LMC Devon

Newsletter

November 2017 – Issue 192

What has the LMC ever done for us?

By Dr Phil Melluish, Chair of the South Devon and Torbay LMC Sub-Committee and an LMC Board Member

With a nod to Python, I would like to reflect on what your dedicated team has been up to recently. This is in no way a comprehensive list, but a flavour of our day to day working.

What has the LMC ever done for us?

Information

We have a new, easy to navigate, comprehensive website. Queries can also be directed to the Executive Team in the office. We publish a summary of negotiations every month, regular updates from sub-committees, and there is, of course, the newsletter. Additionally, we run events, such as the forthcoming Practice Managers Conference which will provide updates on themes like risk management, working at scale, managing and coping with change, employment law, premises and maximising income.

So, apart from giving information, what has the LMC ever done for us?

Support

Our pastoral care network is available to support individuals and/or practices in difficulties for whatever reason. If the necessary skills are not available from within the LMC we can signpost people to where they are. We have helped to develop collaborative boards to give a voice for general practice in a rapidly developing environment. We have made clear to trusts they have obligations in their contracts to allow consultant to consultant referrals, provide fit notes where necessary and give sufficient medications for patients on discharge or from outpatients, if urgent. Although they may be slow to adopt these, we have at least informed them and will continue to remind them! There are template letters available on our website and via the BMA website to help you to decline work which would best be done by someone else.

We have also developed a practice support team, who will offer facilitation of team days, guidance on maximising income, contract options when looking to 'work at scale', supporting practices through mergers or contract hand backs or effectively any aspect/issue where the partnership/practice would like some support and guidance.

Negotiation

The LMC negotiating team has a wealth of experience. This is put to use every month when we meet CCG, NHS England and/or Public Health representatives, as necessary, to look at enhanced services pertaining to general

practice. The team will reject or suggest amendments to initial, sometimes rough and ready, proposals from anyone wishing to make contracting arrangements with practices. The enhanced services, and payments you are offered to provide them, may seem less than perfect, but they are usually in a much better form once discussed and altered through the negotiating process. Ultimately, it is up to individual practices whether or not to take these up, but we know that our involvement makes contracting arrangements more likely to be successful. Recent examples are pre-choice triage in South Devon and Torbay, providing phlebotomy for Clozaril and Denosumab monitoring, and rejecting the concept of GPs being asked to manage peri-operative anticoagulation 'bridging'. We also managed to influence the 'In shape for surgery' programme which was recently launched to make it more advisory and helpful rather than a potential bar to referral.

OK, so apart from information, support, guidance and negotiating on our behalf, what has the LMC ever done for us?

Representation

We represent you through sub-committees and at a multitude of meetings where a GP view is required. As well as local representation we send a delegation to the Annual Conference of LMCs to influence national General Practitioners Committee (GPC) policy. We are extremely lucky to have several representatives on the GPC so that the Devon view is heard loudly and clearly nationally. Special mention must go to Dr Mark Sanford-Wood who has been chosen as Deputy Chair of GPC England and is therefore at the very core of negotiation for, and representation of, all GPs in the country.

Leadership

Through our experience in all of these roles we can offer leadership and direction when needed. A recent change to firearms licensing caused problems for GPs and patients. A solution was developed in Devon and much of this has been adopted nationally. One of the motions we spoke to at Conference called for changes in increasingly unaffordable medical indemnity insurance, and Mark has led this work for the GPC. It seems a solution may now be coming to fruition – see the article explaining this. Through our relationships with collaborative boards, trusts, CCGs and NHS England, amongst others, we can remain in a position to challenge and influence how general practice evolves and survives in increasingly difficult times.

So apart from an informative website, regular communications, meetings, an accessible Executive Team, pastoral care when necessary, conciliation of practice disputes, practice support, representation to, and negotiation with, trusts, CCGs, NHS England, Public Health and anyone else who needs us, and national representation through GPC members and annual conference, what has the LMC ever done for us?

……..Brought Peace?

*With apologies to Messrs Cleese, Palin and Idle: https://www.youtube.com/watch?v=Y7tvauOJMHo

News from Devon LMC

Last chance to register for the Practice Managers Conference

It's your last chance to register for Devon Local Medical Committee's forthcoming Practice Managers Conference.

The event will take place at the Harbour Hotel, Sidmouth, on 29 and 30 November.

The closing date to register is 1 November. Details of how to book, along with the agenda, are available here: http://www.devonlmc.org/trainingandevents

The proposed format for the event was agreed following feedback from practice managers and their local networks.

We look forward to seeing you at the PM Conference, where you can learn, network and be inspired!

Technology and the GP

By Dr Paul Hynam, Medical Secretary at Devon LMC

This is a tricky article to write as there is currently very little robust evidence to support the use of digital tools in general practice and although some of us are keen to embrace technology others see it as sounding the death knell for the 'face to face' consultation.

I'm sure you're aware, however, that there is a lot of encouragement from NHS England – in the form of funding – to invest in technology that 'enables self-care, reduces workload and helps practices work together and supports greater efficiency'.

The CCGs are also receiving funds directly for increased IT support in practices such as wi-fi for staff and patients. There's keen interest in improving the use of online GP services such as appointment booking, script requests and patient access to medical records.

There are a number of other tools that you could consider using as a GP. Local trials of speech recognition software and online (E) consultations are under way and in the very near future a local trial of video consulting is due to take place. If you're already consulting using the phone (very likely), video or online tools (or about to start using them) it's worth reading the GMC's 'Good Medical Practice' guidance on 'remote patient consultations and prescribing'.

Some of these tools are very patient centred and designed to improve access, possibly having the undesirable effect of increasing workload, therefore I'm more interested in discussing those that can be used to improve our working environment.

Giving patients access to their records online will allow them to print their own reports and summaries, which may help to reduce some of our often-unnecessary paperwork. In the future they may be able to share certain aspects of their record with external agencies, cutting the paper out completely. The use of apps to self-manage long-term conditions may also help to reduce GP contact. In a broader sense there are also tools that we can use across federations to make life a little easier. Video conferencing would help reduce travel times to meetings and as a federation GPs could also use this option for large scale teaching and training opportunities, such as conferencing virtual clinics across a number of practices.

So, there you have it…. there are a number of options available. Some more attractive than others.

There's no certainty that any of these strategies will have a magical effect on your workload, however I would definitely encourage you to consider those that could ease the pressure. If you're interested feel free to contact me at the LMC to discuss, or talk to your local GP federation who will have more information about how to access the appropriate funding streams.

Electronic Prescription Service reducing GP workload and benefitting patients

By allowing GP surgeries to send prescriptions directly to pharmacies, the electronic prescription service (EPS) system, which has been developed by NHS Digital, has helped to save patients time and money when collecting their medications.

An audit of patients using the system found that 72 per cent said their medicines were ready and waiting for them when they arrived at their pharmacy, with the average prescription collection around 20 minutes quicker under the EPS system.

The time savings that EPS offers the average GP practice allows staff to have more time to care for patients, particularly during the winter months when there is more demand for their services.

Additionally, with more people falling ill over the winter period, EPS can help patients get their medication quickly and reduce the need for pharmacists to ring the GP about prescription queries.

GP practices on average also saved an hour and 20 minutes each day by signing electronic repeat prescriptions compared to paper versions and an average of an hour and 13 minute a day by producing electronic repeat prescriptions compared to paper ones.

Other time savings for prescribers include:

- Practices save an average of 43 minutes per day by not having to locate paper prescriptions within the practice.
- Practices save an average of 31 minutes every day by not having to re-print lost paper prescriptions.
- Practice staff save an average of 39 minutes every day by not having to wait for GPs to sign urgent paper prescriptions.
- Practices save an average of 27 minutes every day by cancelling prescriptions electronically versus paper.

Mental capacity assessments for financial affairs

By Dr Rachel Ali, Medical Secretary at Devon LMC

The Mental Capacity Act is a fairly straightforward piece of legislation that helps to not only protect our right to make unwise decisions but also to protect those people who may no longer be able to make their own decisions.

The Act contains five statutory principles:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is least restrictive of the person's rights and freedom of action.

Capacity isn't a binary state, if someone cannot make a specific decision today, not only might that change with time but it isn't applicable to other decisions. The BMA toolkit is very helpful in explaining the details of the Act and how to use it in practise.

Given this, how should you respond if you are asked to help a solicitor by assessing someone's capacity to make a Power of Attorney or will?

As GPs we are all adept at assessing our patients' capacity for issues relating to health and welfare, but does that mean that we should be assessing capacity for decisions relating to financial affairs?

There will be occasions where it is clear that a given patient does not have capacity to make a will or to make financial decisions, but often things are a little more grey and difficult to assess without yourself being an expert on your patient's finances. Solicitors are trained to assess testamentary capacity, so you shouldn't expect to be asked for a medical assessment in cases where the answer is straightforward. There have been successful cases where wills were challenged and large settlements made because a court didn't feel the assessment made was rigorous enough.

If you have specialist skills in this area, you may feel comfortable going forward, but if not it is entirely appropriate to ask the solicitor to arrange a private assessment, usually with a geriatrician or psychiatrist. If you do decide to proceed with the assessment, look here for a reminder about how to set your fee for this non-NHS work.

Patient advocacy in primary care (duty to refer)

Patients who lack mental capacity to make decisions about their treatment have a legal right to an advocate in certain circumstances. When this arises in primary practice, GPs have a legal duty under the Mental Capacity Act 2005 to refer for an independent mental capacity advocate (IMCA).

The duty arises when

- The person lacks capacity to decide whether to have treatment,
- The treatment being considered is 'serious medical treatment'; and
- The person has no family or friends willing or appropriate to be consulted as part of the decision of whether to proceed with treatment

Serious medical treatment includes giving new treatment, stopping treatment or withholding treatment that could be offered where:

- there is a fine balance between the likely benefits and the burdens to the patient
- a decision between a choice of treatments is finely balanced, or
- what is proposed is likely to have serious consequences for the patient such as serious and prolonged pain, distress or side effects, potentially major consequences for the patient (such as stopping life-sustaining treatment or having major surgery), or serious impact on the patient's future life choices.

A decision to refer/not to refer to an outpatient clinic or secondary care may require an IMCA referral if all other criteria are met. GPs should also consider whether the criteria for Serious Medical Treatment are met when completing a Treatment Escalation Plan (TEP).

If a person has a right to an advocate, it is important to make the referral promptly.

- For Plymouth – contact info@seap.org.uk or 01752 753 718
- For Devon and Torbay – contact imca.devon@nhs.net or 0845 2311900.

If an urgent decision needs to be made to save the person's life, the GP should make a note in the patient record that there was not time to refer for an advocate.

If you have any questions, or require a copy of the IMCA referral form, please contact your primary care safeguarding nurse:

- For Plymouth – Gill Scoble D-CCG.SafeGuardPrimeCare@nhs.net
- For Devon – Jo Clake D-CCG.SafeGuardPrimeCare@nhs.net
- For Torbay and South Devon – Libby Potter libbypotter@nhs.net

Seasonal flu vaccine offers 2018-19

The LMC Buying Group has concluded negotiations with flu vaccine companies for the 2018/19 season and has agreed its preferred suppliers.

More information is available at the following link and then navigating to the 'Seasonal flu vaccine offers 2018-19' document.

Local finalist in Practice Manager of the Year awards

A GP practice manager in Exeter has reached the final of the Practice Manager of the Year awards held by the National Association of Primary Care. Chris Stoppard, of St Thomas Medical Group in Exeter, was nominated by his GP partners for the prestigious award. The practice serves 36,000 patients and is spread over four sites at St Thomas, Exwick, the Student Health Centre, and Pathfinder surgery.

Mr Stoppard joined the practice in October 2016 during a complete remodelling of the staffing structure. The future for the management of the practice was uncertain, as were many of the job roles within the practice. He joined the practice with a background in customer service and management, but with no previous NHS experience.

During his time with the practice the organisation has changed dramatically. In a time of uncertainty for general practice, St Thomas has employed six new GPs to replace retiring partners. There is now a paramedic and a nurse manager providing extra access for patients. He has worked with and fully understood the complexities of NHS funding streams, and has turned these to the practice's advantage.

Protected training times for all staff in the practice have been introduced and he writes a regular update for all staff each week.

The partners think he is exceptional in his ability to take on board new knowledge, face challenge and make change. St Thomas is now facing a positive future in maintaining a strong primary care service for the residents and students of Exeter.

Advice on GMS1 forms

Devon LMC has received a number of enquiries from local practices about the implications for them following the contractual changes to identify overseas patients.

The GPC advises that these changes were introduced from October 2017. They only apply to patients who are registering with your practice who have a non-UK issued EHIC or S1 form or who may be subject to the NHS (Charges to Overseas Visitors) Regulations 2015. These patients are invited to self-declare at the point of registration.

Practices will be provided with a revised GMS1 form to use, as well as a hard copy of a patient leaflet which will explain the rules and entitlements overseas patients have in accessing the NHS in England. Once a practice has manually recorded that the patient holds either a non-UK issued EHIC or a S1 form in the patient's medical record, they will then need to send the form and supplementary questions to NHS Digital (for non-UK issued EHIC cards) or the Overseas Healthcare Team (for S1 forms) via email or post. Details will be provided shortly about how to do this. Although the form will identify other patients from overseas, practices are only required to send the forms for patients with a non-UK issued EHIC or a S1 form.

Under this system, the patient's country of origin will be charged where relevant. Patients themselves will not be charged for general practice services, but as now, may be charged for some secondary care services. New recurrent investment of £5million will be added to the global sum to support this requirement and the associated administrative workload.

Later in the year the GPC will discuss with NHS England how an automated process could be introduced. These discussions will also include development of systems to automatically collect GP appointment data for these patients to better enable the cost recovery from their home countries.
Note:

- There is no requirement for practices to identify overseas patients.
- There is only one GMS1 form which now includes the supplementary questions.

- Only when the supplementary questions are completed does the practice need to do anything additional to what they currently do.
- Only when the supplementary questions have been completed do practices have to send the whole form to the central service.

**Article reproduced courtesy of Gloucestershire LMC.*

Immunisation and data sharing

By Dr Rachel Ali, Medical Secretary at Devon LMC

At our recent liaison meeting with Kernow LMC, we were joined by a representative from the Screening and Immunisation Team from NHS England. They have been receiving requests from practices who want to know how they are achieving locally against neighbouring practices with regards to immunisation rates. You may recall seeing something about this in the NHS England GP bulletin a few weeks ago when practices were requested to opt-out from data sharing.

As some of you rightly pointed out, opt-outs are not ideal from a data sharing point of view and informed consent to share is preferable when possible.

As from November, Avon and Somerset practices will receive monthly comparative flu data across their neighbouring practices in the form of bar charts (ski slopes). Should Devon and Cornwall practices collectively like to receive the comparative data reports then the Screening and Immunisation Team would be happy to provide these, but will need each practice to opt-in. We'll be talking to practice managers about this at their next meetings to help move this forward. For now, to support Devon and Cornwall practices to review their own data, the Screening and Immunisation Team will include a guide in the GP Bulletin on how to access flu data on Immform.

Should practices wish to be included, the plan would be to share the data in the form of bar charts or 'ski slopes' such as the ones we're used to seeing from DRSS and may be discussed but not distributed at immunisation meetings and flu meetings. There are no plans for this data to be used for any form of performance management. The data used will be that which you can access on ImmForm. Please get in touch if you have any additional concerns.

In additional news from the Screening and Immunisation Team, plans to start immunising pregnant women for flu within maternity services have been rolled out throughout Devon and Cornwall. Practices should expect to be informed within a week whenever a patient is immunised by maternity services. This is in addition to the enhanced services provided by GPs for the seasonal influenza or pertussis (pregnant women) vaccination programmes. Therefore all pregnant women should still be invited and may choose to receive the service via their GP practice. Maternity services will continue to signpost women to their practice if they have not been able to offer a vaccination or if any woman indicates that would be her preferred provider.

Indemnity in general practice update

The Department of Health is planning the development of a state-backed indemnity scheme for general practice in England. Read more at the following link: http://www.devonlmc.org/indemnity

New patient leaflet on referral to a specialist

The BMA, NHS England, and the National Association for Patient Participation have developed a patient leaflet which describes what patients can expect if their GP refers them to see a specialist or consultant, at a hospital or a community centre. It also provides a helpful checklist for patients to use before they leave hospital. The leaflet can be downloaded here. Note in Devon medication supply is for 14 days, not seven days as stated in the leaflet.

Taking on new partners: a practical guide for GPs

The GPC has produced a new three-part practical guide around taking on new GP partners. It is available here.

Update on new CQC regulations

The Care Quality Commission has issued an update on changes to how it will inspect and monitor practices following a consultation process. Read more at the following link: http://www.devonlmc.org/carequalitycommission

Collaboration in general practice: surveys of GP practice and clinical commissioning groups

Working at scale in collaborative arrangements is becoming widely accepted as the future of general practice. In 2015, the Nuffield Trust and the Royal College of General Practitioners (RCGP) published the results of two surveys. This survey found that 73% of practices were already operating in collaborations and were motivated to do so by financial pressures, a desire to expand the range of services offered, and CCG encouragement.

In 2017, a further two surveys were sent to general practice staff and to CCG staff that aimed to find out what had changed in the landscape of general practice and to explore what GPs felt the future held for them. These surveys were conducted as part of the RCGP and Nuffield Trust's 'General Practice at Scale' programme.
Key findings include:

- The scaling up of general practice continues apace with 81% of general practice-based respondents reporting that they were part of a formal or informal collaboration, up from 73% in 2015.
- However, the landscape is complex. Practices often belong to multiple collaborations that operate at different levels in the system, having been set up to fulfil different purposes.
- The main priorities of all collaborations over the last year were: increasing access for patients, improving sustainability, and shifting services into the community. The priorities differed by size of collaboration. Both providers and commissioners reported that time and work pressures were the biggest challenge to collaborations achieving their aims.
- When asked about developments in their local area, over half of GP staff and one-third of CCG staff surveyed felt practices and collaborations had not been at all influential in shaping the local sustainability and transformation plan (STP). Only one-fifth of GPs thought STPs would deliver meaningful change in primary care. CCGs were more optimistic, with 61% reporting that meaningful change was probable.
- When questioned about future models of care, around half of practice partners (53%) said they would be 'unwilling' or 'very unwilling' to give up their current GMS/PMS/APMS contract to join a new models contract (e.g. MCP or PACS contract). The most common reason they gave was that they did not want to lose control of decision-making and leadership in their practice.

Accountable care systems and future commissioning – impact on general practice

There are useful blogs on what does an accountable care system mean for general practice and the impact of commissioning on general practice

'General practice is at a crossroads'

Health commentator and policy analyst Roy Lilley gives his take on the future of general practice – read more here.

Salaried v fixed share partners

Managing partnership changes and staffing are two of the most common issues any practice will deal with and how they are handled can have long-term implications, especially in relation to a new partner joining the business.

One area that can cause confusion is the difference between a 'salaried partner' and a 'fixed share partner'. The two terms are often used interchangeably, but they are very different and it's important that a distinction is made.

The key differences and the implications they may carry for your practice are considered here.

Planning to retire as a GP soon?

The unprecedented pressures on general practice combined with the age profile of the profession are creating a wave of partner retirements. What should you be thinking of before drawing your pension? Read more here.

Due diligence – is it worth the effort?

For any major commercial transaction, you need to know exactly what you're getting into and ensure (as far as is possible) that there aren't going to be any nasty surprises further down the line.

Due diligence when you are merging or acquiring a practice can help you see what's below the surface and avoid you making a costly mistake. Read more here.

Should your surgery building be held as a partnership asset?

A surgery building is one of the most valuable assets a GP practice may own, so it is important to understand the implications of how it is held. Partners need to be clear whether their property is held as a partnership asset or not. The answer can have significant implications in relation to ownership rights and obligations, occupancy and even tax.

The nature of partnership assets is complex, but some of the main features of holding the building inside and outside the partnership are summarised here.

Is your surgery lease coming to an end?

GP practices are increasingly occupying their surgeries as leasehold tenants. It is a trend that has been happening for some time now, so many practices are approaching the end of their lease.

As a surgery lease is one of the most important and complex contracts a practice can enter into, it is important to plan ahead and take action early. Here are some of the key points to address in your plan.

RCGP appraisal and revalidation survey

The Royal College of General Practitioners (RCGP) has launched its new revalidation survey for 2017 aimed at establishing how GPs feel about appraisal and revalidation now, and what the College can do to support them in the future. It can be accessed here.

Help research into young ADHD patients

The University of Exeter's CATCh-uS project is studying transition between child and adult services in young people with ADHD (http://medicine.exeter.ac.uk/catchus/). One of the aims of the research is to understand current practice across the country and make recommendations for policy and practice regarding management of these patients in primary care and specialist services.

The study team are aware that GPs play an important role in the care of this group. If you are a GP, we would like to invite you to participate in a short (approximately 30-40 mins) telephone interview about your experiences of managing young people with ADHD in the process of transition and your views of the role of primary care.

If you would be interested in taking part and willing for us to contact you, please fill out your details in the form here: https://www.surveymonkey.co.uk/r/SP8S2SF You can also request further information from the team about the project.

Produced by: Devon Local Medical Committee, Deer Park Business Centre, Haldon Hill, Kennford, Exeter, EX6 7XX.

Copy submissions for December's newsletter should be emailed to richard.turner@devonlmc.org by noon on 20 November please.

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