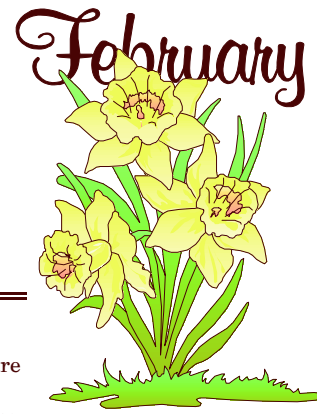


NORFOLK LOCAL MEDICAL COMMITTEE



Wymondham Medical Centre, Postmill Close, Wymondham, NR18 0RF
tel: 01953 608060 fax: 01953 608061 email: norfolkmmc@btconnect.com
www.norfolkmmc.org.uk
February 2008

Can you afford to work for nothing?

It is very hard for practice managers to do their business planning in the current state of uncertainty - how on earth are practices supposed to be preparing for a possible extended hours enhanced service - with its implications for staff and premises - when there is so little firm information? But, whatever the outcome of the extended hours enhanced service argument, the access and choose and book enhanced services are coming to an end. Unless you are happy to pay your staff to do work that brings in no practice income and which takes them away from work that does, or from work which would make your life easier, then we suggest you plan how best to take advantage of ceasing this work - perhaps by redeploying staff.

Of course, many of you will be aware that "Choose and Book" and "Access" are on PCTs' *must do* lists - so it is not impossible that they may suddenly find some money that has fallen down behind a filing cabinet with which to encourage practices to continue from April. But setting up your spread sheets now should make sure that if an offer magically appears on the table you will be able instantly to decide whether it makes business sense or is a bit of a turkey, maybe with a few unappetising strings attached. Also, whatever the outcome of the extended hours enhanced service argument, incomes will drop next year while expenses will increase - ie practice profits will fall again. You should consider very carefully any work you may be doing that is not funded, or which is funded at less than the going rate, and which takes your staff away from what they should be doing. Examples might include phlebotomy, insulin conversion, goserelin injections, suture removal and dressings (from secondary care procedures), complex dressings - formerly done by community staff - and anything else that others might ask us to do but which are not essential services or otherwise funded. We strongly suggest you get those spread sheets revved up, make your business decisions and then act on them. SRL

Dental Matters

The officers regularly meet their opposite numbers from the other representative committees. We recently met Nick Stolls of the Norfolk Local Dental Committee and discussed three issues relevant to GPs and dentists. No doubt the issues raised will also ring bells with colleagues in Waveney.

Smoking cessation: In Norfolk PCT there have been queries from practices whose patients had received level two smoking cessation advice from dentists. If over the counter NRT is required and the patient is happy to pay for it, or has a voucher, there is no problem. However, if bupropion or varenicline or, indeed, NRT on prescription is required, dentists can't prescribe it. These drugs are not included in the current dental formulary; indeed, we understand it is unlikely that they will ever be.

This raises a couple of issues: prescribing responsibility and payment for work. The prescribing issue is the same as with any recommendation by a specialist - you have the option either to prescribe or not - depending on whether you think the suggestion is sensible. Clearly you will have access to information that the dentist does not have - on medication and allergies - and you need to check these, meaning that you are having to do some additional work. Or you may feel that your staff should repeat the assessment so you can have confidence in the recommendations. If so, Norfolk PCT has been very kind and said you may carry out a second assessment and be paid.

Two week waits: the Medical Secretary saw a patient with a tongue lesion that didn't look terribly sinister; he was reassured when the patient's dentist apparently subsequently said that he thought it was caused by a sharp or broken tooth. To cut a long story short it eventually turned out to be a squamous cell

carcinoma and I worry that there might have been a bit of a delay because each of us felt reassured that another professional was involved. Dentists have available an equivalent urgent referral pathway. I wondered if there should be some mechanism for the GP and dentist to swap concerns in this situation but Nick felt it would be difficult to set up something foolproof. He will see if the LDC has any ideas but in the meantime we agreed that the first professional to see an oral lesion that could be cancer has to take responsibility for follow up and/or referral - whether or not a different professional is also seeing the patient.

Antibiotic prescribing: this still causes grief to GPs who see patients who allege that their dentist asked them to get antibiotics from the doctor. Generally this history should be taken

with a big pinch of salt as it is more than likely that the dentist offered to see the patient but the patient preferred not to wait or decided it was more convenient to see the GP. The GP has to either risk the doctor patient relationship by declining to help, or risk prescribing

outside his or her area of expertise. We thought it might be interesting to audit antibiotic prescribing by dentists as, if there is lots, that would imply that the proper (dentist) pathway generally does work and doctors are only rarely sucked in. Of course the opposite result might lead to the opposite conclusion.

Codes 9KK and 9NS2

An eagle eyed, IT literate, constituent campaigner against non clinical coding creep, clutter and confusion asked us to confirm with

GPC that these codes are superfluous and can be dispensed with. The response was that there was a proposal at one time to use these read code entries to identify patients for the Choice DES, but this fell by the privacy wayside and, therefore, the use of these codes can be abandoned. Please make sure that your secretaries know this - or they may lose their chance to not use these codes before we all abandon Choose and Book for good on 1st April.

You can't believe what you read in the funny papers

I gave a chatty interview to Pulse a couple of weeks ago. My rather chequered career in medical politics was truncated to: "LMC Secretary since 1987". This is, of course, not true. Ian Mitchell did the job while I was Chairman and Peter Harvey while I was in PCG/PCT-land thinking that could make a difference. They both did it jolly well, too.

I am sure that you all know that you can't believe the comics. In particular they have a tendency to try to make everything a crisis - because that is what they think will get them read. Please remember this when they are "reporting" current national difficulties.

BMA Eastern Regional Council Open Meeting for BMA Members

The meeting, which takes place at 2 pm (light lunch available from 1.30) on Tuesday 11 March at Madingley Hall, Cambridge CB123 8AQ, is designed to stimulate discussion between primary and secondary clinicians on the future of the profession. Dr Hamish Meldrum, Chairman of BMA Council, is the keynote speaker. Contact lsmith@bma.org.uk or 020 8655 8809

DEATH

In May 2003 the LMC issued guidance, drawn up by Secretary Peter Harvey, entitled: "Deaths in the Community - Guidance for GPs". It was agreed by the Norfolk Constabulary, the Coroner, the Out-of-Hours Service and the Medical Protection Society. However it has become increasingly obvious that the Coroner's Officers now either work to different rules or are interpreting the rules differently. We recently met Mr William Armstrong, the Norfolk Coroner, and one of his Officers. It became clear during quite a lengthy meeting that it would be

very difficult to cover every possible eventuality in LMC guidance. We did not touch on cremation issues; also the office has learned of some new protocols to do with sudden death in children. But some useful themes emerged.

A common situation, that causes concern to the Coroner and his Officers, is delay in them being made aware of a death that, ultimately, they have to investigate. I have certainly been guilty of assuming that a colleague would be willing to do the death certificate in an elderly person they have seen fairly recently - but they later feel they can not; on occasion that doctor has been on holiday - resulting in delay. This situation is difficult for the Coroner's Officers and, no doubt, for the family. When GPs do this I know it is with the intention of saving the family stress and upset - in the belief that the Coroner's process, generally started by a uniformed police officer and ending in a postmortem, would be extremely upsetting for the family. We were strongly reassured that the police officers (who carry out the work on behalf of the Coroner when the Coroner's Officers are not available) are both very well trained and compassionate. Also, many Coroner's cases do not end up with a postmortem.

So, the rule of thumb for the first doctor involved has changed from: "I am pretty sure someone else will be able to sign the death certificate - so lets hang on and see", to asking him or her self: "am I going to sign the death certificate?" If the answer is "no", the next question is: "am I 100% certain that another doctor will be signing the death certificate?" If not, and it is not possible to check with that doctor there and then, the Coroner's Officers should be informed (in-hours), or the police (out-of-hours). It is no longer correct to authorise the removal of the body unless you **know** there is a GP who will be able and willing to sign the certificate. This dilemma is more likely out-of-hours. The Coroner plans to talk to the OOH Service separately. We were able to explain about the list of palliative care/expected deaths that the out of hours service is likely to hold - so there can be circumstances where the doctor working for the OOH service, while having no personal knowledge of the patient, can be confident that there will be no problem with certification. Even then there could be problems - if the information that the OOH service has is quite old.

During the working day, we agreed that it would be reasonable to allow a few hours to check with the doctor who should be able to sign the death certificate; but we also agreed that, if the appropriate doctor cannot be contacted, then the Coroner's Officer must be told **that day**. One practice helpfully sent us the flow chart that they use in these circumstances. The GPs, if they are away for a few days only, have agreed to accept contacts via their mobile 'phones - to confirm that they will be prepared to sign the certificate. The Coroner's Officer thought that this was a good model but, as stated above, wants the matter settled one way or the other on the same working day. **This means that the Coroner's Officers must be informed by 3.00 pm that there could be a problem.** So, if the doctor can't be contacted, even though the practice has no reason to believe that there will be a problem, the Coroner's Officer should be made aware that afternoon. They will then put the family in the picture. The family may, of course, elect to wait in the hope and expectation that the certificate will be issued.

The Coroner's Officers request that we telephone and discuss cases more than we have been - whenever there is any uncertainty in our minds. They accept that this will increase their workload

but feel that it is correct and likely to be best for all concerned. For complicated issues out-of-hours there is an on-call officer, but it is difficult to know what sort of query it would be worth disturbing them for. The default position is that, if out-of-hours you are the first doctor advised of a death and you cannot be 100% certain that you, or a colleague, will be able to certify, the appropriate action is to advise the police.

There was also some discussion about confirming death. I think it is appropriate here to reiterate the guidance given in the previous LMC paper, which has not changed, that the GP should act compassionately and professionally and, even if **confirmation of death does not require the GP**, we have a pastoral duty to bereaved relatives. The Coroner's Officer shared a case with us where, on the face of it, the doctor did not act compassionately, leaving an elderly and infirm husband, who thought his wife had died, to deal with the matter entirely on his own. Of course this may not be an entirely accurate account but, nevertheless, in a situation this sensitive we would urge doctors to be prepared to visit, even out of hours. SRL

Advertisement

An experienced GP on the Norfolk Performers List is happy to do locum work for practices within a reasonable distance of her Cringleford home. Available all week, happy to do house calls etc. Please contact Dr Trudy Welton on 01603 506075 or email at tstebbs@hotmail.com

Advertisement

We are experienced GPs, having recently left partnerships in London to move to Norfolk with our family. We are looking for locum work in the short-term but then permanent jobs and are quite flexible because there are two of us. We are on the Norfolk PCT Performers List and can provide CVs and certificates when requested. Please contact Drs Shona and David Lidgley @ lidgley714@btinternet.com or 01366 380226

Advertisement

Old Palace Medical Practice

Norwich GP part-time around 4 sessions per week. Super opportunity to join a small well-organised training practice from end April 08.

- ▶ Maximum QOF points 3 years running
- ▶ Top quality team approach to care
- ▶ Excellent Salary
- ▶ Current postholder moving on to local partnership

Phone or email for further details to Donna Laws-Chapman, PM, Old Palace Medical Practice, 148 Old Palace Rd, Norwich NR2 4JA. 01603 663363, donna.laws-chapman@nhs.net

Information Governance Security Assurance

Norfolk PCT PMs will have received a rather daunting email from Shane Dark: "Urgent: IG Security Assurance". Practices hold a lot of secure information and it is right that we take good care of it. I am sure that we do, but no system is perfect. Many in the profession criticise government and its IT failures, up to and including warning patients about allowing their medical information to be on "the spine". We have to be confident that our own houses are

in order. Mr Dark has said he will put together more definitive information packs in the near future, based on feedback from practices.

In essence, practices should be careful to ensure that no portable person-identifiable or other sensitive data is transferred unless suitable encrypted (this includes backup tapes for offsite storage or verification, PDAs, laptops, USB memory keys and Removable Hard Disk Drives. Exclusions may only be created on an individual basis with approval of the (practice's) Caldicott Guardian. I am sure that this is the level of security we would all want for our own medical records.



If there are resource issues falling out of this then I would assume that will require negotiation - ideally national (though in the current situation who can say) but local if it has to be. So please advise the LMC if you believe keeping your electronic data secure will cause you problems.

Advertisement

Wymondham Medical Practice Full Time Replacement required for Retiring Senior Partner

- Partnership or Salaried considered
- Close to Norwich & The Broads
- Attractive market town
- Well organised paper-lite practice
- High quality, enthusiastic, forward looking team
- Modern purpose-built premises
- High QOF points
- Run own list
- 12 Doctor PMS practice 18200 patients
- Start date August 2008

Closing date 25.03.08. Interviews tbc but in weeks of 7th & 14th April. Informal visits welcomed, practice profiles from and applications in writing with CV to Kevan Baker, Practice Manager, 01953 713448 or email kevan.baker@nhs.net.

Advertisement

The Long Stratton Medical Partnership Retirement Vacancy, GMS & Rural Dispensing

An Excellent Practice - A Happy Team. Ideally looking for a full-time Partner to start Sept '08. We are flexible enough to consider applications from GPs who would prefer a salaried position. If you feel you could fully contribute to maintaining our happy, dynamic, enthusiastic service, please apply.

- List size 8900 growing slowly, no deprivation
- 5 whole time partners
- Personal lists, holistic care, exemplary clinic appointment structure
- Full QOF Points 3 years running
- EMIS PCS paper light
- UEA medical students
- Cheerful practice team with supporting multi-disciplinary backup
- 6 weeks holiday, 1 week study leave
- Good housing, schools and facilities
- Easy Access to Norwich - a Beautiful City

Informal Enquiries and Visits Welcome. Closing date March 21st 2008 and formal interviews until 7th April. Apply by e-mail or in writing with CV and covering letter to: Lynn Crawshaw, Practice

Manager, The Swan Lane Surgery, Tharston,
Norwich, NR15 2UY, Tel 01508 530781, Email
long.stratton@nhs.net

Domestic Violence

A constituent has asked us to recommend that practices obtain a copy of the DH's publication "Responding to domestic abuse: a handbook for health professionals" as it is in an easy to use folder and also comes with a CD-ROM etc.