Introduction

We are all looking forward to the summer holidays and I hope you find the latest newsletter informative. The newsletter aims to give a slant on issues as they affect us locally and you are welcome to forward any items you feel would be helpful to colleagues in this area. We have another contributor to Dr V Spleen who will continue to remain anonymous.

Information and Data about Patients for PCTs

Legal advice states that if the PCT requests information a practice can provide it if the data is anonymised. If information is anonymised patient consent is not required. If data cannot be anonymised the PCT needs to get patient consent. The MDU has given recent advice on this in its journal of May 2005.

If the PCT wished to access information under the Freedom of Information Act, they need to put a formal request into the practice stating precisely what information they require and for what purpose. The practice can then provide this information, anonymised as necessary rather than allowing general access to patient level data to the PCT. However, if the PCT wish to see the patient data then this falls under the Data Protection Act and the code of practice “Confidentiality and Disclosure of Information” March 2005 will apply.

The LMC is happy to provide advice to the practices that are chosen at random for the Quality and Outcomes Framework Counter Fraud Checks and Post Payment Verification Visits for Enhanced Services claims. Relevant information can be provided.

GPs should be aware of their responsibility to their patients if patient identifiable information is to be released and be prepared to justify their reasons for not obtaining the patients consent if a complaint is made to the General Medical Council.

Request to Disclose Deceased Patients Medical Recs

A colleague received a request from a life assurance company to disclose a deceased patients medical records and asked the LMC if he could do this.

The fact that a patient is deceased does not absolve a doctor from the obligation of confidentiality. The patient may have given the insurance company consent to disclosure of their records after their death when applying for the policy. It is important that the doctor is satisfied that the consent given at that time was valid and that the patient fully understood the nature of the consent they were giving.

If there is no evidence of existing consent from the patient, then the Access to Health Records Act 1990 states that an application for access to a health

record or any part of a health record be made to the holder of the record by: “where the patient has died, the patient’s personal representative or any person who may have a claim arising out of the patient’s death”.

A personal representative is any person entitled to deal with a deceased person’s estate in accordance with their will or under the intestacy rules – which would include executors and administrators. It is important that a personal representative is fully informed of the potential implications of disclosing information to an insurance company. No information should be disclosed about a third party, such as a relative or child, without that individual’s consent.

If a patient specifically refused disclosure of any information after their death, then their wishes should be respected. The GMC advises that:

“You still have an obligation to keep personal information confidential after a patient dies. The extent to which confidential information may be disclosed after a patient’s death will depend on the circumstances. If the patient had asked for information to remain confidential, his or her views should be respected. Where you are unaware of any directions from the patient, you should consider requests for information taking into account:

·whether the disclosure of information may cause distress to, or be of benefit to, the patient’s partner or family;
·whether disclosure of information about the patient will in effect disclose information about the patient’s family or other people;
·whether the information is already public knowledge or can be anonymised;
·the purpose of the disclosure.
·If you decide to disclose confidential information you must be prepared to explain and justify your decision”
(Confidentiality, para 30).

Coroners' Report

New rates from 1st June 2005 are as follows:

Full written clinical report without examination provided at the request of the Coroner £60.50

Extract from the doctor’s records £30.00

The payment of the fee for a full written clinical report is not to be contingent upon the holding or otherwise of an inquest.

Ambulance Bookings Across County Borders

GP staff in three of our PCTs except South West no longer have to arrange

ambulance bookings for Staffordshire Ambulance Service. Unfortunately our neighbouring LMCs do not feel this is a priority to remove this workload from their constituent GPs. South Staffordshire LMC has requested the PCTs to discuss the matter amongst themselves but those GPs on the border that feel frustrated may wish to complain to the respective LMCs.

Methadone Prescribing

Please remember this is an Enhanced Service and therefore voluntary. GPs should not feel coerced into prescribing because of recruitment difficulties in the addiction services.

Trainers' Educational Grant Towards Cont Prof Dev

A local trainers group has enquired as to the above payment for trainers. The review body recommended that all approved GP trainers should receive a separate payment towards their continuing professional development costs of £750.00 per annum. This sum continues to be paid to the trainer for 1 year even if no registrar is allocated to the trainer. However, the directions issued by the Department of Health in 2005 make no mention of the extra £750.00 but do uplift the trainers grant by 3.225% for 2005/06 to £7,024.00 per year. Therefore the reason that the trainers will not have received the £750.00 is because it has not been included in these directions. The General Practitioner Committee has agreed to write to the Department of Health to complain about this.

Normalisation

The GPC has agreed a mechanism with the department for correcting the over and under payments that were made to practices' Global Sums due to errors in the Exeter software that lead to the faults in the quarterly calculation of the normalisation index in quarter 2 and quarter 3 for 2004/05.

Practices that have been overpaid

1.Practices that owe £2,000 or less will have the full sum owing recovered by way of a reduction in their monthly global sum payment for August 2005.
2.Practices that owe more than £2,000 will have the full amount recovered over six, equal monthly instalments by way of a reduction in their monthly global sum payment starting in August 2005.

Practices that have been underpaid

3.PCOs will make one additional payment of the full amount owing to practices in August 2005.

August 2005 has been agreed in order to allow sufficient time for the software to be amended to enable these payments to be made and to calculate the actual amounts per practice. In time for the August payments, PCTs will be

notified formally of the actual amounts per practice and the procedure for making the additional payments and recovering the over-payments. The monthly global sum payment(s) variation will be separately identifiable for practices through the Exeter payments system.

Out of Hours and Staffordshire Ambulance Service

The LMC is concerned that there are no vocationally trained GPs amongst the doctors in the Out of Hours Service provided by Staffordshire Ambulance for over 6 months. This is a statutory requirement and the LMC is pressing for this to be resolved soon.

Dr V Spleen

Dear Reader

PCTs. Dontcha just love 'em? You don't? Ah come on guys, they are on our side after all! At least I think that is the idea!?

If a GP was having problems I am sure they would help? Unless of course the problem was with a patient who had gone moaning to PALS, then they might have to take the patient's side, but that's not their fault, so no hard feelings, eh?

Choose and book? Well that's not their idea, so it's not their fault that they have to shamelessly push it down our throats. If they don't they lose £1000s, so don't blame them for that.

Advanced access? Well, that's old hat now. We all agree with the PCT that it's a good idea now don't we?

The PCTs are after all closer to the people they serve and to us GPs at the coalface aren't they? They have public meetings and GP communication meetings! Sometimes real issues even come up at those, and it gives us a chance to meet the bureaucrats so they can hear directly from us (it's not their fault if the issues move on and they have to ignore our protestations!). I keep meaning to ask what the total number of PCT bods across the LMC patch now stands at compared with the old SSHA numbers. It certainly feels like there are more pen pushers now than there ever were before. Don't worry though, the PCT is steered by the PEC; local 'jobbing GPs' who will be shrewd enough to keep the PCT bandwagon on track. Well, except that some PECs seem no longer to be chaired by GPs, and seem to disregard the views of GPs who manage to remain on the PEC. Plus once there the GPs are employees of the PCT so they cannot really step out of line and truly represent their colleagues.

Ah yes I do so love the PCTs. What a shame they may soon be consigned to the dustbin of history

Yours sincerely

Venture