

Somerset LMC

Newsletter



April 2005

Issue 115

LABORATORY INVESTIGATIONS

More appropriate requesting leads to significant benefits.

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We are all aware that practices have been requesting ever increasing numbers of pathology investigations, most notably because of the demands of the QOF. But investigations are not without cost. The proposed national tariff gives a price for blood investigations is £1.60 per *individual* test, and this reflects an average actual processing price. Investigations carry costs for practices as well - receptionist time in arranging appointments, HCA time in taking the blood, and, of course, GP time in dealing with the results. And we should not forget the cost to the patient who must attend for an appointment and submit to a sometimes painful procedure.

Because results are numerical, it is easy to assume that they give an absolute result. But not only is there variation in the accuracy of the test itself (total cholesterol, for example, is only accurate to around +/- 8-10%) but if the "normal" range is +/- 2 standard deviations, then 1 in 20 results is automatically outside this. When you add in physiological variations, sampling errors and transport delays, it is no surprise that the number of "abnormal" results is fairly high. So whilst some of these can be discounted when the results are seen - some days it seem that nobody has enough lymphocytes - some cannot, and so patients are recalled and reinvestigated leading to further cost and patient anxiety.

The LMC has been discussing these issues with Somerset Pathology which provides the service from Yeovil and Taunton, and we are looking at three helpful developments.

First, the long promised web access to patient results is going to be available later in the year. This will mean that the practice can view all the results on their patients including those requested in secondary care. This should reduce the number of unnecessary repeat investigations.

Secondly, we plan to try and develop a Somerset consensus on how often "routine" investigations should be requested in chronic disease management. For example, should a hypertensive patient on bedroflumethiazide have their electrolytes checked one, twice, or four times a year? Incidentally, the latest pathology request form will allow you to select individual tests rather than groups, so patients on a statin could just have an ALT rather than full LFTs.

Thirdly, the Laboratory is now able to offer practices using the EST or TST service quarterly comparative data on their pathology requests. This will come in the form of bar charts comparing the practice to others (anonymised) in Somerset, along with some supporting numerical tables detailing the practice's individual data and the Somerset comparison. Practices piloting the scheme have found the information very helpful in refining their laboratory use. If you are interested, please email your practice name, total list size, number of male patients over 40, and number of diabetics to: david.james@tst.nhs.uk

COLLECTION OF PRESCRIPTIONS FOR CONTROLLED DRUGS

A recent significant event in a Somerset practice has brought our attention to a case where a prescription for a controlled drug was collected by a person other than the patient without the patient's permission and for fraudulent purposes.

The question is to what extent a practice should go to prevent such criminal acts without causing inconvenience to patients in genuine need of help in collecting their medication, and those kind enough to help them.

Most of the information available about this does not concern the collection of prescriptions from practices, but rather of the dispensed drug. The Fourth Report of the Shipman Inquiry raised significant questions about the role and responsibilities of community pharmacists and dispensing practices. The Inquiry recommended that pharmacists should seek to establish the identity of anyone claiming to be collecting controlled drugs on behalf of patients and to record this information in the pharmacy's controlled drugs register. The Government has accepted this proposal in its response to the report, Safer Management of Controlled Drugs. The Royal Pharmaceutical Society of Great Britain (RPSGB) believes that this recommendation could be easily implemented when health professionals collect drugs. However, it added that, "Many patients ask friends, relatives or neighbours to collect medicines on their behalf...[we are] concerned that special arrangements for the collection of controlled drugs could pose problems in terms of patient confidentiality... [and] also affect the willingness of friends or neighbours to collect...for the patient." Although none of the above strictly applies to the provision of a prescription it is clear that practices will wish to play a role in the prevention of crime. So it seems reasonable that practices should seek to establish proof of identity from persons collecting prescriptions for controlled drugs on behalf of patients where the collector is unknown to the staff member involved, including, if in doubt, contacting the patient by telephone. However care must be taken neither to compromise patient confidentiality nor to

discourage those providing voluntary assistance to patients.

Practices should therefore continue to act in good faith and handing a prescription to a proxy who later proves to be acting illegally is not an offence.

AGENDA FOR CHANGE & GENERAL PRACTICE

The Chairman of the GPC wrote to LMCs earlier in the year with this summary of the current position:

"The present nGMS deal is for the three years up to April 2006. Initially, some elements were built into the costs of the global sum that would have taken some account of AfC but these were eroded by the subsequent deals on MPIG. From 2006 onwards, there will be a renegotiation of the global sum which, combined with the formula review, will lead to certain changes. We will of course be arguing that AfC has added/will add significantly to practices' costs and that the global sum amounts should be uplifted accordingly. There is an agreement that we will be monitor the costs of providing services, rather in the way the old expenses monitoring worked, to help inform these negotiations.

In the meantime, I am aware that several practices are using performance in the QOF to help incentivise our staff somewhat in line with the trends in AfC.

GP practices are under no obligation to implement AfC for their staff but since we work in a competitive market we have to try to ensure that we offer attractive terms and conditions if we are to continue to recruit and retain good quality staff.

So the message is, the more practices start to implement improvements along the lines of AfC and the more we can demonstrate this is happening, the more we can argue for increased resources for the global sum in 2006.

As for PMS, in the past, the government has tended to suggest similar uplifts as for GMS but because PMS is a local contract this is not guaranteed. However, rest assured, the GPC will press strongly for the appropriate funds to be made available for PMS."

CONNECTING FOR HEALTH

It is always worth noting when an organisation changes its name, so whether the change from "NPfIT" to "CfH" is just a silly piece of political rebranding or an effort to shake off an unfortunate image is not clear.

But beyond that, the recent Ministerial announcement that practices will be able to choose from any clinical system whose supplier is contracted to a Local Service Provider (LSP) in England is welcome indeed because it means that for all but two practices in Somerset there will be no need to change to unfamiliar software. EMIS, iSoft and IPS are all now developing versions that will connect to the National Data Spine (N3), so at least the configuration that we are used to will not have to change dramatically. This is the solution that we pressed for in the Newsletter in March 2004, and it is hard not to say "told you so".

It is now not clear what is going to happen to the primary care version of our own LSP's planned software, "Carecast". The last formal announcement was that roll out of this in Somerset has been put back from the previously announced date of June 2008, but an early mock up version demonstrated in December looked impressive with hierarchies of displays nested under on-screen buttons, and a nicely intuitive and user friendly arrangement of data. If development continues along the same lines it will be an impressive system indeed, but, for now, the LMC advice is definitely to stay with your current provider so long as they have an LSP contract.

Connections to N3 continue apace, although the Prime Minister's declaration that all practices will be connected by April 2005 seems to have been quietly forgotten. Expect a visit from the nice man from BT Synergy in the near future who will install the relevant practice connection, but the programme is vast and delays are absolutely inevitable.

As we have said before, there are huge benefits to be gained from integration, but we still have two concerns. First, however complex the security barriers, will patients be happy about having their records stored on a national system to which perhaps half

a million people will theoretically have access? And secondly, will access to the central database be fast enough? In a 10 minute consultation there is just not enough time to take 30 seconds to open the medical record. These matters have to be properly addressed, and soon.

We suspect that GP confidence in NPfIT/CFH will now start to climb from its recent miserable levels, but it is not out of the woods just yet.

COST OF SOME SHORT DURATION PRESCRIPTIONS

Although there will now be fewer cases when you need to write a short duration prescription as responsibility for providing Monitored Dose Systems and other compliance aids has passed to Community Pharmacists under their new contract, it is worth noting that for drugs that are provided in what are classed as "special containers" the PPA will pay for a full container even if only one tablet is prescribed and dispensed.

These include:

- ◆ Fosamax once weekly tablets
- ◆ alfacalcidol capsules
- ◆ cabergoline tablets
- ◆ Persantin retard
- ◆ gtn tabs
- ◆ leflunomide tablets (red drug)
- ◆ nicorandil tablets
- ◆ ranitidine tablets
(classed as pack of 15 tabs)
- ◆ Actonel once weekly
- ◆ tacrolimus capsules (packs of 10)
(red drug)
- ◆ clopixol 2mg tablets

PAYMENT FOR VACCINES

We are pleased to be able to recommend the document "Payment for Vaccines" prepared by the Kent LMC for GP practices in Kent. This has now been placed on the Somerset LMC website. The regulations surrounding vaccinations, and in particular travel vaccinations, have been confused for some time. We were disappointed that the opportunity presented by the introduction of GMS2 to clarify the issue was comprehensively fumbled by the Department of Health when it came to it. It is the only the area in the new contract in which express reference is made back to the Red Book. After the government made the prescription of malarial prophylaxis a wholly private service it was widely, if controversially, expected that the same would happen for travel vaccinations. This was not the case and so it is useful that the Introduction clearly sets out what can and cannot be charged for under the present circumstances. We commend the document to Somerset practices.

IMMUNISATION MATTERS

Two problems of which you need to be aware

Heaf Tests

Both of the devices used for Heaf tests have now been withdrawn for technical reasons, so TB testing for the moment relies on a Mantoux. We've been asked to let practices know that this will mean something of a hiatus in the availability of TB testing, so please can you bear this in mind when considering referring patients for such a test.

MMR

Last year we passed on a request from the Health Protection Agency that young adults from 16-25 be opportunistically offered MMR as there have been some outbreaks of mumps in this age group, often in colleges or universities. However, the LMC has not been able to agree with the PCTs that this be an Enhanced Service, and we have now been told that national stocks of MMR are at a low level, and that it can no longer be supplied for catch up use in students. Existing stocks should be prioritised for use in children to prevent measles and to protect susceptible women of child bearing age against rubella.

LMC SUBSCRIPTIONS

The LMC is funded by your levy payments – thank you very much. As part of a general reorganisation we are planning to change to a practice capitation system rather than an individual GP capitation one, as this reflects the new contact and legal position.

There will therefore now be three categories of membership:

Full members include all doctors working in any GMS or subscribing PMS practice, whether as partners, salaried doctors, sessional GPs, or registrars.

Associate members are those working for a provider organisation other than a practice.

Subscriber members are doctors with an interest in general practice who are not currently working in any practice in Somerset.

Whilst the benefits of the different categories of membership vary, all members are welcome to contact the LMC office for personal support and advice

WARNING!

Superannuation and QOF payments

It is becoming increasingly clear that the final calculation of GP profits and superannuation is going to be more complicated than we had hoped. Specialist accountants have pointed to a number of inconsistencies in the documentation, including an incompatibility between the forms and something called "pension overlap".

Dixon Walsh, who provide accountancy services for a number of Somerset practices have said:

*"We doubt if this could have been made any more complicated if they had tried. This one has a fair way to run but hopefully we will end up with a sensible outcome in due course. **The main thing to bear in mind is not to spend the balance of your QOF monies until the position has been finalised and the quantum of any balancing payment due at the end of February 2006 has been determined"***

Somerset LMC Seminar

for GPs and Practice Managers

“Taking Back Control – a New Way of Managing Demand”

on Wednesday 18th May 19.30 - 21.00

in the Postgraduate Centre at Musgrove Park Hospital

Light supper available from 19.00

A presentation and discussion on GP telephone triage as a way of booking appointments and controlling demand. Traditional appointment systems are overloaded and Advanced Access places nobody, so what to do instead? Find out how one practice has solved the problem.

For catering purposes please confirm your attendance to: Jill.Hellens@somerset.nhs.uk

Small Ads Small Ads.....

HENDFORD LODGE MEDICAL CENTRE, YEOVIL, SOMERSET

We are looking for two motivated and enthusiastic team players to work at our newly acquired Abbey Manor Park practice in Yeovil. The salary scale is £60,000 - £72,000 pro rata depending on experience.

Sessions negotiable, Job share applications welcomed .May suit Flexible Career Scheme No Out of Hours & Few home visits. Full encouragement to develop special interests .

Contact Sian Brammer, Hendford Lodge Medical Centre, 74 Hendford, YEOVIL, Somerset BA20 1 UJ Tel: 01935 470200 or e mail: sian.brammer@hendfordlodgemc.nhs.uk.

BMA COURSE ON GP EMPLOYMENT LAW –

THURSDAY 30TH JUNE 2005

A one-day course featuring speakers from the BMA Bristol office and ACAS.

Main topics will be handling sickness absence, part-time workers and the new discipline and grievance procedures which must be undergone prior to an Employment Tribunal application.

The course is open to GPs and Practice Managers and the cost is £40.00 per person for BMA members and their staff, or £80.00 per person for non BMA members and their staff.

To book a place, please call Yvonne Bull on 0117 9227645.

Yeovil District Hospital Clinical Assistant in the Breast Clinic

Applications are invited for the position of Clinical Assistant within the Breast Care Team at Yeovil District Hospital. This team is well established and continues to meet the government targets for the diagnosis and treatment of suspected and confirmed breast cancer. The post is for one session per week, ideally on a Wednesday afternoon. Previous experience would be advantageous but is not essential as training will be given.

The post is vacant from 4th May 2005.

Further details can be obtained from: The medical Staffing Department 01935 384616 or Dr Jane Baldwin Consultant radiologist and lead clinician for Breast Cancer 01935 384571

THE 7th DEVON LMC PRIMARY CARE CONFERENCE

“Making Change Pay”

17/18/19 May 2005

To be held over three days at two separate venues in Devon and Cornwall


For further details, programme and booking form please contact Mr John Baker the Devon LMC Secretariat Manger Tel:01392 834020 e mail john@devonlmc.org.uk or visit their website www.devonlmc.co.uk



Jennifer's Journal

Good evening everyone and welcome to this year's QOF awards ceremony.

We were promised a senior manager to hand out the awards but unfortunately nobody has arrived - I understand that they are now so remote from the coalface they couldn't find the surgery, but he or she would probably have felt out of place anyway. And so, it falls to me to hand out this year's prizes.

1. The Award for highest points overall goes to the Smarmy Practice with 1346 points out of a maximum of 1050 available. We congratulate them on their success. The ability to score well over the maximum points available was due to a clever bit of creative accounting, a technique that they had learned from their PCT . Surprisingly, nobody challenged the validity of the result and so lots of lovely money for the Smarmies – well done.
2. The Award for co-operation goes to the Goodies. Their cavalier attitude to confidentiality was much appreciated and they even declined to use the embarrassing strip of cardboard that accompanied their QOF visits.
3. The Asthma Award goes to the only practice that successfully managed to administer a flu injection to every single child who had ever looked at a salbutamol inhaler. To persuade the children and their parents that it was in their best interests was beyond the call of duty (or sense?) – well done the Grabbers! Points before patients- that's what I say.
4. The Diabetes Award goes to the Smartarses for getting full marks- shipping a bus load of patients out of region to get retinal screening and (allegedly) acquiring a urine sample from every diabetic on the same day; then sending the samples off to an offshore testing laboratory to provide reports on microalbuminuria – Smart, but oh so sad. Is there no shame left in our profession?
5. You will be wondering who got the wooden spoon. Who got the lowest number of points? Well, by a wide margin, the victor is Dr. Sodoff who sadly is unable to be with us tonight, as he is sunbathing in the Caribbean having muttered something about having better things to do with his time.
6. The prize for producing best evidence linking QOF payments to decreased morbidity and mortality has not been awarded this year, as unfortunately nobody had any evidence. One paper was submitted demonstrating how patient satisfaction had plummeted. This observed that during consultations doctors now played with their computers and paid no attention to their patients. Sadly, although the evidence was good it was not submitted in triplicate and double-spaced and so could not be considered by the judges. 
7. And finally the prize for the best dressed belle at the Performance Managers Ball goes to me, Jennifer. My low cut décolletage had those male managers positively drooling at the mouth, but then, they only understand top down management, don't they?

Jennifer

FootNote

Overheard at an LMC meeting:

"My hero is now the Duke of Cambridge who famously said, "Reform? Aren't things bad enough all ready!" - Change "reform" to "modernisation" and there you have it."