

LMC NEWS

Cornwall & Isles of Scilly Local Medical Committee

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Items for the Newsletter are always welcome, and should be sent to the Editor, Rosalind Winter, at The Sedgemoor Centre, Priory Road, St Austell PL25 5AS (Tel 01726 627978, Fax 01726 76247, e-mail ros@kernow-lmc.demon.co.uk). See also our website at www.kernow-lmc.co.uk

MENTAL HEALTH REFERRALS

The LMC was delighted to receive clarification from Cornwall Partnership Trust on the long-running question of medico-legal responsibility when a GP's referral to the Mental Health consultant is intercepted and diverted to another, non-doctor, member of the Mental Health Team, without the GP's knowledge or consent. Mr Mike Riddell, on behalf of the Trust, has confirmed in writing that the Trust accepts full medico-legal responsibility for any harm to the patient which may occur as a result. So make sure you address ALL referrals to "The Consultant" or to the Consultant by name, and at least your medico-legal position will be secure.

With this precedent, we would hope now to be able to obtain similar assurances from the PCTs in respect of GP referrals which are intercepted and diverted without the GP's knowledge or consent by the Referral Management Centres.

PERFORMING RIGHTS AND TELEVISIONS IN GP WAITING ROOMS

Someone on the LMC Secretaries' ListServer recently posted a request for advice about an organisation which is ringing local doctors' and dentists' surgeries asking if they have a television set in the patient waiting area, and if so pointing out that as well as a TV licence they also need a Performing Rights licence, even if only transmitted TV programmes are being shown.

The organisation is quite right; but beware if this happens to you, because the approach may well be a scam, along similar lines to the popular scam of a year or two ago, where an organisation would

claim to have no record of your practice's Data Protection Act registration, and offer to rectify matters for you for a massive fee. (If you really weren't registered, it would only have cost you about £35 and one 'phone call to do this yourself).

Similarly, it is very quick and easy to register with the Performing Rights Society, and a licence is not expensive (the precise amount depends on the number of seats in the waiting room). If you need to do this, you can register very easily on line by going to: <http://www.prs.co.uk>

DISCLOSURE OF DECEASED PATIENTS' RECORDS

A practice called recently for LMC advice having had a request from an insurance company for a copy of the full medical record of a patient of the practice who had recently died.

These circumstances are covered by the BMA/ABI (Association of British Insurers) agreement, copies of which were sent to every practice when it was first issued. Further copies are available from the LMC Office or at bma.org.uk/ethics

The BMA and ABI agree that details from medical record should only be requested when there is good reason to suspect that relevant information may have been withheld by the patient, for example when a patient dies within a very short time of taking out a policy, or dies of a long-standing condition which was not disclosed to the insurance company on taking out the policy. The insurance company should explain to the GP the grounds for suspecting non-disclosure. The ABI advises its members that it is not acceptable to request the full medical record, and the GP should only provide information that is directly relevant to the patient's death, or to the suspected grounds or non-disclosure.

The GP must withhold information if s/he is aware that the patient did not want it released, if it identifies a third party (other than a health professional involved in the patient's treatment), or if disclosure is likely to cause serious harm to someone's health.

TRAINING IN HORMONAL CONTRACEPTION AND SUBDERMAL IMPLANTS

Enclosed with this Newsletter is a flyer for a three-hour theory course by Dr Sarah Gray at the Kingsley Suite Conference Room, Kingsley Village, Fraddon (see flyer for booking information):

**Hormonal Contraception and
Subdermal Implant Provision**
Thursday 25th May 2006

Suitable for those wishing to train to provide an **Enhanced Service for Subdermal Implants** or simply to update previous knowledge.

FEMALE GP RELOCATING TO CORNWALL

..... AND SEEKING WORK

**My family and I are moving from
Bristol to Cornwall, to establish our
new and permanent life.**

**I am currently looking for part time
work
(4-6 sessions, as I have two young
children).**

**I would be interested in a partnership
or a salaried post, and will be available
for locums until I secure a regular post.**

**My names is Rachel Marsden.
Please give me a ring on 0117 9147508**

PHYTO-STEROL RESEARCH PROJECT IN CORNWALL

Dear LMC,

I was fascinated to read about the proposed new R&D facility planned for Central Cornwall in the issue of LMC News dated 1st April.

I cannot think of a more appropriate place for a hot air factory (although access to a bath could pose a significant problem), nor can I think of a more appropriate body than the LMC to broker and promote a project involving enteric gas by-products. Who is the lead in this, may I ask...?

Yours (with a wealthy retirement in mind),

Stephen Forsdick
The Park Medical Centre
St Austell

FROM THE LMC'S POSTBAG - LETTERS WE SHOULDN'T HAVE TO BE WRITING

To Plymouth University Faculty of Science Senior Administrator:

"It is not part of a GP's contract with the NHS to provide medical certification for students, and it would be an improper use of Dr X's NHS time to do so. There are therefore two options open to you when University Regulations require medical certification for any student:

- to request a private medical report from the student's GP, or indeed any doctor, at a fee to be agreed. We advise GPs only to release private medical reports on receipt of the agreed fee.
- to arrange for a member of the University's Occupational Health staff to see the student, and to provide a certificate if appropriate.

"You should bear in mind that a doctor can only provide corroborative evidence of illness if s/he actually has some corroborative evidence, or, in the words of the General Medical Council, *"This means that you [the GP] must take reasonable steps to verify any statement before you sign a document."* In the case of a minor, self-limiting illness such as flu, unless the doctor actually saw the patient during the

illness, I cannot see what reasonable steps s/he could take to verify the illness, and s/he therefore cannot certify it and should not be pressurised to do so."

To Councillor M J Payne, "Benefit Advocate", Penwith District Council:

"You may recall that many GPs in Penwith, and at least two LMC Chairmen, have written to you on a number of occasions explaining that the Benefits Agency, if it requires medical information in support of a claim for Attendance Allowance, will contact the applicant's GP directly for a report. This attracts a fee payable to the GP by the Benefits Agency.

"Yet again, you are asking a GP for an "assessment" of an applicant, which, if the GP were foolish enough to provide it, would represent unnecessary duplication of work, and which the Benefits Agency would in any case ignore. The LMC is disappointed and exasperated to find you persisting with these inappropriate requests, which waste GPs' time, cause confusion to patients, and can damage the doctor-patient relationship."

LOCAL COUNCIL FREE AND CONCESSIONARY FARES

These have been much in the news lately, and GPs will not have been surprised when patients started asking them to endorse their applications. The County Council is well aware of our views on this; we still treasure a letter telling us that basically they couldn't care less what we or the Cabinet Office say to them about inappropriate use of GP time, they're going to carry on regardless.

One might almost suspect that whilst the Council want to win brownie points by following government policy on concessionary and free fares, at the same time they don't want people actually to apply for these concessions, because that would cost them money. One way to make it really difficult for people to access these concessions is to make them waste a GP appointment to get their forms signed (at a cost to the taxpayer of over £20 a time, of course - but why should that worry the Council? It's not local tax).

You have three options:

- Give in and do it for nothing (but please don't complain to us if you do).
- Say no. This is not a requirement of your NHS contract. Other people can sign these forms. A GP's signature is not essential.
- Implement a brand new strategy for attempting to tackle this problem: do this in your own time, charge the patient a realistic fee, and urge them to complain to their local councillor. We haven't been able to stop the Council wasting GPs' time like this; but elected councillors could. However, they're unlikely to do anything unless enough of their voters complain to them. And if your patients can't be bothered to write to their local councillors about this, then our sympathy for them evaporates.

GPC FOCUS ON ... SFE CHANGES

Enclosed with this Newsletter is a copy of the latest "Focus on ..." summarising the most significant changes to the Statement of Financial Entitlements for 2006-07. Further amendments relating to the new DESs will be put in place by July 2006, and are not covered by this guidance.

TAMAR FACULTY STUDY DAY

RCGP Tamar Faculty Annual Study Day
The Headland Hotel, Newquay
Tuesday, 9 May 2006

**'A plague on both your houses'
'If the birds don't get you, the doctors will!'**

Designed for all GPs and others working in primary care, the Study Day covers two topical and important issues facing health care professionals today.

*The risk of **Global Pandemics** is an increasing concern which leaves many of us wondering whether we are ready and what we can best do to be prepared. With the help of an expert keynote speaker we will explore the subject and consider realistic approaches for our day-to-day practice.*

***Physician-Assisted Suicide** has been an issue for a long time but has now been highlighted by high profile cases in other European countries and recent proposed legislation in the UK parliament. Here we will give you the opportunity to debate the subject with colleagues and 'experts' presenting the arguments for and against assisted dying.*

In the beautiful surroundings of the North Cornish coast, the Royal College of General Practitioners Tamar Faculty Study Day will prove to be an enjoyable and stimulating event.

All GPs, GP registrars, practice nurses and managers and others in primary health care are welcome to attend.

The Faculty AGM will take place just before lunch.

For further details, please contact
Liz Bell at the Faculty Office.
Tel 01392 262744; Fax 01392
432223; Email
liz.bell@pms.ac.uk.

PRE-OPERATIVE ASSESSMENTS AND TESTS

The LMC is grateful to Mr Phil Orwin, Director of Commissioning, West of Cornwall and Central Cornwall PCTs, for the following very helpful letter. This addresses once and for all the issue of secondary care providers assuming that they can treat GPs as junior houseman, and dump on them pre-operative work (for which, of course, their Trust has already been paid) without consultation or payment, often making matters even more irritating by piously explaining that they are doing this entirely for the patient's convenience.

"Many GPs will be aware of a scheme called Payment by Results which has been introduced across the NHS. This sets, for all secondary care providers, a price for each elective procedure carried out. This price covers both the pre-operative assessment and diagnostic tests together with the follow up care.

"It has, however, been raised with me that some secondary care providers are referring patients back to primary care for these pre-operative assessments and tests to be carried out separately. This is inappropriate, as providers are already funded to carry out all such associated tests and assessments, and if a GP refers separately back into secondary care then the tests are not only paid for as part of the elective procedure cost, but are also paid for either in primary care or as an additional referral into secondary care for that particular assessment or test.

"If GPs receive requests for these pre-op tests or assessments to be carried out in primary care I would recommend the issue is referred back to the provider, and that Richard Ellis (Acting Head of Contracting) on 07768 387490 is advised on order that we can pick these issues up with the provider concerned.

"I do hope this both clarifies the issue, and also assists on reducing the burden on primary care."

We've been telling you for years that you shouldn't do this work, and we are very grateful that now the PCT is telling you the same thing.

DEPUTY/ASSISTANT DEPUTY CORONER**H M Coroner for the County of Cornwall****HAS A VACANCY FOR A****Deputy/Assistant Deputy Coroner**

The Coroner for Cornwall is seeking a suitably qualified/experienced person to take on the role of Deputy Coroner/Assistant Deputy Coroner to cover five weeks' annual leave. Extra availability may be required to cover long inquests/sickness/courses and unavailability of the Coroner due to work commitments.

The successful applicant will

- Have suitable post-qualifying experience as a qualified Medical Practitioner and/or lawyer of five years' standing
- Have a sound knowledge of law and legal procedures
- Be aware of emotionally sensitive situations and their impact on others, such as relatives
- Be able to work to set procedures and pay attention to detail
- Have excellent communication skills
- Be able to work with a wide range of people, including Police Officers, Witnesses and the media
- Have good investigative skills and able to think logically

Remuneration will be based on work undertaken (estimated at £8916 gross per annum with extra to be agreed on work done).

Please write to HM Coroner at 14 Barrack Lane, Truro, Cornwall TR1 2DW for an application pack containing full details about this appointment. Please forward curriculum vitae together with a cover letter detailing your reasons for applying for the role by 13th April 2006.

CHILD PROTECTION ISSUES

We have had several queries recently on this subject, and we are grateful to Dr Cheetham of Westover Surgery who forwarded to us a letter of advice on a number of aspects from the MPS.

MPS advises GPs to keep case conference notes separately from medical records, but to ensure that the records are clearly marked so that anyone accessing them is aware that there is further information relating to the patient that should be consulted. In addition, if the GP wishes, relevant points from the report can also be included in each individual child's (or indeed adult's) medical record, in the form of a summary.

The GP will have received a copy of the child protection conference notes; the originals remain the property of Social Services. Therefore if there are any requests for disclosure, the GP should simply redirect these to Social Services.

The question has been raised of whether Social Services should be asked to produce individual documentation for the GP for each individual patient involved in a child protection conference, so that these can be appended to the individual medical records without any potential problem of third-party references. The MPS is currently unaware of any such directions, and suggests that if GPs wish to pursue this, they should write to the RCGP or the Royal College of Paediatrics and Child Health.

The LMC Secretary adds: "I agree that these reports should not be scanned into each individual patient's notes because of the references to others, which could cause immense difficulties in respect of patient confidentiality and potential harm to the patient(s), particularly in the event of any future requests for medical notes under the Data Protection Act, or by a court of law. It is essential to keep these reports separate from the medical record, with a robust "pop-up" system to ensure that those consulting the medical record are aware of their existence.

"I think I can hazard a guess at Social Services' response to a request for multiple different versions of a report on a single child protection conference! They themselves would have no conceivable use for such different versions, and I imagine it would in any case be extremely difficult to produce meaningful individual reports that omitted any reference to the other individuals involved in the situation. So although I agree that it would be highly desirable, from the GP's point of view, if this could be done, I do not think it is really practicable."

THE COLLABORATIVE ARRANGEMENTS

The following is an extract from the DDRB Report that relates to the collaborative arrangements:

Sessional fees for doctors in the community health service and fees for work under the collaborative arrangements between health and local authorities

3.64 The BMA reminded us again this year of its serious concerns about the level of the various fees payable to doctors under the collaborative arrangements (covering services in the fields of education, social services and public health), particularly since the introduction of the new GMS contract, and how the level of fees was discouraging medical participation in these areas of work. The feedback from the medical profession was that the fee rates were no longer economic and that many doctors had lost confidence in the collaborative arrangements system with a significant number refusing to work within the current fee scales. We were told that there were no contractual obligations for doctors to perform this work, unless they were employed directly by a PCO. As there had been no progress on increasing fees under the collaborative arrangements to realistic levels, the BMA said it would have no option but to issue guidance about doctors' rights to withdraw from the work. It would also invite doctors to consider their options to charge on an individual basis, rather than using our recommended fee increases. The BMA said it believed that this was the last opportunity to correct the poor fee levels and reform the remuneration structure of the collaborative arrangements. It therefore recommended that these fees should in future be based on the BMA's 'Treasury' rate and if we could not recommend this, that doctors should be allowed to charge their own market rate. The BMA said that in 1997 we had stated that these fees were not within our remit and had recommended that they should be established at market rates. The alternative option would therefore be a return to this recommendation.

3.65 The BMA also set out its concerns regarding fees for family planning work. The remuneration provided for this work was well below the commercial rates that doctors had secured for other family planning activities and the BMA said it believed there would be a crisis in recruitment if family planning rates were not increased

significantly.

3.66 Asked whether GMPs had any legal obligation to treat patients under these arrangements, the **Department of Health** told us that collaborative arrangements had their basis in Sections 26-28 of the NHS Act 1977. These covered the making available of NHS resources, including staff, to Local Authorities. The resources might include GMS and PMS contractors so far as was reasonably necessary and practical to enable local authorities to discharge their functions relating to social services, education and public health. The Department said it believed that for the most part, payments under collaborative arrangements were probably considered to be outside the GMS contract and it did not see this work as part of enhanced services. There was a structure for paying set fees to GMPs undertaking collaborative arrangements so payment via an enhanced service would seem inappropriate.

Comment

3.67 *Over recent years we have made clear our concern about the lack of progress in reviewing these fees. At the same time, the BMA has argued consistently that we should recommend that its so-called 'Treasury' rate is used as the basis for these fees. We have not been persuaded by the BMA's argument because we have had no evidence on which to make a judgement about the wide-ranging work which is being carried out. **We therefore recommend that doctors engaged in this work should set their own fees for 2006-07.** We believe that this approach is not out of line with the Government's policy of local commissioning of services and of contestability. We do not intend to revisit this issue in the future unless the parties provide us with better evidence on which we can make a proper judgement.*

Comment by the BMA:

Psychiatric assessments (related to the 1983 Mental Health Act) come under the Collaborative Arrangements. The BMA's Professional Fees Committee is currently considering its position in light of the DDRB recommendation. At present the current rates apply, but the doctor cannot assume that a 2.2% increase will take place.

REFERRALS TO COMPLEMENTARY THERAPISTS - NEW GUIDANCE FOR THE GPC

This new guidance is now available on the BMA website. It aims to clarify the legal and ethical obligations of GPs in responding to requests for complementary therapy. The BMA welcomes the greater use of the range of specialist skills within the health service, but has some concerns about the implications for GPs if patients are referred to non-medically qualified practitioners.

GPs are contractually obliged to refer patients for services available under the NHS, and referral to complementary therapists should not therefore be considered a contractual requirement. However, referral to NHS doctors at NHS homeopathic hospitals or NHS homeopathic clinics where GPs and their patients think such treatment is appropriate would fulfil the contractual responsibility. GPs may prefer to suggest that patients visit a therapist without actually making a formal referral, and may offer to recommend a suitable individual, but they must satisfy themselves that the individual is competent in the therapy.

Many GPs will not wish or feel able to advise a patient to consult a complementary therapist. In such cases, the GP should make it clear that s/he has no objection to the patient consulting whomever they wish, and should not criticise or victimise the patient if they choose to do so.

The GMC distinguishes between delegation and referral in *Good Medical Practice*:

“Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient.

“Referral involves transferring some or all of the responsibility for the patient’s care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment, which falls outside your competence. Usually you will refer patients to another registered medical practitioner. If this is not the case, you must be satisfied that such health care workers are accountable to a statutory regulatory body, and that a registered medical practitioner, usually a general practitioner, retains overall responsibility for the management of the patient.”

GPs can safely refer patients to complementary therapists who are registered as doctors or nurses with the GMC or Nursing and Midwifery Council, because these therapists are fully accountable to the GMC or NMC for their actions and the patient can seek legal redress in the event of an accident. This also applies where practising doctors or nurses offer complementary treatment in addition to their normal services. Although the GP remains responsible for the overall management of the patient’s care, s/he is not responsible for the detail of the treatment given.

There is also no problem with GPs referring patients to practitioners in osteopathy and chiropractic who are registered with the relevant statutory regulatory bodies, as a similar means of redress is available to the patient. The GP has an obligation to check that the therapist is indeed registered with the appropriate body. These are currently the only complementary therapists subject to statutory regulation.

Before referral, the GP must first be satisfied that the patient will benefit from the type of treatment, which presupposes that the GP has some knowledge of the basic principles of the therapy, and some belief in its efficacy. If the patient suffers harm as a result of the treatment, the GP could retain some liability and would need to demonstrate that s/he had reasonable grounds for believing the therapist to be competent. Registration with a statutory regulatory body would be regarded as reasonable grounds.

A GP can *delegate* treatment to complementary therapists who are not registered with a statutory regulatory body. In doing so, s/he remains responsible for the treatment given and would bear some liability should the patient come to harm. Whether GPs are prepared to delegate treatment will therefore depend principally upon their knowledge of, and belief in the efficacy of, the therapy, and their personal knowledge of the competence of the therapist.

The BMA advises (*Medical Ethics Today, 2004*) that:

For other therapists [not subject to a statutory regulatory body], the GP is considered to have delegated care and so retains responsibility for the overall management of the patient. When GPs employ CAM therapists who are not subject to a statutory regulatory body, they need to be satisfied that the individual is suitably qualified and experienced to undertake the role. GPs should also be aware that, in such circumstances, they may be held liable for any harm arising to their patients.

In delegating to complementary therapists, GPs must

- ensure that tasks are delegated only to those competent to fulfil them, even though they need not be medically qualified or subject to a statutory regulatory body.
- satisfy themselves that the treatment seems appropriate to the patient’s needs and is likely to benefit the patient. This presupposes some knowledge of, and belief in the efficacy of, the therapy.
- pass on enough information about the patient and the treatment needed. The GP will need to identify the information the therapist needs, and must ensure that s/he has the patient’s consent to the disclosure.
- retain responsibility for managing the patient’s care, eg by asking the patient to see the GP shortly after the treatment to review its effects. The GP must also ensure the patient has access to any necessary conventional treatment. If the patient insists on seeing a complementary therapist rather than following the GP’s advice that conventional treatment is required, the GP should record this in the patient’s notes and confirm the advice to the patient in writing.

DR BASIL BILE WRITES ...

Inspired by recent revelations under the Freedom of Information Act, I thought I would share with you all the entirely honest and transparent process by which our new Practice Manager has just been appointed at the Abandonhope Surgery from a list of five candidates of equal worth.

We used extremely valid and robust criteria and decided to select the winning candidate on the basis of their names ending in the letter "O". Using this methodology the candidates fared as follows:

- 1) Mandy Murko-Murko
- 2) Brenda Burko
- 3) Linda Lurko
- 4) Dr Philip Travaillo (sadly at a loose end)
- 5) Bartholomew Tankard-Fidgett (my brother-in-law)

We on the selection panel (me and the surgery cat) unanimously agreed at this point that we needed in the spirit of fairness and thoroughness to come up with some new criteria, so I suggested the candidates be arranged in reverse order in relation to offensiveness of body odour:

- L. Lurko
- B. Burko
- M. Murko-Murko
- P. Travaillo
- B. Tankard-Fidgett

Now becoming somewhat desperate I had a flash of inspiration and suggested we judged them by the criteria of who was related to me by marriage, at which point we had a clear winner:

B. Tankard-Fidgett

Given the appropriateness of the result which I am sure will be the best value-for-money for the NHS, not withstanding my generous contribution as his employer of 10p every February 29th to Bartholomew's pension fund, you can imagine just how crestfallen a chap I was when I read the simply scandalous analysis by the Internal Auditor, one Mr Antique Lecher, of our wholly blameless procedures when he had the gall to state:

"... even to a congenital idiot the whole process looks decidedly dodgy and biased in favour of the eventual successful candidate."

This was despite my employing Mr van der Wet Porn-Cure from Shipman's Medical Solutions to oversee the whole bally shooting match. My lawyers, Messers Dommett, Scrotum and Groyne, are pursuing the clearance of my good name through the courts, funded I gather by an anonymous donation from the soon to be Lord Emetic-Jones of Cudmore.