

# NORFOLK LOCAL MEDICAL COMMITTEE

Wymondham Medical Centre, Postmill Close, Wymondham, NR18 0RF  
tel: 01953 608060 fax: 01953 608061 email: [norfolkmmc@btconnect.com](mailto:norfolkmmc@btconnect.com)  
[www.norfolkmmc.org.uk](http://www.norfolkmmc.org.uk)  
September 2007



## September

The LMC's 2006/2007 Annual Report and Accounts have been published and circulated to all practices.

### Interaction with the Ambulance Service

I know all practices believe that they provide a high standard of care and I also know that in Norfolk and Waveney this is true. Those who interact with practices, including those who themselves work within the health services, have responsibility to report to the PCT any issues of concern that could indicate potential risks to patients. I have heard from the Ambulance Service that there have in the past been one or two incidents where events occurred which might have required such action. An example would be a 999 ambulance summoned to a patient with severe chest pain who had been assessed at the surgery but who had nevertheless been allowed to drive home to pack their suitcase - with the ambulance picking them up from home. This may well be an apocryphal tale but if the paramedics believed this to have happened then under the present rules they would need to report this to their managers who would contact the PCT. There is no place for avoiding discussion of such issues by, for example, the medical director of the ambulance trust liaising "informally" with the practice - if a disaster occurred and the practice had not modified its procedures then the ambulance service would be culpable (as would be the practice).

I know from my own experience that once the ambulance is on its way you start to relax and, perhaps, get back to looking after other patients - who have probably had to wait. However tempting that is, we need to be vigilant with ill patients until they are properly handed over.

Please bear in mind that you are sometimes on display to the ambulance service; if you have any doubts at all about your internal governance arrangements then you should consider that very carefully. SRL

### Focus on Salaried GPs

The GPC's Focus on Salaried GPs has been revised and now includes a detailed legal view on calculating entitlement to maternity pay, sick pay and redundancy pay for those employed under the model salaried GP Contract. It also includes Flexible Career, Retainer and Returner Guidance. For further information please contact the LMC office or log on to [norfolkmmc.org.uk](http://norfolkmmc.org.uk).

### Choice Read codes for the 2007/08 Choice and Booking DES (England)

We have been reminded by the GPC that practices expecting to participate in the **choice** element (component 1) of the C&B DES 2007/08 should have started using the identified Read Codes, to identify a survey sample population, by **1st September 2007**. This will allow patients who have been identified as have being referred by a GP for a first consultant outpatient

appointment (which is subject to choice) to be included in the survey.

There has been a lot of confusion among GPs about the use of these codes, particularly confusion between the 'Choice' and 'Choose and Book' aspects of the DES. It is important to note that GPs only need to use the codes for the **choice** part of the consultation. These codes have nothing to do with Choose and Book.

### Frequency of repeat prescriptions

A practice contacted the LMC office with a query after a patient had more or less demanded a three month supply of repeat medication. Since this general issue hadn't been discussed for some time Susan put it on the LMC list server for some "round the country" views. These varied, as you would expect, but a consensus emerged.

The evidence is very scanty that 28 day prescriptions save waste - or have some other overwhelming advantage over different (longer) periods. As far as the Secretary is aware, the most recent report on this matter came from the Audit Commission in the early nineteen nineties and, while it did indeed settle on 28 day scripts as generally most appropriate, interestingly three of the four "exemplar practices" described in the Report used 56 days!

There is no clause within the GP contract that compels GPs to prescribe for any particular length of time and patients do not have a "right" for any particular length of prescription. Prescribers should consider issues such as:

- ▶ whether there is a significant risk of wastage, for example, the first prescription of a new drug which is not always well tolerated - when a month's supply or less is likely to be appropriate
- ▶ patients at risk of deliberate or accidental overdose
- ▶ patients with a much reduced life expectancy.

On the other hand, there seems no compelling argument to give only 28 days to people with a good life expectancy, on stable prescriptions - two months or even longer may be appropriate as, of course, we are well used to giving in the case of the contraceptive pill and hormone replacement therapy.

The powers that be, including PCTs, have tended to push 28 days, but they often seem to ignore practices' work creating prescriptions. In the current situation, after a negative pay rise, the onus is on us to work as efficient businesses. It would make a lot of sense for practices to consider whether two or three monthly

prescriptions might be appropriate for many stable patients with chronic diseases.

An alternative is to use the repeat prescription system with pharmacist colleagues more. Many practices nationally, and some practices locally, are using this with considerable success and good patient satisfaction.

So, in summary, the 28 day repeat prescriptions used in, I suspect, most practices, are not well evidence-based and may well not be best for practices or, indeed, for patients. According to individual circumstances, various prescription lengths will be appropriate and, so long as the prescription is clinically defensible, it is perfectly reasonable for practices to take into account their own business requirements, as well as patients' convenience, when deciding their policies.

### GP Systems of Choice

NHS Connecting for Health has launched a new website giving information and guidance to SHAs, PCTs and GPs on GPs Systems of Choice [www.connectingforhealth.co.uk/gpsoc](http://www.connectingforhealth.co.uk/gpsoc).

This website has been developed as a guide to help understanding of the activities needed to progress and the reason behind GPSOC. A full guide can be downloaded in pdf format.

CfH anticipate that this will be the first point of contact for any guidance or questions practices may have. NHS Direct will be signing contracts with suppliers over the next few weeks.

### Meetings with the Norfolk and Norwich Hospital/problems with Secondary Care

The office is receiving an increasing number of complaints from practices about secondary care services. It is probably the case that things **are** getting worse and practices are also frustrated by Norfolk PCT's lack of progress in creating an effective Commissioning Team. Also, concentrating the minds of practices are issues such as increased discharges from hospital follow-up (seemingly by percentage rather than by clinical need) and hospitals' knee jerk reactions to (what they see as) PCT demands on, for example, consultant to consultant referrals. There is a perception in primary care that secondary care colleagues don't really consider, or maybe even care about, the effects on GPs of their actions. Accordingly, the LMC had written a letter which could not be described as demonstrating unqualified support for the Norfolk and Norwich University Trust in its bid to become a Foundation Trust.

The Chairman, Medical Secretary and Dr S Brown recently met with Dr Iain Brooksby

(Medical Director) and Mr David Prior (Chair) of the NNUH. They were impressed by David Prior's response in that he seemed genuinely concerned about the problems within his hospital and anxious to remedy them. Practices should not be afraid to submit evidence of shortcomings directly to the Norfolk and Norwich Management or to Mr Prior himself.

Once it becomes clear who amongst the Commissioners may be able to effect change within the Trust evidence should be sent to them too. The LMC has seen correspondence from Mr Russ Platt, (Deputy Director of Commissioning) that states very clearly that on receipt of firm evidence (ie not anecdote, not shroud waving) Norfolk PCT also will be in a position to take action if the Trust does not.

So, can GPs and practice managers please ensure that they send examples of poor practice to those who can do something about it? The solution may be as simple as empowering a manager at a hospital to employ another secretary or ensuring training for junior doctors on, for example, emergency prescribing for outpatients, or for their seniors on the real rules for inter-consultant referral.

*Note: The principle of receiving adequate and timely information applies equally to all hospitals - so if you are experiencing similar difficulties with, say the JPH or QEH, or any other secondary or tertiary providers we would welcome examples.*

### The Long and Probably Dusty Road

The profession is beginning the long fight back against the deliberate and sustained campaign against GPs. In some parts of the country GPs have featured in articles about their day to day workload, others have written to the papers and at the centre the GPC is contributing widely to the broadcast media. This is not going to be a quick hit as those who are criticising GPs are not going to go away. It will take a lot of effort to reverse the negative spin aimed at the profession. Every GP must refute the lies to prove that the service they offer is of the highest quality and to encourage patients to speak up for them.

Part of the anti campaign has been to call into question the fundamental role of GPs - even should GPs actually exist? What do they do that a machine or any other health professional cannot do just as well at half the price? If you get an opportunity to support the profession please do - be it in the parish magazine, the local rag or, for those who move in more exalted circles, the broadcast media. If you are approached and are unsure about how to respond please don't hesitate to contact the LMC office.

### Diphtheria, Tetanus & Polio - 15 year olds

The LMC has been copied into correspondence which suggests that some practices are still uncertain about their responsibilities for arranging diphtheria, tetanus and polio immunisations for patients at around fifteen years of age. The confusion is understandable because there have been different processes over the years - including school nurses passing out letters in some parts of the county.

Under the new contract, if the practice is carrying out Additional Services including Vaccinations and

Immunisations, then no one else has the responsibility to make sure that fifteen year olds come in for their boosters. Thus practices need processes to ensure that they are able to target that population.

Clearly if the administration required became excessive then practices could cease providing that particular additional service; this would result in a 2% reduction of their global sum. Practices are advised to check that their processes are robust.

For information: The GPC "Focus on Vaccinations and Immunisations" is updated regularly and available from the BMA website.

### Cost Rent Questionnaire

The office was amused by the covering e-mail to a "Cost Rent Questionnaire" recently sent to *some* Norfolk PCT practices. It stated, in effect, that practices were being asked for information that the PCT held somewhere - but the filing cabinet had unfortunately done a runner. The state of your Secretary's home, consulting room and, indeed, brain mean that he is in no position to cast the first stone on matters of important information going astray so the PCT's honesty is to be applauded on this occasion. It is not, however, an excuse we would expect to see used again.

Nevertheless the officers had some concerns. A question about the term of the loan will for many practices be very difficult to answer in the space provided because a common situation will be that there are several loans with different terms, conditions and durations held by different partners.

The issue sent the Secretary back to the "Premises Directions" to check whether the PCT had a legitimate interest in the information: it does.

For practices wishing to check their "Cost Rent Rights" the simplest place to start is the BMA web site - go into the premises section and look at the "focus on premises costs" from February 2004. As it says there the NHS (GMS - Premises Costs) Directions 2004 also should be carefully read.

"Recurring Premises Costs" (section 5.2) is about what most of us still think of as "Cost Rent"; the last three short paragraphs clarify practices' and PCT's duties and responsibilities.

The background is surely that the Cost Rent Scheme is meant to be a way to fund premises but not a way for GPs to make excessive profits (like some PFI developers have!) by reducing borrowing costs while keeping the same (Cost Rent in our case) income.

The LMC discussed the questionnaire with the Norfolk PCT Primary Care team at one of our regular meetings. We are satisfied that the intention was to compile information that the PCT should have so we would suggest that you fill in the form as best you can and the PCT will get back to you if it needs more information.

### Special Allocation Scheme, Norfolk PCT

The PCT is in the process of drawing up a new specification for what some of us think of as the "Violent Patient Scheme". The Secretary's practice recently had a new arrival, a patient whose notes contained a detailed risk

assessment prepared by the Mental Health Trust. The patient was considered to be a threat to Trust personnel but, after enquiry of the PCT and verification from the GPC, the practice was really quite surprised to know that a risk assessment by another NHS body carries no weight as far as the GP SAS Scheme goes. It would only be after an individual has both committed a violent act within the practice, *and* this has been reported to the police, that they would be eligible for the local scheme.

The advice from the GPC was not entirely hopeless; it contained a number of suggestions of actions that the practice could take. In case anyone else is in the same situation I reproduce that information here:

- the practice could apply to the PCT for the patient to be removed from the list. Such removal will not be done automatically. The GPC has produced guidance on removal of patients which can be found at [http://www.bma.org.uk/ap.nsf/Content/GPr emoval](http://www.bma.org.uk/ap.nsf/Content/GPr%20removal). For such removal the reason must be a breakdown in relations. If this is not an option then the following may help:
- If the practice believes it is not secure then a suggestion should be made to the PCT that it might wish to allocate the patient to a practice that is part of the local violent patients scheme as that practice is likely to be better equipped with dealing with potentially violent patients, for example, by having panic buttons in consulting rooms
- If the PCT is unwilling to do this then the GPC advises that the practice should outline its concerns over the patient to the PCT and seek information on how the PCT will help the practice. It may be worth noting that there is a possibility that the practice would be liable for damages to its employees or patients if they were injured by the patient and the practice should ask the PCT how it would support the practice in this eventuality
- The Practice may wish to discuss this with their local Security Management Specialist (LSMS). To find out who their LSMS within their PCT is they should contact the Security Management Director within the PCT and or SHA. If not available they could email [securitymanagement@cfsms.nhs.uk](mailto:securitymanagement@cfsms.nhs.uk).

*I have to say that I don't think that this all really fits in with the idea of "zero tolerance" within the NHS - this issue may well form the basis for a motion from Norfolk to the next LMC Conference. SRL*

### Advertisement

#### Salaried GP

**The Woottons Surgery (King's Lynn)**  
(2 sessions/week but potential for more)

We are looking for an enthusiastic, friendly GP to join our team as soon as possible. The practice looks after 5200 patients with 3 full time GPs and an experienced nursing team (1NP, 2PNs, 1N, 1HCA). Both clinical and administrative support provided.

Please call Stephen Reeves on 01553 631166 ([stephen.reeves@nhs.net](mailto:stephen.reeves@nhs.net)) for more information and a copy of the person and job specifications.

