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# SOUTH STAFFORDSHIRE LMC NEWS

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

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### HEALTHCARE COMMISSION REPORT INTO MID STAFFORDSHIRE HOSPITAL FOUNDATION TRUST

GPs in the Stafford area have always tried to work with their hospital to provide high levels of care. Many of the findings in the report are disappointing but the LMC feels that the micromanagement of targets and underfunding resulted in many of the problems. Concerns had been raised by GPs in the past but GP involvement in monitoring was removed when fund holding was transferred to the PCT.

Matters arising from this have been formulated into a motion submitted to the LMC Conference in June. The reality is that it is the PCT's responsibility to monitor quality and the problems in the hospital are a result of managerial incompetence. The misguided Government target culture led the hospital to losing focus and resulted in the deprofessionalisation of health workers.

### DEVELOPING GENERAL PRACTICE LISTENING TO PATIENTS CONSULTATION

The GPC wants to learn more about the way in which practices respond to patient expectations at a local level and what barriers practices encounter that prevent them making appropriate changes. The consultation 'Developing General Practice, Listening to Patients' has been devised to encourage GPs to discuss practice services with their patients and to feed back to the GPC examples of improvements that they have made in their practices. The document has been circulated to practice managers.

'Customer Care' is the new buzzword for us all in the future. Customers services will be an area to focus on, perhaps akin to the comparison of Ryanair and British Airways if you have ever travelled with them. One GPC negotiator recently commented on the value and funding of GP services - for example GMS average £60 to £70 per patient per year (unweighted) - compare this to the RAC for £150 per year.

### CAUTERY & ADDITIONAL SERVICES

Cautery and cryotherapy are covered in the Additional Services section of the main GMS contract - see paragraph 81 of the standard contract:

'a contractor shall make available to patients where appropriate curettage and cautery and, in relation to warts, verrucae and other skin lesions, cryocautery.'

It is clear that GMS practices should not be claiming for any form of cautery under the minor surgery DES because they are already being paid by Additional Services.

PMS practices need to look at their contracts but it is unlikely there is a clause stating they can claim for electro or cryocautery, again because they are already being paid for it in Additional Services like GMS.

## RETENTION OF HEALTH RECORDS

A common enquiry to the BMA medical ethics department relates to the period of time for which records should be retained. For ease of use a summary of the main points for GP records is given in the table below. The recommendations apply irrespective of the form in which records are held. Record holders are under a legal and ethical obligation to maintain records safely and securely.

Recommended minimum lengths of retention of GP records:

| Type | Retention Period |
|---|---|
| Maternity records | 25 years |
| Records relating to children and young people (including paediatric, vaccination and community child health service records) | Until the patient's 25th birthday, or 26th if an entry was made when the young person was 17; or 8 years after death of a patient if sooner. |
| Records relating to persons receiving treatment for a mental disorder within the meaning of mental health legislation. | 20 years after no further treatment considered necessary or 10 years after the patient's death if sooner. |
| Records relating to those serving in HM Armed Forces | Not to be destroyed |
| Records relating to those serving a prison sentence | Not to be destroyed |
| All other personal health records | 10 years after conclusion of treatment, the patient's death or after the patient has permanently left the country. |

## LMC CONFERENCE MOTIONS

South Staffordshire LMC has submitted the following motions to the LMC Conference on 11 and 12 June 2009:

1. That conference strongly recommends to the Department of Health Advisory Committee on Cervical Screening that the lower age limit for screening should be 20.
2. That conference believes DO NOT RESUSCITATE orders have no place in the community setting.
3. That conference:
   (i) is gratified with the efforts made by the GPC to highlight the good work of current general practice and counter the inaccurate and ill informed reports in the national press
   (ii) is pleased that the focus of the press has moved onto the banking world and its financial excesses
   (iii) urges the GPC to continue its media campaign underlining the fantastic value for money of GPs and their teams.
4. That conference notes the findings of the Healthcare Commission investigation into Mid Staffordshire Hospital NHS Trust and urges the Department of Health to ensure that:
   (i) NHS trusts are statutorily obliged to respond to written clinical care complaints received from individual GPs or their local medical committee and within a time frame similar to current arrangements for patient complaints
   (ii) the Care Quality Commission (formerly Healthcare Commission) is obliged to seek the views of the relevant local medical committee when undergoing an investigation into an NHS body in the area of that LMC
   (iii) primary care trusts are obliged to have mechanisms in place for gathering information received voluntarily from GPs that relates to the clinical care of patients in NHS or private bodies and respond with actions taken within a time frame similar to current arrangements for patient complaints
   (iv) organisations such as the Ombudsman, Monitor and Care Quality Commission are obliged to share NHS complaints with each other and inform the relevant local primary care trust.
5. That this conference believes that the current DH policy for general practice as epitomised by the World Class Commissioning, High Quality for All, Improving GP Services document:
   1. Will result in depersonalised general practice
   2. Will result in a target-driven micro-managed general practice with potential adverse 'unforeseen' consequences similar to those seen in the Mid-Staffordshire Acute Trust
   3. Will result in speed of access and convenience given priority over quality of care
   4. Will result in poorer quality patient services
   5. Must be resisted by all general practitioners and the GPC

## CAR PARK LIABILITY

Although not a problem in the current weather the BMA Legal Department have clarified the responsibility of practices with respect to their car parks and the winter. Do we have a legal responsibility to do our best to keep the car park ice free?

'The matter is one of avoiding negligence claims. A practice must do all that is reasonable to ensure that the car park is safe - that does not necessarily mean that the practice must expend huge amounts of time and money to keep the place safe - the duty is to be reasonable in the circumstances. If however the practice does not have the time, resource or funding to make safe any car park they may simply choose to close it.

Another option used in conjunction with this advice is to have a warning sign outside the car park during icy conditions stating that the car park is icy and patients are advised to park elsewhere. The practice may be able to exclude liability for damage to property but not to personal injury or death so although the sign may mitigate the liability for the practice it does not absolve all liability.

The rule of thumb is to be reasonable and practicable and where this cannot be done than take a decision to close the car park.'

**VAULT CERVICAL CYTOLOGY TESTING**

The LMC enquired with the PCT how it intends to fund their proposed procedure for providing follow up and informing women of the results of their vault cervical cytology. The following reply has been received from Dr Aliko Ahmed, Consultant of Public Health Medicine:

"Vault cytology is no longer part of the cervical screening programme but the number of women who will require this procedure is very small. It has been predominantly accepted as part of the routine duty of care provided by medical practitioners to their patients.

I agree with this reasoning and therefore South Staffordshire PCT will not be providing a LES for vault cytology. I hope that you will also understand, and you and your colleagues will continue to provide appropriate care to this small group of patients.

If, however, you do not wish to provide cytological follow up for these patients please refer them back to their Consultant Gynaecologist. I have discussed this issue with all our local Gynaecologists and they are happy to continue to provide care for this group of women."

**CLOSTRIDIUM DIFFICILE INFECTION QUESTIONNAIRES**

There is no obligation for GPs to complete the antibiotic questionnaires about Clostridium Difficile that are sent from the Infection Prevention and Control team of the PCT. The LMC have received a number of queries about the completion of these forms and advised the PCT that the work needed to be funded. Unfortunately no fee has been forthcoming and therefore it is completely voluntary if you wish to complete the form or not.

**USE OF PATIENTS NHS NUMBERS BY THE PCT FOR CONTRACT MONITORING PURPOSES**

The NHS number is an identifiable item of data (an identifier). The number is so widely used across the NHS and many members of staff have access to the key by which identification of personal information can be accessed, that it does not provide effective anonymisation. It is therefore advised that it is inappropriate to use the NHS number in any context where it can be linked to the patient's personal information (without valid consent to do so, and that other alternatives should be pursued.

Audit for payments for enhanced services would not generally be adequate justification for using the NHS number without consent. It would therefore be more appropriate for the practice to use a local patient identifier that would identify the patient within the practice, but not to anyone outside the practice, thus effectively anonymise the information required. It would be acceptable to pass this anonymised information on, once there were no other identifiers within the data.

In effect this means a practice needs to provide a unique identifier that can only be reverse engineered by the practice. This should be easy as each clinical system also provides a system specific unique patient identifier for this.

**STAMP DUTY LAND TAX (SDLT) GUIDANCE**

The GPC has published general guidance on Stamp Duty Land Tax (SDLT) as it applies to GPs. SDLT is payable on transactions relating to UK land and buildings and although not all transactions involving GPs will be liable for SDLT, it is likely to affect an increasing number of practices in the future, due to the increasing number of premises occupying leasehold premises and the varying nature of the property market. Note that this guidance is not suitable for individually tailored professional accountancy and tax advice and that GPs should always seek such professional advice when considering a transaction that may be subject to SDLT. The guidance can be accessed here:

www.bma.org.uk/employmentandcontracts/tax/stamptaxSDLT0309.jsp

## MANAGING DISPUTES WITH PCTS

A dispute resolution procedure is needed to resolve issues that arise within the contract, for example a dispute as to whether a contract provision has been properly performed by either the PCT or the providers, or a dispute involving financial entitlement under the contract. The GPC guidance has been updated.

Contracts or agreements between GPs and PCTs fall into 3 types, employment, 'NHS contracts' and civil contracts. This guidance does not cover employment disputes, although the Family Health Services Appeals Unit (FHSAU) procedure does apply to payment disputes for GP registrars.

The guidance can be accessed here:

www.bma.org.uk/employmentandcontracts/independent_contractors/managing-_your_practice/disputesPCTsJan08.jsp

## REVALIDATION

You should be aware that no decision has yet been made on a date for the introduction of revalidation and that the earliest this could commence would be in 2011. Dr Hamish Meldrum Chairman BMA, informs us that the RCGPs proposals are just that - proposals - and a decision will not be made on the final form of revalidation, including a revised system of appraisal, until after a full assessment of pilot schemes, which are not due to be completed until the second half of 2010.

GPs should be assured that they will be given full details of the agreed revalidation arrangements in plenty of time to make the necessary changes, before the introduction of validation.

## GP STAFF PAY

Please note the LMC does not recommend any pay rates but has always advised GPs to make awards that will enable them to retain and recruit suitable staff.

When considering pay rates this year you may wish to look at the DDRB recommendations that were accepted by the Government with respect to GMS contract payments, salaried GPs and also the pay settlement for staff elsewhere in the NHS.

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

## DATES OF NEXT MEETINGS

South Staffordshire LMC - 18 June 2009, South Staffordshire PCT, Block D Beecroft Court, off Beecroft Road, Cannock

South East Staffordshire Sub Committee - 11 May 2009, Sir Robert Peel Hospital, Plantation Lane, Mile Oak, Tamworth

South West Staffordshire Sub Committee - 14 May 2009, 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 M Murugan | 01543 870570 |
| 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 V SPLEEN**

Dear Reader

A week or so ago I had what seemed to me a particularly irritating morning, with 2 or 3 incidents which quite annoyed me. Later in the spirit of optimism I though 'how long would it take to compile 10 significantly irritating events?'. Here then are the results which actually happened over the subsequent 4 days. If you think you can present 10 even more frustrating events please feel free to send them to the LMC offices for possible inclusion in a later newsletter. Editor permitting!

1. A patient rang to ask me to send a form to the local wheelchair dept for a temporary chair for her daughter who had broken her eg. They said a hospital OT had told them there was one available from this source. Despite my advice that the Red Cross was a better option they insisted that I check it out (see below). Discussion with the OT concerned confirmed that she wasn't aware of the policy of long term loan only.

2. I rang the local wheelchair department in order to clarify a matter, to hear an answer phone message to the effect that the phone was only manned Monday to Wednesday between the hours of 10 am and 12 am. A message could be left if the matter was urgent. This was mitigated by the return call an hour later!

3. I received a letter from a patient's wife asking for my urgent help as he was becoming very forgetful and cantankerous. She was too afraid to tell him her concerns and wanted me to sort him out, without him knowing she had contacted me. After due consideration I wrote back to her empathising with her predicament but explaining the limitations of my magical powers and implications of consent and confidentiality.

4. A patient came in obviously chewing gum with mouth open and proudly proclaimed that he had started the habit to stop overeating! I hate people who chew gum and converse at the same time!

5. A report appeared in the GP weekly newspaper stating that a former GP, Dr Carson was quoted with reference to General Practice, saying that 'in general there is an inverse care law, with those with the greatest needs being left until last, implying that we are incapable of dealing appropriately with a pale, sweaty patient who walks into surgery with chest pain. I am gathering a deep mistrust of former GPs now working for the Government. David Colin-Thome springing to mind.

6. 2 patients in one surgery have mobiles go off during consultation.

7. A patient's daughter rings me to ask very apologetically if I would fill in LPA forms again as the solicitor had rejected the first lot because the applicant had forgotten to tick 2 boxes. All parts including GP certification were to be repeated and because there is a requirement to fill the form as soon as possible after interviewing the patient I would have to see the patient again! The solicitor had demanded £100 for his troubles.

8. I received a letter from the pct about the local world commissioning plan. I struggled to find it on the PCT web site and when I did I couldn't understand any of it!

9. I had to complete a new style cremation certificate this am. In essence there appears to be only one major new question, which requests why the certifying doctor came to the conclusion as to cause of death. I really do not see how this will prevent a recurrence of a Shipman scenario and does seem to have incurred a huge amount of additional expense.

10. Whilst filling out one of these forms at a local undertaker I was assaulted by a verbal torrent of quips and jokes by one of the undertakers chatting to his female colleagues. This made concentration very difficult and took twice the time to fill in the form. By the way, some of the jokes were actually quite funny!

So there you go, not bad for 4 days. Perhaps I'm getting a bit jaded and cynical. Anyway I believe this list is a little snippet of GP life which I'm sure is repeated every day in surgeries around the country.

**Venture**

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