

# NORFOLK LOCAL MEDICAL COMMITTEE

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April 2006 Flyer

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## Salaried GPs: Prescribing Numbers

Following pressure from the GPC Sessional GPs and Clinical & Prescribing Subcommittees salaried GPs are now entitled to have their own prescribing number. PCTs can apply to the NHS Information Centre (GMS Team) for an individual unique number for each of the salaried GPs on their Performers' List. Salaried GPs should contact their PCT for a prescribing number. The GPC continues to make representations for locum GPs also to have a unique prescribing number.

## Fee for Copying Medical Records & VAT

A dispensing practice raised the issue of where they stood regarding the £50 maximum fee for copying medical records under the DPA and VAT. We have now had the following clarification from a senior policy executive at the BMA:

"At our last meeting with HMRC the officials were made aware that the fee was capped at £50 and agreed to address the issue before any guidance was issued for the implementation process. There is no obligation to levy VAT on access to health records work even for dispensing GPs."

## Guidance for Doctors Certifying Cause of Death

Shipman ramifications continue. The Norwich Coroner's Office has kindly provided the LMC with new guidance from the "Office for National Statistics Death Certification Advisory Group". It is dated April 2005 but has only just appeared. It seems to complement the text pages of the current Death Certificate book. The law itself has not yet changed. When new legislation is passed doctors will receive instructions on changes and be advised of the date from which they will be implemented: this is unlikely to be before 2008/9. The guidance in this article is to "*remind us of the duties on medical practitioners under current legislation, and to clarify best practice*". Accordingly, you should start to take it into account straight away.

I have been unable to find out when the new guidance will be circulated generally and it may be that it will suddenly appear in the near future\*; however I think it is appropriate to list the "highlights" here and now. \*LMC Office chasing.

The doctor should discuss the case with the coroner before issuing a medical certificate of cause of death if at all uncertain whether he/she should certify. For example, 75% of deaths with fractured neck of femur mentioned on the certificate are registered from the original Medical Certificate of Cause of Death (MCCD) following referral to the Coroner; only about 15% go to inquest and 10% are registered after a Coroner's autopsy. A lot of work for the Registrar and additional stress to the family could be saved

by discussing such cases with the Coroner.

Doctors are expected to state the cause of death to the best of their knowledge and belief: they are not expected to be infallible. It is likely that there will be increased scrutiny of Death Certificates and of patterns of mortality as a result of the Shipman enquiry. Suspicions may be raised if death certificates appear to give inadequate or vague causes of death. An example given is instructive (though not especially applicable to general practice) - if a patient dies under the care of an orthopaedic surgeon it might be expected that some orthopaedic condition contributing to the death will be mentioned in Part 1 or Part 2 of the certificate. If it is not, enquiries are likely to result.

The Guidance is especially concerned with the sequence of causes and contributory causes and gives several examples. The Secretary must confess that the recommendation is to give more detail than he has tended to do over the years. If the patient had more than one disease or condition that was compatible with the way that he/she died and you cannot say which the most likely cause of death was, you should include them all on the certificate, they should all be written on the same line and you can indicate that you think that they contributed equally by writing "joint causes of death" in brackets.

The guidance is quite clear - that if you do not know that your patient had any specific disease compatible with the mode and circumstances of death it must be referred to the Coroner. The example given is if your patient died after the sudden onset of chest pain that lasted several hours and you have no way of knowing if he/she may have had a myocardial infarct, a pulmonary embolus, a thoracic aortic dissection, or another pathology, it is up to the Coroner to decide what investigations to pursue.

If further information may be available from an autopsy or from other investigations (for example histology or blood tests) whose results are not yet available, that should be indicated on the certificate by circling "2" on the front of the Death Certificate for Autopsy Information or by ticking Box "B" on the back of Certificate for Results of Investigations.

"Old Age" should only be given as the sole cause of death in very limited circumstances. These are:

- ▶ you have personally cared for the deceased over a long period
- ▶ you have observed gradual decline in your patient's general health and functioning
- ▶ you are unaware of any identifiable disease or injury that contributed to the death
- ▶ you are certain that there is no reason that the death should be reported to the Coroner

The average life expectancy at birth for men is now about 76 years and for women 80 years.

Therefore this guidance recommends that death certified as due to "old age" or "senility" alone be referred to the Coroner unless the deceased was aged at least 80.

The injunction to avoid "organ failure" alone as the cause of death continues, although it can be given perfectly properly as cause 1a with the underlying cause lower in the list.

Clearly, conditions such as renal failure may come to medical attention for the first time in elderly, frail patients in whom vigorous treatment or investigation may be contra-

indicated - even though the underlying cause is not known. When such a patient dies you should discuss the case with the Coroner and, if the Coroner is satisfied that no further investigation is warranted, the Registrar can be instructed to register the death based on the information on the death certificate but, as stated above, the Registrar cannot accept a medical certificate of cause of death that gives only "organ failure" as cause of death without instructions from the Coroner.

In the "neoplasms" section of the guidance the Secretary was interested to see that an example given reads as follows:

1a) carcinomatosis, 1b) small cell carcinoma of the left main bronchus, 1c) heavy smoker for 40 years.

For many years bronchopneumonia was given as the immediate cause of death on a large proportion of death certificates. This may have reflected common terminal chest signs and symptoms rather than significant infection in many cases. The proportion of certificates that mention bronchopneumonia has been steadily falling. If you do report bronchopneumonia remember to report any predisposing conditions particularly those which may have led to paralysis, immobility, suppressed immunity or wasting, as well as chronic respiratory conditions such as chronic bronchitis. As your Secretary started filling in Death Certificates in 1977 this is one he will have to bear in mind.

Substance Abuse: deaths related to diseases due to chronic alcohol or tobacco use need not be referred to the Coroner provided the disease is clearly stated on the certificate. The example given is similar to a previous one:

1a) carcinomatosis, 1b) bronchogenic carcinoma of the upper lobe of left lung, 1c) smoked 30 cigarettes a day.

Drugs due to acute or chronic poisoning by any

## Norfolk Local Medical Committee 20062009

The new Committee met for the first time this month. Attached are details of the constituencies along with the contact details of your representatives.

substance and deaths involving drug dependence or misuse of substances, other than tobacco or alcohol must, of course, be referred.

### The Suspended GP Performer

The GPC last produced guidance on suspended GPs in 2001 since when the legislative frameworks for both GP contracts and the GMC have changed. The LMC office recommends this new paper which provides LMCs and GPs with authoritative guidance on the implication for, and actions required by, a suspended GP performer. It is available from the LMC office/website. It pulls together things that every GP and practice manager should be aware of. Only the unluckiest of GPs are likely to be directly affected by suspension but the issue needs covering in all practice agreements - in case. Just like all the other bits of your practice agreement.

### TB: for your consumption

Your Secretary now thinks he understands the new BCG arrangements for neonates and under-16s after a very useful meeting with Jude Archer (Assistant Director of Quality & Nursing, Norwich PCT) and Jo Hadley (Specialist TB nurse). For the moment, over 16s will continue to be dealt with by the Dept of Respiratory Medicine (NNUH). Apologies if you know all this but here is the story so far in central Norfolk.

In February 2005 the DoH decided to make wholesale changes to BCG policy; with characteristic good timing those who would have to implement change (including schools) were only told during the summer holidays that the national (school based) campaign would be withdrawn from 1<sup>st</sup> September 2005. All things being considered Norfolk has managed the change amazingly well. GPs were advised of the interim and ongoing arrangements in February 2006. In retrospect a bit more flagging up of that e-mail and its attachments plus a short, GP-friendly, summary of the most important bits, would have been helpful - many of us either did not realise the significance of the cascaded information and/or manage to retain it in our long-term memories.

The referral form for Paediatric BCG Vaccination at the Community BCG Clinic is, apparently, little changed from its predecessor for children and adults at the NNUH. It will generally be given by the HV or midwife to the GP - for signature. The criteria refer to "high risk countries"; for those who like to be sure that they agree with what they are signing these are countries with an incidence above 40 per 100,000 listed on the WHO Global Health Atlas site and, no doubt, elsewhere. Your Secretary was concerned that the GP signature might be a pointless, bureaucratic, rubber-stamping exercise that adds no value to the form. He was persuaded that the GP might know of contraindications that the HV or midwife might not; however these will be asked about at the clinic. (In essence, they remain those in your ancient Green Book). He was also concerned at the possible implications of signing agreement that the vaccination site could be checked at the surgery. It was confirmed that all this means is that GPs will be prepared to reassure those who have a bit of a reaction that nothing needs doing; it is NOT code for shifting the responsibility for reading the Mantoux test. (Q: How paranoid can an LMC Secretary get? A: Very!).

In the last Flyer we mentioned a potential problem with the storage of consent forms; I am delighted to say that this is now sorted: the clinic will retain them. GPs will receive a simple letter advising them that BCG immunisation has been

carried out: a good, common sense, solution. There was also an item about the Mantoux test not being licensed, so for a nurse to give it there has to be specific patient approval - signed by a doctor - it can not be administered under a patient group directive. In central Norfolk, you will be glad to know, the pathway does not involve the GP - the doctor working with the community clinic kindly does the honours.

In our meeting we discussed how difficult it is to convey information when we are all so overloaded with the stuff - and agreed that the LMC would be involved in future. Jo Hadley is kindly preparing a FAQ sheet for circulation and is willing to be contacted with specific queries via email (pref) jo.hadley@norwich-pct.nhs.uk or 01603 776750 or 07876591812.

#### For Sale

9 x Amerson Medical Record Filing Cabinets,  
Brown & Cream, 5 & 6 drawer,  
Contact: Rachel Crampton  
Orchard Surgery, Dereham 01362 656942

### Freedom of Information Act (FOIA)

The Information Commissioner (IC) has decided to extend the lifetimes of current publication schemes for at least two years. This will mean that there *will not* be a requirement for practices to rewrite their schemes and submit them for approval by October this year. There remains a requirement for practices to keep their existing schemes up-to-date and to notify the IC of any changes or deletions.

The IC will be producing guidance about the anomalous position regarding the records of deceased patients. A date for the publication of this guidance has not yet been made available. However, the IC will give advice on a case by case basis, should practices require it.

### Pensions employers' contributions/ tax

Following discussion at last month's GPC about employers' contributions and the A9 concession, the position remains as follows: GPs who have paid personal pensions contributions in respect of NHS pension scheme (NHSPS) earnings in 2004-05 and 2005-06 intending to use the A9 concession to waive relief on the NHSPS contributions and claim it on their PP contributions, will have 20% relief waived. This could be up to 29% if the GP is paying added years contributions, NHS additional voluntary contributions or free standing additional voluntary contributions. In such cases, there is nothing in the A9 concession to say that an election to waive relief on NHSPS contributions is irrevocable. So, if their income tax liability has not been finalised yet, GPs may revoke their election for 2004-05 and claim relief on what is now the 20% (6% employee and 14% employer) contribution to NHSPS. HMRC has confirmed that it would have no objection to the PP contributions being refunded in such cases.

The GPC has sought further accounting advice on this issue and will report back on its findings in due course. It will also continue to pursue the overall issue that employers contributions should be tax deductible.

### GPs returning to work after retirement

The DoH has announced that GPs who wish to return to work after retirement are no longer required to take a one month break. This will

provide greater flexibility for GPs who wish to take their pension and return to work in the NHS. There are still conditions which must be met in order for GPs to receive their NHS pension:

- ▶ you must take a break of, at least, one day from all NHS posts, and
- you must not work more than an aggregate of 16 hours a week in the NHS in the month following retirement. The NHS Pensions Agency states that the onus is on the GP to prove that this condition has been met.

GPs should note that they do not need to come off the Medical Performers List in order to access their NHS pension. They simply have to retire from pensionable employment. GPs in a partnership should be aware that they will need to resign from their partnership upon retirement and rejoin upon returning to work. Single-handed GPs should note that they will be required to resign from their contract with the PCO. Therefore, single-handed GP who wish to return to work should ensure that they have a legal agreement with the PCO, before retirement, allowing for and confirming their return.

The NHS Pensions Agency intends to issue further information in the near future. In the meantime, if there are any queries from constituents about 24-hour retirement, they should contact the GPC office.

#### Advertisement

We are looking for a salaried GP to work in our thriving and expanding practice

- ▶ seven partners, one salaried and one Professor of General Practice!
- ▶ 9,805 patients
- ▶ undergraduate teaching (1st & 3rd years at UEA as well as Cambridge University placements)
- ▶ usual nursing staff as well as nurse practitioners and community paramedic
- ▶ no OOH
- ▶ QOF 1046.6
- ▶ Vision system, paperlight

Start date July/August - Salary subject to negotiation/experience. Informal visits welcome. Closing date 31st May 2005.

Enquiries to: Dr Maire Beales or The Practice Manager, Trinity & Bowthorpe Medical Practice, 1 Trinity Street, Norwich NR2 2BQ or email don.chapman@nhs.net.

### Revisions to the GMS Contract, 2006/7 "Delivering Investment in General Practice"

NHS Employers have mailed two copies of this to every GP practice. If you require additional copies you will need to download the PDF version from the LMC website (norfolk.lmc.org.uk) or from www.bma.org.uk/ap.nsf/Content/revisiionnGMS Feb20062

### Tomorrow's People

The GPC has met with "Tomorrow's People", an independent, charitable trust that helps people get back to and stay in work. Not government linked, it already has advisors working in a number of GP practices. Obviously this is not GP work but following the DWP's Green Paper that

envisages some patients being supported by occupational health and employment advisors, it may be a useful resource - <http://www.tomorrows-people.co.uk>.