

# NORFOLK LOCAL MEDICAL COMMITTEE



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April 2008

## Flight or Fight?

The DDRB "award" will have concentrated the minds of partners and managers. No doubt many business plans and projections are being created looking at what used to be "practice profit" (and is rapidly becoming the "practice viability index"). The LMC has been talking and writing about what constitutes "core work" (aka "essential services") for a very long time and we know that practices continue to let their better natures overcome their business senses.

Let me just repeat the arguments. The nGMS contract defined what is work that GPs should do, compared with the previous (Red Book) contract. Before 2004 the definition, such as it was, was simply that GPs do what GPs do - which made it very hard to argue that new work needed additional funding from the moment a substantial number of GPs took it on. But the slate was wiped clean in 2004 and it became much clearer what are "essential" services, what "additional" and what "enhanced" services. We know that in many parts of the UK PCTs pay GPs to carry out work such as post-operative stitch and clip removal, Goserelin insertions, varicose ulcer treatments - including complex dressings and dopplers. Some of this is essentially new work for the Health Service - so nobody may be being paid for it - an example may well be the current, seemingly exponential, growth of MRSA screening and eradication. Some other work, we would suggest, is work that other people *are* being paid for - even though we are doing it. Examples might well be varicose ulcer dressings (which community services have done), post-op dressings and stitch/clip removals which are, we believe, covered in the tariff price for the acute unit that did the procedure in the first place.

If you are ever going to set your business houses in order now is the time. We are in a third year of static or falling income for practices; this will inevitably lead to

reductions in services and it is surely most sensible to reduce or stop those services that attract no funding, particularly if somebody else is being funded to do them. We know that anything that looks like taking away patient services is difficult and that we, our staff (perhaps our nurses in particular) find this an anathema. But practices will be losing thousands of pounds as expenses rise and income falls, so will become less able to provide essential services - let alone these unfunded extras.

The LMC would not suggest that practices suddenly cease to provide services which would

lead to patients suffering until an alternative provider (or the provider who should have been doing it anyway) is sorted - but a couple of suggestions were made at the April LMC which might find favour. Practices could start sending invoices to the PCT (or the acute unit or community trust, whoever it is believed is likely to be being funded for the work) and/or a clear statement could be made that if there is not a properly agreed and funded pathway to support this work in primary care in, say, six months, primary care *will* then cease to carry it out.

Our impression is that the PCTs have absolutely no intention of paying for work that we do for nothing, or of arguing with the acute or community trusts if we are a softer touch. Indeed - from their point of view why should they? But we just keep on accepting it - to the detriment of the future of our practices and of our patients. If you are going to start saying "no" then now (or in 6 months time, with notice) would be a jolly good time to start. SRL

## "Darzi Centres"

The NHS operating framework instructs all PCTs to develop a new GP led health centre. The DoH believes it has consulted within the remit of the Darzi Review; the consultation is on what goes into these centres. This goes against comments made by the SoS and Lord Darzi about PCTs having local control. We have challenged the PCTs on the need for a centre(s) and raising it at meetings with local MPs. David Cameron appears to be attacking the top down management structure of the NHS and saying that the Conservative Party would support GPs in making decisions. We will continue to make representations but it is vitally important that practices respond to the consultations and are not lulled into a false sense of security because the current proposals may be sited a long way from them. We know the DoH has plans for more - this is already evident in large cities - but ultimately the effects will no doubt be felt locally. IH.

## Shoot yourself in the foot and your neighbours in the head

Details of the extended hours DES might be with you by the time you read this flyer or then again they might not. You will have had the "Focus on..." document from the GPC and the DES will certainly not be a million miles away from what is stated there. Most people think the DES is inflexible and dangerous with its lack of provision for adequate staffing for emergencies or chaperoning, for its insistence for sequential rather than concurrent surgeries and that it is grossly underfunded considering

the expenses that will be incurred - even if staff are willing to work the extra hours.

As I am sure you will all know, PCTs have a target of 50% of practices providing extended hours by December 2008. They also have the ability to draw up local enhanced services that could be more flexible, more sensible and properly funded. We understand that in GtY&W a LES is being drawn up and the LMC has no doubt that every PCT in the country will create one if they don't get 50% of practices signing up to the lousy DES on offer. If you feel inclined to offer the services of the DES, at the price of the DES, and with the restrictions of the DES, then that is up to you - but if practices do so they reduce the chances of a better deal being done for all. SRL

## Death holds no terrors...

If you feel a sense of relief when you learn it is a burial and not a cremation then you may be suffering from Part II stress. I get anxious when contacting a colleague for a Part II - knowing how busy everyone is and that there is a degree of post-Shipman anxiety about being part of a process that probably does need reform (although there is little enough evidence of anything happening). It occurs to me that there may well be doctors, perhaps non-principals or retired-but-still-registered, who could be interested in doing Part IIs and who might actually like to be contacted for this work. The LMC will look into holding a list of those who would be willing, perhaps including where they are based: knowing this might be near helpful for more remote practices. This might mean a reduction in stress for both Part I and Part II doctors - and some income and expenses going to those who might like it. SRL. (Let the office have your views)

## QOF Changes 2008/9

Practices were sent details of QOF changes in a letter from the DoH and in the GPC's "Focus on". 58.5 QOF points have been reallocated in the Patient Experience Domain as a reward for patient satisfaction with access. Payment of this will depend on the results of a national access questionnaire (son of PES) focussing on 48hr access/advanced booking. Readers will remember that the last PES survey caused controversy because of the apparently loaded questions. The text and content of the 2008 questions have yet to be agreed and the GPC will be pushing as hard as possible to make sure that it is fair. Unfortunately there are risks and no guarantee that practices will achieve the full 58.5 points. This is in no way linked to the payment for the Extended Hours DES/LES - if one is agreed with your PCT. IH

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## Gt Y & W Constituency - LMC Update

A meeting for GtY&W constituents has been arranged for 13<sup>th</sup> May, 7-9 pm, at Crestview Surgery, Lowestoft, to discuss current local issues. Please try to ensure that at least one GP from your attends (obviously more than one would be very welcome).

**Extended Hours** The PCT is considering a LES to cover the interim until details of the DES is available. We have seen a draft and have concerns around its inflexibility and requirements for ten minute appointments. We hope that the PCT will accept our recommendations on changes to the specification. No payment will be made retrospectively ie backdated to the beginning of April unless a practice is already providing extended hours.

**The Darzi Centre** is intended for central Yarmouth and potential bidders can talk informally to Adrian Grant at the PCT prior to the commencement of the procurement process (beginning of May). The PCT is claiming that lists being open only in rotation has made the need for a Darzi Centre in this location imperative although it acknowledges that a lack of assistance with investment in local premises (PCT Estates Strategy) may have contributed to the inability of practices to increase capacity. A second Darzi Centre located in Lowestoft has been agreed in principle by the PCT Board with procurement likely to start in September 2008. Waveney PBC is trying to ensure that this is not necessary.

**C&B LES** This due to go out on 25<sup>th</sup> April. There is some blurring of Enhanced Services with Practice Based Commissioning but essentially a paper produced by Waveney PBC on Enhanced Services is intended to clarify and equalise the services to be offered and paid for across the area, such that where one practice is unable or unwilling to offer a service it can be offered to all patients elsewhere. As PBC opens the opportunity for other providers in the future it may threaten core primary care business.

**GMS/PMS Review** - this is likely to be published in May but hopefully, judging by the exercise in Norfolk PCT, is unlikely to cause much in the way of fireworks. It seems likely to reflect the significantly lower funding of primary care for this PCT compared with national figures.

**PCT Estates Strategy** continues to be unavailable and does not allow practices to make bids to develop infrastructure and services. This situation has remained unchanged for several years and is totally unacceptable. It would appear that practices who wish to take their development aspirations and projects forward should continue to try to do so and make as much fuss as possible so that the PCT is forced to acknowledge them, as is happening with some projects. We are alarmed that there appears to be no openness, fairness or equity or a clear strategy from the PCT on practice development. Annette Abbott, Chair, GtY&W LMC Subcommittee

### “Employed Doctors?”

**- are you looking after them as they are the future of general practice?** You will recall items in flyers at the turn of the year about the conditions of non-principals throughout the country. The LMC has now had a meeting involving its salaried and self-employed constituency reps and Jeremy Pym of the BMA, to clarify various issues. GMS practices *must* offer the BMA recommended contract - or one with better terms - or they are breaching their contract with the PCT. The GPC and Norfolk LMC believe that PMS practices and APMS practices should also be offering the same. Poorly rewarding employed doctors will only create a dissatisfied workforce that would be happy to work for APMS providers from the private sector - destabilising the model of general practice we believe in. It is probably true that the BMA contract is ripe for a little tinkering. For example the amount of time for personal development in it does seem significantly greater than that which principals themselves are able to take in most practices. It is interesting to note that the RCGP is talking in terms of 50 hours a year for GPs to keep up to date which, on the face of it, is likely to be considerably less than the session a week suggested in the BMA contract for Employed Doctors.

The LMC, and in particular its non principal members, will continue to look at how they can work with, and help, NPs throughout our area.

### Sudden Unexpected Death in Infancy and Childhood

Local guidance about this has come in under many GPs' radar. Whilst most unexpected deaths in infants and children occur in the first two years of life the guidance applies in the investigation of children and young people up to 17 years of age who die. Clearly this is a rare event but it is hoped that this summary will be of some help to any GP involved. The recommendations do not apply to the investigation of the death of a child where the circumstances, whilst unexpected, are readily apparent e.g. a motor vehicle accident. Every sudden unexpected death in childhood will prompt a multi-disciplinary investigation by health professionals, Police and Children's Services. Careful documentation of the resuscitation, history and examination is vital. Occasionally the GP is the first professional to

attend the scene of an Unexpected Death in Childhood. Upon arrival the child should be assessed. If appropriate, life support should be started and a blue light ambulance summoned. The scene should be observed and the position of the child noted. If the child is obviously dead and the GP is the first at the scene they should take responsibility for contacting the Police and the Coroner's Officer via Police Headquarters: dial 999 - the police are aware of the process. The police will also organise the ambulance and, in or out of hours, will inform the Coroner - although there is nothing to stop the GP also doing so.

The GP should not leave before discussing doing so with the police. The police will make a decision if the scene is a crime scene. If this is the case the child will remain at the scene. Even if the GP determines that the child has died it is important that the body of the child is taken to the A&E department and not to the mortuary. If the GP decides to pronounce death he/she should consult with the senior police officer present before allowing the Ambulance Service to remove the body of the child to the hospital. The GP may not issue a death certificate.

To the best of our knowledge the guidance in Waveney is the same but our conversations have been with the Norfolk lead paediatrician.

### Pharmacy White Paper

“Building on Strength - Delivering the Future” While this is mainly concerned with community pharmacy it has a wider context, including dispensing doctors, hospital pharmacies, professional regulation, education and training. It draws on recommendations from the Galbraith Review some of which are sensible, such as streamlining the control of entry regulatory and administrative framework. It also considers issues around 100 hour pharmacies and pharmacists becoming more involved in clinical work thus reducing their dependence on retail sales. Examples include increased clinical input into areas such as smoking cessation, obesity advice, minor ailments and sexual health. There are also sections on the increased use of pharmacists in the care of patients with chronic disease under the banner of “more pharmacy services supporting healthy living and better care”. For example making routine check-ups and

monitoring for people with long-term conditions available on a drop-in basis. It heralds a new relationship between the medical profession and the pharmacists and locally we have added this to the agenda for our forthcoming meetings with both the Suffolk and Norfolk LPCs.

PCTs will be required to make a needs assessment for pharmacy provision as part of “World Class Commissioning” which could potentially have dramatic effect on the level of pharmacy services. The paper talks about supporting contractors who invest in services but also talks about contracts being removed from contractors who fail to come up to standard. There is a specific concern amongst dispensing doctors although there are also opportunities. The thrust will be that both dispensing doctors and pharmacists will be seen as providers of pharmaceutical services and will be expected to attain the same standards. If they fail to achieve these requirements then they will be at risk of losing their contracts. Chapter 8 is a “must read” for all dispensing doctors. Although it is a White Paper this chapter is really a “Green” chapter, in that all the proposed changes are up for consultation.

There will be ongoing discussions between the GPC, DDA and PSNC and DoH. Dr Hume is attending a launch event at the beginning of May and we will keep you updated.

### Employees and NHS Pension Entitlement

Reminder - anyone working for a GP Practice, aged 16-70 is automatically a member of the NHS Pension Scheme unless they choose to opt out.

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