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Newsletter

North Staffordshire LOCAL MEDICAL COMMITTEE

Professional advice for General Practice

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GP of the future

Our CCGs have been tasked with the development of a Primary Care Strategy, to be completed by 31 December 2015. This will be an important piece of work, taking account of the 5 Year Forward View, deciding whether to aim for horizontal or vertical integration of health services, whilst at the same time taking account of the fact that recruitment of GPs and many of our support staff will prove to be difficult in the coming years. The aim of course will be to commission the most effective primary care services for patients within the resources available. As our CCGs have become level 2 co-commissioners they will be jointly responsible (with NHSE) for the commissioning of GP services.

The thinking so far is that future General Practice services may be best delivered by dividing General Practice into 3 separate work streams:

•Urgent Care (same day access, delivered by ANP/NP, Paramedic etc)
•Long Term Conditions (Practice Nurse, supported by Clinical Nurse specialist/community based Consultant)
•Complex & Frail Elderly (GP, extended primary care team, EOL team, Consultant support)

Some small scale trials are already under way, but this system would really only work if you can organise primary care on a large scale, possibly across the 2 CCGs. The GP federation could play an important part in this by helping to facilitate working across practice boundaries. Some practical problems would need to be overcome (such as exchange of information/IT compatibility, contractual arrangements etc) but it looks like the GP of the future will increasingly need to take on the role of a consultant: providing specialist care whilst also overseeing the provision of care by others on his/her behalf.

Please let us know whether above ideas fit with your

vision for the future of General Practice, so we can feed this back to the CCGs.

Dr Harald Van der Linden
Secretary, North Staffordshire LMC

Update on ESCAs

The LMC is in ongoing discussions with medicines optimisation around ESCAs for various drugs. We are concerned that the prescribing of these drugs constitutes an unfunded transfer of workload to General Practice.

As previously reported in this newsletter, the BMA has produced a document to support practices in evaluating the services they provide, with many jobs in day to day General Practice competing for attention. This document - Quality first: Managing workload to deliver safe patient care makes it clear that ESCAs (amongst other work) are not part of the core GP contract, and therefore a voluntary undertaking for practices. As before, the LMC recommends that practices carefully consider whether they have the capacity to safely keep prescribing medication subject to an ESCA, given that there is either no resource attached to this work, or a very small resource (for DMARDs).

It is also worth reminding colleagues that under no circumstances should they prescribe drugs rated as RED on the joint formulary and that **Amber 1** drugs are subject to an ESCA, whilst **Amber 2** drugs should only be prescribed in General Practice after specialist referral.

Champix prescribing

In both North Staffs and Stoke, Public Heath England (PHE) have commissioned smoking cessation services from prime providers who invite sub-contractors, including GP practices, to deliver the service.

In North Staffs the prescribing of Champix is not part of the contract and practices have been asked to issue prescriptions for their patients whilst receiving smoking cessation services from other providers. The use of NHS funds (including drug budgets for the prescribing of Champix) for a PHE contract is illegal. Because of this and the fact that practices should not be providing a service for a contract they have not been commissioned

to deliver the LMC would strongly advise North Staffs practices not to prescribe Champix.

The situation for GP practices in Stoke is slightly different. Here PHE have commissioned a service which includes the prescribing of Champix, so practices (unless they are part of the smoking cessation contract) should not be asked to prescribe Champix. Contractors who do provide this service have been told by PHE to notify the patient's GP of the prescribing of Champix for their patient. The LMC objected to this, suggesting that the patient could inform the GP should he/she happen to need to see his/her GP during the time that they receive Champix, as under this arrangement the administrative burden for practices could be minimised. Although this was originally accepted by PHE they have now muted that this may not be clinically safe/acceptable. A final decision from PHE is awaited but it is possible that in future Stoke practices will be informed of Champix prescribing by the contractor. How practices manage this information will be up to the individual practice, bearing in mind patient safety.

IUCD fitting - does it make business sense

In light of the pressures on General Practice the LMC has evaluated a number of enhanced services which many practices have traditionally provided (under an enhanced service) as part of their day to day practice.

Current payment for fitting an IUCD (for contraception) attracts a fee of £84.84 (Stoke Public Health). Evaluation of the workload associated with this suggests that the practice will need to provide at least 40 minutes of GP time and 50 minutes of nurse time. For this service to provide the same net gain to the practice as core General Practice does, the fitting of an IUCD would have to attract a fee of at least £177. In other words, practices providing this service under current arrangements will do this at the expense of their profit margin.

The LMC is seeking to address this and has arranged a meeting with Public Health in November in the hope that we can agree on a more realistic remuneration.

Tamiflu for the prophylaxis of influenza in nursing and care homes

With the flu season approaching GPs may be asked to prescribe Tamiflu for their patients in a nursing or residential home, where the presence of influenza has been confirmed. However, this is NOT part of the GP core contract, a fact which has been recognised by NHS England (NHSE). The LMC has invited Public Health England, NHSE and the CCGs to commission a service from GPs for the provision of Tamiflu prescribing in this situation, but so far none of the parties have decided to take up the suggestion.

Therefore, in the absence of an enhanced service contract, GPs should not be prescribing Tamiflu as prophylaxis for patients in a nursing or residential home where a flu outbreak has been confirmed.

Requests for completion of prescription charts by District Nurse or carers

After recent queries on this subject we would like to try and clarify the information provided in a previous LMC newsletter. This has been agreed with the CCGs and with SSOTP.

GP prescribing instructions should be clear and comprehensive,regardless of whether patients are reliant on care input or not. There should be no need for duplication of information or transcribing of instructions by the GP, for either nurses, nursing/care homes or carers.

Where variable prescribing is indicated (such as for warfarin or insulin) clear instructions need to be available for the patient, but they may have to be provided by the clinic which leads on that aspect of the patient's care (such as the INR clinic or diabetic clinic). Where the patient is compos mentis he/she should be able to provide this information to the nurse/carer who administers the medication.

In the event that the GP instructions are not clear the

nurse/carer has an obligation to seek clarification which the GP should provide in a timely fashion, where need be in writing. Patient safety is paramount.

GP Recruitment

Unfortunately the recruitment and retention of GP colleagues in the area remains bleak, with only 50% of GP registrar training places taken, many unfilled GP vacancies and regular announcements of colleagues moving abroad or retiring.

The LMC has applied to the GPC to help fund a project to try and recruit GPs from other countries in Europe. The plan is to hold a seminar on the continent to attract GPs who may be interested to work in/relocate to North Staffordshire, to help them with the process of finding a suitable job and with the practicalities of relocating and working in the UK. Alternatively, the LMC would be happy to put practices in touch with a recruitment agency which can recruit people on their behalf (but note - expect to pay approx £8K for every GP recruited!).

The LMC would be happy to hear from anyone who feels he/she has knowledge of the European GP job market.

Healthwatch England

GPC has met with Healthwatch England to discuss charges that GPs can make for work not covered by their contract. The patient group understands the reasons behind charging, their main concern was a lack of consistency between practices and sometimes even within practices.

It was explained that the BMA is not able to set fee levels for this work and is expressly prohibited from doing so, but we did agree to remind practices of our current guidance on charging, which can be found here:

http://bma.org.uk/practical-support-at-work/pay-fees-allowances/fees/fee-finder/fee-finder-why-gps-charge-fees

http://bma.org.uk/practical-support-at-work/pay-fees-allowances/fees/fee-finder

http://bma.org.uk/practical-support-at-work/pay-fees-allowances/fees/check-to-see-gps

PMS Reviews

NHSE has instructed the Area Team to complete a further PMS review before 31 March 2016. It is anticipated that the government will abolish PMS contracts altogether in the coming years. Any funds saved on PMS contracts will have to be reinvested by the CCG into GMS/General Practice contracts within the CCG area where the savings were made, such as local enhanced services. Four options have been put forward by the Area Team/CCGs:

1. Revert straight to GMS (this makes sense if your current PMS contract value per patient is lower than the GMS payment per patient)

2. Phased reduction over 7 years (in equal parts)

3. Formal PMS review (you have to weigh up the risk of keeping what you have vs possibly losing all your excess funding above GMS in one go, and anything in between)

4. A 5% budget reduction per year (most PMS practices will have reached GMS level funding after year 3)

Of course where PMS practices decide to accept a reduction in funding under any of the arrangements above, and they were funded to provide services over and above the core GMS contract, they can reduce their additional services commensurate with the reduction in funding. They would have to consider staffing structures to make sure that the impact on partnership earnings is kept to a minimum.

The current excess funding (above GMS) for PMS practices is as follows:

1. North Staffs CCG - 6 practices - £485K

2. Stoke CCG - 12 practices - £706K

The CCGs have asked that the LMC consider option 4 as a preferred option, as it would relatively quickly free up resources to invest in GMS practices. The LMC committee discussed the options to be offered out to practices, and it was felt that practices should be able to exercise their right to decide what is best for their individual circumstances. Some GMS practices have argued that the excess funding for PMS practices is not always justified, and should be redistributed amongst GMS practices .

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Winter Monies

Our CCGs have been allocated non-recurrent funding (previously known as winter monies) which we would at least in part, expect to be invested into General Practice. Please look out for an announcement of the CCGs in the coming weeks on how they plan to spend this money.

Sessional GP e-newsletter

Here is the October edition of the sessional GP e-newsletter.

GPC Newsletter

Here is the latest GPC Newsletter - issue 3, 16th October

Outcomes of October LMC meeting

Discussions took place regarding Champix, ESCAs and PMS reviews. Updates and advice are included on these subjects within this Newsletter.

In addition, CHP/LIFT building issues were also discussed. The LMC is currently in discussions with NHSE and further updates will be communicated to practices shortly.