Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE

February 2009 Edition

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The annual remuneration negotiations between the NHS Employers and the GPC Negotiators have just started. As always, the aim on the GPC side is to ensure that doctors are treated fairly and that rewards are proportional to the effort put in and the results obtained. We wish them well. High on the list of NHSE targets must be the Correction Factor enjoyed by so many practices. The difficulties lie in discovering what lay behind the calculation of the correction factor for each practice. But that information is necessary to make sure that no practice is disadvantaged unfairly.

HIGHLIGHTS OF THE FEBRUARY LMC MEETING
Highlights of the meeting not specifically mentioned in the main body of this Newsletter are at Annex A.

CLINICAL DIRECTED ENHANCED SERVICES IN ENGLAND
The DES directions and SFE amendments were posted to the DH website in the first week of Feb. Their primary purpose is to introduce payment mechanisms relating to the five new clinical DESs relating to alcohol (new section 7H), ethnicity and first language recording (new section 7I), learning difficulties (new section 7J), heart failure (new section 7K) and osteoporosis (new section 7L). There are also minor changes to some definitions in Annex A of the Statement of Financial Entitlements. The GPC assures us that their negotiators are fully aware that the directions and the SFE are being published much later than planned and are currently discussing the problems associated with this significant delay with NHSE. We will keep you informed of any developments.
The DES directions and the SFE amendments can be accessed here: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_094166

COLLABORATION WITH PHARMACISTS
The Government is determined to see pharmacists taking an increasing share of the clinical work in the NHS. To this end the GPC are negotiating in the areas of repeat dispensing and Medicine Use Reviews. You can read all about it in a joint letter from the NHS Employers, the GPC and the PSNC at: http://www.nhsemployers.org/pay-conditions/primary-211.cfm
A summary of the guide to repeat dispensing is at Annex B, with links to the full downloadable documentation. A similar guide to Medicine Use Reviews is at Annex C. The LMC will continue to liaise with the Local Pharmaceutical

Committee. Any local collaboration is for practices to consider.

CHOOSE AND BOOK

As mentioned in last month's newsletter, if a practice has a log of its Choose and Book bookings that failed because of a failure in the system before the new LES was introduced then if the PCT has promised you that it would pay the £4.50 for each of those failed bookings then you should submit the log to the PCT for payment.

PATIENT PARTICIPATION GROUPS (PPGs)

The BMA have recently published a useful guide on what practices might gain from starting a PPG. A summary is at Annex D.

PERSONAL HEALTH BUDGETS

Following Lord Darzi's proposal in 'High Quality Care for All' in June 2008, the DH has launched a 3-year pilot programme on personal health budgets (PHBs). Here is the link to the recently published 'First Steps' document which reports on early lessons and invites expressions of interest in the pilot programme:
http://www.dh.gov.uk/en/Healthcare/OurNHSourfuture/DH_090018
PCT-led pilot sites will be announced in May, and the **deadline for applications is 27 March**.
There are 3 different types of budget under the pilot programme:

1. 'Notional budget' where patients are made aware of the treatment options within a budget constraint and the financial implications of their choices, but the NHS (the commissioner) maintains all service coordination and contracting functions. The DH considers this to be an extension of personal care plans.
2. 'Real budget held by a third party' who helps the patient choose services. Both this and the 'notional' option are already possible within the existing legal framework.
3. 'Healthcare direct payments' are similar to the existing direct payment model in social care: individuals would be given cash payments to purchase and arrange the services they need. This option is subject to new legislation (the Health Bill) and if passed, this option would be piloted from summer 2010. It is currently envisaged that only a very small number of patients, namely those with complex and multiple health needs who are long-term users of the health service, will find that their requirements lend themselves to a personal health budget. It is also anticipated that for the most part budgets will not cover the full scope of NHS services nor those services which might be considered 'core' services, such as acute/emergency care, rather they will cover specific aspects of care, for example mental health services or NHS Continuing Healthcare.

If any practice in Gloucestershire volunteers for, and is selected as, a pilot we would be very interested in hearing your experiences.

NEW HANDBOOK FOR SALARIED GPs

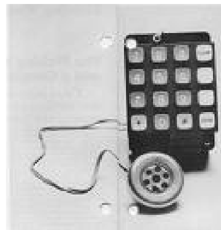
The BMA has launched a new *Salaried GPs Handbook 2009* this past week. It is designed to give employers and employees comprehensive information on the legal and contractual issues facing salaried GPs. A hard copy of the handbook will be sent to all the BMA's salaried GP members and is available to all BMA members on the BMA website. A copy is also held at the LMC.
Please see the following link for more information:
http://www.bma.org.uk/employmentandcontracts/employmentcontracts/salaried_gps/salariedgpbook.jsp

DH GUIDANCE TO PCTs

The Government wants to 'sharpen up' GP Practices and has sent guidance to all PCTs
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093830 to achieve it. This will involve an emphasis on contract management, developing a performance cycle, measuring performance and escalating it. This is to be done practice by practice and the PCT is required by the end of March to have negotiated and signed off objectives and a development plan for each one for the upcoming year. May/June then see the review of the last 12 months performance embodied in a letter to the practice. Quarterly

performance metrics will be posted on the PCT website in Jul, Oct, Jan and Apr. The cycle ends with a review of the performance framework and metrics in Nov/Dec. There is also significant talk in the paper about competition, and the use of APMS contracts, which are said to make it easier for PCTs to make sure that providers are offering the best quality and value for money. Furthermore PCTs are being encouraged to use premises issues as a lever to drive forward changes in the pattern of primary medical care provision, and to implement new models of provision.

TELEPHONE HACKERS
Watch out for another costly misuse of technology. You need to ensure that your practice telephone redirection service used during the weekend etc has all premium numbers barred. There have been incidents, not yet in this county, where criminals hack into the practice telephone system and then use the outgoing line to make calls to those expensive premium rate numbers - the bill still has to be paid by the practice, and it can be considerable.



'BEST PRACTICE'
The BMJ has launched a new website at http://bestpractice.bmj.com/ which aims to give doctors, in effect, an on-line, authoritative second opinion, covering diagnosis, prognosis, treatment and prevention. Do take a moment to view its 5-minute video guide to its services, which should enable you to judge whether or not to use it further.

HEALTH IN PREGNANCY GRANT
From April 2009, mums-to-be who are at least 25 weeks pregnant, and whose due date is on or after 6 Apr 09, can claim a one-off, tax-free payment from HM Revenue & Customs (HMRC) of £190. The payment is called a 'Health in Pregnancy Grant' and is to help the woman prepare for the birth of her baby. The website advice is that they can get the forms from their midwife or doctor. This is the first we have heard of this scheme and these forms. However, the forms are available free from an orderline on 0845 302 1430, which practices should contact.

PRACTICE AGREEMENTS
We have said it before, but it bears repetition: if you have not got a watertight legal partnership agreement in your practice you are risking enormous costs if anything goes wrong.

AGE-RELATED MACULAR DEGENERATION (AMD)
February saw the launch of a national 'be AMD aware' campaign. 'Wet' AMD can cause significant central sight loss within 3 months if untreated. Therapies now exist to treat the condition if caught early on. GPs are therefore being asked to refer suspected cases within 24 hours to the optometrist or eye hospital. The patient should immediately give up smoking and eat lots of green-leafed vegetables. The optometrist should refer cases of Wet AMD on a fast track to the local AMD clinic. Ideally treatment for the condition should start on the same day as the testing in the clinic.

NHS PENSIONS AGENCY
The NHS Pensions Agency has recently contacted the BMA concerning an issue with the completion of forms for individuals applying for retirement owing to ill health. There have been a few cases where, instead of producing a report that includes the specific information/facts required for the relevant condition, the doctor is down-loading the whole medical record onto a CD ROM and posting it in a normal brown envelope. They are then requesting the fee which they would normally receive for a written report rather than a dump of records.

The professional fees subcommittee will be producing some guidance on the correct way to write reports, however, in the interim they have provided some good key points to keep in mind when completing reports:

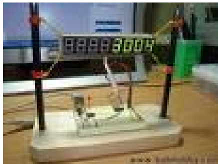
- The information should be provided in the manner requested and should be as complete as possible, providing a

synthesis of essential details from the mass of undifferentiated information on the medical records.

- Reports may be completed electronically or by hand, provided the information is clear.
- The provision of paper or electronic copies of the medical record is not appropriate and is not covered by the patient's consent to the report.
- GPs are responsible for the content of their report and must sign them whether or not practice nurses or administrators have a role in their completion.
- Sending CDs by ordinary post is not a reasonable manner for a practice to undertake its responsibility to protect the confidentiality of patient data, any loss may not only be the subject of legal proceedings but also significant adverse publicity.

LMC COMMUNICATIONS

So many have assured us that they do access the documents on the web, we have had to find out why our hit-counter is failing to do its job. We have investigated, and now discover that if there is a high demand to see a particular webpage (as in this case) every internet service provider involved



puts a copy of the target webpage on whichever of its main computers in the chain is closest to those asking for the information. This 'caching' means that the requesters of the information get it more quickly, less bandwidth is used, and the net operates more effectively. The downside is that the target website does not record the hits as there are none! It is a relief to us to know that the messages are getting through, even though we cannot detect it happening.

OVERSEAS VISITORS

Be aware that the PCT anti-fraud department wants to put on 3 briefings for practice managers and receptionists, possibly with GP attendance at lunchtime, to talk about entitlement of overseas visitors to treatment, and what forged passports might look like. The dates have yet to be fixed – probably in May. GPs have no duty to police the entitlement of patients to free NHS treatment, but in the interests of cooperation may feel they wish to assist.

APHASIA OPEN DAY

Dr Jenny Dautlich DFPH, winner of the 'Outstanding Achiever of the Year' Health and Social Care Award in 2006, suffered multiple strokes which left her dysphasic (having great difficulty communicating). She now helps run a support group for the many people with this condition. It is said to be over 3000 in Gloucestershire, but not all of them are known about. She wonders if you would be so kind as to post the attached leaflet in your surgery to publicise that weekly support is available and that there is an Open Day on 30 Mar.

9TH PLYMOUTH SYMPOSIUM ON OBESITY, DIABETES AND THE METABOLIC SYNDROME THURSDAY, 21ST MAY, 2009 PLYMOUTH POSTGRADUATE MEDICAL CENTRE

Details are now available from the LMC office for this event.

MAX's MUSINGS

My old grandfather was good at figures (arithmetical – his physical figure was as almost as impressive as mine). Then

he retired to flog the water with his dry flies and wet flies and what-not. Everything changed then and he gradually became what was then called 'dotty'. By the end he thought I was my father, was convinced his nurse was his wife, and was quite out of touch with reality. It was the first time I had seen dementia, and I didn't like it. You cannot see anything wrong, but little by little the person you love fades away, leaving a soulless shell. You hope against hope that the real person is inside and will come out again, but my grandfather never did. What was needed then was more knowledge and help, and fewer aluminium saucepans. I did hear a story once of a man going down with Alzheimers who demanded of his wife that no matter what happened to him she was to feed him a high sulphur diet and only use stainless steel utensils. She did. He went absolutely

ga-ga – and then recovered and, so the story went, has since written a book about it. If anyone out there has a copy of the book, or can tell me the reference, I would love to read it. I hear the government will be funding Memory Clinics across the country and will be training us all to recognise the first signs of dementia. I shall have to be more careful where I put my glasses, pen, car keys, diary, mobile phone, pager etc when my young colleagues are around. I remember a cartoon from my early youth in which a female Russian peasant clutching her offspring turns proudly to her husband to tell him, 'Alexei said his first words today – he denounced us!'

I understand that under the forthcoming Coroners and Justice Bill the Government is suggesting that they should be able to use Information Sharing Orders to allow them to share any piece of public sector data for any purpose they wish. Naturally the GPC is fighting this, but I can't help wondering whether this is aimed at covering their tracks when they lose yet another CD or laptop or memory stick.

When I do trust myself to the train services of this country I generally travel first class, more for the extra room than anything else. But having read about the incident in China where a mobile phone exploded, cutting the user's carotid artery, I think I might also ask for a seat in the 'quiet' area. Conversation I can tolerate, especially as my hearing is no longer what it was, but I really can't be dealing with explosions at that time of the morning.

And finally:

Medical Secretaries' Howlers (discovered in Glasgow (as it so happens))

'The patient has no previous history of suicides.'

'Patient has left her white blood cells at another hospital.'

'Patient's medical history has been remarkably insignificant with only a 40 pound weight gain in the past three days.'

'She has no rigors or shaking chills, but her husband states she was very hot in bed last night.'

'Patient has chest pains if she lies on her left side for over year.'

This newsletter was prepared by Mike Forster, LMC Lay Secretary, & the LMC Office

ANNEX A TO
GLOS LMC NEWSLETTER
DATED FEBRUARY 2009

HIGHLIGHTS OF THE FEB 09 LMC MEETING

The LMC considers that, although it is good that the PCT has managed to bring its budget under control, the provision of mental heath treatment and health visiting are both areas that need to be significantly improved. Both are being examined by the PCT and the relevant authorities. Over the next year there will be 40 more psychologists in Gloucestershire, funded mutually by the Government and the 2Gether Trust. It is also planned to simplify access to mental health services, while preserving the right to refer seriously unbalanced individuals to a mental health specialist directly. There is a health-visiting study in progress, and recruitment of health visitors has restarted. GPs are understandably concerned that there is insufficient space in many practices to house either mental health or health visiting clinics; this point is well taken, but is a long-term problem and may require intermediate short-term solutions.

The LMC is hoping to negotiate a sensible compromise with the PCT regarding the triennial update training for GPs and their staff in cervical cytology smear taking – perhaps by having one member of the practice attending the training and then disseminating the information internally to the other practice smear-takers. GPs should not be taken from their work if there is another way of giving them the information they need.

Talks about contracts continue. The LMC's role is to protect the interests of all GPs, and is doing so. It is too early to issue any details.

Document Title: Dispensing with Repeats – a practical guide (2nd Ed)	
Document Originator: NHS National prescribing Centre (NPC)	Document Date: Sep 08
Remarks:	Summary Date: 3 Feb 09
Download Full Doc from: http://www.npci.org.uk/medicines_management/patients/repeatdisp/resources/dwr_for_web.pdf	
Document Summary written by: Mike Forster	
N.B. This summary was correct when issued. Its accuracy cannot be guaranteed in the long term, since policies and organisations change. Although every effort will be made to ensure that it is updated the Reader is urged to exercise caution if the document at the time of reading is more than a year old.	
Bottom Line: For the right patient groups the scheme has merit. It has proved popular and successful elsewhere, and we should be looking positively at it for use in the county.	

The Problem. Two thirds of prescriptions in primary care are for patients needing repeat supplies of regular medicines, involving over 300 million repeat prescriptions and up to 2.7 million hours of GP time.

What it is. Repeat Dispensing (also unofficially called 'batch prescribing') has been available since Oct 05. It gives the clinical prescriber the option of allowing people with chronic conditions that are likely to be stable for the duration of the repeatable prescription (maximum of 12 months) to obtain supplies of their repeat medicines over that time without having to contact the GP whenever they run short. Typical conditions would be hypertension, diabetes and those needing long-term hormone replacement.

How it works. The GP issues a printed (not manuscript) master 'repeatable' prescription on FP10 stating how many instalments are involved. The master prescription is accompanied by a series of 'batch issues', also on FP10, marked with the batch number, the series number e.g. 'Repeat dispensing: 6 of 12' and date of authorisation. Only the original repeatable prescription is signed. Until the Electronic Prescription Service (EPS) is fully implemented the patient will only be able to obtain his medicines from a nominated pharmacist.

Benefits of the scheme:

- Allows the prescriber to carry out at least an annual in-depth review of the clinically appropriate medication, and simplifies life for the patient.
- Saves time for all concerned.
- Although the patient is tied (at present) to one pharmacist, that pharmacist can establish a closer relationship with the patient for medicine use reviews.
- Improves mutual communication between prescriber and pharmacist.
- Reduces waste and risk, and saves money through non-dispensing of drugs the patient does not need.

Putting repeat dispensing in place. The key is communication. The prescriber, pharmacist and patient must all be involved, properly informed, and in agreement. The initiative will often come from the pharmacist, whose National Pharmacy Association has a wealth of advice to give to its members. The PCT needs to be involved also; the lead for repeat dispensing in Gloucestershire PCT is Teresa Middleton. Although only pharmacists must undergo training, PCTs should arrange or even mandate training to encourage and assist efficient adoption of the system. A list of patient inclusion and exclusion criteria is often produced by the PCT, starting small and gradually extending the service to other patient groups. 'When required (PRN)' medicines are best put on separate repeatable prescriptions without a stated interval.

Next Steps. TBD.

ANNEX C TO
GLOS LMC NEWSLETTER
DATED FEBRUARY 2009

Document Title: **Achieving best value from the community pharmacy - Medicines Use Review Service**	
Document Originator: Joint GPC, NHSE, PSNC	Document Date: Jan 09
Remarks:	Date of Summary: 28 Jan 09
Download Full Doc from: http://www.nhsemployers.org/pay-conditions/pay-conditions-4595.cfm	
Document Summary written by: Mike Forster	
N.B. This summary was correct when issued. Its accuracy cannot be guaranteed in the long term, since policies and organisations change. Although every effort will be made to ensure that it is updated the Reader is urged to exercise caution if the document at the time of reading is more than a year old.	
Bottom Line: Patients often get confused and waste many expensive mediciens. The Medicines Use Review is a tool to improve patient's knowledge, understanding and use of their prescribed medicines. For MURs to work effectively the practice and pharmacy must establish direct contact, cooperation and mutual understanding. The MUR does not take the place of a full clinical medication review, nor does it discuss the effectiveness of the treatment.	

Medicines are often wasted: either they are not taken by the patient, or they are used in a way that limits their effectiveness. The aim of the Medicines Use Review (MUR) is to help to ensure that patients take medicines safely and effectively.

The MUR is a structured review carried out by an accredited pharmacist on accredited premises to improve the patient's knowledge, understanding and use of their prescribed medicines. It does NOT involve a discussion on the effectiveness of the treatment based on test results, nor is it a full clinical medication review.

There is a means to report its findings (using an agreed MUR form) to the prescriber, where necessary.

MURs will often be initiated on the basis of patient selection criteria agreed with the PCT, practice etc, but the pharmacist will also have discretion to carry out an MUR if he judges it necessary.

Potential benefits to GPs include: the gathering of information for clinical reviews; the prevention of waste, and more effective use, of prescribed medicines; and the encouragement of patients to consult their GP for clinical reviews.

So far as the patient is concerned, their improved understanding of their condition and treatment should improve their health, confidence and willingness to discuss medicines-related matters with their prescriber.

Successful implementation of the MUR will require effective cooperation, communication and reporting processes between the GP practices and those community pharmacies providing the service.

- It should be targeted at the right patients using suitable criteria.
- It needs agreed referral pathways from GPs etc and corresponding reporting and follow-up procedures with community pharmacies.
- The MURs need to be carried out at the best time.
- The GPs' clinical system needs to carry a Read Code that the patient has received an MUR.
- It would be useful to feed back something positive to the pharmacist, rather than letting their MUR reports drop into a 'black hole'.
- There is a list in the main document of suitable areas that can be reviewed using an MUR.

GLOUCESTERSHIRE LMC DOCUMENT SUMMARY

<table>
<tr><td colspan="2">Document Title: Patient Participation Groups (PPGs)</td></tr>
<tr><td>Document Originator: BMA</td><td>Document Dates: 26 January 2009</td></tr>
<tr><td>Remarks:</td><td>Date of Summary: 12 February 2009</td></tr>
<tr><td colspan="2">Download Full Doc from: http://www.bma.org.uk/patients_public/ppgintro.jsp</td></tr>
<tr><td colspan="2">Document Summary written by: Mike Forster</td></tr>
<tr><td colspan="2">N.B. This summary was correct when issued. Its accuracy cannot be guaranteed in the long term, since policies and organisations change. Although every effort will be made to ensure that it is updated the Reader is urged to exercise caution if the document at the time of reading is more than a year old.</td></tr>
<tr><td colspan="2">Bottom Line: Although setting up a PPG will, at least initially, take practice time, effort and expense, the help and support a well-motivated and active PPG can give a practice is worth the investment.</td></tr>
</table>

Patient Participation Groups (PPGs) are formed under the auspices of the National Association of Patient Participation (NAPP). The guidance note covers 4 important areas: why to have a PPG in the first place, how to set one up, how to run it and how to sustain it.

Why have a PPG anyway? PPGs bring patients and practice staff closer together, providing a valuable means of passing information to patients, and of obtaining feedback and fresh ideas. A PPG also has a respected voice when provision of local healthcare is being discussed; this can help to protect practices from unreasonable changes and support the best possible implementation of good changes. The Local Government Association recommends their formation as they can provide a closer relationship with the Local Involvement Network (LINk). A PPG could also improve accountability for PBC.

How to set up a PPG. Like all projects, initial planning is vital. The point of contact in the PCT is Caroline Smith (Ext 1514). Initially it might make sense to limit the scope, though that can always be reviewed later. All the partners and staff need to be behind the scheme or it could be seen as a problem rather than as a solution, not least because it is going to cost the practice money and cause some extra work for staff, especially in the early stages. Clear aims are essential, especially the desired benefits for patients and practice from its activities. GP partner representation is highly desirable, as is the regular turnover of membership to maintain interest and introduce new ideas. Recruitment will not be easy in the early stages; democratic elections may have to give way to appointment by invitation. Diversity of membership is also important, but initially difficult to achieve.

Running a PPG. In case there is anyone out there who has never organised meetings etc then the guide gives an almost blow-by-blow account of how to do it successfully.

Sustaining the PPG. This addresses issues as various as charitable status, finance, reports, maintaining interest and recruitment, and moral and ethical considerations.