

## Reviewing, Reflecting, Recharging

**With the summer upon us, most have either had or are looking forward to a well deserved summer holiday; recharging our batteries for the challenges we face ahead is an important part of the annual cycle.**

Over the last year, all practices have introduced Enhanced Services, delivered a quality and outcome framework, and negotiated a new GMS or PMS contract. On top of this, practices have or are being asked to introduce "choose and book", (for most without even seeing working software), embrace Practice Based Commissioning (more later) and understand why the NHS locally is in virtual financial meltdown.

Well so far so good - no major problems - general practice can rise to any challenge levelled at it. However the Government thinks that having reformed secondary care, it is now time to do the same to primary care. The new Secretary of State for Health, Patricia Hewitt, has announced a white paper to be published in late autumn entitled "Healthcare outside hospital" to reform primary care. You need not worry because we have assurances that there will be wide consultation both with patients and general practice!

However, I am concerned about "implementation fatigue", all the new initiatives are not once-only actions but move on to new and next issues/initiatives. Work involved in the QOF and Enhanced Services is still as important in Year 2 as Year 1. I am sure that this white paper will cover issues relating to patient choice within general practice. It may address the thorny issue of dual registration and booking of surgery appointments in advance ('restricted booking').

The Prime Minister was surprised during the election campaign when he discovered in some practices patients are only able to book appointments up to 48 hours ahead. I am aware that Strategic Health Authorities locally are following this up and are looking at the situation closely. If your practice has signed up to 24/48 hour access then this is what

you are contractually obliged to deliver and how you arrange the rest of your appointments is for you to decide. PCTs cannot make you offer appointments ahead, but ask you to just take some time to consider the patient. Nearly all practices signed up to 24/48 hour access, some because they believed it to be a better system than they had before, but most because of the financial incentive. Has it worked for your practice?

A personal view is that it is a partial success. On the days I work in practice (yes I do still see patients two days a week), it is certainly easier having more appointments available on the day and gives less rise to GPs being asked to provide additional appointments. There are only so many consultations that can be done in a day so delivering this has resulted in the partial loss of the ability of patients to book ahead. When we offered "free booking", we had few free appointments on the day and 24/48 access has released appointments but at the expense of advanced booking. We need to put ourselves in the position of a patient, if a patient was seriously ill and needed to see a GP 'on the day', they have always been able to do this, even when surgeries were full and overflowing.

If, as a patient, I were lucky enough to have every Thursday off (which I am not) and I wished to see a particular GP for an on-going medical condition it would now be difficult or even impossible in some practices for a patient to see the GP of their choice, thus destroying one of the most important strengths of British general practice, Continuity of Care. The New Contract should be a way of rewarding practices for delivering high quality care, which it largely does and not to reward a system which potentially destroys continuity and provides a poor service to patients. There must be some flexibility in all practices to deliver appropriate access which reflects patients' needs.

*Continued on page 2*

## CONTENTS

### PAGE 2

- New hazardous waste regulations from 16th July 2005
- Confidentiality & Caldicott Requirements

### PAGE 3

- Practice Based Commissioning – progress to date
- Practice Manager Conference
- Farewell Jenny; Welcome Bev

### PAGE 4

- Medical Information for Dentists
- GP Registrars and Performers Lists
- Don't Forget Us!
- 087 and 084 telephone numbers
- Jury Service
- Practice Database

### PAGE 5

- Partners and the Disability Discrimination Act
- Alcohol and drug misuse by doctors - a cause for concern?
- Old IOS Claims

### PAGE 6

- Unlicensed MMR Vaccines
- Violent Patients
- Hep B and Occupational Health

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*Continued from page 1*

Patients' 'needs' are what we define and tell the PCTs and politicians - patients' 'wants' are what patients themselves tell politicians and seem to be placed high on the health agenda. So let's look at dual registration; patients who work some distance from home may find it difficult to see their GP and it would seem a good idea, therefore, rather than having to take significant time off work, if they could see a GP near their workplace; hence they could be registered with a GP at home and at work. This proposal would only be applicable to a small number of patients and certainly not the areas of high deprivation where health need is at its greatest. However, there are questions that need to be answered including who would be responsible for the primary clinical record, on-going management of clinical conditions, practice based commissioning funding, call recall for chronic conditions etc. Assuming the Government will not put any additional funding into this area, who will pay - not the patient, it would be redistribution of existing funding; the financial consequences to some practices may be significant.

When the forthcoming white paper was announced, The Times newspaper reported that 10% of the primary care budget would be used to fund the private sector. The Government immediately denied this statement, so it is probably true! The private sector has already been brought into secondary care in relation to Independent Sector Treatment Centres (ISTCs). These have had some success in providing competition to hospitals, but are largely taking the less complex patients and being funded 20 – 50% above NHS costs. General Practice, I believe, can take on and beat any competition from the private sector but only if the competition is on a level playing field.

### What do the LMC and practices need to do now?

The LMC is working closely with the GPC, Strategic Health Authorities, PCTs and most importantly, practices, to ensure we are well prepared for the challenges we all face. We at the LMC will be preparing information to go out to all practices, the press and local MPs around the time of the launch of the white paper, to inform all of the strengths of traditional general practice in Wessex and of the high quality care already being delivered. We need to 'talk up' general practice rather than allow the media to focus on the small number of failing GPs or practices which patients listen to. The high quality that is delivered in most practices means that we have less to fear than others, but complacency is a risk if we do not continue to look to continually improve the services we deliver.

Poor quality of general practice in the past was difficult for any outsider to change, but not now, PCTs have far more powers to influence practices than they did before. If we do not address the issues we are faced with, then others may try to do it for us. I am optimistic about the future, there are certainly challenges ahead, but history has taught us that when the challenges are great, general practice can deliver better than any other part of the health service. PCTs ignore this fact at their peril. Energy needs to be concentrated on working to a common goal, to provide high quality care to patients with general practice remaining at the heart of healthcare.

NFW

## NEW HAZARDOUS WASTE REGULATIONS FROM 16TH JULY 2005

The current Special Waste Regulations are being replaced by new European legislation as from 16th July and it is important **that practices register now** to comply.

The new regulations mean a business that produces waste in any of the 14 categories in the 'European Hazardous Waste Catalogue' which includes infectious waste, **must** be registered with the Environmental Agency. Most Prescription Only Medicines (POM) **will not** be classified as hazardous waste and will now be governed by the Environmental Protection Act (Duty of Care) Regulations 1990.

Practices must register under the Regulations but may be exempt if they produce less than 200kg of hazardous waste per annum (defined as "approximately 5 small domestic fridges"). However you need to note that this weight limit includes a whole range of substances including:

Those that have a hazard phase i.e. flammable chemicals

Some newly defined categories including electrical waste such as fluorescent tubes and computer monitors (although not if the latter are re-used as opposed to re-cycled)

Infectious waste which is defined as "substances containing viable micro-organisms or their toxins which are known or reliably believed to cause disease in man or other living organisms"

Substances, including POMs like cytotoxics that are mutagenic

The impact on the actual collection of waste from practices is unlikely to be significant as the current contracts for waste disposal have anticipated these changes **but we do advise that all practices are registered even if you do not expect to be generating a large amount of waste.** The annual registration fee is £18 if done on-line, £22 by phone or £28 in writing.

After 15th July contractors **will not remove waste unless they have your registration number or you are exempt.** Beware though as we have heard of one waste contractor offering to register customers for a fee of £49!

To register on-line you must use a credit or debit card and log onto:

[www.environment-agency.gov.uk](http://www.environment-agency.gov.uk)

Click on 'register as a Hazardous waste Producer' then 'Hazardous waste Application'

More information can be found at:

<http://www.defra.gov.uk/news/2005/050324g.htm>

<http://www.defra.gov.uk/environment/waste/special/pdf/hwr-notifguidance.pdf>

[http://www.environment-](http://www.environment-agency.gov.uk/business/444217/590750/590821/502174/496498/?lang)

[agency.gov.uk/business/444217/590750/590821/502174/496498/?lang](http://www.environment-agency.gov.uk/business/444217/590750/590821/502174/496498/?lang)

Remember to register now!

SDW

## Confidentiality & Caldicott Requirements

Can we please remind practices that when you are forwarding copies of correspondence to the LMC which contain patient identifiable information you **blank out** patient details in order to comply with Caldicott requirements.

SDW

# Practice Based Commissioning – progress to date

While not earth shattering in its impact there is a steady rise in the profile of PBC across Wessex. Localities and clusters of practices are showing growing appreciation of the task in hand, if not yet any measurable activity. A proportion of practices and GPs remain blissfully unaware of, or frankly uninspired by, the whole concept and it is via the emergence of local champions, not always doctors, that progress has been made. These champions are often the usual culprits who emerge at times of change, a good thing, but a worryingly high number are also members of the local PEC, possibly not such a good thing.

The LMC view remains that there are good reasons to be involved in PBC both in terms of improving patient care and in terms of contributing to the battle against the financial deficits. Equally, there need to be incentives for practices and individuals not just to be involved but to take a leading role. PBC is not an opportunity to increase practice profits but there must be recognition of the management and clinical time required to make PBC work. This time must be funded if PCTs are to engage general practitioners to the degree that they are hoping to. LMC Directors and Officers have attended a large number of PBC meetings at national, PCT and locality level with much discussion on management costs and the retention of savings. There are clear differences in levels of incentive offered by different PCTs and it is apparent that where

incentives are at the lower end of the scale it has affected the degree to which practices wish to get involved and the rate of travel towards getting some work off the ground.

With one quarter of the financial year gone, the contributions that PCTs were hoping that PBC might make towards easing financial deficits are looking increasingly over optimistic. This is not for a lack of ideas from practices and clusters but ideas, once generated, often suffer from slow progress through layers of bureaucracy. We are urging PCTs to streamline the process so as to encourage early PBC successes which can then be used as examples locally and elsewhere, in order to get the ball moving just a little bit faster.

PCTs have put much time into producing PBC frameworks but have been less successful in producing indicative budgets at practice level. These are a key part of the overall data required which must also include practice specific referral data which will need to be validated and understood. Accurate practice information will be the basis for redesigning services to either keep patients out of secondary care or to minimise lengths of stay once admitted – with an emphasis on reducing unscheduled care through the provision of alternatives in the community. We at the LMC would want to ensure that where service redesign does take place it is beneficial to patients and supported by general practitioners. We will, of course, continue to remain fully involved. AM

## Practice Manager Conference

Wessex LMCs held its inaugural PM Conference on 15th June this year which concentrated on the future of General Practice. Applications to attend the event exceeded the number of places available so unfortunately we had to turn people away BUT due to the positive feedback we are already in the process of arranging future events when invitations would be extended to GPs, PCTs and other organisations. The conference was chaired by Dr John Dracass, Chair of West Hampshire LMC, who managed to effectively control timings. He broke off from the BMA Conference in Manchester to do this for us travelling from Manchester and back, for which many thanks, John!

Our speakers included:

**Dr Nigel Watson, Chief Executive, Wessex LMCs** who provided an overview of the opportunities and threats surrounding Practice-Based Commissioning and the role of the LMC in supporting GPs and practices in this initiative.

**Dr Graham Rich, Operations Director of United Bristol Healthcare NHS Trust**, gave an informative and knowledgeable account of Payments by Results and how this will drive activity in Acute Trusts and the important links to Practice Based Commissioning to counterbalance the effect on service delivery change.

**Darius Ferrigno, Law for Business**, in his usual entertaining style, provided a snapshot of employment law issues that practices need to be aware of.

**Val Hempsey, Gateshead Practice Manager partner** gave a lively presentation on where General Practice is now compared with 1948 and highlighted the successes and flexibility that general practice displays in rising to all challenges and she also suggested the concept of Practice Managers with Special Interests! Finally, she surprised the audience by announcing that when her Senior Partner retires in 2 years time she will become senior partner!

We have received very positive feedback (thank you) not only via the feedback pro-formas, but in emails received in the office the days following the event. Our thanks must go also to Sue Parsons and Ian Dawes from the office who co-ordinated the event (no mean feat!!)

We look forward to seeing you next time (coffee/food facilities to be improved!!). SDW

## Farewell Jenny

At the beginning of June we reluctantly said goodbye to Jenny Steiner as she embarked on a brave new world of unlimited golf and tennis, interspersed and fuelled by lazy lunches, exotic holidays and other unspecified forms of rest and relaxation.

After four years at Wessex LMCs we had come to depend on her common sense and knowledge of life at the practice coal face and know that for many of you she was the first port of call when advice was needed. To say that we are jealous of her new found leisure is to seriously underestimate our feelings, but we wish her a fantastically long and happy retirement.

Jenny dealt with a great number of queries both via e-mail and telephone. Telephone enquiries will be directed to the most appropriate person and e-mail enquiries should now be addressed to [office@wessexlmcs.org.uk](mailto:office@wessexlmcs.org.uk)

## Welcome Bev

We are pleased to welcome Bev Bevan to the LMC. Bev worked for thirteen years with the BMA in Winchester and is to take on the role of Assistant Committee Administrator and LMC Secretary.

## Medical Information for Dentists

GPs have a legal duty of care and a professional obligation to provide dentists with the medical details essential to allow them to treat patients safely. They are not permitted to charge for doing so.

Generally the patient's explicit consent to this disclosure is required, but if an adult patient is not mentally competent the GP must act in the 'best interests' of the patient and may disclose the minimum data necessary to prevent harm without consent if necessary. Nobody else, such as a carer, can consent to data disclosure or treatment on behalf of an adult patient.

You are not obliged to provide information on the standard proforma provided by the dentist and indeed the ones that we have been asked to comment on are seriously flawed.

Factual information only should be provided to the dentist and it may be wise to add a statement to the effect that; 'the information provided is based upon my knowledge of the patient as recorded in the medical records'.

Some dentists ask for an opinion of a patient's competence to provide legally valid consent to treatment. You may have no relevant knowledge or information about this and the patient's mental state may in any case be extremely variable. In this situation it is for the dentist to judge this matter at the time of treatment, based upon the patient's understanding of the proposed treatment.

Opinions regarding specific dental treatments or the suitability of local or general anaesthetic are matters that a GP may be unable to assess.

It is important to bear in mind that patients have the right to refuse testing for and disclosure of hepatitis and HIV status. Disclosure of this information without the patient's explicit legally valid consent would put the GP at risk. CED

## Jury Service

The Criminal Justice Act 2003 established that, as from April 2004, doctors and other key workers would no longer be 'excusable as of right' from jury service, despite considerable opposition to the fact that doctors would be taken away from essential and highly pressured patient services.

The practical and financial implications of this for any GP practice could be considerable, particularly if the jury service was prolonged.

Summoning officers have the power to grant a deferral, but are advised to consider excusal only if it would be unreasonable for the person to serve at any time during the next 12 months. Single handed and very small practices may be able to justify the need for excusal, but this may no longer be assumed.

The SFE is silent on payments for locums to cover any unavoidable absence on jury service. Even if the SFE did include it in its list, these payments are all discretionary. In the current financial climate the level of that support is uncertain. Some PCTs have already committed themselves to assisting and we have raised the issue with all of our local PCTs in order to clarify the position.

In view of the current uncertainty practices should review their partnership contracts and/or consider seeking additional locum cover insurance for GP partners, salaried doctors and other key workers who may be absent on jury service. CED

## 087 and 084 telephone numbers

087 and 084 numbers are both examples of fixed rate Number Translation Services (NTS). The calls are generally more expensive, with no reductions in off-peak hours and without the benefit of special discount.

At the end of February the Department of Health announced that it was banning the use of 087 numbers from April 2005 because so many patients complained that their more expensive calls were effectively funding the practice telephone system.

Systems using 087 numbers were therefore changed to use 084 numbers. There is now some concern because Ofcom is reviewing the use of 084 numbers and is due to report on their concerns in the summer!

We have no knowledge of the possible outcome of any review and would suggest that practices now using or intending to set up a system using 084 numbers should try to clarify the situation with their service provider.

In the meantime Ofcom suggests that organisations using an 084 number should;

- make sure patients are fully informed about the price of calls
- be able to provide accurate answers to questions about the cost of calls
- consider making a geographic number available alongside the 0845 number to give patients a choice

Some practices have been asked to provide the geographic number associated with the NTS under the Freedom of Information Act. If the practice has this information we have been advised by the GPC that they must supply it. However, in most cases the NTS provider has this information rather than the practice and has no legal obligation to provide this to the applicant.

Some practices have also been asked to provide financial details relating to the use of the service. This information if available is unlikely to be exempt from disclosure under the Freedom of Information Act. CED

## GP Registrars and Performers Lists

Can we highlight to Training Practices the importance of reminding GP Registrars nearing the end of their training period to **re-register on the PCT Performers List where they predominantly intend to work** (either as a Locum or Principal).

This has implications on appraisal and Criminal Record Bureau (CRB) checks. In some areas, the PCTs have decided to only register GP Registrars on their lists for the duration of their training so there is a need to check.

It is a requirement for any doctor performing Primary Care medical services to be registered on the Performers List. SDW

## Don't Forget Us!

We are keen to keep our practice database up to date and recently we have had a number of e-mails marked undeliverable. Could you please let us know of any change of e-mail address (or any contact details) IMMEDIATELY, so we do not leave you out of the loop! Please send any amendments to [office@wessexlmcs.org.uk](mailto:office@wessexlmcs.org.uk)

## Partners and the Disability Discrimination Act

The Disability Rights Commission has published a **Disability Rights Commission Code of Practice Employment and Occupation** [http://www.drc-gb.org/documents/employment\\_occupation.pdf](http://www.drc-gb.org/documents/employment_occupation.pdf) to address issues raised by the Disability Discrimination Act. This makes it clear that the Act imposes obligations on partners in firms, as well as employers. Since October 2004 this Act has given a partner, or applicant for partnership, or a prospective partner in a new partnership, similar rights to those of an employee.

This is an extremely complex area of employment legislation and the LMC is unable to offer legal advice, although we may be able to offer some preliminary advice or support.

It would appear that it is unlawful for a firm to discriminate against a disabled person who is an existing or prospective partner with regard to;

- advertisements for a position
- who should be offered a position
- the terms on which a position is offered
- refusing or deliberately omitting to offer a position
- refusing or deliberately omitting to afford access to any benefits
- expulsion from the partnership
- harassment or victimisation
- any other detriment

The duty to make reasonable adjustments applies to a firm in just the same way as it applies to an employer and relates to 'any provision, criterion or practice applied by or on behalf of the firm' and to any 'physical feature of premises occupied by the firm.'

The cost of making reasonable adjustments may not generally be passed on to the disabled person concerned. However, if adjustments are required in relation to a partner or prospective partner who is disabled, the cost is an 'expense' of the firm, to which a disabled partner may be required to make a 'reasonable contribution'. In this respect it would be reasonable to take into account the proportion of the disabled partner's share of the profits.

Partners who believe they have suffered discrimination on the basis of disability do not need to use the statutory procedures before bringing a claim in the Employment Tribunal, but must lodge the claim within 3 months minus a day from the date of the last incident of disability discrimination.

**Any practice or individual should seek specific legal advice as soon as they become aware of any problem.** CED

## STOP PRESS

**As you are reading this, there are plans underway to organise a Practice Manager/GP Conference in Southampton in November. We will keep you informed of events!**

## Alcohol and Drug Misuse by doctors - a cause for concern?

While a BBC survey recently revealed drink and drug abuse in doctors, the BMA estimates 1 in 15 doctors will at some time have some problem with alcohol or drugs. This is equal to or slightly less than similar problems in the general population.

Failure to take early and appropriate action fails both doctor and patients.

Doctors generally find it difficult to seek help, but tend to do well with treatment.

'Protecting' a colleague is misguided and fails both doctor and patients

The doctor risks physical and mental harm, deteriorating relationships, patient complaints, litigation, professional and disciplinary action.

The GMC duties of a doctor require that you; 'act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise.'

There is a clear professional obligation for all doctors to act quickly and effectively in any case of drug or alcohol misuse affecting themselves or a colleague.

Failure to do so potentially puts you at risk of GMC referral.

**We at Wessex LMCs can offer confidential advice and support.**

Further information is available at;  
<http://myweb.tiscali.co.uk/lmclive/genguide/istaff/alcohol/alcohol.htm>

(NB You must type the full address as shown above to go straight to the guidance

or access [www.lmclive.co.uk](http://www.lmclive.co.uk) and search on alcohol – it is the first item in the list.) CED

## Old IOS Claims

**The LMC advise you to check that you have submitted details of claims for non-registered patients for the period 04/05 to your respective PCT as this may impact on your global sum calculations for next year i.e.**

- Temporary Residents
- Immediate & Necessary
- Emergency Treatment

For flu and pneumococcal claims you need to check with your PCT as to how they want you to provide the data for this enhanced service that supports payments and you also need to clarify how they wish you to report your flu uptake figures.

Childhood vaccinations continue to be paid quarterly as an enhanced service and it is important that the shared payment agencies (FHSA, PPSA) receive this information in order to make payments. SDW

## Have we missed something?

If you have an issue which you feel we should mention, or have any comments about The Bulletin, please let us know by contacting us at [office@wessexlmcs.org.uk](mailto:office@wessexlmcs.org.uk)

## Unlicensed MMR Vaccines

Unlicensed American and German MMR vaccines have recently been brought in to make up for a shortfall in the supply of licensed vaccines. This has created a potential medico-legal risk for practices that are obliged to use these unlicensed vaccines.

Nurses are unlikely to be covered for administering these vaccines under a Patient Group Direction (PGD) and they should only be administered under prescription.

Assuming the vaccines are entirely safe it would be permissible for the GP to prescribe immunisation for a number of named patients and to delegate the administration to the practice nurse. The doctor should draw up a list of the patients due to receive the vaccine and sign this on the day of the clinic to authorise the administration. The list must include adequate patient identifiers such as name, date of birth, name of the product and dose.

The explicit consent of a parent with parental responsibility is necessary before any immunisation and this should be recorded in the medical record. In this situation it is essential that the nurse explains to each patient that a supply shortage has necessitated the use of an unlicensed product, but that this is generally considered to be safe. In order for the consent to be legally valid the patient must be legally competent to make an entirely voluntary decision based upon an adequate understanding of full information that has been provided.

The DOH has not so far agreed to indemnify GPs against the potential risk of using these unlicensed vaccines, despite GPC requests.

However, a GP would probably be able to justify use of the unlicensed product since;

- the body of research and official guidance indicates MMR is of benefit
- there have been official assurances regarding the safety of these unlicensed vaccines
- a large number of doctors believe use of these vaccines to be in the best interests of the child in the absence of a licensed vaccine

The DH has produced some robust information and reassurances on Supplies and Administration of MMR Vaccine, which is available at;

[http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/DearColleagueLetters/DearColleagueLettersArticle/fs/en?CONTENT\\_ID=4112143&chk=R6GzLP](http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/DearColleagueLetters/DearColleagueLettersArticle/fs/en?CONTENT_ID=4112143&chk=R6GzLP)

The safety of MMR is still a concern to some parents and if you are concerned about the medico legal risk you should seek the advice of your own medical defence organisation and act on the basis of that advice. CED

## Contacting us

We have recently introduced a general email address for those who want to contact the office and require a prompt response. This address is accessed daily and any messages are re-directed to the person who is appropriate and available to answer. Hopefully this will ensure queries receive immediate attention.

**office@wessexlmc.org.uk**

## Violent Patients

We have been contacted recently regarding a number of cases where patients removed from a GP surgery due to violent/intimidating behaviour have been allocated to another practice and details surrounding the reason for removal have not been communicated to the receiving practice. This was due to the absence of a police incident number (a requirement of the DES to place patients on the Violent Patient Register) and places the receiving practice in a vulnerable position - would you like this to happen to you?

Can we remind you that if you are removing a patient because of violent behaviour you either report the incident to the Police, so that the patient can be entered onto the Violent Patient Register and be seen by the contracted provider of the service in the new area, or you alert the FHSA/PPSA as to why the removal is taking place so that the receiving practice may be forewarned. **The LMC suggests practices should contact the police if practicable as the incident number provides an 'official' warning for the patient and also makes it perfectly clear that it is essential that confidentiality is in order to notify the new practice of the potential danger.** SDW

## Hep B and Occupational Health

We receive a lot of enquiries on this subject. Just to remind you that GPs are under no contractual requirement to provide Hep B for Occupational Health reasons.

If a practice receives such a request, patients should be referred to their workplace Occupational Health department.

If an employee faces any kind of health and safety danger at work, under Health & Safety legislation, the employer is required to undertake a risk assessment. If this shows that a hazard exists, the employee must be offered suitable protection and training if the hazard cannot be eliminated i.e. in the case of Hep B, a health or social care employee may face risk of contracting hepatitis B from an infected person.

Some employers fail to undertake a risk assessment and send their employees to the GP for immunisation. This is NOT a contract requirement and the LMC suggests you give a copy of the appended letter to any patients attending for this service.

Please note that where a patient/employer informs you that they do not have an Occupational Health service then you can charge for providing Hep B **BUT NOT FOR PATIENTS REGISTERED AT YOUR PRACTICE EXCEPT IF YOUR PRACTICE IS CONTRACTED TO PROVIDE THE OCCUPATIONAL HEALTH SERVICE FOR ALL EMPLOYEES OF A BUSINESS OR COMPANY.**

The GPC is currently looking into this matter and we keep you updated on any further clarification on the matter. SDW

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