NORFOLK LOCAL MEDICAL COMMITTEE

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NHS TERMS and CONDITIONS

Some developments in the east of the LMC's area led to the Committee discussing the far from level playing field on which private company providers of NHS services take on NHS bodies - including general practice. A particular issue that exercised the Committee was the NHS Pensions Scheme and whether doctors and, indeed, other NHS personnel, whose contract of employment changes to being held by a private organisation, or who apply for jobs in a private organisation, may well find they no longer have the benefit of that scheme. The GPC sent a very helpful response explaining that it is doing all it can to raise the profile of this issue and is liaising with the other trades unions to try and ensure that those people doing the same jobs - whether in an NHS body or a private company - receive equal benefits. However, the rules are not terribly clear and this wish may well not be enforceable. APMS providers are supposed to provide "similar" pension arrangements - but it is more likely that what will be on offer will be inferior and that this will allow those companies to tender at a lower price than an NHS body which offers the full benefits of the NHS pension scheme.

The GPC is clearly doing all it can centrally but whenever you come across this issue - either with the PCT or with colleagues (doctors and other NHS personnel) - please do try to publicise it. It is arguably especially unfair on non-doctor caring staff, many of whom are on low salaries.

MORE DEATH ISSUES....................

Your Secretary recently attended a useful meeting with the majority of Norfolk's Registrars of Births, Marriages and Deaths, together with the Coroner. There were also a couple of nurses who do great work in the NNUH Bereavement Office. Hospital doctors, the Coroner's Department and GPs all came in for some criticism but, I can reassure you, problems with GP Death Certificates are few and far between. Nevertheless, death certification is one of the most significant things we do and it is a good idea if we, the Registrars and, indeed, the Coroner, make things as easy as possible for each other.

Inevitably, some reminiscing takes place at such meetings and it was with a degree of sadness that I heard that a couple of diagnoses used regularly in years gone by, namely: "natural decay" and "visitation of God" are no longer acceptable.

Apparently there are still problems with handwriting and signatures. This is probably more of a problem with hospital doctors who change frequently or who may be locums, but GP signatures can also be a problem. Interestingly very few GPs use their practice stamps on death certificates, quite possibly because there is no obvious space designated for them (or because it says "residence"). The Registrars would find it extremely helpful if you would use your stamp somewhere near the bottom of the form (not, of course, obscuring any important information). There are some differences in the form the signature takes which may reflect different backgrounds. It is important that the signature and the written name (or the stamp) state the name as registered with the GMC.

There are some other legibility issues: for example, sometimes the diagnosis is not clear; also abbreviations and symbols (such as the # for "fracture") are making a bit of a reappearance - I am afraid they are not really acceptable. Legibility problems cause most difficulty when deaths are registered on Saturday mornings as the Registrars find it impossible to contact anybody (at the hospital or in practices) to seek clarification - to the understandable distress of the relatives and embarrassment of the Registrar.

If one wants to be extra helpful, the Registrars would very much value us putting the NHS number somewhere, perhaps on the outside of the envelope. It is quite common for the informant not to be in know it - but the Registrar needs it. It may also be worth asking practice staff who hand over the death certificates to remind the informants to look at the list on the envelope and the counterfoil slip: apparently informants quite often arrive not having realised that they should have that information available. Some Registrars' experience is that the informant is more likely to have read the counterfoil attached to the outside of the envelope than to have read the envelope itself - so the counterfoil should not be put in the envelope. It would also be helpful if the informant is reminded that all the Registrars' Offices in Norfolk have an appointment system.

Mesthelioma - always notifiable - and using "old-age" as the sole cause of death in those under 80 - were both mentioned in my previous Flyer item; I am pleased to say that none of the Registrars could remember either of those being issues in any recent GP certificates.

Apparently the medical students on the UEA course get good training on death certification so they will be good at it. I suspect the rest of us simply picked up the good (and bad) habits of our seniors as we learnt this (and most of the rest of what we do!) on the job.

There remains some confusion about how to indicate on the death certificate whether the Coroner's Officer has been approached and, if so, whether this has been on a formal or an informal basis. The latter was very common before the fairly recent change in Coroner's Officers in Norwich but is now less so and this is probably appropriate. Please take particular care when deciding whether to circle 4 and about initialling the back of the certificate. You should make it absolutely clear whether a formal contact has been made with the Coroner, in which case the Registrar will need to see a form "A" before they may register the death. Can I reiterate advice given in at least one previous piece? To give time for the Coroner's Officers to get the paperwork done and passed on it is important that the informant doesn't try to register the death in less than 24 hours from when the matter was discussed with them. So please try to make sure that the informant is so advised.

Apparently some practices still use plain envelopes rather than the custom envelopes supplied by the local Registrar's office or offices (if the practice is on the border of more than one area). Nobody at the meeting could see any benefit in using plain envelopes and doing so clearly increases the risk of the informant not having the necessary information to hand when they go to the Registrar. SRL

GPC "FOCUS ON SALARIED GPs"

The GPC has now further revised this guidance to include a detailed legal view on what counts as continuity of service, as well as on calculating entitlement to maternity pay, sick pay and redundancy pay for those employed under the model salaried GP contract. This is available from the LMC website or from the LMC office.

Lord Darzi's NHS Next Stage Review: Interim Report

The interim report of Lord Darzi's Next Stage Review was published earlier this month and can be accessed on line at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh079077

A GPC summary of the report covering the key points and giving more detail on those that are of particular interest to GPs is available from the LMC office or from the GPC website.

CHLAMYDIA

Responses to my e-mail about chlamydia screening suggest a wide range of opinion among practices. The first thing to say is that I am not sure we are all talking about the same thing. When Norfolk PCT's Director of Public Health of talks about "screening" then I am sure he is using the word correctly (ie checking an asymptomatic population for a condition, as with cervical smears and mammography). He is not talking about testing patients with symptoms or where there is a particular reason for testing. From the responses it would appear that quite a number of practices had accepted packs and are using them to check patients' chlamydia status when it is clinically appropriate, for example before fitting an IUCD. I have no problem with practices doing this if it is more business efficient and causes less pain and distress than other forms of testing. But this is not screening. If this is what practices are doing with their packs then it would be a good idea if they make this clear to the PCT because otherwise the PCT Board is likely to receive a report that practices are willing to take on the work and the responsibility of screening patients for chlamydia without any additional funding. This

would have a number of consequences. It would imply that practices have spare capacity and are willing to accept new work without funding; also it would make it extremely unlikely that any form of funding could be negotiated to do this work as an enhanced services (as has, I believe, been agreed elsewhere in the country). I would venture to suggest in today's climate, with practice incomes going down, this is not the message that you would wish to send to the PCT. I may of course be wrong!

Please think very carefully about the consequences of accepting new, unfunded, work both for yourselves, your practices and your colleagues. Remember where good intentions end up getting you. SRL

Medical Records on CDs

We continue to get reports of practices elsewhere in the country transferring patient records on CDs and thereby causing often unsurmountable technical problems for the receiving practice as well as an awful lot of extra work. We have checked with Eastern Support Services and can confirm that the Regulations have not changed. If the patient record is computerised the practice must send a copy in written form to its "home" PCT for onward referral to the patient's new PCT/Practice (unless the receiving PCT has agreed otherwise). If you receive records on, or containing, CDs (and floppy disks - if these still exist?) you are entitled to contact the previous practice and request written copies. If ESS handles your patients' records Rebecca Larke (on 01603 307443) tells us she will be delighted to speak to the practice on your behalf. If the records come from Ipswich then may we suggest you contact them if you are experiencing difficulties.

GPwSIs

In a recent conversation with the Norfolk PCT, the LMC was advised that only a few GPwSIs (those GPs who currently are doing work for, and are in contract with, the PCT) had responded to invitations to contact the PCT about accreditation.

It may just be that it takes time to consider the implications of the documentation, but it does occur to us that some GPwSIs might believe that, as their role is one that is mentioned in much of the literature on improving cost-effectiveness (by shifting secondary care work to primary care), the PCT will be bending over backwards to ensure their continuing availability, ie that the PCT will do the work to get them properly accredited. This is not necessarily a safe assumption - because progress in unbundling tariffs is very slow and the evidence that GPwSIs do actually save money for the health economy is singularly lacking. So if you are a GPwSI in contract with Norfolk and wish to preserve that status then please do liaise with the PCT sooner rather than later.

IT Update: NHS Choices: Practice Profiles

Version 2 of the Government's new online health information service, NHS Choices (www.nhs.uk) is to be released shortly. This will include expanded primary care data and practices will have the facility to edit their own profile data on the site. Each practice will have a profile page that can be populated with details about the practice including practice videos; it will also include data from the Mori Patients' Survey (but not the details of the results to question 9 on extended hours) and selected QOF indicators.

All practices should shortly receive an information pack which will offer the opportunity to take over the responsibility for editing their own data on NHS Choices via an individual secure login and password. The brochure will contain details of the editing facility, with explanatory notes on completing the various text fields etc. Practices can edit their information on a preview site (run in parallel with the public site) before integration of the two sites in November.

NHS PENSION SCHEME

Full details of the final agreement can be found at www.bma.org.uk including a summary of the key changes. (Hint: once on BMA site search "Changes to the NHS Pension Scheme").

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6 Month Locum to Cover Sabbatical

I am looking for a doctor to cover my sabbatical starting as early in 2008 as possible to cover 8 sessions per week (two half days - with holiday) at Gurney Surgery, Norwich.

For further details please contact Dr Jennifer Latoy directly on 01603 448800 or preferably email to j.j.latoy@talk21.com

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GP Sessional Work required

by lady GP living just south of Norwich. Ideally salaried post but will consider locum work too. Immediate availability. Please contact Dr Jennifer Lomax on 01508 493883 or jlomax@doctors.org.uk

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Salaried GP - Harleston - Norfolk

Retirement vacancy from April 2008 in market town on Norfolk/Suffolk Border

- 6 clinical sessions/week
- 6500 patients, GMS, Dispensing
- Standard BMA Contract
- Salary Negotiable

Applications by 16th November to: Terri Clare, Practice Manager. Harleston Doctors Surgery, Bullock Fair Close, Harleston, IP20 9AT or 01379 853216

Drug Misuse and Dependence: Treatment Outcomes Profile (TOP) Form

The National Treatment Agency for Substance Misuse (NTA) has published an updated version of "Drug Misuse and Dependence: UK Guidelines on Clinical Management". This is a new version of the 1999 Clinical Guidelines, aka the "Orange Book". As part of this the NTA has introduced a Treatment Outcomes Profile (TOP) form, a new drug treatment monitoring tool, to be completed at the start of each treatment journey and every three months subsequent, with the results returned to the NTA. This is to allow the NTA to monitor the effectiveness of interventions. Concern has been expressed that one section of the form asks clinicians to ask patients about their criminal activity over the previous four weeks. Questions have been asked about the consenting process which should be used by GPs or other health professionals completing the form and the point at which confidentiality should be broken and information on criminal activity shared.

The BMA Legal Department has confirmed that on no account can the National Treatment Agency ask GPs to enquire into the criminal activity of their patients and there is no basis on which they can request this information. The GPC advice to GPs is not to complete these forms. In the meantime it is raising the matter with the NTA and will keep LMCs advised.

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Woodcock Road Surgery, Norwich

Part-time (minimum 5 sessions) replacement Salaried GP or Partner required

- 3.25 partner PMS Practice, 6300 patients
- High QOF points, Vision Computer System
- Paperlight, Excellent Nursing/Admin Teams
- Partner-owned, purpose-built premises
- Times and days negotiable
- 6 Weeks annual leave + 1 week study leave pro-rata, Start date 01.03.08. - negotiable

For further details and practice profile please contact Cherry Tythcott, PM, Woodcock Road Surgery, 29 Woodcock Road, Norwich NR3 3UA or email cherry.tythcott@nhs.net by 30.11.07.

Out of Hours in Norfolk PCT

Norfolk PCT is undertaking an assessment of the OOH service contracted with the East of England Ambulance Trust. This is based on the National Quality Standards an includes a half day meeting with EAAT Directors and staff involved in OOH provision, followed by visits to the various OOH bases. The LMC has been involved, particularly around the **Quality Requirement 2** *"Providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00 am the next working day. Where more than one organisation is involved in the provision of OOH services there must be clearly agreed responsibilities in respect of the transmission of data* and **Requirement 3** *"Providers must have systems in place to support and encourage the regular exchange of up to date and comprehensive information (including where appropriate an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness).*

If you have any evidence you would like to submit to the LMC office to demonstrate that these requirements have, or have not, been complied with, please forward it to the LMC office as soon as possible.

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GtY&W PCT requires a doctor for 4 sessions a month (subject to review) to work alongside the Designated Doctors for Safeguarding Children. For further information and a job description please visit www.jobs.nhs.uk (reference 713-GYW167-07) or contact Ms S Brabben at the HR Department on 01502 719502