June/July 2016 - Issue 25

Newsletter

North Staffordshire LOCAL MEDICAL COMMITTEE

Professional advice for General Practice

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Releasing Capacity in General Practice - update

You may well be wondering what has been happening since the LMC held the Releasing Capacity in General Practice Event at the Britannia Stadium in April. As the LMC's Practice Liaison Officer I was very involved in organising that event and am subsequently beavering away on your behalf, along with other key people, acting on the summary feedback from the group work.

We have formed an Action Group and have an action plan covering the 10 high impact areas for releasing capacity. There are some potentially interesting and exciting developments coming out of the work we are doing supported by NHS England, the CCG's, GP Federation and Combined Healthcare.

As it's not possible to work on all elements of the action plan at the same time the Action Group is focusing on a few areas initially. Practices will know about the Active Signposting process where I have already gathered information which will be used to inform the training strategy and costs. It will be really important for Practices to work together on this once the training has been agreed.

Another key element of the work we are doing is looking at training to redirect as much of the incoming post as possible from GP's to non-clinical staff so that GP's only see the letters they really need to. This is known as workflow redirection and we are currently negotiating with 2 providers on training costs. All Practices will be able to benefit.

Due to the enthusiasm shown across our two CCG's at the April event and subsequently the NHS England Sustainable Improvement Team has invited us to be early adopters as part of the ' breakthrough collaborative' which is part of the GP development

programme referenced in the GP Forward View. This will provide Practices with the opportunity to have training on quality improvement techniques and you will be supported at a local level by people who are experts in this field. The NHSE Team will work alongside our practices to support them to rapidly implement changes and to quickly make differences that improve the working pressures in general practice. Something I'm sure we all want and can sign up to. NHS England will fund this.

Development of the Patient Charter, which was introduced at the April event, is progressing well with input from SSOTP, Combined Healthcare, UHNM and patient representatives.

There was significant discussion at the event around personal productivity and resilience for GP's and other senior Practice staff. This will be taken up by Kellie Johnson who will shortly be contacting GP's/Practices to undertake a scoping exercise to see exactly what it is that people need and how they would like it to be delivered. When you get this e-mail please make sure that you respond so that any training or workshops are specifically designed to meet your requirements.

For the future of General Practice it is really important that we embrace and implement change. Don't be the ostrich who pretends this is not happening. It's also really important that Practices work together to share information and expertise, to learn together and to support one another. We will be better and stronger together and thus be able to positively manage current challenges and those which will surely come in the future.

Anne Sherratt
LMC Practice Liaison Officer

Update from BMA re Capita/PCSE

The latest update can be found here

Charging for printed copies of test results

A practice in another LMC area has asked if they are within their rights to charge for printing results and what a fair amount to charge would be?

This is, in effect, a Subject Access Request (SAR) under the Data Protection Act (DPA). As such practices can charge up to £10 maximum for access. Practices can refuse to provide the information in the patient's preferred format.

The ICO's Code of Practice for SARs can be found **here**

National Pension Allowances

This year there are several changes to the national pension allowances. Colleagues may need financial advice about IP14 (before 4.17), IP16 and their lifetime allowances, if they hit the £1.25M or £1.00M thresholds. This is calculated by multiplying your projected pension by 23 (20+3 for lump sum). There is now a website access for your pension statements.

In addition and with far more impact than the lifetime allowance, is the reduction in annual allowance from £40K. Doctors can pay the 45% tax bill for excess contributions if they apply or they can elect to choose scheme-pays (which charges 3% above CPI interest off your future pension), but this is by 31.7.16 and the choice applies and must be made annually – hence this reminder.

The LMC is giving this brief reminder as a trigger to check your own status and if necessary get personal financial advice.

The 1995 pension remains very good value and the others less so, but usually worth continuing, but some individual circumstances are now triggering some colleagues to take contribution holidays or ceasing contributions or taking early 24 hour retirement. All these need very careful calculation and advice, which can be hard to source, depending on your proximity to

retirement.

CQC - request for access to medical records of GP partner/registered manager

Colleagues seeking to register with the CQC as a GP partner/registered manager may find themselves being access to allow access to their medical records. Unless there are exceptional circumstances there is no requirement for GPs to allow access to their medical records and the LMC would advise those applying NOT to consent to this. Further advice from the GPC is due to follow soon.

Advertising GP vacancy - Practices beware!

A practice recently paid for adverts in the BMJ and Pulse for vacancies. They had 1 response. Then a while later a recruitment agency rang and offered a new possible applicant. Their terms are 15% of the first years salary (min £8000).

As the practice agreed to see this GP, they are considered to have accepted the terms so without permission the agency then posted 2 re-worked versions of the original advert on GP careers and BMJ careers. They did not ask permission or share the re-wording in advance. The new adverts make it hard to tell who it is about and of course the link is the agency. So now any new applicants come with the “agreed” fee.

Practices need to be aware of this as it is very easy to fall into this clever trap

Retained Doctors Scheme

The Retained Doctors Scheme 2016 will launch in the next week.

The current sessional rate in the SFEs will be increased from £59.18 to £76.92 (for between 1 and 4 sessions per week) and an annual bursary of between £1,000 and

£4,000 based on the number of sessions worked per week will be paid to the retained GP via their practice.

These payments will be available to:
- Current retained doctors
- New retained doctors joining the scheme an in post by 31 March 2017

The increased funding is available for up to 36 months from 1 July 2016 to 30 June 2019. During this time a review of the retained doctors scheme will take place.

Nursing Associates

Health care employers and education providers are invited to put forward partnership applications to be part of an innovative and high profile two year programme of test sites across England. These test sites will pioneer the introduction a new role for health and social care: the Nursing Associate.

This important initiative is a key component of the government and HEE's commitment to build capacity to care and capability to treat within the health and care workforce for today, and to meet future needs. The Nursing Associate role will be challenging, rewarding and valuable and will provide a route into the Registered Nurse degree as part of the over-arching nursing career framework.

Large GP federations, employers or groups of GPs are ideally suited to put forward an application from Primary Care.

Enquires can be made for more information by contacting: Karen Storey HEE (West Midlands) Primary Care Nurse Lead or your local Community Provider Network Lead or Bev Ingram HEE (West Midlands) Executive Clinical Lead.

Applications and further information can be found here HEE (West Midlands) will also be holding two webinars (13 Julyand 25 July) providing information on HEE recruitment process of test site partnerships.

Staffordshire Thrombosis and Anticoagulation Centre launches: the end of the Dalteparin debacle?

The STAC launch took place recently at the Postgraduate Medical Centre. The LMC was in attendance and noted the strength of feeling from local GPs at the frustrations of past service experiences. The opportunity was taken to press the new service on their commitment to continue Dalteparin prescriptions in complex cases where ongoing anticoagulation decisions had yet to be made. It was unfortunate to note there was some vacillation from UHNM, despite the accompanying literature clearly stating that Dalteparin prescribing was the responsibility of the new STAC service. Commissioners at the meeting confirmed this, unless there was agreement by the GP to take on prescribing under an ESCA in cases of pregnancy and cancer only.

The LMC has repeatedly made calls to make Dalteparin a red drug, where not subject to an ESCA in cases of pregnancy or cancer, order to clarify the new commissioning arrangements. In the last Area Prescribing Committee (APC) meeting which the LMC attended, there was a repeated failure of Medicines Optimisation and UHNM to appreciate the safety risks of current arrangements. Medicines Optimisation would rather not listen and response was to call to have a more malleable representative on the APC. The LMC will keep the pressure on to gain this change in the formulary. In the interim, the LMC advises not to prescribe Dalteparin given that it is commissioned elsewhere. After all, Dalteparin is in the 4th most harmful class of drugs according to the presentation at the STAC launch, with anticoagulants 3rd most dangerous (opiates are 1st and antibiotics 2nd).

Frailty? Consider QOF exemption

Frail patients consume large quantities of the local budget but presently in a way that may not be in their best interests such as being admitted to acute hospital beds for long stretches.

At the last LMC open meeting, there was agreement between LMC, CCGs, and providers present that frailty was one of the biggest issues encountering the local health economy.

The LMC notes the recent adoption on clinical computer systems of the eFI, electronic frailty index, that highlights patients that are likely to be frail.

The LMC notes that QOF has gone from Scotland and that its end is being negotiated for 2017/18 in England. There was agreement when LMC suggested that it may not be in the best interests of severely frail patients for GP to aggressively follow QOF targets in their individual case. Not chasing QOF targets would allow more time to discuss prognosis to inform patients' and sometimes more importantly carers' expectations.

Dr Shipman, medical director at SSOTP, states that frail patients have on average 1000 days of life left. Clearly palliation is more important than tick boxes in these cases?

If the eFI score is too dry for you then click here for this powerful silhouette picture of levels of frailty according to Rockwood. Print it out and put it on your wall.

Avoid dodgy death certification by letting the hospital do their duty:

Some months ago, the Treasurer and Dr Guindy attended a meeting with the Coroner in their capacity of deputy medical referee, and medical referee to Carmountside Crematorium, respectively. The Coroner had agreed with those present that his officers would assist in asking a hospital doctor to complete the necessary paperwork such as the medical certificate of cause of death and cremation form for if a patient dies within 14 days of discharge from hospital and there is no GP available to complete the necessary paperwork. The 2008 cremation regulations guidance published in 2012 expects the medical practitioner to have seen the deceased within 14 days of death or the case must be referred to a coroner.

The above is being communicated in the newsletter because there are worrying reports that doctors are felt compelled to sign paperwork for palliative patients

"discharged to die" where; they may not have even met the patient if discharged to a new residential home; or not in their last illness or within 14 days in the case of patients discharged to their original address but after a prolonged hospital stay. The guidance is very clear:

"It should never be acceptable for the certifying medical practitioner to have seen the body only after death and not treated the deceased during the last illness"

In the vast majority of these cases, by the hospital doctors signing the paperwork, it would solve this worrying state of affairs.

Breakdown of the 2016/17 £220m investment contract uplift

Below is a breakdown of the 2016/17 £220m investment contract uplift

£220 million is being invested into the GP contract in recognition of rising financial pressures facing practices. This is more than double the 2015/16 investment and seven times that added in 2014/15. This breaks down as follows:

- CQC fees: £15 million
- Indemnity: £33 million
- National Insurance contributions: £57 million
- Superannuation: £14 million
- Increase to vaccination and immunisation item of service fee from £7.64 to £9.80 (28% uplift): £30 million
- Increased QOF point value (CPI adjustment): £13 million
- 1% pay uplift: £57 million

The funding for the dementia enhanced service (£42 million) was added to the Global Sum with no OOH deduction, meaning all the funding has been retained within the contract. The OOH deduction for 2016/17 is 5.15%, and only applies to the £58 million 1% pay uplift.

The above investment has led to an increase in Global Sum for 2016/17 to £80.59 per patient (5.9% increase - click here for details) and an increase to the value of a QOF point to £165.18 (3.1% increase).

Our own war on workload

See #PulseWOW for the national campaign. Send in your ideas.

Medical exemption forms:

Did you know that FP92A medical exemption applications do not require countersigning by a doctor?

A receptionist with access to the notes can stamp and date the form instead.

There are common pitfalls however such as confusion between diabetes mellitus and diabetes insipidus; and hypoparathyroidism and hypothyroidism. The following common pitfalls information sheet might help both patients and staff.

Postponing menstruation for holiday, a necessity or a luxury?

Could charging a fee for a norethisterone prescription to postpone menstruation on a foreign holiday by using paragraph 1. h) of schedule 5 of the GMS Regulations be used to dissuade patients and manage demand?

DMARD Workload Tools

If you use EMIS web enter population reporting then EMIS library. There is a folder called "workload analysis", and within that "prescription breakdown". There is a search for "patients on DMARD medication breakdown by year". Here you can see how the number of patients on DMARDS is increasing or otherwise to inform your practice policy on whether this part of your practice workload needs reviewing.

GPC Newsletter

Here is the latest GPC Newsletter. which includes the Sessional GP e-newsletter.

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