SOMERSET LMC

Newsletter

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CLINICAL INDEMNITY COVER – TIME FOR A CHANGE

Inside this issue

The decision by the Government to include in practice payments an element for the annual increase in indemnity costs is a welcome recognition that the cost of the cover that practising clinicians are required to have is a growing burden. The traditional model under which doctors paid a standard subscription, and other clinicians paid little or nothing because they were never wholly clinically responsible for patient management decisions, has broken down for all sorts of reasonsand although the extra annual cost of cover for GP partners may be met for now, that is only a temporary fix. New models of care mean that many professionals are sharing clinical responsibility, GPs and others are working in new ways and with wider populations, and patients are moving much more freely across traditional NHS boundaries. We are all aware that the Medical Defence Organisations have responded to that by making the extent and cost of cover much more complicated and role dependent, with some doctors facing considerable increases in the price of protection, and a few being unable to obtain cover at all.

The GP Indemnity Review published in July https://www.england.nhs.uk/wp-content/uploads/2016/07/gp-indemnity-rev-summary.pdf is a good and concise summary of the position, but it does not suggest a definite solution. Adopting good customer care principles, having sound internal protocols and dealing with complaints quickly and constructively all help reduce the risk of legal action, and in the end something will have to be done to control the compensation culture or it will consume not just the NHS but the entire public service. But we still need to devise a better way of indemnifying primary care as a whole rather than as separate providers or professionals.

The Academic Health Science Network has been discussing the idea of being a pilot site for the procurement of indemnity cover at a larger scale and to consider this further it has organised a South West Indemnity Insurance workshop with the NHS England National Team on 29 November 2016 at Exeter Racecourse which should be fascinating. You can register here.

This is not a simple matter as GPs will wish to continue to have occurrence rather than claims based cover, and the MDOs offer a range of services, such as representation at various panel and tribunals that go well beyond medical indemnity. We also must not risk destabilising the existing providers. But equally we need a system that is flexible enough to cope with the evolving new models of care as well as comprehensive enough to meet the need of individual clinicians, our patients, and the service as a whole.

For the right solution to be found the group working with the AHSN on this – which includes the LMCs - needs to know about your current indemnity arrangements. Practice managers have been asked, where possible, to reply on behalf of the partners and salaried GPs to the short survey just released, but we also need information from sessional doctors and other independent clinicians, so we ask for your help in encouraging all clinicians working in general practice make sure that their information is included in the survey here. It will be open until 21st October.

Even if we have no quick solutions, showing that we are tackling the problem will add to the growing body of evidence that in the South West in general, and Somerset in particular, the real needs of practices and GPs are being actively addressed and that this is a great place to live and work.

SMALL ADS… SMALL ADS… SMALL ADS...

For current practice vacancies please see the jobs section on our website at: **https://www.somersetlmc.co.uk/jobs/**

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GPS AND COMMUNITY PHARMACISTS: NATURAL BEDFELLOWS?

Once upon a time GPs would scribble a prescription that patient would take to the avuncular pharmacist in the Chemist's shop up the road. The man in his white coat would squint at the form, ask the patient what his symptoms were, and decide that the request for 2,000 penicillamine really meant 20 penicillin - which he would duly dispense to the satisfaction of all parties.

Nowadays, the gap between the corporate world of pharmacy chains with their 100 hour "outlets" and modern large practices is wide. Legible prescriptions drop into the pharmacists electronic in-tray via EPS, and direct conversations with GPs become ever rarer. Both professions are the worse for that.

Meanwhile, as the pressure of demand on general practice continues to rise and the GP workforce attenuates, both commissioners and providers are looking around for solutions. Pharmacy is the only healthcare profession with a workforce surplus (albeit mostly in cities with Schools of Pharmacy rather than rural counties), which means it is logical to turn to them for help. But what contribution can pharmacy make to front line GP work?

There are several possibilities. First, any pharmacist – whether or not she or he has had community pharmacy experience – should be able to undertake medicine use reviews and to report to prescribers on concordance and other medicines management problems. This may not provide immediate respite from the barrage of urgent demand, but we know patients who understand their medicines are more likely to take them and less likely to consult.

We are all familiar with the more experienced pharmacists working with the CCG and practices on medicines rationalisation and brand switches. Although the primary purpose is to save money, there is no doubt that concordance and outcomes are better when patients are supported through these changes by a knowledgeable professional.

Pharmacists may already take part in the Minor Ailments Scheme which is being recommissioned and extended by NHSE SW. Although the numbers are small these are patients that are taken out of the GP workstream, and any increase in that will be welcome.

However, the biggest gain will come from prescribing pharmacists who will not be able to provide a wider range of interventions as community pharmacists under the Scheme, but could also run chronic disease management clinics in practices with considerable effect.

The Local Pharmaceutical Network in the south West is already developing the most comprehensive post-graduate programme for pharmacy in the country, and the Community Education Provider Networks (ours is based on SGPET) should be able to gear up quickly to provide local training. We'd like to see pharmacy as a clinical profession reclaimed from the retailer sector and re-integrated as part of multi-professional primary care to help increase both recruitment and pharmacists' job satisfaction.

Our immediate challenge is, of course, 'flu immunisation. The LMC believes that introducing the competitive market was a wrong turning, and as health and social care services are moving towards collaboration and integration in just about every other respect, we are much more likely to make progress through a joint contract. Each party has something to bring to the table: we have the patient lists, and pharmacies have the footfall.

NHSE has indicated that it might be prepared to consider such a contract even at this late stage, and the LMC and LPC are discussing a potential local pilot designed to protect current income whilst incentivising collaboration to increasing immunisation uptake. It would good for both professions and our patients if we could make it work.

EAR WAX

Discussions underway with the CCG on the role of ear syringing

Ear syringing is one of the treatments provided by practices that patients really love. If you have ever had blocked ears yourself, you'll know why: it's quite a pleasant sensation and often spectacularly effective at restoring normal hearing.

However, It is not certain that the definition of essential services in the 2004 contract means that practices are obliged to provide this service, and with the relentless tide of unresourced work flowing out of secondary care - understandably, given the number of patients flowing into the hospital service – many practices are beginning to feel they have to stop providing free goods to ensure they can continue to offer safe core services.

Under the GMS contract practices are required to arrange a suitable consultation with patients presenting with symptoms such as a hearing problem, to undertake an appropriate examination if required, and then "to make available such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services….." The wording is important here. "Making available" is not the same as "providing", and the words "necessary" and "appropriate" add important qualifications.

That means patients with ear wax should be seen and advised to get, or occasionally have prescribed, some suitable wax solvent and given clear instruction about how long and how often to use them. As with any condition, If the patient re-attends because the problem is unresolved, the practice may offer further treatment or refer on to a suitable commissioned provider

One of the problems for practices is that providing ear irrigation has become increasingly complicated, although it is generally a safe procedure using modern equipment, and Propulse irrigators are relatively inexpensive, proper decontamination needs to be undertaken which adds to the nursing time needed for the actual treatment. When a practice is under real pressure it will have to prioritise treatments and understandably ear syringing has a low medical priority though hearing loss does have significant social consequences and increases accident risk. However, ear wax is a problem that is often amenable to self care and there are a number of inexpensive devices that patients can buy which may be useful

There are CCGs elsewhere in England that commission ear care as part of a "treatment room care" basket Enhanced Service, and others commission it from community services. The the LMC would like to reach asimilar agreement in Somerset. Whilst these discussions are underway we ask that practices that currently offer ear irrigation, if possible not to stop doing so. We think it is better for everyone if a shared plan can be agreed, so long as this is not too delayed.

Meanwhile, there is some good news: several practices have been in touch with the LMC about the disposal of decontamination fluid, and although the data sheet for the tablets used to make the fluid says they must be disposed of as hazardous waste this is not the case for the dilute solution which can be disposed of into the drains.

SGPET AND THE COMMUNITY EDUCATION PROVIDER NETWORK

Health education to support new models of care

CEPNS have been set up by Health Education England to strengthen arrangements for education and training for primary healthcare workers. Originally based on the "training hub" concept, their role has evolved into improving the capabilities and capacity of the workforce in primary and community care through education and training for individuals and teams that cuts across professional and organisational boundaries. So, for example, in the coming year the new Somerset CEPN will be commissioning and organising: multi-professional workshops on end of life care, education about long term conditions, frailty and dementia for HCAs in general practice, training for practice staff about "Releasing Time for Care" by improving system efficiency, d workshops help for GPs to develop skills in mentoring and supervising the new clinicians coming to work in primary care.

Somerset CEPN will work with all the relevant providers of education. In recognition of the role and experience of SGPET as the major provider of education activities for practice nurses and GPs in Somerset, the CEPN will be based at SGPET and will receive administrative and organisational help from it whilst SGPET remains an independent subscription– based provider for practices

The CEPN has a modest budget and is commissioning education rather than providing it so advertising, booking arrangements and charges for events will be the responsibility of the group actually putting on the meeting or course.

SGPET believes Somerset CEPN can use education as a real lever for change and to help the existing primary care and community care workforce feel more confident and capable, whilst helping develop the new style of workforce that we need to meets the demands and challenges that the NHS faces.

QUALITY IMPROVEMENT SAFEGUARDING AUDITS

Are you confident about your safeguarding process? And will the CQC agree?

If not, we can recommend the help available at modest cost from Care Focus, a locally based Community Interest Company providing training, tools and audit.

enquiries@carefocussw.co.uk 01823 274627

Dr Whimsy's Casebook: Risk Management

Bolam's test says that a doctor's action is not negligent if it is in accordance with practice accepted as proper by a responsible body of medical opinion. It was replaced in 2015 by the Montgomery test (http://tinyurl.com/Mx-risk).

14 Sept 10,000 BC – 20 March 2015 AD

Dr W: Hello, Mrs Dictum. What can I do for you today?

Mrs D: I think I've got tonsillitis, doctor.

Dr W: Let's have a look. Open wide please. Say 'Ah'.

Mrs D: Ahhhhh.

Dr W: Hmm. Can't see much. I need to hold your tongue down with this tongue depressor. Try again.

Mrs D: Ahhhhh.

Dr W: OK. Your tonsils are fine. It's a viral sore throat. A gargle or pastille should sooth it, and I'm sure it will get better soon. Come back if it doesn't.

Mrs D: Thanks, doc. Sorry to trouble you.

Dr W: No trouble at all, Mrs Dictum. It's given me time to fill in some more forms before my next patient.

21 March 2015 onwards

Dr W: Hello, Mrs Dictum. What can I do for you today?

Mrs D: I think I've got tonsillitis again, doctor.

Dr W: I need to take a look. The risk of doing so–

Mrs D: Ahhhhh–

Dr W: Mrs Dictum! What on Earth are you doing?

Mrs D: I'm saying Ah. You wanted to have a look.

Dr W: Of course, but not yet. We've got reams of stuff to get through first. Have you the slightest idea of the danger you're in?

Mrs D: Danger? What, opening my mouth? I've been doing it for 60 years to let food in and to shout at George, and I haven't come to any harm yet.

Dr W: You have been lucky, Mrs Dictum. The world is fraught with peril. For instance, if I ask you to open your mouth now, a blackbird might crash through my window, spear you in the mouth, and stab your spinal cord with its beak, leading to paralysis, pneumonia, and time off work.

Mrs D: What's the chance of that happening, doc?

Dr W: Let me look it up… ah, here we are, one in 84,000,000.

Mrs D: Not very likely then, doc, so why are we wasting time talking about it?

Dr W: Well, up to now I have used my own experience and judgement to assess the risks of performing – or not performing – examinations, investigations and treatments, and to warn you about significant hazards. Just like any reasonable doctor.

Mrs D: Sounds good. You know more about it than me, so leave out the chaff and give me the wheat.

Dr W: But it's all changed. Now I must guess what you would find significant, then let you decide whether to proceed. I don't know what your particular concerns are, so it's safest to tell you everything that could happen.

Mrs D: That includes the thing with the blackbird?

Dr W: Yup. It's unlikely, but it's possible, and if you've got a thing about blackbirds you could sue me if I hadn't warned you.

Mrs D: But it could happen at home, couldn't it?

Dr W: Indeed so, but then you'd no longer be under my care. You could be hit in the eye by the locking nut from a 1936 Bentley supercharger and you'll not get a penny out of me.

Mrs D: OK, doc, I accept the risk. Now, let's get–

Dr W: Not so fast, Mrs Dictum, I've hardly started. It's a good job we have 60 minute appointments now.

Mrs D: So what else could happen?

Dr W: Well, if you open your mouth too wide your jaw could dislocate and I'd have to reduce it, with the risk of fracture, damage to the facial nerve–

Mrs D: And the chance of that is…?

Dr W: Um… one in 34,000. Relatively common, really.

Mrs D: Listen, doc, I'll sign a waiver if you like, but I have to meet George at the chippy in a minute.

Dr W: OK, it's your call. Open wide. Hmm, can't see much. I need the tongue depressor, but it might snap and leave splinters in your tongue, or I could have a stroke, fall forwards, and stab your spinal–

Mrs D: Dr Whimsy.

Dr W: Yes?

Mrs D: Shut up and get on with it.

Dr W: As you wish. Sign here first, please. OK, your tonsils are fine. It's a simple viral infection. It should get better without treatment.

Mrs D: What do you mean, "should"?

Dr W: Very well, there's a 5% chance that it's a bacterial infection which might need treatment.

Mrs D: 5%? That's higher than the level of risk that made you start my cholestipol treatment.

Dr W: It's not really the same thing, Mrs Dictum.

Mrs D: Maybe not to you, but you say it's my choice now, and I want some antibolotics.

Dr W: Do you know they'll probably make no difference, but they could make you feel ill, and they might breed resistant organisms?

Mrs D: That's a risk I'm prepared to take.

Dr W: But an epidemic of untreatable bacteria could cause the extinction of human civilisation.

Mrs D: OK, what's the chance of my sore throat leading to the destruction of life on Earth as we know it?

Dr W: Umm…. one in a few hundred million?

Mrs D: So where's the harm? Give me my prescription and I'll be on my way.

Dr W: Well, let me check for bacteria with a swab first.

Mrs D: And stab my spinal cord with it? No chance.

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

Somerset Local Medical Committee, Crown Medical Centre, Venture Way, Taunton TA2 8QY

Tel No: 01823 331428 Fax No: 01823 338561 E-mail: lmcoffice@somersetlmc.nhs.uk

LMC Website: www.somersetlmc.co.uk