Fareham and Gosport Primary Care Trust NHS

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Code A

FAX TRANSMISSION

TO: Karen Woods	DATE: 8th May 2003 TIME: 11.30am
FAX NUMBER Code A	NUMBER OF PAGES 3

MESSAGE

Code A Grocock

Copy of clinical advisers report. Have sent copy in post to you and to Mr Haikney, Lay Chair today.

From: Ann Turner Complaints Manager Unit 180, Fareham Reach 166 Fareham Road Gosport PO13 0FH	If you do not receive all the stated pages of this fax, please call Code A immediately. Thanks

Clinical Adviser Report

Complaint Ref 007/2002

Complainant/Practitioner Names Code A **against Dr Grocock**

Has the complainant received as full an explanation as possible covering all the clinical issues?	Yes adequate flu reminders Most practices see over 75's opportunistically 16 month gap acknowledged seen on house call with his wife but nor entered in notes Cyproterone prescribed by Dr Grocock who has responsibility for monitoring but patient being reviewed regularly in Haslar and they were monitoring bloods
Are there any issues outstanding?	5/99 note added in handwriting to clinic letter noting increased bilirubin level and asking cyproteone to be stopped in 6 weeks 11/99 states on Zoladex not clear if he ever received this 7/01 risk discussed with patient in clinic letter states Code A insistent he wants to continue'
Are there any unaddressed or disputed clinical issues?	7/97 Haslar states about prescription of Cyproterone acetate 'I have given him the first months treatment and would be grateful if you would continue until he is reviewed in 3 moths when we will consider converting to Zoladex 4/98 Reviewed in clinic letter state 'Remaining well on Cyproterone acetate and I think he should remain on this indefinitely' 2 months supply common amount given on repeat presciptions
Is there any further practical action which could be suggested for local resolution?	May be worth further meeting some of the issues complainant is dissatisfied about could be explained. 2 issues remain-failure of Practice to respond to handwritten note at the end if a hospital letter –an error which has been acknowledged. failure to monitor repeat prescriptions-Dr Grocock has acknowledged this. Perhaps should state what systems are in place to prevent this happening again.

Does the explanation/response which has been given stand up to independent scrutiny?	Yes explanation of error of missed instructions on letter-are processes on place to prevent this happening? Long gap in review with repeats need protocols to prevent this. Dr Grocock has apologised for this.