

# Somerset LMC Newsletter



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Issue 126

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## PRESCRIBING BUDGETS

*Do not stop providing cost effective evidence based treatment*

What a sorry affair the practice prescribing budget setting for 2006/07 has been. Against a background of an anticipated 6-8% increase in prescribing cost for the year the PCTs initially uplifted the budgets by 3.5%, and then, to meet their local savings targets, a reduction of £3M was applied, with a further £1.5M allocated to possible incentive payments under PBC. Interestingly, the PECs were not consulted on this decision.

The result of this is a net *reduction* in the total cash value of budgets by something like 1- 1.5% across the county. At the same time all budgets were rebased by ASTRO PUs, with all local PCT historical spend adjustments removed. But despite the PCTs having access to morbidity data from QMAS it appears that no attempt was made to adjust for this, nor was there any correction for relative deprivation. We are constantly told how low prescribing costs are in North Dorset and how we should aspire to match them, but not everyone is fortunate enough to live in Sherborne and the NHS was supposed to be about meeting *need* - Nye Bevan would surely have had a few words to say about this!

We do not know what level of prescribing spend is the most effective in health delivery terms. We believe that *all* Somerset practices are below the national average and, of course, there is evidence that good prescribing in primary care reduces secondary care costs on the long term. This is not to say that there are not sensible savings to be made. For example, you can treat four times as many people for the same cost if you use lisinopril rather than perindopril, or simvastatin rather than atorvastatin, but for many practices there is precious little fat left to cut off prescribing costs and we run a real risk of depriving patients of appropriate treatments if prescribers are constantly looking to save money. And, nationally, all the pressure is in the opposite direction. We should be treating more patients with statins to reach those with 20% cardiovascular risk, NICE expects us to switch patients from older, cheaper antihypertensives to newer and more expensive ones, and full implementation of the QOF indicators for CKD could be very expensive indeed.

Using the rebased budgets we estimate that about 20% of practices could make savings, which may be an appropriate reward for those good and loyal servants who have worked hard to contain their costs. At the other end of if the scale another 20% of GPs face cuts of perhaps 10% in their allocation. Adding this to the true annual growth of 7% means a 17% reduction in prescribing - a figure that is quite frankly impossible to achieve safely in a year. But this is exactly what is required under the local framework for PBC, for any prescribing overspend is carried forward to the subsequent year. Given that most practices will have a neutral budget at best and have no opportunity to make savings on their secondary care

budget this year, PBC is beginning to look singularly unattractive.

But this is all secondary to the central point, which is that we should be attempting to provide cost effective, evidence based treatment for our patients. If the arbitrary cash allocation from the PCT will not meet that need, then it is their problem and not ours. So, continue to work constructively with your prescribing advisors and make reasonable savings where you can, but do not stop giving patients prescriptions for the medications that they require.

## **T&S TRUST MATTERS**

### ***New Number to Call for Medical Admissions to T&S***

In response to GP concerns about long waits to talk to someone at the Trust to arrange medical admissions, T&S has allocated a dedicated telephone number, **01823 343144** solely for GP's use. This allows us to phone the MAU Co-ordinator direct rather than going through the switch board and bleep system. This is being trialled from 10th July 2006 and will be reviewed after 3 months. If the line is very busy and you need to speak to someone urgently, you can still ask the switchboard to put you through to the medical registrar on call.

### ***Post Menopausal Bleeding Referrals***

The Gynae Department at T&S has asked that all PMB patients be referred using the gynae cancer 2 week wait fax system. Apparently at present the majority are not, and this has led to delays in diagnosis and treatment

### **What to do about rimonabant?**

#### ***You should not issue a private prescription for Acomplia to an NHS patient***

It has been suggested that as rimonabant has not yet been considered by the Prescribing Forum and is therefore not in any PCT formulary, patients who request it should be given a private prescription. Sadly, it is the LMC view that this would be a breach of contract by the GP. If a newly launched medicine is licensed and not blacklisted it can be prescribed under the NHS within its licensed indications. You cannot arbitrarily decide that you will only prescribe it privately.

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However, NHS doctors are not obliged to prescribe any particular product, and GPs should not prescribe products with which they are unfamiliar unless they are guided by a secondary care doctor who is experienced at using such a treatment. There is nothing wrong with GPs being cautious over the use of new products and we do have established alternative medications. We should, of course, also be wary of using black triangle products. Finally, there is the GMS requirement not to prescribe "excessively or inappropriately" and PCT guidance says do not use this drug until the evidence has been reviewed and its place in therapy decided.

So the GP is not obliged to issue an NHS prescription.

If the patient refuses to take anything other than rimonabant the GP may advise that they seek private treatment, or may refer them for a second opinion to someone more familiar with the medication in question, but he or she should not issue a private prescription for it to a registered patient.

## **IDENTITY VERIFICATION FOR PASSPORT APPLICATIONS**

### ***Is NOT our responsibility!***

We understand that some Passport Offices are now suggesting that some passport applicants approach their GP for proof of address (according to their NHS records) and to confirm that the patient has been seen in the last 3 years. Apparently, the Passport Agency thought about letting GP's know through the BMA but decided they would get to know in the next couple of months anyway as letters started arriving at GP surgeries!

The Agency asks applicants for:-

'A letter from your dentist (or only if absolutely necessary your GP) confirming from their records that you have consulted the dentist (or GP) between June 2003 and June 2006 and confirming your current and previous addresses from their records.'

If you get such a request please can you let the LMC office know as the GPC has agreed to pursue this with the Passport Agency and the Better Regulation Executive, immediately. They also confirm that this is not NHS work and the LMC therefore advises GPs not to participate.

## NATIONAL DIABETES PATIENT QUESTIONNAIRE

*Do not respond to this without obtaining patient consent.*

We have had a concerning report from a practice who were approached by a private sector company who have been contracted by the Department of Health to undertake a national survey of a sample of patients with diabetes. The company in question requested a list of such patients registered with the practice which, entirely correctly in our view, the practice declined to provide without patient consent. When the practice offered to send the letter to the patients on behalf of the company, the latter said they would go elsewhere. Just because an organisation is acting on behalf of the DH does not mean that the usual rules on confidentiality are suspended and we suggest they if you are approached for this information you also decline to provide it.

## GLUCOSAMINE AND CHONDROITIN

*Can be effective but may also have drug interactions*

Thanks to Jon Hincks from Cheddar Medical Centre and the South West Medicines Information and Training Service at the BRI for these interesting snippets:

- Glucosamine + chondroitin in high dose may enhance the effects of warfarin, but apparently not at recommended dose of glucosamine 1500mg & chondroitin 1200mg daily ( but perhaps a check INR shortly after starting Rx might be a sensible precaution?).
- Glucosamine may have an effect on insulin resistance but does not appear to affect control of blood sugar in patients with type 2 DM, or interact with antidiabetes drugs.
- Glucosamine (& also chondroitin) might exacerbate asthma by an unidentified allergic mechanism, therefore "use cautiously in patients with asthma"
- Preliminary research suggests Chondroitin may cause the spread or recurrence of prostate cancer.
- Theoretically glucosamine might induce resistance to certain chemotherapy drugs - etoposide, teniposide, & doxorubicin.
- The sulphate bit of glucosamine sulphate may decrease the effectiveness of paracetamol.

## GLOBAL SUM ADJUSTMENTS FOR GMS PRACTICES 04/05 TO PRESENT

*It may be worth getting your accountant to check the sums paid by the PCT*

*We are very grateful to the LMC's Accountancy Adviser, Andrew Spear of Lentells, for the following item.*

The Department of Health in January 2006 undertook an exercise to recalculate the quarterly global sum figures for all GMS practices backdated to 1 April 2004. This was in order to correct the historic formulas which did not treat correctly the normalisation indices and the weighting for list turnover and nursing and residential homes.

As a result of these calculations, it appears that the original basis on which practices MPIG payments were based had been altered. It still remains that the MPIG should be the difference between the global sum payments (excluding temporary residents) at 1 April 2004 compared to the global sum equivalent (GSE). The GSE was based on the historic 'red book' fees and allowances which were inflated and adjusted for changes in list size.

It appears that in a number of these Department of Health calculations, the revised global sum and MPIG no longer agree to the GSE - and practices were therefore being underpaid. Practices will therefore need to ensure that the adjustments made to their global sum payments and MPIG correction factors in January were correct and if the PCT has not made the data available of how this was calculated, then practices should ask for a copy of the DoH calculations.

As a result of meetings I had earlier in the year with South Somerset PCT where I raised this as an issue, that PCT has carried out a full review of all payments to practices and have corrected them where appropriate. However, of all the practices we act for, there have only been two where this has been a significant problem.

## TALKING POINT

*A new feature in which we will put forward some radical views for debate – and we would welcome your letters or emails in reply*

### **The role of strong opioids in the management of people with persistent pain not related to cancer.**

The PCTs have estimated that across the whole of Somerset GPs spend £1 million on fentanyl and oxycodone products, a sum that is rapidly increasing. Sensibly, they turned to a Pain consultant for advice. This what he said:

“Epidemiological studies show that up to 40% of the population have daily pain that has been present for more than 3 months. A significant proportion- perhaps one in ten of these people- are severely distressed or disabled by their pain. The majority of these people have a musculoskeletal problem and many of them have arthritis. So far, all seems clear.

But the situation is far from clear. There is only a loose relationship between reported pain severity and disease severity. There is even less correlation between disease severity and quality of life. More perplexingly, strong analgesics don't seem to work that well for the majority of people with persistent musculoskeletal pain. This is a real problem.

Over the last 3 years, a number of drug companies have gained product licences for strong opioids in the management of people who have persistent painful disorders. Each product is marketed alongside an impressive set of data attesting to its efficacy. However, there is another story.

2 meta-analyses now suggest that we should use caution when prescribing strong opioids for people with persistent, non-cancer pain. Evidence from Denmark suggests high addiction rates (13% in some longitudinal studies). An editorial in the journal *Pain* in 2004 said it all “*Using opioids for persistent musculoskeletal pain; flying blind*”. Essentially, good quality data is lacking. Individual people might be helped, but overall, the evidence suggests that few

people have an increased quality of life on strong opioids and, sadly, there is a real risk of addiction.

The national guidelines on use of opioids for persistent pain (see British Pain Society [website http://www.britishpainsociety.org/](http://www.britishpainsociety.org/)) suggest they should only be used as part of a goal-directed rehabilitation plan. I also believe that morphine should be used in all instances as the first line strong opioid and that fentanyl patches have a very limited role indeed to play (I don't recall ever prescribing a fentanyl patch...). Oxycodone seems to have a role in management of neuropathic pain (when other drugs have failed), but again, only as part of a rehab programme and not as an end in itself.

I guess one specific point of great importance is that we don't know what pain is. We should actually be helping people to manage pain related disability. It's a crucial distinction, because for many people, analgesics don't work that well they could escalate up the ladder very quickly unless analgesics are used essentially to facilitate goal-directed rehabilitation. This core distinction could help reduce analgesic prescribing across the board and really should reduce strong opioid prescribing for people with non-cancer pain to a very low level indeed (I see perhaps 25 new patients with chronic pain per week and suggest strong opioids for less than 10 patients per annum) The first thing pain fellows learn when they come to my clinic is that I only use 5 drugs....it ain't what you do, it's the way that you do it.

Perhaps some bright practice or group of practices may come together in the future and commission a primary care pain clinic lead by a trained nurse prescriber that could deal with many of these issues and also those patients who inevitably become addicted to painkillers and interventions .I'm sure there must be numerous referrals for neurology and back pain etc which would be better managed in a nurse lead primary care pain clinic.”

*What do you think?*

## SOMERSET LMC POSITION ON ETHNICITY RECORDING IN CLINICAL CORRESPONDENCE

### Background

There is an increasing expectation by Government that ethnicity information will be provided when a potential user contacts health or social services, or when a referral is made between providers within such services.

The LMC has reservations about the appropriateness of this for the following reasons:

### Confidentiality

The LMC starts from the assumption that only information relevant to the service being sought should be collected from an individual wishing to access that service. Similarly, referrals should only disclose confidential information provided by such individuals when it is necessary for the third party receiving the information to have it.

### Autonomy

It is absolutely the right of an individual to decide for themselves whether his or her ethnicity is relevant in all such cases.

### Clinical Relevance

Although there are recognised statistical links between geographical origin and health (for example, the greater incidence of CHD in South Asians or the difference in usual first line antihypertensive between black and white populations) this is not actually to do with “race” but individual genetics. It is wholly inappropriate to make health care decisions based on broad assumptions rather than personal need, not only for ethical reasons, but because it is inaccurate. For instance, there are individuals in the UK “indigenous” population with thalassaemia who are aware of no family connection with the Mediterranean

### Social Relevance

There is a further assumption made that some “racial” groups do not have equitable access to care services. This is also an oversimplification, as the problem is actually more likely to do with culture, language, and education rather than geographical origin. It

would be hard to argue that a High Court Judge with Caribbean parents or a neurosurgeon with roots in the far east would be socially disadvantaged due to their ethnicity

### Place of Social Engineering

The racial group categories used by government appear to related more to social engineering than individual need ( Why White British and Irish as separate groups?). Whilst this may be very useful for planning purposes it is not relevant to the health care of the individual, and sadly ethnicity recording does not have a good historical record and may itself lead to discrimination

### Conclusion

The LMC recommends that clinicians only disclose ethnicity information in written or verbal form to any other party, whether within or without the NHS, were this is clearly relevant to the referral and the patient has given express consent.

However, we do advise that information required to allow the patient to have equitable access to services, such as the need for a translator or any special cultural circumstances, is shared appropriately.

### GP REQUESTS FOR “URGENT” AMBULANCE TRANSPORT

*What to ask for if you need an ambulance within the hour*

The new ambulance response standards have caused some concern because of the standard 3 hour response time, although this can be shortened to 2 hours if necessary.

However, if you need a vehicle more urgently that that, this is what to request:

A **green emergency call** will generate an ambulance within 60 minutes to the patients house at normal road speed (i.e. with no lights or sirens.)

An **amber call** triggers a 19 minute response to the patient with lights and sirens)

A **red call** produces an 8 minute response to the patient which may be an ambulance car to provide assistance in a life threatening incident.

## MICROBIOLOGY UPDATE FROM SW GP LABORATORY USE GROUP

The LMC has a representative on this group which discusses the use of microbiology services by GP practices. As well as producing guidance for GPs on the management of specific problems, it discusses a wide range of microbiology related issues. Topics covered in the last couple of meetings include:

### Helicobacter testing

The current best investigation for active helicobacter is a stool antigen test which is preferable to serological testing as the latter does not distinguish current from past infection. As we adopt the NICE guidance on "test and treat" for HP infection it becomes more important that we have an accurate investigation. This will need to be funded, but there should be significant savings on endoscopy. However, not all gastroenterologists are keen on this! One to take to your PBC group?

### Ear swabs

There is a 10 fold difference between high and low requesting localities in the request rate for ear swab bacteriology. Consensus is that bacteriology is of little use in *otitis externa* - better to treat empirically as per the BNF. However, it is worth thinking about swabs for public health reasons if there is a sudden increase that could be attributable to, say, a contaminated swimming pool.

### Venous Leg Ulcers

Nurses should only be taking swabs from venous leg ulcers in accordance with RCN guidelines (which specifies markers of infection like increasing erythema, pain, exudate etc). Interesting discussion on significance of results, probably only staph. and strep. are worth reporting as other organisms may be commensals. Treatment of choice is probably *flucloxacillin 500 qid for 10 days* and there is an argument for using this before taking any swabs at all.

### MRSA

Is probably unstoppable, and the best strategy may be to concentrate on general anti-staph precautions, notably hand washing (yes doctor, this means you too!). Note that if

a patient has previously had MRSA, negative swabs do not mean the patients is completely clear and further antibiotic treatment may select out MRSA again. The group will try and produce a consensus view on decontamination, but this should probably be done shortly before admission as recolonisation may occur from fomites in the home which can be infective for up to 2 years especially if kept damp

### ESBL

Is another resistant organism, though apparently less of a problem in the South West than some parts of the UK. It is a beta lactamase producing coliform that is resistant to penicillins and cephalosporins (including third generation ones). Considered to be potentially a bigger threat than MRSA.

### PVL Staph aureus

Yet another nasty bug is the Panton-Valentine leukocidin producing strain of Staph aureus. Although not new, it has come in to focus again as the cause of recurrent furunculosis in otherwise fit people, and occasionally as a cause of repeated infection within families. We await guidance on whether it is something GPs should request investigation for in any particular clinical circumstances.

### Urinary Tract Infection

Very useful discussion on the value of urine culture when treating simple UTI in practice. For adults from 15-65 two urinary tract symptoms is 70% predictive for UTI, with positive nitrite dip test this rises to 87%. Generally if nitrite and leukocyte + on dip test, reasonable to treat with trimethoprim and only send culture and change to second line antibiotic if patient fails to respond. Incidence of trimethoprim resistance in simple UTI in the community still seems to be low. More on this to follow.

### Chlamydia

There has been a delay in the extension on the national screening programme throughout the UK. Take up by practices in pilot sites has been patchy. There is some concern about what to do with positive results and we will need to sort out with the PCT exactly how these are going to be handled. In some areas the screening co-

ordinator is responsible for treatment and contact tracing, in others (notably in rural areas) the practices do this. Funding seems to be very variable. There is also unease about whether positive patients should have a full STI screen, and if so who is going to do it given that GUM clinics have no capacity and few GPs are trained in this field. It was commented that, for example, single dose azithromycin may lead to partially treated syphilis that is resistant to macrolides. But this remains nationally advised treatment of choice in asymptomatic patients.

### **Pandemic Flu**

The national guidance on treatment suggests a deferred prescription for co-amoxiclav for at risk patients. However, stocks are unlikely to be sufficient to rely on this agent alone. Tetracyclines (especially doxycycline) and azithromycin were suggested by individual microbiologists present as reasonable alternatives.

### **Virology FAQs**

The UK Clinical Virology Network is developing their website to contain information and links relating to common GP queries. It can be found at [www.clinical-virology.org](http://www.clinical-virology.org) and has an excellent GP section.

### **Small Ads Small Ads.....**

#### **LOCUM GP REQUIRED**

##### **Maternity Leave Cover**

Start date 2nd October 2006 for six months, to cover 4 sessions a week, preferably all day Monday and all day Thursday, but negotiable.

Friendly rural practice, with EMIS clinical system with a large support team of clinical and non clinical staff

For further information please contact:

Wendy Eggleton, Practice Manager  
The Blackdown Practice  
Station Road  
Hemyock

Cullumpton EX15 3SF

Tel: 01823 680555

[Wendy.eggleton@gp-L83044.nhs.uk](mailto:Wendy.eggleton@gp-L83044.nhs.uk)

### **Practice Manager Mid Devon**

#### **30 Hours per week**

We are looking for an enthusiastic Practice Manager to work with us in our small, friendly dispensing practice in rural Devon. They will be responsible for the efficient running and development of the Practice in line with the GP contract and Primary Care Initiatives (including Practice Based Commissioning).

The successful candidate will need to demonstrate staff management, interpersonal, financial and IT skills. General Practice management experience is strongly preferred. The post is 30 hours per week and attracts a competitive salary, negotiable according to experience and qualifications.

For further details and an application pack please contact:

Dr Hugh Sheridan or Dr Charles Ristic  
Sampford Peverell Surgery  
29 Lower Town  
Sampford Peverell  
Tiverton  
Devon  
EX16 7BJ  
Tel: 01884 820304  
Fax: 01884 821188

### **MEDICAL SECRETARY**

#### **Part Time**

Small but busy rural practice seeks an experienced medical secretary, Monday to Friday 8.30-1.00 PM  
Competitive rates of pay, NHS Pension Scheme.

Please apply in writing enclosing a C.V to

The Practice Manager  
Creech St Michael Medical Centre  
Creech St Michael  
TAUNTON  
TA3 5QQ  
Tel: 01823 442357

*We are pleased to welcome a new occasional back page commentator to the Newsletter this month. But rest assured that Jennifer will be back..... after finishing her sentence for setting fire to that conference of Health Authority Chief Executives.*

## **THE COBBLER'S CHILDREN GO BAREFOOT**

As a general practitioner the County Doctor does his best to keep an open mind and listen carefully to the complaints of all those who consult his professional opinion. Nevertheless, no man has an inexhaustible supply of compassion. It is only fair to assume then that some "regular attenders" sometimes receive shorter shrift than they should. Not to put too fine a point on it, as a doctor I admired greatly in my formative years once put it, "Never forget, even hypochondriacs get sick sometimes."

It is well-known, but little admitted, that certain patients attempt to find or otherwise make up for something lacking in their own lives by visiting their doctor frequently. They may well be unwell, or at least genuinely believe themselves to be, but not necessarily in the way they think.



The question of whether this is appropriate scarcely occurs because this sort of patient rarely ever considers the matter. Indeed, it is a maxim of mine that the patient who opens by apologising for "wasting my time" never is. The sensible doctor can never tell straight away but the problem for the patient here is that two main errors can occur. The first is that the doctor, made cynical and hard bitten by seeing the same people with the "urgent" problems year after year, is determined to find nothing seriously wrong in any event. Next, and perhaps most common, is the doctor who starts to feel uneasy with his own reassurances and begins to doubt himself in the face of the patient's refusal to get better or, at least, to stop attending. Then more complex investigations are ordered and referrals made as the desperate net is cast wider. Sometimes these haul in unexpected minor abnormalities and the doctor happily begins to concentrate on these, attributing the findings to some "underlying" condition. Eventually an impasse is reached as the patient and doctor finally realise that they are at cross purposes.

Referral to hospital can be even worse as the specialist finds something to interest him or her amongst the patient's myriad and conflicting symptoms. Often the more objective hospital doctors find "nothing wrong" and send the patient back to the GP. Then, at least some time has passed. After all, "You believed me and sent me to the hospital." Unspoken is the understanding, "You've had a break...shall we try again now?"

The County Doctor sighs and makes his way home. He knows that the lump in his throat was an involuntary tightening of his gullet muscle. He knows that his blood pressure rose when he bit through his Biro consulting the customer who has baffled medical science. He knows what real illness is and that he can go for weeks without seeing a case. He knows that really sick people just do not behave like that. Certainly he would not display the same weakness!

But what does he find at home? Despite his sense of invulnerability he meets the same vicissitudes as in any other household – occasional accident, injury and illness. Unfortunately the GP may be so conditioned to maximisation of symptoms that, freed from the restraints of professionalism, he plays down the trouble. Hence the country doctor's daughter, when aged three, was left for five days to dehydrate from the gastroenteritis. She made a full and rapid recovery on a drip, only to suffer a fractured wrist a few years later for which the best treatment was "not to make a fuss." The suffering family is greeted with raised eyebrows and a gruff, "Well, what have you taken for it then?" He can get away with it at home you see. Is there no cat to kick?

Happily there is a specific and sovereign remedy at hand: I always advise my nearest and dearest in distress to see a "proper doctor." It saves embarrassment all around.

*The Country Doctor*

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