

# NORFOLK LOCAL MEDICAL COMMITTEE

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



## 2008 Conference of LMCs - Report from Dr Simon Lockett, Medical Secretary

**Prelude: Conference statistics** One million two hundred and thirty six thousand and eighty five (1,236,085): the number of patients who, within just three weeks, signed the petition supporting the BMA's campaign to save general practice as we know it. Male representatives in ties: down to around 40% this year; male representatives in shorts - one on each day (it was far from warm in London). Ratio of male to female representatives: this seemed higher than usual this year, perhaps 80-85% of representatives appearing to be male. Neighbours of Norfolk LMC Secretary whose fizzy water exploded (even though they swore blind they hadn't shaken it): 100%. Percentage of votes cast on motion 355 (iv): 101%. This rather called into question the legitimacy of the electronic voting system.



**The First Morning** Not an auspicious start - SRL arrives 10 minutes late. Twenty years of conference attending had convinced him that he didn't need to study the agenda in advance — he was expecting a 10 o'clock start rather than 9.30. Fortunately, nothing significant seems to have happened in the first 10- minutes. The main event of the first morning is generally the Chairman of the GPC's speech. This year, I guess we knew what Laurence was going to say - but he said it so well that he got three standing ovations.

Some of the main themes of Dr Buckman's speech were: The ongoing distancing of NHS General Practice from the government - resulting in a mutual level of mistrust that does no one any good. "It is bad for society, corrosive to the body politic and dreadful for our patients. GPs just want to be left to get on with the job of healing the sick". The pensions judicial review got its mention as the big victory of the year.

84% of patients expressed satisfaction with GP hours, yet the government has managed to come up with an unattractive and rigid scheme to make GPs sit in surgeries in evenings and at weekends. The majority of GPs were already willing to provide extended hours if properly resourced.

A "score card" on the New Contract - from both GPs' and the Government's points of view. GPs: Essential Services delivered; Quality Outcomes Framework - delivered; Enhanced Services - delivered; Additional services - delivered; Efficiency Gains - delivered. The Government: MPIG - broken promise; Pensions - broken promise; Guaranteed Enhanced Services Floor - broken promise; Equitable PMS Return - broken promise; Contract imposition only in "National Emergencies" - broken promise.

Conference heard that things are better in Wales, Scotland and Northern Ireland - although there are worries in all the Celtic Regions that duff ideas from England will cross their borders. The London government's analysis about GPs is that "we are not required and what voters want is a fast service from anyone"; whereas we know that patients come to us because they see us as providing continuity, something that matters to many. There was plenty of applause for his next comment: "when asked how long we spend with patients we can say 25 years".

The next section of the speech was about the "vertical playing field" which makes it almost impossible for General Practice, however well organised and excellent its standards, to bid - and then to win a bid - for an APMS contract. Then more quotes: "Why is the Government trying to offload parts of the NHS? Is it so everyone can be blamed apart from the Government when things go wrong.....". "The NHS should be putting money into GP premises and staff rather than PFIs for the benefit of private shareholders. It will cost the country a fortune over the next 25 years."

The next sections were about GP led health centres and "polyclinics" - which might be all right in some places *with local consultation and agreement* but not elsewhere. Dr Buckman referred to the timely King's Fund Report (from the previous week) that had said there is very little evidence to support polyclinics - so they are a pretty bad idea.

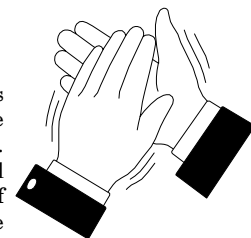
We then got the numbers for the campaign that you've all worked so hard at - resulting in a petition signed by one million two hundred and thirty six thousand and eighty five patients in only three weeks. It was to be delivered to Downing Street later that day.

Turning from the depressing recent past and immediate present, Dr Buckman then moved on to the future and how important it is that we do our best for the next generation of GPs. Many new GPs want to be brought into the workforce as partners or otherwise permanent staff, not roving locums. All of us must find a solution to the problem of how to accommodate our successors into meaningful roles before private providers poach them. Our patients need good doctors and there are plenty of underemployed ones out there. All of us need to think how we could add one to our own practice establishment.

There followed a brief mention of the current shambles that is Practice Based Commissioning - when it could have been great.

Dr Buckman then went on to give a brief historical resume of GP pay issues, the MPIG and the DDRB report.

Then, back to the future with advice to GPs and a commitment on behalf of the GPC. In dealing with a Government which seems to be unable to stop trying to attack us, GPs must show firmness and politeness. We must encourage the Government to introduce only evidence based policy. We must keep the public on side and never do anything to harm patients or the services they receive. Our patient allies will only understand while we defend the NHS. We are there to deliver for them, and we will. The GPC will keep civilised pressure on those who, witting or not, are going to wreck what GPs have spent the last 60 year developing. If Government want to work with general practice then that would be fine, if they don't then we will show our patients what the politicians are trying to do to their services. "So, what's it to be Government: peace and construction, or a never ending fight to protect the NHS". Dr Buckman was game for either.



*There followed the final standing ovation.*

The rest of the morning's business tended to be big motions on big issues with big majorities voting for them - generally unanimity. There were motions that confirmed Conference's view of the value and effectiveness of traditional general practice and the threat it is under; that discussed the actions that might be taken if the threat continues; on the confidence (or lack of it) in the Government's stewardship of the NHS; a demand for honesty from Government about what a cash limited NHS can afford; wanting a good evidence base for change and then pilot studies; proper expenditure on supporting premises development; supporting small practices; confirming how badly Choose and Book is running in most parts of the country and opposition to referral management systems

Darzi reviews were discussed in a chunk with a lead speaker followed by lots of one minute contributions from the floor. The main speaker was Professor Steve Field, Chairman of Council, RCGP, who reminded Conference that general practice is not only the "jewel in the crown" of the NHS but also the

workhorse - thereby demonstrating its versatility. He talked about the federated practice model - which the College is working on with the GPC - and told Conference that he was being invited as a guest speaker to Harvard University where the Americans are actually anxious to learn about the benefits of British general practice (at the same time as our Government seems to be trying to implement some of the worst aspects of the US health care system). In this section Conference professed no confidence in Lord Darzi personally (against the advice of the platform that doesn't think that we should "do personal") and of his review in general, also in his ability to carry out a review "independent of political control and free of pre-determined outcome"; another motion emphasised the lack of evidence that Darzi centres will accomplish anything and were generally unwanted by most of the key players. Another issue that has appeared in some SHA's responses to the Darzi proposals (that children should be looked after by some sort of "specialist practitioners" rather than by GPs) was felt to be a) impossible - considering the number of consultations that there are and b) inadvisable - leading to the opposite of holistic care for the child and its family.

Norfolk representatives then stuck it out in a rapidly emptying hall through the next section "charities" before exiting for a rapid lunch.

**Transcribing amusement** Elaine (my wife) who wanted to transcribe my dictation ("it's the only time you talk to me"), turned Darzi into Darcy. I now can't rid my head of a most disturbing image: Lord Darzi rising from the lake - his rippling chest muscles emphasised by his tight wet surgical scrubs. Thank goodness my crinolines are loose it being a Sunday.

**Interlude: light etiquette** At the start of your speech a green light shows; it turns yellow when one minute remains and red when you've had your lot. Many speakers seem unable to pace themselves. Sometimes this is because they've written an excellent speech during which they have had to pause because of applause and/or laughter. When a speech is going down well Conference will invariably shout "more" when the red light comes on - often before the Chairman has had a chance to tell the speaker to finish off. For those whose speeches are less well received, the red light brings forth a variety of responses. Many just try and read the rest of their speech faster and, when told by the Chairman that the "really must wind up", they speed up still further. Some say "just one sentence" and then continue with everything they had been planning on saying, substituting "and" for each full stop. The best rejoinder to the Chairman's attempts to get a speaker to stop was when Fay pointed out to a particular speaker that he was very experienced (with the implication that by now he really ought to know when to stop) which met with the excellent rejoinder "but I always ignore the lights".



**First day, afternoon session** Norfolk got back within moments of opening time but, at first, bottoms were thin on the seats - so the electronic voting apparatus given to each representative had to be used to determine whether Conference was yet quorate and business started a few minutes late. Important matters discussed during the first afternoon included whether the contributions made by the LMC to the General Practitioners Defence Fund should vary across the four nations and whether it would be fairer to link it in with the Carr Hill formula (of course not); also various governance matters - including a motion somewhat critical of the Healthcare Commission and another criticising "performance frameworks" and "balanced score cards" as leading to unscientific criteria and data being used to judge practices.

"Workforce" motions restated the theme that everything possible should be done to encourage entrants into general practice to become practice partners - when that is their wish. A set of motions from the GP Trainee sub-committee demonstrated that things are very difficult out there for those going through their training - with particular problems getting out-of-hours training - and for newly qualified general practitioners. For example, in some parts of the country GPs who have recently finished Vocational Training are finding it very hard to get work for out-of-hours services on the grounds of lack of experience.

A good laugh is always helpful to relieve some of the Conference's tensions; the best speech of the day to this end was to a slightly contrived motion from Cambridgeshire LMC on "translation services": apparently, some PCTs are withdrawing funds from this service - which is extremely important in many parts of the country. The "speech" consisted of the main speaker reading it out sentences in a real or imaginary eastern European language, with another Cambridge representative providing a translation of sorts with the obvious-in-retrospect-but-amusing-at-the-time verbal gags that such a performance allows.

**Question time with the negotiating team** This was a half hour slot: I don't think any of the questions or answers will have come as any great surprise to any who read the Flyer and what comes from the GPC. One clear message for all GPs is that, when having one's arms twisted to work for little or nothing - by PCTs (for example: extended hours) or by hospital colleagues (work shifting from secondary to primary care) - do look carefully at "the bottom line" and stand together.

**More Debates** After that there came the customary motion (emphasising Conference's democratic credentials) denigrating the skill of the GPC, its negotiators and publicists and asking for the appointment of "independent professional negotiators (who possess an equally unprincipled and obdurate attitude as that of number 10 and its advisers)". The opinion of Conference, in the light of the perceived success of the petition, was that the GPC was doing pretty well - with an impossible job in an impossible situation. Even the speaker did so pretty unwillingly - this critical motion had been cobbled together from several put in by unhappy LMCs, most of which he probably didn't agree with. Conference was on his side, if not on the side of his motion, from when he said that he wished that Gordon Brown were attending the Conference because then he, the speaker, would not be the most unpopular person in the room.

Strategically placed after this section was **Pensions**, giving conference the chance to give the negotiators their much deserved pat on the back for being sufficiently brave to go to judicial review and for winning. Following this was the regular motion on charging ones own patients for services that they want and which you are able to provide but which are not commissioned locally - which was carried. That was more or less the end of the first day.

**Interlude: Bag etiquette** Attendees of the conference get their papers in a cool bag. The Secretary can't remember what was provided at his first few conferences at the end of the 1980s - probably just a cardboard envelope file. Then, for a number of years, a plastic pouch folder - generally sponsored by Wyeth - did the job. These remain indestructible and useful but many will, no doubt, lie in landfill for as long as there is NHS general practice - or a lot longer. Towards the end of the 1990s these clearly became insufficiently grand and annually upgraded canvas shoulder bags became the order of the two days. These became of higher and higher quality but, interestingly, this seemed to peak in 2005 and 2006 becoming smaller, and less endowed with pockets, since then. Clearly there is a direct proportional relationship between our income under the New Contract and conference bag luxury. I'm not entirely sure why this should be so but, as the bags' sponsors no doubt hope that they will attract money from GPs, it is perhaps a reflection of their (accurate) assessment that disposable income has been going down for two or three years.

The bags are proudly emblazoned "LMC Conference" and "BMA". Outside the conference hall some wear them with pride over their shoulders with the writing on the outside, others, perhaps more faint-hearted and aware of the fifty million people who *have not* signed the petition, have the writing on the inside. Other representatives of a similar bent put them inside another bag. Or maybe, Elaine has taken it upon herself to add to my initial dictation, it suggests some individuals just don't like to advertise their medical connections in case someone at the station collapses and they are called upon to help. She knows me too well. Weirdest of all (in my view) is a practice adopted by one of your Norfolk team some who bring their bag from years ago and put the new bag therein. What message this is meant to convey and to whom, is unclear.



**Second Day, Morning** We started on time although many representatives looked somewhat the worse for wear after the Conference dinner. I can't tell you anything about that because I don't go but, perhaps for this year only, would have quite liked to as the speaker was Jo Brand.

The second day always seems to include a wider range of motions. This makes the day less coherent but you are more likely to get some slightly off the wall and, dare I say it, more interesting motions, such as one about obesity in particular and medicalising behaviour and "social problems" in general. A couple of proud-to-be-fat speakers, both male, entertained Conference and we heard about a new cause for obesity - Alzheimer's bulimia; this is when the patient eats too much, but forgets to vomit. Also in the "public health" section, unplanned and un-evidenced screening programmes for the over forties came under criticism as did, in fact, pretty much everything else that was talked about. Topics included: the lack of resources for the training

of GPs, F1 and F2 doctors and medical students; the difficulties trainees are experiencing getting their out of hours experience (again); the implementation of the Tooke report's recommendations to increase general practice training to five years; the Government's (in)ability to store records safely and keep information confidential. Privatisation was criticised, as was a motion - for calling it "creeping" privatisation while Conference felt it was overt, fast and extremely threatening. Conference was not enthusiastic about a suggestion that GPs might go back to having 24 hours a day, 365 days a year, responsibility for their patients. The government's enforced changes to the QOF - going against clinical care and evidence-based change - were, of course, criticised.

The "clinical and prescribing" section led to a request for some rationalisation of travel and some other immunisations; again this is pretty well an annual motion - Conference heard that the problem is with the immunisation committee that never discusses what it concludes, or negotiates its implementation, with general practice.

The dispensing section included concerns about the Pharmacy White Paper and what might happen to dispensing as a result of it. The platform reiterated reassurances previously given that the most threatening sections of the White Paper are for discussion and consultation and may well not lead to change sooner than a change in government.

A section on "GMS negotiations" followed - this seemed to cover much of the same ground as similar motions on the first day.

The morning session finished a little late - which made it slightly unfair that representatives were lambasted for conference being unquorate for a few minutes after the break. No meals are provided on site, so representatives are subject to local geography and speed-serving in the local eating-houses.

**Interlude: outside the main hall** So much business is crammed in to each session that it is very difficult to take either comfort or refreshment breaks. Traditional slots for doing so include the "reports from the other countries", the charities and, I suspect, dispensing issues (for non dispensing representatives). The seating in Logan hall is steeply raked with long rows, generally a trip to the loo necessitates hopping over a number of chairs on to a lower tier this risks physical damage to the bodily part which will shortly be required.

Each day, representatives get half a dozen brightly coloured beverage-billet-doux to exchange for drinks on the conference site; I am sure nobody manages to use them all up. Lunch is off site; the Logan Hall is not such a pleasant environment that one would contemplate bringing food and eating in - so lunch tends to be a race towards indigestion and a rapid return. That being said, getting out to eat some lunch is something that colleagues in surgeries are most unlikely to be able to do - so I guess the representatives do not have much to moan about.



**Second day: afternoon session** On the face of it - some more repetition: there were motions on public relations, GP pay and the DDRB - although Conference quite rightly rejected motions bringing into question the independence and level of knowledge of the Review Body and one of "no confidence" in the Review Body. Representatives were well aware that over the years the profession has done better than would have been expected if there had been no DDRB.

A lengthy part of the afternoon was then given over to a debate on the mechanisms of funding for general practice. This had a similar structure to the previous day's Darzi debates: an opening speaker outlined some issues, followed by numerous contributions from the floor. This time, discussions started with a personal view from Dr Eric Rose who has been a Conference regular for many years and whose last conference this was. Contributions from the floor included: the failure to increase the global sum and the MPIG issue; whether there could, or should, be a better formula; seniority pay and the unsatisfactory way in which PCTs go about reimbursing locum fees in the event of maternity, paternity and adoptive leave; also in the case of sickness.

After this came: motions on PMS, medical certificates and reports, extended hours and access (including the CBI's contribution to the debate). All resulted in the expected votes. Motion 615 reminded GPs that it is hypocritical to promote continuity of care but not to offer it (food for thought in a big, split sight practice like that of your Secretary; motion 618 led to Norfolk's sole platform speech - an excellent one from Tony Allen on the difficulties caused by the under-resourcing of, and changed working patterns for, community staff.

A brief "soap box" session livened up the late afternoon - four representatives spoke on matters dear to their hearts. These included first aid training for school children (more use than Religious Instruction), women's health, the regulation of other health professionals and child immunisation records - the suggestion being made that GP practices should have direct access to those records wherever they are held. Conference then finished after a final motion deploring the lack of enthusiasm for PBC amongst PCTs.



**Postlude 1) Norfolk's Contribution** For several years now Norfolk has not summoned up the enthusiasm necessary to send in motions on the subjects that everybody knows will be debated - on the off chance that a Norfolk member will be called to speak. Addressing Conference is a mixed blessing unless you really want to become a medical politician and feel that you must be seen and heard regularly throughout conference. For more normal representatives, the downsides of speaking are obvious: the chances are that you will get called third or fourth when all the points you would have wanted to make have already been made by someone who seems several times as eloquent as your rapidly draining self-confidence makes you feel that you are. Norfolk sent in several motions that were top of their section in Agenda: Part 2 (motions not prioritised for debate) ie interesting but not terribly relevant (a reflection of its Secretary, perhaps). This suggests that if there had been a third day we would all have had our moments in the spot light. Norfolk's representatives were present most of the time, listened very carefully before sticking up their hands - doing their bit for the profession's democratic processes in what is a very difficult time for general practice.



**Postlude 2) Mood of Conference** In the hall there was certainly a feeling that what we were doing was making a difference. This was buoyed up by the public's response to the BMA led campaign. Certainly being amongst hundreds of GP colleagues - all of whom know what a mess the Government is making of a service that it should be really proud of - unites and strengthens.

However, after two days it is back to the real world and some disappointment at the lack of cover of the important issues that were raised. The Secretary's Guardian, no friend of the Government, gave only a very short report on the first day, giving Gordon Brown the last word on the petition. An awful lot of work is left for us to do within our practices, with our patients and with our PCTs, just as there is for the GPC and the negotiators with the Government, if we want there to be something recognisable as great British General Practice in which the next generation of family doctors can work. **SRL June 08**

#### Out of Hours - Great Yarmouth & Waveney

Please would GtY&W practices log any out of hours issues/complaints as critical incidents. This should include the TCN call number, the patient's NHS number and sufficient anonymised detail for TCN and the PCT to investigate. Also, please copy in the LMC office and the PCT when you write to TCN in order that we may have an overview.

#### Dumped Work: Next Steps

Several recent items in the Flyer have been about unpaid work being done in practices. Examples include clip and stitch removal and dressings after secondary care procedures, also complex ulcer dressings. At the very least there is a cost to the practice in staff (generally nurse) time - although to add insult to injury someone else is probably being paid for doing some of this stuff and some even require the practice to purchase equipment. Another related issue is

providing unfunded Chlamydia *screening* - which some practices seem only too happy to do. As ever, GPs' and their nurses' altruism is wonderful to behold - but General Practices are businesses and do require positive, rather than negative, cash flows. Your practice's incomes will go down this year and probably went down last year. That will affect the services you provide. If you are tempted to do something about this then you might like to know that you will not be the first. The LMC office has been copied into letters from practices which are grasping the nettle. For example, one is giving

three month's notice that they will be referring such work back to the acute provider or the district nursing service as appropriate, another will be billing the hospital for sterile suture removal packs.

We suggest you look carefully at your surgery finances and decide if now is the time to take a stand.

### Bidding and Tendering a Guide for Doctors

In the brave new world of Darzi Centres and APMS this document, produced by BMA Business Support, may be useful. We cannot circulate it as it is "only for BMA members" but I am sure someone in your practice who is a member will be able to lay their hands on a copy on the BMA website.

### DDRB News or Not

The DDRB recommended a 2.7% uplift for the core contract. The LMC is arguing that all practices should receive this uplift. This means following a national route for GMS and a local route for PMS. Speaking to other LMCs it is clear that PCTs are waiting for national guidance so on this issue PMS and GMS are inextricably linked.

We wish to see equity which appears to have at least two different outcomes. Either everyone gets 2.7% or no-one gets anything.

If a zero percent increase is the outcome we should see the 1.5% extra investment as guaranteed in the earlier poll but this will be attached to additional work so do not count on it being a financial saviour.

I will be following this up with GPC and appreciate that you all want to see the matter resolved. Until a decision is made on GMS we are unlikely to see any movement on PMS contracts. Clearly a very unsatisfactory situation. Ian Hume, LMC Chairman and GPC member.

### Pharmacy White Paper update

The following motion received overwhelming backing from the LMC Conference

*That conference is gravely concerned that implementation of the Pharmacy White Paper, "Pharmacy in England building on strengths - delivering the future" will, by effectively outlawing dispensing by doctors in the vast majority of the country, deprive patients choice and local access to a much appreciated service, destabilise rural general practice without providing appropriate local alternatives, cause an unnecessary increase in the NHS budget and calls on GPC to fight the proposals with utmost vigour.*

Norfolk LMC has now had an opportunity to meet with the Secretaries of both Norfolk & Suffolk Local Pharmacy Committees. It is clear that neither the pharmacy profession nor the medical profession want to see major changes in the present regulatory framework. Both professions recognise that the Pharmacy White Paper offers significant opportunities and challenges. We need to work together to make it a success. The DoH has made it clear that no decision has been made on possible changes to control of entry regulations and that further consultation will occur later in the summer. The BMA will work closely with the DDA and pharmacists to influence the outcome of these discussions in line with the above Conference policy. IH.

### Advertisement

Experienced GP recently returned to Norfolk after working in Canada. Available for short and long-term locum work and very interested in part-time salaried position. Currently based in Hethersett. Please email Dr Nina Blinkhorn at [ninaa4@googlemail.com](mailto:ninaa4@googlemail.com)

### Advertisement

**Castle Partnership - Gurney Surgery - Norwich**  
6, 7 or 8 session Salaried GP  
for a 6 month contract, start August 2008

We are a friendly well established city centre practice with a clinically diverse patient population.

- We have three surgery sites, 11 partners and over 16800 patients
- The practice is paper light and uses the TPP clinical system
- We have well established clinical governance and clinical development systems in place, high achievement on QoF and a friendly approachable management team to support you.
- We have a well developed nursing team and a Nurse Practitioner based at our Gurney surgery
- We are a training practice

If you have **energy, enthusiasm, commitment and a sense of humour** - why not join us. For an information pack please email [sandra.edgell@nhs.net](mailto:sandra.edgell@nhs.net) with your CV and details of preferred number of sessions and days of work by 27 June 2008.

### Advertisement

#### VIDA HEALTHCARE

Kings Lynn and Dersingham

A Unique Opportunity to Work in Norfolk's  
Newest Health Centre and Earn Around  
£80,000

**FULL TIME FIXED SHARE GP**  
**PART TIME FIXED SHARE GP**

(two days a week - pro rata salary)

You will be based at the brand new Carole Brown Health Centre at Dersingham and as part of Vida Healthcare you will also be a member of the team that provides the highest quality of care to 22,000 patients (6000 at Dersingham)

Needless to say there is every opportunity for personal development and to contribute to the varied work in a premier, training Practice.

To get all the information please see the vacancies section of our website [www.vidahealthcare.nhs.uk](http://www.vidahealthcare.nhs.uk) or call our Managing Partner Graham Dickerson on 08444 996 881 or email [graham.dickerson@thehealthcentre.org.uk](mailto:graham.dickerson@thehealthcentre.org.uk)

### Maternity Locum Reimbursement

We are about to enter discussions with both GtY&W and Norfolk PCTs following the issue of further guidance from the DoH. It would be very helpful to know if any of you have experienced problems obtaining reimbursement or if you have been reimbursed whether the PCT has paid up in full.

### Advertisement

#### King's Lynn Norfolk

#### **F/T LOCUM FOR MATERNITY COVER with POSSIBILITY OF SALARIED POST**

We are looking for an enthusiastic and motivated doctor to join our large, thriving and friendly practice, initially for full-time maternity cover from September 2008 with the possibility of salaried post from April 2009. Job share will be considered.

- 9 sessions per week over 4½ days
- 10 GPs plus 1 salaried GP
- 16,600 patients
- PMS practice
- Vision computer system, paperlight
- Training practice
- Excellent nursing and admin teams
- Well organised, innovative, flexible and forward looking
- High QOF achievement

For further details and practice profile contact Mrs Elizabeth Batstone, Practice Manager, St James' Medical Practice, County Court Road, King's Lynn, PE30 5SY, tel 01553 774221 or email [Elizabeth.batstone@nhs.net](mailto:Elizabeth.batstone@nhs.net). Please apply in writing enclosing a curriculum vitae to Mrs Elizabeth Batstone. Closing date for applications 19th July 2008

### Advertisement

#### Wensum Valley Medical Practice

#### **SALARIED GP OPPORTUNITY IN NORWICH**

3-5 days per week

We are seeking a Salaried Doctor to work in a busy group practice with a list size of 12,000. We operate from 3 sites covering an inner city area. Working in partnership with the community trust, local schools and non statutory agencies, we are able to offer access to a wide range of services including sexual health, substance misuse and crisis intervention.

We are looking for a flexible person who enjoys the challenges this type of work presents and is comfortable working in a dynamic and innovative culture. For further information or to request an information pack please email the Practice Manager, [mary.taylor2@nhs.net](mailto:mary.taylor2@nhs.net)

#### **Orthopaedic Shoes - Provision/Referral Central Norfolk**

Following a query from a constituent we have had the following confirmation of what is happening in "Central Norfolk" - which we assume means practices that refer to the NNUH.

Norfolk NHS recognises there is a gap in the commissioning of the provision of orthotic items, where the provision of that item is not part of an acute episode of consultant care. The PCT is therefore planning to undertake a full review of the commissioning of orthotic services in 2008/9 in order to improve access. In the meantime the current referral arrangements for patients requiring orthotic items that are not provided as part of an acute episode is as follows:

GP referral → orthopaedic triage services - north, south and central → orthopaedic choice team at Lakeside → signed and checked by Ms L Browning, Assistant Director Acute and Primary Care Commissioning → NNUH.