SOMERSET LMC

# Newsletter

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## CLINICAL NEGLIGENCE SERVICE FOR GENERAL PRACTICE – A SUGARED PILL OR A PLUM PUDDING?

Inside this issue



On 1st April the Clinical Negligence Service for General Practice (CNSGP) came in to being. Make no mistake: this only happened because the government's (HMG's) hand was forced by the failure of the Medical Defence Organisation (MDO) market. The MDOs – predominantly the MDU, MPS and MDDUS - could not fund the c. £60 BILLION of potential liabilities over future years. This was, in turn, largely owing to HMG's changing the Personal Injury Discount rate. The prolonged, much lower than average interest rates since 2008 mean that return on investment is down and so adjusting the discount rate caused rising awards to mushroom further.

The CNSGP is not "Crown or State" indemnity - it is "state backed", funded from GP contract money but it is not just for GPs. People conducting NHS primary care are "beneficiaries" not members of the CNSGP: there is no need to "join." This will encourage PCN development as anyone providing services under an NHS contract is now covered seamlessly. You can go from a salaried job at the hospital, to a partnership seeing PCN patients, to an OOH shift and all will be indemnified.

It is administered by NHS Resolution (NHSR) which used to be the NHS Litigation Authority with 20 years' experience of running the hospital scheme (the name changed in 2017). One advantage NHSR sees is it will now gain a complete picture of the "journey of patient safety" as people making complaints have often travelled from primary to secondary care and back again. Not only will they run "claims management" but also will use all this intelligence to promote learning to improve safety. NHSR aims to provide value for money to the taxpayer by thus saving money in future. Sceptics have countered that as NHSR, being a government agency, has an unlimited supply of money this may not be conducive to moderating lawyers' claims. Just like the MDOs NHSR is looking forward to fixed recoverable legal costs and reform of the law of Tort of negligence to "no blame." Oddly lawyers' groups oppose this. Some say that GPs require the punishment meted out in negligence cases to really understand they have to do better. The legal fees are, of course, entirely incidental to this altruism.

NHSR expects training and governance of teams to "support effective practices with competent staff" to help prevent claims arising. They have started by promising two free regional events to share learning from claims next year. All the materials will be on their website (a source of reliable information about how the CNSGP works) for those unable to attend. NHSR hopes that investigations will be improved, with better patient and family involvement, to settle claims without recourse to Law. One third of complaints dealt with already are thought to have arisen from frustration with the inadequacy of initial responses and investigations. The advantages of fast resolution for the welfare of Health Care Professionals (HCPs) are obvious but NHSR maintains the savings to the NHS, as learning spreads and safety improves, will also improve patient care.

MDOs will still be needed to provide personal professional as opposed to clinical negligence claim advice. NHSR will not give you advice on responding to a complaint – apart for some template letters - or represent you at an Inquest, in the Courts or before the GMC. HCPs without a professional body or regulator (like HCAs) are an acknowledged gap in provision now that MDO practice group schemes have ended. NHSR hopes that, despite this, a lead professional could take MDO advice on behalf of their HCA. It is accepted that this could be a "black hole" but we have just seen the MDOs accept liability in this way for peer-to-peer flu vaccinations.

A complaint usually starts with a request for the medical record, a Letter of Claim or a

request for compensation. Sometimes a patient will go straight to Law. NHSR needs to be contacted during the complaint handling advice stage if a Letter of Claim is received, or legal process started, via its helpline or website where the referral criteria are clearly set out and aims to respond within 72 hours. In cases straddling the 1st April NHSR will cooperate with the responsible MDO. It will instruct experts to advise it on case strategy and the HCP will be able to question them. Agreement will always be sought before a claim is settled and HCPs will be able to appeal against an admission of liability although this is expected to be a rare event.

It is encouraging that NHSR is aware that the new HCPs coming in under PCNs will lead to more care handovers and so more risk of claims. NHSR says that the future of primary care will see fewer doctors but they will be "working at the top of their licences" with less direct supervision of care. Digital services will also have an impact as the subtleties of face-to-face contact are lost. Less personal relationships tend to lead to more claims.

The state-backed indemnity scheme sugared the pill of PCN DES for many. Will a state monopoly – albeit not yet outsourced – be more efficient than the competitive MDOs?; if not all that promised improvement will be illusory. That said, the MDOs were often perceptibly less "on the member's side" in recent years as it became more expensive to defend a claim than make a payoff. Then there is all this expected additional training and governance but NHSR assures us that the new scheme should support Primary Care rather than "drive or impede it." Some hospital doctors have reported feeling treated with less professional respect under their scheme with an eagerness to settle trumping their dignity. Maybe that is all just special pleading and we have to stop taking it all so personally? The trouble is that the best doctors often do. As the proverb says "the proof of the pudding will be in the eating."

**MEDDCARE SOMERSET**

For many of you reading this article, this will be the first time you have come across Meddcare - the new name for the Integrated Urgent Care Service (IUCS) in Somerset. Meddcare Somerset will be run by Devon Doctors, who have been providing out-of-hours primary care in Devon for over 20 years.

In shaping the brand one of the key objectives was to develop an identity for the Somerset IUCS which stood it apart from the Devon Doctors brand. However, we wanted to retain the heritage of Devon Doctors and all that it stands for. We did this through the use of the 'dd' – an abbreviation for Devon Doctors in the Meddcare brand as well as retaining Devon Doctors brand colours.

Somerset patients were also involved in shaping the brand via a series of focus groups and explored what was important to them.

The development of Meddcare Somerset supports our long-term commitment to Somerset patients, staff, and healthcare partners, a service others aspire to be.

As you probably already know, out-of-hours urgent care provision in Somerset has faced various challenges over the past decade, with a number of different providers and the introduction of 111.

Here is a little background to our Somerset journey.

In May 2018, Devon Doctors stepped in to provide out-of-hours primary care in Somerset on an interim basis ahead of winning the contract to provide the IUCS which took effect from February 2019.

Devon Doctors combines a wealth of experience and expertise with a forward thinking and innovative approach to healthcare solutions.

The success of this approach is evident in the swift, interim, and bespoke solutions Devon Doctors have provided to ensure the urgent care needs of patients in Somerset have been met over the last 18 months.

We continuously monitor and refine our operations to ensure clinical resource is utilised to the best-possible effect.

A good example of this is the creation of a bespoke 111 solution the "Call Handler Risk Identification System" (CHRIS). This initiative won Devon Doctors the prestigious HSJ Value Award for The NHS Support Service Initiative of the Year. It was also highly commended in the Primary Care Initiative of the Year Award.

Another good example of our long-term commitment to Somerset patients, staff, and healthcare partners is the investment we have made in establishing a Clinical Assessment Service [CAS] at our Ashford Court base in Taunton.

This is our Somerset headquarters; a home for our Somerset services and a facility for CAS and remote-based colleagues, as well as wider stakeholders, to meet.

**Dr Chris Campbell, Associate Medical Director, Devon Doctors**

**POST-NATAL CHECKS AND "CHILD SAM" DR JO NICHOLL, NAMED GP SAFEGUARDING CHILDREN**

You may remember some time ago we told you about a serious case review involving "Child Sam"?

This case involved a young couple with a new baby. Both parents had mental health problems, were young and inexperienced. The mother had just escaped an abusive relationship and moved in with her new partner who had a violent history. He was not Sam's father. He suffered a bereavement that caused a further deterioration in his mental health and started drinking. Very sadly Sam was shaken by his step-father and this left him with serious and irreversible brain damage. His step-father is now in prison.

The review found that there were missed opportunities to diagnose and engage Sam's mother with her own mental health problems. There was a lack of what Lord Laming calls "professional curiosity" about Mum's partner and it was wrongly assumed that he was Sam's father. There were missed opportunities to discover the domestic violence.

Consequently the review recommended the implementation of a better process to identify domestic abuse, mental health problems and the effect of becoming a parent on not just the mother but also her partner. The post-natal review, which although is not statutory is usually carried out by most GPs at the same time as the 6 week baby check, represents a good opportunity to explore these questions.

The new Q-Masters template "Postnatal mother examination (v11.8)" is much more detailed than previous EMIS templates on parental mental health and domestic abuse enquiries and the CCG would like to recommend its use. Using this template will allow quick recording of a significant number of important matters, prompt GPs to remember to ask questions about paternal mental health, domestic abuse and ensure that there is evidence that these questions were explored.

It is to be hoped we will then be more likely to pick up those who are vulnerable to the pressures of a new baby allowing early help to prevent another Child Sam.

**Dr Jo Nicholl, Named GP Safeguarding Children**

**THE SOMERSET RED BAG SCHEME FOR CARE HOME RESIDENTS ADMITTED TO HOSPITAL**

The Somerset Red Bag Scheme for care home residents puts their paperwork, medication and personal belongings in one place when they are admitted to hospital, enhancing safe care and enabling quicker handovers.

The red bags have room to carry personal belongings, which provides dignity and can help put patients at ease in their new surroundings. There's space for day clothes, too, to promote patient enablement on the ward.

The bags are primarily used for care home residents being admitted to acute hospital care. But community hospital staff could see some patients admitted with a red bag, such as those on the stroke step down pathway.

Each red bag stays with the patient throughout their hospital stay and is returned home with them. Their care home then reuse the bag for other residents.

If you have any queries, please contact Cathy or Helen in Musgrove Park Hospital's discharge liaison team: cathy.phillips@tst.nhs.uk or helen.greene@tst.nhs.uk.


**PRIMARY CARE NETWORKS – THE GPC ANSWERS YOUR FAQS.**

1. What will PCNs do?

- Provide collaborative structures to support the partnership model of general practice
- Put general practice back at the centre of community care
- Provide better care for patients by diversifying and expanding teams
- Control GP workload

2. What will PCNs not do?

- Solve every commissioning problem in the NHS
- Address Third World debt
- Reverse global warming
- Resolve the impasse on Brexit

**LETTER TO JENNIFER**

Dear Jennifer,

I am writing this now as it is ten years since you went on holiday and never came back. Having ignored your pain and tiredness for months you only found time to visit your own GP when you were on leave. Then your metastatic cancer was diagnosed and your and your family's lives thrown into turmoil. Your colleagues were left with an empty desk and a deep sense of loss. You died about 18 months later, having faced the inevitable with courage and equanimity.

You used to write this column on the back page of the LMC newsletter. It was funnier and more pertinent than mine. Sometimes it had to be toned down by the editor who added a disclaimer. I remember the new contract of 2004 and the advent of QOF, you wrote about ticking off everyone's smoking status and cholesterol level for the QOF points. You followed this up with the declaration that "**POINTS MEAN PRIZES!**" The tabloids then said GPs took their pay home in wheelbarrows so it wasn't very subtle. Hilarious though.

What a lot has changed in a decade - yet so much is the same. Endless new initiatives with complex rules to remember, only for them to fizzle out after a year or two. Your indignation and contempt would know no bounds. The different organisations are mind-blowing, all with impossible acronyms and subtly different roles. The CCG did not exist in 2009. You never heard of NHSE&I, Federations, CQC, SPH, Symphony, HCPs, Networks, Neighbourhoods or a myriad others.

You would barely recognise the practice although the building is the same (we *still* struggle with the windows). Doctors and nurses come and go and the receptionists all look very young. District nurses and Health visitors have moved out to "hubs" where no-one can find them or know who is covering their patch. There is a wonderful, innovative idea to bring them back into surgeries– how novel! Social services have had dangerous budget cuts. But everyone still does their best for patients, some of whom, incidentally, still mention you fondly.

I am the only doctor left who worked with you and have taken your place as the senior old lady here. Now I am the one who endlessly asks the young docs which days they are working and struggles to find the right referral pathway or Read code. But I am not as amusing as you were, nor as quick to get to the heart of a matter with an astute comment. I have given up being pedantic about words because nobody is interested; language is "evolving" so apparently you can say whatever you want.

The staff from your day and I miss you. We remember you often and keep in touch with your family. Two of your children are GPs and one of mine is now a junior doctor: she was in a baby car seat when we first met!

Time passes but General Practice is the same in many ways. The pressures and frustrations are considerable, but so are the rewards. And now and again there is something to raise a smile: a letter about a psychiatric patient with paranoia and has "no insides whatsoever." Another patient, with back pain, was given a "cordial" epidural – I wonder whether it was lime or elderflower?

I have just been looking back through the archives at some of your articles. They are quite political with references to Tony Blair, Boredom Gordon and Dave the Rave. My favourite is your "email to TB" on DOGPISS (Destruction of General Practice In Six Stages). C&B really infuriated you. After years of picking the specialist you particularly wanted your patient to see, based on your professional knowledge of both, it was a shocking affront to our expertise. How meekly we accept it all now!

So just for nostalgia's sake here is a poem you wrote in 2005 which I think reflects the spirit of the times –

*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 him "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, "do you know 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"*

With love, from one old lady to another

**A "mature" GP (aged 57 and ¾)**



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