Notes for Keynote Presentation to HEE EoE Spring Symposium Thursday 23rd March 2017.

1. Backdrop of PHP. Why that service was deemed to be needed and was set up in 2008.

Dr Daksha Emson's tragic extended suicide in 2000. Daksha had tried to hide her own bipolar disorder as she feared its impact on her career as a young Psychiatrist. The Inquiry after her death, highlighted the stigma of mental illness within the NHS, and the problem of her being both 'doctor and patient', telling herself she was able to manage her own illness and treatment. She died aged 34. She had set herself and her 3month old baby on fire when she became psychotic. Her baby died instantly of stab wounds. She died three weeks later in a burns unit. Her radiologist husband found them ablaze on his return home from work. Her death has ultimately lead to the establishment of a bespoke service for doctors own mental health care based in London, PHP, lead by Clare Gerada.
Free, self referral, confidential and tailored to the very specific needs of doctor patients.

Doctors actually have higher than average rates of mental ill health, suicide, alcohol and drug misuse than the UK average. Young female doctors are particularly at risk of suicide, twice the population average.
Doctors also tend to present later in the course of their illness and when much more unwell.

3000 professionals, all grades of doctors (not just GPs) and dentists, have accessed PHP in the past nine years, with very beneficial outcomes.
80% remained in, or returned to work. Most with addiction problems are clean within 6months, 90% are still abstinent 6years on. In huge contrast to non-doctor addicts who relapse easily.

2. Why are doctors different and why do they their own service? .

Some home truths about us being humans too!
Same body parts, same illnesses affect us.
We are no different to our own patients. Sometime we too can get sick.

But Doctors' own unhelpful behaviours sometimes make them into awkward or reluctant patients.
Our training can dehumanise us, and taint our attitude to our colleagues too.
Sickness is all too often viewed as weakness. Especially when it comes to mental health.
Viewed as a weakness, or a failing. It is sometimes doubted, or mocked, or dismissed as a explanation for poor performance, and then - to add insult to injury, the individual is judged by their performance alone. With no regard to their health and wellbeing.
Doctors fear others judgement.
We worry about our job and career prospects if a diagnosis becomes known.
We don't trust our colleagues to treat us with the same respect as our patients. And sometimes, sadly all too often, that is for good reason too. We experience first hand, the double standards that still exist within our profession.

Barriers like stigma and prejudice are rife within the NHS and actually DO make it all worse.
An unwell or absent colleague is viewed as a practical and financial burden on a practice.

The mixed agenda of Partnership (colleague, employer, business owner etc) all adds unhelpful complexity when issues of money and workload can so easily pitch GPs at loggerheads - even if the underlying problem causing the sickness absence is genuine mental ill health.

Compassion goes out the window when everyone is so stretched and stressed.
There is simply no capacity for kindness in some quarters.

3. So... what can be done?
The new GP Health Service launched just 7 weeks ago, the funding for this service comes from the GPFV budget. NHSE have commissioned an England wide rollout of GPH modelled on, and effectively co-ordinated by, the PHP service based in London.
Established in all 13 regions. Each with a Lead like myself in post, to coordinate the service, develop local systems, and to promote awareness and uptake.
With GP Clinicians in post across the country, the goal is for every practising GP in England to be within 2 hours drive of a GPH assessing clinician.
Face to face appointments are offered at times and locations to suit the GP patient.
GP Health Service is open 8-8 Mon to Fri, 8-2 Saturday. Closed Bank Holidays.

Not an emergency service but a timely service. Access to a first assessment is usually within a few days. Booked via an App, and with the practitioner patient in control of who they see, where and when.
Treatment follows on after an MDT discussion determines the treatment plan specifics, informed by the outcome of that very full 60-90 minute first clinical assessment conducted face to face.
GPH then authorises the codes for the treatment to proceed, and also to enable selfbooked follow up appointments made via the smartphone App.

4. Who it is for?
ST1s through to 1 year post retirement GPs.
Projected uptake 750/year.
Actual uptake was 20% of predicted year presented in the first month.
150 new cases self referred in February . Still coming.....perhaps the rate will slow, but the breakdown of problems mirrors the PHP experience to date.
Depression, Anxiety, Stress, Burnout, OCD, life events or physical illness affecting the GP or their next of kin. Sometimes it's just one last straw, a complaint or adverse patient outcome, that breaks the back...
GPH is also there for doctors with addiction problems, alcohol excess is very common, prescription drug misuse and misappropriation, sometimes there is recreational use of illicit drugs.
Sometimes multiple co-existing problems are compounded over time by the ongoing reluctance to seek help for fear of being judged. A potent recipe for disaster, ultimately suicide for some when the last straw appears. All coping strategies exhausted, it can seem like there is no other option.
Tragic - and so avoidable if the right help is there at the right time.

5. How it GPH accessed? And used? Who provides what by way of assessment and treatment?

Self referral ONLY. Via email or phone to start the process. Cannot be referred and GPH will not solicit referrals either. Supportive colleagues CAN guide each other towards the service but the initial contact HAS to come from the GP patient.
Confidentiality is paramount and is guaranteed. The first telephone contact can even be under an assumed name until agreement is reached to set up an assessment appointment at which point true identity must be used. But will be protected even within the service.
Records held on the Cloud in a system called Crosscare which is NOT linked to standard NHS records.
Appointments are then made via a smartphone App - the GP patient chooses an assessing clinician, time, location to suit their needs. And times for the follow up.
All assessments, appointments and treatment are FREE to the GP patient.
CBT is the mainstay. A national provider of CBT to medical professionals, called EFFICACY, is now in place under contract with GPH.
Short term psychological interventions are offered via face to face, Skype or online as suits the individual. The treatment is targeted and specific, in order to stay affordable within the limits of what has been commissioned.

Major psychiatric illness and it's care remains within standard NHS services. GPH cannot carry that case load too, and is not intended too. It can assist, bit not replace.
Addiction specialist services are also available where needed. Including inpatient detox, though this is unusual. Most GP patients have more routine needs.
Where possible all drug prescribing is done by the own registered GP after an appropriate discussion and a handover request to prescribe ongoing treatment made via a written communication - usually deliberately brief and without detail beyond the very essential.
The service does not have its own Prescribing budget. Mindful of polypharmacy issues and all the associated risks of prescribing by multiple sources.

6. Key principles of GPH - especially the Self Referral nature and re Confidentiality.
It offers safe, secure care, independent of formal regulatory processes.
Designed not as a cosy soft touch 'doctors looking after doctors club' - far from it - but as a safe and very sophisticated service able to cater for the complex situations that unwell GPs can find themselves in. Often compounded by the additional concerns of how and when to return to work, especially in geographic areas where Occupational Health services are not geared up for the specific needs of GP patients.

7. What GP Health Service IS, and IS NOT.
It is NOT in lieu of Occupational Health, NHS routine care nor any of the regulatory bodies either.
If there is concern about a GP that puts them, or indeed others, at risk; then there may need to be disclosures made.... but they are only made after actively asking for consent from the GP patient, and only if they are deemed to be otherwise unavoidable.
A doctor not currently working, for instance, actually poses no risk to his patients.
Context matters greatly.
There is huge expertise within the PHP service - senior Clinicians with years of experience working within and alongside the GMC for instance. The boundaries are very clear. The memorandum of understanding between PHP and the GMC protects the doctor patient's privacy AND is aligned to good practice principles and the need to protect patients and the public too.

8. Records, logistics, interfaces with regulators etc
The service is well constructed and the regulations adhered to properly.
But this is a treatment service, NOT a regulatory body.
It is here to help, and to treat GPs. Compassionately and with dignity too.

9. Uptake and outcomes data - broad brush. From PHP historic data.

Doctor patients actually do very well once the white coat is metaphorically removed.
Which sometimes takes only minutes. The time lag is in the phase before self referral. Once contact is made, progress and recovery can be remarkably fast.

The cost benefit ratio is proven by PHP outcome data since 2008.

GPs are expensive to train and sadly are all too easy to lose from the workforce.

The GP Forward View plan already recognises the need to look after the GP workforce, to address issues of recruitment and retention and particularly by attending to the the previously under recognised issue of the mental well being of GPs.
Hence the millions of GPFV money being put towards this GPH service now.

10. The key message is loud and clear....

- that this is not a massive cavalry coming over the hill able to solve ALL of the GP mental health and workforce problems everywhere...

- and it is clear that we as GPs do still ALL, as professionals, have a duty of self-care to ourselves and a duty of care to each other - as well as to our NHS patients.
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- Prevention of mental illness, and access to workplace support before problems build up, all being just as important as access to a cure.

- GPH resources are finite. The therapy provided is high quality and is tailored to the needs of GP patients. Those providing it are senior experienced individuals and have particular expertise in looking after sick doctors. But we also need to educate and improve the culture and the working environment in order to effect change at an earlier stage. Both in prevention, and earlier intervention.
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And finally, just to give some idea of the scale of GPH...of what a huge task is being taken on by some very very enthusiastic and capable people nationwide.

I'm effectively contracted to work one day per month on average in this GP Health Clinical Lead role.
To cover the whole of the East of England - Norfolk, Suffolk, Cambs, Herts and Essex.
And I'm it.
There is no admin structure or office behind me. Just me.
So far most people and organisations I have interacted with think I'm working full time on this!
I wish I could. But the funding is finite. And the resources are limited.
This is a shared vision. To improve the mental health of the GP workforce needs all of YOU to be on board too.

The GP Health assessing Clinicians.... all are very experienced Clinicians with vast mental health expertise and experience of looking after doctor patients - but they not being employed 24/7 by GP Health. They have day jobs too. Many are busy frontline GPs and no less busy than you.

Most are very very part-time indeed in their GPH role - the cost envelope IS limited.
Each GPH Clinician may only care for a handful of GPs per year.
A few, like Claire Gallagher, do work much longer hours within PHP.
All are very committed to the cause. And it WILL make a difference.
But it cannot do everything, and culturally, the GP world needs to do what it can too.

To support individuals and embrace GPs own mental health issues with the same maturity as when dealing with physical health.

And lastly, a key point I feel I need to make clear. And for which I seek your engagement too.

In addition to GP Health picking up those GPs who do fall ill and stumble, there is still a very real need and desire to do something constructive one step earlier... to ensure there is much more support in place, accessible to individuals, and more attention and thought about prevention.

More care towards the GP workforce itself, more attention paid to early signs of stress and mental ill health, and far more effort made to avert major illness by giving individuals access to the right support at the right time.
Even if that support is just a listening ear or a shoulder to lean on. It can make all the difference in the world to an individual who is teetering....

And THAT bit needs real engagement from the whole GP profession. Not just reliance on a new service like GP Health Service.
It needs engagement from leaders, educators and from all of the GPs on the ground.
Not rocket science, not expensive.

Just needs an injected reminder of the importance of compassion and common sense in the everyday working world of General Practice.
Good employment practice and good partnership dynamics. Simple stuff, but vital stuff.

Remember... it could be you, or one of your colleagues that will one day need help.
Remember that 1 in 4 statistic.
We are not immune by way of our medical degree.
We can, and should, both help ourselves, and help each other.
It's a win win situation if we do. More GPs will stay well and be work fit.
That benefits everyone, whether it be the doctor patient, the working colleague or the NHS patients that we serve.

I hope this leads on neatly into Claire's illustrations of some vignettes and cases...

Then we will have Q&A - and hopefully some sophisticated discussions.
We can develop these discussions further in the Workshop later this morning.
Any questions?

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