

Somerset LMC Newsletter



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Inside this issue:

Brand or Generic Prescribing	1
Gluten Free Foods	2
Treatment by a Specific GP	2
Not the Queen's English	3
Choose & Book Referrals	4
Walk-In Thefts	4
National Survey	5
Seven Day Prescriptions	5
Support for Staff and associate Specialist Doctors	5
Assura Medical	5
Small Ads	5
Jennifer's Journal	5

BRAND OR GENERIC PRESCRIBING?

The pharmaceutical market in the UK has long been managed as a typically British compromise muddle. Governments recognise that as an important export earner the industry needs a strong home market, but on the other hand, as the NHS is by far the largest customer, they have wanted some price control. Manufacturers appear to have done pretty well out of the deal – hence the trend to “parallel importing” by pharmacies of often UK produced drugs that are sold more cheaply in other European markets – and also, incidentally, the recent spate of counterfeit products in this country.

Inevitably the current Government has had to fiddle with the system, and, unsurprisingly, this has produced unintended consequences. Category “M” of the Drug Tariff includes a range of products that are “readily available” where the DH calculates the reimbursement on information provided by manufacturers using an arcane formula. It was supposed to divert resources from community pharmacy dispensing income to other services under the new pharmacy contract. However, the effect has been some bizarre price distortion. 32 paracetamol are £1.90 whereas in the supermarket they retail at 16p for 16, and old and formerly cheap drugs are suddenly expensive – 28 x100mg phenytoin tablets are £62.29. Meanwhile, previously expensive brands are suddenly cheaper than the generic with 1% hydrocortisone at over £10 and Efcortelan only 75p. Even more strangely, pack size prices vary wildly, with prescriptions dispensed from packs of 100 EC sulphasalazine four times as costly as from packs of 112, and *nine* times as much as if you had written Salazopyrin EN in the first place!

It now becomes clearer why the PCT has been issuing quite so many prescribing recommendations – each swing of the market is producing huge changes in costs, and, potentially, enormous potential savings for practices. We could argue that all this is none of our business, and that the job of the GP is simply to prescribe the medicines that the patient needs, but this is real money that the NHS is spending, and it is hard to stand by and see it wasted. But on the other hand, the last thing we need to be doing is constantly switching patients between brands just to chase few pence difference in price

The pragmatic answer seems to be to continue to prescribe generically where possible, but to add a comment for the pharmacist in the dosage or patient advice field if you want a brand or branded generic dispensed. So, when writing a prescription for omeprazole add “please dispense Mepradec”. If the brand name is on the prescription the pharmacist is expected to dispense it, - and the patient has the benefit of having a consistent product – but the generic name is on the prescription head, which is better for patient safety, and if you do need to change brand there is much less likelihood of confusion.

None of this inspires confidence in the capacity of the DH to manage anything, let alone a system as complex as the NHS, but once again we seem to find ourselves on the same side as the PCT in making the best of a bad job.

Our thanks to Angus Thompson for much of this material which is greatly expanded in an article he has written for The Pharmaceutical Journal

http://www.pharmj.com/pdf/spectrum/pj_20070609_misformayhem.pdf

PRESCRIBING GLUTEN FREE FOODS

All GPs are aware that there is a wide variation in the number of prescription items requested by patients with coeliac disease, but what is appropriate? The range of gluten free products available for NHS prescription to patients with gluten sensitivity is wide, and in theory any can be provided in line with the recommendations of the Advisory Committee on Borderline Substances.

The decision on which of these should actually be prescribed rests with the doctor responsible for the day to day care of the patient, which will nearly always be the patient's GP. However, the doctor's decisions should be guided by current good practice in medicines management, derived from a mixture of GMC and NHS regulatory requirements, local PCT recommendations and sensitivity to individual patient needs.

The first principle is that NHS prescriptions should be issued on the basis of need and not want. When prescribing for adults with coeliac disease we interpret this as meaning that staple foods may be prescribed, but as a rule it is difficult to see how the provision of luxury food items can be justified as NHS "treatment". For children under sixteen you will probably wish to take a slightly more relaxed view. The second principle is that in a resource limited service each expenditure must be considered in relation to other possible uses of the resources. Therefore, the medical benefit of each prescription should be considered against the possible benefit of an alternative prescription for another patient. In this situation is the health gain from prescribing a particular gluten free product greater or less than, say, increasing the statin dose for a patient at risk of serious cardiovascular disease?

Historically the prescription of gluten free products was started at a time when both eating habits and the range of foodstuffs available to buy were very different to the present. It is now perfectly possible to maintain a gluten free diet without using any specialist products, so although it is more convenient for patients to have items prescribed, it is arguable that it is not necessary at all. This seems a little hard hearted, so we would suggest that a modest number of gluten free staples should be

offered on prescription although some coeliac patients prefer to avoid these altogether on the grounds that they taste pretty bland. Gluten free products are more costly than the wheat based equivalents (although the difference is lessening) and a reasonable starting point may be to ensure that the patient is not out of pocket in their weekly shopping by providing some items on prescription. Of course, the needs of the particular patient must also be addressed. Some people are obviously more able to manage their diet than others and, for instance, a patient with learning disability may well need more prescription items than a university graduate. Intercurrent illness or disability may also be relevant.

The Coeliac Society issues some very useful guidance on likely quantities of prescription staple foods that coeliac sufferers may require and though the PCT continues to recommend that prescriptions should be issued on a monthly basis, if your normal practice is to issue for 56 days this seems reasonable to us, bearing in mind that some GF products have a short shelf life. Prescribing for longer periods or in larger quantities may make you liable to action by the PCT under the "Excessive Prescribing" amendments to the GMS contract.

Sometimes patients forget that prescribed items are strictly provided for their own consumption and that using them for other members of the family is, strictly speaking, fraudulent. Very occasionally a GP may suspect that this is being done systematically and in such cases we recommend that you contact the NHS Counter Fraud Service in the Chard office of the PCT for advice.

PATIENT REQUEST FOR TREATMENT BY A SPECIFIC GP

How far do you need to go to meet this demand?

The GMS contract (and most PMS agreements) require the practice to inform patients on registration that they may (Clause 185.1 of the Standard GMS Contract) "express a preference to receive services from a particular performer or class of performer either generally or in relation to any particular condition." However, this

obligation is limited by Clause 186 “ The Contractor *shall endeavour* to comply with any *reasonable* preference expressed under clause 185 but need not do so if the preferred performer has *reasonable* grounds for refusing to provide services to the patient...”

The LMC interprets this as meaning that the practice is expected to attempt to fulfil the requests of patients who wish to consult a particular doctor or gender of doctor and cannot impose a blanket rule that patients may only see the doctor who has been identified by the practice as their “usual” GP. However, the implementation of this expectation is moderated by the very sensible English legal concept of “reasonableness”, which I think we may here interpret as meaning that the practice is not required to make a disproportionate effort that may, for example, compromise the care of other patients or place an undue burden on a specific practitioner.

For example, in any practice there are some doctors who are perceived as more sympathetic and who may need to be protected from the overwhelming demand from patients with complex psychosocial illness that they might otherwise face if open booking was allowed. The practice may therefore need both to moderate the potential demand placed on them by patients and also be prepared to make workload adjustments between partners to allow for the extra work in this field that they will nonetheless have to do.

We should remember that the contract is now between the PCT and the practice, not the individual GPs, and so before it could consider preventing any transfer of patients between doctors the practice must also make reasonable changes, which might mean altering the distribution of the work between current GPs, training nursing staff up to undertake some of the tasks, or even bringing in a sessional doctor; for example a female GP to help in an all male partnership. Exactly what would be reasonable depends on the particular circumstances of the practice. Having said that it is legitimate for the practice to control patient demand for access to specific doctors there must nonetheless be a way for patients to ask to see a different doctor to the one to whom the

practice allocates them. We think it would normally be reasonable to require, say, that this request was put in writing to the practice manager.

Finally, it is worth considering what grounds a patient may have for asking to see a different doctor. Anti-discrimination law should presumably apply to GPs as well as patients, so we see no reason why a patient should demand to see a doctor on the grounds of their age, religion or race; but we do accept that language skills and gender are of genuine importance for some patients.

NOT THE QUEEN'S ENGLISH?

Congratulations to Dr Barry Moyse for this prizewinning entry to a Daily Telegraph competition to write a paragraph of the most irritating modish phrases

“The Trust are committed to sharing best practice and are passionate about facilitating appropriate skills through workshops and learning events around these issues across the piece. Monitoring using a web-based toolkit will empower users to drill down to assess local needs interactively. Stakeholders will be fully engaged in a consultation exercise breaking down barriers, pushing the envelope towards a seamless, one-stop shop service. Safety and value for money will be paramount so we are investing a funding stream to put in place a multidisciplinary team to head up this exciting upcoming project, providing local ownership and robust clinical governance. Doing nothing is not an option: subject to independent review lessons will be learned, and accountability made transparent to commissioners, providers, and service-users to ensure that this tragedy will never happen again.”

PS I think the NHS has an unfair advantage in your competition: send that paragraph as an email to general practitioners and most would believe it to be genuine, not despite it being cliché-ridden and ultimately meaningless, but precisely because it is.

CHOOSE AND BOOK REFERRALS & GP LETTERS

As Somerset moves towards an 18 week referral to treatment target for all new referrals it becomes increasingly important to ensure that there are no delays at any stage of the process. If you make a C&B referral the clock starts ticking as soon as this is logged, but occasionally GPs are a bit dilatory about attaching their referral letters. Particularly if an intermediate care assessment is required, leaving an apparently “non-urgent” letter of a couple of weeks can cause significant problems. Please can you therefore try and ensure that the C&B referral and the letter are generated at the same time if possible – using the medical secretary C&B method obviously helps with this.

The LMC has also reached an understanding with the PCT about the handling of rejected referrals that is based on where the “choice” discussion was held. If you have agreed with a patient a particular referral destination and it transpires that the provider in question does not offer the treatment needed, the RMC will contact the practice asking for an alternative choice. However, if the patient was referred by the practice to an intermediate care service who in turn referred them on to a surgical provider, it will be up to the intermediate service to contact the patient to arrange a different choice.

Practices may also receive rejections from Trusts directly into the “rejection worklists” on Choose and Book. You should aim to review this worklist on a regular basis, ideally daily, and deal with any referrals that are posted there as the 18 week clock is still ticking. The PCT has a local rejection protocol agreed with Trusts so in the C&B rejection “comments” field the Trust should be telling you 3 things:

- a) Why the referral has been rejected (e.g. wrong specialty, unfunded treatment, referral sent straight for a test procedure)
- b) What they have done with the referral (e.g. returned for re-referral, dealt with manually etc...)
- c) What they need the Practice to do with this referral. (e.g. re-refer, delete from Choose and Book)

If this information is not clearly given please can you let the RMC know - ideally with a screen shot of the actual comments - and they will take this up with the trust directly.

Finally, agreeing with the patient the widest range of referral options you can at the time of referral means that the RMC has much more flexibility in finding the best way of hitting the target meaning you are less likely to be bothered with requests for alternatives if your primary referral centre is unable to

WALK-IN THEFTS AND CONFIDENCE TRICKS

Please be extra vigilant!

Following our item in the January Newsletter, your editor is embarrassed to have to admit that his own wallet was stolen from his consulting room a couple of weeks later. A man entered the building on a busy Monday and asked for some information and to use the toilet. Shortly after he left a second man entered, and from images on the CCTV recording was in the building for over an hour and a half, nipping in and out of rooms as staff left them for some purpose. He was challenged twice and gave a plausible story, only departing when he finally found something to steal – I left the room for literally seconds to get something from reception and noticed him standing in the lobby apparently taking on his mobile phone as if wanting to take a personal call away from the hubbub in the waiting room. 20 minutes later his accomplice was presenting my personal and LMC business bank debit cards in the nearest branch to obtain £800 in cash – which the bank refunded as he had neither my PINs nor any photo identity, although remarkably it seems that neither of these are actually required for a cash withdrawal, just a card and a reasonable attempt at the signature that is on it!

Since then we have heard that a man gained access to a Bridgwater office by following a member of staff through the staff entrance. He was seen leaving the building 4 minutes later. Later an employee was contacted to take an urgent personal call from a man who said he was “Colin Howard, Head of Security from Lloyds TSB” who had been alerted to a suspicious amount of spending on her card that afternoon. She looked in her bag and

discovered her purse had gone. The man said that 21 transactions had been made, but they had a couple on CCTV at a checkout in Bristol who were using her card and he had security ready to pounce on them if she could confirm some information. He said they were looking agitated so she needed to do this quickly before they got suspicious. He asked her to confirm her account numbers, middle name and then asked her for personal identification numbers. The panic and pressure "Colin Howard" created seemed real and she willingly gave the information desperate to stop the transactions. By the time she realised he was a conman the thief had managed to get his hands on over £600, which it looks like the bank will not cover because of the information given.

NHS buildings can never be fully secure, and it is just not possible to function in general practice if one constantly has to lock and unlock doors, but the message must be that if you cannot keep valuables on your person, keep them locked up – and NEVER tell anyone your PIN numbers.

NATIONAL SURVEY OF GP OPINION 2007

A message from Hamish Meldrum, GPC Chairman:

"The survey has now been sent to all GPs so I hope you have all received your copy and found an opportunity to complete it. There will always be arguments about why some questions were included and not others and it's true that we did have some difficult judgements to make. Please complete it before the deadline of 6 July, as it is important that we get a high response rate to ensure meaningful results."

The survey is also available on the BMA website for GPs to complete online <http://www.bma.org.uk?ap.nsf/content/nationalGPSurvey07>

SEVEN DAY PRESCRIPTIONS

Just a reminder that you should not issue short term prescriptions for patients needing medication packed into MDS boxes. Assessing patients for medication compliance aids is now the responsibility of the community pharmacist and is paid for under their new contract, so you should issue normal 28 day prescriptions in such cases.

SUPPORT FOR STAFF AND ASSOCIATE SPECIALIST DOCTORS

BMA members are urged to sign this online petition regretting delays in the SAS grades contract implementation

The BMA Staff and Associate Specialists Committee is seeking the support of all doctors across the profession to support their demand for urgent Treasury approval of the SAS contract and to proceed to a ballot without further delay. Please sign the petition and encourage your colleagues to do the same to support SAS doctors.

<http://www.bma.org.uk>

ASSURA MEDICAL-FAQ

The LMC has been asked by Alison Foulkes the Management Partner at West Somerset Health Care PMS to inform practices who have questions on Assura Medical to contact either herself or Rachel Stark Practice Manager at East Quay Medical Centre, they will address any queries and forward a list if FAQ's.

Please contact either

Alison.foulkes@willitonsurgery.nhs.uk or

Rachel.Stark@eastquaymc.nhs.uk

Small Ads Small Ads Small Ads.....

Pedigree Yellow Labrador Puppies for Sale

The LMC Chairman needs your help!

We have 7 wonderful yellow Labrador puppies that need a good home.

KC Registered with good working pedigree

Mum and Grandma perfect family pets

Dad and Grandad working labs with lovely temperament and excellent with children.

6 Bitches 1 dog, regularly handled by our children, would all make wonderful family pets.

Ready from 7th July onwards

Contact Berge Balian on 07976 295277 (daytime) or 01460 73868 (evenings) for info/photos/viewing.

JENNIFER'S JOURNAL

Obesity is this year's cholesterol - the evil killer of 2007. The trouble is we can hide our cholesterol levels but not our fat. Rumour has it that QOF payments are changing to fines instead. If you have too many fat people on your list then you are going to lose money. So, we are getting ahead of the game and are installing a new revolving front door. As patients approach their height is sensed by a laser beam. When they step into the revolving door their weight is captured by the under-floor scales and their BMI is instantly flashed up. Any one with a BMI above 30 will not get in. The alarms will sound and the internal door will remain shut as they are revolved back out into the street.

Now smoking is not to be allowed in public places, so it will soon be with fat people. Fat people have become associated with ill-health and depression. Why should we look at the obese any more than breathe smoker's cigarette smoke? Why should the doctor be fined for having a fat patient? Let's fine the patients. Just as smokers will be committing a criminal offence for smoking, fat people will be fined for being in a public place.

(At this point Jennifer appears to have fallen asleep, judging by the chardonnay stains on the manuscript and the transition to a scrawl – Ed.)

The Health Police offer a whole new career for fanatics as they patrol shopping centres and country pubs! All citizens must have on their persons Health Licence recording their latest BP and cholesterol levels. The police carry equipment for spot testing. Its not just would be drink-drivers they're after but anyone not complying with the British Health Standard (BHS).

The Government sets targets for every individual. We all have our own BHS target to achieve and each year it is cranked down. Health Care will only be available to those who achieve their target, as will any activity in a public place. Only beautiful people are to be seen. Disease will be banished and the world becomes a better place.....



Meanwhile the ghettos grow. To start with they were depressing tawdry places full of fat smokers. The black market developed and before long the ghettos had the best restaurants with the most unhealthy food. Quality cigars became widespread. The clubs became places of joy, fine wine, laughter and music. Creatives thrived in the environment. The middle classes in the cold outside carrying their BHS cards became more depressed and would pay enormous prices to visit the ghetto clubs and restaurants. Terms of employment in all public services included achieving your BHS target so more and more people were losing their jobs. A crisis developed as the NHS, schools and the civil service could no longer recruit staff. Out of the chaos a new political party grew with Jennifer as its leader. Our motto was 'You can't cheat death so enjoy life while you've got it'. It was a landslide victory. Was there a sudden increase in mortality? We don't know because public health data was banned. Population studies didn't exist and we all died happy.

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

Jennifer

FOOTNOTE

We've asked in previous editions for the longest genuine medical word that you have ever seen in a letter or report. The LMC Chairman, Dr Berge Balian, claims this is the new prize-winner, at 28 letters, "Oligoasthenoteratozoospermia". But perhaps you know better?