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SOUTH STAFFORDSHIRE LMC NEWS

Website: www.sslmc.co.uk E-mail: enquiry@sslmc.co.uk

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OUT OF HOURS

The LMC would be grateful for any information about problems with the out of hours provider in your area. This will either be Staffordshire Doctors Urgent Care (SDUC) or Badger. Please remember to always inform your CCG if you are having issues.

COMPLAINTS LEAFLETS

The LMC has obtained clarification of the procedure for dealing with complaints that cannot be settled by GPs in their practices or where patients do not wish to complain in house. Any information about complaints procedures i.e. leaflets/notices/website should be updated to remove any reference to PALS and LINKS.

The Patient Services Team can be contacted at Anglesey House, Rugeley on freephone 0800 030 4563 and there is an e-mail address feedback@staffordshirecss.nhs.uk.

Complaints can also be sent to NHS England on 0300 311 2233 or nhscommissioningboard@hscic.gov.uk. Complaints sent directly to NHS England will be forwarded to the Patient Services Team at Rugeley.

There is also the Independent Complaints Advocacy Service (ICAS) which offers some assistance guiding through the NHS complaints process on 0845 337 3054. Healthwatch Staffordshire can also be contacted at 0800 051 8371.

DEFINITION DM013 AND DIETARY REVIEWS BY PRACTICE NURSES

The QoF wording in DM013 is:

The percentage of patients on the register who have a record of a dietary review by a suitably competent professional in the preceding 12 months.

Does this have to be a dietician or could it be a GP or a nurse?

The GPC refused to accept this indicator in negotiations because they believed it was unacceptable to micromanage how we delivered QoF in this way and knew that the definition of ‘suitably qualified’ was a minefield. The GPC won the argument last year when this indicator was put forward but was brought back this year as part of the imposition. The GPC Survival Guide states:

"'Suitably competent' will be defined as 'a healthcare professional with specific expertise and competencies in nutrition', which may include a 'registered dietician who delivers nutritional advice on an individual basis or as part of a structured educational programme', or a 'practice nurse who has reached level 1 in the Diabetes UK competency framework for dieticians'.

The GPC believes this is too prescriptive and constitutes micro-management. It should be implicit that both GPs and practice nurses are already capable of doing routine chronic disease management without having to do any extra training.

Whether it is cost effective to fulfil this indicator will therefore depend on whether the practice needs to invest in further training for a practice nurse and the amount of additional time any healthcare professional needs to spend performing a dietary review.

If no 'suitably competent' healthcare professional is deemed to be available within the practice, this indicator is likely to lead to an increase in referrals to professionals outside the practice, which is at variance with current Clinical Commissioning Group (CCG) pressure to reduce such referrals. Dieticians are already in scarce supply.

DM013 is worth 3 QOF points or £470.76 to the average practice."

So yes it could be a nurse or a GP if it is cost-effective to do so but remembering that the QOF guidance says "they should conform to the level one competencies described in the Diabetes UK framework as a minimum".

INTERIM SENIORITY FIGURES

The Health and Social Care Information Centre has published seniority figures 2013/14 for GMS GPs in England. The figure is £96,183.00. Further information about the calculations and the methodology may be seen on the Primary Care section of the Health and Social Care Information Centre website at www.hscic.gov.uk.

FITNESS FOR PARACHUTE JUMPING

A GP has been requested to complete a parachute fitness jump certificate and felt that it was inappropriate because he was not in a position to guarantee a patient's fitness for parachute jumping.

The Medical Protection Society has advised that in terms of liability, if you sign a form confirming the patient is physically and mentally fit to undertake a parachute jump, you could potentially be subject to a claim in medical negligence if a sub clinical condition pre disposing to cardiac disease or a nervous breakdown was not identified and the patient suffers harm. It will be difficult to defend a claim if you had knowingly signed such a form against your better clinical judgement.

The MPS advise amending the wording to a version that suits clinical judgement that we would be comfortable signing, such as 'the patient does not have a condition to (your) knowledge that precludes him/her from undertaking a parachute jump'. If the patient is unable to do the parachute jump due to his organisation's dissatisfaction with the amended form, it is ultimately a matter for the patient as to whether he or she chooses to undertake the parachute jump. It is unreasonable to expect doctors to guarantee fitness which is not clinically possible to guarantee under the physiological and emotional challenge of such an activity.

Dr David Dickson
LMC Secretary

DATES OF NEXT MEETINGS

4 July	Edric House, Rugeley	**LMC**
5 Sept	Samuel Johnson Community Hospital	**AT**

The meetings with the **LMC** are for the full committee of LMC members without the AT.

The meetings with the **AT** are for the LMC Executive and the AT alone.

LMC MEMBERS

The following is a list of current members of the South Staffs LMC

Dr V Singh (Chairman)	01543 870580
Dr D Dickson (Secretary)	01283 564848
Dr P Gregory (Executive member)	01543 682611
Dr G Kaul (Executive member)	01543 414311
Dr P Needham (Executive member)	01283 565200
Dr T Scheel (Executive member)	01283 845555
Dr A Burlinson and Dr O Barron (job share)	01889 562145
Dr J Chandra	01543 870560
Dr J Eames	01785 815555
Dr A Elalfy	01785 252244
Dr C McKinlay (Treasurer)	01283 564848
Dr E Odber	08444 773012
Dr A Parkes	01827 68511
Dr A Selvam	01543 571650
Dr E Wilson	01922 415515
Dr A Yi	01543 870590
Dr H Zein-Elabdin	01922 702240

DR V SPLEEN

Dear reader

Many years ago, when I was a houseman doing my 3rd night of a 4-day on call weekend (yes, my young colleagues, we used to start at 9 am on a Friday and finish 6 pm on a Monday!). I was called for the umpteenth time to see an old man on the ward.

He was having IV fluids and palliative chemotherapy for advanced leukaemia, and I had been called by the nurses to see him many times through the night as his drip kept tissuing and needing re-siting. This time I glanced at the bottle on the drip stand which seemed to be dripping away nicely. "What's the problem? Everything seems OK" I said to the nurse and yawned. "Actually we think he has died and we'd like you to confirm death so we can lay him out" said the staff nurse, almost smiling despite the sadness of the situation. Since then I was nicknamed 'the doctor who could not diagnose death'. As often happens in medicine, with its 'dark humour' this is something (I hope!) medics can see the funny side of, but which has a central important point at its core.

The nurses had recognised his life had ended, not called the crash team and commenced CPR but accepted the inevitable. I do not recall asking if a DNAR order was in place (and if it had not been calling the crash team after all!).

The nurses had exercised common sense, knew the patient and been pragmatic.

How can we be certain someone has died, or more importantly how do we decide that death is inevitable and so resuscitation and active treatment is no longer appropriate?

At a recent meeting I heard a colleague explain how he had

explained to care staff in a home that at some point towards the (very) end of life a person will stop breathing and no amount of active treatment or CPR will start it again, so it was OK to do nothing except hold the patients hand whilst life ebbed away (as long as this had been agreed beforehand) to allow a peaceful and dignified death.

However even this can be contentious when hospital admissions are expensive, care and nursing homes risk being censured by relatives or the CQC if their death rates are 'too high' and hospitals don't want nearly dead people admitting to die in A&E and ruin their stats.

Carers feel obliged to call 999, paramedics will then commence CPR and transport many patients to A&E with a flicker of activity on the ECG, only to be confirmed 'dead on (or within minutes of) arrival' and thus classed as a death in hospital.

The onus may therefore fall on GPs more and more to sign DNAR orders on patients at earlier stages in their end of life pathway, but this could surely result in more accusations from relatives that we are hastening their loved ones off this mortal coil, or doing this to save money or reduce 999 calls or reduce 'unnecessary' admissions.

Despite my great wisdom, and many years of practice, I think this remains a difficult judgement to make, and one never to be made lightly, but for the most purely medical patient-centred reasons.'

Venture

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