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NO. 1

# SOUTH STAFFORDSHIRE LMC NEWS

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### 2010/11 CONTRACT

The GPC have confirmed that following their negotiations with NHS employers for 2010/11, the Extended Hours Access Scheme DES and four clinical DESs will be rolled over to 2010/11.

The PCT need to have a plan by 26.03.10 which shows they are using the Extended Hours monies from practices that have declined the DES. This may involve other practices that are willing to provide the DES.

### SUMMARY CARE RECORD (SCR)

South Staffordshire PCT would like to progress the national initiative of implementing the Summary Care Record across the South Staffordshire area. This will involve a public information programme informing them of the SCR and providing choice to the general public. It gives the public 12 weeks to respond if they do not want to have a SCR. The PCT provided 5 SCR awareness sessions for GP practice staff over the last 6 months to provide an understanding of the project. In order to secure the central funding to support this national initiative the PCT would need to complete the PIP by the end of March 2010.

The LMC sought the views of the GPC and the IT Lead replied : -

The overall view is that the SCR is beneficial to healthcare. However, the BMA view is that it has been over expensive, that the consent model is wrong (i.e. there should be individual consent prior to upload), and that the work required to prepare records for upload should be remunerated. He also felt the consent issue is one which he does not believe we will ever reach agreement on.

LMC members raised concerns with the PCT about the security of the system. Whilst recognising there may be benefits the LMC have grave concerns about implied consent and the workload for GPs.

The majority decision of the LMC was that it is unable to support the PCT recommendation for the Summary Care Record implementation across South Staffordshire. The LMC notes that it will be individual GP practice choice whether they wish to switch on the upload after the public information programme.

### QOF BUSINESS RULES

Version 16 of the business rules has now been published. Please note that for the QoF CVD PP1 indicator (Cardiovascular disease—primary prevention 1), the business rules have been amended to exclude patients under **30** years of age from indicator PP1. The age range for this indicator is now set as **30-74 years**. Patients outside this age range should still be individually assessed and their risks reduced, although risk equations do not apply and thresholds for reductions are not currently available. PP2 applies to all age groups, as do the blood pressure control indicators in the hypertension set.

**SWINE FLUE VACCINATION**

The Swine Flu Vaccination LES for under 5 year olds has been finalised by the PCT. They have authorised the use of extended hours between now and March for the delivery of the vaccination and provision by the PCT of stationery and postage for letters to patients. The current position is that there are 33,048 children to be vaccinated. 58 practices have accepted the LES and 38 practices have declined the LES. The PCT has commissioned its Provider Arm to undertake the vaccination programme for those practices who declined the LES. The LMC will reflect later on the uptake rates.

With respect to the Swine Flu letter sent by the PCT to housebound patients, please note that 385 patients out of 2298 have responded to the request to attend the vaccination centre or arrange a home visit. The LMC is concerned at the poor uptake by this vulnerable group who should have been automatically visited.

**A PATIENT HAS ASKED FOR A REPORT TO SUPPORT HIS APPEAL AFTER HAVING HIS INCAPACITY BENEFIT WITHDRAWN. DOES HIS GP HAVE TO PROVIDE A REPORT?**

No. GPs, as certifying medical practitioners, have a statutory obligation to provide statements of incapacity to patients on their list and certain information to a Medical Officer when requested. However, under their NHS contract there is no requirement for GPs to provide reports or offer an opinion on incapacity for work to anyone else unless requested to do so by Jobcentre Plus.

Claimants should contact Jobcentre Plus or the Appeals Service, where appropriate, if they think that further medical evidence is necessary to support their claim or appeal. They should state clearly their reasons for believing that further evidence is necessary.

If Jobcentre Plus or the Appeals Service consider that further medical evidence is necessary, they will seek it. They will be responsible for paying any fee to the doctor providing the report.

So NHS GPs are under no obligation to provide such evidence to their patients nor to provide it free of charge. If a GP does not agree to provide additional evidence for their patient then it is a private matter to be resolved between the GP and their patient.

**(This is an extract from the DWP website)**

**A PRACTICE MANAGER ASKS: CAN GPS CHARGE FOR A CONSULTATION LINKED TO TRAVEL VACCINES?**

Whenever a GP gives a vaccination it is good practice to advise the patient of the efficacy/value of the vaccine, and any other protection that may be advisable, and to discuss relevant side-effects or concerns the patient may have. This advice should be accepted as part of the normal process in the provision of travel vaccinations. The supply of travel vaccines is a predominantly private service, and it is appropriate for the fee charged by the GP to reflect the necessary advice. We do not advise GPs to separate the fee for advice from the fee for the administration of the vaccination because some of the vaccines are given on the NHS and charging for giving travel advice when administering Hepatitis A or Typhoid would be charging the patient for an NHS service.

There is also guidance on this on the BMA website: - http://www.bma.org.uk/health_promotion_ethics/drugs_prescribing/InfoOnPrescribe0904.jsp?page=5

**CRB CHECKS**

The LMC would like to clarify that it is now mandatory for those taking up a new post as a GP, practice nurse or healthcare assistant (as they undertake 'regulated activity') to have had an enhanced CRB check undertaken. This only applies to new recruits and those who are changing jobs who will undertake 'regulated activity'. It does not apply to receptionists, practice managers, cleaners, etc.

With regard to the issue of whether employers have to see an enhanced CRB check before taking on a new recruit to a 'regulated activity' (namely, the post of a GP, nurse or healthcare assistant), the GPC lawyer's opinion is that the employer does NOT need to see this.

Section 9 of the Safeguarding Vulnerable Groups Act 2006 states as follows:

"9 Use of barred person for regulated activity
(1) A person commits an offence if—
(a) he permits an individual (B) to engage in regulated activity from which
B is barred,
(b) he knows or has reason to believe that B is barred from that activity,
and
(c) B engages in the activity."

In order not to fall foul of the law, we advise employers to ask new recruits who will be undertaking a regulated activity (as defined above) if they are on a barred list. Also, of course, if you suspect that a person undertaking a regulated activity is on a barred list then further investigations must be sought. But as noted above there is currently no legal requirement to require or see an enhanced CRB check for those that you do not suspect.

Please note that from July 2010 ISA registration will be introduced for new recruits and will become mandatory from November 2010.

More detailed guidance will follow.

## SUPPORT FOR PATIENTS WITH MANAGING THEIR MEDICINES AND SEVEN DAY PRESCRIPTIONS

Under the Disability Discrimination Act (DDA) 1995 it is the responsibility of all Professions involved making reasonable adjustments to help disabled people take their medicines appropriately. It should be emphasised that the definition of disabled is not restricted to those registered as disabled. A person is said to have a disability if they have a physical or mental impairment which has a substantial and long term (> 12 months) adverse effect on their ability to carry out normal day to day activities. This could include for example patients with severe arthritis, MS, visual impairment and/or poor short-term memory.

When looking at medicines supply services all professionals should determine if the service they provide make it impossible or unreasonably difficult for the disabled person to use their medicines. Prescribers should therefore take account of a disabled patient's ability to comply with, and be prepared to make reasonable adjustments to, their medicines regimen. This may for example, include altering the choice of drug and or formulation in order to simplify a complicated drug regimen that is impossible or unreasonable difficult to follow for a patient with a loss of short-term memory.

Dispensers should make reasonable adjustments and action should be taken to help disable patients comply with their medicines regimen. This may, for example, include supplying medication in an easy open container as a child resistant container may make it impossible or unreasonably difficult for a patient with severe arthritis to use their medicines. It may also extend to the provision of reminder charts and medicines compliance aids (MCA).

Under the new pharmacy contract disabled patients may ask the pharmacist for support with medicines use. If a prescriber is aware that a disabled patient has problems using their medicines, and they have made all reasonable adjustments to their medication regimen, they can suggest that the patient approaches the pharmacist for advice and assessment. Historically pharmacists have asked for seven-day scripts as a means of covering the cost of providing an MCA. There should now be no need for new requests for seven day scripts but the pharmacist is under no obligation whatsoever to supply patients who are not disabled with an MCA.

## ASSESSMENT OF MENTAL CAPACITY

New guidelines to help professionals assess mental capacity has been published by the Law Society. This edition provided jointly with the BMA provides practice advice on assessing a persons capacity where it may be in doubt. It also provides up to date guidance on the lawfulness of providing treatment to people who lack capacity to consent to treatment on their own behalf. This new guidance is fully compliant with the Mental Capacity Act 2005 (MCA).

The book can be purchased via www.lawsocietyshop.org.uk

## VIAGRA FOR ERECTILE DYSFUNCTION

A GP has queried whether he must continue prescribing Viagra on the NHS after his patient has been discharged from a specialist centre following the diagnosis of severe distress.

The DH has made it clear who can receive these drugs on the NHS and the regulations are outlined in the BMF. When the condition is causing severe distress as defined by the DH it is available from specialist centres commissioned by PCTs. The patient must receive the drug from the specialist centre and therefore the GP cannot prescribe it for severe distress. Prescribing responsibility remains with the specialist.

The GP is required to endorse the prescription "SLS" to confirm the patient meets the criteria. We are advised that to prescribe for severe distressed patients and endorse SLS is potentially fraudulent, and therefore, one of the reasons why we should insist that the specialist service retains prescribing responsibility.

## LMC CONFERENCE, LONDON, 10 & 11TH JUNE 2010

The last date for motions to the Conference is 12th April 2010. Please forward to the LMC any topics that you would like South Staffordshire LMC to raise on your behalf.

**Dr David Dickson**
**LMC Secretary**

## DATES OF NEXT MEETINGS

South Staffordshire LMC - 11th March 2010, South Staffordshire PCT, Anglesey House, Towers Business Park, Rugeley.

South East Staffordshire Sub Committee - 25th January 2010, Samuel Johnson Community Hospital, Lichfield

South West Staffordshire Sub Committee - 21st January 2010, South Staffordshire PCT, Anglesey House, Towers Business Park, Rugeley.

## LMC MEMBERS

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

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|---|---|
| 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 |

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|---|---|
| Dr P Reddy | 08444 770924 |
| Dr J Chandra | 01543 870560 |
| Dr A Elalfy | 01785 252244 |
| Dr P Gregory | 01543 682611 |
| Dr K Owens | 01543 278461 |

**Dr V Spleen's New Year Dream**

Dear Reader

I drove to work – there was no traffic.

I entered my surgery room – the computer started immediately and worked without hiccup, at my pace, all day.

I treated patients all day, for their problems only.

I wrote prescriptions for drugs that the patients needed.

Mrs Jones - diabetic, hypertensive, angina sufferer, with a BMI of 45 admitted that she was the way she was because she ate cream cakes and chocolates all day.

Bill - drug addict – requested an early script for his dihydrocodeine and diazepam so that he could sell them on the street to pay for extra heroin.

The PBC chairman thanked me, even though I had a million pound overspend on my acute medical services bill, it was more important that my patients had choice and got their problems sorted fully and quickly.

The Chief Executive of the local PCT wrote asking me to organise a patient centred community based Primary Health Care Service that would be fully funded. The Secondary care would have to deal with what was left.

I rang a Consultant about a clinical problem with a patient and he said "just send him up to the next OPA with a covering letter and he would have a look at him".

I have a discharge letter from the local hospital that contained all relevant information to enable me to provide ongoing care.

A mentally disturbed patient was threatening suicide. The Crisis Team Social Worker said they would love to help and would see and assess the patient immediately.

All the Government Specialist Medical Advisors resigned and offered to retrain in the purpose of population medicine by becoming face to face HIV workers in Africa.

The Chief Medical Officer wrote to me apologising for the total cock up in managing the Swine Flu Epidemic, in causing so much confusion to the profession and public as well as wasting so much public money.

The local Darzi Centre has been closed down and re-opened as a day centre for the elderly and in the evening as a Casino to raise money for Community Projects.

Gordon Brown agreed with the majority of GMPs that he could save money in the NHS without damaging patient care by: -

- Shutting down Choose and Book
- Cancelling the National Information Spine
- Reclaiming all profits for PFI initiatives
- Stopping Privatisation
- Banning the use of Private Management Consultants
- Reducing Administration
- Getting Rid of Choice

The money saved – half could be spent on patient care gaining votes, with the other half going back to the treasury. A small amount could be spent on clinical IT that actually worked.

The bankers decided not to take their Christmas bonuses and give it to carers and low paid workers in the NHS that need and deserve the money more.

I try to put a HAD score into my computer and it flashes input error, the QOF has been cancelled, it has been shown to an extremely costly distortion of quality health care.

My Practice Manager rings me and says for some reason there have been no requests for appointments or visits tomorrow so I can have the day off!!

I suddenly wake with a slight sweat, palpitations, heartburn and central chest pain. Was that a dream, or nightmare of life past, life present or the future. None of these, the blue cheese was off!!! Where's the Gaviscon Advance? Bugger I can't even have that!

Happy New Year to All

**Venture**

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