

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



"Those DESs"

Many practices are understandably wanting something in writing from their PCT before they start to do anything differently to prepare for the long delayed DESs on Choose and Book, Improved Access and Practice Based Commissioning.

The SFE (Amendment) (No.3) Directions 2006 was recently circulated by the LMC and contains the details of the schemes, but in the holiday season it may take PCTs a little while to get their acts together - so the SFE may be all you have to go by for a while.

If you intend to work for these DESs (and you may decide that the "rewards" do not justify the effort for some of them) then we would urge practice managers to consider the SFE as soon as possible as we are almost half way through the financial year already.

The GP Survey Results are out

We are delighted to see Norfolk and GtY&W have achieved excellent figures for satisfaction in all areas of the survey. We think that this should be celebrated. It is clearly impressive that we have achieved these results when we are all dealing with more enquiries, experiencing an ever increasing caseload both in volume and complexity and, at the same time, demonstrating high quality.

The Survey clearly showed that for the majority of practices there is no significant demand for weekend or extended opening. You may want to share your practice's success with your patients.

It is also useful to remember that this survey has cost the NHS £11m and has simply told us what our own practice surveys have already demonstrated. Is this good value for money? Well Done! Ian Hume, LMC Chairman.

Southern Norfolk Refuse Collections

A practice reported an elderly patient being told by "someone from South Norfolk District Council" that if they did not get a letter from their doctor to confirm that they were unable to take their wheelie bin to the front gate they would be charged by the council.

On checking the LMC office discovered that this was complete nonsense. A very nice lady at the Ketteringham Depot advised that all patients who think they are eligible for an "assisted collection" - in other words for the refuse collector to cross their property to collect and return the bin from wherever it is kept - need to do is ring 01603 819999 and ask for an "Assisted Collection Request Form". We know practices are always sympathetic to their elderly and vulnerable patients so thought this information might be useful. We assume that other councils

must have similar arrangements.

Summer thoughts from a Medical Secretary

I recently received a letter dated 3rd August in reply to mine of the 1st July, as follows:

"My apologies for not responding to your letter of 1st July but the correspondence took some time to find me and I have had some difficulties in clarifying the response to the points made. Unfortunately I am now on leave for the next two weeks but hope to respond to your points on my return."

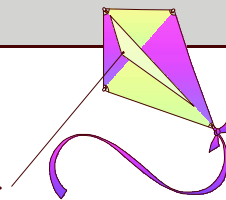
I had to laugh; my son Peter asked me what I was laughing at; I explained and he said he thought the writer had the right idea about getting priorities right and being sensible with your personal time. As this conversation was when I was catching up on my LMC in-tray late on a Sunday evening maybe Peter had a point! Simon Lockett.

Mental Health Issues

The LMC has a couple of meetings arranged with senior clinicians at the Norfolk & Waveney Mental Health Care Partnership. The office received lots of complaints regarding the shambles the trust made around discharging patients last year which it took up and hopefully things have settled down. But, please let us know if they have not. Ditto any other problems you are experiencing in your areas.

Post-operative Care for Private Patients

We are reviewing the issue. Practices that feel they do a significant amount of this work - it would be really helpful if they could let us know roughly how many people they see, how long it takes, whether they think their staff are being asked to do specialist tasks (eg complex dressings) and whether the patient remembers if they thought they had paid to have the work done but then decided it would be more convenient to come and see the GP or whether they haven't paid for it and have been told that they could or should go to see the GP.



Domestic Abuse

The BMA Board of Science has produced an interesting and unfortunately relevant document on domestic abuse, cover dated June 2007. It is available from the BMA and is worthy of careful inspection. Domestic abuse (of adults) is obviously a worrying problem and, looking at the figures, around 100 of our practice patients are likely to be suffering. The book seems helpful and well balanced with excellent references to follow up. It also does not shirk from saying that many of us have not been trained in discovering

which of our patients are suffering and helping them if they do confide in use. Nor does it refrain from pointing out that well intentioned but ill informed advice to sufferers can have serious consequences. As I read it, the evidence is not yet there for some sort of blanked questioning of patients in primary care at, for example, new patient checks. However, pregnancy is singled out as a time of significant risks and midwives and health visitors may well be more aware of the subject than other members of the primary care healthcare team. In the report domestic abuse is defined as "any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners, or family members; regardless of gender, sexuality, disability, race or religion". While it is a crime perpetrated on both men and women, statistically 80% of reported domestic abuse victims are women. The report acknowledges the lack of training available both within undergraduate training and for those who are qualified. Home Office guidance recommends that health professionals use the mnemonic RADAR, R - routine enquiry, A - ask direct questions, D - document findings safely, A - assess victim safety, R - resources; give victim information on resources available and respect their choices. For those of us who feel rather inadequate at dealing with this area then at the very least it would be helpful to remember the freephone domestic abuse helpline numbers; for women 0808 2000247 and men 0808 8010327 and to pass these on to patients either when domestic abuse has been found during the consultation and also to publicise within the surgery posters and educational leaflets containing the message that abuse is not acceptable. As sufferers are extremely likely to have mixed feelings about being seen to be over interested in such literature or writing down phone numbers or taking leaflets then this might well be an appropriate subject for information within the surgery patient toilet. I accept of course that my unfamiliarity with the subject and therefore my wish to publicise what seems excellent and helpful advice may not be necessary for many colleagues who practice in other parts of Norfolk and Waveney but for those who share my ignorance and concern I would highly recommend the book.

Weekly Prescriptions

You may have been slightly confused by the item in the June 2007 Norfolk Prescriber about weekly prescriptions. The LMC does not agree with all aspects of the flow chart. The Committee, supported by the GPC, believes that seven day prescriptions should only be given when clinically indicated, for example if the patient is at risk of overdose or if there is a likelihood that the medication may not be tolerated or may need changing for some other reason after a very short time. It is never appropriate to give seven day prescriptions as a quasi-method of reimbursing the pharmacist (or, indeed, dispensing doctor) for the additional

work required in perhaps filling MDSs. If a patient has been assessed as DDA then funding is included in the pharmacy and, I believe, dispensing doctors' contract/reimbursement, for the additional work required (to ensure that the patient can access their medication in a safe and appropriate manner).

I am unclear whether dispensing doctors could charge patients if providing a MDS for "social need only" as implied at the right hand end of the flow chart, indeed I rather doubt it. As ever, a test case would be fascinating.

We are reintroducing dialogue with the prescribing team (as used to happen with the previous PCTs) and hope that in future when advice comes out it will be advice that both we and the PCT can agree on.

Treating our American Cousins and MDO cover

The comics have recently highlighted this topic and as a result caused disquiet in some practices. The GPC sought legal advice along with clarification from the MDOs about their position. The situation, which the GPC does not believe to be as critical as some of the comics may have made out, is as follows:

The possible problem occurs when practices see US citizens who are in the UK and entitled to NHS treatment. The concern arose when an MDO intimated that it would not protect a GP in an American court should a legal action be initiated. Although this situation would be rare, it is not impossible. This places practices in a difficult position as there are three competing parts of the Regulations:



- A requirement to have insurance/indemnity
- A requirement to provide immediately necessary/emergency to all irrespective of other entitlements
- A duty to register on the basis of equity, for those entitled to NHS primary services (broadly those here for a settled purpose of >6 months)

The GPC sought advice from all the major MDOs to confirm their position in respect of this. All confirmed that there was no problem indemnifying the doctor for treating the US citizen for treatment in the UK against litigation in the UK Courts, but none would indemnify for a claim in US jurisdiction. However all agreed that, with civil litigation, the appropriate jurisdiction for a claim is generally that in which the service was provided. Patients who claim they have been negligently treated in the UK should sue in the UK.

In the hypothetical situation that such a claimant pressed ahead in the USA, it would be difficult for the claimant to show that US law should apply to clinical services provided in the UK. And, even if claimant tried and succeeded, the understanding is that the judgment would not be enforceable in the UK. Although this leaves a theoretical risk that an outstanding order could be enforced on a UK citizen if he or she were visiting the USA, again this is unlikely. Furthermore no MDO reported ever having seen a claim arising from treatment provided in the

UK litigated in the USA. Therefore, all MDOs believe that the requirements in respect to indemnity arrangements are still fulfilled in these circumstances and believe that there is no cause for concern. However, we would encourage any doctor with questions on this matter to contact their MDO advisory team directly for advice.

The legal advice about registering US citizens in the practice is that, if the MDO say that they will cover GPs for treating patients on the UK territory, there is absolutely no reason why GPs cannot continue to treat these patients as there is no valid reason to object or remove them from the list. Therefore practices should not refuse to register or treat those patients, who are US citizens, in the UK who are entitled to NHS treatment as defined by the regulations.

and another issue from the Comics

Personally Administered Items

Apparently (if the comics are to be believed) some practices nationally may have missed the changes to the SFE for 2006-2007. The new paragraph 17.3 implemented a new payment system for dispensing which entailed the removal of the on-cost, container and VAT allowance and created a new VAT allowance for non-dispensing doctors on personally administered items. It might be worth checking that your practice has picked this up as it does have implications on income.

On what makes a locum an employee (acknowledgements to Andrew Lockhart-Mirams and Pulse)

The distinction between employee and self-employed is important, as an employer has greater responsibilities towards an employee. This includes holiday and sick pay provisions, redundancy pay, National Insurance contributions and income tax. These rights are not afforded to self-employed persons and it is therefore attractive to treat a locum as self-employed. The label given to the relationship is not definitive nor are the intentions of the parties. It is important to look at the facts, as a tribunal would do. Although the locum may be regarded as self-employed (if they pay their own NI and tax), this does not preclude a finding that they are an employee for the purposes of employment rights. If the locum must provide services personally and cannot appoint a substitute, if the employer has control over the locum, if the employer is obliged to provide work (and the locum obliged to accept it) and if the practice obtains cover when the locum is absent, it is likely the locum is an employee and the practice would be responsible for them as such. Also the longer the arrangement between the parties the greater the likelihood of finding employee status. Put a formal agreement in place that contains provisions that minimise as far as possible the risk of a tribunal finding the locum to be an employee.

Bereavement Support - CRUSE

We have been asked to remind GPs about the referral criteria for CRUSE as some of our colleagues have been advising bereaved patients to contact the organisation a bit too soon! The two criteria are that the patient shall self-refer (to the number in the telephone book) and that

the referral should be made **not less** than eight weeks after the death of their loved one. The logic is that CRUSE, quite rightly, states that they are not there to help people through normal bereavement but for people who have extended problems with adjustment to loss.

*Note from LMC Office: **Where does the name 'CRUSE' come from?*** It is derived from a passage in the Old Testament about a widow's cruse, or jar of oil, which never ran out thus signifying that support would be given as long as it was needed. However, it must be stressed that despite the derivation of the name, CRUSE is a non-religious organisation and welcomes people of all beliefs and none.

Advertisement

Experienced GP with Retainer Scheme funding and special interest in Sexual Health looking for 2-4 clinical sessions per week in or around Norwich area. Temporary or permanent position considered. Contact Dr Sally Butt on 01603 612412 or paddy@wilson-paj.fsnet.co.uk.

Advertisement

Heacham Group Practice Maternity Cover for Salaried GP

Needed from 1st December 2007 for maternity leave cover
37 hours per week (8 sessions)
Salary - £70k pro rata

We are a friendly 4 partner training practice in West Norfolk, part dispensing, with a practice list size of 8000. Informal visits or enquiries welcome. Please contact Lucy Woodall, Practice Manager, on 01485 579267 or lucy.woodall@nhs.net

Advertisement

I am a newly qualified GP having trained in Norwich, looking for short term contract/locum work in the Norwich area from September. Please contact me on 07971 233068 or email tinkerbellsim@hotmail.com. Thanks, Dr Simin Hussain.

Advance Directives: The LMC office thought those who took part in a postal survey of attitudes of Norfolk GPs towards advance directives might be interested in the following report from Jo Gilson of the , Heathgate Medical Practice, Poringland (01508 494343) who carried out the survey.

"I would like to thank all of those who contributed to my research by returning the questionnaire- I thought you might be interested in a brief summary of the results. The response rate was 52%- which is generally considered good for a postal survey. Generally doctors displayed a positive attitude towards advance directives; however there was less support for the legalisation of such- the Mental Capacity Bill becomes law in the autumn of this year and contains provisions for giving directives legal backing. A positive attitude towards advance directives was not associated with age, gender or length of service in general practice. I received a very useful amount of free text comment, which showed that doctors expect their patients

*to start discussions on advance directives-
although research on patients show their
expectation is that doctors should initiate such
discussion. The issues raised which prevented
discussion were mainly concerns about
"appropriateness" and fear of giving offence.
If anyone would like further information on the
results of the project please contact me."*