Lampard, RCGP Chair, said:

where they already exist, they

a decision is made about their

– are ‘filtered’ via methods such

and other primary care

patients – referred by GPs

using the system whereby

England are reported to be

'patient trust' .

It advocates three methods:

Specialist advice services

through which GPs can seek

advice from consultants by

phone or email about

management of a patient or

whether they think a referral

is appropriate;

Local expertise initiatives

whereby GPs with a special

interest can make referrals to

local services;

Peer review and reflection

whereby another GP or groups

of GPs in the practice review

referrals before they are

submitted to ensure the most

appropriate routes and timely

use of investigations. This can

also be done retrospectively to

inform future behaviour.

RCGP Vice Chair Professor Martin Marshall, who co-authored the paper, said: "It's referral support, not referral management that will really

benefit GPs, and in turn our patients and the wider NHS. It will be in the best interests of everyone for CCGs and other decision-makers in the health service to take the recommendations made in our report on board."

Dr Robina Shah (PhD), Chair of the RCGP Patient and Carers Partnership Group, said:

"The relationship between a patient and their GP is unique in healthcare and built over time and we must approach any initiatives that threaten this with great caution.

"It trust my GP to make the right decision about my referral – I don’t want bureaucracy getting in the way."

The College has also hit back at allegations that GPs were receiving cash incentives for not referring patients – labelled as ‘cash for cut’ by the media.

Helen Stokes-Lampard said: "Cash incentives based on how many referrals GPs make have no place in the NHS, and frankly, it is insulting to suggest otherwise.

'CCGs all over the country are desperately trying to transform services in order to make them sustainable but with no additional resource to facilitate this.

"We understand completely that the NHS is strapped for cash – nowhere is feeling more acutely than general practice – and we know that CCGs often have to make difficult decisions. But the most pressing priority seems to be shifting work out of secondary care and that's not right."

In April the College will launch a campaign to end the commissioning of referral management centres. GPs can get involved via our website, and on social media using #ReferralEnd. Read the full report at www.rcgp.org. uk/policy/rcgp-policy-areas/ referral-management.aspx

Whenever Dr Laurence Dorman sees a patient with strange headaches, unexplained muscle weakness, or sudden paralysis, he is reassured to know he can email Dr Raebourn Forbes – a local neurologist based at Craigavon Area Hospital, in Belfast – for timely advice.

It sounds simple, sensible, and, in many ways, obvious, but this type of relationship is increasingly uncommon in the modern NHS and years of intense resource pressures and service commissioning changes have broken down many links between primary and secondary care colleagues.

"Patient care is suffering as a result of barriers to interface,” says Laurence, who worked at the Mourne Family Surgery, in Kilkeel.

"If I have a patient who is in need of secondary care or allied health professional care, then that care is often delayed for six to 12 months, or more, with current outpatient waiting lists in Northern Ireland. There may be other action that can be taken, but access to timely guidance is not always easy.

"My father was also a GP and I remember his generation would meet regularly, and often socially, with hospital consultant colleagues.

"It was a good thing and people communicated freely but things have changed now – we are all too busy.

At the moment, there are endless hoops a GP must jump through to contact secondary care colleagues for quick advice, and quite often GPs are left with no choice but to send a referral letter to the department they think is best.

"Hospitals seem to think that GPs love writing referral letters and nothing could be further from the truth. But when I have to do it, I only want to do it once and to the right place. I'm perfectly happy for secondary care consultants to guide me on that, but I hate getting that blank letter which says 'I'm in the wrong place and have to try again. It just wastes time.

"That's why Dr Forbes' clinic is very valuable. Neurology lends itself quite well to this system because patients' symptoms can be very vague – people can have tingles and weaknesses – and he can advise on all that, he's so polite and nothing is a silly question.

"If a patient needs a scan, I email him whenever I think and he emails me back with helpful advice on how to manage the patient.

"I have a patient who is quite eccentric and complained of vague neurology symptoms of a funny smell along with a couple of unexplained collapsing episodes at home.

Dr Forbes was able to do an MRI very quickly, which I otherwise.

"This work is catching on – non-negotiables and urologists in Laurence's area are also making themselves more accessible, and the GP himself has launched his own initiative, 'Dear Colleague', to help improve interface work.

"I do GP appraisals and I was speaking to an older GP who was saying that he used to be able to phone up the hospital consultant, but that it's not the same anymore," Laurence added.

"He said he felt like we're not on the same team anymore and I thought that was very sad.

"This is vital work. We need to be on the same team. If we improve interface issues, we improve patient care."

The College is calling for an end to referral management centres that ‘put cost savings over patient care’.

In its new report Quality Patient Referrals: Right Service, Right Time, the College highlights its concerns that too many decisions are being based on cost and not patient need.

It says there is no evidence to suggest that referral management centres are cost-effective, and that the process is ‘undermining GP professionalism and eroding patient trust’.

Around a quarter of Clinical Commissioning Groups in England are reported to be using the system whereby patients – referred by GPs and other primary care professionals to secondary care – are ‘filtered’ via methods such as triaging referral letters before a decision is made about their treatment pathway.

The College’s report states that no new referral management centres focused on reducing referrals should be introduced by CCGs – and where they already exist, they must prove that they are both cost-effective and safe for patients.

Professor Helen Stokes-Lampard, RCGP Chair, said: “The purpose of the College is to raise and maintain standards of patient care, so we cannot simply sit back and say nothing about some ethically- questionable initiatives that put cost-saving over patient safety.

“They undermine GPs’ professionalism and the decisions we make in the best interests of our patients and this erodes the important trust our patients have in us.”

The report raises further concerns that referral management centres will cost the NHS more in the long run as referrals are sent back to GPs for reconsideration, or when a patient’s condition deteriorates. As well as undermining the clinical expertise of GPs, it claims that this also damages the relationship between GPs and colleagues in secondary care.

Unsurprisingly, the College’s stance has attracted criticism from some CCG board members who argue that 'carrying on as we are is not an option' and that referral management centres are proving very successful.

But the report has received support from some unlikely sources, receiving positive national media coverage, including in the Daily Mail.

Quality Patient Referrals acknowledges that reviewing referrals is an important part of good practice, and a constructive part of professional development for GPs. However, the report suggests that ‘referral support’ would be a more effective and beneficial approach for GPs and patients, than ‘referral management’.

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We launched the campaign on 12 March to encourage GPs and hospital doctors whenever they’re contacting each other through referral, discharge letters, or email advice, to start with a courtesy greeting of ‘Dear colleague’.

The idea is that whoever writes it will stop momentarily and think about the person who is receiving it.

This has set the scene for future work that Laurence will lead on in his Strategic Advocate role for RCGPNI. In partnership with other Royal Colleges in Northern Ireland, he will be developing a protocol for professional behaviours and communications which should influence training and induction of health professionals across the system.

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Making the GP voice heard

The College’s Regional Ambassadors scheme in England was launched following the announcement of the GP Forward View in April 2015, in order to ensure the GP voice is heard at a local level in sustainability and transformation planning. Now, similar ‘Advocate’ schemes are now being rolled out across Northern Ireland, Scotland and Wales.

Here, ‘Advocates’ from each of our Devolved Councils talk about their new roles and aspirations for what they hope to achieve.

NORTHERN IRELAND

“When I heard about the newly created posts for GP Strategic Advocates in Northern Ireland, I saw it as an opportunity to highlight important issues that matter to grassroots GPs on a forum where perhaps primary care’s voice had not been heard before,” says Dr Siobhan McEntee, advocate lead for Workforce, Training and Leadership.

Siobhan is a GP principal in Glengormley, Co. Antrim. She is also an associate director in GP specialty training at the Northern Ireland Medical and Dental Training Agency (NIMDTA). The Strategic advocate position is the first College role she has held.

“I’ve always had a keen interest in GP education,” says Siobhan. “One of my priorities will be working to address GP recruitment in NI. I aim to highlight the positive aspects of a career in general practice: the intellectual challenge; the diversity; and the opportunity to shape your career specifically to your skills and interests.

“We know many younger GPs here want a portfolio career – let’s welcome that and train people accordingly. Along with my NIMDTA colleagues, we are trying to make GP training appropriate to the needs of both younger doctors and our local population.

“Another of her key concerns is waiting lists for patients to be seen in secondary care and for procedures. Siobhan has been working as one of the clinical leads in Elective Care Reform trying to improve the services to patients by developing pathways for the delivery of more specialist services, such as skin surgery, in the community.

“We are working with surgeons to develop a skill base in general practice,” Siobhan continues, “ultimately we want our patients to see an appropriately trained doctor in the right place, at the right time – and often that is in a community setting.”

Siobhan sees the interface between primary and secondary care as essential.

“We need to work together to improve communication and move away from silo patterns of working,” she says “and the new RCGPNI #DearColleague campaign (see feature, page 7) is going to be a major driving force in improving dialogue between GPs and our hospital colleagues.

“I’m here to get the problems – and potential solutions – heard at the highest levels. I feel it is important that decision makers hear from healthcare professionals working on the ground to ensure that the correct information is heard.”

Siobhan acknowledges that with no government in NI, the lack of a local Health Minister may delay the implementation of new initiatives, but she has already met with the Chief Medical Officer and the Director of Primary Care and has received a very positive reception.

“It’s been really positive. I’ve been enjoying the role so far, particularly supporting RCGPNI to get the GP voice heard amongst many of the influential decision makers in healthcare in Northern Ireland.”

CYMRU WALES

Part of Dr Julie Keeley’s reason for becoming an RCGP Local Advocate in Wales is ‘to highlight the good things that GPs do that might not come across in the media.’

“We don’t blow our own trumpets enough, so I see it as my role to do that, at the highest levels I can – there aren’t many GP voices at high levels. I also want to advocate for giving us the tools to deliver quality care,” she says.

“Four months into the role as Local Advocate for Powys, Julie has already met with the Medical Director for the Powys Teaching Health Board to discuss the main challenges facing general practice in Wales.

“One of these is recruitment in rural areas. It’s a concern she knows well. “Powys covers 23% of the land mass in Wales, but just 4% of the population”, she explains, “so healthcare professionals come here, they love the people and the area. Encouraging people to come is the challenge in recruiting to rural areas.”

“The Medical Director was receptive and keen to have GP involvement. She particularly appreciated the independent review approach to the Advocate scheme,” continues Julie.

Another of her big concerns is GP access to both mental health and out of hours services for patients. “These are areas I plan to seek to improve to ensure quality patient care,” she says.

“OOH services as we know them in Wales are under threat and it looks like things are moving towards Local Health Boards becoming the provider – they haven’t had responsibility for this before in our area. It’s been a long time since 2004 when GPs no longer had 24-hour responsibility for patient care and many GPs are worried that this may force them to be responsible for this again.

“Grassroots GPs don’t think decision makers are being told how things are so I want to advocate for people’s genuine concerns – about the profession, and about our patients.”

Julie continues, “I see my role as liaising with the Health Boards, and providing GP input into decisions being made, but also in formulating strategies to address problems. Julie moved to Wales in 1990 to do her GP training and has never looked back. “It’s a lovely place and a lovely place to work,” she explains, “you have a good quality of life, people are kind and friendly and our patients are hospitable. Working here really allows you, as a GP, to become part of the community.”

“JThere’s a misperception that to work as a GP in Wales, you have to speak Welsh. Well, it’s not true, I don’t, I’m from Ireland and have always felt welcome here.”

SCOTLAND

Dr John Kyle sees his role as a GP Local Advocate in Scotland as helping to steer general practice through some big changes.

“The Quality and Outcomes Framework was abolished here about 18 months ago, and we’ve moved towards a ‘peer-led, values-driven’ approach to quality in general practice.

“We’re now working in ‘clusters’ which have a key role in maintaining and enhancing patient care,” John explains.

Clusters are small groups of GP practices in a local area that meet periodically – sometimes virtually – to develop and share quality improvement initiatives.

John’s role covers the Argyshire and Arran, Lanarkshire and Greater Glasgow Health Boards, which include 67 clusters in total.

“Being an Advocate is an exciting opportunity to help develop and share initiatives and resources to help clusters to meet their full potential,” John says. He has been engaging with medical directors of Health Boards, cluster quality leads, and quality leads for individual practices.

“So far, there has been a mixed reception,” John admits, “some have been very positive whilst others have been wary, I think this is because clusters are relatively new and everyone is so busy.”

A first sessional GP in the West of Scotland, John does four sessions a week in general practice, and four sessions as an academic GP at Glasgow University.

Another big change in Scotland is the new GMS contract, which will be introduced in April 2018. John is cautiously optimistic, saying that it will ‘hopefully address many of the issues we as a profession are facing,’ but that change ‘will take time.’

“Scotland shares many of the challenges that GPs elsewhere in the UK face,” he says, “we have an ageing population, increasing multi-morbidity, increasing demand and challenges in terms of recruitment and retention. This has resulted in increasing workloads at a time when funding has been squeezed.’

His aspirations for the future of the role are to ‘have a better understanding of initiatives and challenges facing clusters and to help share developments and best practice.’ In time he would hope that this will have a positive effect on the evolution of cluster working and accelerate the positive impact clusters have on patient care.”

News from the Devolved Councils

GP Frontline  April 2018
A very busy day but really worthwhile – and can we do it again next year? That was the verdict of delegates at the College’s inaugural Faculty Chairs’ Conference held at its 30 Euston Square headquarters. Attracting almost 100% attendance, the ‘Leading your College locally’ event brought together colleagues from across the UK to network and share ideas, along with the opportunity to take part in training sessions including leadership and maximising the potential of social media to promote the excellent work that Faculties are doing.

Before snapping a ‘selfie’ with everyone, RCGP Chair Helen Stokes-Lampard gave an enthusiastic account of how she juggles leading the College with being a ‘real’ GP, sharing her experience of a recent practice merger and how her own local Faculty – Midland – has given her enormous strength and support over the years. College President Mayur Lakhani, an active member of Leicester Faculty, announced that he would shortly be embarking on a ‘listening exercise’ with Faculties across the whole of the UK.

Meanwhile Chief Operating Officer Valeria Vaughan-Drick outlined what the College was doing to support Faculties – and called for suggestions on how this could be improved. Colin Hunter, Chair of the Trustee Board, and former RCGP Wales Chair, Paul Myres, who now oversees the College’s Audit Committee, kickstarted a discussion about local structures and the types of services and support that Faculties might need in the future.

An ‘open house’ session gave Faculty Chairs the chance to share the diverse range of issues affecting their local GP members including workforce and workload, retention, technology, quality of care, and the CPD and educational events that their respective Faculties are running. Operational challenges, such as how to encourage time-pressed GPs to attend Faculty Board meetings and the barriers to local engagement, were a recurring theme.

One of the most popular sessions of the day was a ‘sharing best practice’ workshop where three Chairs talked about their different approaches to local leadership and engagement.

Veronica Wilkie discussed the Midland Faculty’s Veterans Accessibility Project which is encouraging GP practices to identify and support ex-service personnel, while Miles Mack, former Chair of RCGP Scotland, spoke on how ‘virtual’ board meetings were encouraging greater participation for North Scotland Faculty. James Greenwood, Chair of the South Yorkshire North Trent Faculty, spoke on ways of encouraging ‘new and younger’ doctors to get involved in their Faculty and how TACAs (Talk About Something You Care About) are transforming board meetings.

The conference concluded with a presentation by East London GP Sir Sam Everington on what it takes to be a local leader, where he shared successful initiatives adopted by his Bromley-by-Bow practice. The Chairs then attended the RCGP Winter Dinner where the guest speaker was English Health Secretary Jeremy Hunt.
Bawa-Garba: the case that has shaken medicine

Dr Hadiza Bawa-Garba

Earlier this year, Dr Hadiza Bawa-Garba, was removed from the General Medical Council's medical register. Almost seven years previously, as a sixth-year trainee paediatric working at Leicester Royal Infirmary, she had made a number of tragic mistakes that led to the death of six-year-old Jack Adcock, and to her being convicted of gross negligence manslaughter.

She received a 24-month suspended prison sentence in 2015 and in 2017 the Medical Practitioners Tribunal Service ruled that Dr Bawa-Garba should be suspended for 12 months, but that she should stay on the medical register.

The GMC appealed this decision – an action that has received widespread condemnation across the medical community, with both Health Secretary Jeremy Hunt and Chair of the General Medical Council, Dr Nathan Smith, saying they were concerned about the implications for doctors, particularly those in training. Following extensive discussion of the case at UK College in February, RCGP Chair, Professor Helen Stokes-Lampard issued this statement: “Dr Bawa-Garba’s case has shaken the entire medical community in the UK – it is now essential that lessons are learnt from this case, and are used to shape the future of medical practice in the best interests of NHS staff and patient care.”

“It is vital that we never forget that at the centre of this tragic case is Jack Adcock, the child who died, and first and foremost our thoughts are with his family. But the case has also caused considerable anxiety for GPs, particularly GP trainees, who are worried about the repercussions of the ruling and how it might affect the way they practise in future.”

“Patients need good, safe doctors, but in order to continuously improve, doctors need the freedom to reflect openly and honestly on the care that they deliver and the systems within which they work.

“The implications for general practice, more specifically, are significant given that we work independently, largely on our own, seeing the greatest number of patients on a daily basis in the health service. We do this without effective mechanisms to control our increasing workload, and a vital part of our role is to deal with uncertainty and manage risk. A response from Sir Terence Stephenson, consultant paediatric doctor and Chair of the General Medical Council

Small changes, big impact

Improvement is rarely about making big, radical changes. Often it’s about a commitment to doing the obvious, and making changes in smaller, incremental ways. East London GP Dr Nazmul Hussain shows how this approach has transformed his surgery.

In 2016, the Wordsworth Health Centre, in East Ham, enrolled on a Quality Improvement (QI) initiative in a bid to better its services and care to patients.

A year later and the practice, once described by the CQC as ‘requiring improvement’, was given an overall rating of ‘good’, with its leadership and services for mental health ranked as ‘outstanding’.

“We learnt what was and how it could be implemented at a practice level,” Dr Nazmul Hussain, a partner at the Wordsworth Health Centre, said.

“We looked at a lot of possible changes, with different skills we had, and how we could all get involved. We used many of the QI tools to assist us. For example, defining aims, measuring data, making small-scale changes, and evaluating through the Plan, Do, Study and Act cycle. We also learnt about run charts and interpretation of data, driver diagrams and the use of a prioritisation matrix.

“It may seem hard and challenging at first, but it pays off and patient satisfaction improves.”

The scheme, run by UCLPartners with the Newham Clinical Commissioning Group, involved a total of nine practices and encouraged by working to identify problems, make small changes to fix them, and then monitor their success.

The programme may have ended, but Nazmul and his staff still keep two huge post-it note boards up behind reception, where all staff can continue to track QI and contribute their own suggestions for more improvements.

“There’s a simple code – pink post-it notes are for problems that need solving, blue ones are for new ideas, and yellow represents the steps that need to be taken to reach the end goal. And it works.”

“It would not be right for us to comment on the judicial process and verdicts, but we have well received the Government’s review into cases of gross negligence manslaughter. We will be responding to this and hope the conclusions from this investigation will help us to all work together to improve our health system for patients and staff throughout the NHS, both now and in the future.”

A response from Sir Terence Stephenson, consultant paediatric doctor and Chair of the General Medical Council

I am a practising doctor on the front line and I work with trainees. I completely acknowledge the pressure they’re under and the sense of distress this case has caused, and I am sorry for the effect it has had on our colleagues. Dr Stephenson told the Observer.

“I’ve worked in it all my life and never seen it so pressured. It’s under-resourced and under-staffed and it’s cracking. Doctors have been angry about that for some time, as has the GMC. We’ve spoken out repeatedly. We’re very concerned doctors are being asked to work in what are almost intolerable circumstances. This issue has been a lightning rod for a deep-seated dissatisfaction with the environment doctors are asked to work in.”

Although we sometimes have to take difficult and unpopular decisions, and doctors want to see public support for such doctors, we want to better support every single doctor in every medical leader and medical leader experience gone wrong – not when harm has happened to patients and doctors.

For the future, Sir Terence Stephenson, Chair of the General Medical Council, said: “The whole practice team is now energised to keep up our efforts, and go from strength to strength.”

“I have a scanner in my room, so I don’t have to ask reception for it or me, and I dictate my notes into a device which is much faster.”

“It also means you don’t have to file everything, for example, pictures of skin lesions. You take a picture of a patient’s lesion, with consent, load it into the system with the notes and it’s done. So also good because then you can see if your treatment is working.

“It’s something that looks abnormal and you are sure about it then you could also upload it for referral and send it to a consultant and they actually can see what it is. Also, if I’m on holiday then a colleague who sees it can check and compare it. It’s much easier than me looking down with it and it looked like, how big was it – a picture says a thousand words.”

Next up, Nazmul wants to tackle ‘missed diagnosis’ cases and make sure a respite room for autistic children, transform the dental job into a tranquil garden, and even study for a MBA in high-level leadership.

“Failure is success if you learn from your mistakes,” he said. “We had the CQC inspection, were rated as ‘requiring improvement’ in the last year, and we were going to get ‘outstanding’ overall. We didn’t.

“The one thing that limited us was our patient satisfaction questionnaire, which had been done during the time of the old system, so it didn’t reflect our improvement.”

“We were deflated and upset, but through that we’ve made so many more changes and are glad that we didn’t get because I think we would’ve become too complacent.”

“The whole practice team is now energised to keep up our efforts, and go from strength to strength.”

Small changes, big impact

Improvement is rarely about making big, radical changes. Often it’s about a commitment to doing the obvious, and making changes in smaller, incremental ways. East London GP Dr Nazmul Hussain shows how this approach has transformed his surgery.
Breaking the cycle of ‘destructive’ commissioning

Nottingham GP Dr Stephen Willott calls for a radical rethink on how drug and alcohol services are funded in primary care.

There were over 3,700 drug-related deaths registered in England and Wales in 2016. That’s more than 10 deaths a day and a 44% increase on 2012 figures. Each one is a tragedy. Yet at a time when drug-related deaths are higher than ever before, we still often see a destructive three-year cycle of recommissioning drug and alcohol services which threatens and undermines the very support and care that these services are meant to provide.

At the most recent RCGP annual drug & alcohol conference – which the College has hosted for the past 22 years – delegates told their stories of how this practice is destroying the quality and continuity of the care they can give to patients. Several were in tears as they shared their experiences of how well-functioning services had been re-tendered and then lost, usually because another service had undercut their budget.

We know from the evidence, reinforced by the Advisory Council on the Misuse of Drugs (ACMD) report on commissioning, that this three-year cycle of commissioning and tendering drug and alcohol services is detrimental, particularly for people who use drugs or alcohol. Even where there are longer cycles of commissioning, many areas are seeing ever-increasing cuts to funding, which is harming services despite evidence-based returns on investment.

In the report submitted to the Home Office in September 2017, the ACMD expressed its concerns that reduced funding may be doing ‘serious damage’ to the treatment system, highlighting that this could ultimately lead to increased levels of blood-borne viruses, drug-related deaths and drug-driven crime in communities.

ACMD Chair Dr Owen Bowden-Jones says: “Drug and alcohol treatment appears to be facing a disproportionate decrease in resources, likely to reduce treatment penetration and the quality of treatment in England.

“The situation is compounded by frequent re-procurement of services that is using vital resources, creating unnecessary ‘churn’ and disruption and resulting in poorer recovery outcomes.”

The report records a number of negative impacts on treatment prior to the start of a contract, and then one and two years into the contract.

It also claims that the majority of evidence from providers and commissioners described a level of reduction in funding – but that this was not apparent when local authorities published their financial returns.

At the RCGP conference, we called for a change to the practice of the three-year cycle and made two main recommendations to help reduce drug-related deaths and improve continuity of patient care, which remains the cornerstone of general practice.

These are:

- **Recommissioning services only if the service is failing, and only after support to change the service has been tried.**

- **Adopting the recommendations in the 2017 ACMD commissioning report, particularly in establishing a minimum of five-year (and preferably 10-year) cycles of commissioning services for people who use drugs and alcohol.**

We believe that the local commissioning of drug and alcohol services is contributing to poor continuity of services. We are also concerned about the lack of emphasis on harm reduction in the Government’s 2017 drug strategy.

We must challenge both if we are to continue providing some of our most vulnerable and disadvantaged patients with the care that they need and deserve.
When Dr Martin Johnson was in his third year of medical school his grandfather contracted shingles of the sciatic nerve.

"He was in agony," explains Martin, "and one time I remember being on the phone to my grandmother and hearing him in excruciating pain in the background, but the only medical advice she'd been given was 'give him paracetamol, he’ll be alright.'

"At that moment, I made a pact to myself that I had to do something about pain."

He’s now Clinical Lead for Chronic Pain at the College, as well as Vice President of the British Pain Society (BPS) and Co-Chair of both the Chronic Pain Policy Coalition and Opioid Painkiller Dependency Alliance. This is all on top of his day job as UK Medical Director at Synexus, a GP-founded British company, which is now the biggest clinical research organisation in the world – unsurprisingly, Martin’s key interest there is pain research.

"There are 28 million people in the UK in chronic pain, it’s a huge part of a GP’s workload," says Martin.

"The advice a GP gives a patient is powerful – far more powerful, actually, than the bit of green paper we can give them at the end of a consultation, so it’s important it has a basis in high-quality research. There is so much pain research out there, but much of it is very poor quality.

"We’ve come a long way," says Martin, "it wasn’t long ago that the advice we gave to patients in chronic pain was the dreaded R-word – ‘rest’. We now know that we need to get them moving. If you’re in bed and you get a cramp, lying there won’t sort it, you need to get up and stretch – it might hurt in the short term, but it’s the only way to achieve longer term relief.

"Evidence and pain is a difficult issue," he continues, "GP’s often baulk at complementary therapies, but where chronic pain is involved, things like acupuncture and osteopathy can provide relief. They won’t cure anything – but chronic pain is a long-term condition, there’s no cure, it’s about managing it, and different patients find that different things work."

Martin was a GP partner in Barnsley for 25 years before an unexpected double-heart bypass, with complications, and other life issues, made him rethink his career options and he subsequently worked as a locum for a further five years in Huddersfield & Leeds before taking up his current research role.

Recovering from his heart operation coincided with chronic pain becoming a clinical priority for the College, which it was between 2011-2014, and this, along with his involvement in the BPS, gave Martin the capacity and opportunity to apply for the role of Clinical Champion.

"It was chance to get pain on the map. There’s a limit to what can be achieved in three years but we made strides in getting pain incorporated into the QOF, and I think our advocacy to NICE around the need for guidance on generic pain certainly sparked the upcoming guidelines," says Martin.

"We certainly don’t want the opioid situation in America to be replicated here," warns Martin, although he doesn’t think this is likely. "People can ‘doctor-shop’ there – if they are addicted to opioids and one doctor won’t prescribe more, they can find another who will, and doctors have the fear of being sued to contend with if they don’t.

"Opioids are more difficult to get here – the NHS, and specifically general practice, are quite literally lifesavers in this respect. But to further avoid a US-style ‘crisis’, as it’s often called, we need to take regular reviews of patients taking opioids – at least annually. Unfortunately, this may add to GP’s workloads, but a simple template to follow could help.

"When you hear about opioid prescribing in the press, it’s always seen as a negative. But drug therapy can be hugely beneficial for some patients and taking the option away will disadvantage a lot of people. It’s using them appropriately, and managing their use properly that we need to get right.

"If patients are in pain, it’s understandable that they want a quick fix. But with chronic pain there are no quick-fixes. We need to give GPs the tools to recognise when pain is short or long term, and to say to patients, this pain that was acute has now become chronic, and we need to deal with it in a different way."
In 2004 Dr Kevin Barrett was diagnosed with the inflammatory bowel disease Crohn’s Disease. Now he is aiming to raise more awareness of IBD in primary care through the College’s clinical Spotlight Project programme.

"IBD is frequently confused with IBS," explains Kevin, referring to the more common and more well known irritable bowel syndrome, “but IBD refers to the chronic, idiopathic relapsing and recurring inflammation of the bowel. There are two main forms: Crohn’s Disease and Ulcerative Colitis.”

Kevin only went to see his GP after suffering from symptoms for more than a year, and only after being persuaded by his wife. “I put it down to the stress of becoming a GP partner and having four children under the age of five,” he admits.

"Once I got to the GP, my diagnosis was very straightforward,” Kevin continues, “but when I became more interested in the condition professionally, and did more research, it became clear that for many patients, the pathway to diagnosis is more difficult."

"Unfortunately, treatment pathways in some areas are better than in others – Stockport, for example, is excellent."

"One thing we know that can really support GPs is access to an IBD nurse – a clinical specialist nurse based in secondary care who can offer phone advice to GPs, signpost to nutritional advice or psychological support, or in some cases see patients. The gold standard is 1.5 per 250,000 patients, but it’s patchy across the country.”

Around one in 250 people have IBD in the UK – IBS is ten times more common – and it predominantly affects younger people, with 25% of diagnoses in teenagers.

"At this time of a patient’s life, they are going through a lot with school and university and other common life pressures," says Kevin, "so it’s easy to put symptoms down to stress or lifestyle – like I did.”

"Symptoms of IBD such as diarrhoea, weight loss, fatigue, anaemia and abdominal pain could be so many other conditions and this makes it a difficult condition to diagnose," he explains. "There is also an overlap with endometriosis and anorexia, which might seem like more appropriate diagnoses."

"Where older people are concerned – another peak is in patients aged 50 plus – there is overlap with symptoms of bowel cancer, which makes things particularly complicated as there are strict guidelines around cancer referral.”

Kevin grew up in a non-medical family in Devon. He did his medical training at King’s College London, graduating in 1997. His first house job in gastroenterology shaped his career.

A GP partner at the New Road Surgery in Croxley Green, Hertfordshire, he sits on the charity Crohn’s and Colitis UK’s Primary Care Advisory Group, through which he became the College’s Clinical Champion for IBD.

"When we embarked on the Spotlight Project, we surveyed GPs and found that the majority lacked confidence in diagnosing IBD and treating flare-ups,” he continues, “and they were also unsure about when and how to use the faecal calprotectin test, which is a relatively new but very useful test for diagnosing IBD."

"Our aim is to raise awareness of IBD amongst GPs and other primary care professionals but also to support them in the identification and various treatment paths available.”

Since IBD became a Spotlight Project in March 2017, an online toolkit for healthcare professionals has been developed, and educational events have been held across the UK. Kevin is particularly proud that through the project, IBD has been ‘more appropriately’ embedded in the GP training curriculum.

"We have a patient on the project’s steering group and her voice is vital in helping us to see things from a patient’s perspective.”

"It’s about empowering GPs to empower their patients. IBD is a long-term condition – there is no cure, but it can be managed, and patients can play a huge role in that through things like regular exercise and being supported to look after their mental health.”

The partnership with Crohn’s and Colitis UK has now been extended for another year, and Kevin has ambitious aspirations.

"The toolkit is a living document and we want it to be a one-stop shop for GPs, and to answer all their IBD FAQs: what treatments are available; how to manage flare-ups; how to treat IBD in pregnancy, and so on. It already includes a lot of advice, and there’s more to come; it’s had three updates already."

"We also want to host more events, and link up with other clinical priorities, such as liver disease and cancer. Ultimately, we’d love to see a network of Clinical Champions for IBD across the UK to raise awareness at a local level. We’ve got lots of ideas.”
Dr Gabriel Hendow started his medical career as a surgeon in Iraq before finding his true vocation in UK family medicine. It was obviously a good move as he is still practising at the age of 72!

He is a single-handed GP based within the Bransholme Health Centre, an inner-city practice in Hull that serves one of Europe's largest council estates. His Dr Hendow Practice has an overall outstanding rating from the Care Quality Commission.

Gabriel was born in Basra, Iraq, and did his military service during the Arab-Israeli conflict. “I was somewhere on the Syrian and Jordanian front. It was a tense and worrying time because you’re young and in the middle of a war zone. You wait eagerly for your discharge papers,” he said.

As soon as his service was over, Gabriel travelled back to Basra to train as a surgeon before gaining a postgraduate degree in General Surgery in Baghdad.

His father was a family doctor, and was appointed physician at the Health Authority for Basra and Director for the Centre of Endemic Diseases for Southern Iraq, helping to eradicate malaria in the region – achievements which have cemented the Hendow name in Iraqi medical history.

Aged 32, Gabriel moved to the UK where he worked in orthopaedics at London’s Whittington Hospital, Grantham, King Edward VII in Sheffield, and Bassetlaw Hospital in Worksop.

“Surgery was rewarding, orthopaedics was challenging, but I felt I needed more interaction with my patients that those disciplines could not offer me,” said Gabriel.

His patients helped him realise that general practice was for him.

Despite his years of experience, including working as an appraiser, clinical assistant in a minor injuries unit, and a GP with a specialist interest in ear, nose, and throat care, he’s continued to develop new initiatives to improve his services for his patients.

“I started a food clinic in the surgery to improve the lives of my patients. We changed the way they cook. They started to understand food properly; they lost weight, their blood pressure and their cholesterol levels improved.”

He later introduced an exercise clinic followed by another dedicated to teenage healthcare.

He also developed a Home Monitoring Service, using volunteers to visit frail and vulnerable patients, and those who haven’t visited the surgery for a while, to ensure their overall healthcare needs are addressed.

News of his work has spread far and wide, earning him a plethora of awards and nominations, including the RCGP Humber and the Ridings Faculty Award for Celebrating Good Practice.

Most recently, he was announced as one of five nominees for the UK Health Hero Awards – an achievement which included a trip to 10 Downing Street.

“It was surreal,” he said. “Theresa May said she’d heard so much about me and that I reminded her of when she was a little girl and had a family doctor. I told her that was what we were about – being a family-oriented practice.”

“She said she was delighted at what I’d achieved.

“When I first told my father that I wanted to become a GP he said, ‘that’s fantastic, but don’t just become a GP be a family doctor.’

“I didn’t understand, but he said I would one day.

“It’s taken me years to change the work culture within my practice. Family medicine is such a unique area of medicine. It’s not about issuing unnecessary prescriptions. It’s about listening, and having a holistic approach to patients and their families’ overall needs.

“When someone says I’m their family doctor, it means the world to me.”

It’s often said that twins can read each other’s minds.

And for Drs Wendy and Grace Wong, this holds some truth after they both decided to head to medical school to study general practice.

They always knew they wanted to become GPs, although sibling rivalry means there is some contention over who chose the speciality first.

“Grace still believes to this day that I ‘pooped’ her in applying for Leeds,” Wendy, 31, joked, “but I let her have it.

“I think I’ve always wanted to work in medicine. I remember being so excited when I was given the Pla-Mob ambulances set for Christmas as a child.

“Our father is an ophthalmologist and our mother was a district nurse, so we were naturally exposed to the experiences of medicine – including the time our father was called into work on Christmas Day as he was cutting the turkey!

“I think there was always an instinct of wanting to know how the body works and wanting to help people. I believed health was, and still is, one the most important things in life. It’s often only when you or loved ones’ health deteriorates that you appreciate its value.”

After applying to Leeds Medical School, the sisters were both accepted onto the same course and trained together until graduating in 2010.

And although the idea of studying alongside a sibling might not suit everyone, it had its uses for Wendy and Grace.

“We are mirror twins, which means we are identical reflections of each other. For example, I am right-handed and Grace is left-handed,” Wendy explained.

“Our parents still can’t tell the difference when we stand in front of the mirror. Grace was born after me and we always joke that I am the more competitive one who got out first, but then Grace says, ‘I pushed you out’.

“We trained together during our foundation years, often working in the same departments, just at different times.

“There were perks to training with your twin. We would often get mistaken for each other by senior colleagues, so we looked very keen by seeming to work two jobs at once.

At other times, it had its drawbacks.

“I was once congratulated on Grace’s marriage, to which I replied, ‘thank you very much, we are very happy’, Wendy remembers.

“Luckily for me Grace is a hard worker, so I was quite happy to accept compliments from staff on her behalf.

Unfortuantly for Grace, I used to bake, so she would get the feedback on my ‘not so Mary Berry’ baking skills.”

After years of living and studying together, Wendy now works in York and Grace in Walsall, Wirral – but they continue to ring each other for advice. Their thought processes are very similar, as is their threshold for clinical concern for patients,” said Wendy.

“Having Grace there is like having another, often more rational, me.”

Grace said: “GPs are often patients’ first port of call for further advice, reassurance or help. As GPs we have the chance to get to know our patients better and provide more individualised care. I am also lucky to work within a great team at my practice.”

“We wanted to join the other members of the College who are working towards the same goal of providing the best care we can to the whole family,” Grace said.

True to form, the twins (above with former College President Dr Terry Kempley) received their RCGP membership during the same ceremony.

“We’ve always done everything together since the start, so it was only right we marked the special occasion together,” said Grace.

“It meant so much to me that I could graduate with my sister. I had felt wrong to do it without her,” Wendy added.

“But I did get to walk on stage first – I am 12 minutes older after all!”

Twin sisters Wendy and Grace Wong have twice as many good reasons for becoming GPs.
There is a lot of delusion in general practice at the moment – time, workload, and stress are all killers. But I also think one of the reasons we are so disillusioned is that we’re unable to help patients to the extent that we would like with nebulous symptoms that don’t respond to the treatments we currently have available, so they keep coming back disaffected.

“Lifestyle is a soft word – but we’re not taught enough about the science around it or the way to effectively address it in our consultations. We need a bigger toolbox to deal with these issues.”

The 40-year-old, who has two children, says his goal is to spread his learnings to other GPs, based on a simple and effective evidence-based approach.

His Prescribing Lifestyle Medicine course, accredited by the RCGP, is backed up by the latest science around lifestyle medicine – and is designed to be delivered in the standard 10-minute GP consultation.

“It looks at what specific interventions can help a whole variety of different conditions and what biochemical changes need to occur in the body. The feedback from GPs, psychiatrists, gynaecologists, nurses, and others says how it actually works has been overwhelming.”

To find out more about the next Prescribing Lifestyle Medicine course being run in April, visit: www.rcgp.org.uk/learning/rcgp-educational-accreditation-for-education-providers/accc-courses-prescribing-lifestyle-medicine-course.aspx

Rangan has also launched a new podcast on health which is now being used by many doctors and healthcare professionals as a free resource for their patients: www.acast.com/feelbetterlivemore

"Many patients also had artificial limbs from being attacked, if not from the war in Syria, during their migration to Egypt. "I felt the number one thing they needed from me was to listen to them – they want to be heard, even if it’s a minor complaint. You have to have this understanding that they’re not angry at you or acting in a bad way.”

The 34-year-old graduated from the Faculty of Medicine and General Surgery in December 2007 and began her career in the Egyptian Ministry of Health as a GP in the primary health care unit where her passion for primary care flourished.

In 2016 Nancy joined Save the Children as Health Manager and is advocating to change the system by working with government to help them understand the unique needs of refugees and provide them with primary healthcare services. As part of this work, she’s also improving the technical capacities of doctors and nurses who treat refugees and is training community health workers to conduct home visits for refugees on nutrition, antenatal care, family planning and more.

Nancy also carried out social prescribing, linking patients to housing and migration support and coordinating access to ongoing healthcare.

For refugees who have chosen to stay in Cairo, Nancy says a big part of her work is helping to integrate them into their new communities.

“We also work on psychosocial programmes to support them, to ensure they can have a future here with livelihood, training, education and work opportunities, and access to healthcare services. “Once they are stable and well-established in the community you don’t see them a lot – they don’t come for free services anymore.”

The refugee population is around 250,000 in Egypt and more than 60 per cent are Syrian. While the number of refugees to Cairo have slowed in recent years, she says refugees from Syria, Sudan, South Sudan, Ethiopia, Iraq and Yemen continue to steadily arrive.

“We are seeing recently among the newcomers are Syrians and Africans coming through Sudan and via illegal migration routes, where they face a lot of risks, so we’re seeing a lot of SGBV cases.”

Nancy has been an RCGP member since 2015 as part of the International Overseas Network. She joined the College to link to international support and resources and has been working to raise the profile of the College in Egypt.

Nancy, who is married with a seven-year-old son, says her work treating Syrian and African refugees has changed her life.

“I started this work as a GP in a clinic and I found that helping refugees is something I want to do for the rest of my life – I see it as my personal mission and it’s very rewarding to give people hope again. “In a matter of days, these people had everything and now they have nothing. This changed my mindset; when you act day-to-day with these people you realise how fortunate you are to have your home, your stable job, your family – it is something we take for granted.”
Time-pressured GPs can now boost their learning with a new College series of ‘bite-sized’ video presentations that take only five minutes.

*Five Minutes to Change your Practice* takes topical issues that are relevant to frontline GPs and delivers these to GPs online.

“Meaningful learning that provides deep understanding of a topic is difficult when you just don’t have the time – the whole idea behind the videos is to give you one or two ideas on how to change your practice and improve patient outcomes without taking up much of your time,” says Dr Dirk Pilat, a GP in Essex and RCGP Medical Director for eLearning.

Written by GPs for GPs, the content is updated monthly and topics include cervical cancer prevention, PSA testing, lupus, migraines, perinatal mental health, how to support self-care in patients, single inhaler therapy for asthma and many more.

The five-minute presentations are not meant to replace the comprehensive eLearning modules on offer to College members, but to “run in addition to them,” says Dirk.

The College’s eLearning programme has more than 100 free courses on offer and while the vast majority of courses are clinical, there are a number of non-clinical courses on offer including commissioning, social prescribing, safeguarding, and multidisciplinary working.

With nearly 100,000 users accessing the resources, the eLearning programme is multi-award winning and continues to be one of the most popular resources offered by the College, according to membership surveys.

The eLearning department won silver at the Learning Technology Awards in November 2017 with an award for Best learning technologies project – UK public and non-profit sector.

The courses are targeted at GPs, GP Specialty Trainees and GP Educators and there are courses for all members of the healthcare team.

Dirk has been a GP since 2000 and practises at Longfield Medical Centre in Maldon where he does six and a half clinical sessions per week.

He says the benefits of eLearning are immense, from gaining CPD credits and upskilling, to the excellent educational benefits that you can bring to your consultation and have an immediate impact.

“eLearning is also a great way to respond to Patient Unmet Needs (PUNs) because you can immediately plug that knowledge gap that came up during a consultation. Your patients will benefit and you can prove you turned that Doctor Educational Need (DEN) into something your appraiser will be happy with.”

The College’s eLearning courses are based on the RCGP’s training curriculum and the eLearning team works with an external collaborator, usually a charity, to fund the course and deliver it cost-neutral to members.

Funding for eLearning courses can come from the private sector, charities or Government, but the College has come in for criticism when particular companies have sponsored a course, the infant feeding module funded by a commercial food company being a recent example.

Dirk clarifies that external funders do not have editorial influence over the content and have to follow a strict code to sponsor a course.

“We did the infant feeding module because, as working GPs, we struggle to find good information for our patients around infant feeding. We found a vast gap of knowledge for GPs in this area and thought it was time that GPs were supported with sound advice to help mothers who are finding breastfeeding challenging.

“But we need to be balanced, so we are currently writing a breastfeeding course with the help of a very knowledgeable lactation consultant.”

If you are wondering what eLearning course to take, the GP Self-Test should be your first point of call.

“The GP Self-Test will assess your own educational needs by asking a range of questions and will help determine what area you might need to update. You can then pick and choose a course that will help you with that,” says Dirk.

He is optimistic that the eLearning programme will continue to go from strength to strength.

“I would hope we could cover the full curriculum and have CPD across the whole thing – it’s a pretty mighty aim but it’s something I’d really like to see.”

Find out more about eLearning and find your next course at [http://elearning.rcgp.org.uk](http://elearning.rcgp.org.uk)