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

Glimmer of hope for our beleaguered profession

Editorial by Dr Bruce Hughes, Chair of Devon Local Medical Committee

Once again things are moving quickly for GPs both nationally and locally. The contract deal for 2017 has recently been announced after an inexplicably long delay. On the whole it looks to provide a glimmer of hope for our beleaguered profession. The measures announced are by no means intended to produce major change, but at least a degree of stability and some breathing space for practices in financial difficulty.

In the 2017 contract the quality and outcomes framework (QOF) is unchanged, a welcome move that means that GPs and their staff will not have the annual 'getting up to speed with QOF changes' sessions, so our work can continue seamlessly. The avoiding unplanned admissions DES (direct enhanced service) is retired. For many this DES has not worked in the manner intended when it was conceived. The funding for this DES will shift to the core contract and we will be required to use a standardised tool to interrogate our patient records in order to compile a frailty register. Those patients on the frailty register will require an annual review in the manner of our choosing (I suspect we would have been reviewing these patients annually anyway).

CQC fees will be met in full, relieving the cost pressure on practices of the seemingly inexplicable hike on fees we have seen in recent years. Funding for the rise in indemnity fees will be lodged with practices, but it is important to note that we will need to ensure that it is fairly distributed to all GPs irrespective of contractual status.

There are some more minor changes, but one which may be of relevance to our smaller more rural practices. In essence if the practice regularly closes for a half day it will no longer be eligible to undertake the Extended Hours DES. Exact details of how these and several of the other changes will be implemented are yet to be forthcoming – the GPC website is likely to provide the most useful updates. More information about the new contract is available on page 5.

On both a local and national level Sustainability and Transformation Plans (STPs) have been in the news. The report from the National Audit Office (see page 9) has cast some doubt about the mainstay of many STPs, the closure of hospital beds and caring for ever more complex patients in the community. Devon LMC has concerns regarding the implementation of this type of strategy across Devon. We have until recently been frustrated by the relative paucity of GP input into the STP. Happily, things have improved in this respect. We have an LMC Board member regularly attending the Clinical Cabinet and the Board has had a productive meeting with Angela Pedder, Lead Chief Executive of

the Success Regime. Several LMC members have participated in the STP GP engagement events alongside Dr Nick Roberts, Accountable Officer of South Devon and Torbay Clinical Commissioning Group and GP Lead for the Primary Care STP workstream, and several more grassroots GPs have attended facets of the acute services review meetings.

Devon LMC's main concern in this process is relatively simple. Patients of an acuity usually cared for in hospital will be moving into the community. These patients will need medical consultations just as they do whilst in hospital. General practice is in crisis with the double whammy of workload beyond that which we can manage and a diminishing workforce.

We have promoted the concept for a while now of intermediate care and have had some success in gaining acceptance from our commissioners that intermediate care will need separate contractual arrangements. The next issue we will face is that even with suitable contractual arrangements in place we may not be able to medically staff these arrangements. Perhaps we need to look again for a local variation to our core contracts which would allow us to stop doing things of little or no clinical value to patients and free up clinical time to focus on these new ways of working?

Seeing through the gloss and dross

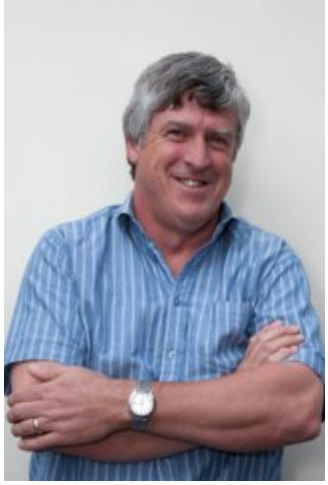
By Dr Anthony O'Brien, Chair of the Northern and Eastern LMC Sub Committee and LMC Board Vice Chair

If a monkey given infinite time (and a typewriter) could write a Shakespeare play, then how many monkeys given five years would it take to produce just one of the 100+ page NHS strategy documents that keep landing in my Inbox? Probably not an infinite number given the quality of these booklets. They are long, repetitive, and have a similarity which suggests a Sixth form student might be putting them together in some well paid gap year project; having to cut and paste as many different arrangements of cute phrases about working seven days at scale with a few hubs strategically thrown in. The language is grand, the detail is thin but they do fill the vacuum between the political rhetoric and the practical reality. The cover page always seems to have a photo of a relaxed NHS employee (where did they find this person?) smiling benignly at a patient often in a setting that is suggestive of a care home – ironic since the lack of these is never mentioned.

My wise old trainer told me that if you cannot communicate your thoughts on any subject on one side of A4 then you probably need to do some more thinking. I have yet to find an NHS logo labelled document that meets this A4 rule. However, they do have some gems of light relief hidden within them. The most recent strategy document I read proposed the introduction of a new doctor grade, 'Hospitalists', to be the sole arbitrator in future decisions about hospital admissions. Presumably the rest of us will then be renamed 'Homekeepers'. The idea of 'renewable energy' carers was also mentioned but no further explanation of who or what these are. Maybe they will lead to further environmental NHS combinations such as mass harnassing of hydroelectric power from saline drips, solar cryotherapy (need magnifying glass) or wind powered rising beds for the elderly.

The art of politics is to not lose sight of the destination and tolerate the indirect route you need to take to get there. The problem with all these NHS publications is that the main driving factor they list is saving money (so important that I have seen it highlighted in red ink). A vision of care in the community with smaller hospitals, more social reablement and prioritisation of prevention is a fair destination but we will end up sinking in quicksand if we try and go there directly. The objective to cut NHS budgets by introducing changes whatever the clinical cost, as long as 'financially beneficial', is unrealistic. We actually need more money to pump prime any changes. This needs to be invested immediately and directly into social care and general practice for the journey to succeed.

Atul Gawande *(Being Mortal)* writes eloquently about old age and how we could best optimise care for this exponentially rising demographic. Cutting and pasting from his book would produce better NHS documents. The ideas for continuous, comprehensive care within the community would be similar but the 'how' would be much clearer. Realistic innovation and investment – now that is a title of an NHS document I would like to read – as long as it is short in length and big on detail.



Are you seeking your next career challenge?

By Dr Mike Richards, Medical Secretary at Devon Local Medical Committee

Devon LMC currently has two Medical Secretaries each working a day a week based in the LMC office at Kennford. (And before you ask no shorthand or touch-typing skills are required!). I will be retiring in May this year and we are seeking an enthusiastic individual to take up this challenging but very satisfying role.

Much of the work we do is behind the scenes from the frontline of general practice, so many of you might be asking what do we do and why do we do it?

There is no simple answer to this question, but at basic level it is to provide support to the LMC Executive team with a clinical as well as managerial eye. No two working days are the same with an assortment of meetings, one-to-one conversations, negotiation and support at personal and practice levels. In essence we fulfill the Devon LMC strapline '*To Lead, Represent, Inform and Support General Practice'.*

It is a part-time role, currently one day a week worked by each of the two Med Secs, with a requirement for daily email access/response (funded by honorarium arrangement) and some additional meetings at other times. Unlike the variation within clinical practice there is space to be able to think, plan and control the work pattern.

A GP background certainly helps in understanding the pressures individuals and practices are facing under in the current NHS. An interest in the wider medico-political scene opens the communication route from consulting room through to GPC national policy, through direct links and attendance at LMC national conferences.

Looking back at the past month, my personal work has extended from advising GP partners about the transition to salaried roles, supporting practices in merger discussions and meetings with NHS England, chairing meetings at a time of potential conflict, developing and costing proposals for the negotiating process, representing general practice at STP events, advising on contractual regulatory issues and it goes on.

There is also the internal working of the LMC such as supporting the development of a practice support system with other members of the team. My personal interest in figures and data has been useful in updating the Ready Reckoner for the next financial year and reviewing CCG spend on enhanced services seeking assurance that the reinvestment of PMS premium actually happens.

So the role is certainly varied, with changing schedules, but the job satisfaction is huge. Relationships are key and continue to remain strong, whether with NHS England, CCGs or providers – we need to be able to agree to disagree without falling out, in what are the most challenging times in my now concluding career in general practice.

The current Med Secs would be happy to discuss any aspect of this role in more detail with anybody interested.

New LMC job vacancies and opportunities

The LMC has three 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

As mentioned, applications are invited for a Medical Secretary vacancy at the LMC. 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, 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 Kate Gurney, 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.

Chair

The term of office of the LMC's current Chair will expire in May, 2017.

Expressions of interest and/or nominations are invited from elected LMC members for the position. If the election process moves to a vote, this will be held at the LMC's Annual General Meeting on Thursday, 25 May, 2017.

This highly-visible role includes Chairing the bi-monthly Board and monthly Negotiations meetings and attending the LMC National Conference.

The position is for a two-year period and is funded by honorarium.

Expressions of interest and/or nominations should be made by Friday, 12 May, 2017. For an informal discussion about the vacancy, please contact Angela Edmunds, Director of Operations at the LMC, on 01392 834020.

GP contract will provide 'much-needed stability'

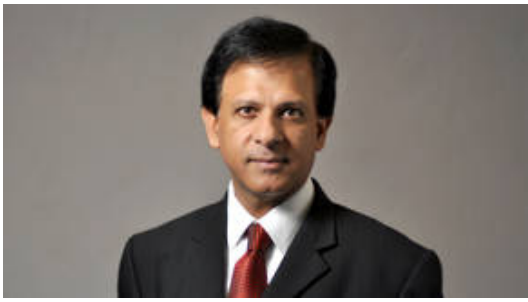
A £30million fund covering indemnity fee costs has been secured for GPs in England, as part of agreed terms for the 2017-18 GP contract.

The money, which will be paid directly to practices, will assist GPs in meeting the burdens posed by indemnity charges for general medical services services, and is among a range of measures designed to provide general practice with increased financial support.

In confirming the new contract, the British Medical Association (BMA) and NHS Employers have agreed to scrap the DES (direct enhanced service) for avoiding unplanned admissions from 31 March, a move that will free up £157m for core funding.

The 2017-18 contract will also see for the first time GP practices being fully reimbursed for CQC registration costs, which will offset recent rises in the regulator's fees.

The contract will also make compensation for practices hit by staff absences relating to sickness or maternity an entitlement rather than a discretionary payment.



It has also been agreed that sickness and maternity reimbursement payments will not be subject to pro-rata application.

BMA General Practitioners Committee (GPC) Chair Chaand Nagpaul, pictured, said he believed the new contract would provide important and much-needed stability and support to a general practice workforce beset by challenges.

He said: "I am pleased we have reached an agreement which we believe offers important and significant improvements to the contract.

"The changes will provide some much-needed stability and respite for GP practices by reducing bureaucracy and providing financial relief in key areas.

"Progress on ending the bureaucratic unplanned admission DES is welcome as it will enable GPs to spend more time looking after frail older patients, rather than on box ticking.

"It is encouraging that NHS England were prepared to listen to GPs' concerns in many of these areas and work with GPC to deliver workable solutions."

Dr Nagpaul stressed, however, that the improvements negotiated by the BMA were not in themselves the solution to the challenges facing GPs in the form of flatlining budgets, lack of staff and rising demand.

He said: "While many of these new arrangements are a step in the right direction, what we really need is for the Government to properly resource general practice to ensure that GPs can provide the time and care needed to meet the increasing needs of patients."

Among the other additions to the new contract, which will take effect from 1 April, were:

- Funding to cover additional work generated by the Capita patient-record transfer service.
- Increased funding to support vulnerable patients through the learning disability enhanced service.

- A new system to identify overseas patients and facilitate the claiming back of treatment costs from their country of origin.

Sign up for GPC Roadshow

Following the recent national announcement about the new 2017/18 GP contract, the GPC will be holding a roadshow for local GPs and Practice Managers in Devon and Cornwall on Tuesday, 7 March, from 6:15pm-8:45pm, at Plymouth Science Park.

The new GP contract is a significant improvement on previous annual contractual deals.

Places are still available on a first come first served basis. Please email richard.turner@devonlmc.org by noon on Friday, 3 March to confirm if you wish to attend.

Dr Mark Sanford-Wood, BMA GP Committee England Executive on secondment from Devon LMC, pictured, will be presenting and there will be opportunities to ask questions.

Ongoing issues with NHS Property Services

The GPC has written to NHS Property Services about ongoing unresolved issues – including service charges – affecting some practices. You can read the letter from Ian Hume, GPC policy lead, here.

NHS needs £9.5bn to transform

Plans to transform and integrate health and social care services require at least £9.5bn of capital funding – but NHS leaders don't have the cash and will ask for demands to be 'reviewed' and 'refined'.

A BMA investigation into the 44 Sustainability and Transformation Plans (STPs) in England has revealed the vast sums needed just to create the infrastructure to deliver the projects, with costly building projects and investment in community facilities vital to the plans. Read more here.

Think Tanks says investment in communities required to deliver STPs

A study by the King's Fund about STPs has highlighted that proposals to reduce capacity in hospitals will only be credible if there are robust plans to provide alternatives in the community. Read more here.

STPs lack focus on general practice

NHS England should reject 'a significant proportion' of STPs owing to their lack of focus on general practice, a conference has heard.

Royal College of GPs Vice Chair Kamila Hawthorne warned that a number of STPs do not adequately take planning for general practice into account, with five failing to address the sector at all. Read more here.

Continuity of care reduces hospital admissions, finds study

Continuity of care is vital for doctors and patients – and GP practices need investment to be able to provide it.

That is the message from doctors leaders after a study revealed older patients seeing the same GP over time can reduce hospital admissions.

The study, published by *The BMJ*, analysed the data of older patients from English primary and secondary care records for more than 230,000 patients aged between 62 and 82 years between April 2011 and March 2013.
It found that patients who saw the same GP a greater proportion of the time experienced fewer admissions to hospitals for ambulatory care sensitive conditions than other patients. People with medium continuity of care accounted for nine per cent fewer admissions and those with high continuity of care 12 per cent fewer.

BMA GPs Committee Deputy Chair Richard Vautrey, pictured, said: "This provides further evidence of the importance and value of the long-term relationship with patients that a GP practice can provide, which benefits not only individual patients but also the wider healthcare system.

"A recent BMA survey also highlights how continuity of care was one of the elements of general practice that was most valued by GPs.

"It's why the BMA has consistently called for investment directly in to practices rather than funding separate and often fragmented access schemes."

The study suggests continuous care might promote a more effective and trusting relationship between patients and doctors, leading to a better understanding of health problems and more appropriate care.

Read the study

New models of care: what to look out for as a sessional GP

By Dr Pooja Arora, representative for the GPC's Sessional GP Subcommittee
The landscape of general practice is changing rapidly, and new models of care are being presented as innovations to solve the workload, workforce and funding crises. We have all heard about the emerging super-partnerships, federations and now MCP models of care coming forward, but has anyone thought about the implications for a sessional GP?

Currently, with the independent contractor status, practices that hold a GMS contract must offer terms no less favourable than the model salaried contract. However, with these new models of care the protection of the model salaried contract can potentially be lost. Technically these practices may no longer be bound by GMS regulations and therefore do not have to offer the model salaried contract.

This can have advantages and disadvantages, depending on how you look at the situation. New models can offer flexibility and incentives such as reimbursement for postgraduate diplomas in specialties, for example in dermatology. Or by losing the GMS contract, it can make the sessional GP more vulnerable as they lose the protection of the salaried contract and are left open to a locally negotiated contract.

The main point to remember in this current climate is to respect your own value and not to rush into agreeing any new terms and conditions without understanding their implications. Just because new models of care are trying to solve the general practice crisis, the value of the sessional GP must not be forgotten and it is imperative that sessionals are thought of in any new plans. Sessional GPs are part of the GP workforce and should not be scapegoated to meet the new model's needs.

If in doubt, please contact the BMA service to check your contract to highlight any potential flaws. However, as mentioned earlier, things are changing rapidly – so while being cautious about this new environment, please keep an open mind as these models may expand your own horizons to equip you with the right skills to face this new era of general practice.

Sessionals Newsletter

The latest edition of the Sessionals Newsletter includes an update on changes to funding for indemnity and progress on pensions issues. You can read it here: http://bma-mail.org.uk/t/JVX-4RN48-1BJCJOU46E/cr.aspx

HMRC changes to how locum tax is managed

It has been brought to our attention that changes are imminent in relation to locums and their classification as employed or self employed – further complicated by whether they are paid via a company or directly.

The issues are addressed here.

It is important for practices to consider these changes and take financial advice from their practice accountants to avoid unwanted future bills

Access to medical reports for insurance purposes

The BMA has published updated guidance which addresses important changes about how practices will be approached by insurance companies in future

The guidance can be found here.

Hopefully this clarifies issues and addresses some of the concerns raised by practices.

New confidentiality guidance

The General Medical Council (GMC) has published revised, expanded and reorganised guidance on confidentiality for all doctors practising in the UK.

The guidance – Confidentiality: good practice in handling patient information – comes into effect from Tuesday, 25 April this year.

Revisions have been made to the guidance, last published in 2009, following a consultation exercise. While the principles of the current GMC guidance remain unchanged, it now clarifies:

- The public protection responsibilities of doctors, including when to make disclosures in the public interest.
- The importance of sharing information for direct care, recognising the multi-disciplinary and multi-agency context doctors work in.
- The circumstances in which doctors can rely on implied consent to share patient information for direct care.
- The significant role that those close to a patient can play in providing support and care, and the importance of acknowledging that role.

The new guidance can be found here.

The GMC has also published a decision making flow chart, and revised explanatory guidance to show how the core guidance applies in situations doctors often encounter, or find hard to deal with including:

Patients' fitness to drive and reporting concerns to the DVLA or DVA

Disclosing information about serious communicable diseases

Disclosing information for employment, insurance and similar purposes

Disclosing information for education and training

Reporting gunshot and knife wounds

Responding to criticism in the media

Interim assessment of the GPFV

The Royal College of General Practitioners has published its interim assessment of the General Practice Forward View. You can read the report – which includes 10 key recommendations – here.

LMC response to National Audit Office report about the Better Care Fund

The LMC received prominent media and stakeholder coverage – including Tweets from GPC Chair Chaand Nagpaul and Healthwatch Devon – following its response to the National Audit Office report about the Better Care Fund and its wider implications for STPs.

Here's our statement:

Dr Bruce Hughes, Chair of Devon Local Medical Committee, which represents GPs, said: "We note today's report by the National Audit Office about the Better Care Fund, which reaffirms our serious concerns about transferring some hospital services and care into the community.

"The report's findings indicate that this approach doesn't tangibly improve patient outcomes and experience, reduce emergency hospital admissions or save money – something we fear could be replicated locally as the same principle of community-based care underpins much of the Sustainability and Transformation Plan (STP).

"We urge our STP leaders to pause the transformation process in the local healthcare system and closely examine the report to ensure that the STP and its aspirations aren't seriously flawed.

"We also ask for clarity about how any transfer in local activity from hospitals into the community will be funded and resourced, as general practice and some other healthcare services in the community are already grappling with heavy demand on stretched services.

"We look forward to working closely with STP leaders in the coming months, as general practice is the gateway to the wider healthcare system and has a crucial role to play in the successful delivery of local transformation, to ensure high quality patient care." You can read the full report here.

General practice and secondary care working together – 'The six must dos'

Six new requirements for hospitals were introduced in the 2016/17 NHS Standard Contract to clarify the expectations across the hospital and general practice interface and to reduce avoidable extra workload for GPs.

Amongst these was an expectation that consultants could refer a patient on to a colleague without recourse back to the GP. The local process for this has been clarified at the recent LMC negotiation meeting and will be shared once again with our consultant colleagues.

Further details are available here, together with some suitable template letters to address any breaches of these requirements.

The Devon LMC office would also like to hear of any examples, with copies of anonymised letters, so that we can pursue this with the appropriate authorities.

LMC Buying Group update

Devon LMC is a member of the LMC Buying Groups Federation – meaning all practices are eligible to access the discounts the Buying Group has negotiated on a wide range of products and services.

If you're not sure if your practice is a member of the Buying Group you can call them on 0115 979 6910, email info@lmcbuyinggroups.co.uk or put your practice code into their website to find out. If your practice isn't a member, you can contact them directly to sign up.

If you're not sure what the Buying Group is all about then this short video explains what they do.

By registering with the Buying Group's website you can view all the suppliers' pricing, contact details and request quotes. The Buying Group also offers any member practice a free cost analysis which demonstrates how much money your practice could save just by swapping to buying group suppliers.

And if your practice is part of a GP Federation group then the Buying Group Plus initiative could help you save additional money as a group.

Devon Home Choice – patient information to support application

If local authorities need to obtain supporting evidence from an applicant's GP they should not send the supporting evidence form or encourage applicants to do this.

Local authorities should instead send a secure email (from a gcsx email address) to the admin email address of the relevant GP practice[1] requesting a 'brief patient summary', providing information on the patient's key conditions and medication, and that the GP confirm how the patient's health and wellbeing is affected by their current home.

It should be noted that GPs may still charge patients to respond to these requests, but the cost should be much lower than the cost of a GP completing the supporting evidence form. It is confirmed on both the health and wellbeing form and the supporting evidence form that the Devon Home Choice partners will not make any payment for the supporting evidence form to be completed.

[1] A GPs personal email address should **not** be used

Safeguarding update

NHS Safeguarding App

A new guidance and information app for adult and children's safeguarding is available to download for free from any app store. This is a 'must have' app - just search 'NHS safeguarding guide'.

The guide contains information on professional responsibilities, definitions of abuse, and information on how to raise concerns in different localities across the UK. Under 'contacts and resources' click on a region, and county, to get local contacts and websites. In the South West area Devon, Torbay and Kernow are all separately listed.

There is also a desktop link: www.myguideapps.com/nhs_safeguarding

Child Protection Planning

Devon is currently rolling out a strengths-based planning and review model for child protection planning. Strengths-based approaches concentrate on the inherent strengths of individuals, families, communities, groups and organisations, deploying personal strengths to aid recovery, change, empowerment and resilience.

The model balances a rigorous exploration of danger/harm alongside indicators of strengths and safety, but is strongly focused on harnessing, developing and targeting those positive areas far more intensively and deliberately. The model depends upon a collaborative approach in which families receive a strong and explicit message that agencies will try to develop a trusting and positive working relationship with them. Families will be helped to identify their own strengths and resources. Agencies will be crystal clear about what they are worried about and what is needed to bring about positive change. Parents, families and children must be central to and not a passive recipient of each stage of assessment and planning.

Further information is available on the Devon Safeguarding Children Board website especially about submitting reports for meetings and sharing their content with families beforehand.

CQC registration update for vanguards and other new models of care

The Care Quality Commission has issued a registration update for vanguards and other new models of care. More information is available by navigating to the 'CQC' folder in the document library of the LMC's website.

Guide for GPs looking to recruit a practice pharmacist

Guidance is available for GP surgeries looking to recruit a practice pharmacist. The Primary Care Pharmacy Association's advice is available here

Carers' support contract re-commissioning

The draft specification for the delivery of support services to unpaid carers is now out to consultation.

The consultation is open until 24 March, 2017, and is available here. We are keen to hear any views you might have on the draft service specification.

User group to shape new LMC website

Places are still available to join a small user-group to feed into the development of a new website for the LMC.

Expressions of interest should be emailed to: richard.turner@devonlmc.org

Data validation for Diabetic Eye Screening Programme

Public Health England is reminding practices to code and submit returns for the national Diabetic Eye Screening Programme (DESP) to identify the eligible cohort and newly diagnosed patients. More information about the programme is available here

New Devon CCG Newsletter

The latest edition of New Devon CCG's monthly newsletter – including an update on next steps with the acute services review – is available here

Healthwatch Devon Newsletter

Healthwatch Devon's latest newsletter – including an update on their role in the STP engagement process – is available here

Stocktake on Plymouth Associate Medical Director's first year

By Karl Trimble, Associate Medical Director at Plymouth Hospitals NHS Trust

A year into my role as Associate Medical Director, I have had the opportunity to work and interface with colleagues from all over the region.

To be able to leave the 'ivory tower' and work collaboratively with other providers has been vital in trying to build a picture of how we may work differently, in a severely financially challenged system. We now work closer than ever with fellow acute trusts (RD&E, Torbay, N Devon), with DRSS, with GP provider and representative groups (LMC, Western Board) and commissioners.

So what's new?

Pre choice consultant triage, advice and guidance
Neurology has been providing a pre choice triage, advice and guidance service for some time. Pilots have also been running in gastroenterology, urology and dermatology. Further pilots were due to start in orthopaedics in February, followed by paediatrics at a date to be confirmed.

There was a proposal that consultant opinion at the referral stage may help direct the patient pathway more efficiently, reduce duplication, unnecessary appointments and ensure patients are seen in the correct forum. The benefits to the system of advice and guidance are complex and differ dependent upon the specialty. We are working through a full evaluation of the first three pilot areas and will feedback results when they are available.

Clinical admin
Our administrative processes are a vital part of our patient's pathway when they are referred to us, and the impact it can have on patients is huge. As part of our Elective Transformation Programme we want to ensure that we review and where appropriate develop robust administrative processes which support the patient's elective journey. We are working closely with our Admin teams in gastroenterology and urology and as a result have seen typing delays significantly reduced. We are now embarking on the same work in neurology, orthopaedics and hepatology and will roll out to other service lines over 2017/18.

Understanding variance
Data shows countrywide variance in referral patterns and operative interventions across a range of elective surgical procedures. All regions will have subtle variance, but understanding significant variance is key to ensuring the right patients are treated at the right time in the right location. There have been some really productive regional meetings to

understand variance in intervention rates. The aim of the working groups is to produce more reliable, system-wide pathways, collaboratively owned by primary and secondary care.
A wider understanding and awareness of referral guidelines and commissioning policies will hopefully help clinicians in both primary and secondary care understand when and when not to refer patients.

Virtual eye clinics
The Royal Eye Infirmary is testing a different approach to managing their follow ups. Patients will be invited to attend a Friday afternoon clinic where they will see a nurse and technician and have all of their relevant investigations carried out. Following which the consultant has two weeks to review the outcomes and write to the patient and yourselves advising of the outcomes. The outcomes would be 1) to come into clinic, 2) discharged to screening programme, 3) remain on virtual follow up. This clinic will be delivered 50 weeks per year, and initially will be provided for glaucoma and diabetic/retinal patients. It is expected that there will be 40 patients per week seen through this route.

Fibromyalgia – Body Reprogramming Course
In conjunction with the University of Plymouth and the University of St Mark and St John, we are trialling a new community based Body Reprogramming course for patients diagnosed with fibromyalgia or central sensitisation syndrome.
The rationale for a community intervention is that if patients are treated early enough, this will avoid the deterioration that occurs gradually in these patients with eventual referral to secondary care accompanied by a substantial financial burden to the NHS.

Body Reprogramming compromises of weekly two-hour sessions in groups of 10 for six weeks facilitated by a lifestyle coach with input from a pain consultant, psychology professor, GP and expert patient. The focus of the course is on lifestyle, self-care and education and is an exciting development locally. An evaluation process has been created to determine if the service should run continuously so patients can expect to complete a number of questionnaires before, during and after the course. As this is a 12-month pilot we are initially offering it to patients registered at selected GP practices, as agreed with the LMC.

Fitness for referral
To help reduce the potential surgical complications associated with patients undergoing elective procedures, we are looking in depth at pre-referral community optimisation of comorbidities such as diabetes, hypertension and anaemia.

Save the date: Fit for the future

Devon LMC is very aware of the daily challenges faced in general practice because you – our members – tell us. Having listened to what you are saying, and recognising that this is not sustainable, we want to support you with the opportunity to take time out to think about how you can build resilience for you and your team, reflect on how you deal with change, and review your working practices now and in the future.

We are planning on holding a fun and interactive event for local GPs where you will consider:
- How you can improve and manage the impact of change and work pressures on you and others
- A current workplace issue and how to deal with it effectively
- Take away ideas to keep you going.

The event will take place on 28 June, from 10am-4:30pm. Further details, including the location and an agenda – will be circulated in due course. Expressions of interest should be emailed to hannah.baxter@devonlmc.org by noon on Friday, 31 March.

News from Devon LMC

Save the date – LMC AGM

Our AGM will take place at Exeter Racecourse on Thursday, 25 May from 5:30-7:30pm. More details – including an agenda – will be communicated in due course.
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 and PMs.
Expressions of interest to attend should be emailed to richard.turner@devonlmc.org

Produced by: Devon Local Medical Committee, Deer Park Business Centre, Haldon Hill, Kennford, Exeter, EX6 7XX.
Copy submissions for March's newsletter should be emailed to richard.turner@devonlmc.org by noon on Friday, 24 March please.