SOMERSET LMC

Newsletter

SUMMER 2018

Issue 210

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SMALL ADS… SMALL ADS… SMALL ADS...

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GP In Somerset

SOMERSET GP BOARD – PROVIDING A REPRESENTATIVE VOICE FOR THE "JOBBING GP"

Somerset GP Board (SGPB) was formed in 2017 to bring together the LMC, Somerset Primary Healthcare Ltd (SPH – the provider group owned by all Somerset practices), and some key individuals to give the developing Strategic Transformation Partnership (STP) a single organisation to provide a representative GP view on its plans, and to contribute to the planning of primary care services in the new world.

The membership is made up of LMC representatives (including Chairman Dr Nick Bray, Vice Chair Dr Karen Sylvester, Executive Director Jill Hellens and the Medical Director Dr Barry Moyse), and SPH nominees (Drs Nick Chapman, Emeline Dean and Sue Roberts, and Practice Managers Rachel Stark and Tracey Pike), the directors for Primary Care of the two NHS Trusts (GPs Drs Kathryn Patrick and Andrea Trill) and one member of the CCG Clinical Operations Group (Dr Alex Murray). The meetings are always chaired by an LMC or SPH member. The Secretary is Dr Harry Yoxall assisted by Sarah Johns. Others can be co-opted as is needed from time-to-time.

The Board has representatives on all the key STP-Health Community planning committees, including the Local Workforce Action Board which works closely with Health Education England on all aspects of workforce planning, and the A&E Delivery and Elective Care Development Boards, responsible for unscheduled and planned care respectively.

Following the shift in planning focus from organisational integration - with the goal of developing an Accountable Care System - towards reconfiguration based on the evolving Health & Care Strategy of the CCG led by Dr Rosie Benneyworth, the main role of the SGPB has shifted from responding to STP plans towards trying to provide a representative voice for the "jobbing GP" on the many medium and short term working groups that have been set up. The Board also is creating a number of discussion and position papers that lay out its view of matters such as the use of the GP Forward View Transformation Fund, Providing Primary Care at Scale and Managing the Interface between Primary and Secondary Care: once finalised these will be available on the LMC or SPH websites.

NEW SOMERSET LOCAL MEDICAL COMMITTEE 2018

The LMC elected in April met for the first time in May. The LMC is the only organisation which by statute represents all GPs and the primary care teams in the county. The committee welcomed the representative of Salaried GPs' Dr Robert Weaver of Grove House Surgery, Shepton Mallet, the Sessional GPs' representative Dr Angus Robin and the Registrars' Dr Gareth Jones. Dr Tim Deegan of Summervale Surgery now represents Chard, Langport, Ilminster & Crewkerne, Dr Guy Miles from Brent Area Medical Centre is for North Sedgemoor, and Dr Tim Smith of Ryalls Park and Dr Jon Upton have joined as South Somerset and Taunton Deane constituency members respectively.

The full committee's details are available on the Somerset LMC website. Please get in touch and use your local constituency member: they are eagerly awaiting your emails!

THE NEW PRE-CONCEPTION SERVICE AT TAUNTON & SOMERSET

Midwife Charlotte Nolan of the Pre-Conception team writes that P-C care is important because the health of women at the time of conception and in the early stages of pregnancy not only affects their babies but also has an impact on the rest of their lives. It allows physical and mental health conditions to be addressed and managed before pregnancy. Couples can be advised of potential risks which allow them to make informed decisions about conception and pregnancy. Women can be referred to the service if they have any of the following:

- Diabetes;
- Epilepsy;
- Inflammatory bowel disease;
- Renal disease;
- Cardiovascular disease;
- Mental health disorder (on treatment or with previous psychosis);
- Haematological disorders;
- Neural tube defects;
- Coeliac disease;
- Thyroid disease;
- Hypertensive disease;
- Rheumatic diseases;
- Chronic respiratory disease;
- Previous thromboembolism;
- HIV;
- Hepatitis B or C;
- Previous bariatric surgery;
- BMI 35 or above related to illness or to lifestyle;
- Smoking;
- Gestational diabetes;
- Pre-eclampsia, eclampsia or Haemolysis, Elevated Liver enzymes and Low Platelet (HELLP) syndrome;
- Pregnancy induced hypertension;
- Small for gestational age birthweight baby (<10th centile).

GPs in the T&S catchment area are asked to refer women of childbearing age they feel could benefit from this service. They can also currently accept self-referral from patients via email. For further information and to make a referral please email preconceptionteam@tst.nhs.uk.

REGISTRARS ARE LOOKING OUT FOR YOU… BUT THE GDPR IS GETTING IN THE WAY

It appears that colleagues are not always fully completing the Medical Certificates of Cause of Death ("Death Certificates" to GPs). It has been a statutory duty for some years for the certifying doctor to add his or her full name and GMC number but, as it would require an Act of Parliament to add a relevant section to the certificates (and it is not much of a priority for HMG) this is unlikely to change soon. The LMC has learned from the Registrar for Somerset, Alison Hicks, that her colleagues are going to great lengths to avoid contacting surgeries when signatures are illegible. This is why they always asked for updated lists of GPs, specimen signatures and GMC numbers from practices to try to match up the names to the signed certificates, consulting these securely online.

Now they have been told that with the GDPR they will not be able to hold the signatures without consent (the names and GMC numbers are in the public domain). The County Council legal team has said it cannot pursue a Privacy Notice to work around this so, in future, if the signature is illegible the Registrar will have to contact a probably baffled and busy receptionist at the practice. Long delays in getting through can lead to the family being sent away. Registrars have fixed 30 minute back-to-back appointments not just to register the death but also to sort out notifying e.g. the DWP about pensions and benefits under the "Tell Us Once" policy. Although we all make sins of omission families are not happy to be sent back to practices under those circumstances.

The answer is of course for GPs to fill the forms in fully and, it seems, the appearance of a stamped name and address on the paperwork raises a cheer. The Registrar is proposing to individually stamp all Death Certificates in NEWLY issued books with sections for "full name" and "GMC number" and also add this to the envelopes as a failsafe. Alison Hicks hopes that practice staff will check the envelopes are completed when handing them to relatives. We think that this is another example of the Registrars "going the extra mile" for GPs. Furthermore we hope that practices will agree to supply their bypass telephone numbers to the Registrar, if requested, given the time constraints we all have and the importance of these interviews to families?

LEARNING DISABILITIES MORTALITY REVIEW (LEDER) PROGRAMME: IMPROVING THE STANDARD AND QUALITY OF CARE FOR PEOPLE WITH LEARNING DISABILITIES

The LeDeR programme is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England. It is being delivered by a team based at the University of Bristol.

Many of the delivery team were involved with the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) which reported that for every one person in the general population who dies from a cause of death amenable to good quality care, three people with learning disabilities will do so. One of the key recommendations of CIPOLD was for the greater scrutiny of deaths of people with learning disabilities. In this way, potentially modifiable circumstances leading to a death could be identified and avoided in the future through improvements to health and care services.

The LeDeR Programme supports local reviews of deaths of people with learning disabilities aged 4-74 years of age across England. A confidential telephone number and website enables families and other key people to notify the LeDeR team of the death of someone with learning disabilities. An initial review of the death will then take place. The purpose of this is to provide sufficient information to be able to determine if there are any areas of concern in relation to the care of the person who has died and if any further learning could be gained from a multiagency review of the death that would contribute to improving practice. If indicated, a more in-depth, multiagency review will then be conducted. As part of the review, the local reviewer would speak to family members, friends, professionals and anyone else involved in supporting the person who has died to find out more about their life and the circumstances leading to their death.

If you would like further information about the LeDeR Programme, please contact:

Pauline Heslop, Programme Manager LeDeR Programme, University of Bristol, Norah Fry Research Centre, 8 Priory Road, Bristol BS8 1TZ.

Tel: 0117 3310686.
Email: leder-team@bristol.ac.uk

Website: www.bristol.ac.uk/sps/Leder

GP PRACTICES ACROSS THE COUNTRY TO BECOME 'VETERAN FRIENDLY'

GPs are signing up to become 'veteran friendly' under a new national scheme to improve medical care and treatment for former members of the armed services who may face additional challenges when they return to civilian life. The scheme, called the Military Veteran Aware Accreditation, has been adopted by NHS England and the RCGP as a nationwide initiative so that family doctors can better identify and treat veterans, ensuring they get access to dedicated care where appropriate. While healthcare for veterans is already prioritised, the NHS wants to support GPs and practice teams to ensure veterans are fully aware of the dedicated help available to them.

The expansion follows a successful pilot in the West Midlands where 90 GP practices have signed up so far. The nationwide rollout will be a phased approach and it is hoped that over the next few years every veteran will receive the best possible NHS care from their GP.

To become accredited, GP practices need to: have a lead for veterans' issues within the surgery; identify and flag veterans on their computer system; undertake dedicated training and attend armed forces healthcare meetings; increase understanding of the health needs of veterans amongst both clinical and administrative staff. Despite the inevitable requirement to attend meetings (for which we do not know if funding will be available) the scheme has much to commend it.

Dr Jonathan Leach, a GP, who served in the army for 25 years and chairs the NHS England Armed Forces Clinical Reference Group, is calling for GPs across the country to sign up. He said: "We are committed to providing veterans with a seamless, high quality service when it comes to their health needs. Our priority is to make sure that no matter where a veteran lives in the country, they will have access to a GP who understands their military related health needs and supports them to get the right treatment and support. We are therefore urging every GP practice to sign up to this important scheme."

CREMATION FORMS: A POLITE NOTICE FROM COLLEGE WAY SURGERY, CREMATORIUM REFEREES FOR TAUNTON DEANE

"We would just like to give everyone a gentle reminder over the rules for completing cremation forms particularly in light of multi-professional working in primary care.

Regulations state that the doctor who completes form 4 (first part) of a cremation form MUST have seen the patient both BEFORE and AFTER death otherwise they cannot complete it. These regulations are separate to those rules the Coroner applies to death certification i.e. if the Coroner says you can complete a death certificate it does not mean you can complete the first part of the cremation form.

In the event of your having any queries please contact College Way Surgery before completing the form. "

ERROR, NEGLIGENCE AND FAULT

To mark the end of Dr Harry Yoxall's long tenure as the esteemed editor of the Somerset LMC Newsletter we are taking the opportunity to republish this article from January 2002 as an example of his unparalleled common sense. We hope readers will find it as comforting as the new editor did more than 16 years ago.

Getting it wrong… Error, Negligence and Fault

How accurate is your decision-making? Taken as a whole, how often are you right about things like decisions to treat, refer, or investigate? 50%? 80%?

Let us say that you are Dr Perfect. Despite overwork, nights on call, dysmenorrhoea, domestic strife and burnout you clock up a regular 90% accuracy. Let us also say, for convenience, that you make 200 significant patient decisions a week, 50 weeks a year – the exact numbers don't matter, but as few consultations contain only one decision this isn't far off.

This means that you will make 10,000 decisions a year, of which 1000 are going to be wrong. Of course, most decisions are not that critical – probably only 10% really matter. That means you make 100 important wrong decisions annually.

Now, a single wrong decision is not usually a disaster. But in how many cases do you make two wrong decisions? Using our 10% rule, 10 out of the 100 patients above will have a second wrong serious decision – and this is the patient who will die or suffer serious harm: one, each year, if you are the perfect doctor. Error is therefore inescapable. It is not always due to incompetence, system faults, or working patterns – sometimes it just happens. We cannot provide a perfect service.

Negligence, on the other hand, is a legal term defined as "failure of duty of care". The council may be negligent if the pavement is uneven and somebody trips, a GP is negligent if he or she gives penicillin to someone who is allergic to it (Yes, I have – and I suspect a lot of you have as well) but there should be no moral overtones to the word. If by your, or your practice's, omission or commission someone comes to harm, then you may have to pay compensation. This is why we pay our defence organisation subscriptions. The fact that we are doctors dealing with individual lives rather than architects dealing with buildings or lawyers with transactions makes no difference to the legal process.

However, the natural emotional reaction of a caring doctor is to assume that it is his or her fault. You are to blame, and must carry the burden of emotional liability for the catastrophe. Well, perhaps you did roll over and go back to sleep when the worried patient with crushing central chest pain rang for help, but I doubt it. Nearly always the doctor has done their best but either missed or forgotten something, been confused or misled, or just made a correct decision on the facts available that later turned out to be wrong. Hindsight is a very distorted view, so stop blaming yourself for something that usually could not have been prevented. Use critical event analysis to correct system faults but do not try to design systems to avoid the unavoidable random event, because it won't work. And remember, you didn't make the patient ill in the first place – even if the problem arises from treatment you have given.

Finally, try to separate professional problems from your private life. You are not less of a person because you got something wrong. Your family will still love you just the same. Unless you have teenagers of course, in which case you may have to get your affection from the dog.

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