Devon LMC
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Your Local Medical Committee representing and supporting General Practice
Serving General Practices in: Devon County Plymouth Torbay

Risky business

Editorial by Dr Anthony O'Brien, Chair of the Northern and Eastern LMC Sub Committee and LMC Board Vice Chair

Medicine is not binary, it is complicated and grey. History and examination lead to differential diagnoses along with an assessment of the risks, the pros, the cons of the next intervention. Often as GPs this is 'as much nothing as possible' (The House of God, Samuel Shem). Watching and waiting, not ordering tests, not writing referral letters is a difficult negative to quantify but this does not mean it should not be highly valued or properly rewarded; it is after all the hardest skill to master.

Clinical risk decisions are appraised by their outcomes and how quickly this occurs depends on the specialty you work in: Acute medicine and Intensive Care often hour by hour, us GPs day by day, Pathologists, well, death by death or visualized cell by cell. Recently the RD&E experimented in asking their Consultants to raise their thresholds of risk for a week in an attempt to try and free up bed space. I do not know how effective this was in reducing admissions/increasing discharges but it strikes me that this would have been a very difficult thing to actually put into practice. It is only by comparison with peers and what they do in certain situations that you can grade yourself in terms of how risky your risk management is. Guidelines guide, obvious boundaries are respected but within these there is an accepted wide variation in good practice. The Defence Societies are the experts in how risky is too risky but none of us want to explore this area in any depth. This balance is currently playing out everyday. When a bed crisis is announced and the accompanying standard e-mail is sent to GPs most of us will ignore it, convinced that this knowledge will not influence our clinical assessment. Fascinatingly the statistics apparently show that acute referrals do drop. This suggests our levels of risk do alter, presumably sub-consciously, as no-one is going to write in the notes "wanted hospital to assess but due to their problems have decided to take more of a risk this time".

Decreasing hospital beds will inevitably transfer clinical decisions about risk away from the front door of the hospital, where the acute consultant, armed with a multitude of blood tests and X rays, can decide to send home or not. In Eastern Devon community support teams are already being bolstered to help keep patients at home. It is hoped that these changes will mean GPs are more likely to prolong some of our watchful waiting, reassuring patients and their carers that all is now going in the right direction. However we will undoubtedly end up with a lot more visits, to make a lot more decisions on sicker patients. When these carers are relatively inexperienced this takes longer and often involves more than one visit as well as numerous phone calls (the riskiest part of our job). This large increase in risk management is going to be difficult to quantify but will be enormously time consuming and stressful work. This needs to be recognized and is much more complicated to properly reward than looking at Item of Service payment models that the purchaser

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provider system (now fortunately in its final throes) was so focused on. As GOMER's (Samuel Shem definition) increase, there must be a real, direct, clearly identifiable rise in GP funding. If this arrives as promised then many of the current risks to general practice may be diverted.

Levy increase reflects rising workload for LMC

Statement from Devon LMC Board of Directors

Devon Local Medical Committee is committed to delivering a high quality and value for money service to its member practices, as well as assisting its elected LMC members to support, represent and negotiate on their behalf.

Never before has securing the future of general practice been so important. Due to the challenges facing the profession, it has been necessary to raise the levy to reflect the increasing workload of the LMC – such as pastoral support and attendance at regular practice and multi-agency meetings – and the resources required to deliver this.

The levy has been held at 50p for the last five years, but to do this the LMC has used some of its reserves and unfortunately it now needs to increase the amount requested from practices to sustain the services offered to them.

The levy will therefore rise from 50p to 54p per patient for the 2017/18 financial year. Half of this increase will cover the additional operational costs in providing key services to GPs and practices, preventing further erosion of reserves.

The other half will fund a dedicated practice support program, a rapidly expanding area of work which includes support in mergers, working at scale, disputes and resilience measures.

The LMC's Board, which approved this difficult decision at its latest meeting, is very conscious that there is never a good time to raise the levy and acknowledges the current financial pressures on practices.

Nevertheless, the LMC believes that it delivers value for money and fulfils its purpose. On a national level the LMC is highly regarded by the General Practitioners Committee for the quality of its work.

The officers and members of the LMC will continue to make the most effective use of levy payments and manage expenditure carefully, never losing sight of the source of the funding.

The LMC's accounts for 2016/17 will be available at its Annual General Meeting on 25 May when there will be opportunities for GPs to ask questions about the LMC's work and its finances.

The LMC would like to reassure practice managers that the levy increase does not involve them in any extra work as the arrangements are automatically made by NHS England.

The LMC continues to encourage sessional GPs to make a voluntary contribution of £100 a year towards its services, which they are entitled to access in full. The LMC represents and supports sessional GPs as forcefully as their employed and independent contractor colleagues.

GPC Roadshow – GMS Contract Negotiations 2017/18

By Dr Andy Mercer, Chair of the Western LMC Sub Committee and LMC Board Member

After a long wait, the detail of the 2017/18 contract negotiations has finally been released and I think it is worth congratulating the GPC Executive for the job they have done. Considering the current climate and some of the rumours of what may have been enforced or be lost in the contract negotiations, I feel that they have achieved a good outcome for general practice.

Dr Mark Sanford-Wood visited Plymouth in March to present the recently negotiated contract changes and answer questions as part of the GPC Roadshow. Mark is currently one of the GPC Executives working directly with Dr Chaand Nagpaul, GPC Chair, in contract negotiations. His local familiarity enabled a healthy and frank discussion about the contract changes and enabled them to be put it into context for a 'grassroots' GP. Overall expenses covered will give a 1% uplift to the global sum.

The key points I took away from this positive meeting were:

1) Full reimbursement of CQC fees – once paid by practices they should send an invoice to NHS England and fees will be fully reimbursed.
2) Funding will be given to GP practices to help with the rise in indemnity costs – this payment will be based on Raw List Size (unweighted) and is designed to be available to the whole GP profession (works out approximately £2 per session worked in practice).
3) Learning Disability DES – payments will increase from £114-£140 per check.
4) The unplanned admissions DES will cease with the money moving directly into core funding – this is a win for general practice as this money as a DES was at risk of being pulled. Moving the funding into core retains it for the future. Instead of having the unplanned admissions care plans, practices will have to use a Frailty Tool with an annual review of medications and post-fall review. This should not be too onerous and the consensus was that this was good practice anyway.
5) Maternity payments – payments made to practices when a GP is absent on maternity leave will no longer be 'pro-rata'. Practices can claim up to a maximum of £1,734 per week (by the usual submission of invoices) for the first six months.
6) Sickness payments – when GPs have been signed off sick (MED3 required) after two weeks practices will be able to claim up to £1,734 per week for the first six months and then £867 for the next six months (claimed in a similar way to maternity claims). There is no waver for pre-existing conditions and this is seen as a real bonus. Practices are encouraged to look at their locum insurance with their broker.
7) Overseas visitors – will have to self-declare their county of origin on the new GMS1 forms (awaited in practices) – general practice will not have to chase up, confirm or police this. Returns will be made to NHS England and a small amount will be added to the global sum as a contribution to this work (equates to one hour of reception time per week in an average practice).
8) Core working hours remain from 8am-6:30pm – there is a commitment to be locally responsive and if practices have to close on an afternoon it is worth contacting the LMC office to facilitate any discussion. Practices which have to close during the week on a regular basis would not be eligible for the Extended Hours DES.
9) QOF – no changes at present – we still have it – for better or worse – there is no indication yet on whether or not it will remain, what will replace it or if it does disappear how the funding will be transferred into core.
10) Prisoners will be able to register with a GP prior to their discharge from prison. This will enable a practice to have sight of medications and address early any medical needs. This may reduce the impact of the Friday night attendance at 5.45pm with the possible request for medication, allowing practices to safely prescribe.
11) Firearms – the BMA has recently issued a reworked guidance on what general practice can do – when approached for information for a firearms licence application. (There are five new letter options covering all eventualities).
12) QRISK – after the problems created in practices with a glitch in the TPP software system for QRISK, a payment will be made to all practices of £6.50 per patient where amendments had to be made.

These points are only some of the key issues I felt were very relevant to local practices, but there was also a great deal more covered in the meeting and for those who were unable to attend I would certainly recommend looking at Dr Sanford-Wood's slides below.

There is a great deal going on in general practice at the moment and it will be interesting to see where the negotiators take things next year. We are also eagerly awaiting further information and clarification on the MCP contracts which may be offered in the near future.

The General Practice Forward View (GPFV) monies promised to primary care have yet to be realised in our localities and we hope there will be a push to demonstrate the will to work with the programme – moving the resource into general practice where the need is great.

The presentation about the new GP contract shared at the GPC Roadshow is available here. As previously communicated by the LMC, more information about the GP contract, including a letter from Dr Chaand Nagpaul, Chair of the GPC, outlining the final agreement is available here. A list of FAQs is also available here.

Firearms licensing process – new GP guidance

The British Medical Association (BMA) has issued new guidance for GPs about the process of firearms certification.

This brings further clarity to a longstanding issue which has concerned Devon Local Medical Committee (LMC) and its members.

The new guidance provides better protection to GPs from a legal, ethical and safety standpoint, if approached by the police for medical records for firearms ownership applications and opinions about whether patients are deemed medically fit to hold certificates.

It will help GPs to respond safely and professionally in a way that fits their circumstances.

You can view the new guidance – which is subject to further updates as national negotiations with the Home Office continue – here.

Dr Mark Sanford-Wood, our Medical Secretary who is working in the Executive Team at the General Practitioners Committee England, has been instrumental in achieving this outcome at a national level and our thanks go to him. You can read Mark's blog on the firearms issue here.

From an LMC perspective, our advice to local GPs remains to think very carefully whether you consider yourself to be qualified to provide the opinion being sought.

Promised funding fails to reach frontline GPs

NHS England must urgently address its failure to pass promised GP resilience funding down to the frontline.

That is the warning from doctors leaders after a BMA survey revealed the promised £40million fund is not yet finding its way to GP surgeries in need.

The survey of local medical committees found that in February this year, practices had only been identified and notified of their receipt of resilience funding in just over half of the areas that responded – 24 out of 40. And of these, funding had found its way to the frontline in only 16.

The BMA GPs committee has written to NHS England calling for immediate action – warning that the funding must be retained, ringfenced and sent to practices that need support before patients are affected or surgeries forced to close.

BMA GPs Committee Chair Chaand Nagpaul, pictured, said: "The resilience funding is a key element of the GP Forward View aimed at supporting practices that are under incredible pressure from rising demand, stagnating budgets and staff shortages.

"It is completely unacceptable that the BMA's survey shows that a postcode lottery has developed, with wide disparities over where the funding is being practically delivered. This is scandalous given that CCGs were allocated these funds in the autumn and under the Government's promised plan, practices should have been notified by December if they were eligible, with the resources supposedly arriving this month. In many cases these deadlines are being completely missed.

"The BMA has written to NHS England asking them to urgently address this serious operational failure. This funding must be retained and ringfenced for its intended purpose and not lost from CCG budgets due to their failure to spend it in this financial year.

"It is vital that every eligible practice should have access to this vital support, to prevent any adverse effects on patient services, or even in some cases practices closing."

BMA response to planned prescription rule changes

Responding to comments from Simon Stevens, NHS England's Chief Executive, on proposed changes to the rules governing the issuing of prescriptions by GPs in England, Dr Richard Vautrey, GPC England Executive, said:

"GPs have a long history of cost effective prescribing compared with many other health systems around the world, but recently there has been increased frustration that clinical commissioning groups have been taking different approaches to prescribing restrictions. This has lead to confusion and irritation for patients and potentially dangerous pressure to repeatedly change branded generics and implementing varying restrictions on particular items. This post-code lottery is unfair and there is a need for clear national arrangements that apply to all.

"However, rather than tinkering with the system, there needs to be a fundamental review so that all patients are treated fairly, no matter where they live, and GPs are not placed in an unacceptable situation of being pressured to limit prescribing when their patient is requesting a prescription. In addition, any new scheme needs to ensure that

those who are eligible for free prescriptions should be able to obtain these products directly from the pharmacist rather than making an appointment with a GP."

Budget fails to address NHS crisis, says BMA

The Government has failed to address the funding crisis in the NHS and politicians from all parties must come together to address the problems urgently.

This is the message from doctors leaders after the Spring Budget 2017 failed to offer any significant encouragement or remedy to the health service. Read more here.

The BMA has also compiled a Budget briefing for members which can be accessed here. Please note that as this has been produced as a member benefit, it requires login on the website.

New web resource on opportunities via the GPFV

The BMA has created a dedicated new web page where you can learn more about the opportunities available to you through the General Practice Forward View. It is available here.

Extension of NHS England Winter Indemnity Scheme

NHS England's Winter Indemnity Scheme has been extended and will now run until Sunday, 30 April, 2017.

General Practitioners Committee representatives had previously called on NHS England to extend the 31 March deadline to cover the Easter period.

Further details are available below:
www.england.nhs.uk/2017/03/gp-support-ideminity-costs
www.england.nhs.uk/gp/gpfv/investment/indemnity/winter-indemnity

The GPC has also issued a new briefing about the indemnity payment – to cover rises in indemnity insurance costs for all doctors delivering GMS work – which announced in the recent 2017/18 GP contract agreement. Read more here.

Government climbdown on national insurance rises welcomed

The GPC and the LMC has welcomed the Government's u-turn on national insurance rises announced in the Budget for the self-employed.

Dr Richard Vautrey, GPC England Executive, said: "We are pleased that the Government has listened to the concerns of organisations like the BMA and abandoned its plans on national insurance, which would have unfairly affected GPs."

TPP SystmOne – FAQs for GP practices

The GPC has issued new advice to address concerns around data governance at TPP practice sites. More information is available here.

Guidance for employing shared staff

The GPC has issued guidance for GP practices who are considering employing shared staff. More information is available here.

Sessionals subcommittee newsletter

The latest sessionals newsletter focuses on the sessional GPs survey and advice on changes to IR35 – the legislation which affects how people work through limited companies. You can read the newsletter here.

Medical records reminder – advice from PCSE

The GP Contract regulations require that records of deceased patients and those who have moved abroad should be printed in full and sent to Primary Care Services England (PCSE) though the usual route.

The records that do not need printing are those that have successfully transferred via GP2GP v2.2a. When you receive a read receipt then you don't need to print off the record, but you still need to put a slip in the Lloyd George envelope stating 'transmitted GP2GP and returned via the normal courier system to PCSE'.

Any Lloyd George envelopes/folders should be returned to PCSE.

The Acute GP Service in Western Devon: Primary care in secondary care to support patients and GPs

By Dr Ben Jameson, Clinical Director of the Acute GP Service, Livewell South West

The Acute GP Service started in Plymouth more than 10 years ago to manage the interface between hospital and home. GPs provide compassionate and skilled care for weeks, months and years before an individual needs hospital assessment and accept ongoing responsibility when people leave hospital. The knowledge and values from this relationship can be lost when care moves into a hospital setting.

Our service is built around a clinical conversation with referring doctors at the point of need for acute medical assessment. We capture and record this information and have the capacity to offer an assessment by a GP with access to the resources of the hospital. We are well placed to understand the resources available in the hospital and in the community, and aim to use this knowledge to support community GPs and their patients.

Our presence in the hospital gives us a unique perspective. There are tensions within secondary care and challenges around the interactions between providing services in patient best interest. There are detailed complications from the ways in which our GP systems interact with hospital processes. We have built good relationships with our secondary care colleagues and work alongside them in the ambulatory care unit.

The Spring budget contained the ominous statement: "I have one further announcement related to the NHS..." The Chancellor went on to highlight hospital pressure caused by delayed discharge of elderly patients and "...inappropriate A&E attendances by people of all ages." He proposed making £100m of capital available for 100 new triage projects in English hospitals by next winter.

As a primary care service based in the hospital, we have engaged in many initiatives to support the smooth running of the Emergency Department (ED). We have looked at patterns of presentations and contributed to discussions around the appropriateness of attendance. Our view is that there is not a significant problem with primary care attendance at Derriford ED. Properly resourced and supported general practice and primary care has an important role to play in keeping patients well and avoiding emergency admissions. Our successful service, supporting GPs at the point of referral for assessment has a demonstrable effect on hospital admissions.

With any extended scope GP work, there is potential to stretch a limited primary care workforce. This must be balanced against the benefits of using skilled generalists across the system and creating stimulating careers to promote recruitment and retention. We should remain cautious about policy proposals that may not be a good fit for the local picture and could detract from pressing issues like recruitment and resources.

‘GP led triage is not the magic bullet to reduce emergency department crowding’

Dr Ian Higginson, Consultant in Emergency Medicine in the Emergency Department at Derriford Hospital, Plymouth, shares his views about GP-led triage emergency departments in a blog for the *BMJ*. Read more here.

Repatriation of missing items from NHS SBS

The GPC is reminding practices that NHS England is expecting a response from them – whether it states ‘no impact’ or ‘patient harm detected’ – in relation to the national issue about the repatriation of missing items from NHS Shared Business Services.

How to access the new GP Health service

GP Health is up and running and the local clinical team in Devon includes Dr Andrew Tresidder and Dr Jenny Docherty.

If you need confidential help, please contact the service by emailing gp.health@nhs.net or calling 0300 0303300. The service is available from 8am-8pm Monday to Friday and from 8am-2pm on Saturday.

After registering with the national service – to collect demographics and a brief resume of the issue – plus a short telephone triage, you will have a choice of local clinicians via the NHS Booking App. For more information, visit http://gphealth.nhs.uk

New occupational health provider

Following a procurement process, NHS England has appointed Heales Medical Group to provide the new occupational health service to GPs and NHS dentists across the region.

Heales Medical is an established provider of occupational health services to both private and public sector organisations and the new service will be available from 1 April 2017. More information is available here: Heales Medical Group.

Care Quality Commission – local and national update

As you may be aware Devon LMC meets regularly with local Care Quality Commission (CQC) Inspectors. The first tranche of inspections has been completed and every practice in England has now been inspected.

There are, however, a few practices in the region who are being re-inspected and these are either as:

- Follow up inspections to look at your action plans
- First comprehensives – where mergers have taken place or where new practices have formed
- Focussed inspections where there has been a concern raised and a targeted inspection is required.

Some practices locally may also be inspected in cases where their original inspection was carried out in the very early stages of the new inspection process before the methodology was fully embedded and following changes in the Key Lines of Enquiry (KLOEs). CQC will also be inspecting a small percentage of good and outstanding services.

Evidence – If you are about to have a follow-up inspection it is advisable to review your report carefully and ensure you have addressed all the ‘must dos’ and ‘should dos’ listed within your report as these will be the focus of the re-inspection. Ensure you have evidence of your improvements and a completed action plan. Also, if you think you are providing outstanding care then again think how you will evidence this. Don’t just say ‘we have been involved in a pilot’; ensure you include the outcome measures and evidence it with an audit of results. Some examples can be found here.

Our advice is that practices should also read the CQC 'Guide to Meeting the Regulations' http://www.cqc.org.uk/content/regulations-service-providers-and-managers carefully before any inspection.

Changing the face of inspections – It is also important to be aware that practices that have previously received a Requires Improvement Notice will be on the CQC 'radar' and it is very likely they will be the first ones to be targeted under the new inspection process which will commence from October 2017 following the outcome of the consultation around the CQC's Strategy 2016 to 2021.

The new strategy will look at all aspects of care and the CQC will focus on 'Place Inspections', i.e. where care is delivered, and they will also be looking at care pathways. They will be seeking information from GPs around discharges (delayed discharge, failed discharge) and the impact on patients and looking at mental health providers.

GP Insight – One of the key priorities of the new strategy is that the CQC deliver an intelligence driven approach to inspection. CQC is using GP Insight to provide transparency regarding the information inspectors use to monitor practices. GP Insight forms part of a wider approach to gathering data to be used by the CQC prior to inspection.

Registration reminder for practices merging – if you have recently merged or are thinking about merging please refer to the guidance http://www.cqc.org.uk/content/registration-notifications-fees . The key is if you have changed the legal entity then you must update your Statement of Purpose, Check your Certificate of Registration, partner's names are all accurate and your main location (and branch location) is correct. Practices that have been taken over or are no longer operating under their original legal entity must de register. For any changes to your registration please refer to the CQC website http://www.cqc.org.uk/organisations-we-regulate/registered-services/making-changes-your-registration

Devon's GP practices among best in the country

Devon's GP practices have been rated among the best in the country, according to new research.

The *Health Service Journal* collated all Care Quality Commission (CQC) reports on England's GP practices published by 1 March, 2016.

Read more in South Devon and Torbay Clinical Commissioning Group's localised media release here.

Partnership disputes – the early warning signs

Partnership disputes can be expensive, time consuming and destructive – and unpleasant for all parties involved.

The most common causes for partnership disputes in a practice and advice on how to avoid them is available here.

Pharmacy First – re-commissioned and updated services

The General Practice Forward View states the effective impact that community pharmacy can provide GP practices by taking away some of the on the day patient demand. The Pharmacy First services that have been in place since 2015 in the NEW Devon and South Devon and Torbay areas have seen over 25,000 patients, reducing a significant patient demand on local GP practices.

The Pharmacy First minor ailments services are going to be re-commissioned by NEW Devon Clinical Commissioning Group (CCG) and South Devon and Torbay Clinical Commissioning Group, due to NHS England deciding to remove the funding for the services. The updated services that will start in April will include similar patient conditions, but there are significant changes to be aware of, effective from 1 April 2017.

Minor ailments

1) Urinary tract infections is now for 16-65 years (past service had no upper age limit)
2) Bacterial conjunctivitis is now only for 1 year infants (past all ages above 1 years)

3) Oral thrush service has been decommissioned.
4) South Devon and Torbay CCG has not re-commissioned the emergency supply service. NEW Devon CCG has, but is limited to weekend and bank holidays.

Emergency repeat medicines

South Devon and Torbay CCG is not re-commissioning this service.
NEW Devon CCG is commissioning a local emergency repeat medicines service, which will be available at weekends, bank holidays and extended to school holidays if authorised by the CCG.
Due to the expected increase in demand over the Easter holiday period, NEW Devon CCG is extending the availability of the emergency supply service to cover visitors to the area from Monday, 3 April to Thursday, 13 April inclusive. The service can be offered to visitors to the area throughout the opening hours of the pharmacy on those days.

Devon Local Pharmaceutical Committee has produced a Pharmacy First guide for GP practices which has been designed for use by the GP reception team when navigating patients. You can view it here.

Guidance on employing a practice-based pharmacist

The Primary Care Pharmacy Association has produced guidance for GPs considering employing a practice-based pharmacist.

Primary Care Model can deliver improvements

Speaker slides from the King's Fund's recent New Care Models event are now available. They include a presentation on the Primary Care Model, which has delivered improvements in general practice. Read more here.

Checklist for making a Multi-Agency Safeguarding Hubs (MASH) enquiry

The following information – if known – should be provided when making a Multi-Agency Safeguarding Hubs (MASH) enquiry. However, if there are some gaps, please don't let that delay the process.

1. You will be asked by MASH if you have sought parental consent. Unless by asking this the child would be placed at immediate risk of harm, you should inform parents why you need to make this enquiry. This keeps an open and honest approach with the individuals concerned. If you cannot gain consent state why when making your enquiry and on the enquiry form.

2. If there are multi-agency concerns one enquiry should be submitted which includes all professionals concerns.

3. Ensure your contact details are included on the form in case MASH needs to contact you for further information.

4. Ensure all core personal details for the child and parents/family members are included, eg up to date phone numbers for the parents/guardians.

5. Please include all details of who lives in the family home. Father, step father, mother's partner, grandparents, other family members and friends.

6. Record who has parental responsibility.

7. Information on the enquiry form needs to be clear and concise, not lengthy. However, there does need to be sufficient information to enable MASH Team Leaders to make a decision.

8. If there has been a specific incident, such as an assault, please detail the date, time and where there is a visual injury and any discussion you have had with the parent.

9. Detail clearly what you think the risks are to the child.

10. State what you or other agencies have done to address the risk/s you have identified. What support services have been provided to the family at 'early help level'.

11. State what strengths are in the family.

12. Ensure the MASH enquiry is submitted in a timely manner.

Send your enquiry to mashsecure@devon.gcsx.gov.uk

Please be aware that should your enquiry result in a child protection conference and you are able to attend you will be asked your opinion on whether the child should be placed on a child protection plan.

DoLS no longer a death 'in state detention' from 3 April

In recent years the law has developed to require all deaths where a Deprivation of Liberty Safeguards (DoLS) authorisation was in place, to be referred to the coroner. This is because such patients are deemed to be detained by the state, which triggered the automatic requirement for an inquest to be held. In practice, this had an unintended effect and led to a large increase in the number of natural deaths referred to coroners, particularly by NHS Trusts, care homes and GPs. Further, where the death is not a natural one, a jury is currently required.

Now, the long awaited amendment has arrived and the law will change. From 3 April 2017 the Coroners and Justice Act 2009 will be amended so that people subject to authorisations under DoLS will no longer be considered to be 'otherwise in state detention' for the purposes of Section 1 of the Coroners and Justice Act 2009. This means that coroners will no longer be under a duty to investigate a death solely because a DoLS authorisation was in place. Such deaths will only be reported to the coroner if the cause of death is unknown, or where there are concerns that the death was violent or unnatural. This effectively brings the position in line with deaths which do not involve DoLS, and the circumstances where a jury will now be required will be rare. The practical effect of this change will be to reduce the number of referrals to the coroner, and the number of associated witness statements and inquests.

Therefore it will be important for all doctors and care home staff involved in death certification and referrals to coroners, to be trained about this change before 3 April 2017. Your coroner will expect the referrals from 3 April to comply with the new law, and families will want accurate information as to whether the death can be registered. It will be beneficial to talk to, and work with, your local coroner's officers.

Key points:

- All 'DoLS' deaths which occur prior to 3 April 2017 must still be reported to the coroner, and an automatic inquest will be held (even where the death is natural). These deaths must be dealt with under the 'old' law, and will require a jury if the death is not natural.
- DoLS deaths which occur from 3 April 2017 onwards, do not need to be automatically reported to the coroner; the usual considerations as to the circumstances of the death apply.
- It is the date of death, not the date of reporting to the coroner or the date of the inquest, which is relevant.

How we can help:

Capsticks can help with advice and representation in relation to all areas of death certification and referrals to the coroner. We can advise whether a referral to the coroner should be made, and our in-house inquest team can support you, if your coroner's office does not change their approach from 3 April. Visit: www.capsticks.com

New LMC job vacancies and opportunities

As previously advertised in the newsletter and on social media, the LMC has some exciting senior level positions available at a pivotal time for local general practice, which is facing unprecedented challenges and opportunities.

Covering information follows and more details are available in the role profiles by navigating to the 'LMC job vacancies and opportunities folder' in the document library of the LMC's website.

Medical Secretary

Applications are invited for a Medical Secretary vacancy at the LMC due to the forthcoming retirement of the current postholder. We would like to hear from GPs with the enthusiasm and potential to develop in this exciting role.

Our Medical Secretaries are involved in the management of the day to day business of the LMC and are often the first port of call for all GP queries. They provide tailored one-to-one advice and support to any individual GP or practice.

The successful applicant will play a key role in securing the future of our profession by joining the LMC at a time of significant transformation in the local healthcare system.

The position will commence in early June following the retirement of one of the current post-holders.

Remuneration is for one office day a week – there's some flexibility which day – plus payment of an honorarium equivalent to half a day a week for work offsite, such as responding to emails and phone calls. There is also a pension scheme.

Applications should be made to the LMC by Thursday, 13 April, 2017, via a covering letter outlining the candidate's skills and experience for the role, along with a CV. Interviews will provisionally be held on Tuesday, 25 April, 2017.

For an informal discussion about the position, please contact one of the LMC's current Medical Secretaries, Dr Mike Richards or Dr Mark Sanford-Wood, on 01392 834020.

Treasurer

The Treasurer is responsible for all financial matters for the LMC including supporting the management of budgets and setting of the Levy, ensuring transparency and accountability are maintained to high professional standards.

The LMC has agreed that the position will now be an appointed post rather than an elected one. The tenure is two years and is remunerated on an honorarium basis, plus a meeting attendance fee.

Attendance is required at Board meetings on a bi-monthly basis.

Applications should be made to the LMC by Thursday, 13 April, 2017, via a covering letter outlining the candidate's skills and experience for the role, along with a CV. Interviews will provisionally be held on Tuesday, 25 April, 2017.

Practice Managers Conference

The LMC will be holding its annual Practice Managers Conference later this year.

We want to ensure that the event meets your needs and welcome feedback about any training and workshops that you want holding to help with your everyday work and challenges. Email your suggestions to richard.turner@devonlmc.org by noon on 26 April.

The logistics are being arranged and we will confirm the venue and date soon. We look forward to seeing you at the conference, where you can learn, network and be inspired!

Peer supported appraisal scheme puts practice managers through their paces

A peer appraisal from one practice manager to another is enormously beneficial and has been rolled out to LMCs around the country. Read more here.

Free appraisal for practice managers – deadline extended

We are looking for more practice managers who would like their appraisals completed by our newly trained team – the deadline has been extended until 28 April 2017 to give greater flexibility.

The appraisal isn't a performance review, but an opportunity for reflection on your work to help identify areas for improvement and development. If you would like an appraisal to be performed by one of our team, please contact Helen West helen.west@devonlmc.org to arrange a convenient time and location, which could be at your practice.

Practice manager pensions guide

Practice Index has created a practice manager's guide to auto-enrolment pensions. This looks at the new rules which practice managers should be aware of, including eligible and non-eligible job holders, entitled workers and exceptions. To read the guide, click here.

Been there, done that?

We've all heard the stories of the annual 'team-building workshop' and whether this involves a bit of bonding over a bowling tournament or trust exercises where employees catch one another as they fall backward; how many of them really help to improve team effectiveness?

Team building exercises can be a powerful way to bring a group together and really unite them in a shared purpose or goal. They can prove a valuable way of developing team strengths and addressing shortcomings – but only if the exercises are planned and carried out strategically. There has to be a clear purpose, a specific goal in mind rather than just an opportunity for a day out!

Team building that builds teams

The most important stage of planning a team building exercise is starting by identifying the challenges your team faces and then choose exercises that will help team members actively solve the problem.

Consider the root cause of problem, such as conflict between team members; do team members know each other well enough; do members focus on their own success rather than that of the group; does poor communication make success hard to achieve; are members resistant to change; or does your team need a boost in morale?

Once you have identified the key area you want to tackle, you can start to think about what type of activity that will help the team overcome the specific weakness. We found some great team-building exercises here: www.mindtools.com/pages/article/newTMM_52.htm

Top team building tips

- Have a clear purpose for your team building activity.
- Aim to include team building exercises in your weekly or monthly routine.
- Plan your events so that the team has to truly rely upon each other in order to succeed and steer clear of 'winners' and 'losers'.
- Give opportunities and time for participants to get to know each other better and socialise.
- Value each team member as unique people with irreplaceable experiences, points of view, knowledge, and opinions to contribute.
- Keep the dialogue flowing once you are back into the day-to-day.

Here at Sapience HR we can help you create spot-on team activities to ensure that the learning and your investment is being used and maximised back into the day-to-day work. Call us on 01736 339384 or email hellothere@sapiencehr.co.uk to see how we can help.

CQC Report acknowledges DPT's progress

Devon Partnership NHS Trust – which provides local mental health services – has just received its Care Quality Commission Report and has been rated overall as 'good'. It was also rated 'good' across the following domains: safe, effective, caring responsive, well-led. You can read the report here.

New diabetic eye screening provider

From 1 April 2017 the Plymouth diabetic eye screening programme will have a new provider. NHS England has appointed EMIS Care to deliver the local programme. The service will continue to run as before, with EMIS Care working in partnership with local optometry stores to provide diabetic eye screening appointments. More information is available here.

Reprocurement of Child Health Information Services

NHS England recently announced its intention to recommission Child Health Information Services across the South West as the two largest existing contracts are due to expire in 2018. An online survey has been developed outlining the potential options available and can be found here.

News from Devon LMC

Staffing update

The LMC welcomes Dr Mark Sanford-Wood back to his Medical Secretary role next week following a short sabbatical to establish himself in his new GPC England Executive position.
Mark will work at the LMC on Tuesdays from 4 April – and continues in his role at the GPC on Wednesdays and Thursdays.
Our thanks go to Dr Kate Gurney for all her hard work covering as Medical Secretary on an interim basis during the past six months. Kate will continue on the LMC Board and as a member of the North and East Devon LMC Sub-Committee, whilst retaining her role as our Safeguarding Lead.

Save the date – LMC Annual General Meeting

Our Annual General Meeting will take place at Exeter Racecourse on Thursday, 25 May, from 6:30-8:30pm.
Dr Nick Roberts, Primary Care Lead for the Sustainability and Transformation Plan, is the keynote speaker at the event.
There will be plenty of opportunities for the audience to ask questions during the event and we look forward to seeing a good turnout of GPs. All Devon GPs are welcome – to register your attendance email richard.turner@devonlmc.org by Thursday, 18 May.
Any resolutions to be moved at the AGM should be in accordance with the LMC's Constitution.

LMC fax machine

Please note that we will no longer have the use of a fax machine in our office at Kennford from 1 May this year.

Education and Events in Devon

If you are interested in finding out about clinical events and educational opportunities available in Devon, please check the Education and Events section of our website: www.devonlmc.org

Vacancies for GPs and practice staff in Devon and Locum GPs available for work

If you are seeking a position, or are a Locum GP seeking work in Devon, please look at the Vacancies and Availability section of www.devonlmc.org

If you have a vacancy to advertise, please complete this template: Advertisement Template for Practices.doc and send as an attachment to: admin@devonlmc.org

Produced by: Devon Local Medical Committee, Deer Park Business Centre, Haldon Hill, Kennford, Exeter, EX6 7XX. Copy submissions for May's newsletter should be emailed to richard.turner@devonlmc.org by noon on Wednesday, 19 April please.