

# NORFOLK LOCAL MEDICAL COMMITTEE

“Serving the Practitioners in the County of Norfolk”



June 2006

## PENSIONS CAP

The pensions cap is now a serious issue as it is limiting the pensions of those who joined after 1989. It may mean that some GPs will only be able to pay contributions on about two thirds of their actual NHS earnings and hence their eventual pension will be based on that too. So after forty years they will not get half their earnings but half of two thirds of their earnings. We suggest that if you joined the scheme after 1989 you discuss this with your accountants.

## THE STATUTORY LEVY

The Committee has not raised the statutory levy for several years. This year the LMC has increased payments to members by 3.225% - I think a rather modest sum when compared with the new contract increases. In the light of this, and the fact that the statutory levy has not been increased for several years, the Committee is requesting an increase of 5% from practices. This is arranged by ESS and is fully tax allowable. SRL, LMC Treasurer

## PERSONALLY ADMINISTERED

**Q:** When is "personally administered" not "personally administered"?

**A:** When the "person" is the patient, not the practitioner

While following up a complex query involving VAT, pharmacists' clinical governance arrangements and the current pathway for methotrexate injections (being made up by a hospital pharmacy and supplied to a surgery), the Secretary has come across an issue that might trip up practices. The same difficulty could occur with any injections that are dispensed by practices (even for non-dispensing patients) as they are usually "personally administered" by GPs or practice nurses. This problem arises if the patient wishes to self-administer their injection. If that is the case the practice can no longer dispense the injection to a non-dispensing patient and must not suggest on the script that the injection has been personally administered - that would be fraud - obtaining inappropriate dispensing profit.

At least one practice was under the impression that the PPA is aware of this as an issue and has given its tacit approval for the imaginative use of the "personally administered" label but I am afraid that the GPC is aware of no such arrangements - so I would urge practices to stick to the letter of the law and give pharmacist work to pharmacists. SRL

## COLLABORATIVE ARRANGEMENTS and the notification of infectious diseases

An eagle eyed GP has noticed that notification of infectious diseases was included in some of the lists about "collaborative arrangement" work (so practices could, at least in theory, set their own fees which would, wholly reasonably, be a lot more than the current derisory payments). The LMC enquired of the GPC whether this was

indeed the case and has received an answer - unfortunately it is one of the less informative kind. It advises that *"this would be an occasion on which an ethical and clinical judgement would supersede any fee setting and that individual GPs would need to fulfil their obligations"*. So now you know. I assume they mean that if the black death breaks out in your practice area you are supposed to tell someone - even if a goat is all that is on offer. SRL

## 2006/07 INTERIM DYNAMISING FACTOR

This will be of little interest to some of you and lots to others.....The GPC, NHS Employers and the Health Departments have now agreed the interim dynamising factor for 2006-07.

The **interim figure** for 2006-07 will be 1.0% (NB, it can never be less than 1.0)

The **final figure** for 2006-07 is judged likely to be around 2.6%

As with 2005-06, the 1.0% interim figure was agreed according to the statistical analysis provided by the Technical Steering Committee which determined there was 90% confidence that the final figure would be higher than 1%.

The interim figure announced will only affect those GPs who receive their pension between 01.04.06. and 31.03.07. This provides retiring GPs with a more realistic pension. All other GPs will have their earnings increased by the final figure that will be announced in 2008. Pensions taken between 01.04.06. and 31.03.07. will be recalculated by the NHS Pensions Agency once the final factor is determined and they will arrange for the amended pension (with any arrears due) to be paid.

☺ if you find that one of your partners has highlighted this item and drawn lots of smiley faces on it - then it is time to start advertising.

## VENLAFAXINE and ECGs

At last - helpful advice! This issue was causing some stress for GPs who resented being asked to do consultant psychiatrist work; (and, I dare say, for consultant psychiatrists who wondered if they could remember how to read ECGs!)

You should have received updated prescribing advice for Venlafaxine from Professor G Duff, Chairman, Commission on Human Medicines. I won't repeat all the clinical stuff here (I hope The Norfolk Prescriber will) but the ECG issue appears to be resolved, as the requirement for a baseline ECG has been removed from product information.

Specialist supervision (including shared care arrangements) is now only required for initiation of Venlafaxine treatment in those severely depressed or hospitalised patients who require doses of 300mg daily, or more. Regular measurement of blood pressure is recommended for patients receiving Venlafaxine. For patients who experience a sustained increase in blood pressure, either dose reduction or discontinuation should be considered.

## DANGERS OF TRAVEL

THE LMC office has heard a rumour that some practices may be sailing close to the wind when charging for travel advice. If anyone does charge for *'researching'* the vaccinations needed by NHS patients who plan to travel abroad then I am afraid that I have to advise you that this is improper. SRL

**GPC Advice:** *"practices need to be very careful here. Some of this is a private service and some available on the NHS and so they run a serious risk of being accused of charging for something which is available on the NHS. The advice we would always give is to build in additional charges into the (private) vaccine charge"*.

## FLU PANDEMIC

The joint RCGP/GPC Flu Pandemic Emergency Planning Group has produced a practical guide on infection control to help practices plan for and respond to the threat of pandemic flu. See [bma.org.uk/ap.nsf/Content/Hubflupandemicpreparations](http://bma.org.uk/ap.nsf/Content/Hubflupandemicpreparations).

## PERFORMING RIGHTS SOCIETY (PRS) Campaign Targeting GP Surgeries

*With many thanks to Devon LMC and the GPC:*

Practices require a licence to play music even if they have purchased a TV licence. The PRS is conducting a health campaign targeting GP surgeries and you may be contacted: See [www.prs.co.uk/health](http://www.prs.co.uk/health), but basically.....

- ▶ If you are already playing music in the waiting room you will need to pay a higher charge for the first year and then a standard charge for subsequent years
- ▶ If you are not playing music but are going to in the near future you will be charged at the standard rate
- ▶ The tariff also varies depending on the number of seats in the waiting room
- ▶ If you are using a CD player as well as a TV/radio the number of seats included in the fee reduces
- ▶ Any extra seats incur an extra charge!

Regarding the "other licence" a practice requires to play music in the waiting room - see [www.ppluk.com](http://www.ppluk.com). The licence money obtained from PPL goes to record companies and performers and the money paid to the PRS goes to composers and publishers, which is why you are required to have two licenses.

The PPL fee is £88.11 plus VAT regardless of how much or how little you play recordings. Also, depending upon how your system is set up, there may be a license fee for having telephone music when on hold.

## THE CONFERENCE OF LMCS 2006

Attached is Simon Lockett's personal reflections on the goings on at Conference. Enjoy! →

## 24 HOUR RETIREMENT

Further information is still awaited following the changes to the requirements for GPs who wish to return to work after retirement. In the meantime GPs should be aware that although the GPC can confirm that the required period of retirement has been reduced to twenty-four hours, the process remains the same with the same problems, particularly for single-handed doctors. Definitive guidance is awaited.

## NATIONAL DIABETES SURVEY

The Healthcare Commission (HC) has resurrected a proposal to send a survey to practices on a diabetes audit. Having finally consulted with the GPC it is re-releasing the survey which will contain the covering note:

*"We have also consulted with the GP Committee of the BMA who are content that practices, that wish to do so, should take part."*

This makes it clear that this is an entirely voluntary exercise and that GPs do not need to get involved. The HC looked at practical issues and made further reassurances about the safety/reliability of the software. What is now clear is that the survey is voluntary so practices do not have to participate unless they choose to, which should remove the concern about extra practice workload. If you do participate you may choose whether the PCT or the practice run the survey.

## eGFR & CKD

The QOF sub-group of the BMA has discussed the many issues that LMCs have raised about eGFR and the QOF CKD indicators. Both sides acknowledge that the indicators, and the work that could flow from them, have raised problems that had not been anticipated. Further guidance is being prepared, with the "expert panel" advising on how work on these indicators can be taken forward.

## PRACTICE BASED COMMISSIONING & CLINICAL GOVERNANCE DIALOGUE

NNUH Education Centre, 7 pm on 12th July  
This meeting is aimed at Lead GPs involved in PBC (and their clinical teams) and is an opportunity to meet with the NNUH Clinical Leads of Diabetes, Respiratory, Diagnostic Imaging, Dermatology and the Divisional Directors of Medicine, Women & Children's Services and Support Services. Refreshments & buffet. Contact: Rachel Leeds on 01603 813844 or email [Rachel.Leeds@norfolk.nhs.uk](mailto:Rachel.Leeds@norfolk.nhs.uk).

## CHOOSE & BOOK June Aspiration Target

Following calls from LMCs the GPC has now negotiated with NHS Employers to remove the June target on which aspiration for the Choose & Book DES was to be based. All practices have to do now is to aspire to use C&B to get their aspiration payment. However, just as before, what they keep is dependent on use of C&B in between September 2006 and the end of

February 2007. This hasn't changed.

The June target was intended to get practices (and PCTs) to start using C&B well before September so that they have a reasonable chance to hit the 50% mark. Removing the target means more practices will get the aspiration payment but there is a greater risk of some finding it clawed back if they don't start using C&B as soon as they can rather than delaying until September. However, just as before, if the system can't be used for reasons out of the control of the practice (assuming of course that they are trying to use it) they should be recording these failures and the PCT should take these in to account at the end of the year.

If practices have achieved the June target then they will only be entitled to the same aspiration as other practices who commit to use it. However, if the June target has been met it is hopefully a good sign that the September to February target will also be met and therefore avoiding claw back of payment. The SFE and DES Directions that support this change should be available shortly.

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For further information contact: Ms J McCarthy, Practice Manager, St Clement's Surgery, 24 Marshland Street, Terrington St Clement, Kings Lynn, PE34 4NE, Tel: 01553 828475 or email [jane.mccarthy@nhs.net](mailto:jane.mccarthy@nhs.net) or [cal.deane@nhs.net](mailto:cal.deane@nhs.net)

## PASSPORTS

We thought we had cracked this one when, back in March 2001, the Cabinet Office "Making a Difference - Reducing GP Paperwork" Project clearly said that "GPs will no longer be expected to counter sign passport applications". However we are now hearing that the Passport Office in Liverpool is suggesting that patients approach their GP for proof of address and confirmation that the patient has been seen in the last 3 years! We understand that the Passport Office thought about letting GPs 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!

Please can you let the LMC office know of any approaches you may have from the Passport Agency. The GPC will be taking this up with them (and the Better Regulation Executive). Guidance is quite clear regarding - this is not NHS work and GPs are advised not to participate.

## NATIONAL BOWEL SCREENING

You may have already received details of this National Programme. It has been piloted in Warwickshire and Tayside and will be rolled out nationwide in the next three years. In Norfolk it is planned to start shortly with a target

population of 60-69 year old patients in the "central cluster" of PCTs. We have been told there is no direct GP involvement- and that it is more like breast screening than cervical screening. Kits will be sent out by the regional hub and second stage screening will be done at the NNUH. GPs will be copied into results and will doubtless get questions from patients. The hub will provide a helpline number and will deal with patient queries. There is reference in the booklet to a "discernible, albeit modest" impact on primary care workload. Let the LMC office know if you come across any problems and we will do what we can to resolve them.

### Advertisement

#### NEW MEDICAL STUDENT TEACHING OPPORTUNITY IN DEREHAM

Have you always wanted to teach medical students but been worried at the amount of time and effort it might take, or lacked support from your practice? We can offer the opportunity to teach undergraduate medical students on Monday or Friday afternoons as part of the Dereham undergraduate teaching project.

Organisation, administration and amazing teaching facilities will be provided by the Dereham Teaching and Learning Centre and the three Dereham practices will be hosting the students for clinical experience in the mornings and providing patients to support your group teaching in the afternoons.

This will suit a partner, a part-timer, or a sessional GP who is interested in getting involved in teaching but can't spare a whole day or who does not have the facilities in their regular place of work.

If you would like to get in touch with us for more information and informal discussion please contact:

David Barns, Senior Administration Assistant to Primary Care Group, School of Medicine, Health Policy & Practice, UEA, Norwich, NR4 7TJ, [d.barns@uea.ac.uk](mailto:d.barns@uea.ac.uk) and tel. 01603 593929

## MISUSE OF DRUGS REGULATIONS

Home Office Ministers have now signed off the Misuse of Drugs Regulations Amendments. They will require practices to make some changes in procedures and the timescale is short. A copy of the Regulations/Explanatory Memorandum were e-mailed to your practice on 14th June 2006.

## "THE NON & NEW PRINCIPALS GROUP" Department of GP Continuing Professional Development, NANIME

A further meeting is to take place at NANIME (NNUH) on 20th July commencing at 7.15. For further info tel: Carol Meager on 01603 286882

## AGREEMENT TO INVESTIGATION/TREATMENT Colonscopy/Flexible Sigmoidoscopy

A GP reported that a patient asked to her sign this form to confirm the patient's consent to the procedure. The NNUH GI Dept assures us that

it has never been their intention for GPs to become involved and that patients should be referred back to them.