November 2016

University Hospitals of Leicester NHS
NHS Trust

GP Newsletter

Caring at its best

Welcome to the November edition of the GP Newsletter

Primary Care Temperature Check Survey - 2016

Thank you to everyone who completed the survey in September.

Initial analysis of the data received through the Primary Care Temperature check survey has been completed. Overall satisfaction with UHL as a provider has fallen slightly since 2015.

On a scale of 1 (Low satisfaction) to 10 (high satisfaction) we were rated 6.7 in 2015 and 6.5 in 2016. However, more colleagues from Primary Care took part in the survey and therefore we have more feedback to work with to ensure we work to make our services better for patients.

As a direct action from the survey undertaken in September we have ensured that each Practice has received an up to date telephone list of ward numbers and locations. This was emailed to practices on 16 November. More actions will be reported in the GP Newsletter as they are agreed.

Catherine Headley, Head of Services for GPs

Discharge letter audit

As part of our on-going Audit of Discharge letters, we are asking Primary Care to feedback to us directly issues with data quality and accuracy.

For the month of December we would like you to feedback via **UHLGPServices@uhl-tr.nhs.uk** concerns with Discharge letters as you receive them.

This exercise is to look at the quality and accuracy of information contained within the discharge letters. If, in December you are aware of specific letters where there are errors or the letters are poor quality, please let us know immediately. We will need specific Patient Identifiable Data and as much information regarding the patient as possible so that we are able to look into the letters in a timely way. Direct feedback to the authors of letters will take place in order to support improvement. In addition, examples will be used in the scheduled teaching of medical staff.

Dr Steve Jackson has agreed to lead on this.

NHS Healthcare for the **Armed Forces**

As part of our commitment to the Armed Forces Corporate Covenant we are promoting the e-learning packages available to support Healthcare Professionals understand both the context of military life and also how to appropriately respond to patient need.

The programme is broken into three broad areas - the NHS care of current serving personnel, the NHS care of the families of military personnel and veterans, and finally veterans themselves.

We have included the links below for your information.

- Dr Jonathan Leach - I salute the new e-learning programme
- NHS Healthcare for the Armed Forces

Spurious Hyperkalaemia

Although severe hyperkalaemia is life threatening and a medical emergency, spurious hyperkalaemia (pseudohyperkalaemia) is commonly seen in blood samples taken in primary care and can be problematic, particularly out of hours and is a source of avoidable referral to accident and emergency.

It is usually because of sample collection, storage or sample transport problems.

The aim of this short article is to highlight the possible causes of spurious hyperkalaemia and offer guidance to minimise the problem

The causes of spurious hyperkalaemia include:

- Leaving a tourniquet for an extended period when collecting blood sample
- Difficult venepuncture
- Excessive fist clenching before the blood sample is collected
- EDTA contamination of sample when a full blood count specimen is collected before the U/E 's sample using the vacutainer tubes
- Vigorous mixing of sample after collection
- Collection of sample using small gauge needles (eg. orange needle)
- Prolonged time between sample collection and analysis in the laboratory
- A patient with platelet count greater than 1000
- Sample exposed to low temperature for an extended period before analysis

Hyperkalaemia is most likely spurious if the patient has normal renal function and there is no predisposing factors like potassium supplement, drugs that raise potassium or combination of potassium raising drugs.

Minimising the problem

Try to avoid using a needle and syringe as haemolysis can occur if syringes are used. This is because the blood is squirted through the needle into the collection tube.

Biochemistry samples should always be taken first before collecting other samples. This is to avoid contamination from other sample bottles with additives, which would otherwise artificially raise potassium levels. Samples should be stored at room temperature and never in the fridge and always send samples to the laboratory the same day.

For further information or queries, please contact
Dr Ginny Lee, Consultant Clinical Biochemist **Virginia.lee@uhl-tr.nhs.uk**

Good news for East Midlands mums-to-be

University Hospital of Leicester introduce private non-invasive prenatal testing to pregnant women

The Government has recently announced the introduction of non-invasive, prenatal testing (NIPT) to all high risk pregnant women (those with a < 1:150 chance of having a pregnancy affected by Down's syndrome) on the NHS by 2018. This has led to an increased interest in this type of screening from pregnant women. By providing the test privately at an affordable price within the NHS care pathway all pregnant women from 10 weeks gestation, regardless of risk score, have the opportunity to access the benefits of NIPT. We have partnered with Premaitha Health to provide a private NIPT screening service for pregnant women in the region offered at a significantly reduced price.

This is an important step towards increasing the accessibility and choice of non-invasive prenatal screening in the East Midlands. We are absolutely committed to ensuring that as many women as possible have a choice to opt for non-invasive testing, and welcome the news that it will become available as an NHS test in 2018. We've chosen IONA® as we believe it is a highly effective screening test and we look forward to working closely with Premaitha to deliver the best value for our patients. The test is safe with a detection rate of 99% for trisomy.

The test provides peace of mind to new mums who are recommended screening for Down's Syndrome and other serious chromosomal problems such as Edwards' and Patau's Syndromes. The IONA® test is safer for the baby and avoids the risk of miscarriage from a more invasive procedure such as amniocentesis or CVS. The blood test provides rapid information for parents within just 3-5 working days. Furthermore, we offer the test with formal counselling by specialist midwives and at a lower price. In addition, Leicester is currently offering this test free of charge for our all pregnant women with twins as part of IONA-Twin research study.

For further information on this test please contact Dr Tommy Mousa, Consultant in Fetal and Maternal Medicine, **Tommy.mousa@uhl-tr.nhs.uk**

Remote monitoring for **Thyroid & Prostrate Cancer**

UHL will shortly be launching remote monitoring for selected low risk thyroid cancer and prostate cancer patients.

The aim is to provide an effective and safe service to identify and act on any blood results/symptoms that may require clinical review. The results of remote monitoring will then be communicated to both the patient and general practice.

Why

The increasing incidence of these cancers has placed a significant burden on secondary care where traditionally follow up has been carried out. For some of these patients with an excellent prognosis, survivorship is not enhanced by hospital attendance. Reducing hospital visits for such patients will allow hospital clinicians to spend more time on those requiring expert input.

Who

Low risk patients can be referred to Remote Monitoring by a Consultant, Registrar or Associate Specialist. The referring clinician is responsible for ensuring that the patient meets the inclusion criteria, explaining the follow-up process to the patient and getting the consent of the patient in clinic.

Patients would be considered for remote monitoring where they have completed treatment and have been shown to have a good response with stable blood markers. They will be issued with a treatment summary outlining the diagnosis, treatment and on-going management plan. It will also include any alert symptoms requiring referral back to the clinic.

Patients with higher risk factors would continue to be monitored in clinic.

How

The patient will attend for their blood test in the Primary Care setting. The blood test result will be recorded on the pathology system and populated into InfoFlex.

Where the result is satisfactory, the administrator will send a letter of confirmation to the patient and GP. They will also be sent the blood forms and a date for the next remote review. The letter will contain a contact number for the Clinical Nurse Specialist (CNS) team should the patient have any queries or concerns.

Where an alert is triggered or the patient has not attended for blood tests, the administrator will work with the CNS to ensure appropriate action is then taken in a timely way and communicated to all necessary parties.

The CNS/administrator will record details of all action taken and any communication relating to the care of the patient on the InfoFlex system.

When

The process will start from 1st December. The patients will be added to the system as they attend outpatients. This will give a gradual start to the process over a period of a year.

For further information please contact Ros White Thyroid CNS, **Rosalyn.white@uhl-tr.nhs.uk**

Leg ulcers: the microbiology role in diagnosing infection

A large proportion of the wound swabs we receive from primary care are taken from venous leg ulcers.

All leg ulcers will contain bacteria: most of these are colonisers, that is, they are merely resident in the ulcer and not causing disease. A swab of the ulcer will indicate which bacteria are present. It will not indicate if the ulcer is infected as this is a clinical diagnosis. Even if there are features of infection, it is not necessarily the case that what is grown from the swab is the cause of infection. It therefore follows that many ulcer swabs do not impact on diagnosis and management, particularly if they are not indicated or taken correctly. National guidance1 gives the criteria for considering an infection:

- increased odour or increased exudate from the ulcer
- enlarging ulcer with abnormal bleeding or bridging granulation tissue (incomplete epithelialisation with tissue forming 'bridges' across the wound)
- increased disproportionate pain
- cellulitis (particularly if spreading), lymphangitis or lymphadenopathy
- pyrexia, or sepsis

If any of these criteria are present microbiology samples should be taken before antibiotics are started

1. Cleanse the wound with tap water or saline to remove surface contaminants, slough and necrotic tissue. Do NOT simply swab wound discharge as this may pick up colonising organisms only.

2. Swab viable tissue which displays signs of infection, whilst rotating the swab.

For all specimens, include all clinical details (patient details, site, nature of wound and current or recent treatment), to enable accurate processing and reporting of the specimen.

The most likely pathogens in infected ulcers are β-haemolytic streptococci and Staph. aureus. In such cases patients are treated according to the Primary Care cellulitis pathway2.

Most other organisms such as coliforms and pseudomonads are colonisers and do not generally adversely affect healing.

1.https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/536231/Venous_Leg_Ulcers_Quick_Reference_Guide.pdf

2. http://www.lmsg.nhs.uk/wp-content/uploads/2015/05/Cellulitis-Pathway-March-2015-FINAL. pdf

Dr Andrew Swann Consultant Microbiologist **andrew.swann@uhl-tr.nhs.uk**

2WW form for Suspected Cancer with Iron Deficiency Anaemia

A new iron deficiency anaemia 2WW suspected cancer PRISM form will be launched on 5th December 2016.

This form should be used for referring patients with iron deficiency anaemia who you suspect may have cancer who are aged 60 and over.

The definition of iron deficiency anaemia is detailed below:

Males: Hb <110 g/l AND Ferritin <23 mcg/l

Females: Hb <100 g/l AND Ferritin <10 mcg/l

Haemoglobin and ferritin results must be included on the referral form.

If the patient does not fulfil these criteria but you are concerned about serious pathology, please consider using the eRS Advice and Guidance system as to how best to refer your patient into UHL.

Please use this form in conjunction with NICE guidelines NG12 published June 2015. Please send your referral via e-referral system

Mandatory requirements for referral

- The patient must be fit enough not only to undergo the investigation, but to potentially undergo treatment for any condition found - please see suitability below.
- You must have informed the patient that this referral is to confirm or refute a diagnosis of cancer.
- FBC, U&E and haematinic results within the last three months must be available, or if no recent results are available, you must arrange for the blood sample to taken within two working days of referral. If no results are available to the Cancer Centre 2WW staff at 48 hours after referral, you will be contacted to ask for the referral to be withdrawn and resubmitted when results are available.

Most patients on the 2WW pathway go 'straight to test' (CT and endoscopy) rather than seeing a clinician in the outpatient clinic in the first instance.

The patient must be available to attend for the appointment within the next 14 days. If the patient absolutely cannot attend, please consider delaying your referral until the patient is available.

Do not use this form for patients who do not meet the 2WW criteria, as you may be asked to withdraw the referral.

Please use a standard referral letter and indicate the urgency.

For queries or further information, please contact the 2WW office.

GP Education & Events

UHL Clinical Senate – Yulemeet

02 December 2016
11am - 5pm (drop in event)
Free event - Lunch provided
Venue:
King Power Stadium
Click here to book:
https://www.eventbrite.co.uk/e/llr-clinical-variation-uhl-third-yulemeet-2016-tickets-29017227308

Event description

You are warmly invited to the annual Yulemeet event, hosted by the UHL Clinical Senate and joined by our community partners across LLR, in which we round up the year's events and look at our priorities for the coming year. It is free of charge and being held at the King Power Stadium, lunch provided. The venue will hold up to 120 people, so you are encouraged book early, as we have had to close to bookings for recent Senate events, having reached capacity before the date.

If you would like more information about any articles in the newsletter or have suggestions for future editions, please do get in touch.

Catherine Headley
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And finally...

For general information such as referring to us, GP education and previous editions of the GP newsletter, you can find it all (home or at work) by clicking here:

www.leicestershospitals.nhs.uk/professionals/