AUGUST 2017 NEWSLETTER

LOCAL MEDICAL COMMITTEE
LMC
GLOUCESTERSHIRE

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The GPC is asking practices how they would feel about implementing a national closure of lists. Only the BMA, as the doctors' union, can instigate industrial action, and unilateral national closure of lists would not only be industrial action but might also be construed as breach of contract. The LMC is not part of the BMA and so is unable to promote, advise or suggest any such action. All we can do is give information. A FAQ is at Annex B.

List closure attitude survey

Note the following important points:

- The purpose of this ballot is for GPC to understand what practices would actually be prepared to do. GPC is not advising practices to vote yes or to vote no to either of the options in the ballot.
- GPC has not proposed that all practices collectively (or otherwise) close their lists at this stage.
- Practices are currently able to take the decision to temporarily suspend patient registrations (provided they have reasonable and non-discriminatory grounds for doing so), or apply to close their lists, based on their own specific circumstances, for example in order to protect the quality of patient services. This ballot is separate from this. If enacted, the BMA would be calling for collective cessation of patient registration as part of a campaign of industrial action.

The new Chairman of GPC England and GPC UK

Dr Richard Vautrey, until now the Vice Chairman of the GPC, has been elected to the roles both of Chairman of GPC England and Chairman of GPC UK. (The two posts do not automatically go to the same doctor.) We wish him well in his arduous task over the next three years.

The Capped Expenditure Process (CEP)

You may hear the term 'CEP' bandied about. There are 14 health economies affected, the nearest to us being that of Bristol, South Gloucestershire and North Somerset. What will be involved no one knows, but CEP is an attempt to reduce overspend so we may expect to see a reduction in services in those areas. The BMA opposes CEP.

Whistleblowing

This is a reminder for practices to ensure that their policies and procedures align with the new NHS whistleblowing policy by September this year. In brief, every practice must have a named individual, who is independent of the line management chain and is not the direct employer, as the 'Freedom to Speak Up Guardian'. He or she is responsible for ensuring that policies on whistleblowing are in place and the staff know who they should contact if they have a concern. Note that the named individual need not be a member of the practice. You might like to consider GDoc Ltd to provide this service. Further information,

including a link to the NHS England guidance on raising concerns for primary care providers, is available here:
https://www.bma.org.uk/advice/employment/raising-concerns/guidance-on-raising-concerns-for-primary-care-providers

Change of status

GP registrars are already on the national Performers List (NP)L when they conclude their training but there are concerns that there may be delays in processing the change of status on the Performers List in a timely manner. Anecdotal information suggests that this is compromising the ability of the GP to secure substantive independent work until the change in status is effected on the Performers List. PCSE give the following advice on their website:

a. GP Trainees legally cease to be trainees when the GP registrar achieves their CCT and the GMC register is updated.
b. NHS England policy requires GP Trainees to provide evidence that they have completed their training and to complete a change in status form, enabling Capita to update their status on the Performers List. If they have evidenced this, they have fulfilled their obligations under the regulations and NHS England policy.
c. The change in status on the NPL itself does not require MD/RO approval as this is a routine administrative process.
d. During this period of time and in the event that an enquiry regarding their status is received from either the recently qualified trainee or an organisation wishing to use their service, MDs or their delegated officers should assure themselves that the trainee has completed their training by either checking the GMC register, and/or liaising with HEE if they are a GP registrar. If the MD or their delegated officer can assure themselves via this route, there should be no reason why the trainee should not be permitted to practise independently whilst the administrative change in status is undertaken.

Mandatory training

There is often vagueness on what training is or is not mandatory. The main difference lies between clinical training and non-clinical training. See our webpage on the subject.

Digital child-health events project – online survey

NHS Digital are developing a standard (known as the e-red book) to share information effectively with health care professionals and to be made available to parents/carers through the personal electronic child health record. This standard should be fit for purpose and be embedded across all nations of the UK. NHS Digital, and related organizations, are now defining the information sharing requirements for such a community child health record

As part of that work, NHS Digital have commissioned the Professional Records Standards Body (PRSB) to consult with parents, carers, health and care professionals, industry and clinical informaticians on their draft requirements. The Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of General Practitioners (RCGP) are leading the consultation, supported by the Royal College of Physicians Health Informatics Unit.

Their online survey is seeking views from parents and carers and health and care professionals on the information content of the child health record to ensure that all data items are meaningful, relevant, complete and feasible to record/incorporate into clinical information systems.

The survey should take approximately 20 minutes to complete and will close at 5pm on 21 August 2017.

Should you have any questions, please contact informatics@rcplondon.ac.uk

LMC Buying Groups Federation

Gloucestershire practices show an encouraging increase in their use of many of the varied bargain offers from the Federation's authorised suppliers. Reducing overheads is as good for the bottom line as an increase in income. We therefore commend the Federation to you. For those not aware of the Federation have a look at our website (http://www.gloslmc.com/Federation_of_LMCs_Buying_Groups.asp)

and consider whether your practice could benefit from the free cost analysis the Federation offers.

The interface between primary and secondary care

The new NHS Standard Contract for 2017- 19 has been in place long enough to have settled down. All hospitals, and all departments within hospitals, should be abiding by it. Key messages for NHS clinicians and managers gives useful guidance on how the contract is to be applied. The main points can be summarised as follows:

DNAs. Hospitals cannot automatically discharge DNA patients – it depends on clinical advice and the patient's circumstances.

Onward outpatient referrals. Subject to any specific CCG pathways, a hospital department can make onward outpatient referrals to any other service if that referral is directly related to the condition for which the original referral was made, or which caused the emergency presentation, or the patient has an immediate need for investigation or treatment (e.g. suspected cancer).

Investigations. Within their contract from the CCG the hospital is responsible for arranging and carrying out all the necessary steps in a patient's care and treatment; they should not ask the GP to do it.

Communication. Hospitals must themselves answer patient queries about their hospital care and communicate to the patient directly the results of investigations and tests which the hospital has set in train. This is a matter of clinical responsibility.

Discharge Summaries and clinic letters. Discharge summaries must be sent to the GP within 24 hours of discharge, whether inpatient, day case or A&E. Clinic letters must be sent after any attendance where the secondary care clinician believes the GP needs to act. Where needed, clinic letters must be sent within 10 days of the patient's attendance (7 days from 1 Apr 18). It is suggested that the form and content of both should be agreed such that discharge summaries (now) and clinic letters (by 1 Oct 18) can be sent electronically as structured messages of coded clinical information using standardised clinical headings.

Medication. On discharge, the minimum period for which medication is to be provided is 7 days (shorter period only if clinically appropriate). After attendance at a clinic the hospital must provide sufficient medication to last until the GP can reasonably be expected to have received the clinic letter and thus take over prescribing.

Shared care protocols. The contract makes clear that the hospital must only initiate care for a patient under a shared care protocol where the individual GP has confirmed willingness to accept clinical responsibility for the patient in question.

Fit Notes. On discharge or after a clinic appointment the hospital must issue a fit note if one is required and that note must cover until the patient is expected to be fit for work or until the next clinical review. (GPs should be informed that the note has been issued, the reasons given and the exact dates covered.)

More about ear irrigation

You will soon receive, or may be have received, from the CCG the specification for the interim ear irrigation service. Note that this service will only run until the end of March, after which some other service will be commissioned. There is a risk that this other service will not be commissioned from practices so our advice is that you should think twice about buying new equipment before the details of the 2018/19 service become clear. In the interim, it will be a block payment calculated from the agreed £11.27 per treatment multiplied by the expected size of the cohort based on the incidence of past treatments already reported. There will be caveats, which you should note.

Trainee survey by Pulse magazine

Pulse are running their first-ever survey solely for GP trainees. GP trainees' career intentions are unknown. In particular, there are no figures on the number of GP trainees that stay in general practice. The survey is to rectify this. Pulse are offering free pizza for a year for one lucky respondent. You can access the survey at:
https://www.surveymonkey.co.uk/r/6TMR6S2

Information about switching to a career as a GP - FAQs and examples

HEE (Health Education England) has recently seen an increase in the number of enquiries about how to become a GP from trainees across all specialities, consultant, trust and staff grade doctors. The changes in the NHS over recent years means that more and more services are, and will be, provided by GP-led multi-professional primary care teams. The Primary Care Workforce Commission report, 'The future of primary care, creating teams for tomorrow', gives more insight into these developments.

HEE recognises that it is not easy to find information when you have moved on from the normal training cycle. With that in mind, some case studies and frequently asked questions have been published on the GP National Recruitment Office (GPNRO) website, which can be shared with colleagues, peers or friends who may be interested about switching to a career as a GP.

Email gprecruitment@hee.nhs.uk if you would like to be put in contact with someone who has retrained as a GP.

EXIT 'READ CODES', ENTER 'SNOMED CT'

The 'Systematised Nomenclature of Medicine Clinical Terms' (SNOMED CT for short) is an international clinical vocabulary used within a clinical system to ensure that data is entered into patient records consistently. The vocabulary covers content such as diagnoses, interventions, symptoms, allergies and family history. The use of a consistent vocabulary enables reporting and clinical decision support to function reliably.

SNOMED CT is used in 50 countries and is the clinical vocabulary chosen to replace the two versions of clinical codes (Read v2 and CTV3) currently in use. The NHS needs a single clinical terminology (SNOMED CT) for clinical data to be exchanged accurately and consistently across all care settings; this will, eventually:

- Enable better patient care.
- Improve how clinical data can be analysed and reported on.
- Reduce the requirement of additional manual input.
- Reduce data entry errors.
- Provide business efficiencies.

All GP surgeries will move to SNOMED CT though not at the same time, but all must have converted by 1 April 2018. The burden on practices should be minimal; the burden of this change will be on the suppliers of GP clinical systems

Secondary Care, Acute Care, Mental Health, Community systems and other systems used in the direct management of care of an individual must use SNOMED CT before 1 April 2020, although a number already do use SNOMED CT.

Clinical systems suppliers will preserve existing Read codes and automatically map them forward to the new SNOMED CT codes. After the move systems will, of course, use the new codes – the 'map' only maps forwards, not backwards.

Usefully, if a particular Read Code has not been accurately forward-mapped this concern can be reported to the Terminology Request Submission Portal and all clinical systems have agreed that they will accept modifications to the 'map'. SNOMED codes will be updated twice a year (in October and April).

Initially not all of SNOMED CT will be available in systems; a subset of SNOMED CT has been created that largely reflects the Read codes. The current plan is for supplier systems to use all of SNOMED CT in April 2018, although practices will continue to use their own formularies/subsets and, indeed, be able to create new formularies.

The supplier of your clinical system will provide end user system training using their preferred training tools for any changes to their system. Queries should be directed to your GP system supplier. However, general awareness training can be accessed via:
https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=300083

The Delen website at https://hscic.kahootz.com/connect.ti/t_c_home/groupHome carries an updated FAQ list which, once you have registered on the site, is located at Workspace Home|Managers Only – Resource Library|Guidance Document. (I have summarised the main points from it above.)

District Nurses data entry on GP clinical systems

We understand that GCS has not instructed District Nurses not to enter data on GP clinical systems, SystmOne or otherwise. Thus, if such refusals should arise in future please let this Office know about them.

GDoc Ltd Summer 2017 newsletter

Here is the link to the latest GDoc Ltd Newsletter.
https://www.flipsnack.com/FFE5BE86AED/1014367-gdoc-newsletterspages-fdnad8s3z.html
All practices are members of the company.

Sessional GPs e-newsletter - UK

This month's edition of the GPC's Sessionals' newsletter focuses on priorities for the coming year.

Job opportunities

A list of recent job opportunity notifications is at **Annex A**. A full list of unexpired job adverts is at http://www.gloslmc.com/blog-job-vacancies.asp and links to them are also at Annex A for ease of reference.

Max's Musings

If Peaty can do it perhaps I can too. At least Archimedes' principle must be on my side as I am sure I displace so much water that I should float for ever with minimal effort. It will, however, require courage to face the imagined ridicule when I buy a pair of swimming trunks that fit me. It may take even more courage to wear them. I shall have to pick a very isolated spot for our holiday or go dipping after dark. On the plus side, my body is a wonderfully large Vitamin D receptor.

I visited a friend the other day who admitted that the small back lawn in his garden had died a horrid death from being trampled on and had finally died of impaction and thirst. Consequently, he had the patch (no more than 15 feet by 10) laid down to artificial grass. I admit that my immediate reaction was mild horror tinged with traces of disgust. But over the next couple of days I reflected. After all, it is always splendidly green, and thus easy on the eye. There is no need to mow it. I also found it surprisingly comfortable to lie on (even for chap of my bulk). I must confess to being something of a convert. When we finally downsize (the house I mean, not me) that will be one of the things we will put in to make life easier.

I hope you enjoy your holiday this summer (if you manage to get away) as much as I intend to.

And finally,
Beware of predictive text! Seen in a recent email to do with something not going according to plan: "The group are much exorcised…"

This newsletter was prepared by Mike Forster and the staff of Glos LMC

ANNEX A TO
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JOB VACANCIES

The full list of current vacancies is at: http://www.gloslmc.com/blog-job-vacancies.asp.

GLOUCESTERSHIRE			Date posted	Closing Date
Tewkesbury Choice Plus	Gloucestershire	Choice+ rota	9 Mar 16	Open
Partners in Health	Gloucester	Partner/Salaried GP	20 Jul 16	Open
Dockham Road Surgery	Cinderford, Forest of Dean	Partner or Salaried GP	21 Apr 17	Open
Gloucester City Health Centre	Gloucester	Salaried GP leading to partnership	31 Aug 16	Open
Coleford Health Centre	Forest of Dean	Salaried GP/partnership	31 Aug 16	Open
GP Retainer Scheme	Gloucestershire	GPs (plural)	22 Nov 16	Open
Royal Crescent Surgery	Cheltenham	GP Partner (Part-Time)	11 Jan 17	Open
Bartongate Surgery	Gloucester	GP Partner	28 Apr 17	Open
Regent Street Surgery	Stonehouse	4.5 sessions for a Partner, salaried GP	23 May 17	Open
London Medical Practice	Gloucester	Salaried GP (4 sessions per week	14 Jun 17	Open
Seven Posts Surgery	Cheltenham	Salaried GP	19 Jun 17	Open
Hadwen Medical Practice	Gloucester	Maternity cover/locum GP	19 Jun 17	31 Jul 17
Churchdown Surgery	Gloucester	Part-time Partner	20 Jun 17	31 Jul 17
Walnut Tree Practice	Dursley, Glos	GP Partnership Opportunity	05 Jul 17	31Aug 17
St George's Surgery	Cheltenham	Practice Nurse – Band 6	19.Jul 17	01 Aug 17
Staunton & Corse Surgery	Near Gloucester	Salaried GP	19 Jul 17	09 Aug 17
ELSEWHERE				
Pensilva Health Centre	Liskeard Cornwall	GP Partner	02 Nov 16	Open
Irnam Lodge Surgery	Somerset	Salaried GP	21 Jun 17	Open
Avon LMC	Avon	Nurse	25 Apr 17	Open
The Locality Health Centre Group	Weston-Super-Mare	Treatment Room Nurse: Medical Coder /Summarisers: IT/Data Administrators	21 Jun 17	Open
Martock & South Pemberton	Somerset	Salaried or Partner GP	10 Jul 17	31 Aug 17
Mount Pleasant Practice	Chepstow	Salaried GP	25 Jul 17	31 Aug 17

REMINDER: *If you are advertising with us and fill the vacancy please let us know so we can take the advert down.*

ANNEX B TO
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List closure ballot FAQs

We are aware that practices have started to receive their ballot papers from the BMA asking you to vote as to whether you are willing to consider collectively closing your list in response to the crisis in General Practice, in line with the motion that was passed at LMC conference in May which said:

"That conference believes that the GP Forward View is failing to deliver the resources necessary to sustain general practice and demands that GPC ballot GPs as to whether they would be prepared to collectively close their lists in response to this crisis."

The LMC is not a trades union and can only offer information, not advice. Within this limitation here is a list of FAQs which we hope are helpful. We urge you to read this in conjunction with the FAQs sent out by the BMA and stress that in this ballot you are not voting to close your lists but to give GPC a steer as to whether you are willing to consider this action. This initial vote is to strengthen the hand of GPC when dealing with the Government. Only after a YES vote in this survey will GPs be balloted on whether they will actually close.

Q: Why is the GPC balloting for willingness to take action?

A: It is beyond doubt that General Practice is in meltdown with dangerous levels of workload every day. The public sector pay cap has meant that doctors have effectively taken a 22% pay cut in the last decade. In general practice this means the small business we run to care for our patients rapidly becomes unviable. Practices are closing across the country. Regrettably, the GP Forward View and a couple of other sweeteners such as reimbursement of CQC fees are simply not enough to be able to provide the care our patients need.

Q: Why are GPC proposing list closure?

A: General Practice is governed by contract. Refusing to comply with many clauses in the contract, such as refusal to cooperate with CQC, would risk a breach notice. List closure however, if carried out on the grounds of patient safety, is allowed under the contract.
https://www.bma.org.uk/advice/employment/gp-practices/quality-first/manage-inappropriate-workload/list-management
"A practice can decide not to register new patients, provided it has 'reasonable and non-discriminatory grounds for doing so', (such as protecting the quality of patient services.) In such cases, the regulations allow practice to refuse to register new patients (Schedule 6, Part 2, paragraph 17)."

Any action by medical professionals is only done with a heavy heart. In advising practices to consider list closure, the GPC is clear that this is a way of causing maximum disruption to the government's plans for the NHS, registering our disdain at their failure to adequately fund general practice, whilst causing no harm to our registered patients.

Q: What should I say to patients?

A: Be honest. Tell them we regret taking this action and do not do it lightly, but that the Government have not listened to years of warnings about the strain on General Practice and that now it is on the point of collapse. We must do something to stop it breaking down altogether. We struggle to provide a safe service due to our workload and this is not good for patients. Ask patients to support you: put a petition in the waiting room and ask them to write to their MP. Our patients are the strongest weapon we have in fighting for general practice. Tell them what you are doing and why.

Q: My practice has a high turnover, if we close our list we will rapidly lose income.

A: For practices like yours, consider deciding a minimum list size to sustain the service, then temporarily close your list until patient numbers have dropped below this. You could then re-open until your safe limit is reached, closing again and so on. Remember the aim is to highlight the dangerous working conditions we all face and the impact this has on patient care. You can still achieve this.

Q: What about the patients who are not registered with a GP?

A: GPs will remain able to see patients as temporary residents in emergency circumstances. We regret that this action will mean a delay in registering fully with a GP, but failure to act will lead to the collapse of General Practice which would mean a lack of access for all. As a profession we do not do this lightly, but the risk to our patients is greater if we do nothing. NHS England will still be able to allocate patients to closed lists, as is the case currently in many areas where all practices have closed lists. If this list closure happens nationwide however it causes a significant increase in workload for NHSE, as well as public embarrassment to the government.

Q: I understand the need to take action, but I am nervous.

A: Of course. We are a caring profession who are reluctant to do anything to hurt or upset our patients. Having considered many options, the GPC genuinely believe this is the best choice to cause maximum disruption for Government, but minimal harm to patients. The risk of continuing to provide care at this unsafe workload outweighs the risk of carrying out this action.

Q: Why is the GPC balloting for "collective" list closure?

A: Because together we are much stronger and can have a much bigger impact. If we stand united across the profession, supporting each other we can make rapid gains. Uniting GPs across the country means we can deliver a stronger message and hopefully achieve our aims quickly.

Q: What do you want the Government to do?

A: There are many things that Government could do. These are some suggestions:

1. Enact BMA policy and fund the NHS to the level of comparable countries and at the same time increase the proportion of NHS funding which is allocated to General Practice to at least 15%. In 2015 the UK spent 7.3% of GDP on the NHS. This is lower than most other European countries and is set to decease to 6.6% by 2020. The UK has fewer hospital beds per head at 2.8/1000 than the OECD overage of 3.3 and has fewer doctors and nurses per head than comparable developed nations. Despite this the NHS is regularly found to be the most cost-effective health care system in the developed world.
   http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror
2. Take responsibility for GP indemnity in the same way that they do for hospital doctors.
3. Allow patients to directly refer themselves for services such as antenatal, terminations of pregnancy, podiatry, physiotherapy, weight management programmes etc, to remove needless administrative burden from general practice.
4. Remove all the hoops that we have to jump through to obtain multifarious and relatively small sums of money. Funding must be made directly available for all practices.

5. Deal with the incompetence of companies such as Capita and NHS Property Services whose failures cause such time wasting in surgeries.
6. Sort out NHS Property Services so that they stop wasting practices' time with repeated premises surveys and sending unjustifiable service charge bills.
7. Attract doctors and nurses into General Practice, both young doctors and those who have left. Increasing doctors and nurses will help decrease the workload which 84% of us have said undermines our ability to provide safe patient care and enable us to provide a safe service for patients.
   https://www.bma.org.uk/news/2016/november/workload-strain-compromises-patient-safety-finds-survey
8. Confirm the residency status of all non-British-born doctors and nurses immediately so that they remain here making their vital contribution to our health service.