

# Norfolk Local Medical Committee

Serving the General Practitioners in Norfolk and Great Yarmouth & Waveney



August 2008

Wymondham Medical Centre, Postmill Close, Wymondham, Norfolk, NR18 0RF  
Tel: 01953 608060, Fax: 01953 608061, Email: [norfolkLMC@btconnect.com](mailto:norfolkLMC@btconnect.com) and Website: [norfolkLMC.org.uk](http://norfolkLMC.org.uk)

## Old Problem (New Wrinkle)

I seem for ever to have been writing Newsletter items urging GPs to ensure they have current, competent, partnership agreements - and that these kick in as soon as there are partnership changes. All the old reasons why this is a good idea continue to be true - but there is a really important new one. If there is no partnership agreement, the partnership "at will" ceases with the departure of an outgoing partner - by retirement or otherwise. The Contract is with the Practice not the individual partners so, with no partnership agreement, the partnership with which the PCT has its contract has ceased to exist. I am aware of examples from elsewhere in the country where, in these circumstances, the PCT has said that the contract has ceased and that it (the PCT) has discretion over the selection of a new contractor. Indeed, some PCTs have said that they are obliged to go out to tender in this situation. Similarly, again from elsewhere, a practice without a proper agreement that is going through a split has been told by its PCT that both new practices will be offered APMS contracts. You have been warned. SRL

## TRUST

*(Note: Simon Lockett wrote this article from his experience of working with Norfolk PCT but the LMC office believes it is equally relevant to the LMC's relationship with GtY&W PCT)*

I am preparing the LMC Annual Report from last year - a regular August job. Looking at my old Reports led me to reminisce about an LMC Conference, getting on for 20 years ago, when Dr Michael Wilson "commended to the profession" the contract changes that he and the then negotiators had discussed with the Thatcher Government and which then became the 1990 Contract. As I remember it, Dr Wilson was criticised for not keeping the profession informed about what was going on during the discussions. Dr Wilson believed that trying to work with government would result in the least worst changes to the contract and, to be allowed at the negotiating table, confidentiality had to be promised. I am sure it is a coincidence that I have started thinking about this but I do believe there is always a risk, when negotiating, of upsetting those you are negotiating for.

I suppose it is inevitable really as negotiation = compromise = pleasing no one (glass half empty) more often than negotiation = compromise = win/win (glass half full).

You may well wonder what on earth I am on about (I often do too). Well it is like this. There is quite good evidence of improving relationships between Norfolk PCT and the LMC; this has led to more "working together". In some ways this is less comfortable than being in your bunker lobbing grenades at each other but, then again, you don't get anywhere if you stay in your bunker. An example of what we believe to be a success is the improved extended hours LES after constructive discussions between the LMC

officers and the PCT's primary care team. You may feel the improvements are modest and, of course, it is not what any practice would like it to be *but* the PCT has moved and this is while it is under very considerable pressure from its bosses not to budge an inch. In this case the benefits that the LMC has worked for are available to all Norfolk practices but the LMC officers are beginning to be invited to meetings where the outcomes may benefit only some practices or may even seem to disadvantage some practices. Of course the usual safeguards are followed: interests have to be declared and the LMC representative member will try to inform the discussions and generally not have a vote - but the position is not always wholly comfortable. In Norfolk examples are:

*GP Action Group* - where matters such as changes in practice areas, closure of branch surgeries and locum payments for sickness and maternity leave are discussed

*Estates Strategy Group* - where primary care developments are discussed "strategically"

*GMS/PMS Rapid Action Group* - where differential funding in favour of the poorest funded practices is being considered

The LMC officers take the view that it is better to be involved and to try to create win/wins for practices and for the PCT as much as possible. We will continue to do our best to do our jobs with the support of the Committee. We also are well aware that, as elected representatives, constituents will have the opportunity to do something about it - quite soon as it happens - if they are unimpressed. SRL, August 2008

## Patient Health References

I was recently asked about a request for a report for a health reference because a GP's patient wanted to be registered with the Health Professions Council (HPC). The query was of the nature of "does it need to be done", "does the GP need to do it", "into what detail does the response have to go" and "what about a fee".

I investigated the issue by following the helpful link through [www.hpc-uk.org/publications](http://www.hpc-uk.org/publications) and found that the HPC have had an obligation under the Health Professions Order 2001 to obtain this reference from an applicant, the obligation does not extend to paying for the reference and any costs must be paid for by the applicant. The guidance is quite complicated so I don't think I can summarise it. There are particular issues about disabled people and the advice gives quite a few examples. Such a reference does need to be completed before the individual can practice so therefore it does have to be done, probably the most appropriate person is the GP, it has to be completed by somebody who has been the applicant's doctor for at least three years or must have access to their medical records for the past three years.

In a way the fact that it is quite complicated and

that different professions might have different issues with health of the practitioner (although the paperwork makes it clear that we are not expected to give the opinion that an occupational health specialist would be able to provide) demonstrates a degree of complexity in the process which I think will make it easier for doctors to charge an appropriate amount for providing the reference.

In summary, I think that the individual you are being asked about does need this reference or they won't be able to practise; the GP is probably the best person to do it; it does involve some work, reflection and thought and I know if I get one I will need to look it up again on the website so it is absolutely right and proper to charge an appropriate fee which reflects the work carried out and the responsibility taken. SRL

## Changing medical records of adopted children

Under adoption legislation, an adopted child is given a new NHS number and all previous medical information relating to that child is put into a newly created health record. Any information relating to the identity or whereabouts of the birth parents should not be included in the new record. The change of name, NHS number and transfer of previous health information into a new health record should take place for both GP records and hospital records. There should not therefore be any difficulty in obtaining information about the child's previous treatment in secondary care. Whilst changing or omitting information from medical records would usually be contrary to ethical and professional guidance this is not the case for the records of adopted children as there is a legal requirement that it takes place. The DoH is looking into the issue of health records for adopted children in connection with the NCRS.

## WARNINGS!

*prompted by Norfolk but relevant to everyone*

A couple of issues arose at the most recent Independent Contractors Clinical Governance meeting (NPCT). One was the National Patient Safety Agency Rapid Response Report on reducing dosing errors with opiod medicines. I believe this should have appeared in practices recently.

Like many national safety warning documents it is not terribly well drafted for primary care. Some warnings are, of course, of absolutely no relevance to primary care (such as "failure of the grossit valve on the declinicator of the special care defragulator" - alright I made that up by you know what I mean!) This particular one is relevant for primary care and should be read carefully. I suppose we might feel like giving ourselves a slight pat on the back as Table 1 showing Patient Safety Incidents involving Opioid Medicines by Care Setting, shows general practice contributing only 1% of the cases. Top of the charts is Acute General Hospitals, followed by Community Nursing, Medical and Therapy Services including Community Hospitals, followed by the Mental Health Service, followed by Community Pharmacy. But we must not be complacent, there have been at least two unexpected opiate related deaths within

Norfolk in recent memory.

The example incidents which should be a strength of this sort of document unfortunately are from a mixture of settings and the flow charts are rather simplistic but are certainly worth a read and a quick reflect. A few years ago I suppose I would have sneered at the flow chart line which precedes from "is administrator familiar with therapeutic characteristics of opioid prescribed" via a "no" box to "administrator to familiarise themselves with therapeutic characteristics of opioid to be prescribed, or seek appropriate advice". Now as I have to look up practically every prescription I write I realise the advice is not quite as fatuous as I would have once thought it was.

The second issue relates to anticoagulant problems. NPCT believes that it has identified a patient risk and has started some preparatory work by contacting practices. I was somewhat astonished to find that of the twenty-four practices that had responded six stated that they had no protocol for anticoagulation. One practice stated that they followed the LES but had no separate protocol and it maybe that the other five do the same, or follow some instructions or a computer programme that they don't think of as a protocol. Somewhat weirdly the PCT didn't seem to be wholly aware of what level of service practices were providing which seemed strange as, presumably, one part of the PCT is paying the practices for providing a particular level of service. The hospitals are apparently anecdotally reporting an increased number of admissions relating to problems with INR monitoring and anticoagulation dosing. Again, as this is anecdotal, it may be incorrect or it may simply reflect the increased use of anticoagulation with atrial fibrillation patients for example, or it might of course be real. It would be hard to argue, and I wouldn't actually try to do so, that this is not a legitimate area of interest for the PCT and, indeed, practices. Practices are therefore likely to be asked to provide some more figures to help in an audit into the design of which clinicians and the LMC will, as I understand it, have had input,

As ever I made the point to the Committee that there are many things that could be done in general practice that would improve safety and/or patient care but doing anything extra either requires resources to fund additional work or for something else to not happen which, in itself, might have consequences for patients. I will certainly do all I can to ensure that a sensible process arises so that, if necessary, sensible improvements can be made within individual practices or the system. It may even be that out of this piece of work will tumble a solution to the problem of a high INR on a Friday evening problem which I am sure has given many of us sleepless nights over weekends waiting to see whether our patients have bled over the weekend.

In passing, NPCT mentioned the use of non steroidal as another piece of work that it might be interested in doing with practices in the future as problems with these drugs also figure highly in causes of avoidable patient harm.

Again what is likely to happen is that we will help to agree an information gathering phase to see whether there is a significant problem in Norfolk and then will no doubt be involved in looking at potential solutions. You can be sure that we will make the resource argument and my gut feeling is that we are probably not far from the lowest level that is actually achievable in the real world but you never know. At the very least I hope this item will make people just think a

second more before prescribing opiates and non steroidal anti-inflammatories and that any practices who think their anticoagulation monitoring might not pass muster should really have a good think about it. It is an enhanced service which means practices don't have to do it but if they accept the cash for so doing clearly have to provide the work to a high standard. SRL

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**HPV Extension**

Dr Alistair Lipp has confirmed that GtY&W PCT will be in touch with practices very shortly to say how it plans to take this forward. In Norfolk the PCT has written indicating that it is likely to offer a LES for any girls who miss the school based programme.

*Cerarix vs Gardasil* We are awaiting advice from the GPC regarding a GP's position if asked to prescribe Gardasil, bearing in mind that this would come from their prescribing budget whereas it is likely that Cervarix will be free. What is not clear are the potential legal implications of what happens when a patient develops a condition in the future that would have been covered by Gardasil but the GP refused to give it, using Cervarix instead. We will forward any further information as soon as we receive it.

**MMR Catch-up**

Both GtY&W & Norfolk LMCs are commissioning the MMR Catch-up via a LES

**Sharps Boxes**

We have been copied into some correspondence from Norfolk PCT about the disposal of sharps waste in the community. There is a reference in it to different PCTs having had different arrangements previously and the office has heard of some practices' concerns that the change might lead to a significant increase in workload and perhaps storage problems. The guidance the PCT has written does state that "in exceptional circumstances it is recognised that a local council collection may be required" while pointing out that when this happens the PCT might be seen as paying twice for the service, as arrangements are already in place and funded for collecting sharps bins from surgeries and health centres.

Its always difficult to know how to respond to issues that haven't arisen in one's own practice as a problem so it would be very helpful if practices do find that there has been a significant change in arrangements and that it is causing difficulties for them and for their patients to get in touch with the LMC and the PCT and we will see what we can do about changing arrangements either for that particular practice or, if problems are widespread, more systemically.

**PCT Commissioned Beds in Care Homes**

The LMC office has been told that PCTs are commissioning beds in care homes for patients whose condition might previously have meant their being looked after in a Community Hospital under the care of a local practice with a contract for that care. It is apparent that in some cases the PCTs are no longer commissioning the medical care for these patients resulting in local GP practices being expected to take on this intermediate care as part of the normal GMS/PMS service they provide. If you are aware that this happening in your locality please let the office know as we are trying to ensure that whoever commissions this short-term care (presumably to release capacity in acute hospitals) also makes sure that medical care is included in the package.

**Bidding Against the Big Boys (in Norfolk)**

I am sure that practices considering bidding for contracts within the NHS, perhaps for a new APMS practice or to take over an existing chunk of work that is being tendered, will know that the playing field is far from level. The comics say so, the GPC says so, and this flyer and LMC Committee also say so. But that does not mean there is no point at all in applying. Clearly no practice or group of practices is ever going to have the same resources as an international conglomerate in putting its bid together. But I have had an "off the record" conversation with a Norfolk PCT officer in which it was said that the PCT does see advantages in working with local practices who know the area and the patients and with whom the PCT has an existing relationship against an amorphous outside contractor who, after all, might simply act as a locum agency bringing in individuals who had absolutely nothing to do with making the tender bid. So if you are heartened by this and decide to apply then do remember that the national arrangements for the application are stacked against practices and you have to take them seriously. You have to get through the first stage to get to the stage where the PCT can use some discretion. In recent applications practices have completed the initial paperwork less than perfectly leaving out sections, not doing homework that would have allowed them

to make a far more convincing application and even declining to provide information that is requested. There is no point in even making an application if you are not going to do the paperwork properly. I suspect what has happened is that practices have felt that the playing field is so uneven that they have no chance of succeeding but feel duty bound to put something in into which they put the amount effort that anyone would put into achieving something that they know they won't achieve. But as I say, things might not be entirely hopeless.

If you decide you do want to apply the NPCT might be able to assist you with the application; the LMC also might be able to give some general advice. If a PCT officer advises a practice then obviously that person will not be involved in judging the bids. For what it is worth I felt this was a genuine conversation and a genuine offer so if you do find yourself in this situation then speak to the PCT early and do take the process seriously. SRL

### Norfolk County Council Children's Services

The attention of Senior Managers has been drawn to the fact that they should not be asking GPs for authorisation to give "homely remedies" when children are admitted into short-break residential care. Hopefully requests should cease but if they don't please let us know. Ditto if similar requests are being received from Suffolk County Council Children's Services.

### Norfolk Local Pharmacy Committee

Following our meeting with Suffolk LPC (reported in the May flyer) we have now met with Norfolk LPC. As ever a number of items of mutual interest were discussed and we felt the following items worth passing on:

Mix of Committee: The LPC membership is a mixture of independent pharmacists and those representing "chains" which equates to five nominees from chains and eight independents; however 70% of pharmacies are in fact run by multiples. At the moment the bias is towards the independents but this may need to change which is perhaps a signal for the future of LMCs if APMS really gets going.

Repeat Dispensing by Pharmacists: This has not taken off very fast in much of the county although it is proving reasonably successful within Norwich. This is work that you may be able to shift and which pharmacists are willing to do and interested in doing. Communication with your local pharmacists would be an excellent idea - they may even be willing to suggest from amongst their regular customers those of your patients for whom this might be feasible,

Medicines Use Reviews: Take up is variable but if you want particular sorts of patients looked at then again communication with your local pharmacy is the place to start.

GP/Pharmacy Links: Not necessarily an issue locally although it may well become so. There is concern at patients being directed towards pharmacies (perhaps inadvertently by practice staff) in which their GPs have a financial stake. Be very careful about this. Sooner or later somebody will come a cropper, possibly with the Competition Authorities, maybe with the GMC.

Deceased Patients: Not sure how feasible this one is, but if you have a close relationship with your local pharmacist and a pretty good idea of

which patients attend then following the bereavement of a patient, it might be kind to advise the pharmacist so they don't put their foot in it when they next see the survivors. That being said, there may well be confidentiality issues - it might depend if the pharmacist is considered to be part of a clinical team looking after the individual patient or whether they are a bit more remote than, for example, district nurses or hospital consultants who are involved in the clinical care of the patient.

Pharmacists are going to be able to help with emergency contraception for 13-19 year olds. At present this is just happening in Norwich but will be rolled out at some stage. In parallel with this pharmacists may become involved with chlamydia checking. If it becomes clear that the LMC is informed about either of these initiatives before practices we will, of course, let everyone know.

### The Corporate Manslaughter Act Duty of Care

GPC Guidance has been produced to alert GPs to the details of the Corporate Manslaughter Act 2007, which came into effect on 6th April 2008 and applies to organisations, including NHS bodies, across the UK. It was introduced in response to high-profile disasters such as the Potters Bar and Paddington train crashes, which highlighted the difficulty of securing criminal prosecutions against large corporations. The GPC recommends that practices should familiarise themselves with the Act and adapt their day to day running accordingly. It is available at [www.bma.org.uk/ap.nsf/Content/Hubmanagingyourpractice](http://www.bma.org.uk/ap.nsf/Content/Hubmanagingyourpractice).

#### Advertisement

### THE FAKENHAM MEDICAL PRACTICE LOCUM REQUIRED

We are looking for a long-term locum cover, to cover the maternity leave of one of our GPs. The position will start in October 2008 and be for up to 12 months. We are looking for someone to do 6 sessions per week over 3 days, preferably Wednesday, Thursday and Friday, but will consider other options.

For more information or to arrange a visit to the practice please contact Ann Kerrison, Practice Manager, The Fakenham Medical Practice, Greenway Lane, Fakenham, NR21 8ET, or tel: 01328 850320 or email [ann.kerrison@nhs.net](mailto:ann.kerrison@nhs.net)

### Occupational Health for GPs

All doctors in Norfolk (including those in the "old" Great Yarmouth PCT area) should:

Self refer to: NNUH Occupational Health  
Aldwych House, Bethel Street  
Norwich NR2 1NR  
Tel: 01603 287034

In Waveney doctors should:

Self refer to: Ipswich Occupational Health  
Ipswich Hospital NHS Trust  
Heath Road, Ipswich IP4 5PD  
Tel: 01473 704011

Both centres will make "out of area" referrals.

Other organisations offering help include:

Norfolk LMC 01953 608060

(Note: at weekends contact numbers are left on the LMC's voicemail)

BMA Confidential 24-hour  
Counselling Service 08459 200169  
Doctors' Supportline 0870 7650001  
Sick Doctors Trust 0870 4445163

### Fixion Intramedullary Nails

Yet again we are hearing that these nails are presenting problems for the crematoria, or at least Mintlyn Crem in King's Lynn. According to the Deputy Superintendent, from a crematorium's point of view these nails have an explosive capacity potentially greater than that of a pacemaker. He advises that the initial pressure needed to inflate the nail may be approx 50psi which means that, heated to 850 or more during the cremation can increase the pressure to perhaps as much as 2000psi.

We have been assured in the past by the local orthopaedic surgeons that they do not use these nails, but that does not mean that patients moving to the area have not had them inserted elsewhere.

Cremation does not seem to be a practical option for these patients so if you are aware of cases it might be worth mentioning the problem to the patient when an opportunity arises. Also, if local surgeons are using this technique it might be worth asking the hospital to ensure that it is noted on any discharge documentation or, better still, for the hospital to make the patient aware of the consequences.

### SCAMS

**National:** The GPC is aware that an organisation called NovaAG seems to have been sending communications to UK practices about their publication "Physicians and Therapists Guide". The letter states "Please return this form in the enclosed business reply envelope, by doing so you will be helping to keep the Medical Directory up to date". In the small print at the bottom of the form it makes clear that in returning the form you are signing up to pay for what is essentially an advertisement in this publication.

Some practices have returned the form without noticing this, and have subsequently been invoiced for the cost (which is several hundred pounds). When practices have tried to get out the company has insisted that they have made a legal commitment and are obliged to pay. Legal advice is that there is not much that can be done in this situation. The company is based in Switzerland, and therefore both it and the contract is the subject of Swiss law. The Swiss Embassy or the Law Society may be able to offer more specific advice on the systems in place in Switzerland. Practices need to be aware if they receive these letters what exactly is involved. Anyone who has signed up must cancel the contract formally to avoid it rolling over for a further twelve months.

**Local:** The LMC office emailed all practices about persons pretending to be from Norfolk Police who, by various methods, are trying to get practices to part with money. Several practices replied saying they had been and were still being approached. If your practice is contacted the police would like you to express an interest, obtain what details you can and then get in touch with them at Wymondham Police HQ on 0845 4564567 and quote Ref 378.