

NORFOLK LOCAL MEDICAL COMMITTEE

Wymondham Medical Centre
The Surgery, Postmill Close
Wymondham,
Norfolk, NR18 0RF
July 2005

July 2005 Flyer

Tel: 01953 608060
Fax: 01953 608061
e-mail: norfolklmc@btconnect.com
Website: www.norfolklmc.org.uk

Partnership Agreements

The GPC has dealt with some cases of difficult and acrimonious partnership splits recently, mainly due to the fact that there was no partnership agreement in place. In the absence of a partnership agreement a 'partnership at will' will operate and the partners will be governed by provisions of the Partnership Act 1890. This could result in:

- the loss of the practice NHS contract, with no obligation on the PCT to award a new contract to the remaining partners
- the forced sale of partnership assets including the premises
- significant legal costs
- the inability to exclude one of the partners without a lengthy dispute resolution process or a court case.

Practices are urged to ensure that they have a written partnership agreement in place and to check that it is up to date and includes all partners. Further guidance is available at: www.bma.org.uk/ap.nsf/Content/PartnershipAgreements0504

"Partnerships in General Practice"

All the more reason to put 11th October 2005 in your diaries. Unfortunately the "Partnerships in General Practice" event scheduled for the evening of the 7th July had to be postponed. Indeed Dr Holden and Mr Lockhart-Miramis were both in BMA House when the bus blew up outside and Dr Holden was one of the doctors who assisted the victims. This event has been re-arranged - with the same cast - for the evening of Tuesday 11th October. Full details with the August flyer.

Muddle, Misinformation and MMR

A letter that appears to originate from Hartsmere and St Albans & Harpenden PCTs a month or two ago has been circulated to some Norfolk practices much more recently by at least one local PCT. This letter claims that the Local LMC (Beds & Herts) has advised its GPs to give unlicensed MMR vaccine. In fact, Beds and Herts LMC clarified its view after contacting the GPC and sent round a letter of correction to the original letter's audience which did not advise GPs one way or the other. That letter has not been circulated in Norfolk. This little saga demonstrates that it is unwise to rely on old information - though I have sympathy for those who decided to circulate the letter as it seemed, for one glorious instant, to make a confused situation clear. Sadly, we are now deep in the murk again. As you know, MMR vaccine has had to be imported from Germany and the USA because the British stuff has run out (NHS long term planning comes up trumps again). The DoH says it is fine and GPs are not to worry because the manufacturers have confirmed that the

unlicensed MMR vaccines are identical to the licensed MMR products already used in the UK. If the product were found to be unsafe and a patient suffered injury or illness as a result of its use it is most likely that this would result from some defect in manufacture of the product and that it may be possible to bring a product liability claim against the manufacturer of the vaccine. A claim can also be brought against a doctor who prescribes a medicine if the patient can show that the doctor was negligent in prescribing it. Although each case would depend upon its own facts, the fact that the product is licensed in other EU member states and the United States, and is identical in its formulation to a product licensed in the UK, is likely to provide a good defence to any claim in negligence against an individual doctor.

On the other hand, the GPC currently takes the view that if the potential liability is clear the Government should be happy to provide indemnity to GPs for any problems that arise from using these vaccinations. This has not appeared. Other possible complications that have been raised include:

- apparently the prescribing doctor is responsible for ensuring that patients give informed consent to the prescribing or administration of any unlicensed medicinal product. This would include explaining that it is not licensed. This remains the prescribing doctor's responsibility even if the product is administered and the consent is collected by a nurse.
- The Department of Work & Pensions operates the Vaccine Damage Payments Scheme. This Scheme provides compensation for patients who suffer 60% or greater disability caused by any vaccination within the UK child health programme (subject to certain rules). But the scheme would need to be extended to include giving 16-23 year-olds MMR and for use of unlicensed vaccine.
- Patient Group Directions (PGDs) cannot be used with unlicensed products. Patient Specific Directions (PSDs) can - they are a signed list of suitable patient names and a written instruction from a doctor to administer a Prescription Only Medicine. The written instruction can be the relevant PGD for the licensed alternative. In signing the list of patients' names, the GP is accepting responsibility for the appropriateness of the vaccine for each patient even if the GP has not checked the individual medical record for contraindications.

What is the poor GP - who just wants to do the best for his or her patients and to not end up in the High Court - to make of all this? I know we are the experts in clinical risk management but this isn't the sort of risk management we are expert in. A defence society view has been sought

and may be helpful.

In many ways I agree with the GPC - it would be outrageous if a GP was blamed for anything that went wrong because of problems with this vaccine as it certainly is not GPs' fault that someone forgot to make enough. Surely the Government should confirm that unequivocally. But, on the other hand, can we risk stoking up another vaccine scare and leaving patients un-immunised while some bureaucrat decides whether or not to get his or her finger out? As ever, I suspect we will pay the penalty for being "reasonable people" and sign the lists our nurses bring us (maybe with our fingers crossed in case of disaster) and hope that someone else will be sufficiently bolshie to make sure the government sees sense. SRL

Stop Press: We have now had a sight of the MDU advice and it seems to be that the unlicensed vaccine can be used by doctors but that we must be conscientious about recording details of what has been given and about explaining to patients/parents what is going on.

VAT allowance on dispensed drugs

Following consultation with DDA the GPC has agreed to an amendment to Para 18.3 of the SFE relating to the VAT allowance paid on dispensed drugs. An error in the transcription of this provision from the SFA to the SFE led to the SFE stating that the allowance was calculated on the basic price before, rather than after, deduction of the discount. This meant that in 04/05 there was a considerable overpayment of the VAT allowance to dispensing doctors, which the DoH has agreed not to claw back. We understand the GPC is satisfied that this was a genuine transcription error and therefore has agreed to an amendment to the SFE for 05/06 to correct it with immediate effect and to avoid further overpayment.

Jury Service

The BMA has met with the Dept of Constitutional Affairs to discuss the implications of jury service on GPs. As a result the BMA is drafting guidance for doctors who may wish to be excused jury service or for it to be deferred. This should be available in the autumn. In the meantime any application for excusal or deferment should be accompanied by detailed reasons, including the implications for service delivery. Locally the Norwich Combined Court was unable to give the LMC any assurance that GPs might be released from jury service. Jurors are summoned for a two-week period and GPs would not normally be treated any differently to other jurors - even judges are no longer exempt from jury service. If a trial was estimated to last longer than two weeks the trial judge would ask jurors to give reasons why they were unable to sit on that trial.

Orthopaedic Triage

The LMC is receiving mixed reports on the

success, or otherwise, of the various orthopaedic triage services said to be operating locally. → For the ones that struggled at first it is claimed (by those running them) that they are improving yet, on the other hand, GP complaints to the office seem to be increasing. The intention was that triage would deal with those cases that did not need a specialist opinion, freeing up consultant time for those that needed their technical or diagnostic skills and thereby speeding up through-put and shortening waiting times. Some GPs believe that the triage service simply adds an additional hurdle to the patient pathway - especially when the GP, patient and, ultimately, the consultant all agree that joint replacement is required. Your views would be much appreciated - especially on whether things are improving compared both with before, and during, the early days of the imposition of the triage systems.

Advertisement

The Prospect Medical Practice, Norwich

Has a vacancy for a full-time salaried GP or part-time (minimum six sessions). Attractive financial package. For details contact Mike Hall or Will Mirza on 01603 488477 or email prospectmedical.norwich@nhs.net

**ANNUAL CONFERENCE of LMCs 2005
A report by Simon Lockett, Med Sec**

In my opinion there are three broad types of resolutions passed at the Annual Conference of LMCs. The first, which are generally self-evident (at least to GPs) may be on the agenda for "political" reasons - which can include wanting the issue to get into the medical or general press or to demonstrate that the democratic process is being followed - especially if others are advising the government that GPs believe, or will do, something that they don't or won't. The second type is when clarification is needed - because the profession has not yet decided what is to be done about an important and current issue. The third used to be the most enjoyable ones: maybe just one GP in one LMC somewhere has picked up an anomaly in the rules, or has a special interest or insight, or is completely bonkers - and their motion on the anomaly, the insight or the weirdness has sneaked into the conference agenda. Sadly, these latter were few and far between in 2005. I should also mention that some resolutions are accepted as "references" (to the GPC). This is when the motion is not acceptable as it is, but there is something in it which the GPC can chew on and may incorporate into policy one day.

Here are a few examples of each. If you find them interesting you are LMC material. If you want to see all the resolutions then you are GPC material. The full list is available on the BMA web-site - follow links to M11 2004-2005 Conference News. If you can actually find it there - you are negotiator material! (*SRL's comments are in italics*):

Self Evident but need to be said.....

Jury Service: That conference in considering support for practices where GPs have been called for jury service:

- deplores that no proper provision has been made
- instructs the negotiators to seek to establish

adequate support

Locum Payments: That conference instructs the GPC, as a matter of urgency, to seek an uplift to payments for locum reimbursement related to maternity, paternity, adoption, prolonged sickness of salaried GPs or partners, suspension and prolonged study leave and insists that:

- there is a national agreement for reimbursement of actual costs for all GPs regardless of contractual status
- sufficient funding be made available to PCOs
- the level of payments is not at PCOs discretion
- the current list size reimbursement thresholds be renegotiated or removed to ensure fair and equitable distribution
- such locum allowances be paid when such periods of prolonged leave are covered by partners. *This composite included a Norfolk motion*

Funding for General Practice: That conference:

- demands that the review of the global sum allocation formula is undertaken with transparency
- insists that the global sum allocation formula be published
- believes that any pay system which results in the vast majority of practices ending up with a MPIG is unsustainable and must be replaced with a properly funded scheme
- demands that the inequities caused by the application of normalisation at PCT level be resolved as a matter of urgency. *The final bullet point issue has been exercising practice managers locally*

Employers' Superannuation: That conference instructs the GPC to continue to press for full central funding of employer's superannuation payments for all NHS work undertaken by GPs.

Motions needing debate as the consensus view is not known.....

QOF: That conference believes that the Quality and Outcomes Framework and the QOF prevalence formula should be adjusted to accurately reflect the true workload of having a high prevalence population. *This is a bit technical but current payments are adjusted so that practices that have very few patients with a particular condition (perhaps a young age profile in a healthy part of the world - so few COPD patients) gets a (statistically) "smoothed out" reward resulting in more payment than would have been the case using the absolute numbers. This is good from the point of view of not destabilising practices through big swings in income and not disadvantaging such practices when most of the New Contract rewards (and Superannuation reimbursement) are via the QOF, but not so good for practices with a high incidence and workload for a condition who get proportionally less money for their work.*

Conference took the view that using absolute values would be fairer - though I am sure no representative could work out the impact on their own practice before voting - possibly a good thing.

The idiosyncratic sort.....

That conference instructs the GPC to negotiate:

- a logical system of immunisation for travel immunisation
- a system for occupational hepatitis B immunisation
- systems for other national or local

immunisation campaigns

- the introduction of a comprehensive hepatitis B programme as recommended by the WHO.

well, the last bullet point must demonstrate a special interest on somebody's behalf

References.....

In an otherwise straightforward "British General Practice is Great" motion that belongs in the first category, one part was:

- the overwhelming priority of the GPC should be to resist the destruction of independent contractor general practice

this was accepted as reference because it is hard to say that this is the top priority issue.

GP Education and Training: That conference regrets that the DDRB has yet again failed to recognise and remunerate the work of GP trainers and course organisers, and (*other parts accepted*)

- if there is no satisfactory package of remuneration and resource in 2006 calls for the BMA to ballot trainers on a withdrawal of their services

This had to be accepted as a reference as it would cost the profession's money to do and as there are implications under trades union legislation that will need careful thought and, possibly, legal opinions

Motions that were lost.....

Few of these - which probably is simply a reflection of the number of "unusual" motions that made it to the agenda. One example:

That conference demands that any funding review should include a full market forces factor to reflect the full cost of living expenses of doctors and their staff.

This motion is saying, in essence, if you are "unlucky enough" to practice in an expensive part of the world where your house costs a lot and school fees are high, then you should get more pay. Obviously I do not know why other people voted against it but suspect it was to do with it being a doctor's choice where he practices and because he would do jolly well under this system if he flogs his house and moves to Norfolk when he retires.

I should add that any motion that proposes special help for poor, unfortunate dispensing doctors often gets the same cynical reception from the rest of conference as this motion did.

Premises Survey

The GPC will be undertaking a comprehensive, one-off survey on the state of GP practice premises and the position of GP finances with relation to their premises primarily to help build a case for increased revenue and capital funding for premises, to enable GPs to provide a wider range of services under the new contract, to engage in practice-based commissioning and to help deliver funded shift of work from secondary to primary care. The GPC will be seeking information not only on the physical condition of premises but also views on what GPs would do with improved premises. Please take time out to complete this survey, which is to be published shortly as it is vital for general practice that more

funding is made available for premises development.