PRACTICE OBSERVED

Law and the General Practitioner

Statutory sick pay: keeping records

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You are required by law to keep the following sickness absence records: (i) dates of sickness absence of at least four consecutive days (including Saturdays and Sundays) reported to you by your employees; (ii) any days within these sickness absences for which statutory sick pay was not paid, together with the reasons for not paying; (iii) details of each employee's qualifying days in each period of incapacity.

All these records should be kept in a form that allows an inspector from the Department of Health and Social Security to have access to them on request, and you must be able to produce them within a reasonable time if you are asked to do so. They are, of course, your source of information if an employee asks you for a written statement of his or her entitlement to statutory sick pay for a past period.

As long as the records conform to these requirements they may be kept in any way that is convenient to you. You must retain them for at least three years after the end of the tax year to which they relate. There is a penalty for failure to produce them (see table). The DHSS has produced a record sheet (form SSP5), which has been designed solely for this scheme. Sheets are available free from local DHSS offices.

You are also required by law to keep records showing, for each pay day and for each employee, any sick pay that is paid as well as the usual records of pay, PAYE income tax, and National Insurance contributions. And when making your annual returns of pay, tax, and National Insurance contributions to the collector of taxes, you must also provide details of the gross amount of sick pay paid to each employee and the total amount paid to all employees during the tax year. Further details of what is required are given in the *Employer's Guide to PAYE* (booklet P7) (available from any tax office), leaflet NPS15 (paragraphs 114-119) (available from any DHSS office), and the *Employer's Guide to Statutory Sick Pay* (paragraphs 137-142).¹

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In addition to the above records that you are legally obliged to keep there are other records that you may find useful to keep for your own purposes. (1) Any doctor's statements or sick notes; you may wish to retain or copy the originals, since if there should

(3) Two of your receptionists have a job sharing arrangement; they fill one post by working alternate weeks. One of these receptionists is sick on Monday, 11 July, a day in the week when she would not normally be working. On Wednesday 13 July you receive a doctor's statement stating that she will be fit to return to work on Thursday 21 July. Your receptionist is paid £260 gross each calendar month. Her average weekly pay will be (£260 ÷ 12) = £21.67.

You have agreed that her qualifying days should be those days on which she would normally work—Monday to Friday—and you have regarded each week as a normal working week even though the works alternate weeks, simply because the two receptionists sometimes vary by agreement the sequence of their rota. (You are free to agree any pattern of qualifying days so long as there is at least one qualifying day in each week. Indeed, if you had limited the qualifying days to Monday to Friday on alternate weeks, the Wednesday in the week not normally worked would have been deemed a qualifying day.)

The number of qualifying days on which statutory sick pay is due is five: 11, 12, and 13 July are waiting days. The weekly rate

of sick pay is £33.75—the middle level of payment. The daily rate of sick pay is £33.75 ÷ 5 = £6.75. Total gross sick pay due is £6.75 × 5 = £33.75. You already pay half pay for sickness, and your receptionist will have been paid £22nd. £130 ÷ 20 = £5 for her five qualifying days on which sick pay is payable. She is therefore due to receive a further £42.20 to comply with the scheme.

This is calculated by dividing the total number of working days in July—22—by the number of qualifying days on which statutory sick pay was payable and you also paid your own sick pay.)

I thank Dr John Ball and Dr W G A Riddle for advice. Any omissions or errors are mine.

This is the last article explaining the statutory sick pay scheme.

Reference

¹ Department of Health and Social Security. *Employer's guide to statutory sick pay*. London: DHSS July 1982.

The GP and the Medical Student

Students from London teaching hospitals

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For over 25 years as a rural practitioner I have been concerned with undergraduate and postgraduate education in general practice. Students are attached to our practice—the "University of Thaxted," as one called it—and so I was able to translate the idea of "exposure to general practice" into practical terms. We have offered a week or two at Thaxted to about four students a year. All have found it interesting and stimulating—one so much so that she won a national essay prize on a write-up of a patient seen there.

"We have a student coming for the second week in September," I tell my wife, my partner, the practice manager, and my personal diaries. The unknown man or woman telephones a week before to learn how best to travel here on a Sunday evening. The daily coach from London has been withdrawn on Sundays, so it means a train journey to Bishop's Cleeve, and my wife or I driving the 12 miles to meet the student. On the drive home the generation gap, becoming more noticeable each year, is quickly closed, and we have had no difficulty in establishing an empathy with the student, though each I think has found it a strange experience. A cold supper, a brief drive round the village to establish the nature of the community which I describe as "an island in an agricultural sea," and early bed is our routine.

For the next two days I invite the student to be a "receptive shadow." He or she accompanies me from breakfast until bed-

time observing, being observed, and talking or looking matters up quickly in our personal libraries. New illnesses are introduced—anything from acne to zoster—and previously studied conditions are reviewed and seen in a different light. The student meets the staff and my partner on a chance basis, and no opportunity is missed. "This is my partner, he's especially interested in physical treatment of back pains. This is my other partner, she's our family planning expert. This is our community sister," and so on. At the end of two days I have some idea of the student's character, strengths, weakness, and wishes.

On Tuesday evening I plan the rest of the week with the student. Usually the student spends the next day with my partner visiting a local Army barracks for sick parade and families' surgery, home visiting, and accompanying a partner home for lunch and discussions. A visit to our local hospital at Saffron Walden to attend a patient in casualty, see x-rays, or attend a patient in one of the remaining GP beds gives the student a different insight into patient care. In the evening we often go on to an inn at a nearby village for supper, frequently meeting some of our patients in their more natural surroundings.

By the next day the student has either shown a particular interest, become concerned with a particular patient, or I have become anxious over some obvious weakness in the student's education which I feel I can support. Medical history, ethical behaviour, religion in medicine, prescribing and dispensing are obvious subjects as the "props" are so readily available, and part of this day is usually devoted to special interest subjects. I usually have a research project in hand and try to interest the student in doing some research work during their week here. It requires retrospective statistical work concerning the incidence of malignant disease and fatal coronary occlusion in patients in

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Offences and penalties

The Social Security and Housing Benefits Act 1982 and its regulations provide

Offence	Penalty
(1) Failure to pay sick pay within the time allowed, when an insurance officer, local tribunal, or social security commissioner has given a formal decision that it is payable	(1) (a) For any one offence, a fine not exceeding £200 (b) For continued failure to keep records after conviction, a further fine of up to £20 for each day of such failure
(2) Failure to keep the required records in connection with sick pay	(2) (a) For any one offence, a fine not exceeding £200 (b) For continued failure to keep records after conviction, a further fine of up to £20 for each day of such failure
(3) Failure by an employer to provide an employee with the prescribed information, by the prescribed time, in connection with a claim for sickness benefit, maternity allowance, invalidity pension, industrial injuries benefit, non-contributory invalidity benefit—that is, failure to provide an exclusion or transfer form	(3) (a) For any one offence, a fine not exceeding £200 (b) For continued failure to provide such information after conviction, a further fine of up to £20 for each day of such failure
(4) Producing, furnishing, or causing or knowingly allowing to be produced or furnished, any document or information that is known to be false in a material particular, when purporting to recover amounts paid by way of statutory sick pay	(4) A fine not exceeding £1000 or a term of imprisonment not exceeding three months, or both
(5) Recklessly producing or furnishing any document or information that is false in a material particular, when purporting to recover amounts paid by way of statutory sick pay	(5) A fine not exceeding £500
(6) Failing to provide, when requested in writing to do so, information required by an insurance officer, a local tribunal, a social security commissioner, or the Secretary of State for Social Services or his authorised representatives, the formal determination of any question arising in connection with statutory sick pay	(6) (a) For any one offence, a fine not exceeding £200 (b) For continued failure to provide such information after conviction, a further fine of up to £20 for each day of such failure

be some dispute about days of sickness knowledge of the date on which the doctor signed the sick note, when you received it, the period it covered, and the nature of the illness could be useful. (2) Details of your rules on the notification of sickness, and the dates on which your employees notified you of sickness. This information will be useful if there is any dispute about eligibility for statutory sick pay.

How sick pay will affect the direct reimbursement of staff salaries

Unless some adjustment is made to the directly reimbursed salaries of trainees and ancillary staff who continue to be paid when sick there will be an element of double payment to doctors. It has been agreed that: (a) trainees should inform family practitioner committees of the amount of statutory sick

pay paid and recovered when their trainees are sick and that family practitioner committees should reimburse the trainees' salaries net of sick pay; (b) doctors should, when informing family practitioner committees of the salaries paid to staff under the ancillary staff scheme, declare the amount of sick pay paid and recovered when their staff are sick and this will be set against the amount directly reimbursed by family practitioner committees. The *Statement of Fees and Allowances* (the "Red Book") will be amended accordingly.

Examples of how statutory sick pay works

(1) Your receptionist works six days each week, Monday to Saturday, and you have agreed that her qualifying days should be Monday to Saturday inclusive. Although she only works half days on Wednesdays and Saturdays, all six working days count as qualifying days. Your rules about notifying sickness absences are that employees must telephone on the first qualifying day of sickness.

Your receptionist does not come to work on Monday, 14 November 1983, and she telephones you that morning to say that she is ill. She returns to work on Tuesday, 22 November 1983, and completes a sick certification form, saying that she was sick from Sunday, 13 November until Tuesday, 15 November, and provides a doctor's statement dated 16 November, which states that she will be fit to return to work on 22 November. Her weekly earnings are £125 gross. Her approximate weekly rate of statutory sick pay is £40.25, and her daily rate is £40.25 ÷ 6 = £6.71 (the weekly rate divided by the number of qualifying days in the week).

The first three qualifying days, 14, 15, and 16 November are waiting days for which sick pay is not payable. Sick pay would be payable for 17, 18, 19, and 21 November at £6.71 per day, making a total of £26.84. But since you are already paying her full pay of £125 per week (£20.83 for each day of sickness absence), which is well in excess of your liability for sick pay for each payable day, you need pay no more than this. Your liability for sick pay has been more than met by your own sick payments, but you should, of course, reclaim the gross amount of sick pay due (£26.84) by deducting this from your next monthly payment of National Insurance contributions and PAYE (income tax).

(2) Your practice nurse works on mornings only—each Wednesday, Thursday, and Friday. You have not agreed any qualifying days with her in advance (although you should have), but she is aware of your rule about notification of sickness, which says that employees should telephone you on the first day of absence.

She does not come in to work on Wednesday, 1 June 1983, but telephones that day to say that she is ill. It is her first absence for over a year. As a part timer she is not entitled to any occupational sick pay from you.

On Monday 6 June you receive a self certificate form stating that she has been incapable of work since Saturday 28 May, together with a doctor's statement dated 4 June, which states she will be fit to return to work on Friday 10 June. She returns to work on that day.

Her pay over the eight weeks before the fell sick has been £39 a week gross, payable each Friday. Which days are qualifying days? In the absence of any agreement as to qualifying days, they are those days that you and your employee agree would normally have been worked—that is, Wednesday, Thursday, and Friday.

Thus there are three qualifying days in each week. The weekly rate of statutory sick pay is £27.20, being the lowest of the three flat rates. The appropriate daily rate is therefore £27.20 ÷ 3 = £9.07.

This spell of sickness includes five qualifying days. The first three are waiting days, and sick pay is therefore only payable on 8 and 9 June. Since the daily rate is £9.07, the total gross sick pay due is £18.14. This should be reclaimed in the normal way by deducting it from your monthly payment of National Insurance contributions and PAYE (income tax).

the practice, and I hope by showing my interest in these subjects to educate the student into this aspect of family practice.

By Friday we know each other quite well. The student often requests the opportunity to sit in on surgery to see again some of the patients seen on Monday and Tuesday who perhaps are coming back to bear results of investigations. Friday afternoon is "free" for the student, who is gently but firmly persuaded that Thaxted's famous church and guildhall should not be missed, nor, if time allows, the church in nearby Hemstead that contains William Harvey's tomb (1578-1657). The week still has some new experiences for the student, since at any time of the day or night the radio beep may summon us to a roadside emergency call, the drama of which students seem to enjoy. This voluntary service in the Saffron Walden Accident Group, a member of the British Association of Immediate Care Schemes, and my position as commissioner for St John Ambulance in Essex promotes discussion on the details of first-aid and on the relation of the voluntary services to our society. Students have sometimes accompanied me on visits to St John units elsewhere in Essex.

A birth at home is statistically not likely to occur during the week, but students who have attended confinements here have been impressed by the degree of skill brought to the home by the midwife and the potential of the GP obstetrician, as well as by the domesticity of the whole affair. Medical politics and the work of the royal colleges are briefly discussed during the week, prompted by literature from the local medical committee and the Essex Faculty of General Practitioners and the Association of General Practitioners, as well as by the national medical press.

As there is a direct coach service at 9 am on Saturday to King's Cross, this usually completes the visit with promises of positive health. One commented on the unexpected amount of psychological illness that he saw, saying "I would have expected to see such entities as severe depression, paranoia, and schizophrenia in larger cities, certainly not in the quiet and peaceful surroundings of the English countryside. One too quickly associates severe mental disorders with the complexities and rushing about in the large metropolitan areas, and does not think that rural life would be associated with emotional problems, severe enough to develop into psychoses. The apparently simple life really isn't so simple!" This statement really characterises the student's impressions: many are overconfident about the present state of knowledge and ability of modern medicine, and I think are humbled, informed, challenged, and stimulated by seeing so much "incurable" and recurring ill health.

What good or harm does it do the student?

It is not easy for me to judge the good or the harm, as the students are usually too polite to make much critical comment. They are requested to write their thoughts to the director of the department of general practice concerned. I think that the experience truly leads the students out from previous conceptions of a rural doctor's life, from previous attitudes to health and illness, and from previous priorities. Many seem to learn of their (and our) enormous lack of knowledge. Their faith in their teachers is confirmed, as one student observed, "You do exactly what we are being taught." Differences between the three partners in the practice are always commented on, and the student realises that there are many ways of working towards positive health. One commented on the unexpected amount of psychological illness that he saw, saying "I would have expected to see such entities as severe depression, paranoia, and schizophrenia in larger cities, certainly not in the quiet and peaceful surroundings of the English countryside. One too quickly associates severe mental disorders with the complexities and rushing about in the large metropolitan areas, and does not think that rural life would be associated with emotional problems, severe enough to develop into psychoses. The apparently simple life really isn't so simple!" This statement really characterises the student's impressions: many are overconfident about the present state of knowledge and ability of modern medicine, and I think are humbled, informed, challenged, and stimulated by seeing so much "incurable" and recurring ill health.

What good or harm does it do the GP?

Having a student certainly slows down the work of the practice, and the reception staff do not like the "no double

booking, a student is coming" rule. Patients do not seem to mind, but perhaps once a week one will respond positively to my question to each one of them, "Do you mind the presence of a student?" It is undoubtedly stimulating to have a young, refreshing, inquiring mind, and having a visitor in the practice puts us all on our best behaviour. It is encouraging to have one's own knowledge confirmed so often, as well as helpful to learn of deficiencies in both ourselves and the students. One student from a metropolitan area was intrigued by the pleasure of rural life and wrote: "My one-week course in agriculture now enables me to distinguish between wheat and barley, and in fact I can spot a game partridge at 50 yards running down a freshly tilled field!"

What good does it do the practice?

Any professional visitor, particularly one with a young, interested, observant mind, does a practice good, producing in us, as visitors do, a stimulus to show one's best. Contact with the directors of departments of general practice in London teaching hospitals adds an extra dimension to our lives as general medical practitioners.

During the first day of the student's visit I usually make the analogy between medicine and horticulture, again as the props are so readily at hand. The flowers are our patients: as we walk around the garden (the project in hand) we see a flower in bloom, ready for picking and sending to the florist (the consultant) for further work-up. Others are not suitable for picking, and yet are just as interesting and beautiful. Others are just emerging, and we cannot yet see their true colours. Others have bloomed and died. All should be studied.

Attendance allowance scheme

I would like to canvass the views of other general practitioners throughout Britain on the working of the attendance allowance scheme. I work in an area with a high proportion of elderly people, most of them living on small fixed incomes. Accommodation in geriatric hospitals and homes for old people is limited, and most of the elderly and disabled people are cared for at home with the help of families, friends, and neighbours.

If they are completely disabled and "helpless," I am not suggesting that the responsibility for looking after dependent relatives should be taken away from the family, but with an expressed policy of returning more chronic sick people from institutional care to the community I think that we should recognise the additional physical, psychological, and financial strains that this imposes on the attendants who have to carry out the extra work by granting attendance allowance. It makes sense financially, too. It is far more expensive and far less satisfactory for individuals to be confined to institutions, which may so easily develop into "geriatric ghettos."

I would be interested to hear from any doctors who have had similar difficulties in their area and, indeed, as interested to hear from those who have found the attendance allowance scheme to be "alive and well" and fulfilling what I see to be its real function—enabling as many as possible of our elderly, infirm, and disabled patients to remain and be cared for in their own homes—H. STACEY, general practitioner, Union Surgery, Llandysul, Dyfed SA44 4QS.