

# NORFOLK LOCAL MEDICAL COMMITTEE

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November 2006 Flyer

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## Co-options to LMC Constituencies:

**Waveney:** Waveney GPs are entitled to four representatives on Norfolk LMC; only two transferred over from Suffolk, Dr Annette Abbott and Dr Manjeet Seehra and therefore the LMC wishes to co-opt two further members to represent Waveney GPs. Volunteers must be Provider/Performers (partners) - there is a separate constituency for Salaried and Freelance doctors (see the next item). As the Suffolk LMC elections were due in March 2007 and Norfolk & Gt Yarmouth LMC elections not until 2009 it has been agreed to hold a "Waveney" only election in the New Year, representatives to serve for 2 rather than the customary 3 years, which will bring it in line with the other constituencies. This means the co-opted members will serve for only a few months, giving an opportunity for them to have a taster of LMC membership without a long commitment. Anyone interested please contact the LMC office. The LMC meets monthly on the 3rd Tuesday at St Andrew's (old NHA HQ), attendance is reimbursed at £164.05 and travelling at 56.4p per mile.

**Salaried & Freelance Constituency:** Following the resignation of Dr Rob Colebrook the Committee is seeking to co-opt to a vacancy in this constituency to March 2009. To be eligible the doctor must work in a practice or practices in Norfolk or Waveney (being on the Norfolk or Gt Yarmouth & Waveney Performers Lists is not sufficient). Again, please contact the LMC office if you are eligible and interested.

**Southern Norfolk Constituency:** Similarly two of the seven slots for Southern Norfolk are vacant. Anyone interested?

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## The Turnaround Process in Norfolk

If you read the local press, or have seen a Norfolk PCT Project Initiation Document (PID) that recently arrived in some practices to the surprise of its sender, you will be wondering how the LMC's "negotiations" are going with the Norfolk PCT. As the PID stated that these started on 20th November and will finish on the 4th December (tenses correct at time of writing) there should be something significant to report. Alas - there is not.

On 19th September the LMC was told it would have sight of relevant portions of the Turnaround Plan within a week or two. Nothing ever appeared. At the LMC meeting on 17th October, PCT representatives stated that regular consultation with the LMC would take place; eventually, at the LMC's request, a meeting was arranged with the PCT Chief Executive on 21st November; she DNA'd. A meeting to discuss the local locum policy (ie when practices may expect PCT support if a doctor is on maternity, paternity or sick leave - bread and butter LMC/PCT consultation stuff) was arranged without discussion of date, time or venue, so could not be attended. At the moment things do not bode well for a productive relationship. The best that can be said today is that, as it is a new organisation, at least there are only 57 days of mistrust to counteract before we can make a better start.

There is a little something to report: I hesitate to write the word "progress". Two meetings have taken place with Diana Clarke and some of those actually doing the work on the Primary Care and Prescribing work streams. Unfortunately, little or no useful information was provided to allow sensible discussion or negotiation until very much the eleventh hour; nevertheless we may have just begun to get somewhere

The LMC is being proactive. We have organised a sub-group of suitably experienced GPs so that, once there is something we can have an informed debate about, we can participate properly. We have already met with some of our secondary care clinicians so they also understand the implications of the turnaround process. We are being very careful not to undermine the work of the PBC consortia and we need to share intelligence with and have the support these groups. We also need to co-ordinate with the practice managers' groups, particularly around the implications of proposed changes to the enhanced services. The Chairman, along with fellow Chairs of EoE LMCs, met with the CEO of the SHA when there was a frank discussion about the state of play. Whether the PCT is really interested in listening is, of course, another matter.

As GPs who work in the Norfolk PCT area will already know from the LMC Chairman's letter dated 14th November, the LMC expects the new PCTs to abide by the following principles, which the LMC will itself use to derive its negotiating position.

- ▶ ***honour contractual obligations***
- ▶ ***recognise clinical priorities, good patient care and governance***
- ▶ ***support primary care***
- ▶ ***support clinical engagement***
- ▶ ***are honest with regard to service cuts, including being honest with the public***
- ▶ ***provide alternative treatment pathways when services are cut***
- ▶ ***do not attempt to transfer work without appropriate resources***
- ▶ ***uphold equity***

In November the LMC agreed that the National GMS contract is not up for negotiation. PMS is, of course, a local contract so, no doubt, PCTs will try to renegotiate on *their* preferred terms. You can see from the above list, the LMC believes in equity and will, of course, support PMS doctors on that basis.

What is the best that could happen? Well, it could all turn out to have been a horrible accounting error. After all, the figures have changed an awful lot in the last few months - so there have clearly been plenty of mistakes. Unfortunately, everything that has come to light so far has been in the wrong column, but, hey, who's counting? (Not the people who should have been, obviously). Or, we could all work together to save what can be saved without harming services or mistreating NHS staff and then the PCT could go public on what would result from implementing the rest of the plan and shame the politicians into funding the NHS properly (or they will have to explain to the electorate why the can't). Or, practice based commissioning could be given the encouragement and resources it needs so it can ride to the rescue.

What is the worst that could happen? Well, I am not sure I understand enough about "alternative providers" to be able to picture it, even on a damp and dismal Sunday afternoon. But I know it won't be anywhere near as good as general practice and I don't think I want to be a patient under it, thank you very much. I do know that time is short, that the PCTs will try and rush change, that they will threaten worse things for us and our patients if we say "no" to their suggestions (ill thought out as many of them are) and that we will hear the words "don't shoot the messenger" so often that we will be tempted to say: "Why not?" or else: "OK, but maybe you should work for a different General".

When there is something to report we will make sure you know as quickly as possible; when we need to know what you think we will ask, please respond; when we advise you to do something, or not to do something, please consider the request carefully. Good luck on a bumpy ride. **SRL**, 26.11.06.

ps: The LMC officers are currently seeking an urgent meeting with the GtY&WPCT as we understand that it too is likely to be subjected to the turnaround process!

## Death, Taxes and Housing Notes

All three seem to be certain. We pay taxes which, in turn, pay us; we do what we can to delay death and he is not going away; but why, oh why, do requests to GPs for housing notes have to be inevitable? Sightings have been reported once again.

Every few years there is an agreement to sort this. GPs don't want the bureaucracy, Local Authorities don't want every one who wants to go on the housing list to be clutching a note that says: "I am the GP and he/she/it/they will be healthier with a roof over their pate/perm/tail/heads and a garden to sit in/hang up the washing in/crap in/play in.

GPs should not do "notes" on demand - it helps no one. If housing departments want clinical information they can and should write formally to the GP, with patient consent, and the fee arrangements should be clear. If a decent report will help decision making then they deserve a proper report prepared with care. The time that this takes the GP must be properly funded. Please train yourself to say: "No". You are really going to need this skill in the coming months.

## Flu Vaccines and Norfolk Social Services Front Line Employees

Norfolk LMC has once again agreed that Norfolk Social Services "front line" employees, who do not fall into the "at risk" categories, may have an opportunity to receive a flu vaccine.

As per previous years, the patient will present a proforma produced by NSS, which will also act as an invoice. This must be completed and submitted to Eastern Support Services for payment. ESS, in turn, will be reimbursed by NSS. These vaccinations attract a fee of £17.50 but, as it is a private arrangement, you are under no obligation to take on this work. However, the LMC does believe that it is important for Social Services front line staff to remain well during any influenza outbreak as they provide a vital supporting role for some of our most vulnerable patients. Therefore we would urge practices to take part in the scheme - *manpower and vaccine supplies permitting*.

Also, as in previous years, Social Services is trying to encourage the owners of Care Homes to have their staff vaccinated - on the same basis - ie the patient will present with a proforma - but in this instance the £17.50 is payable by the care home.

Please note that as this is being provided as a quasi occupational health measure for registered patients with no health-related risk factors, and funded by an outside organisation, an NHS script would not seem appropriate.

## AAA or GMC

Some practices have been invited to become involved with Abdominal Aortic Aneurysm screening by a private company. The practice writes to its patients and the patient pays for the scan. Some payment is made to the practice. Please be very careful about this. You may well have the best of motives and believe that this screening should be available on the NHS. However, please think about whether patients who cannot afford £95 are being frightened, whether the NHS can afford lots of false positives being referred for repeat scans or a

vascular opinion, whether the available treatments are so effective and risk free that you would advise your asymptomatic granny to have them (and if not - why frighten even those who can afford £95) and whether you really believe everything in the template letter and want it to go out under your name. Please also consider very carefully the GMC's "Good Medical Practice" - a new edition of which you should have received recently. Paragraphs 72, 74, 75 and 76 may well be relevant.

## Giving Depot Neuroleptics in the Community

We have been advised by a practice that requests are being made for primary care to carry out depot neuroleptic injections. With the current financial difficulties it is not surprising that such requests are being made but I would urge extreme caution. There has been a, not to put too fine a point on it, disaster in the Secretary's own practice with a patient that we were kindly injecting. I would urge any practice that is asked to be involved to either immediately say no, or insist that there is a clear statement at handover as to what they should do and who they should contact if there is any evidence of non compliance. Until, and unless, there is a foolproof process, I would again advise declining this work. Even if there was an acceptable process and the practice wished to help their patient clearly this a transfer of historic work to general practice and would require funding.

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Sally Ross-Benham (PM) Staithe Surgery, Lower Staithe Road, Stalham, NR12 9BU, tel 01692 582000 for informal enquiry or email sally.ross-benham@nhs.net. Closing date 31<sup>st</sup> December.

## NANIME Charity

The NANIME Charity trustees met recently and I am delighted to say that we had two bids from general practice. One was a bid for a data projector from a practice that arranges educational events both for itself and others in the area. The Charity has supported this sort of bid in the past - the only proviso is that when the Charity funds equipment it should be available to as many doctors, dentists and other local clinicians as possible.

The other bid was, in essence, a preliminary bid to fund acquiring educational materials, including computer assisted learning software and licences for web-based learning for primary care professionals in the community. The trustees are looking to receive more information but as the GP trustee I can see no reason at the moment why this bid is unlikely to be successful. We also saw the DVD produced by Dr Tony Press, as advertised in the last flyer, and were

very impressed.

With the recent stock market rise the charity has more money than it knows what to do with so please put your thinking caps on and think of any ways in which you may be able to use this local resource.

Sadly for those in West Norfolk and Great Yarmouth & Waveney the Charity covers practices that have tended to use the Norfolk and Norwich Hospital for postgraduate education

## Advert

Doctor available immediately for Locum Work 10-15 mile radius of Norwich. Please contact Dr Nicky Manley - email manleynm@yahoo.com or mobile 07837 088286

## Available from the LMC office

- The IM&T DES: Interim Guidance for PCOs Sept 2006 (GPC & NHS Employers)
- BMA Sessional GPs Newsletter (also on website)
- Guidance on the completion of health reference forms for prospective registrants with the General Dental Council
- Primary Medical Services Contracts: Advertising and Appeal - GPC Guidance
- Practice based commissioning - practical implementation - Gateway Ref: 7444

## Private IVF Referrals to Barts

The Norfolk Fertility Clinic is using the NHS proforma for private patients. Clearly a GP has a GMC responsibility to pass on relevant information when making a referral, be it NHS or private. However this proforma is intended for the NHS pathway and using it implies that the GP has a responsibility to arrange the tests listed. The LMC advice remains - only complete what you can from the notes; do not arrange any additional tests etc.

There is no reason to think the situation is any different with a private patient. The provider should do the necessary tests, presumably at the expense of the private patient. In fact, it might be wrong for additional blood tests to be carried out on the NHS as one assumes the reason the patient sought private care in the first place was that he/she was not eligible for NHS care.

## Nurse Led Clinics and Sick Notes

We are receiving reports that patients are turning up from nurse led clinics at the NNUH (and from other hospitals for all we know) asking the GP to give them a sick note. With more and more nurse - who cannot write sick notes) - led treatment at the hospitals this problem needs addressing. We need to know the scale of the problem - let us know if you have been asked.

## Gateway Protection Programme, Norwich

15 Congolese families (previously in a refugee camp in Zambia) are coming to live in Norwich in December as part of the Gateway Protection Programme, with two further groups in January, totalling around 60 adults & children. They have

full refugee status and are therefore eligible to the NHS and statutory agency support. The Gateway team which will provide support, including a HV and a specialist nurse, is based at West Pottergate Health Centre. For more information or help please contact [Eilay.laurie@norfolk.nhs.uk](mailto:Eilay.laurie@norfolk.nhs.uk)