NORFOLK LOCAL MEDICAL COMMITTEE

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March 2006

March 2006 Flyer

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Disability Discrimination Act Responsibilities for Dispensing Doctors

I alluded to this in a previous flyer item. At a recent meeting between the LMC and the LPC the pharmacists reported a case of a disabled patient being passed by their dispensing doctor to the nearest pharmacy (which was far from near) because the patient needed a modified dosing system. This "referral" was done without any discussion between the doctor and the pharmacist.

May I suggest that if any practice is tempted to do this, that they consider very carefully. They should certainly read the Disability Discrimination Act guidance. It appears that dispensing doctors and their staff have exactly the same responsibilities as pharmacists to ensure that disabled patients receive their drugs in the appropriate form and in the best way to enable compliance. If dispensing doctors send these patients elsewhere then that would provide ammunition for those who say that dispensing doctors provide an inferior service to that provided by pharmacists. In addition the DDA is **law** - there could be serious consequences if dispensing doctors fail to act within it. If anyone ever needs to pass on complex dispensing to a pharmacist I suggest that a personal conversation with the pharmacist - in advance - would be wise. SRL.

"NHS Cervical Screening Programme Audit of Ceased Women"

SRL had a useful meeting with the unfortunate ESS officers who have had the thankless task of "inviting" practices to take part in the "NHS Cervical Screening Programme Audit of Ceased Women". ESS agreed that stakeholders, especially practices, had not been involved early enough and have apologised. Allegedly practices were warned in the "SPC Newsletter" in January (if anyone has seen this august publication I would be delighted to view a copy). As is usually the case, the chief villains seem to be the centre - who imposed a ridiculous timetable on local screening services, based on financial year ends rather then when the work would be least inconvenient (for both screening services and practices).

ESS tried to help by doing much of the paperwork in advance and sending it out to us; the flip side of this was, of course, the heart sink and irritation (or worse) resulting from said reams of A4 arriving, out of the blue, in practices. The information collected is going into ESS's computers and should not be required again, though I gather that, unfortunately, some questions still need to be asked about a few over-60s. This is likely to be via a person to person call from the screeners to practices and will involve many "please"s and "thank you"s.

Some good has come from this muddle. In Norfolk a hundred or so "ceased" ladies are back on the recall system and a dozen or so cervixes appear to have re-grown and are now happy to present themselves for inspection! So, it may be that a life or two will be saved. Sorry about the staff overtime bills, though.

Later ... the LMC office has heard that enough fuss has been made nationally for the timescale to be made more reasonable. Apparently in some parts of the country practices were given an even more ridiculous timetable than in Norfolk.

Are there any additional lessons to learn from this development? Well, the LMC officers do feel slightly peeved about it! Norfolk was one of the first, possibly *the* first, LMC to report this problem. We felt we got lukewarm support from the GPC at that stage or we would have advised practices to have nothing to do with it until a more reasonable timescale was agreed. So, one lesson might be to make sure the GPC has plenty of members who understand grass roots Norfolk GP problems!

Another reason it was hard to take a stand was that several practices had returned the work within a matter of days - which kind of implied that it was easily do-able. Clearly, those practices have commendable internal administrative systems, but it is hard for the rest of us to live up to their standards! So, another lesson might be, if a chunk of work arrives that may not be your job, please consider checking with the LMC office before cheerfully doing it.

TB stuff

Your Secretary is flummoxed by the new TB vaccination arrangements: both what to do with the forms thrust under his nose in his practice and what to do about queries that have come to the LMC office. There is a juicy one at the moment about consent forms and who, if anyone, should store them. He has a horrible feeling that he will end up having to make a time-consuming fact-finding visit to those running it in Norfolk - if he can work out who they are.

The intention would be to do what he can to make the pathways as practice and patient-friendly as possible. If anyone out there has any thoughts or is aware of any problems he can raise, please let the office know. Or, if anyone out there understands the system and thinks it is perfect - please tell the office that, too. In the meantime, SRL is so out of touch that he doesn't know if the following item from the GPC is relevant in Norfolk, or not. So, for safety's sake, here it is:

Mantoux testing A local PCT prescribing development group had raised the issue of the new TB vaccination schedule, part of which involves the introduction of Mantoux testing - because Heaf tests are no longer available. Although the tests would still be administered/ read by school nurses, the problem is that the Mantoux test is technically an unlicensed medication and the suggestion was being made that, for every child, the GP would need to sign a form of authorisation. In our view GPs should not be signing such authorisations. The product is unlicensed and GPs are unlikely to know the child, the indications for giving it or who is giving it etc. GPs should not accept the full clinical responsibility for this test and GPC would support any GPs who refuse to sign these forms.

Healthcare Commission Diabetes Survey

It was planned to ask practices to take part in this survey, which involved putting software on their computers to draw out a sample of diabetic patients, each of whom would then be sent a patient satisfaction survey. We expressed doubts about the consequences of monkeying around with clinical systems, concern at confidentiality and questioned whether this was work practices should be doing. On 17th March the GPC wrote:

"We met with the Healthcare Commission this week who produced this (survey). It is currently going through a second pilot stage - and that is why only some areas will have had requests regarding it. Needless to say they recognise that this pilot has shown a number of key flaws that you have highlighted and they will run a third pilot later on in the year. GP practices are not contractually bound to be involved in any of this.

Stop Press: The Healthcare Commission now accepts that its proposals were flawed and has withdrawn the survey for the time being.

PBC & C&B

We would like to thank Dr Kathy Lavelle of Dereham for sharing the following GPC advice:

"The new DH guidance on PBC "Achieving universal coverage" (Jan 2006) makes no mention of C&B. This states that it "replaces the detail" of the earlier DH guidance "Making PBC a reality: technical guidance" (February 2005) where the direct link between PBC & C&B was originally made. The relevant DH Q&A document goes further and says that it "supersedes" the earlier guidance. In addition the "Towards PBC DES" spec also makes no specific mention of C&B That said, it is clear that practices and PCTs are expected to address the choice agenda to a certain degree in their approach to commissioning, but whether or not this should be directly linked with C&B is for local agreement"

"Doctor .... am I fit to go on holiday?"

Having taken advice we understand that it is not possible to prevent insurers (and/or travel agents acting on their behalf) asking policyholders' GPs for a medical opinion upon their fitness to travel. Travel insurance is not covered under the BMA agreement with the Association of British Insurers (ABI) and therefore complaints cannot be channelled via that route.

GPC member, Dr Peter Holden, has suggested a possible way forward - he plans to ask the Cabinet Office Better Regulation Executive ⇨

to look into this and would welcome evidence - copies of letters etc to the LMC office please. He also plans to commission an article in BMA News highlighting this as a growing problem for GPs.

Patient notes & personal injury claims

An annoyance "possibly" solved? The Cabinet Office's "Making a Difference" initiative has announced that from June 2006 the Law Society, the ABI and the Association of Personal Injury Lawyers have agreed, subject to the expert witnesses view, that no patient records will be requested for claims below £10,000. It is hoped that this will bring about a very real reduction in the number of requests for copies of patient notes - bearing in mind that of the 755k+ accident claims recorded in 2004/5 75% were for claims below £10k. This is very welcome so long as solicitors/insurers stick to the agreement and we will be writing to their local representatives to ensure they are aware of it. Bearing in mind the above statistics if you don't see a real reduction in requests from June onwards please let us know and we will feed back to the centre.

Contract Review 2006-7

The joint GPC-NHS Employers guidance "Revisions to the GMS Contract 2006/7 - Delivering Investment in General Practice" was sent to your practice in February. The SFE has yet to be finalised.

The Patient Experience Survey Project Board (inc two GPC reps) is discussing confidentiality, procurement of software to extract and analyse data and sampling methods. A pilot is planned. Negotiations with respect to the childhood pneumococcal imms and Hib B payments are still to be addressed and the data accreditation process for the IT DES also needs finalising. We will pass on GPC guidance immediately it is available.

QOF & QMAS The final version of the Datasets and Business Rules for the QOF have been published by the GPC; details on how to access them were sent to your practice on 17th March. In the GPC's view it is unlikely that QMAS will be updated before August. How quickly suppliers upgrade their own software may be determined by how much pressure they get from you!

Meeting with the Local Optical Committee

The purpose of this meeting was initially to discuss the different pathways for direct referral from opticians to the various hospital eye services and the fact that some opticians use the pathways, some don't and some, who would like to, can't get the forms or are not allowed to use them.

The LOC feels that it is not worth putting a lot of energy into integrating and rationalising the current small number of protocols as a much wider initiative will probably materialise sooner rather than later - perhaps with a nudge from PBC. The LOC is certainly far from content with the way the system runs at present. There are ludicrous difficulties with obtaining new referral forms (NNPCT attempted to charge optometrists for them!) or even being allowed to have them under any circumstances. Eg, an optometrist practising on the edge of two hospital catchment areas did not believe he was allowed to use the direct referral process because of the patient's place of residence (in the "wrong" PCT). There are difficulties tracking down those able to make decisions to improve or slightly-smooth current pathways; it certainly sounded rather chaotic.

The LMC heard that the General Optical Council had changed its rules on optometrists referring patients that are in need of attention to medical professionals. The GOC has made additional provisions allowing direct referral to hospital ophthalmic depts, centres specifically constituted for the onward referral of ophthalmic patients to secondary ophthalmic services and to other suitably qualified personnel. This allows all optometrists to refer directly all patients who are in need of care by the hospital eye services.

The LOC shared a document from West Sussex HA (depressingly dated - in view of how slowly things change here - January 2002) which showed agreed referral guidelines for abnormal ocular conditions, divided (helpfully) into *"hospital same day"* (one or two being "GP same day", eg herpes zoster and dacrocystitis) *"soon" and "non-urgent" (which is called "in turn")* - again the lists are divided into those where the referral would be straight to hospital and those where it is more appropriate to go to the GP. Finally there is a column of *"optometrist managed" conditions.* The LOC was fairly optimistic that practice PBC would provide them with an opportunity. They felt they would be able to significantly undercut the trusts for many conditions. It was agreed that we would have further discussions in due course - when it should be more obvious whether the climate had changed sufficiently. There were a few messages for GPs on this and other matters:

- the different forms and their more confusing aspects were not the responsibility of local opticians
- sending some "emergencies" to the optician raises issues as opticians are funded to provide **sight tests** rather than an **acute eye service**. A patient with sudden onset of lots of floaters or a red eye will often be seen but may well not attract any funding for the optician - so goodwill could be jeopardised if this happens too often
- it might be worth discussing with your local optician colleagues whether there are things that can be done to help each other - both for now and to lay good foundations for our mutual rosy PBC future!

PMS Contracts & Superannuation

Available from the LMC office - guidance prepared by the Londonwide LMCs and endorsed by the GPC on PMS contracts and employer's superannuation. Whilst helpful for those using the model Lockharts contract agreement it should also be useful for practices with locally agreed contracts to help identify the type of clause that may allow for full reimbursement to be made.

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Dr Julian Adams is available for sessional/locum work from 1st April 2006, ideally within 45 minutes of Norwich. Contact 07759 814509

Dementia Drugs & the Memory Clinic

Thanks to those who raised the issue of dementia drug long-term follow-up moving to general practice and for those who responded to the flyer.

The LMC at its February meeting ended up needing one of its rare votes to confirm its view that *"TAG (should prepare) a clear statement on the planned guidelines to be distributed to GPs, stating that although these guidelines differed from NICE guidance they had been produced and adopted by the local health economy in the interests of patients to ensure quicker access to memory services and that checking MMSE regularly was not called for/supported and that TAG would take responsibility for any doctor following the TAG/Memory Clinic advice".* There may, however, still be some i's to dot and some t's to cross - so watch this space.

Norfolk Knowledge Management Site nww/www.knowledgenorfok.nhs.uk

The current contact list is being updated, opened to a wider audience and more targeted in content - ie any user can ask to be included on the distribution for all or specified areas, although practices may continue to name a single contact. If you wish your name to be added contact sarah.dutton@norfolk.nhs.uk giving the following details: Forename, Surname, Position/Job titles, PCT, Practice Address (if not a locum), Email, Clinical System(s) if requesting information about referral forms, Updates required for currently available Guidelines, Prescribing, Referral Forms, Suggestions for other update reminders

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For further details please contact: Dr Alan Collett (alan.collett@nhs.net) or Stephanie Barnes (Stephanie.barnes@nhs.net) or tel 01328 701568

"CPD and the Sessional GP" 06.10.06.

This conference offers a chance for those interested in CME and PD for Sessional GPs to come together and share research, ideas and examples of good practice. The programme is available from the Norfolk LMC office. For further information telephone BMA Conferences on 020

7383 6137/6605 or email confunit@bma.org.uk. Or
register online at www.bma.org.uk/conferences.