NORFOLK LOCAL MEDICAL COMMITTEE

Wymondham Medical Centre
The Surgery, Postmill Close
Wymondham,
Norfolk, NR18 0RF
May 2005

May 2005 Flyer

Tel: 01953 608060
Fax: 01953 608061
e-mail:norfolklmc@btconnect.com
Website: www.norfolklmc.org.uk

Dispensing Issues

It can be hard to get the balance right between being alarmist and passing on intelligence so that practices can be informed as they plan their futures. The new pharmacy regulations do affect dispensing doctors - in the last Flyer we advised you about premises registration. The following is the LMC's current understanding of some implications of the new regulations. As ever, there may be differing interpretations, drafting failures (or loopholes!) may come to light and, horror of horrors, there may be test cases which clarify or change our understanding. What is clear is that dispensing practices do need to consider the changes very carefully especially if they are thinking about moving or amalgamating. We are grateful for David Thorne's guidance on this issue.

- Controlled localities and the prejudice test remain
- The mile rule becomes 1.6km
- Dispensing consent will be attached to premises rather than GPs - so if, for example, Drs A B & C successfully apply for consent to dispense to eligible patients from surgeries X and Y, the consent remains in existence for surgeries X and Y even though over the course of time Drs A B and C move on. However if the practice opens a third surgery or moves to another surgery it will have to apply for consent for the new premises
- If a practice relocates more than 500 metres it will have to apply for outline consent again in order to retain dispensing rights. We are advised that only if the PCT considers that there is a significant change does the practice have to re-apply for dispensing consent. The LMC has no reason to believe that they should assume that this is likely to be refused as the effect on existing local pharmacies would be neutral. But it is anybody's guess what would happen if the application coincided with a pharmacy application or a plan for expansion by a nearby pharmacy
- A move of less than 500m would automatically retain dispensing rights
- The concept of "reserved locations" within controlled localities has been introduced. It applies to areas with a registered population of less than 2,750 within 1.6km of a proposed pharmacy. Pharmacies can open in these areas subject to the "necessary or desirable" test only but GPs retain the right to continue dispensing until the population exceeds 2,750 when the pharmacy would have to go through the prejudice tests if it wanted to "take over" GPs' dispensing patients. All patients can opt for pharmacy dispensing if they wish. Reserved location status is not automatic - it has to be granted by the PCT; The LMC has no feel for whether this would be an issue. There is a right of appeal
- A non-dispensing practice located within 1.6km of a pharmacy will not be able to apply for dispensing consent. Existing dispensing practices in these situations are not affected
- If a non dispensing practice merges with a dispensing practice the merged practice will have to apply for outline consent. If it fails to do so, or is refused, the original dispensing practice has residual dispensing rights for its former patients only, but only while working from the original premises
- All existing dispensing premises must be registered with the PCT.

Attached

"Partnerships in General Practice"

Details are attached of the seminar the LMC, along with Lovewell Blake and Lloyds TSB, are organising for the evening of the 7th July.

We are delighted that Dr Peter Holden, GPC Negotiator has, as well as contributing, agreed to chair the meeting. We are also very pleased to announce that Mr Andrew Lockhart-Mirams, of Lockharts the BMA solicitors, has agreed to give a presentation. Mr Lockhart-Mirams was closely involved in the legal aspects of the new GMS contract and his company has prepared a PMS contract which at least one Norfolk PCT has adopted. However, on this occasion he will be talking about "Partnerships".

We anticipate that the evening will be well attended - therefore, **please, please,** if you register and then change your mind let us know - otherwise we may be turning people away unnecessarily

Here we go again: Erythropoietin

You would have thought there was a sufficiency of current battles without going back to re-fight old ones. In the LMC Winter Newsletter of 1994 I wrote about attempts being made by some renal physicians to transfer the prescribing and administration of this drug to general practice. Then, as now, the fundamental issue is clinical responsibility. Norfolk TAG guidelines (and the TAG includes hospital representatives!) list this drug as "Red" - which means it is most certainly the consultant's responsibility. If this changes then there will need to be an agreed, funded shared-care agreement and/or patient pathway signed up to by all parties.

The LMC has received reports that one hospital clinician has made statements to patients that could prejudice the GP patient relationship, even though the GP was acting appropriately within TAG guidelines by declining to be involved. We hope this was an off-the-cuff comment from a stressed hospital colleague.

Remember: do not prescribe Erythropoietin, do not administer Erythropoietin and do let the LMC know if you feel pressure is being put upon you to do either of those things. SRL

MRSA screening

The LMC has received much correspondence on the, no doubt well intentioned, letter sent to practices from the Norfolk and Norwich University Hospital about a "pilot survey with elective orthopaedic patients" asking practices to organise swabs and, if necessary, supervise "decolonising" (or is that de-colon-ising?)

The LMC believes you and your staff should not get involved in this and, what is more, you should not feel at all guilty about it. Enthusiasm is to be commended, but unfortunately the gun seems to have been thoroughly jumped in this instance.

There is an existing process for achieving effective changes in "patient pathways" which is designed to ensure agreement among the parties involved (especially GPs, specialists and the commissioning bodies) and that the results are cost-effective. The LMC understands that the MRSA initiative has not even started along that route (by being raised at the "clinical dialogue group"). There is also the little matter of funding: if anyone is funded to do this work it is the hospital.

PS - it seems to be spreading - a GP has since reported that a patient has been advised by the cardiology department at the NNUH to ask the practice for an MRSA screen prior to admission.

Keep the LMC up to date - please

Whilst the LMC office tries to keep up to date with changes within practices, the way primary care is now organised means it is not always

made aware of changes. Eg the appointment of a new practice manager, a change of address/phone number/ fax etc. In order that we can disseminate information quickly and efficiently we would appreciate being kept in the loop.

SESSIONAL GPs

We have been asked to remind everyone who used to be called "non-principals" but who now have varied titles - under the banner of "Sessional GPs" - of the names and contact points of your representatives on the LMC.

Dr Judi Agnew (Oulton) 01263 587313
Dr Rob Colebrook (Sheringham) 07884 392395
Dr Andy Latten (West Beckham) 01328 878090
Dr John Martin (Stanfield) 01328 701260

Student Care Workers
Health clearance for blood-borne viruses
GPs' responsibilities?

The LMC is hearing from practices that are being approached by students going into, or already on, health related courses. The students are often armed with impressive documents from impressive centres of learning. GPs are unsure what their responsibilities are and, if they agree to help, need to know the funding arrangements for the practice and for the laboratory and for any vaccinations that might be required.

I am afraid that the guidance is not entirely clear but I have not found anything to suggest that carrying out this work is currently part of a GP's terms of service. This does not mean, of course, that GPs could charge their own patients for the work if, for example, they arrange the necessary blood tests in their practices. It must be best for the individual to have testing and any immunisation required carried out by an occupational health service; if that is really not possible, second best would be for them to attend the laboratory which can, as far as I am aware, charge for both the phlebotomy and the testing.

The whole issue is covered, at least to some extent, in the DoH Guidance: *"Health clearance for serious communicable diseases: report from the Ad hoc Risk Assessment Expert Group"* published 18/12/2002. My understanding is that this guidance has not been fully accepted/actioned by the government - which is, of course, part of the problem.

Where the report is helpful is that it summarises which health care workers and students need to be tested because they will not be able to avoid exposure-prone procedures during their training. It also mentions counselling and consent processes which again make an occupational health setting most appropriate. *The groups requiring clearance are:*

....pre-registration dentists, dental nurses, hygienists, therapists, midwives, paramedics, ambulance technicians, podiatric surgeons

For medical students and nursing students the guidance states that, as there is no requirement to perform exposure-prone procedures in order to graduate, it is not compulsory that clearance be sought. Hep B testing for medical students is recommended as is the *offer of* Hep C testing.

Section 7 of the guidance is "Policy Implementation Issues" and at 7.4 it points out that *"the lack of access to specialist occupational health services ..."* is *"a significant obstacle to improving implementation/compliance with screening measures";* and 7.5 includes (there are) *"major implications for recruitment procedures and for admissions to higher education ...."* and mentions the need to ensure *"costs are equitable for all applicants ..."* While these issues are unresolved by the powers that be, it can not be for GPs and/or local laboratories to subsidise the service. If no funding stream has been arranged, and the student's workplace or educational establishment occupational health service does not help, then, sadly, the student may well have to pay. Because of the well known issues with charging a practice's own patients, the hospital may well be where this work ends up.

SFE - Quality Payments

Since the publication of the Statement of Financial Entitlements a drafting error has been found regarding the 60% methodology for the 2005-06 quality aspiration payments. The SFE currently states it is 60% of the 2004-05 achievement payment (defined as total achievement in 2004-05 minus aspiration in 2004-50) when the agreed policy is 60% of total achievements in 2004-05.

The Department of Health has confirmed that this is an error and an amendment will be made. The Department has also confirmed that QMAS makes the correct calculation, so the error in the SFE should not result in practices receiving incorrect aspiration payments in 2005-6.

The Golden Hello Scheme has gone

The "Golden Hello" scheme ended on 31st March 2005. This scheme was additional money provided by the DoH and it was not in the professions gift to hold on to it. It was always made clear that the scheme was time-limited and would be reviewed and replaced in due course.

A new primary care development scheme was due to come into effect on 1st April 2005. Unfortunately the final framework for the new scheme is still awaited from the DoH. Once this is received we understand the GPC will be preparing guidance which the LMC office will circulate via its email cascade to Practice Managers. It will also be posted on the website.

Research in Practice

The Norfolk & Waveney Mental Health Partnership and Norwich Primary Care Trust are jointly organising a course aimed at health professionals with little or no experience of research. It will focus on how to obtain and use research findings to inform and improve clinical practice and will explore how undertaking research can benefit practice.

The course will take place over 26th, 27th and 28th September 2005 at a cost of £150 - although we understand that it will be free for GPs. Anyone who is interested can obtain an application form from: Barbara Staffa, Research & Development Office, St Andrew's House, Norwich, NR7 0HT, 'phone 01603 307346 or email barbara.staffa@norwich-pct.nhs.uk

Vaccine Supplies

Have any practices experienced difficulties in the supply and withdrawal of drugs over the last year, particularly where supplies were given to practices with a very limited use-by date?

If so please forward any receipts of paperwork that highlights this problem as further evidence to present to the ABPI and the DoH.

BMA & ABI Reach Agreement on Fees for GP Reports

The BMA Professional Fees Committee and the Association of British Insurers have agreed a fee increase for GP reports and medical examinations undertaken for life assurance and income protection purposes.

From 1st July 2005 the new fee for a GP report will be £70.50. Medical examinations will be £77.50 and the fee for a supplementary report, at the time of the original request or later, will be £18.00. Increases are linked directly to pay increases for GPs and there is a clause allowing for adjustment in the fees for 2007/08 and 2008/09.

BMA Professional Fees Committee Chairman, Dr Peter Holden, has said that it is important doctors produce reports in the format required rather than reproducing a patient's health record.

Criminal Record Bureau Checks for all NHS Staff

On 13th October 2004, John Hutton announced the government's intentions to introduce Criminal Record Bureau (CRB) Checks for all NHS staff. This would include receptionists, cleaners etc as well as staff who have direct contact with patients.

It is **not** a legal requirement for all NHS recruits to undergo CRB checks at present. If there are steps to introduce such legislation the financial implications to practices will be raised by the GPC.

Further information about CRB checks is available from the BMS website in the September 2004 edition of the Sessional GPs Bulletin.

Advertisement

Retainer Vacancy

Retainer GP required for four sessions per week at five partner, 8100 patient, practice in village east of Norwich.

Practice uses Vision, is paperlight and scored well under QOF.

Please contact Andy Gray, Practice Manager or

Dr Ian Gibson at The Medical Centre, The Dales, Brundall, Norwich NR13 5RP. Tel: 01603 712255.