Norfolk & Waveney Local Medical Committee

Serving the General Practitioners in Norfolk & Waveney

SEPTEMBER 2010

MEETING WITH THE NORFOLK CORONER

The Medical Secretary and the PEO recently had another of their irregular, but extremely useful, meetings with Mr William Armstrong, the Norfolk Coroner. We covered a wide range of issues including:

1. The Coroner's office is now centralised for the whole of Norfolk however much of the following may just as easily apply to Waveney doctors.

2. Practices in which there has been a patient suicide will find that the request for a report asks for more information than was previously the case. I believe that this is a very reasonable request; practices will, no doubt, have discussed these cases at internal clinical governance meetings – so the requested information should be to hand.

3. We clarified payment for reports for the Coroner. These are reimbursed but practices cannot be paid in advance - however the Coroner's office comes under Local Authority arrangements – ie bills must be settled within 28 days. The rate paid is laid down but the good news is that, by and large, the Coroner prefers reports that are short and to the point, so hopefully there will not be too much of a mismatch between the work involved for the practice and the reimbursement. The Coroner has no legal power to enforce a request for a report but does have the power to call a GP to an inquest if there are unanswered questions - so, generally, writing a report seems a better option. The Coroner tries very hard not to ask GPs to attend inquests, but clearly this is sometimes necessary and we would urge you to think of this as part of your responsibilities to the bereaved and the state, so please try and agree dates whenever possible.

4. Procedure in deaths of under 18s: there were a couple of hiccoughs at the start of the new (statutory) process (because GPs had not been adequately informed about it). However neither the Coroner nor ourselves were aware of any recent problems.

5. Deaths Out of Hours, especially in homes, have formed the subject of much of the discussions at previous meetings, but our mutual understanding is that the system is now working well. There are still (hopefully apocryphal) stories of doctors refusing to attend to confirm death and, while this can be entirely correct if, for example, the patient is in a nursing home, compassion for others present should result in a visit if requested for a death at home, for example, even if it was "expected". This was made clear in our advice issued in 2008. We took the opportunity to re-show this guidance to the Coroner, which he informed us was still up to date. This guidance has been attached. Please carry on trying to make arrangements within the practice so that expected deaths can be appropriately certificated, bearing in mind holidays and other causes of GP absence.

6. Apparently some death certificates still mention conditions such as mesothelioma, where automatic referral to the Coroner is required, but that referral is not made. The introduction to the death certificate book is helpful, clear and well written: it should probably be regularly revisited.

7. Communication: we are trying to work with the Senior Coroner's Officer (SCO) to look into e-mail communication between practices and the Coroner's Officers, as sometimes telephoning (in both directions) can be problematic. This may not be entirely straightforward as urgent issues need a rapid response, which means that e-mails would need monitoring but nevertheless, there are situations where e-mail could be a useful method of contact.

8. Finally, we had an interesting discussion on some of the diagnoses entered onto death certificates. There was some disagreement about the appropriateness of the diagnosis of dementia (or Alzheimer's disease) as the cause of death. We will discuss this further but, in essence, there was some suggestion from the SCO present that it was helpful to either have other medical conditions listed as contributing to the death or, if the patient had just "faded away", the suggestion was made that the "real" cause of death may be "starvation" (as a result of their dementia). I must say that I felt that putting that down was far more likely to raise issues (about the quality of the care, for example) that would be distressing for all concerned. I tend to believe a primary diagnosis - stating that death was due to the dementing process (the brain no longer being capable of sustaining life – just as any other vital organ can pack up) is perfectly reasonable. It may be that we have to agree to differ, but some clear, agreed, guidelines would obviously be helpful.

We may be meeting with the Registrar of Births, Marriages and Deaths who, I am sure, will have some interesting views about this particular issue, as well as some of the others we touched on, so let the LMC office know if you are having problems with "death" and its certification. SRL

An article on the White Paper for Non-Principals

It cannot have escaped your attention that a Health White Paper ("Equity and Excellence: Liberating the NHS") was published in July. If its proposals are implemented It will have an enormous impact on patients, GPs, and everybody and anybody working in, and for, general practice. At the moment the advice from the GPC is that the implications are far from clear - so practices should not be making detailed plans or arrangements at this stage – certainly not signing up to anything that could not easily be changed. On the face of it, those owning and running practices need to be most involved as, from 2013 - if the timetable proceeds as stated, practices will be responsible for ***real*** budgets as well as assuming many current PCT responsibilities.

While it is less clear how, and to what extent, the changes will affect non-principals, I would urge you to try and keep abreast of the issues. You may be applying for a partnership in the future, the decisions that locums make on referral and prescribing have implications for the commissioning plans of their practices and we are all patients – so it is vital that we help our NHS to work as well as it possibly can. There are excellent papers summarising and clarifying White Paper issues on the BMA website - I would urge you to make that your first port of call for authoritative statements. As ever, the popular press will be more likely to report sensation rather than being objective – so I would be pretty sceptical about anything from that source. SRL

NHS White Paper

Andrew Lansley has written a letter to all GPs as part of the ongoing engagement with the profession on the White Paper proposals and to set out the next steps on commissioning. The letter discusses the responsibilities of GPs with respect to the commissioning proposals, the support GPs will receive and the organisational and governance arrangement of commissioning consortia. There has been no decision on the value of the management allowance, while the letter re-iterates that the size of consortia will not be determined centrally, and there is no pressure to form new arrangements at this stage. The letter is available here: www.bma.org.uk/images/dohletterwhitepaper_tcm41-200329.pdf
GPC guidance on the White Paper is available on the BMA website: www.bma.org.uk/healthcare_policy/nhs_white_paper/gpcwhitepaperguidance.jsp

Seasonal Flu

We have received reports from elsewhere in the country that there have been some cases of swine flu already this year. We would expect to see swine flu circulating - this is not an unexpected occurrence.

There has been some debate recently about whether or not we need to advise patients that this year's seasonal influenza jab includes swine flue vaccine - particularly as we obtained consent last year. The bottom line is that GPs always get consent when we give an immunisation regardless of whether the patient consented the last time. We specifically obtained consent and explained the consequences of swine flue last year because we were giving a relatively new vaccine and were delivering it in multi dose vials. There has now been sufficient time for this year's vaccine to incorporate swine flu -as you would expect as one of the potential dominant strains we will see this year.

The vaccine has undergone full testing and is in a standard format; therefore it is not unreasonable to undertake business as usual. Some patients may be surprised to know that their seasonal flu jab regularly contains a mixture of vaccines. It may be worthwhile explaining to patients that this year's jab also contains protection against swine flu. You should always get consent and explain appropriately to patients in a way that they will understand.

Everyone should be following the DoH recommendations for the "at risks" groups as outlined in its letter to the profession. If I could also bring your attention the recent advice about some forms of vaccine which should not be used in children, namely the Enzira and CSL Biotherapies, which was sent out by the MHRA recently. IH

Summary Care Record

Following the representations regarding the SCR, particularly around consent issues, the Minister undertook to set up a review. This has been chaired by Professor Sir Bruce Keogh who is independent. They have had two workshops recently with representation from the BMA, patient groups, Connecting for Health, PCTs and Liberty. We expect the report to sent to the minister shortly, but it still maybe several weeks before we know the outcome. We will liase with both Primary Care Trusts regarding their implementations plans as soon as we have the details. We anticipate a significant change to the present model and will let you know as soon as the report is published. IH

Patient Safety Alerts - Calling all Locums:

Since I retired from my practice I no longer regularly see the "Patient Safety" alerts. While I know these frequently seem irrelevant and that many (hopefully apocryphal) tales are told of reams of them relating to drugs or equipment never used in primary care - some are relevant. I know that it is hard for practices that employ locums to ensure that their "locum pack" is always up-to-date and even more difficult for locums to find time to read and absorb this stuff. I have looked at the website (https://www.cas.dh.gov.uk/Home.aspx) - it is surprisingly user-friendly - so I would suggest that, to be on the safe side, locums dip into it, perhaps once a week, just to make certain they are not caught out. SRL

Can you recommend...? Sometimes the LMC office is asked if it knows of individuals who can help practices with "awayday" issues. I suppose the traditional model is someone from outside to help make communication even better (if you are already nearly perfect), or to deal with issues that have proven hard to resolve (in practices that are under a bit of pressure - ie most of us). If you have used anyone you would recommend, indeed would use again, please let the office know - so we can tell practices that approach us? The LMC officers are sometimes asked to help and will always do what they can - but time is, of course, a constraint - certainly the whole "awayday" thing: seeing partners and members of staff individually, planning, facilitating an event (and, possibly, follow up events) and writing report(s) can be too consuming for the officers to take on personally. If there appears to be a local, unmet, need then the LMC will think about setting something up - or trying to link in with a scheme that Cambridge LMC co-ordinates in their patch. SRL

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BMA GP Employment Law Courses Autumn 2010: BMA is again offering courses on Managing Change, Managing Performance and Managing Staff. Open to GP Partners and Practice Managers at discounted rate to BMA Members. www.bma.org.uk/whats_on/employment_related_courses/gplaw10.jsp