

# NORFOLK LOCAL MEDICAL COMMITTEE

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June 2005 Flyer

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Principals' Edition

## Grapefruit to Plummet

NICE is currently inviting contributions for its Appraisal Consultation Document on CHD - statins; the closing date is 11<sup>th</sup> July. If you are desperate to add your two penny-worth then you can do this via the NICE web site. If, on the other hand, you are desperate to invest your two penny-worth then simvastatin shares are likely to be a better bet than grapefruit growers!

## The Norfolk Prescriber Number 61 - June 2005

**Revaxis** The advice given in the article on Revaxis in the June edition of the Norfolk Prescriber has now been superseded.

As you are aware, Revaxis is now only centrally supplied and funding was to cease from 1st June. The PPA has now clarified the situation.

The move to central supply was on 1st April but because practices still had stocks it was agreed this would be reimbursed through April and May. That is where the 1st June date comes from. In the meantime, however, the PPA has received many calls from doctors pointing out that they still have supplies brought in. As a consequence the DOH has advised the PPA that it will continue to be reimbursed for a time so that those of you with stock can be recompensed.

The PPA has advised that it is important that, when seeking reimbursement, practices do not use an FP34 nor the appendix form. They must submit an FP10 in this instance to claim the PA fee.

**New TAG "traffic lights"** One of the intentions of the new GP contract has been to help GPs to control their workload. It has had some success but the June "Norfolk Prescriber" reminds us of another local, evidence-based, consensual mechanism which has also achieved considerable success: TAG and its "traffic light" system. TAG has representatives from PCTs, Hospitals, the Mental Health Trust and the LMC and publishes really helpful guidance about which drugs it is appropriate for secondary care to ask primary care to prescribe. Unfortunately inappropriate request do sneak through occasionally from inexperienced or overburdened colleagues who should know better, or from regional centres (which probably consider themselves "above" local guidelines!)

When in doubt check TAG's "traffic light" guidelines and tell the consultant asap if they or their junior have made a mistake (with a copy to us). Don't put the medication on your repeats list, planning to think about it later - you will forget - and by the time someone picks up on the problem your patient will expect you to continue

to dish out their dangerous and expensive drug and blame you for being awkward, however much you try to explain "prescribing responsibility" to them.

## Rural Dispensing

From Ian Hume, LMC Chairman:

There are several issues which are concerning the LMC with regard to dispensing practices. We know that some small rural practices have for years relied upon dispensing income to support the services they providing to their patients. This has been a very cost effective way on ensuring the viability of rural practice, ensuring high quality care, easy access and convenience for patients, in addition to providing a dispensing service in areas that would otherwise not support a pharmacy. The government seem to be very keen on the concept of super surgeries and large practices. What is needed is a plurality of provision. Large surgeries with additional services in some locations may be the way forward, but we should not undermine the stability of our rural practice and lose some of the unique features that are valued by the rural population.

There are a multitude of factors that have a bearing on dispensing practice. Dispensing profits are superannuable which is clearly an advantage to long-term pension provision but this is not centrally resourced and could lead to cash flow difficulties.

The new Pharmacy Regulations require premises to be registered; at present this is a formality but we do not know how future changes will be handled as a premises relocation of more than 500m will require a fresh application to dispense.

Currently the biggest impact is probably the introduction of the M class drug list. This dramatically cuts the cost of many common drugs, with a consequent decrease in the profit margins. The savings (some £300 million nationally) are being recycled into paying for the pharmacy contract. Unfortunately none of this comes back to the dispensing practices leaving a £30m hole.

The GPC is aware of this and is feeding into negotiations with NHS Employers.

We hope that some of the impact will be softened by the extra resource coming in from the QOF. We also hope that PCTs will see the sense in developing drug incentive schemes that promote cost effective prescribing but which also support rural practices. Longer term there may be significant benefit to be had from practice based commissioning. The present difficulty is that these changes are all happening at once. It is difficult for rural practice to suddenly find

alternative income streams and in some areas it would be impossible. We must not allow the Department of Health to destabilise rural practice.

## 2005 LMC Conference sketch

A "Personal View" from Simon Lockett, Med Sec

The next Flyer will include a full report, informed by the minutes and a period of reflection. In the meantime you will have to make do with the Secretary's befuddled memories of his thirteenth LMC Annual Conference:

### Good things about the 2005 LMC Conference:

1. it remained quorate until the official close
2. no Norfolk member was photographed yawning, scratching, worse for wear after lunch, studiously pretending to read one of the comics during an important speech at the request of a friendly journalist, asleep, pointedly voting differently from everyone else, picking their nose etc
3. the Norfolk LMC representatives
4. Susan
5. democracy works (mostly)
6. staying with old friends
7. coming home

### Bad things about the 2005 LMC Conference:

1. two days of no natural light - in June for heaven's sake
2. decent jokes - few and far between
3. indecent jokes - none (there probably were some at the conference dinner, but the LMC Secretary is too antisocial to go)
4. where have all the "characters" gone?
5. no Norfolk speakers called - maybe explains (4)!
6. only "sensible" motions - maybe explains (5)!

### Weird things about the 2005 LMC Conference:

1. the electronic voting machines: an innovation. Numbered - so THEY KNOW WHO YOU ARE; when used because the arms waving in the air were too close to call the majorities were almost always large - do we have to concentrate harder to press a knob rather than lift an arm? (Turning off the telly is harder than drinking a pint - discuss)
2. the electronic voting machines: how did one find its way to Edinburgh by close of play on the first day? →

3. the electronic voting machines: what would have happened if I had been brave enough to press not "1 for yes" or "2 for no" but 3, or 4 or 5 or 6? Would the platform have disappeared in a puff of smoke? Would share prices or the weather forecast have appeared? If I had pressed 4 and 2 would I have known the answer to the universal question?
4. me

### Venlafaxine

The LMC has received reports of GPs being asked to arrange, or carry out, ECGs and BP monitoring for patients before, or during, venlafaxine treatment. In the LMC's opinion this is an inappropriate request as the CSM recommends that: "... treatment with venlafaxine should be initiated and maintained under specialist supervision only." There is no local shared care agreement for this drug, so the LMC believes it is up to the psychiatrist to organise whatever tests and assessments are required to ensure that it can be used safely.

The LMC is writing to the Trust accordingly.

### Norfolk LMC Membership

Due to pressure of work Dr Andrew Latten has resigned from the "Sessional" doctors constituency of the Norfolk LMC and Dr Siobhan Rowe has resigned from the Southern Norfolk Constituency. The LMC office will be writing to them both to thank them for all their work on behalf of Norfolk's GPs.

Currently there are four vacancies on the LMC:

2 in Southern Norfolk  
1 in Great Yarmouth  
1 "Sessional" doctor

There are nine months left to run of the 2003/2006 LMC and this seems to be an ideal opportunity for anyone who is interested to come along and put their "toe in the water". The Committee will be up for re-election in March 2006.

Please contact Susan Payne on 01953 608060 or email [norfolkLMC@btconnect.com](mailto:norfolkLMC@btconnect.com) if you would be interested in being co-opted. Obviously if we are overwhelmed with applications elections may need to take place - but somehow we suspect not.

### Hepatitis B

When Susan Payne and I die I am sure you will find the words "Hepatitis B" lying in our hearts - or livers. I would not be surprised if the LMC has to invest in a microfiche system in order to stop the entire office being taken over by files on this ever popular subject. Well, there is good news and there is bad news. The good news is that the following Norfolk motion to the LMC Conference was accepted without debate:

*"that GPC should produce definitive guidance on Hepatitis B immunisation including advice on the following issues:*

- ▶ *w h i c h categories of patients GPs must immunise under their GMS or PMS contract*
- ▶ *whether a GP ever has a responsibility to arrange for an occupational health specialist view*
- ▶ *i n w h a t circumstances may a GP legitimately charge their own patients for Hepatitis B immunisation*

▶ *whether exceptions to any of these points are possible in unusual practices, for example a university practice with a high proportion of healthcare workers".*

So sooner or later we should have some answers.

The bad news is that this must mean that no one knows the answers yet but, unfortunately, patients and employers still keep putting the question to GPs.

Until the GPC guidance materializes the Norfolk LMC view remains that there are no circumstances in which a GP can charge patients of his or her practice for immunising them against Hepatitis B and that a GP probably has a responsibility to immunise (as part of essential services) a patient who is clearly at risk of contracting Hepatitis B in their normal occupation. The situation is confusing - or our motion would not have been needed - and employers also have responsibilities to ensure safe work conditions and immunisation for "at-risk" staff. It may even be that employers have a "prime" responsibility - if there is such a thing in law. If so, maybe a GP would not be found culpable if a patient that the GP had declined to immunise until an employer agreed to pay and/or arrange an occupational health assessment, became infected. Whatever the outcome, such an event would not enhance the reputation of general practice and the LMC

would not encourage any Norfolk GP to volunteer to be a test case. We apologise to those who genuinely believe that the LMC should be taking a different, more uncompromising line on this issue.

### Lithium and Read Codes

The Quality and Outcomes software for all of the GP clinical systems will only count the patients that have a lithium level between 0.6 - 1.0. In Norfolk, where we have a central service for monitoring Lithium levels, we have a locally agreed therapeutic range of 0.4 - 0.8. The MH5 indicator requires a record of one of the following in the last six months:

44W80 Lithium level therapeutic  
44W8 Serum lithium level and qualifier normal or value 0.6 - 1.0

It has been agreed that a patient whose lithium level results lie in the range 0.4 - 0.6 may be coded as being in the therapeutic range by adding the code 44W80 to the patient's record. This entry should be given the same date as the original pathology result. By adding this Read coded entry the patient will then be added to the total of patients achieving the target and there will be no need to make a manual adjustment for this indicator at the end of the QOF year.

Our thanks to Jenny Jones, Norwich PCT for this advice.

### CAFCASS

CAFCASS (Children and Family Court Advisory & Support Service) is a government organisation which prepares reports for the courts regarding the arrangements of children. In Norwich CAFCASS deals with the arrangements for Portuguese children when they are disputed by their parents in the Portuguese civil courts. It claims it has no funds to meet any professional fees. The LMC has written to clarify this but suggests that doctors should not comply with requests for reports from this organisation for nothing. We will include a follow-up item in the flyer if and when we find out anything further.

### Hospital scripts - NNUH

Sadly we are still getting reports of additional work being caused to practices by errant hospital prescribing processes. Patients turn up at surgeries with hospital scripts to turn into FP10s. Practices, it is alleged, will be delighted to stop whatever they are doing in order to do someone else's prescribing. Various reasons are given, such as: the hospital has not got the drug, the hospital transport would not wait, the script was lost in the hospital internal post or the hospital pharmacy was shut. As you know from a previous LMC Flyer, there is supposed to be a post box at the NNUH pharmacy for scripts if it is closed - so the medication can be sent to patients. Has anyone ever seen this letter box?

I think the saddest thing about this is that it suggests that some of our hospital colleagues still have no conception of what general practice is about and how it works. Roll on the changes in postgraduate medical education which will, we hope, change that. That is if it is funded properly and premises problems are solved so there are places in practices for potential consultants to sample primary care. But that is another story.

We will, as usual, be raising the hospital scripts

### Appraisers

As we meet different Norfolk PCTs we are aware of some variation in appraiser payments; this is a national phenomenon. We thought Norfolk appraisers might be interested in knowing what some of their colleagues elsewhere want or are getting for this work. Happy negotiating!

**Essex:** £539 (LMC contends this excludes 14% employer's superannuation - PCTs resisting - our money is on Dr Brian Balmer!)

**Birmingham:** £570 including superannuation

**Southern Norfolk:** £500 + 3.225% + superannuation + mileage etc

**Kent:** £516 + a retainer of £1000 pa to cover all other costs including attendance at meetings, travel, 'phone, secretarial etc + 14% employer's superannuation

### MMR imports

A practice locally has expressed concern about the use of unlicensed MMR vaccines. They are right to be cautious. The GPC has said: "... while we do not have a problem with the vaccines themselves we do want the Department of Health to confirm that they are prepared to indemnify GPs for using the unlicensed product. We have written to the DoH accordingly..." We will let you know what transpires.

issue with consultant colleagues at our liaison meetings - lets hope we make some progress (this time).