Somerset LMC Newsletter

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PROTECTING PATIENTS AND THEIR DOCTORS

My last patient in morning surgery was a 14 year old lad who had been sent along by his mum with a sore throat. She was herself poorly at home so she had rung to ask if he could come on his own. He turned out to have quite a nasty tonsillitis with a high fever, and when I was sending him off to get his penicillin I saw it was pouring with rain. Being a 14 year old, he had, of course, come out with no coat. No problem, I thought, as I rang his mum, I can run him home on my way to my first visit. She was grateful for the offer, so all seemed straightforward. I duly went out to ask the receptionist to let me know when he came back so I could get my car, but she looked a bit anxious: they were short staffed and it was going to need a bit of juggling to release someone to go with me. In her mind there was no question of my having a child in a car on my own.

She was, of course, entirely right. For better or worse clinicians now need to ensure that there is no way in which an allegation of improper behaviour can be made, and the key to that is avoiding the risk whenever possible. We know that most GPs behave with scrupulous professionalism and most patients understand this and are grateful for it, but there will always be some doctors who abuse positions of trust and authority, and some patients who misunderstand clinical procedures or, occasionally, deliberately make false accusations.

And without evidence that you have followed the right protocol it as all too easy for a presumption of guilt to be made - unless the presence and identity of a trained chaperone is documented for every intimate procedure the doctor will always be at risk. Despite following your policy to the letter patients may make allegations about any consultation, whether or not an examination was performed. But we must all get into the habit of assessing the risk and erring on the side of caution. And we will all be a little different. Male GPs will probably be happy to do a rectal examination for an older man with prostate disease without a chaperone, but what about a 17 year old with lower GI tract symptoms? And what about a woman GP in the same position?

If you have known a patient for 20 years, you may well feel neither of you need a chaperone present, but there is never any harm in offering one, and then documenting the almost inevitable refusal – though some patients will always feel more comfortable with someone else present for an intimate examination. There will be times when you would be unwise to proceed without one, for example if the patient is vulnerable , perhaps because she or he is young, learning disabled, not known to you, or has a history of emotional disturbance or abuse. In such cases the wise doctor will insist on having a chaperone present, and wherever possible she should be a trained nurse, experienced in the role, who observes you perform the examination.

There will very occasionally be circumstances when you need to perform an examination without help, or at the patient's home - one of most unwell women I have ever seen had cervical shock that was dramatically relieved by removing the abortus from her cervix - but this should only be in such potentially very serious circumstances, and if all your antennae are buzzing a warning *do not* undertake an intimate examination on your own, wherever you may be. Summon help, bring the patient back to the surgery later when you have a nurse available, or even arrange an urgent hospital assessment, but do not put yourself at risk because it seems quicker and easier just to go ahead.

The PCT and the LMC are working on local guidance based on recent national

recommendations for the use of chaperones, we hope you will read and implement it, but the key messages are to *think* about the risk, *offer* a chaperone, and *record* the outcome. Tiresome as it may seem, the risks of not doing so are just not worth taking.

And the 14 year old? There happened to be a medical student attached to the midwife who was prepared to have her lunch disturbed to come with me!

COUNCIL TAX – SEVERE MENTAL IMPAIRMENT

Clarification on Eligibility

It has apparently been suggested elsewhere in the UK that that patients apply for council tax exemption on the grounds of mental health impairment because of drug abuse or schizophrenia. Glasgow LMC obtained this guidance on the matter:

"*The Regulations state that to qualify for this discount the condition should be 'a severe impairment of intelligence AND social functioning (however caused) which appears to be permanent'. This includes people who are severely mentally impaired as a result of:*

- *Degenerative brain disorder (e.g. Alzheimer's disease)*
- *A stroke*
- *Other forms of dementia*

An argument might be made for a patient with chronic schizophrenia whose condition left them impaired but it is doubtful the same can apply to drug addicts (who may come clean) or schizophrenic patients whose condition is being controlled by medication."

Patients with severe learning disability are obviously also eligible.

DISCHARGE MEDICATION – MINIMUM QUANTITIES

When patients are admitted to hospital they should normally take their own medication with them, and ideally this will be used during their hospital stay. Where a patient has a longer stay or medication is changed, inpatient treatment will start with a new 28 or 30 day pack, and when the patient is discharged this will come with them. The Trusts' contract with the PCT specifies that not less than14 days of medication should be supplied at discharge so if there is less than 2 weeks worth left in the pack a new one should be issued as well, meaning the maximum duration will be 42 days. Do let us or Medicines Management at the PCT know if you are having problems with patients not having enough medication on discharge.

ADVANCE CARE PLANNING TRAINING FOR GPS

The DH End of Life Care Strategy identifies Advance Care Planning (ACP) as important in the provision of end of life care. In Somerset the PCT has commissioned education and training for practices on ACP from St Margaret's Somerset Hospice and Dorothy House Hospice Care. GP updates will be offered in practices by Community Palliative Care Nurse Specialist (CPCNS) and will cover the 'Planning Ahead' documentation and ACP policy as well as answering questions about the ACP process. Part of the objective is to ensure practice and Somerset Community Health (SCH) staff can look after patients with less complex needs. The nurse specialists linked to each practice will liaise directly with practice managers to arrange a convenient time for the update.

There is a more formal ACP course, primarily directed at registered practitioners working for SCH intended to increase knowledge and understanding of the process of ACP, the documentation involved and to explore how conversations with patients can be initiated. The course consists of a one day workshop and a half day reflection session to explore participants' experiences of putting their learning into practice. More details at: www.somerset.nhs.uk/training

IS YOUR SELF EMPLOYED LOCUM REALLY AN EMPLOYEE?

Take care to get this right!

There are two financial hazards for practices employing regular locums – the NHS pension scheme and HMRC. In NHS pension terms GP Locum work is short-term deputising work. Fee based GP work over a longer period is regarded (under the statutory NHS Pension Scheme Regulations) as type 2 Practitioner work with the Practice/APMS Contractor responsible for paying employer contributions. So, if you use a specific locum on a regular basis – say, one or two sessions a week - this may constitute employment so far as the scheme is concerned, and the practice not the PCT is responsible for paying the employee contributions.

If your locum is deemed to be an employee there are also tax and National Insurance implications, so the costs of getting this wrong can be considerable. HMRC have a useful online tool that allows you to determine whether someone is self employed or an employee: http://www.hmrc.gov.uk/calcs/esi.htm.

SURGERY NETWORK FOR PRACTICES

An ingenious ordering and stock control system that should pay for itself

This clever system was originally developed by Rob Legge to help large companies manage their purchasing, and he has now developed it into a system for GP practice use. He has over 100 practices who are members of the network and a couple in Somerset have been trialling it with considerable success.

The basic system is for ordering and stock control. It is web based and each practice builds a list of common purchases – domestic items, clinical consumables, drug stock and so on. Once set up all ordering can be done with a few clicks and so it no longer has to be done by a senior staff member – ours is done by an HCA. All the orders are processed electronically and logged securely on the system. SNfP has negotiated some very good deals with their 15 preferred providers (others can be added to the system) and they also ensure that products are of good quality.

This may all sound pretty routine, but there are several very clever features that make SNfP stand out. If another provider is offering the same of a similar product at a better price this is displayed on your order list, and a couple of clicks shows you the alternative item in more detail. Members can add comments about products as well. You can plot your buying costs over the year, and also compare your practice with others of a similar size and structure as well as see how much you can save by switching to another supplier. The system can be used for credit control to check against supplier invoice errors (which are surprisingly common), and as well as having an inventory function it allows the practice to do things like reconcile FP34 claims very easily. A real plus is that ordering is supported by a dedicated buyer who has developed a very good relationship with suppliers ensuring any problems are quickly addressed. In essence the system eliminates just about all of the problems of ordering and stock control, and as a bonus SNfP are now working with the RCGP to help practices become greener by using eco-friendly products and minimising delivery miles.

There is a joining fee to cover set up and training costs, but if you have not had "Train for Gain" funding in the practice this will cover it. The monthly cost depends on practice size, but for my practice the savings more than cover this, so the efficiency, security and quality benefits are all on top of that.

SNfP is well worth a look and we hope to introduce it at practice manager forum meetings across the county, but if you want more information now contact Rob Legge on 01722 789207 or legge@surgerynetwork.org.

SMALL ADS SMALL ADS SMALL ADS .....

SALARIED GP: WINCANTON HEALTH CENTRE

Starting from May 2010. Friendly, four partner, 7,900 patient, GMS practice in market town of Wincanton. New premises planned for April 2011. Eight sessions required but happy to consider part time combinations. Salary negotiable according to experience. Informal visits welcome. Please contact Janet Loe on 01963 435703 or email janet.loe@wincantonhc.nhs.uk. Visit our website at www.wincantonhealth.co.uk for more details.

SALARIED GP: SOMERTON SURGERY

Six sessions available from June 2010 in Somerton Surgery, an urban/rural PMS EMIS 5500 patient practice. Somerton is part of a small but dynamic 2 surgery Group and a new surgery has been funded. Applications or informal contact: Len Chapman, 01935 470816, len.chapman@pennhillsurgery.nhs.uk by 16 April.

MEDICAL RECEPTIONIST/SECRETARY: MILLBROOK SURGERY, CASTLE CARY

Required to join our friendly team, 15 hours per week. Computer skills are essential. Please apply by sending or emailing your CV with covering letter to Mrs Sue Hamlin (Practice Manager) Millbrook Surgery, Millbrook Gardens, Castle Cary BA7 7EE sue.hamlin@castlecarysurgery.nhs.uk.

SOUTH WEST REGIONAL BARIATRIC STUDY DAY

Friday 16 April 2010 at 0900-1530 at the Lecture Theatre, Musgrove Park Academy, Musgrove Park Hospital, Taunton. For further information contact Yasmin Ferguson, Bariatric Clinical Nurse Specialist, Musgrove Park Hospital 01823 343561 or to book contact the Learning & Development Department 01823 342228.

SOUTH WESTERN AMBULANCE SERVICE

South Western Ambulance NHS Trust are now recruiting GPs and have opportunities throughout Somerset & Dorset. We offer suitable and well-paid work to fit in with your availability and commitments. Call to find out more on 01202 851312 Monday-Friday between 9am-5pm and ask for Iain or Katie.

DR WHIMSY'S CASEBOOK

It is night. Deep in Megamedicopolis Health Care Delivery Centre even the surgical robots are asleep, but in a silent consulting room lit by a guttering candle, there is the faint scratching of pen on paper: Dr Whimsy is writing up his casebook from the day's video consultations.

QOF: A User's Guide. No.82 - Depression

GP: Come in, Mr Troutfence. My, you look as if you've been crying.
Mr T: Yes, doctor, that's what I've come about. I feel so desperate.
GP: I'm sorry to hear that. *[Glances at computer screen]* Anyway, do you still smoke?
Mr T: I don't know what smoking's got to do with it, doctor, but I do smoke, yes.
GP: How many a day?
Mr T: I don't know, doctor. Everything seems so black…
GP: Twenty? Thirty?
Mr T: Oh, about twenty, I suppose. I've lost all my energy…
GP: Twenty. And do you know it's bad for you?
Mr T: To be honest, doctor, I don't care any m…
GP: You could get lung cancer, heart disease, diabetes, and you'll smell so bad Mrs Troutfence won't want to sleep with you.
Mr T: If you remember, doctor, Edith died three weeks ago.
GP: Oh, that's right. *[laughs]* Silly me. Now, what were you saying?
Mr T: I can't see the point of going on any more, doc…
GP: Ah, yes. Now then, Mr Troutfence: over the last two weeks, how often have you been bothered by having little interest or pleasure in doing things?
Mr T: Edith and I used to do everything together…
GP: Not at all? Several days? More than half the days? Nearly every day?
Mr T: I miss her all the time, I can't think of…
GP: Nearly every day, then. And over the last two weeks, how often have you been bothered by feeling down, depressed or hopeless? You know – yuck.
Mr T: Honestly, doc, sometimes I think of just ending it all.
GP: Is that: not at all, several days, more than half the days or nearly every day?
Mr T: I'm not sleeping at all, I haven't shaved for…
GP: We'll make that more than half the days. Over the last two weeks, how often have you been bothered by feeling bad about yourself, or that you are a failure or have let yourself or your family down?
Mr T: My family's been great, I don't know what I'd do without them, but…
GP: Is that: not at all, several days, more than half the days or nearly every day?
Mr T: I don't know, doc, I just need some help…
GP: *[a little testily]* OK, already – this won't take long if you'll just concentrate.
Mr T: Sorry, doc, I just can't seem to concentrate on anything, it all seems so hopeless…
GP: Have you been, you know, bobbing about more or less than usual?
Mr T: Bobbing about?
GP: Or watching the telly?
Mr T: Doc, forgive me. I just want to know – am I getting depressed?
GP: Dunno yet, we haven't finished the questionnaire. Tell you what, though…
Mr T: *[brightens]* What's that, doc?
GP: We've got to do this all over again in 5 weeks.

The views expressed in this column are those of the author and not necessarily those of the LMC.

GPC CONTRIBUTIONS - THE "VOLUNTARY LEVY": SOME GOOD NEWS

The LMC is getting a one-off rebate of 26% of the 2009 levy

You will know that the work of the GPC is funded by the GP Defence Fund that raises money from subscriptions paid by GPs as part of the LMC levy. Doctors can opt out of this if they wish, and in the past there have been a few Somerset GPs who did so, but at the moment every practice in the county pays the roughly 5 ½ pence per patient. Due to careful housekeeping and some changes in meeting arrangements to cut costs, the GPDF underspent in 2009 and is offering the LMC a rebate for the year that amounts to about £6500 for Somerset. We plan to hold this in reserve against future increases in the levy, and as a fighting fund should the need arise.

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