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SOUTH STAFFORDSHIRE LMC NEWS

Website: www.sslmc.co.uk E-mail: enquiry@sslmc.co.uk

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CCG CONSTITUTIONS

The relationship between Clinical Commissioning Groups (CCGs) and practices should be characterised by genuine clinical engagement and collaboration. The CCG should not be seen to regulate or penalise practices and practices need to feel empowered to hold their CCG to account for the decisions made on their behalf. The CCG constitution will play an important role in determining the relationship between practices and CCGs.

All CCGs are working towards becoming NHS statutory bodies on 1st April 2013. To achieve this they all have to successfully complete an authorisation process. In order to be authorised, a CCG is required to have a constitution outlining a robust governance structure, with the support of member practices. The constitution will define the governance and operating policies of the CCG and will impact on the relationship between practices and the CCG. It is therefore essential that every practice understands the components of the CCG Constitution.

The four CCGs in South Staffordshire have used different firms of lawyers to work on the Department of Health template CCG Constitution. The LMC has forwarded the draft constitutions to the BMA lawyer for advice. The LMC would consider observer status on the board but not be a voting member. A suitable sentence in a CCG Constitution would therefore be:

'The role of the LMC

LMCs are independent bodies and the statutory representatives of the GP profession and an provide an important but separated role from the CCG. It is important that there are effective working relationships in order to ensure that the aims and objectives of clinical commissioning are achieved whilst ensuring the appropriate safeguards for the profession and individual practitioners.

The LMC will hold full observer status on the Governing Board and the Chair of the CCG will regularly attend meetings of the LMC by invitation to provide updates, briefings and respond to individual areas of concern. Other opportunities for engagement will be set out in the member practice engagement strategy.

The LMC also plays an important role in independently running the election process for locality GP representation.'

The LMC will be happy to support the revised constitutions when the amendments from the BMA lawyer are included together with the sentence on the role of the LMC. Please note the LMC does not provide 'a seal of approval' for the CCG constitutions.

INFORMATION GOVERNANCE

The use of data for commissioning is a challenge for Information Governance and practices. Commissioners require accurate, timely data from multiple sources in order to make informed decisions, but the linkage of this data must not compromise patient confidentiality. GPs need to be clear that as Caldecott guardians they are responsible for ensuring that Patient Identifiable does not leave their practices.

Dame Fiona Caldicott is leading a review that is considering the balance between protecting confidential patient information and sharing it to improve patient care. The BMA is submitting written and oral evidence to the review, emphasising that the benefits of data sharing must be achieved within an information governance framework that protects patient confidentiality.

QUALITY OF GP REFERRALS

A consultant colleague has queried the quality of some GP referrals which are along the lines of 'this patient's HBA1C was 7.3 at Christmas and is now 8.2 - please see and advise.' Unfortunately the letters have no drug list, past medical history or description of what current care has been offered to the patient.

The LMC does not need to remind colleagues about their GMC responsibility in appropriate communications with colleagues but feels that the description of the quality of GP referral falls below the acceptable.

TO RECORD OR NOT TO RECORD UNSOCIAL INCIDENTS

GPs have a GMC duty to "keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment."

They also must provide good clinical care "adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient."

The GMC also describes the doctor-patient relationship which is "based on openness, trust and good communication".

It would therefore seem appropriate to record behaviour traits that might influence how a patient is treated. The GP would need to share these concerns with the patient if they were thought to be impairing the doctor-patient relationship.

The LMC would urge caution in how these traits are being recorded and be mindful of the patient's right to access their medical information. The GP might have to justify any entries in the records that might be thought later to be derogatory, discriminatory or prejudiced.

Joint RCGP and GPC guidance on Good Medical Practice can be read on pages 9 and 30 which mention record keeping and the doctor-patient partnership.

The LMC has no policy on this issue other than the GMC guidance on Good Medical Practice and would direct your colleagues to their Defence Organisation if they have concerns.

DECLARATION OF FITNESS IN RELATIONSHIP TO PARACHUTE JUMPING FOR CHARITY

A patient has requested a statement of fitness so he can jump out of a plane for 'charity'. The LMC's advice is that the patient should be informed there would be a charge to perform a medical examination and countersign his form stating that he would be fit. There is no obligation for GPs to 'sign them for free'.

Practices need to decide a clear policy that all of the GPs follow. Signing of these type of forms is not GMS and are a private procedure for which you are entitled to charge.

Many GPs feel that medico legally this is an area that is not without risk so advice may be required from your defence organisation.

CHOICE OF GP PRACTICE

The DH has produced guidance for PCTs dated 26 January 2012 concerning the choice of GP practice. Please note the following which is an extract from paragraph 6.

6. Open and Closed Lists

6.1. We intend to make the system of practice lists more transparent for patients, so that they can be clear whether or not a list is open or closed to new registrations.

6.2. A practice's list of patients must be either open or closed.

6.3. An open list means that a practice is able to accept applications to join its list. A practice with an open list can refuse an application only where it has non-discriminatory grounds for doing so.

6.4. When a list is closed, a practice may only accept applications to join its list from immediate family members of its registered patients. Practices have to gain approval from their PCT to achieve this status.

6.5. Under the current arrangements, practices may have to give up providing additional or enhanced services in order to close their list. This has led to some practices declaring their list "open but full". This is not a legally recognised term within the contractual arrangements, and it is confusing for patients.

6.6. PCTs currently agree a time period of up to 12 months for a practice's list to remain closed, but with a default of 12 months in the absence of an agreed shorter period.

6.7. From 2012/13, we intend to introduce legislation which will simplify the processes so that there are no incentives for practices to seek to declare "open but full" lists and so that there is a shorter default period for a closed list. Under the new arrangements, our proposals include:

The new list closure procedure to start with a practice making a written submission to their PCT setting out the reasons for seeking to close their list: this will be a new requirement, replacing and expanding on the current 'closure notice';

The restriction on a practice's ability to withdraw its application to be removed;

The discretionary discussions with the practice in stage 2 to become mandatory (currently a mandatory discussion must take place at stage 1, with further discretionary discussions at stage 2);

When determining a practice's application, the PCT to be required to consider explicitly the effect of the list closure on patients;

The practice to have more say over the closure period and to be able to re-open the list when it wishes, subject to a notice period;

There will no longer be provisions that allow lists to re-open and close according to rises and falls in list sizes (the so-called "ping pong" arrangements);

The assessment panel procedure to be abolished; and

A practice with a closed list to retain its right to deliver additional and enhanced services, and any proposal for withdrawal from such services to follow the normal contractual rules.

PARTNERSHIP AGREEMENTS AND CCGS

The GPC advises that each partnership should have discussions about the need for the GP representative for CCG matters to be defined and described in partnership agreements. This will be important where a combined decision on a matter is required from a practice especially where the votes generally tend to be allocated on the basis of 1:1000 patients.

LMC ELECTIONS

We have two vacancies for elections to the LMC in East Staffordshire and Seisdon districts. Please consider coming forward and joining the LMC at this important time.

Dr David Dickson
LMC Secretary

DATES OF NEXT MEETINGS

20th Sept South Staffordshire LMC **PCT**
Mid Staffordshire Postgraduate Medical Centre, Stafford

11th Sept South Staffordshire LMC **LMC**
Samuel Johnson Community Hospital, Lichfield

The meetings with the **LMC** are for the full committee of LMC members without the PCT.

The meetings with the **PCT** are for the LMC Executive and the PCT alone.

LMC MEMBERS

The following is a list of current members of the South Staffs LMC

Dr V Singh (Chairman)	01543 870580
Dr D Dickson (Secretary)	01283 564848
Dr P Gregory (Executive member)	01543 682611
Dr G Kaul (Executive member)	01543 414311
Dr P Needham (Executive member)	01283 565200
Dr T Scheel (Executive member)	01283 845555
Dr A Burlinson and Dr O Barron (job share)	01889 562145
Dr J Chandra	01543 870560
Dr J Eames	01785 815555
Dr A Elalfy	01785 252244
Dr C McKinlay	01283 564848
Dr E Odber	08444 773012
Dr A Parkes	01827 68511
Dr C Pidsley (Treasurer)	01283 500896
Dr P Reddy	08444 770924
Dr A Selvam	01543 571650
Dr E Wilson	01922 415515
Dr A Yi	01543 870590
Dr H Zein-Elabdin	01922 413207

DR V SPLEEN

Dear Reader

The ascent of man has been accompanied by countless advances in many areas. Not least of which has been the computer. It has been said the moon landings were achieved with an onboard computer less powerful than most of us carry around in our smart-phones today.

New names for numbers, so unimaginably large, have had to been invented to be able to explain the number of calculations per second that the latest electron driven behemoths can perform. Machines making sense of a universe, that Mr Higgs might be able to explain, but just leaves me wondering how many of his bosons have to attach themselves to my next patient's waist, before they will meet the PCT's hurdle for the bariatric surgery which they crave, albeit slightly less than the calories in their next feast.

Meanwhile I wonder what would happen if I give in to the intense craving of my own. The metal and plastic lump of uselessness filling my desk is once again driving me to despair and is in danger of going out of the window.

As tools go this has to be one of the most useless things ever applied to the practice of the art of Medicine. Science, for all the great things it has given us, has really dropped a clanger here.

Too many years ago now, I was brainwashed into sneering at the humble Lloyd George GP record. The wonderful training practices were all racing to the A4, hospital style records. I was ready, after all Dilys Howells had taught me how to sellotape the lab reports in straight, the single most important aspect of patient care on most ward rounds at the now vanished Burton General.

I was lucky enough however to join a Practice that questioned everything and accepted nothing verbatim. Not Luddites however, one of the partners had already written a program for his BBC computer which ran our Cervical Smear recall system, producing uptake rates in the 90%+ range which is sadly better than it is now, nearly 30 years later.

Now here I am, sitting with a patient, trying to get the lab results up while the screen mocks me with a look blanker than a PCT facilitator. EMIS?, it should be called penis and even then would need some Viagra to become half useful.

The sad truth of course is the machine does nothing to improve my care of an individual patient; to the contrary it often makes it harder. No, what it does is make the corporate practice of medicine the modern standard.

No longer does it matter what my individual patients think of me and my style. As long as the templates are full, the medicines linked and the QOF monster fed then I am performing adequately.

As long as I obsessively record all my learning activity on "My Little Website" kindly provided at a right Royal cost by the College of Fisher Price then I must be a "good" GP and not the next Shipman (Harold, I mean).
As far as I can see all it does is act as a tool of control, a way of minions swarming over our data to check I am not stepping out of line and putting my patients first.

How did we ever get here? Not sure, but I despair when we start acting more like the PCT than they do, by arranging commissioning meetings which take doctors away from work on a Friday, for less than two hours of actual work ending in lunch after which how many will go back to their practices? I despair for the future of General Practice which unfortunately will have me for longer as a patient now, than as a worker.

Regards

Venture

The views expressed in this column are those of the author and not necessarily those of the LMC