Somerset LMC Newsletter

July 2012

Issue 175

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PRACTICES, FEDERATIONS AND THE SOMERSET CCG

Although there is still much detail to be filled in, the configuration of the new NHS is now becoming clearer. The exact configuration and responsibilities of our Commissioning Support Organisation and the Local Area Team of the National Commissioning Board are still evolving, but the commissioning structures for Somerset are now much clearer and our relationships will primarily be towards the North.

For the enormous effort already to get us this far to prove worthwhile and to produce tangible improvements in patient care, we must all accept the two fundamental tenets of clinical commissioning. First, that every decision a clinician makes has a cost consequence that has to be set against the expected benefit, and secondly that everyone in the NHS knows at least one way in which the service could be made a little better and should contribute that knowledge to the decision making process.

That in turn means there must be an easy way in which ideas and suggestions can be fed up to commissioners, and the consequent changes and improvements reported back down. It is absolutely essential to success that communication is simple, effective and timely.

The CCG will be responsible for something like £700M of public money each year and of course must therefore have a formal structure with proper accountability and all the necessary bureaucratic support that goes with it. As members of the CCG, practices will be part of this and their role in the CCG is defined in its constitution. You will shortly be sent a copy of this, and although the LMC has been involved in the drafting and we are confident that it is fit for purpose, we do urge that someone in the practice finds the time to read at least the main document, although you may prefer to take the appendices as a given!

At the time it was proposed, the Somerset model of a large CCG with semi-autonomous geographical GP commissioning federations was unusual, but a growing number of commissioning groups are adopting it. In parallel with drafting the constitution, a lot of effort has gone into preparing a "memorandum of understanding" that identifies the purpose and function of commissioning federations, as well as the arrangements for funding their work. The LMC has also been closely involved in the preparation of this, and we believe it clearly states what is expected of all the parties whilst avoiding laying any unreasonable obligations on practices or commissioning federations.

It may seem that all the CCG has done so far is produce reams of paper, but all this work has a purpose and has to be done before we can start clinical commissioning in earnest. The CCG Governing Body is made up of a strong team of experienced NHS managers, a good selection of GP commissioners and some wise non-NHS representatives. We wish them well in their task of continuous improvement to the NHS in Somerset. Balancing the need for innovation and pathway changes with the need to control costs in the current climate will not be easy, but with the support of practices and the traditional good working relationships in the county, we believe that it can be done.

SALARIED AND RETAINED DOCTORS END OF YEAR RETURN TO NHS PENSIONS AGENCY

Please note that this is a legal requirement

For GPs who are *not* named contract providers ("Type 1 practitioners" in Pension Agency code) but who work in practices as salaried doctors, retainers or the Flexible Careers Scheme ("Type 2 practitioners") there is an obligation to provide an annual return of all your NHS pensionable income to the NHSPA. This is so that each Type 2 can be allocated into the correct contribution band. If you are working exclusively in one practice it may be that the practice accountant has been submitting this form for you, but in any case you should check to make sure it is being done.

Please note that locum work is counted as a separate employment, and sessional doctors will already be reporting their income using Forms A&B.

The revised form for 2011/12 can be found at http://www.nhsbsa.nhs.uk/2668.aspx (scroll down to the line "2011/2012 Type 2 Medical Practitioner Self Assessment of Tiered Contributions" and should be returned to Patient and Practitioner Services at the PCT.

REQUESTS FOR MEDICAL INFORMATION IN SUPPORT OF HOUSING APPLICATIONS

We have covered this perennial problem in previous Newsletters (see No 149 April 2009) and remind readers that providing this information is not part of the GMS contract and therefore may be charged for, although as most people in need of such letters are by definition disadvantaged, that will often not feel appropriate. This article offers little more of the legal background, and if you are wishing to know more an expanded version is available on the LMC website.

When a person who is homeless or threatened with homelessness applies to the local authority for re-housing a panel will decide whether the person is vulnerable and therefore in priority need under the terms of the Housing Acts.

The definition of vulnerability has proved contentious and has been considered in various legal actions, and several judgements have drawn attention to the quality of the medical evidence used by local authority to decide vulnerability. Case law suggests that "*vulnerable...means less able to fend for oneself so that injury or detriment will result when a less vulnerable [person] will be able to cope without harmful effects."* And in this context *"The vulnerability to be considered is vulnerability loosely in housing terms or in the context of housing*" and "*is to be assessed by comparison with the average homeless person."*

Judges seem to have been far more liberal in their definition of vulnerability than housing authorities and personal knowledge and examination of the person who is homeless or threatened with homelessness has been particularly valued by judges who have advised local authorities not to give equal weight to the opinions of doctors who have not examined the person. In other words, what a GP says about a patient he or she knows well does carry weight if the matter ever gets to court.

YOUNG SUDDEN CARDIAC DEATH

Refer all first degree relatives for cardiological assessment

The story of Fabrice Muamba made national news for several days and raised the profile of cardiac arrests in young people. Young sudden cardiac death is an umbrella term used for the many different causes of cardiac arrest in young people, cardiomyopathies, ion channelopathies, myocarditis, coronary artery abnormalities and Wolff Parkinson White syndrome.

Although not common (approximately 12 deaths per week in the UK) it can be devastating for the families who believed their child to be fit and healthy. It is recommended that all first degree relatives should be referred by their GP to a cardiologist where there have been young sudden deaths in a family. GPs should also consider referral to a cardiologist when a young person presents with exercise related chest pain, breathlessness, palpitations, dizziness or fainting.

Cardiac Risk in the Young (CRY) is a charity that offers support for young people and families affected by young sudden cardiac death. See www.c-r-y.org.uk.

REDUCING THE RISK OF HARM FROM BOWEL CLEANSING SOLUTIONS

Now policy in all Somerset Providers

In February 2009 the National Patient Safety Agency issued a Rapid Response Report (NPSA/2009/RRR012) on reducing the risk of harm from oral bowel cleaning solutions. The report noted that death and harm from electrolyte abnormalities, dehydration and serious gastro-intestinal problems have been reported following the inappropriate use of oral bowel cleansing solutions such as Picolax, Citramag, Fleet Phospho-Soda, Klean Prep, and Moviprep prior to surgery and/or investigative procedures. Frail and debilitated elderly patients, children and those with the listed contraindications are particularly at risk. Bowel cleansing products in patients with renal or heart failure can cause significant problems with electrolyte imbalance, so please remember that whenever you refer patients for barium enema or an investigation that is likely to require bowel cleansing, you should check that he or she is suitable to have one of these agents, and make sure there is a recent creatinine and electrolytes result available.

TRANSFER OF PAPER NOTES AND CONFIDENTIALITY

As the size of patient records continues to rise exponentially with the constant accretion of clinical system printouts the old paper Lloyd George envelopes are frequently not up to the job, so everything gets bundled together in rubber bands. This has led to two problems. First, bits and pieces get detached from the package and mislaid, so please try to make sure all the paper is inside one of the gusseted envelopes, even if you have to use lots of them. Secondly, when folding printouts try to do so with the printed side inwards. Although it is tempting to put the patient information facing out, summaries may contain sensitive information as well as the simple demographics and should therefore not be exposed.

OUTPATIENT PRESCRIBING

We have been asked to clarify that whilst a practice can take up to 10 days to issue a prescription if requested to do so after a patient is seen in outpatients, it is obviously good practice to do so as soon as you conveniently can. The distinction is really between urgent treatment – which the hospital doctor should prescribe – and routine and long term medication which is the responsibility of the practice.

BORING MEETING? YOU NEED JARGON SCRABBLE

Time to move on from Buzzword Bingo

Many of us have passed time at a tedious management meeting with a discreet list of current NHS buzzwords that can be surreptitiously ticked off as they crop up. The winner can either leap to his feet and shout "BINGO!" when the last on his list is reached, or, more subtly, make a little note of the time this happens to compare with other players after the meeting.

We are now proud to introduce a new game, but one that has participants hanging on every word spoken. Jargon Scrabble is simple, but requires concentration. Every jargon word is scored by the following normal word, using normal scrabble letter values. So, if the speaker says "stakeholder vote" the score will be four for "v" and one each for "o", "t" an "e" making a total of 7. Double and triple word scores are triggered by two and three consecutive jargon words respectively. Thus "ongoing stakeholder vote" scores 14 whilst "ongoing robust stakeholder vote" gets 21.

We would be interested to hear your high score examples, and should you ever find yourself in a dispute about whether a word counts as jargon the LMC Assistant Medical Secretary will doubtless be happy to give a definitive opinion.

TEXTING PATIENTS

Although most of us will be used to getting text reminders of appointments with a dentist or optometrist, it is not clear that practices can start to send text message reminders of any kind to patients without getting their specific informed consent to use this medium. There seems to be no authoritative national guidance on this matter, so the LMC has written to the Information Commissioner for advice although this is likely to take some time to arrive. In the meantime we suggest that practices should continue to be cautious in the use of text messages to patients unless formal consent has been obtained.

SUIs, SEAs AND RCA

What on earth do these mean and why are they relevant to GPs?

As GPs we are increasingly being asked to be reflective practitioners and demonstrate that we are constantly learning from what we do. Much of the revalidation process will require doctors to demonstrate this. SEA (significant event analysis) forms an important part of both individual doctors' appraisals and clinical governance within practices.

Significant events in general practice are those events which give the individual practitioner an opportunity to review the way he or she works, and to reflect, learn and improve on the way care is provided. Such events can be episodes when things have gone wrong, or when they have gone well. Equally they can be unexpected outcomes or a review of information obtained from routine data collection in areas such as prescribing, referrals, new cancer diagnoses. SEAs should be discussed in the practice at a designated significant event meeting held in line with NPSA and relevant learning should be shared. For an individual GP this will be at his or her next appraisal, if concerning practice systems they should prompt a system review, and if relevant to other practices or organisations they should be shared through the PCT SEA reporting process.

SUIs (serious untoward incidents) are when things go wrong and patients suffer significantly as a consequence. SUIs should be reported to the PCT patient safety team promptly so that they can be investigated, and all the contributing factors identified. Examples of incidents which should be reported to the team include deaths on surgery premises or unexpected deaths that occur shortly after visits, complaints which allege assault by a medical practitioner (either physical or sexual), death or near death of a patient in which the actions of a health professional or equipment or premises may have contributed, including prescribing errors, faulty equipment, delays in diagnosis etc. It is important that SUI investigation is not seen as a way of apportioning blame, but more a way to identify system problems which can be addressed to prevent further incidents.

RCA (root cause analysis) is a method used to identify all the factors contributing to an SEA or SUI. It is well known that when things go wrong it is rarely only one thing that causes the problem, and RCA helps identify all the potentially modifiable elements, including patient, clinician and physical factors (premises and equipment), as well as systems within the practice, IT, other local health service factors and wider NHS contributors. So, if an abnormal blood test that has not been acted on, it would be simple just to say "Dr X must remember to look at results properly in future", but using RCA this SEA can be looked at in much closer detail. Did the patient understand the importance of the test, were they available to get the result? Did the requesting GP ensure the result would be seen and acted upon? Did the GP looking at the result have enough knowledge and time to act on the result? Does the practice have a reliable system for dealing with test results and was this used? Are there enough computers for GPs to be able to check results and phone lines to contact patients, are there enough computers for GPs to access results? How are test results received and was there an IT problem? Is there a local policy on treating the condition in question, or is there relevant NICE guidance which affects this result? Once all the possible elements have been identified they can be looked at in more detail by using a process called the "serial whys": you keep asking "why?" until you can go no further. In our example we might have discovered that the GP receiving the result had filed the result without acting upon it. But why did the Dr not action the result? *Because he was rushing to finish at the end of the day*. Why has he rushed? *Because his surgery had been particularly busy*. Why was this? *Because it was the day after a bank holiday*. So the way to prevent this from happening again could be to ensure the practice had extra appointments immediately after public holidays!

Dr Kate Staveley, Patient Safety Lead GP

LETTER TO THE EDITOR

Dear Editor

Somerset Patient Safety and Quality Programme

Working through the CQC guidance has highlighted to me just how big a contribution the PSQP has made in preparing practices for CQC registration. In many registration areas we have found much of the groundwork has already been done because of our participation in the PSQP. I am sure the same will apply to other new requirements – such as revalidation and so on. We would therefore like to use your columns to thank Karen Beckett and Dr Lindsay Smith for their hard work and foresight.

Yours

Rachel Stark, Practice Manager, East Quay Medical Centre.

SMALL ADS..... SMALL ADS .....

GP PARTNER: SUMMERVALE MEDICAL CENTRE, ILMINSTER

Details: 6 sessions per week from required 1st October 2012 (salaried GP considered).

Contact: Applications in writing with CV to Susan Harris, Practice Manager, Summervale Medical Centre, Wharf Lane, Ilminster, TA19 0DT or susan.harris@summervaleilm.nhs.uk. To arrange an informal visit/for further information please email or ring 01460 52354.

GP PARTNER/SALARIED GP: HENDFORD LODGE MEDICAL CENTRE, YEOVIL

Details: Interesting partnership seeks interesting GPs!

Contact: For an informal discussion please contact Sian Brammer, Practice Manager, Hendford Lodge Medical Centre, 74 Hendford, Yeovil BA20 1UJ. Telephone 01935 470200 or email sian.brammer@hendfordlodgemc.nhs.uk.

GP PARTNER: PRESTON GROVE MEDICAL CENTRE, YEOVIL

Details: 6/8 sessions per week, start date negotiable.

Contact: For an informal chat/visit please ring Karen Lashly, Practice Manager Partner on 01935 474353. CV to Preston Grove Medical Centre, Yeovil, BA20 2BQ or email Karen.lashly@prestongrovemc.nhs.uk. www.prestongrovemedicalcentre.co.uk. Closing date Friday 24th August 2012.

PART TIME PARTNER: COLLEGE WAY SURGERY, TAUNTON

Details: 4 sessions plus 2 fixed profit share sessions per week from March 2013.

Contact: For informal enquiries contact John Parkinson, Practice Manager, College Way Surgery, Taunton TA1 4TY. Telephone 01823 259331 or email john.parkinson@collegewaysurgery.nhs.uk. Applications in writing please with covering letter and current CV.

SALARIED GP: OKEHAMPTON MEDICAL CENTRE, DEVON

Details: 8-10 sessions per week, 4 sessions sharing a list with current partner. 4-6 sessions running acute clinic in the morning and 16 bedded Community Hospital in the afternoon. This could be one position or two for an initial 12 month contract to commence on 1st October 2012 (possibility to start earlier if mutually convenient).

Contact: Apply in writing with detailed CV to Alison Shelton, Practice Manager, Okehampton Medical Centre, East Street, Okehampton EX20 1AY or email Alison.shelton@nhs.net. To arrange an informal visit/for further information please call Alison Shelton on 01837 52233. Closing date 24th August 2012.

CLUB DOCTOR: YEOVIL TOWN FC

Details: Yeovil Town FC is looking for a new club doctor to work in conjunction/rotating basis with the existing club doctor Christoph Kollmeier to provide medical care for the players during home matches and occasionally during the week. An interest in sports medicine would be useful but not essential. Registrars welcome. Closing date 31st July 2012.

Contact: For further information contact Christoph.kollmeier@langportsurgery.nhs.uk or mobile 07952 964336.

PART TIME PRACTICE NURSE— MARTOCK & SOUTH PETHERTON

Details: Two experienced part time nurses required, hours by negotiation.

Contact: Please apply with CV and covering letter to Karen Harley, Business Manager, Church Street Surgery, Church Street, Martock, Somerset TA12 6JL. For an informal chat about the post please contact Hazel on 01935 822541. Closing date 13th August 2012 with interviews 24th August 2012.

DR WHIMSY'S CASEBOOK: QUALITY CARE

Dr W: Well, Mrs Prolapse, I need to examine you now.

Mrs P: That's fine, doctor, you go right ahead.

Dr W: First I have to get your consent.

Mrs P: I consent, doctor. Let's get on with it.

Dr W: You have to sign your consent.

Mrs P: Never had to do that before, and I've known you for years. Just do your job, doctor.

Dr W: New rules, I'm afraid. This form is to say you understand why I have to examine you, this one's to say you agree to the examination, and these three are to say that I haven't discriminated against you on the grounds of gender, musical taste or circumference.

Mrs P: OK, where do I sign?

Dr W: Not so fast, Mrs Prolapse. I have to get the practice solicitor to witness it.

Mrs P: Why?

Dr W: So you can't say I coerced you into acquiescence to intemperate acts of gross moral impropriety.

Mrs P: Uhh? Look, I've always trusted you, doctor, and if you were going to do something improper I think it would have been in the days before I had five children and several years of pie and chips.

Dr W: Not even then, Mrs Prolapse. You know that, and I know that, but those highly experienced and thoughtful people in their offices at the Quality Monitoring Board don't. [Presses intercom button] Please send the solicitor to my room.

Receptionist: She's witnessing a sick note for Dr Prune.

Dr W: Well, send her in as soon as you can. And a lay observer, please.

Receptionist: Certainly, doctor Whimsy.

Mrs P: A lay observer?

Dr W: Yes, our solicitor is paid by us, so to avoid any suspicion of collusion we need an independent person to supervise her. The receptionist will pluck somebody out of the waiting room.

Mrs P: But I just want you to get on and deal with my problem.

Dr W: Be patient, Mrs Prolapse. We have to find a chaperone yet. Read this poster please.

Mrs P: Doctor, I haven't got me specs, and I don't want to waste time. You have my consent and I don't need a chaperone.

Dr W: We can never be too careful these days, so bear with me. [Presses intercom button] Please send the chaperone nurse to my room.

Receptionist: She's helping Dr Bernout with a hernia examination at the moment.

Dr W: Do we have any other trained chaperones?

Receptionist: Not today, doctor.

Dr W: Well, please send a practice nurse, and a Health Care Assistant to supervise her.

Receptionist: I'll ask them to stop what they're doing right now, doctor Whimsy.

Mrs P: Can't you trust me, doc? This is taking forever.

Dr W: Not long now. Once your consent is signed, countersigned, witnessed, checked, ratified, stamped, scanned, photocopied, filed and sent to the QMB, PCT and GMC we're almost done. [The nurse and HCA arrive]

Dr W: Ah, thanks for coming, but I'm afraid we haven't obtained consent yet.

Nurse: That's OK. Dr Bugroff is waiting to do a breast check so we'll go and help her. [They depart] [The solicitor arrives with a lay person]

Mrs P: [to the layman] Hello, love.

Solicitor: Do I take it you know this person?

Mrs P: 'Course I do. He's me 'usband.

Solicitor: I'm afraid he's not independent. [Presses intercom button] Another lay observer please.

Receptionist: That shouldn't be difficult – the punters are queuing round the block now.

[The nurse and HCA return]

Dr W: Hello again, ladies. Bit of a mix-up, and I'm afraid we're not ready with the consent yet.

Nurse: No problem. Dr Strewth needs us for an eye examination. Back in a moment. [They depart] [Another lay observer arrives and consent is obtained]

Mrs P: Can we get on with it now, doctor? It's a warm day and I've got a haddock going off in the car.

Dr W: Any minute now, Mrs Prolapse. We just have to wait for the nurses to come back.

[The nurse and HCA squeeze back into the room]

Dr W: OK, everybody. Are you ready Mrs Prolapse?

Mrs P: I've been ready for half an hour.

Dr W: Solicitor?

Mr G: We're consented and clear to go.

Dr W: Layman?

Layman: Everything in order, sir.

Dr W: Nurse?

Nurse: Ready when you are.

Dr W: HCA – where are you?

HCA: I'm at the back behind Mr Prolapse. Go ahead.

Dr W: OK, Mrs Prolapse, let's have a look at this ankle of yours. By the way, did you book a 40 minute appointment for this?

Mrs P: I thought it would take five minutes.

Dr W: Oh dear, I'm afraid we don't have enough time. Please make another appointment. Bye everyone.

This column is written for humour and does not necessarily reflect the views of the author, his or her practice, or the LMC.

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