

LMC NEWS

Cornwall & Isles of Scilly Local Medical Committee

IN THIS MONTH'S NEWSLETTER :-

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Your Chairman writes

Another 'Consultation' wings its way toward you from DoH, this time on the future of QOF. I spent a day in Birmingham telling them what they already knew on the Pharmacy W.P., they listened and I hope they heard. The deadline for submissions is Nov 20 for Pharmacy, and much later for QOF; it is important we each put in our submission as there is strength in numbers. The clear message from the Pharmacy events has been 'if it ain't broke....', however the temptation to meddle may be unbearable for those living in the rural wilderness of Kensington and Chelsea. Listening Events are to be held on the QOF changes, we will be

represented. The particular issue of local QOF will be contentious, as this should be paid for and funded through LESs and not have money extracted from QOF.

The LMC is still unhappy about the probity of installing the Apollo data-mining software on Practice systems. It is clearly expedient, but whether it is appropriate to lose control of data you store on your patient's behalf without their consent is another matter. Alternative methods for data verification are being looked at that would leave practices in control but will be more cumbersome. I have also held discussions with the PCT about the use and transmission of electronic data by Outlook SW as part of a national project. Again an assumption of 'implied consent' was used to allow sensitive data to be sent outside the practice for research purposes. I understand this has stopped while an appropriate explanatory leaflet and consent form are written. Both the PCT and Outlook reacted quickly to what was, in essence, a national problem. It is timely to remind you that you should seek written confidentiality agreements from everyone who accesses your systems, and that Caldicott guardians do have genuine responsibilities.

General Practice is often, it seems the backstop or sinkhole when other people's systems become dysfunctional or overstretched. It is worth checking the regulations before agreeing to a reconciliation of patient names on a screening register, or, dare I suggest, performing pre and post op work. Should we subsidise the cost of national research projects by checking patient details for free, or should that have been included in the costs and generate a fee? In each case someone else is either being paid for a task they are not carrying out, or have assumed we will subsidise their livelihoods with our staff time.

A Word to the Wise.

Unless and until changes are made to the regs., Practices should remember it is illegal to sell such items as 'pregnancy testing kits, to registered patients.

Continuing Care Reports

We have recently picked up this article from Wessex which very neatly summarises the situation with continuing care reports, and it is reprinted for your information.

“More and more GPs are being asked to provide Continuing Care Reports.

A GP is required to always act in his patient’s best interests and this information should only be provided with the patient’s consent.

It is not obligatory to provide any report if it is:

- Not part of the essential services as detailed in the New Contract and therefore included in the global sum.
- Not included in the Schedule 4 List of Prescribed Certificates under the new GMS 2 regulations.

If a GP chooses to provide such a report he or she may charge a fee.

Practical Clarification

If a report is required purely for the purposes of making an administrative funding and / or rationing decision, and is not for the purposes of a clinical decision on treatment. This is most definitely not essential services and a fee may be charged. It is sensible to agree the fee before compiling the report to avoid any subsequent misunderstanding.

A full clinical assessment is required as part of a comprehensive care record.

A consultant or other clinician in a multidisciplinary team would normally prepare this. If a GP is required to do so a fee may be charged. It is sensible to agree the fee before compiling the report to avoid any subsequent misunderstanding.

A brief list of major diagnoses is required to assist a placement decision (palliative care for example). This is part of essential clinical services and no fee is permitted.

A brief list of major diagnoses is required to confirm a specific diagnosis that will enable a clinical practitioner to make an individual decision about treatment or support. This is part of essential services and no fee is permitted.

GMC Registration

Just a gentle reminder to all GPs and perhaps their practice managers to make certain that all GPs working within your surgery have current GMC registration.

A number of cases have occurred where the registration has lapsed, often the GP did not have a direct debit in place, did not inform the GMC of a change of address and the Practice did not have a robust system in place for checking ongoing Registration.

All GPs should check their current registration status, this can be done via the GMC website

All GPs should inform the GMC of any change of address

All practices should have a system in place that checks the status of each and every GP working in the practice, this should include the GMC registration and MDO cover.

GPs are now a threat to national security!

You will be alarmed to hear that in another part of the country a GP, who was not engaged in C & B, or GP2GP has received the following from his PCT.

“If you have an N£ connection (Internet) then you are part of the Connecting for Health programme even if you are not engaged with certain aspects such as Choose & Book or GP2GP.

The N3 connection means that you must sign the Information Governance Statement of Compliance to ensure that you are adhering to all current legislation. Failure to do this would mean that the PCT had to report you to the Healthcare Commission who in turn would investigate and report this to MI5 as it is classified as a risk to national security.

Ultimately the Healthcare Commission following the investigation would make recommendations on the suitability for continued practice.”

You just could not make this up if you tried.

For the last three years General Practice has been overpaid and underworked according to the Department, and that s for signing a contract the Department wanted, and general practice did not,. Now it is a treat to national security,. Next I predict that proof has been found that a GP was spotted entering the Northern Rock B/Soc just before it folded, and another GP was found to be chairman of a international Bank with a fundamentally unsound business model.

Screening for MCADD

Screening for MCADD (Medium Chain Acyl CoA Dehydrogenase Deficiency) is due to start for all babies screened at the Bristol Newborn Screening Laboratory from October 1st.

MCADD is a serious condition caused by lack of an enzyme required to convert stored fat to energy. The incidence is about 1:10,000 births.

The short term effects are low blood sugar, coma and sudden death and the long term effect is neurodisability.

The test will be performed on the newborn blood spot and should identify about 60 cases per year in England.

Once babies are identified and given simple treatment, the risks of acute, life-threatening episodes needing emergency and intensive care and of death are substantially reduced.

All screen positive results will be notified by the NSL to the GP to ensure appropriate follow up care is in place.

Further information can be obtained by contacting the Bristol Newborn Screening Laboratory or by following this link www.newbornscreening-bloodspot.org.uk

We do not anticipate that this will cause problems in general practice, if in reality it does, please let us know.

Staff checks CRB etc

The NHS E is shortly to release a new series of instructions regarding vetting and barring of staff in relations to safeguarding vulnerable people.

A comprehensive FAQs papers has been received by the LMC and has been posted on the LMC website for your information.

Changes to prevalence weighting

The BMA has sent through the following explanation of the changes to the prevalence weighting. It is copied word for word as it seems to summarise the situation quite well.

“You will be aware that part of the recent agreement with NHS Employers embodied a move to true prevalence over a relatively short period of time. The extract from the agreement is as follows:

Prevalence

We agree that the current prevalence arrangements (used to determine QOF payments) will be amended over two financial years in the following way:

on 1 April 2009, the square rooting component of the current arrangements will be discontinued

on 1 April 2010, true prevalence will be used to determine QOF payments, i.e. the current cut off arrangements will be discontinued.

The overall effects of these changes are broadly cash neutral as they will largely redistribute QOF resources between GP practices. However, it is recognised that a small number of practices may experience a significant loss in their current QOF income. As a consequence, the following guidance will be issued by Health Departments to their PCOs:

“PCOs should work with practices which identify themselves as experiencing a significant loss in their income to understand the impact of the changed arrangements on their current service provision.

PCOs will also wish to use the opportunity to consider the local health needs of populations and, working with LMCs and practices to identify whether new services or improvements in care should be commissioned to address these local needs.”

This is in line with LMC Conference policy. Since the new contract was negotiated, many GPs have expressed to us their dissatisfaction with the square rooting mechanism and its perceived unfairness. We therefore sought a way to remedy this, but as the solution needed to be cost neutral it was inevitable that practices would be affected in different ways – some gaining, and some losing.

While most practices will welcome this, we are well aware that there are practices that will lose significant amounts of money as a result of the move. During the negotiations, it was recognised by both sides that these practices must be supported by PCTs and that different arrangements – possibly involving the negotiation of LESs – would need to be made to ensure that these practices were not compromised. It was felt that dealing with the relatively small number of big outliers could probably only be done at local level because of the particular nature of the practices concerned. For this reason, we agreed a reasonably strong form of words and it is certainly the intention of all the negotiating parties that action will be taken locally to deal with this.”

The expectation is that very few practices will be effected, those that will include practices with high student populations and few elderly. However as the whole exercise is supposed to be self financing it must mean that if there are any gainers in the system, there will be losers. We are advised that we will be able to find out which practices might be effected by the change and when we do, we will contact them and see what we can negotiate locally. At present we have no more information than you do.

**Good Medical Care for Elderly
People,
A Study Day**

**Organised by RCGP Tamar Faculty &
Elderly Care Physicians, Exeter**

Tuesday, 2 December 2008

**Exeter Postgraduate Medical Centre
For further details, please contact the
faculty office**

**Tel 01392 262744, Email
liz.bell@pms.ac.uk**

**Consultation on QOF revision—
developing a new, independent
process**

The Department of Health has now launched a consultation on a new process that is independent for future changes to the QOF.

It can be found on:

[http://www.dh.gov.uk/en/Consultations/
Liveconsultations/DH_089778](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_089778)

The new style of consultation continues with the DoH giving specific questions it is looking for responses, a form for completion and an end to the consultation on 2 February 2009

13 / 18 week wait problems

GPs are advised that the lead officer for Choose and Book has changed yet again, however Terry Goldsworth is now leading on the achievement of 13 / 18 week waits.

If you have any problems, for example with patients being bounced for practices asking for re-referred, please let Terry know and she will sort it out.

**Her email address is:
Terry.Goldworthy@CIOSPCT.
cornwall.nhs.uk**

**Have you ever wanted to become a member of the RCGP and
not known how to go about it?**

The RCGP is offering the potential for established GPs (of more than two years' standing) to become members of the College (MRCGP) through an interim arrangement (iMAP – Interim Membership by Assessment of Performance). This is a portfolio based assessment. Candidates must be eligible for independent practice (normally) in the UK or the HM armed forces for at least two years immediately preceding their application. The cost for associate members of the College is £2,300 which is payable in three instalments - £900 at application, £700 upon submission of portfolio and £700 when called for oral assessment. For non-members, the cost is £2,530 split into £990, £770 and £770 paid at the same stages.

This is a window of opportunity which will close in July 2009. After this date, all those wishing to be members will be required to complete an assessment route similar to the nMRCGP assessment with a portfolio equivalent to Workplace Based Assessment. For further information, visit www.rcgp.org.uk and follow the links to GP Training - iMAP or contact the iMAP office on imap@rcgp.org.uk

Methotrexate Injections

There has been some concern about the initiation of methotrexate injections within secondary care, but asking primary to prescribe.

Our understanding is that the process should be:

- Rheumatology nurse has initial appointment with patient makes a supply and describes how to administer, how to dispose of injection and may mention in future that the GP will be asked to prescribe
- Patient returns for second visit, sees Mr Scott, further supply made, if everything ok, patient told that future supplies may be obtained from GP, if GP agrees to prescribe. Mr Scott e-mails practice with standard letter to establish whether happy to prescribe or not.
- It was accepted that a number of GPs may feel unable to take over this prescribing.
- If there are any further queries please contact Mike Wilcock via groupwise.

Locum Pensions

Locum GPs are reminded that if they spend more than three months not having any employment within the NHS, their current employment with the NHS Superannuation scheme will end.

It will restart when they do their next NHS employment, and they will earn benefits at whatever rates apply at that date.

Clinical Engagement and the Darzi Report Meeting

Sir Ian Carruthers, Ann James and others will talk on clinical engagement and the Darzi Report, and what is next for Cornwall. There will also be a panel discussion.

This meeting is a must for strategic, tactical and operational thinkers and planners.

The meeting will be held at the Knowledge Spa, Treliiske on the evening of 15th December 2008, supper will be provided.

MPs

The BMA's Parliamentary Unit has written to all Westminster MPs inviting them to visit a GP practice in their constituency before the end of the year. The initiative is one part of a wider campaign by the unit to raise MPs' awareness of the issues facing GPs.

Within Cornwall these requests have been focused through the LMC office and we have managed to obtain a number of willing volunteer practices who all have issues of services that would be of interest to the MP.

So for example we have:

- A dispensing practice
- A practice that needs replacement premises,
- A practice who has used the increased income to redesign their surgery
- A practice who provides a wide range of non GMS services

If you are approached directly by the MP for your area, please let Dawn at the LMC office know.

HPV Immunisation: Quick-reference guideline responses to requests for out-of-programme immunisation

Aims

To provide a consistent approach across Cornwall and Isles of Scilly to the cervical cancer prevention strategy
 To support the Department of Health national programme
 To avoid undermining the DH choice of vaccine by recommending the use of Cervarix first-line
 To issue basic prescribing guidelines for HPV vaccines outside the target cohorts

Scenario	Response
Patient within cohort requesting Gardasil instead of Cervarix	Only Cervarix is available under the NHS programme. Patient (or parent) demand for Gardasil requires careful explanation that Cervarix will provide the required cancer protection. Gardasil can only be provided privately and this is not available to registered patients – another surgery or provider may be able to offer this. Gardasil may be offered on the NHS only if there is a clinical need, or a genuine severe latex allergy but will require an FP10 prescription to be issued for dispensing No LES payment is payable however this will count towards the target %
Patient in school years 9-12 this year requesting vaccination	The vaccination programme will provide catch-up cover for these girls over the next two years. If they are not sexually active and not exposed to the virus then the delay is not a problem. If they believe they are at risk they should discuss this with their GP If the GP identifies a clinical need to vaccinate early, an FP10 prescription for Cervarix should be issued. No LES payment is payable however this will count towards the target % for the year the girl was originally due to be vaccinated
Patients in school year 9-12 this year requesting contraception/STI advice	HPV vaccination should be discussed and consideration given to earlier vaccination if at risk of exposure. The expectation is that Cervarix is offered on an FP10 prescription for consistency unless individual circumstances dictate this to be inappropriate No LES payment is payable however this will count towards the target % for the year the girl was originally due to be vaccinated
Female >age 18 outside the cohort requesting vaccination	Vaccination is appropriate if not yet or only just sexually active. The expectation is that Cervarix is offered on FP10 prescription for consistency No LES payment is payable
Female > age 18 outside the cohort with established sexual activity.	The probability of exposure is unknown but routine immunisation was deemed not cost-effective by the JCVI as efficacy of the vaccine will be significantly reduced. The patient should be encouraged to attend regular cervical screening
Female >age 25	The vaccine is not licensed
Heterosexual male	Vaccination is not offered under the NHS programme. The patient may be advised to seek a private source but inform them that Cervarix is not licensed for males and Gardasil is only licensed for males aged 9-15 years
Homosexual male	They are potentially at increased risk of penile and anal margin cancers. Cervarix is not licensed for males and Gardasil is only licensed for males aged 9-15 years. If not yet or only just sexually active off- license vaccination using Gardasil may be considered on FP10 prescription but this must be accompanied by appropriate counselling and the decision clearly documented. Safe sex and STI screening messages should be reinforced.

*Episode Cinq/Cinque/Cinco/Pende/Pet/
Khamisa (or the number between 4 and 6 for
the less well travelled reader)*

*[The story so far: Special agents Basildon Bond
and Dolores Downunder have been recruited
by the Cornwall and Isles of Scilly LMC to take
on dastardly bounder Sir Liam Harrumphier up
at the Sadistic Health Authority who, along with
his sidekick Lord Dafti, has sinister plans to
destroy rural general practice...]*

Faced with the prospect of Sir Liam's six and a half year old godson Totali Barmi opening a string of pharmacies all over the Grand Duchy and putting Cornish dispensing GPs out of business, LMC Supremo G had gone for a lie down while Miss Spendapenny soothed his furrowed brow with an imaginative use of methods outlined in the Camping For Girls publication "One hundred and one things to do with a vegetable marrow and a box of matches on a rainy day in Mevagissey" (Volume 8).

Dolores and I turned to each other, but as she was a foot taller than me she looked straight over the top of my head. The only way I was going to be able to stop her peering down on my bald spot was to do handstands, and then she would notice I had odd socks on. That wouldn't have been so bad but I also had odd shoes on. And inside those were a pair of very odd feet with some very peculiar toes.

I decided to engage her in a face to face conversation so I found a large box to stand on. This babe was statuesque. She was on a pedestal, had an arm missing, was a grubby grey colour, and was covered in pigeon crap.

Then I suddenly remembered the golden specially adapted Sim's Speculum that LMC Boffin Simon Le Bonk had been about to demonstrate to Dolores and I in Episode Four when he had been interrupted in full flow. Prostatism is a terrible bind. The sinister looking metal object was glinting in its box but there was no sign of Le Bonk who had done a bunk and worse, no sign whatsoever of a book of instructions as to just exactly how this medieval gynaecological contraption was supposed to help us in our mission to rid the world of Sir Liam Harrumphier and his ilk*. [* an "Ilk" is a tiny moose –Sir Liam had a pet one called Charlotte which was his constant companion].

Suddenly Miss Spendapenny appeared at the door looking somewhat flushed and clutching a

very battered looking marrow and a handful of bent matches. "I will shop at Waitrose in future" she complained by way of explanation and then added "You need to leave now. You are in immediate danger. There is a Jehovah's Witness at the front door trying to sell issues of The Watchtower."

"Quick, the tradesman's entrance" yelled Dolores.

"NO" Miss Spendapenny huskily implored us. Then she did an impersonation of a Labrador, followed by a Dachsund. "That way lies even greater danger" she barked.

"What? Somebody trying to sell the Big Issue?" I panicked.

"Worse, it's Dr Jonah Blackberry from the Peeceetee wanting to talk to you about your prescribing costs. Quick, climb into the refuse chute" she urged.

Pausing only to grab the box containing the golden speculum I found myself being bundled unceremoniously into the rubbish chute along with my aussie companion. Her perfume had a hauntingly familiar aroma until I recognised the unmistakable whiff of vegemite. We tumbled over and over and finally were ejected out onto a pavement in a St Austell side alley.

We clambered unsteadily to our feet and dusted ourselves down trying to remove the coating of used teabags and discarded fag ends that adhered to our special agent designer clothing. Sadly Woolworth's got the Secret Service contract so I am kitted out in the latest Ladybird fashions, but at least the short trousers show off my very manly knees to their best advantage.

"What horrible knees you've got" observed my companion.

Before I could respond I heard the unsettling twang of a long bow, the hiss as the arrow flew through the air, and the indescribable agonisingly excruciating searing unbearable discomfort with a score of 11 on the 1-10 pain scale.... *[alright Basil, we get the picture: Ed]*

Well it jolly well hurt

To be continued....