

NORFOLK LOCAL MEDICAL COMMITTEE

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October 2006 Flyer

Welcome to our Waveney Constituents whose first flyer this will be. We hope that you will find it useful and will be willing to respond as and when appropriate. We would also be only too happy to consider contributions in future.

Norfolk LMC and the Primary Care Trusts

In case you have missed it - and you had only to blink - the local NHS has undergone yet another change. Five PCTs joined together to form the Norfolk PCT and GPs in Gt Yarmouth left the Norfolk fold and became part of the Great Yarmouth & Waveney PCT. GPs in Yarmouth & Waveney were consulted and as a result we won't be saying goodbye to the Yarmouth Practices instead, as you can see from the banner above, we have pleasure in welcoming colleagues in Waveney. As ever in the NHS this change to be implemented with unseemly haste and we are working to ensure that the LMC's constitution properly reflects the interests of the GPs in both PCT areas. In the meantime it is business as usual for the LMC office.

Choose & Book DES

I had hoped by now to be able to advise practices which are hoping to receive payment for component two of the "choice and booking" DES what evidence they should keep in case the IT continues to cause problems and does not record correctly the number of patients referred.

I wrote to the former PCTs on 8th September and raised the matter with nascent nearly-Norfolk primary care leads on 21st September 2006. They acknowledged that there is a problem and "further work is required on how best to manage this on a coherent PCT-wide basis". They stated that problems may result in delayed payments but that practices should be paid for any work done. Reassuring as far as it goes, I suppose, but it doesn't really get us any farther forward. I may be being unduly cynical, but I suspect that ensuring that practices receive full and proper payment for everything they do is not high on the list of priorities for the new PCTs.

I can only suggest that you either give up on this DES or keep appropriate evidence (which might even have to be paper based) to aid you on doomsday. With luck practice clinical systems are up to doing this if you can find a decent Read code - but the way ours keeps falling over when anyone is unwise enough to link us to the spine, who knows? SRL

Financial Recovery in Norfolk PCT

The text for today is taken from Hilary Daniels recent epistle to the GPs entitled (possibly ironically) "Financial Recovery in Norfolk". I apologise to the Great Yarmouth and Waveney congregations for taking up space with Norfolk PCT specific stuff - I really hope this item remains uncanonical for you. (Sorry, I really shouldn't write on Sundays).

The third paragraph of the letter included the following "Initial examination would suggest that against national benchmark information primary care funding to Norfolk practices is considerably above the national average...". No doubt this is true - it is the result of Norfolk GPs having understood the pre-1990 contract and working with a supportive FPC which encouraged high quality staff and premises development. A model worth following I would suggest! However,

the sentence continues "...and above the weighted capitation allocation for primary care received by the PCT." I am less certain that this is true. The end of the paragraph does acknowledge the good primary care services available locally - so I am probably being unduly sensitive in even wondering if the earlier part is meant to "soften us up" by implying that practices are getting more than they should.

Your Secretary was under the impression that PCT allocations reflected (GMS) practices' Global Sum and MPIG - so is seeking clarification. Perhaps there are other funding streams where Norfolk primary care is thought to be "over-performing" by those who have no idea about what we do.

GMS remuneration in the new contract is, of course, mapped through from the previous contract. You will recall that consisted of two parts, GPs' personal income - as set by the Review Body as fair in comparison with what others get - and expenses. These were calculated from tax returns - ie the actual amount that practices cost to run. It is therefore illogical to suggest that "efficiency" (or any other) savings are possible. If anyone tells you that you should make your practice run on less, or fund it by working even harder or reducing your wholly legitimate income, then I suggest you say "No". This is a word that we are all going to need to practice saying - at least until the next pre-election give-away budget.

Note: I do apologise for the bitter and twisted content of this item. This is, of course, entirely due to the lads being whipped 3-0 by West Brom today and has nothing to do with being p----d off that some people appear to believe that GPs' contracts can be varied by one party alone (unlike, no doubt, their own three-week-rolling-contracts). SRL, Sunday 22nd

Potential Pension Pandemonium

And speaking of reneging on freely entered into agreements.... You may be aware that not everyone is glad that GPs have made a success of the new contract by rising to its challenges and improving patient care. The powers that be are trying not to honour new contract pension arrangements by trying to introduce a "cap" - so the hard work that practices have done would not increase pensions in the usual manner. The GPC feels very strongly on the matter and it is likely that giving way would lead to high profile resignations. Nevertheless, we live in a world where disagreements often turn into compromises. So anyone who is about to make an irrevocable decision to retire may want to take a brief "time out" before committing him or herself - until it becomes clearer what the government is up to.

The Gt Yarmouth and Waveney GP Alliance meet 5/11, venue to be announced. We would welcome any Gt Yarmouth GPs who want to come along to see if this is a vehicle that they could use for local issues (eg JPH issues). Nigel Drane (Ndrane9562@aol.com)

Errata: WN GPs please note for requests for hospital transport to QEH & Nth Cambs ring 0845 602 9205 and not as previously advised

Drug Switches, the Norfolk Grey List and Thrift in general

You will have noticed by now that PCTs believe that a lot of money can be saved for the local NHS by drug switches. You will almost certainly have seen stuff extolling generic Simvastatin and you will soon hear about the "Norfolk Grey List" - if you have not already.

The LMC's view is that drug treatment has far better evidence than much else that we do. GPs who prescribe in an unorthodox way must be very confident indeed that they have good grounds for going against the evidence, especially if they are behaving differently from most other GPs. The majority of GPs around the country clearly believe that Simvastatin is a good drug, appropriate for first line use. It is much cheaper for the NHS than other statins, so it would be hard to justify using anything else apart for individual patients where problems with intolerance or failure to achieve the required cholesterol levels have occurred (and are documented).

Of course, it is true that drugs in a particular class vary in tolerability and efficacy; also our personal experience of either prescribing or taking drugs will influence our opinions and our prescribing; the Secretary feels fine on his Simvastatin. Nevertheless, the LMC view is that it is fraught with difficulty if one acts contrary to the science because of unreliable evidence from those whose job is promoting a product, personal impression or any other spurious influence.

The GMC does make it clear that doctors have a responsibility to use limited NHS resources wisely. The LMC believes that the case is clear for statin switches. This is not to say that the LMC accepts this as a precedent for all times and for all switches. For example, if PCTs began to put pressure on doctors to make monthly changes - according to what was the "loss leader" that month - the LMC would be unlikely to support the PCT. The burden of bureaucracy and the risk of confusion among patients would argue against such a policy.

Norfolk PCT Grey List

I may be courting controversy here but this looks like a list of mostly crap drugs with some nasty examples of drug company trickery intended to preserve income as lucrative drugs went off patent. If you can prove the "rationale for inclusion" is untrue fair enough - carry on prescribing, but if not ... That being said, if they really want us to stop prescribing co-proxamol they will have to stop the stuff being made (I thought that was supposed to have happened ages ago). Actually in the current climate I am surprised they don't want us to put everyone on it - as it costs peanuts.

On the more general issue of pressure being put on practices to save money by working

differently, the LMC believes it is important for practices to be able to justify what they do, especially if what they do is different from what other practices do and costs more. I realise that I am running the risk of sounding like the (failed) PEC Chair that I was - once upon a (very depressing) time. I don't mean to. PCTs will undoubtedly come up with some very silly cost-cutting suggestions that would harm patient care, reduce GP morale and risk the future of general practice - even though it is one of the greatest successes of the NHS. Defeating the daft is likely to be a lot easier if we do not try to defend the indefensible as well. SRL

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Insane register

Constituents are getting concerned about the less than speedy sorting of the Read Code fiasco which is including depression in MH 8 even though this register is meant to be patients with schizophrenia, bipolar disorder and "other psychoses" (stet).

I understand that the appropriate GPC subgroup will get a chance to see the revised Data Set and Business Rules at the end of this month which means that IT suppliers are unlikely to receive the final version until the end of November or beginning of December. Not good news.

I guess practices can hope for a (national) IT solution, or a "fudge" with PCTs agreeing proper payment after 31st March 2007 whatever the figures show, or consider re-coding depression as "depressive disorder" which does not seem to cause the same problem (though, for all I know, might cause a different one). SRL

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GT Retainer

We are looking for a GP retainer for up to 4 sessions per week. For more details please contact Heather Watts, Practice Manager, Willow Wood Surgery, Aslake Close, Sprowston, Norwich NR7 8TT or tel: 01603 425608

GP Returners: GPC Guidance - available from LMC office or www.norfolmc.org.uk.

Dispensing Services Quality Scheme

Well there's good news and there's bad news about this. The good news is probably more for the PCTs than it is for practices. Apparently the scheme is being funded from savings generated by the change in VAT treatment in dispensing practices, such that PCTs will actually see a net financial gain even if all practices sign up for, and fully achieve, this enhanced service. The bad news is that it may well not be worthwhile for some practices to even attempt to achieve it. A practice with a small number of dispensing patients, particularly if it employs several part-time dispensers, might well find the additional

training required to be prohibitive in cost and staff time. There is a risk with a scheme like this that what is "enhanced" practice may come to be seen as *good practice*, which may in turn come to be seen as *normal practice*. This is clearly an **enhanced service** and therefore not achieving it is perfectly consistent with a practice employing safe and effective dispensers.

The Health Professions Council

A Waveney constituent has reported that the HPC continues to request prospective members (eg dietitians, chiropodists, arts therapists etc) to obtain their GP's OK that they are in good health. GPC advice is that completion of HPC reference forms is not a GMS contractual obligation (although PMS GPs should check their contracts) and therefore you may refuse or charge a fee and....

The General Dental Council

The GDC recently introduced a requirement for all prospective registrants to have a health reference form completed by their GP. The BMA has raised concerns and is in discussion with the GDC. In the meantime the BMA Professional Fees Committee has confirmed that completion of these forms does not form part of a GP's Terms of Service and therefore they may charge.

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The DVD has been produced with a grant from the Norfolk and Norwich Hospital Institute for Medical Education and we are happy to sell you copies at cost price. We would ask you not to duplicate it, but copies and further information can be obtained from:

Dr. Tony Press / Elaine Paice, The Doctors Surgery Great Melton Rd, Hethersett Norwich NR9 3DH, 01603 811649 E-mail: elaine.paice@nh.net Price £ 9.00 each including VAT and post/packing (Cheques payable to Humbleyard Practice - no credit cards)

Too Nice x 2

1 Practices may well have been in receipt of a letter inviting them to be accommodating with regard to Hepatitis B immunisations for *police personnel*. It is always difficult when fellow GPs, albeit wearing occupational health hats, write to colleagues asking them to be generous but I would urge you to continue to use the

GPC's excellent guidance on Hepatitis B immunisation for occupational health purposes which means, I am afraid, that you should not help out. It is a minefield if you do, with the risk of not only using up your own time or your nurses' time doing work that you should not be doing but also costing the NHS (if NHS prescriptions are written or immunisation testing creeps through under the wire) for work that should be funded in another way.

2 I am sure it can have escaped nobody that the local NHS believes itself to be in a financial crisis. Debts that would have (perhaps) rolled over in the past are being called in by the Treasury. There is likely to be pressure, greater than any of us practising can remember, on all aspects of NHS spending. When it is harder and harder to earn the money practices require to run it may become easier to realise that we do need to say "no" to unfunded work and to concentrate on the work we are supposed to be doing. For example, some of the new QOF targets are going to be difficult to hit. There is clearly a better chance of hitting them if staff are concentrating on that rather than, for example, providing unfunded stitch removals or doing dressings that a trust should be doing and has been paid for.

Subfertility Services & NNUH

We have been asked by Mr Morris, Clinical Director of O&G at the NNUH to remind GPs that his Department does not offer a service for the management of subfertility. We understand they have been receiving increasing numbers of requests for fertility opinions.

Heel Ultrasound & Peripheral DXA Scans

The EoE Regional DXA Strategy Group wrote to all practices at the beginning of October warning about osteoporosis scans offered by "non regulated independent commercial providers". This issue had already been brought to our attention by the Theatre Royal Surgery in Dereham and we would urge you to treat any of these reports with caution and judge each case on its clinical merits, using the appropriate guidelines as to whether they should have a proper scan or not.

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