

Somerset LMC Newsletter



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Issue 114

Practice Based Commissioning

What on earth is the Government up to?

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It would appear to be an act of extraordinary folly, never mind breathtaking arrogance, for the Government to go down the route of linking PBC to "Choose and Book". Although this was suggested by John Hutton in December, recent revelations leading to the complete collapse of GP's willingness to be involved in CAB means that far from linking the two leading to an acceptance by practices that they must take on CAB, it seems far more likely that CAB drag the whole PBC process down into the mire with it. This is not the time for a wise Government to start trying to railroad GPs and practices into accepting ill thought through new initiatives.

There is already ambivalence about PBC, with practices wanting to look carefully at the balance between potential benefits, which are very real, and the equally real dangers – particularly that the process will in the long term lead to a shift to practices of the risk *and cost* management of all hospital referrals, including emergency admissions.

We now hear that the NHS Alliance has expressed concern that there are significant deficiencies in the activity information provided by acute Trusts (including, to nobody's great surprise, inadequate discharge summaries) and that commissioning against payment by results will be distinctly unreliable.

We could have told the Government that introducing so many changes to an NHS management that is already struggling to keep afloat is unlikely to work, that GPs and PCTs still need time to absorb and implement all the new work arising out the new contract, and that discussing their development programme rather than imposing it might, just possibly, have encouraged more involvement from front line staff.

But they chose not to listen to our concerns, and have insisted on pushing forward policies that look increasingly flimsy and transparently political. From NPfIT to Community Matrons there is not one that is not in trouble – and that curious humming to be heard in the corridors of Richmond House is the sound of Nye Bevan spinning in his grave.

Chaperones

When should you use one?

The latest recommendations on the use of chaperones are particularly unhelpful for general practice, as they suggest that one is considered not only for internal examinations, but also for breast examinations and even ophthalmoscopy – presumably on the grounds that the patient's body space is invaded. This may be fine for hospital outpatient clinics, but hardly realistic in the GP's surgery. Furthermore, it's no good just getting a receptionist in the room. A proper chaperone should, apparently, be suitable qualified, able to determine that the conduct of the examination is appropriate, and actually observing the examination.

What is worrying about this is that it militates *against* good medical practice. Clinicians will be less and less inclined to examine patients at all, never mind p.r. or p.v., and presumably it will no longer be acceptable to examine a patient at home at all – which will doubtless lead to more emergency referrals for assessment.

We cannot swim against the inexorable tide of professional regulation, and we also have to accept that there are some rotten apples in the barrel. Sporadic cases of sexual abuse of patients by doctors continue to be reported, so is there a way in which patients can be kept safe without every NHS consultation needing to be conducted by at least two people?

Well, you do need to think about it, discuss the matter within the practice, and come up with a policy. It is a good idea to have a notice in the waiting room and in the practice leaflet that says that if a patient would like to have a chaperone, would prefer to have intimate examinations undertaken by a same gender clinician, or would like to come back on another occasion with a companion, they just have to ask when the examination is proposed. It is also a good idea to make sure that staff who do act as chaperones, whether clinicians or

not, have some understanding of what examinations are likely to be done (and for what purposes) and that this training is recorded.

Just when you offer a chaperone remains a personal decision, but a bit like asking depressed patients whether they have suicidal thoughts, it gets easier with practice. At a minimum, it is wise to do so routinely for rectal or vaginal examination of patients whom you do not know well, especially if they are much younger than the doctor or of the opposite gender. A male GP might feel comfortable about examining a patient that he had known for 20 years and whose two children he had delivered, but would be wary of the unfamiliar young female patient with funny pelvic pain. For the latter don't ask, just go and get the nurse. There are two parties at risk in this procedure, and whatever the patient may feel you *must* protect yourself.

Do record if a chaperone is offered and refused, and also note the name (or at least the initials) of the person who does it if you do use one. Remember that women doctors are not immune to accusations of inappropriate behaviour, and although the risk is less, it is there. Everyone should stick to the practice policy, not only because that is safer all round, but also because any unusual conduct then becomes much more obvious.

But remember that abusive doctors and vexatious patients really are infrequent, and although human evil is endlessly ingenious, most problems arise out of a misunderstanding. Good communication is the key to avoiding this. A man who presents with rectal bleeding may be expecting a rectal examination, whereas if he has prostatic symptoms he may not. Similarly, a woman who makes an appointment for a smear has chosen to see that particular person knowing what the procedure involves whereas if she

develops acute abdominal pain she may just take any appointment available without knowing that an internal examination may be necessary. So make sure you explain why an examination is appropriate, and offer the patient a chance to come back on another day – and to see a different doctor if they prefer.

Most important of all, make a conscious decision on whether to offer a chaperone, and listen to your instincts. If something does not feel right do not examine the patient without having someone present – and if that means bringing the patient back for another appointment or even a hospital referral, then so be it.

Responsibility for Acting on Abnormal Tests Results

Primarily rests on the person requesting the test

Recent problems with Pathlinks between practices and the Somerset Pathology Service, leading to results requested by hospital doctors being sent to the GP, have prompted us to seek some advice about who is responsible for acting upon abnormal test results.

Medicolegally, the test requester has the primary responsibility, and part of the process of arranging a test should be to ensure that the result is received and acted upon. So, for example, practices must ensure there is a safe system for dealing with results when a GP requester is away on leave. By the same token, a hospital doctor cannot abrogate responsibility for a test result just by saying “send result to GP” unless they have ensured that the practice is aware of the test and the need to act if it is abnormal. If a consultant wants the GP to act on a specific result, the LMC recommends a system whereby he or she writes on the report form “please would GP treat” in clear large letters, and faxes this to the practice. This ensures that there is an audit trail, and that the result is received quickly – hospital letters sometimes taking several weeks to arrive.

But do be aware that everyone with clinical responsibility who sees or handles a result has a secondary responsibility to act if they see that a test report that needs action. You need to have in place a procedure for making sure that any significantly abnormal result is not filed until it has been confirmed that action has been taken. This sounds laborious, but the number of such results

Supporting Carers

A little effort produces a lot of benefit

It has been estimated that about 10,000 people in Somerset see their primary role as being a carer, but despite a real national political will and a number of initiatives, it is far from clear that their needs are being met. Carers groups all agree that primary care in general, and the family doctor in particular, can help ensure that they are. We will all have a number of patients who are struggling to look after an ill or frail relative or friend, and who may not be aware of the help that there is out there. All we are asked to do is to think about who fills the caring role when we see a patient who is being supported in this way, and to make sure that the carer has the name and phone number of the Carer Support Worker who covers the practice. If you don't know who yours is, Care Direct on 0800 444000 can tell you.

In particular we are concerned about the carers of patients with long term mental illness notably dementia, recurrent psychotic illness, or long term depression. The impact on the long term physical and mental health of those looking after sufferers can be immense, but without them the NHS and Social Care Services would simply collapse. As one carer describes it *“I have been living with my husband's severe depression for 20 years. Almost every day he talks of ending his life, and every time I put my key in the front door I wonder if this is the day that he has”*

We know that this is yet another thing to think about in an increasingly congested consultation, but thank you for trying.



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Certificates of Fitness to Exercise

Do not guarantee patient safety

With the explosion in leisure centres, gyms and fitness clubs, practices have seen a large rise in the number of patients wanting a letter or certificate signed to say that they are “fit to take exercise”. Experience from cardiac and pulmonary rehabilitation suggests that very few patients do not benefit from exercise, even those with significant cardiopulmonary disease, but is it safe for them to go to the gym? The answer is, of course, that you don’t know. Not only is the risk of a cardiac event linked to exercise unpredictable, but you also have no knowledge of the exercise regime planned.

You therefore cannot issue a statement that any patient is fit for exercise.

But why does the patient need such a certificate? Presumably either as a requirement of the club’s insurance, or perhaps just as a way of shifting liability if a client drops dead in the gym. Either way, this should not be our problem, and if you choose to, you can just say no. There is no legal or contractual obligation on GPs to issue such certificates. It would be perfectly reasonable to have a standard note to send to patients along the lines :

We are sorry that we are not able to issue the certificate that you have requested to say you are “fit to exercise”.

Although there are very few people for whom the health risks of exercise are greater than the benefits it is not possible to predict exactly who could have problems , so we cannot guarantee that you personally will not run any health risks.

We do not know exactly what your exercise programme involves, and as GPs are not expert in this the doctor cannot say whether it is safe and appropriate or not.

We do encourage everyone to take suitable exercise, but if you have any concerns about whether your programme is suitable, you should make sure you discuss this with an exercise professional or sports therapist.

However, we don’t want to discourage patients from taking exercise, so you might consider something along the lines of:

This letter is to help you decide about your planned exercise programme

We recommend that everyone takes exercise if they are able to do so. It is very unusual for the health risks of exercise to be greater than the benefits, but if you have any health concerns about your programme you should make sure you discuss them first with an exercise professional or sports therapist.

From your health records I note that you have the following recent health issues which need to be considered when you plan your programme. Please note that a full analysis of all the health records we hold has not been undertaken and this list is not exhaustive.

..... (eg diabetes mellitus)

..... (eg hypertension)

..... (eg osteoporosis)

Your most recent blood pressure recording was/ on/...../.....

If you are on any medication you should let the exercise professional advising you know what you take

As this is a private service you can charge a fee for such a letter

Travelling costs

Occasionally GPs are asked to travel outside their practice area to complete the Part B cremation form.. The cremation fee offered excludes travel, so if the deceased has been removed to another area before you have had a chance to examine the body and make arrangements for another doctor to complete Part C, then you can charge for travelling. Two professional bodies for funeral directors (SAIF and NAFD) have agreed to the BMA Fees Guide which currently sets mileage at 56.4p, if the undertaker in question is not a member of either you should negotiate your rate before attending.

Some doctors ask that the body be returned to a convenient place for examination. The LMC feels that this should be either a mortuary or the premises of a local funeral director

This is a private service, and you may decline to provide it and although this is not a course of action we would generally suggest, the estate is then left with the options of either arranging a burial or arranging a private post mortem through the crematorium medical referee in the area where cremation is to be carried out.

“Fixion” intramedullary nail

This is a device rarely used in the UK (but a bit more often in some other European countries), generally for fixing humeral fractures. The problem is that for some reason it has a 70bar internal pressure, and one has exploded inside a cremator. You may be asked in future to sign that a patient does not have one, which may be difficult if they have had an internal fixation whilst abroad on holiday. Clearly these are not going to be easy devices to remove!

Referral of Children requiring surgical assessment to T&S

We have been asked to let you know that for a trial period from February to August children up to 16 (and 16-17 if appropriate) who require surgical admission to MPH should be admitted via the *paediatric SHO* and not the surgical team. If you want to discuss a case or seek advice, then contact the surgical registrar as usual

Small Ads Small Ads Small Ads.....

Staff Grade in Old Age Psychiatry – Taunton

A flexible 5 session job in the old age community/liaison team, this would suit someone either wanting a bit of a career change or someone who wanted a pleasant job with quite a lot of autonomy but also with supervision. The job would involve taking mainly referrals from the CMHT for medication advice/ confirming diagnosis/ helping in emergency assessment of patients at home , in residential units and at MPH. At least 6months psychiatric SHO experience required.

For details ,contact Dr Kolowski's Secretary on 01823 284940

Conference on Children’s Services

“ Delivering Early Intervention: Implementing the Vision”

Weds 4th May 2005 at Westland Leisure Complex, Yeovil

A conference for staff and managers in local authorities, the NHS, and the voluntary sector who are involved in delivering services for children. It will look at effective early intervention, multi-agency working, raising awareness of issues arising out of recent legislation, and also discuss improving local practice.

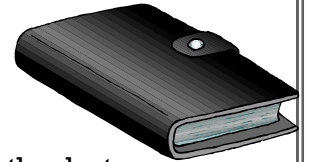
£ 25 including lunch. Details from: Theresa.Raison@dsha.nhs.uk

Jennifer's Journal

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Jennifer is disappointed that 'choose and book' is unlikely to make it to her surgery. Can you imagine the feeling of power as you spend £53,000 of Government money on every appointment made. Such fun to spend so much money on a few strokes of the keyboard instead of the irritation of penny-pinching prescribing.

I wanted to adopt the scheme, but with a little alteration; not 'choose **and** book' but 'choose **a** book'. Now that would be fun, helping patients to find the right novel for themselves. We could issue them on prescription and instead of drugs, the pharmacy would dispense books. If feeling unwell, first trip should be to the library for an over-the-counter popular paperback. If no better in a few days, see your GP and get a script for a mighty tome. We could set up book club self-help groups. This could be the start of a literary revolution- imagine how interesting medical school would be. And the potential for corny jokes: Great Expectations for the pregnant, etc..... but I digress.



Jennifer thought it would be nice to celebrate 'Choose and Book' in verse. Many thanks to her friend Fanny for the second offering'

'Now focus Mrs. Jones, for you have to make a choice:

Do you want the local mini or an elegant Rolls Royce?'

'I'm sorry If I'm slow to chose and cannot make a pick

But thinking straight is tricky when so desperately sick.

The family might join me on a European flight

But I'd like to take the nearest if you think they are alright.'

'Good decision, Mrs Jones and I'll check it with your daughter

But the nearest is the best when you've ruptured yer aorta!'

I was offered by my doctor

A chance to 'choose and book'.

He said 'it's on computer,

So let's both take a look:

It seems there's choice a-plenty

If you don't mind going far'.

'Well that's no good', I answered

'I haven't got a car!'

He didn't seem to hear me;

Just kept looking at his screen.

'Now this one looks superb' he cried

'Have you been to Aberdeen?'

'Perhaps you'd rather pick the chap

Who's going to wield the knife.

Would you rather he was young and green

- or later on in life?

I can offer you a team from France,

A hospital that's new,

Or a centre full of students...

It's really up to you!'

By now my head was in my hands.

'Doc, is this scheme a must?

'Cos all I need is the local place

And a man you know and trust'

Jennifer