
Somerset LMC

Newsletter

Issue 97



July 2003

GMS2 – What Next?

If the outcome of the vote was not a surprise, the size of the majority certainly was. Perhaps the inexorably negative correspondence in the popular medical press has skewed perception of how GPs have been thinking, but we now have an absolute majority of voters prepared to regard the new contract as, at worst, the “least bad” option.

However, the delays mean we will have to compress a lot of work into the next 9 months, though much of this will have to await detailed guidance from the GPC and others. PMS practices in particular urgently need information on which elements of the new arrangements will affect them, and also about their options if they wish to consider reverting to GMS.

We recommend that practices should start planning their work programmes as soon as possible, particularly in relation to the quality framework. Generally it is worth starting to think seriously about several areas:

Partnership agreements

With practice based contracting and other changes practice agreements will all need to be changed. As more and more of us have commitments away from direct clinical care, and with the ending of personal patient lists, you may need to link profit share to hours worked rather than nominal whole time equivalence. Do you need to specify patient contact time? What about non-medical partners?

Profit Sharing and cash flow

Although the global sum gives a secure income stream to run the practice, a large amount of total profit will be tied up in achievement payments for Quality. Do you need to accumulate a cash buffer to deal with this? Are you clear which payments will be superannuable? And what arrangements will you make for a profit sharing partner who leaves in the middle of the year? How will you deal with the end of PGEA and changes in Seniority?

Enhanced Services

We are promised genuine new money for next year. Some services are likely to be offered by most practices, but are there any local services you would like to bid for? What are the set up, training and running costs?

Quality Framework

We glibly say that Somerset practices should be able to achieve well on this, but do you know? Although you do not have to report on outcome until April 2005, you need to know where you are starting from to put in a sensible aspiration bid in March 2004. Have you started to tidy up your disease registers? Have you any idea how much extra staff time will be needed to undertake, record, and report the work? How well coded is your data – probably not as well as you think.

IM&T

The modernisation money is jam tomorrow, and we have to start the work today. If your system supplier does not have an accredited version you need to start planning at once. Changing suppliers should only be a last resort (recent experience in Somerset has been frankly catastrophic) but do you need an upgrade? It is clear that when funds do arrive they will not be enough to meet the backlog of demand within practices, so how long can you carry on with your present equipment? There may be a case for investing your own money now if this makes the difference between achieving substantially different quality payments.

But perhaps the most important question is how all this is going to be project managed. It is certain that it cannot be just another job for the practice manager to do. She or he will need dedicated time and help to tackle what is a large programme of change, and that is the first thing for us all to address

Enhanced Services

Over the next few weeks PCTs will be asking practices about which Enhanced Services they wish to provide under GMS2. Some of these may already be included in PMS agreements, but PMS practices obviously will wish to compare the terms offered. Nearly all practices will wish to continue to provide some of the Directed Enhanced Services (Flu immunisation for example), but the LMC has identified three National Enhanced Services which we will be pressing PCTs to make priorities. These are:

- Anticoagulation Monitoring
- Near Patient Testing (Monitoring DMARD/ immune modifying drug treatment)
- IUCD fitting and checking

We anticipate that all practices will wish to offer at least two of these, and the PCTs are aware that GPs will not be prepared to continue to do this work without proper remuneration after the end of March 2004.

Progress on Out of Hours

Somerset is looking at a county wide solution for medical cover.

The four Somerset PCTs are working together on a model for the provision of out of hours services in the future. It has been agreed that we should aim to have a system up and running by midsummer 2004, so that by the time practices are no longer responsible for OOH care in January 2005 it has had a chance to bed down. Practices will be asked to declare by October this year whether they intend to continue to provide their own out of hours care. ***We recommend that practices opt-out*** because it is unlikely that there will be a local co-op structure left to support them, and it will be better all round if the new service starts with a clean sheet when looking at service provision. You will also be asked whether you are likely to wish to work sessions for the new service – this is obviously important for manpower planning. The LMC has made it clear that both remuneration and working conditions will have to be right for GPs to want to do this work and although we anticipate that there will be fewer doctors on duty (especially overnight) the workload on each shift will still have to be reasonable. It is clear that much of our current out of hours work can properly and safely be done by other health professionals, and each PCT will be developing nursing and other skills within Primary Care Centres and Community teams to this end.

Immunisation for Travel Overseas

Thank you to everyone who returned the travel immunisation questionnaire circulated by Health Protection. We have had a 95% response and the results will be important in formulating an LMC view on which travel services should be provided in general practice. We are keen to promote an agreed policy throughout the county as there are wide variations in practice at the moment, although 86% of respondents make at least some charges.

It now looks as though one of the changes to be introduced under GMS2 will be to make all travel immunisation a private service. This should overcome the uncertainty about what can and cannot be charged for, and it will also do away with the confusion caused by the hopelessly outdated paragraph 27 of the Red Book. This seems to us to be a positive step as the LMC has held the view that holidaymakers should pay for their immunisations in the same way as they pay for other preventative items like anti-malarials, and, indeed, their sun screen.

Childhood Immunisation and Travel

With the increase in family holidays abroad, it is worth reminding the parents of children who are not up to date with their normal immunisation schedule that these infections may be a bigger risk in some countries than more exotic illnesses, and that full UK immunisation is advised for travel overseas. For example, MMR is not provided by the health services in all parts of Spain & Portugal and where it has to be paid for, local uptake may be poor. Southern Asian countries generally also do not provide MMR routinely, so there too native viral infection may be circulating and the prevalence of infection will often be higher than in the UK.

Asylum Seeker Placements

We now understand that ClearSprings, the commercial agency responsible for placing asylum seekers in Somerset, has found 59 bed places in Bridgwater and 9 in Taunton, and plans to start bringing people in during August. There is a theoretical maximum of 300 places in Taunton Deane and 160 in Bridgwater, with no plans at present for placements outside these two areas. The LMC has asked the two concerned PCTs to make sure that proper arrangements are made in good time for the arrival of this long anticipated group of people with specific health needs, and we are still urging them to set up a Local Enhanced Service to make sure that things are properly co-ordinated. Somerset Coast plan to appoint a nurse to undertake the co-ordinating role for the time being.

The LMC has been closely involved in a bid for central funds to support the local placement of refugee health professionals of the same ethnic background as the asylum seekers who are then able to contribute to health care whilst obtaining the relevant qualifications to practice in the UK. We hope to hear shortly whether the bid has been successful.

Meanwhile, arrangements are in hand for practices to be able to use a telephone interpretation service, and for the provision of a dual language information pack and personal health record for service users that will explain to them how they should access NHS services.

Special Patient Messages Out of Hours

Just a reminder that if you have a patient about whom the Out of Hours GP may need to have special information - for example, terminal care, specific instructions for treatment, warnings about potential violence etc - then you should complete one of the GPSC "Patient Special Message" forms (All practices using the GPSC have been sent copies of this) and fax it back to them. That patient's record is then tagged with the appropriate advice.

There are few things more irksome than spending two hours overnight wrestling with what seems to be a serious problem only to be told the next day "Oh, she always does that." ***Please do use this system.***

LMC and Somerset Pharmaceutical Advisers Rapid Assessment

*We have recently resurrected the "quick and dirty" assessment process by which two PCT Pharmaceutical Advisers and two LMC GPs review the evidence about newly introduced products to make a provisional recommendation, to GPs, pending a more detailed analysis of whether they should be prescribed. This month the group has reviewed the contraceptive patch Evra, and has concluded that they do **not** recommend that prescriptions for this product should normally be initiated in general practice.*

Private Prescriptions

GPs relatively rarely find themselves needing to issue private prescriptions, and the LMC has been asked to offer some guidance on the circumstances under which this should be done.

A private prescription is, by definition, not an NHS service and therefore in some circumstances a professional fee may be levied for its issue. There is great variation of views between GPs about this, and the LMC is not allowed to suggest an amount to charge. Most doctors feel that there is a difference between a truly private patient and an NHS patient for whom a private prescription is issued because that particular medication happens not to be available through the NHS, but however you view it, it is important to have a clear and agreed practice policy.

Private prescriptions must not be issued on an NHS form, but can be computer generated on the counterfoil. They are usually used in the following circumstances:

A charge CAN be levied in the following circumstances:

1. Private Patients

Patients who attend the practice but are not registered as a NHS patient because they wish to have private general practice care may not normally be issued NHS prescriptions.

2. Patients resident overseas in countries with no reciprocal agreement with the UK

Most visitors to the UK are eligible for NHS care because there is a reciprocal healthcare agreement with their country of origin, the major exception being the United States. Whether you see non-eligible patients as NHS temporary residents or private patients is still left at the discretion of the GP, although in recent years hospitals have been encouraged to charge them. But remember that it is country of *residence* and not *nationality* that determines eligibility, and do make sure that you do not mix elements of private and NHS care for any particular individual.

3. Products for the prevention of illness that may be contracted abroad

As previously mentioned, this notably includes antimalarial treatment but also some non-NHS immunisations where the practice does not hold

stock and the patient needs to order and purchase the item themselves.

But a charge CANNOT be made for prescribing the following:

4. Items which are “blacklisted”

For some years a number of pharmaceutical products have not been available on NHS prescription, and a few patients still request these – for example flurazepam (Dalmane) as an hypnotic. It is appropriate to offer an alternative product on an NHS prescription, but if the patient chooses to take a blacklisted product, then it should be issued on a private prescription. Blacklisted products are clearly marked as such in the BNF and MIMS. Products occasionally move in or out of the blacklist, just to keep you on your toes!

4. Items which are “restricted”

A number of products have limited indications for NHS use, notably those for the treatment of erectile dysfunction, but also clobazam and Dianette - and not forgetting the “borderline substances”. It is usually pretty clear whether a man is eligible for ED treatment (again, the indications are clearly listed in the BNF) but there is a let out clause of “severe distress” although this is supposed to be a consultant decision. Ineligible patients should be given a private prescription.

British National Formularies for Non-Principals

BNFs are now centrally provided and all GP principals should get one twice a year. Assistants and retained doctors should have a copy provided by the practice as the practice manager should request BNFs for each doctor in post.

If you are a locum or the practice where you work has not ordered a copy you can get one by contacting the NHS Responseline (0871 555455) quoting your name, GMC registration number, and address.

Child Protection and Confidentiality

Following the item in last month's Newsletter we have been asked to clarify the position on the disclosure by GPs of confidential information relating to children and families where a child protection concern is being investigated. There is, as ever, a balance to be struck between information sharing and confidentiality. Ideally, full consent is obtained from all family members concerned before any

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information is disclosed but often this is not realistic. GPs have recently been sent a summary booklet for involved professionals called "What to do if you're worried a child is being abused", and appendix 1 of this gives a simple and helpful summary of the position. It mentions the principle of "proportionality" under which you should disclose only that which needs to be disclosed, and this only to those who need to know it. You are neither obliged nor expected to disclose anything to anyone that is not strictly relevant to the case.

GP Reviewers for CHI

CHI is looking for GPs willing to be reviewers for the round of assessments of PCTs that are being undertaken in 2003/04. There is a half-day selection session followed by an intensive 2 ½ day training course for successful applicants. Each review requires 10 days, remunerated at £350 per day, and the commitment is to between one and three reviews a year. Details at www.chi.gov.uk/eng/cgr.reviewers

FootNote

We were interested to see that in the USA a BP of 120/80 is no longer normal – it is pre-hypertension. Presumably to an American physician life is a pre-death experience.

However, we also have at last found the explanation for the differences in morbidity between nations:

- The Japanese eat very little fat and suffer less CHD than the British or the Americans
- The Mexicans eat more fat, but still suffer less CHD than the British or the Americans
- The Italians eat some fat but drink red wine and suffer less CHD than the British or the Americans
- The Portuguese eat more fat but also drink red wine and suffer less CHD than the British or the Americans
- The Germans eat a lot of fat and drink beer - but *still* suffer less CHD than the British or the Americans.

Moral: Eat what you like, it's speaking English that kills you.

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