April 2015 - Issue 13

Newsletter

North Staffordshire LOCAL MEDICAL COMMITTEE

Professional advice for General Practice

In this issue .....

Amber/Red prescribing & "Why isn't chemotherapy available over the counter"?

Why isn't chemotherapy available over the counter? Any patient would be able to tell you the most easy answer to this: "Because it is unsafe". Patients also appreciate that you can get some drugs from any corner shop, late night garage, or even hotel vending machine. Paracetamol is an example of this. Therefore, I think doctors would have no difficulty explaining that not all drugs are equal: some are more complicated than others. It is not much of a leap of faith to explain that some medications may fall between these two extremes and so some, but not every doctor may be willing or able to prescribe every prescription drug they come across. Furthermore, patients appreciate that a GP cannot know everything: as evidenced by requests by patients for referral to see a specialist, even sometimes when a GP is more than capable and more than happy to manage the condition with which they present! Yet when the boot is on the other foot and a GP feels uncomfortable prescribing a drug and wishes the hospital to prescribe; why do patients seem to fully expect we should "just prescribe the drug"? The answer unfortunately is that it is the hospital.

When secondary care is involved with our patients there is a complex three way relationship at play between GP, patient and hospital. It is unfortunate to note that when it comes to amber, red and non-formulary prescribing; there appears to be a collusion between hospital and patient that undermines the clear logic shown above that "not all drugs are equal" and therefore not all drugs are safe to be prescribed by a GP in every case.

GPC News

Click here for the latest GPC Newsletter

The collusion comes in many forms. There is the "convenience to patients" collusion. There is the "if your GP does not prescribe the drug you will go without it" collusion. There is the "the GP simply must prescribe it, they have no choice" collusion. There is the "there is no prescriber in the hospital available" collusion. Of course, ignorance of shared care arrangements, new to follow up appointment pressures, workload, budgetary constraints undoubtedly play a part; but one might say they play a part in both primary care and secondary care. The hospital arguments are false. Up with this collusion general practice should not put.

I usually admire the "just do it" ethos of general practice. But in this situation, often the pressure of the patient needing the drug and the hospital refusing to prescribe, places a GP under so much pressure that it is easier to "just do it" and risk unsafe prescribing than the effort of getting the hospital to prescribe and the risk of a patient complaint.

The "just do it" ethos is perpetuating unsafe prescribing, reinforces the myths used in the hospital collusion with patients, and risks worsening the recruitment and retention issue in general practice.

We do not question the laboratory refusal to test a sample with a missing DOB. It is annoying when it happens. The patient needs the test, but we realise that safety is at the heart of the policy. So why do we not equally say no to requests that do not get properly handed over by the hospital using the necessary paperwork and with the necessary support?

So if the prescribing request is inappropriate:

-Send the request back to the hospital using;
"Template response to inappropriate prescribing requests" (which can be found on the LMC website here)

-Place the code "shared care prescribing declined" (8BM6) in the notes.

-Datix the request and send an anonymised copy to the LMC.
-Use this article to explain your reasoning to patients.

You are not being obstructive or officious. You are just being safe.

Dr James Parsons
LMC Treasurer

Workforce Minimum dataset

The contentious national requirement for GP practices to provide a comprehensive data set about their staff has been reviewed by the GPC, which has issued the following guidance. You will note from the document that the work involved in providing these data is not resourced, but the GPC is advising LMCs to seek funding for practices from local commissioners. The LMC has therefore written to the Area Team of NHS England on behalf of practices, seeking financial support to compile the data. A response is awaited.

BMA sessional GP newsletter-April

The major features this month are the new national GP Induction and Refreshers Scheme and the sessional GP specific findings from the recent GP survey. It also features news and information aimed at supporting sessional GPs as well as blogs from sessional GPs, including one from Dr Bill Vennells about receiving feedback.

The April edition of the sessional GP e-newsletter is available here

Pharmacy Flu Campaign

Last winter saw the introduction of a pharmacy flu campaign in Staffordshire/Shropshire, in direct competition with GP practices. Public Health England have undertaken an evaluation of the scheme, and despite the fact that pharmacies only managed to do approximately 0.6% of all vaccinations, and despite strong objections from the LMC, the scheme is set to be

continued in 2015-16. No official announcement has been made yet, but it is thought that pharmacies will only be allowed to vaccinate patients age 16-65 in the at risk groups.

Staffordshire Diabetic Eye Screening Service

Following a query from a practice, the LMC has written to the Diabetic Eye Screening Service regarding the letters they send out to practices to ascertain whether diabetic patients are able to attend a screening centre. The LMC has suggested that the letters would be better addressed to patients or their carers. The questions raised on the form are really best answered by the patient (or their carer) themselves, leaving GPs often guessing how to answer them. The LMC asked the screen service to consider changing their routine of writing to GPs to obtain this information, to writing to patients direct in future.

Dr Andrew Brown, Clinical Lead for Staffordshire Diabetic Eye Screening Service responded saying that they had reviewed the process for "medical exclusion". If the service holds patient details and also has information regarding the reason for medical exclusion, the medical exclusion process will be actioned by the clinical lead (Dr Andrew Brown) or one of the clinical staff without the need to contact the patient's GP at all.

It is more problematic for patients who have never attended for screening examinations and these fall into two groups a) patients who have been invited for screening twice (and have failed to respond to both invites), and b) patients who, following an invitation for screening, contact the programme informing the Screening Service that there is a medical reason why they cant attend. For both these groups of patients, national protocol dictates the following:

- That the Diabetic Eye Screening Service contacts the GP of patients in group A to confirm if there is known medical reason why the patient cannot attend

- That the Diabetic Eye Screening Service contacts the GP of patients in group B to confirm the medical conditions

Dr Andrew Brown assured the LMC that he would try and keep requests to GPs concerning this issue to an absolute minimum.

Risk Stratification Tool

The CCGs have been in discussions with the LMC about the adoption of a risk stratification tool by practices. It is felt that the improved quality of patient data generated by this can help practices target their resources more effectively, and possibly reduce morbidity and hospital admissions. The LMC is not against the use of a risk stratification tool in principle, but has concerns that the knowledge gained from using this tool cannot be "unknown" or ignored, and may therefore generate more (unfunded) work for practices. Because of this the CCGs have promised to rewrite the risk stratification policy, taking account of these concerns.

Personal Health Budgets

Following further discussions between the LMC and CCG commissioners it has now been agreed that it is NOT the patient's GP's responsibility to support and sign a patient's application form for a Personal Health Budget. The application form will be amended to make this clear to the patient. Of course this would not prevent GPs from signing the form, should they wish to.

Hepatitis vaccines for patients

For patients who require Hepatitis vaccines for work purposes (where the employer does not have occupational health), practices can choose to either decline the work or accept. When accepting practices can either charge the employer, or simply claim for the immunisation. Practices should never charge the patient.

The BMA has some recent guidance on this.

LMC Officers

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Primary Care Support Services - changes to financial arrangements

Practices will be aware that from 31.1.5 NHS NHS England Area Team de-commissioned the service of processing payments on behalf of CCGs, but continued to make payments to the end of March 2015. Dr Ken Deacon from the Area Team will be in attendance at next month's LMC meeting to discuss the new financial arrangements, and we will update practices accordingly.

We have been informed by the CCG that if practices wish to receive remittance statements electronically from Wakefield, this can be set up by calling the following number **0303 123 1177**.

Outcomes from April LMC meeting

Public Health alcohol brief interventions LIS - North Staffs CCG area

The LMC has been informed that this will be funded at £2.13 per patient and will be rolled out in May.

NHS Health checks Stoke

The normal fee for health checks has not increased i.e. the fee before a GP reaches the 60% target. The Secretary asked for a formal RAG rating for this and has informed Public Health that there has to be some uplift and recognition as these targets are difficult to achieve. Public Health have agreed to increase the achievement fee by £2.50 but the normal fee has stayed at £20. **The committee RAG rated the normal fee ORANGE.**

ASPC
is affiliated with the RCGP, RCS and ASGBI. The conference might be of interest to any local GP's who operate or are thinking of operating in the community.

INNOVATION . OPPORTUNITIES . CHALLENGES

ASPC Annual Conference

Hinckley Island Hotel, Leicester

A conference for all with an interest in community surgery.
Clinicians and allied professionals, doctors in training, nurses, HCAs, managers, commissioners and regulators – we welcome you.

Friday 12th June | 09.00 – 17.00|Followed by dinner
- Risk Management - MDU
- From Florida, renown vasectomist Dr Doug Stein
- Revalidation, Community Surgery GP's - GMC
- Raising the profile of your service using social media
- Address from senior NHS commissioner
- The future of community surgery

Saturday 13th June | 09.00 – 16.00 | Including Lunch
- Glove up for practical workshops
- Improve your techniques
- Explore new procedures
- Training and Mentorship
- Bespoke sessions for Managers inc CQC and Contracts
- Training for Practice Nurses and HCA's who assist with procedures

For further information contact lisa.gregory@aspc-uk.net or visit our website www.aspc-uk.net

	Members	Non Members	Training Grade	Nurses/ Managers
Both Days	£150	£225	£150	£75
Friday	£100	£150	£100	£50
Saturday	£100	£150	£100	£50
Friday Dinner	£30	£30	£30	£30

ASPC
Association of Surgeons in Primary Care