DECEMBER 2011
NO. 7

SOUTH STAFFORDSHIRE LMC NEWS

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

CONTENTS

PMS REVIEW 2011/12

The final meetings of the Clinical Review Group for the PMS Review 2011/12 by the PCT have been completed.

The aim of the LMC involvement was to make recommendations to the PCT, improve equity and fairness and avoid destabilisation. With the help of Dr Fay Wilson we have underlined the concerns of GPs that were made clear in the meeting held in Uttoxeter on 23rd November.

It is the advice of the LMC that it is premature to publicise the review to patients or write to MPs until the process is completed.

REFERRAL PROTOCOLS AND TRANSFER OF WORK TO PRIMARY CARE

The following statement has been sent to CCG Leads and Chairmen together with the PCT following communication from another LMC:

At its November 24th meeting, the LMC discussed the question of referral protocols and (often) associated new work being requested from primary care. The issue was raised in respect of specific protocols from our local Hospitals.

While the LMC is all in favour of streamlining patient pathways and ensuring good clinical communication, we do need to make a point that GPs are required to make referrals for services provided under the NHS Act whenever they feel it is necessary and appropriate. It is unsafe for Providers to reject referrals on the grounds that particular pro-formas have not been filled in correctly. If the GP has enclosed sufficient information (in whatever format) to make it clear that a referral was appropriate then clinicians in the Provider service could find themselves liable for any harm that befell a patient as a result of any rejection of the referral.

Moreover, many such referrals protocols nowadays request significant input from primary care, in the form of pre-referral blood tests or gathering of patient information etc. This often entails extra work for Practices and needs to be resourced.

The LMC has asked me to write to you to request that your CCG bears these concerns in mind when negotiating contracts with Provider Trusts and makes it clear that compulsory referral pro-formas are inappropriate.

CLINICAL COMMISSIOING GROUP AND AGREEMENTS WITH THEIR PRACTICE

Concern has been raised about Agreements circulating in Staffordshire between CCGs and practices. The GPC discussed these Agreements with DOH and has sent us the following advice: -

Please could you advise all your practice to reject such documents and not sign it at this time.

I would make the following observations:

1. CCGs are in shadow form and are not statutory bodies and therefore currently have no legal status.
2. CCGs are defined by the Health and Social Care Bill 2011, as a membership organisation, the members are practices and the practices should approve a constitution, Governance Framework and such an agreement, not have one imposed.
3. The DoH is currently developing a Governance Framework, which will give examples of constitutions etc. which can be adapted and adopted locally by CCGs.
4. Much has been said and written about what could be done about practices who are not engaging or "failing". It is not expected that a CCG will be able to expel a practice and therefore at this time there is no place for this to be part of any local document.

CCGs are expected to work with practices and achieve a high level of clinical engagement. They should be supporting practices and will use support, peer pressure and peer review to improve quality and outcomes of clinical care. The GPC believe it would be inappropriate and a conflict of interest for a CCG to hold practice contracts (we know these will be held by the NHSCB) and in addition any action which is taken in a formal way against a practice, needs to be independent of the CCG and have strong involvement from the LMC.

QOF UPDATES AND GP COMPUTER SYSTEMS

You may be aware of the delay in the GP software suppliers putting QoF changes in place onto your GP systems.

We believe this is because the new business rules and data set are released by the DoH in September and then given to the clinical suppliers. They then adapt them to their own systems and patch them out in October.

The GPC has provided the following explanation: -

"Some of the delay is due to QMAS and that is because we concluded negotiations so late last year. However, NHS Employers have informed us that system suppliers have had the QOF changes detail for a few months now but haven chosen not to update clinical systems until QMAS went live (24 October). This wait is apparently not necessary as QMAS really only comes into play for payment purposes and operates independently from system suppliers.

The NHS Employers are preparing both the business rules and indicator wording as we speak, which we will be working together with them on with the hope to finalise by the end of the year. This will mean QMAS can be instructed early in the New Year and system suppliers will therefore get the details much earlier than last year. We will inform LMCs as soon as this has been finalised."

CHANGES TO THE DISABLED PERSONS (BADGES FOR MOTOR VEHICLES) (ENGLAND) REGULATIONS 2000

The Disabled Persons (Badges for Motor Vehicles) (England) (Amendment) (No.2) Regulations 2011 were laid before Parliament.

The regulations apply to England and, subject to Parliamentary process:

I. **From 1 December 2011:** amend the grounds by which a local authority may refuse to issue, or withdraw, a badge
II. Introduce a new Blue Badge design for individual and organisational badges that are issued from **1 January 2012** onwards
III. Enable local authorities to charge a maximum fee of £10 for the issue of a badge with a start date of **1 January 2012** onwards
IV. **From 1 April 2012:** require that eligibility under the 'permanent and substantial disability' walking criterion (at regulation 4(2)(f) of the Principle Regulations) is confirmed by an independent mobility assessor, unless an applicant's eligibility is self-evident

A Local Authority Circular will shortly be available on the DfT's Blue Badge pages at: http://www.dft.gov.uk/topics/access/blue-badge/ This provides more information on these regulations.

Dr David Dickson
LMC Secretary

DATES OF NEXT MEETINGS

South Staffordshire LMC - 26th January 2012, South Staffordshire PCT, Edwin House, Second Avenue, Centrum 100, Burton on Trent.

South East Staffordshire Sub Committee - 16th January 2012, Sir Robert Peel Hospital, Plantation Lane, Mile Oak, Tamworth.

South West Staffordshire Sub Committee – 12th January 2012, South Staffordshire PCT, Anglesey House, Towers Business Park, Rugeley.

LMC MEMBERS

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

Dr M MacKinnon (Chairman)	01785 813538
Dr D Dickson (Secretary)	01283 564848
Dr C Pidsley (Vice Chair/Treasurer)	01283 500896
Dr A Parkes	01827 68511
Dr V Singh	01543 870580
Dr E Wilson	01922 415515
Dr A Yi	01543 870590
Dr A Burlinson and Dr O Barron (job share)	01889 562145
Dr P Needham	01283 565200
Dr G Kaul	01543 414311
Dr A Selvam	01543 571650
Dr J Holbrook	01543 503121
Dr T Scheel	01283 845555
Dr S Dey	01889582244
Dr P Reddy	08444 770924
Dr A Elalfy	01785 252244
Dr P Gregory	01543 682611
Dr C McKinlay	01283 564848
Dr Zein-Elabdin	01922 413207
Dr E Odber	08444 773012

DR V SPLEEN

Dear Reader

It is pretty evident that the practice of medicine both in hospital and in primary care has changed drastically over the last 30 years. It is tempting to suggest that matters were much better in the past. I happened to cast my mind back to when I was a house officer 29 years ago. The first job I did was general surgery. In the first week of this attachment, the consultant performed both a pulmonary lobectomy and an oesophagectomy, for patients with cancer. The surgery proceeded well for both but as a house officer I was required with the help of my registrar to care for them both in an ITU with no dedicated medical staff. Needless to say there were a lot of hairy moments. Eventually both were discharged, but I was aware of many similar cases, who did not survive. I have to say from a patient's perspective I am glad that both these procedures are not even done in most District hospitals let alone by one surgeon with inexperienced junior staff. Other long lost practices include explorative laparotomies or 'open and shut' cases where surgery was carried out to make a diagnosis, only to find that nothing could be done as the cancer was inoperable.

On a lighter note I recall a large group of junior doctors being taken to a local expensive restaurant by a representative selling a new drug called Osmosin. This was a new non -steroidal analgesic which had a novel delivery system in that the active ingredient was contained within a semi-permeable membrane which was ph sensitive. The theory was that once the capsule entered the small intestine it would release the drug due to the PH rise thus avoiding the risk of stomach ulceration. To demonstrate this we had on the table glasses of water with dye filled capsules to drop in. We were quite entertained by watching blue dye leak out slowly over the next 3 minutes. (You have to remember mobile phones did not even exist at this time let alone those with Android operating system to provide entertainment.) Needless to say most of us returned to the wards the next morning eager to try out this new drug, creating some concern for the pharmacy department, as it was very expensive. 3 months later the drug was withdrawn as it was found that the capsules tended to lodge in the rugae of the intestine and actually bored a hole in the bowel as the drug was released into a very localized area! I think most of us would agree that it is for the better that this kind of inducement is a thing of the past.

One other practice thankfully banished was the ability of the doctors in one hospital I worked to be able to help themselves to medications from the pharmacy when working out of hours! I used this once to treat conjunctivitis but a wide range of medications were available without checks although I presume the CDs were locked up. I never checked!

So maybe the good old days were not as good as the rose tinted specs would suggest. Certainly not for the patients!

Venture

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