Somerset LMC Newsletter

October 2005
Issue 121

Inside this issue:

Oseltamivir	1
Flu immunisation	2
Flu Vaccine Supplies	2
LMC/GPC survey	2
New Oxygen Service	3
QOF Changes	3
Agenda for Change	3
Patients on warfarin-New Guidelines	4
OOH Service	5
Medical Examinations of Taxi Drivers	5
Message from Bob Hart	5
Jennifer's Journal	6
LMC E mail addresses	6
Small Ads	7

OSELTAMIVIR – A DILEMMA

We thought readers might be interested in this email correspondence which started with a query from a GP to the LMC office. We would welcome the views of readers on this subject

Dear LMC

A lady with a nursing daughter in Australia came asking for Oseltamivir in case we have an epidemic (*of avian flu)* They are advising patients in Australia to hold this and she felt it prudent on her daughter's suggestion to have some at home. We discussed the HMG stockpiling but she realised that there may not be enough to go round, or for her to be able to get it quickly enough, and she sensibly wanted to plan ahead.

It is not indicated in the UK at present, as you know, and we have no specific advice yet, but is presumably prescribable. She is adamant that she wants it and is prepared to pay, Can I issue an NHS script or can I give a private one to an NHS patient for a prescription drug?

Reply from a PCT Prescribing Adviser

The prescribing of anti viral drugs on the NHS is covered on pages 526 and 527 of the October Drug Tariff.

Basically as an SLS drug it can only be prescribed on FP10 under restricted circumstances. If prescribed outside of these circumstances then the PCT should ask the prescribing GP to repay the costs of the drug. (Prescribing would also be a breach of n GMS contract, but we wont go there !!)

There is nothing to stop the GP prescribing this drug on a private prescription, in the same way that GPs will prescribe Viagra on a private script for those patient who fall outside of the SLS rules for that drug. By issuing a private prescription you would still have medico legal responsibility.

You may feel clinically justified if you consider it a rational request (although the NHS does not agree and will not fund it) or if, for example, by issuing the private prescription you will be allaying undue anxiety, obviously these are clinical decisions for the prescriber to consider.

LMC Secretary's Response

For the moment, I can only give you my personal view. I do not think you should prescribe it. Certainly you should not issue an NHS prescription as there is no clinical indication for you to do so – she does not currently have influenza, nor has the Health Protection Agency announced that Influenza A is circulating.

I do not think you should issue a private one either. There is a grey area about issuing private prescriptions for products available under the NHS but not for the indication in question, and generally you cannot charge for such a prescription, although the patient pays the pharmacist to supply and dispense it.

However, the nub of this is the medical need for this prescription. As NHS doctors, albeit contractors not employees, we should be following the current advice from the Chief Medical Officer. At present he does not suggest that patients should hold a supply of an antiviral drug, and it feels uncomfortable to me that patients able to purchase medication privately should be ahead of the queue. And, of course, we do not know whether, when, or for how long medication is going to be needed. For instance, a 10 day prophylactic course of antiviral will be of little use during a 3-4 month pandemic.

So, if the patient wishes to obtain an antiviral I would advise her to see a private doctor to discuss this. A private prescription might then be issued, which would take the whole transaction out the NHS. I would still be a bit unhappy that this will encourage panic buying, but this is not a matter over which we can have any control.

Do get back to me if you disagree.

FLU IMMUNISATION AND PNEUOMOVAX FOR THE ELDERLY MENTALLY INFIRM

Questions of Consent and Clinical Benefit

A practice has recently contacted the LMC office about the appropriateness of routinely immunising old people with dementia in nursing homes against respiratory disease. We thought that the issues raised were worth airing here

The NHS recommends pnemococcal and flu immunisation for all elderly people and given that these offers proven health benefits, our default position should be that all eligible older people should be offered the immunisation.

However, immunisation should only be given with informed consent. If an adult is unable to give consent, nobody else (except where a Court is involved) can give it for them. The decision then falls to the doctor responsible as to whether the health benefits of a treatment are sufficiently great to merit giving it without consent. The doctor is answerable to a Court for his or her decision. Good practice dictates that this decision is as well informed as it can be , which means discussing it with the patient (as far as is possible) , the carers - especially those that are professionally qualified nurses - and the family if available.

Generally, relatives, carers and GP will agree. As a rule we would advise that if any one party wants the patient to have the immunisation, you should go ahead and give it unless you have clear evidence that this would be contrary to the patient's wishes. Writing to relatives may be a helpful way of gathering the information you need to reach a decision.

Previous medical records can be useful here. If a patient has always refused immunisation in the past it is reasonable to assume that they would not change this view. If a patient has accepted it before their current illness, but has made a clear statement in the form of an Advance Directive or some other written note that they do not want life prolonging interventions in the event of an incapacitating condition, then you should consider withholding immunisation.

Each decision must be individual to the patient concerned, so a blanket decision for an entire home would not be appropriate. Decisions must also be non-discriminatory. It is not legally or ethically acceptable to decide not to offer immunisation just because a patient is demented, you need to be able to show that the potential health benefits for that particular person, which could be defined in terms of quality of life for that individual, are not sufficient to justify the giving of a treatment without consent.

FLU VACCINE SUPPLIES

Because of the high demand this year, a number of practices are reporting difficulty in obtaining enough vaccine. There is no contingency supply being held in the county this year, and manufacturers do not have unallocated stock. It is therefore unlikely that patients will be able to get individual prescriptions for vaccine filled, at least for the present. Whilst it would be wise to focus your attention on the highest risk groups, do not forget that NHS employers, including practices, should be offering immunisation to staff.

LMC/GPC SURVEY OF GP CLINICAL SYSTEM FUNDING

Thanks to the practices that responded, the results have gone off to the GPC to be collated nationally. In Somerset some predictable points emerged: delays in fulfilling orders, PCT instigated upgrades coming along, often at short notice, with little regard to day-to-day practice workload and sometimes leading to irritating teething problems that make updated computers work less well than before for a while. Also there was considerable sympathy for overworked Informatics staff and a feeling that the managers directing them are not in touch with what goes on in practices. The process for obtaining even minor upgrades sometimes appears Byzantine, and, as ever, suppliers appear happier to blame one another for technical problems rather than actually resolve them.

FootNote We have a response to Dr Edmondson's challenge to find the longest word in a letter to a GP. Dr Bob Jones has sent us "pseudomucinouscystadenocarcinomatosis" which at 37 letters looks like a clear winner……

NEW OXYGEN SERVICE

Major Changes from 1st February 2006

You will be aware that the whole system for providing domiciliary oxygen is changing. From 1st February 2006 all oxygen supplies in each region will be provided by one contractor. In our case this will be Air Products. Patients potentially needing Long Term Oxygen Therapy (LTOT) will in future be assessed by a specialist medical service, which could be community based but is more likely to work from a hospital trust as the assessment included arterial blood gas measurements. After this assessment an "Oxygen Therapy Direction" (OTD) will be issued, which is essentially a prescription instruction to the supplier. Thereafter, the patient communicates with the supplier for new cylinders, concentrator servicing, or whatever.

To get ready for the transition PCTs are preparing a register of patients on oxygen , and will be contacting practices to verify and update this. Current LT0T users will take between 6 months and 2 years to be reviewed, so in the meantime each PCT will be asking current prescribers to issue an interim OTD sometime in January so the new provider has appropriate supplies and equipment prepared before the changeover. We do not yet know exactly what the OTD will look like.

GPs will continue to be able to prescribe oxygen for short term and palliative care, and in emergencies. This will be by a phone call/ fax to the new contractor. Patients travelling within the UK, and even going abroad in some cases, will be able to arrange their oxygen supplies through their home contractor without needing to involve GPs at all. Do note that emergency oxygen supplies will be charged at approximately 10 times the normal daily rate, so this is something to avoid if at all possible.

In the meantime, you can now start to prescribe the new 2122 litre cylinders as these will be replacing the familiar 1340 ones over the next few months.

For more information go to

http://www.primarycarecontracting.nhs.uk/uploads/HOS/issue1.htm

QOF CHANGES

Some useful new Exception Codes

We are indebted to Mrs. Dorothy King, the practice manager at Bishop's Lydeard, for the following snippets of useful information. Patients with IHD who have been appropriately managed by proceeding straight to angiography, for example those with severe symptoms or the elderly in whom an exercise ECG is not a practical option, appear to be suboptimally managed as far as the QOF is concerned, i.e. their records show "exercise test absent" as this is the criterion used as a measure of appropriate referral. Now the Read code 33BE, "Exercise tolerance test contra-indicated," can be used in these patients' records to help give the satisfaction of a job well done and seen to be done.

In the asthma and COPD domains there are two new useful codes, again perhaps useful for the frail, the housebound and the chronic non-attenders: 816L, "Spirometry not indicated" and 813b, "Spirometry declined."

There is a new code for liquid based cervical cytology, 685R and new codes for exception coding women from the smear denominator group. our favourite is 9O8Y, "No smear needed, no uterus," but a full ruleset is available at http://tinyurl.com.3tsz6.

AGENDA FOR CHANGE

Whitley Council Pay Scales to be abolished from next April

Practices should be aware that the familiar Whitley council pay scales that many have borrowed and used as a basis for setting the remuneration of staff will no longer exist from April 2006. Agenda for Change (AfC) is the new NHS recipe for setting salaries and involves a form of appraisal and applies the concept of "personal career development" with an initial "job matching" in a "re-banding" exercise currently sweeping through the NHS.

The LMC view remains that this is not a process that we can recommend to practices but colleagues may choose to look at the new AfC Bands particularly if they are in competition for staff with other NHS organisations that will be using them.

NEW LOCAL GUIDELINES ON THE MANAGEMENT OF PATIENTS ON WARFARIN

We all know that the safe management of patients on warfarin requires constant surveillance and the use of proper protocols, but as the number of patients on anticoagulation has increased, the risks of an adverse event have grown proportionately.

The LMC has discussed some of the problems with the haematology department for Taunton and Yeovil, and we are very grateful for the following advice:

1. Non-urgent (community) initiation of warfarin treatment

Many patients with, for example, newly diagnosed AF, will be started on warfarin under GP supervision. It is now advised that most adult patient should go onto 5mg as a loading dose, with an INR check after 5 days (or from 4-6 days to avoid a weekend day). Adjust the dose on the basis of that result, generally by changes of up to 1mg per day, and repeat the INR twice weekly until you have had two results in the therapeutic range. Interestingly, evidence from the Somerset audit suggested that individual clinical decision making on dose changes was more accurate than using decision support software during the initiation phase of treatment. If your patient is very small, frail, or high risk consider using a dose of 3mg rather than 5mg for loading. Once in range, switch to using your software.

2. Restarting warfarin after a break (e.g. for surgery)

If a patient has been off warfarin for three or more days, restart the patient on double their previous maintenance dose for three days and then check the INR - You are aiming to reduce to the maintenance dose when the result is in the therapeutic range. Repeat the INR after a further week, and then, if in range, after another 2 weeks. If all is well you can at that point go back to the usual monitoring regime. You may need to review the restarting dose if, for example, the patient has been started on new interacting medication

3. Community management of over-warfarinisation

Annual bleeding rates of fatal, major and minor bleeding for warfarinised patients have been reported as 0.8%, 4.9% and 15% respectively. The two variables that are most consistently associated with bleeding risk are intensity of anticoagulation and age. The risk of bleeding at an INR > 7.0 is 40 times the risk at an INR in the range of 2.0 – 2.9 and 20 times the risk at an INR in the range 3.0 - 3.9). Management depends on the perceived risk of bleeding and the presence/absence of minor or major haemorrhage.

3.1 Major or life-threatening bleed in warfarinised patient (any INR)

Life threatening bleeding requires rapid and complete reversal of anticoagulation and urgent hospital assessment is required.

3.2 INR > 8.0, no bleeding or minor bleeding only

More rapid reversal of over-warfarinisation is required when a patient presents with an INR > 8.0. This can be achieved by temporarily stopping warfarin and giving low-dose vitamin K. The aim of intervention is to bring the INR back into the therapeutic range without rendering the patient resistant to further warfarin therapy.

Management

1. Withhold warfarin for one or more days (duration dependent on INR)
2. Give 1mg vitamin K preparation ORALLY: use Konakion MM Paediatric (Colloidal formulation) 2mg/0.2ml. The bioailability of other vitamin K preparations is inferior to, and more variable than, that of this product.
3. Restart warfarin once the INR is < 4.0 (target INR 2.5) or < 5.0 (target INR 3.5).

3.3 INR 6.0 – 8.0, no bleeding or minor bleeding only

Withholding warfarin results in slow reversal of anticoagulation (33% of patients after 24 hours, 68% after 48 hours and 89% after 72 hrs in one study.) So, the majority of over anticoagulated patients will return to the therapeutic range within 3 days of stopping therapy. Importantly, a

delay of 24 – 36 hours is seen before the maximal rate of fall of INR begins. Non-emergency reversal is therefore appropriate when a patient presents with minor, non-life-threatening haemorrhage or, more commonly, with an INR perceived to be associated with a significantly increased bleeding risk.

Management

1. Withhold warfarin and repeat INR after 48hrs (24-72 hrs on weekend, dependent on patient; early if becomes haemorrhagic).

2. Restart warfarin when INR < 4.0 (target INR 2.5) or < 5.0 (target INR 3.5).

3.4 Unexpected Bleeding at Therapeutic Levels

Investigate as for a patient who is not on anticoagulants.

Reference: http://www.bcshguidelines.com/pdf/bjh715.pdf

PS *we have been advised that the* ***risk of flu vaccine seriously potentiating warfarin is small*** *but do bear in mind the possible interaction of the next INR is high*

OUT OF HOURS SERVICE DEVELOPMENTS

Negotiations continue between the Somerset PCTs and Dorset Ambulance Trust on the transfer of responsibility for the Somerset Out of Hours service. However, it has become clear that the Somerset service is relatively costly, and it is likely that the PCTs will have to make some changes before the Trust will be in a position to take it on. There will be some savings with the transfer of call handling from NHS Direct to a directly managed service but changes in GP sessional hours and skill mix are likely to be required as well. The Strategic Health Authority has said that the provision of a safe service is paramount, and the LMC remains confident that Dorset Ambulance are the right organisation to take over the Somerset provision as not only do they have a good reputation amongst GPs, but there are obvious economies of scale from the merger, as well as efficiency gains to be had from sharing a service across our longest county border.

Medical Examinations for Taxi Drivers

Are likely to be more exacting in future

Responsibility for licensing taxi drivers rests with the Environmental Health Department of District Councils in Somerset, and we are aware that they are tightening up on the medical evidence required. At least one (Sedgemoor) has taken the entire text of the new DVLA PCV/LGV licence application form and put it into their own format, but at least this makes charging easy - most of us will presumably charge at the same rate as a standard PCV/LGV examination.

The LMC has some reservations about the Sedgemoor form. Section 10 on whether the patient meets or does not meet the DVLA criteria is acceptable but we would suggest the doctor strikes out the phrase "and having paid full regard to his/her medical history" as this is an open ended statement that could be a real hostage to fortune, especially if the doctor examining the patient does not have access to the notes.

Section 11 asks the doctor to indicate when the next examination will be required. We do not think that it is possible for an examining GP to answer this, and we suggest that you do not attempt to do so.

Message from Dr Bob Hart

I am due to retire as Medical Director of St. Margaret's Somerset Hospice at the end of October. Dr. Murray Fletcher, Consultant in Palliative Medicine will take over my role as Medical Director, working partly in Yeovil and partly in Taunton. Due to the national shortage of Consultants in Palliative Medicine, we have not so far succeeded in appointing a new consultant, but as we have an experienced medical team in place there should be no difficulty in maintaining our service. I have greatly valued the friendship and support of colleagues around the county during the last 12 years, and thank you all for the partnership we have shared.

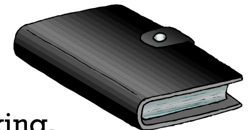
JENNIFER'S JOURNAL

Editor's note: Jennifer had promised us that this month she would find something light and humorous to say, but the latest Department of Health "consultation" exercise seems to have stirred her up a bit. Personally, I blame her GP for making her stop HRT and cut down on the gin.

'Your Health, Your Care, Your Say – Improving Community Health and Care Services'.

This is your chance to express your views to a listening Government. The web site includes a questionnaire that you are invited to complete on line and submit; a time consuming ordeal requiring a response to 69 items and 16 questions about yourself. No problem, you might think until you read the questions. They are not asking you if you are happy with present services at all. It is blatant propaganda. There is a list of Government planned changes and you have to select how much each of them would improve things for you. There are no options to suggest anything could be worse. The results guarantee an endorsement even if you disagree with it all! The section on General Practice should be read by GPs while sitting comfortably with anger management counselors on standby. 'How much of an improvement would each of these options be…..' it starts. Options include GP opening earlier in the morning, opening later at night, opening at weekends. GP spending more time with you, being able to see a doctor within 24hrs., register with more than one doctor, no need to register and use walk-in centres….. it drones on. There is no way you can tell the Government that you like your doctor and have excellent access to him/her and that no that change is needed.

As someone who once studied questionnaire design I find it difficult to believe that the Government can produce such a crass amateurish piece of work. Once recovered from the blatant propaganda, lack of balance, stupidity of content etc. you might think we could rationalize and say 'well, it is only on some obscure web site; nobody will ever see it anyway.' But, no; and here I come to my point: The Strategic Health Authority has instructed PCTs to photocopy the questionnaire and take if forth into the community and to help the disadvantaged fill in the forms. I have found a pile of them in our District Nurses' office and even more with the Health Visitors. They have been instructed to get them completed by their clients - an enormous time-consuming project! It is lucky the nurses have very little else to do!! I gather it hasn't always been easy. The residents of an EMI home had difficulty focusing on the complex questions and even their carers had difficulty understanding them. It was all so irrelevant : do you want advice on safer drinking, tackling drug use, safer sex etc….?



Health Professionals working out of my practice, are approaching my patients with blatant Government propaganda and nobody has had the courtesy to inform me.

So visit the website

http://www.dh.gov.uk/NewsHome/YourHealthYourCareYourSay/fs/en) for a laugh and let us raise a glass to all line managers in the NHS who blindly promote this propaganda without a thought and who probably don't even bother to read it.

The views expressed in this column are those of the author and not necessarily those of the LMC

Jennifer

LMC EMAIL ADDRESSES - CLOSURE OF OLD ACCOUNTS

Please may we ask correspondents to check that they have the LMC's current NHS net addresses (somerset.nhs.uk) prefix with either lmcoffice, harry.yoxall, jill.hellens or elaine.kelly. The old demon addresses are no longer in use, and the website address is www.somersetlmc.co.uk All details for the LMC secretariat, Chairman, officers and members can be found in the contact area of the website http://www.somersetlmc.co.uk/contact.htm

Editor Dr Harry Yoxall

Somerset Local Medical Committee, c/o Taunton Deane PCT, Wellsprings Road, Taunton TA2 7PQ
Tel No: 01823 344314 Fax No: 01823 344390 E-mail: lmcoffice@somerset.nhs.uk
LMC Website: http p://www.somersetlmc.co.uk