Summer email update

Date sent: Thursday 21 August 2014

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Wessex LMC email update

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Content highlights

1. General Practice Update

There is quite a lot going on at the moment. This will provide a summary of the things that could be done to help practices and also current issues the LMC is involved in relating to NHS England, Area Team, the CCGs and Health Education Wessex.

2. Learning Disability Medicals – how to improve service and income? (plus learning difficulties questionnaire)

In our region we are outliers compared to the rest of the country in terms of providing this service.

Objectively I would argue that they provide good care, improve the quality of medical care, are valued by the patients and their carers, are financially worth doing especially when they can also be included in the Dementia Screening Programme and Admissions Avoidance Care plans.

This section will detail how to deliver this service in a cost effective way.

3. Wessex Survey of GP Trainees

Laura Edwards, one of the LMC's Medical Directors, undertook a survey of GP trainees. This was sent to all GP Trainees in Wessex and with the support of UK Deaneries the survey was sent to most trainees.

Over 2000 responded, and once again this gives an insight to the current and future plans of younger GPs.

4. Deprivation of Liberty Safeguarding (DoLS)

This is an important area that is relevant to all GPs following a recent court case. All patients who lack mental capacity and are a resident in a care home when they die, their death will need to be reported to the Coroner.

5. Safeguarding – Important Update

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This is probably the area where we get most questions and causes the most conflict between what GPs and practices think they are required to do and what external bodies believe is the responsibility of a GP or practice.

This section gives an update on the latest guidance and also looks to what might be expected in the future.

6. GP Contract Update V4

This provides a link to the updated GP Contract guidance.

7. Acute Kidney Injury (AKI)

This will become more relevant to GPs. In the near future pathology labs will start reporting where patients have a change in creatinine level which will be described in certain circumstances as AKI 1, 2 or 3.

This section will provide you with an update.

1. General Practice Update

Every meeting we attend is dominated by discussing the pressures that GPs and practices face in terms of recruitment, retention and workload.

In the last week I have undertaken one TV interview and four Radio interviews on the subject.

As you are aware there are no quick fixes to these challenges but solutions do need to be found.

At a national level the RCGP and GPC have campaigns that have raised the issues with the public and politicians. I believe the message is getting through and despite some continued negative media coverage about general practice there has been far more sympathetic coverage, particularly on national radio and television.

The national agenda as set by NHS England on behalf of the Government, is all about providing personalised care, patient choice, care planning, care out of hospital, reducing the dependency on hospital based care, managing health and social care within a budget that does not keep pace with rising demand.

For general practice there are also some separate themes that include working at scale, integration with community based services, meeting the needs of the elderly (those aged 75+), urgent care, access, 8-8 working, avoidable hospital admissions.

Working at Scale

One size does not fit all, and practices have great strength in terms of the registered list, continuity of care, life long medical record etc. However, there is an increasing need to co-ordinate and lead care out of the hospital. For the vast majority of patients that will be best met by the GP or practice.

The needs of a rural area vs. a market town vs. a city are vastly different. We need to find a way of retaining the existing strengths of general practice and by working in groups of 20 - 50,000 avoid becoming a faceless, impersonal, bureaucratic provider of healthcare!

I am sure many will ask the question, why?

It is clear that we need to have a larger team to help and support GPs and practices in the provision of healthcare in the community. We cannot cope with the workload now, let alone the demands that will face us over the next couple of years.

Organisations in healthcare still operate in silos. This is difficult for patients who perceive that care is fragmented but also for GPs who find it difficult to co-ordinate care across organisations, which is not seamless but has organisational barriers.

We frequently see difficulties in A/E or winter pressures, where hospitals and community

providers are given additional funding to meet these demands, yet general practice has failed to attract similar funding despite the fact that over 90% of the episodes of care occur in general practice.

To have a place at the table when additional funding is made available we need to work as larger provider organisations. This is one of several reasons we need to consider working at scale.

Integration with Community Based Services

This builds on the previous arguments; we need to have much greater integration with all community-based services but especially community nurses. This means working as one team for the benefit of individual patients.

This should be a priority for CCGs as the commissioners of community services.

Meeting the needs of the elderly (those aged 75+)

All CCGs are in the final stages of considering the plans and proposals for investing an additional £5 per patient to help practices cope with the rising demands from this group of patients. This comes from the guidance published earlier this year called Everybody counts: Planning for patients 2014 – 2019.

One or two CCGs have stated nationally that they are not able to fund this due to financial pressure. This is really not acceptable, general practice experiences the same if not greater pressures than the hospital does - in the past general practice has simply worked harder to meet rising demands. We have reached the point where GPs cannot take on any more unresourced work, it is therefore essential for the future of general practice as well the wider NHS that services and resources are put in place to help and support GPs to meet these demands.

Although GPs and practices should and will be involved in these discussions this money has not been guaranteed to be directly invested in practices.

Urgent Care

This is defined as the need for same day intervention. I am sure your practice, like mine, spends a significant proportion of its time delivering urgent care to your patients. This can be between 30 – 50% of the daily workload. Many practices see a surge in demand between January to March as a result of the winter pressures and the demands caused by respiratory tract infections and the assorted complications.

In the past practices have worked harder to meet these winter demands.

The problem now is practices are finding it increasingly difficult to meet the demands with the current capacity, let alone with the difficulty in recruiting and retaining GPs.

Each year the NHS looks at winter pressures and invests in hospital and community services to help with this predicted demand.

This year the guidance is called “Operational Resilience and Capacity Planning for 2014/5”, a really snappy title! But the important aspect of this document is that primary care is considered for the first time.

Although 7 day working in primary care is referred to repeatedly, CCGs are specifically asked to increase capacity in primary care.

Please see below my view on 7 day working and 8 to 8 services.

The LMC has been in contact with each CCG, asking who is representing general practice at the meetings where providers are present. The hospitals, community providers, ambulance service and voluntary sectors attend these meeting and have submitted proposals for additional funding. We need to ensure general practice also has a place at the table, especially as we are responsible for 90% of NHS consultations.

This is a powerful argument for groups of practices working together in the form of a GP provider company. This organisation working on behalf of a number of practices, looking to provide a service covering a wider geographical area has more chance in succeeding than

individual practices will.

We are also asking CCGs to report on what additional funding they have made to increase the capacity in primary care.

The LMC will share this information with GPs and practices and compare what each CCG has invested and the additional services commissioned.

Seven Day Working and 8-8 Access

I would argue that general practice is already available over seven days and that rather than being available 8-8 each day it is available 24 hours a day. During the hours of 8am – 6.30pm on weekdays this service is provided by individual practices and at all other times is provided by the Out of Hours (OOHs) service.

Despite this argument and the need to invest additional funds in both daytime general practice and OOHs the argument will not go away.

Seven day working is being implemented in hospital and it will not be far behind for general practice. My personal belief is that it would be impossible to deliver at practice level and could only be delivered by small groups of practices working together with additional funding.

If you are sad enough to read all the newly published NHS documents then 7 day working is identified repeatedly in these.

Access

Often referred to as our Achilles heel, yet recent Commonwealth publication put the UK as number 1 in terms of access to primary care in the 11 industrialised nations of the OECD.

Labour have committed to offering patients an appointment with a GP within 48 hours if they are elected and believe this can be delivered with an additional £50m of funding.

Access can be improved but the cost will be continuity or the ability to book appointments further ahead unless additional resources are made available.

The only way to deliver this is to separate urgent care from routine care and put additional capacity into general practice.

2. Learning Disability Medicals – How to improve the service and income

This DES was introduced in 2008, as there is good evidence that people with LDs die at a younger age, and have more health problems than the rest of the population.

The DES covers patients with a diagnosis of LD. This is particularly focused on patients with moderate to severe LDs but may also include those with mild LDs. This group will normally be expected to be known to the Local Authority (LA) and established on their register.

Recently information suggests that the uptake in our area is quite low, with only 18% of people with LD in Bath & NE Somerset, Glos, Wilts and Swindon having had a medical in the last year and the 2nd lowest in the country to Wessex where 32% have had a health check in the last year.

If the data is incorrect, which I suspect is part of the problem, then practices are not using the correct Read Codes. It is worth checking these, see Tables 1 and 2 below.

For those with the correct diagnostic Read Codes, the reason for the low uptake is still unclear, but probably results from a combination of reasons such as the training required, the fee available to deliver the service being deemed to be inadequate and the detail required, if you follow the Cardiff health questionnaire for people with learning disabilities, is deemed to be excessive.

Perhaps it is time for your practice to think again?

This service is of great benefit to your patients and makes financial sense if delivered by your nursing staff.

What is required to fulfil the DES?

1. Practices should liaise with the LA to obtain a list of patients with LDs. If this is not possible then use the patients who have the appropriate code – attached is a list of the Read Codes that should be used.

2. Practices will create a registered list of patients with LDs. This is easily done using the appropriate Read Codes and covers the population aged 14 or more. See Tables 1 and 2 below.

3. The register is kept up to date.

4. Practices providing this service attend an initial training event.

Patients on this register should be invited to have an annual health check that is based on the Cardiff health check protocol.

This is quite long and a shortened version has been agreed which would include the following:

General Health

- Height, weight and BMI
- Blood pressure
- Smoking and alcohol data

Communication

- Hearing
- Vision
- Speech

Medication Review

Many patients with LD have medical conditions and are prescribed regular medication – this should be reviewed annually.

Behaviour Issues

- Aggression
- Self harm
- Overactive

These are all more common in people with LDs, are their needs being met?

Are these OK, do they limit their daily activities? Do they need further assessment?

Health Related Problems

The prevalence of epilepsy, dementia and diabetes are more common in this group.

- Epilepsy – as per QoF,- medication review, control of fits etc
- Diabetes – as per QoF
- Dementia – as a high risk group should be screened and this can count for the screening DES as well as LD DES

Health Action Plan

As an outcome of the review you should consider if the needs are being met. Is the collaboration with social care, LD teams and, if appropriate, secondary care effective.

The evidence is that this not only has clinical value but also is felt to be of value by the patients, their families and carers.

Please see attached questionnaire.

Does it make financial sense to offer this service?

The funding available for this DES is costed at £102.16 per patient.

These patients are all at risk of dementia if they have Down's Syndrome age 40 or more and for patients aged 50 or more with LD. The screening is paid for under the Dementia DES and is not insignificant.

Link with Admission Avoidance Plan – remember many of these patients are at high risk of hospital admission and therefore they could be on your Admission Avoidance Register as well. You need to have 2% of your adult population on the Admission Avoidance Register.

Each Admission Avoidance Care Plan is worth about £88 per plan.

Suggest Action Plan:

1. GP Review - It is worth the GP reviewing the records, undertaking a medicines review and identifying any issues that require action.

2. Health questionnaire and appropriate investigations - The practice sends out a health questionnaire and invites the patient for a medical review with a trained nurse (blood tests carried out beforehand if required).

3. Medical and Health Action Plan - The nurse carries out the medical, offers appropriate advice, completes a care plan, which is essentially an admission avoidance plan and then shares this with the patient, the family or carers (if consent given) and others as agreed.

Dementia screening undertaken in the at risk groups.

Generally the medical takes about an hour, but may need additional time to complete and agree the care plan.

The review can take place in the surgery and could be preceded by a questionnaire for the patient or carers to complete.

The most cost effective way of delivering this service is by the appropriate combination of nurses with GP overview.

Further resources are available on the RCGP website: www.rcgp.org.uk/learningdisabilities/

Table 1: Learning Disabilities Read Codes Diagnostic Codes

	Read v2	Read CTV3
Mental retardation	E3...%	E3...%
[X]Mental retardation	Eu7..%	Included in E3...%
[X]Developmental disorder of scholastic skills, unspecified	Eu81z	Eu81z
[X]Mild learning disability	Eu816	XaREt
[X]Moderate learning disability	Eu814	XaQZ3
[X]Severe learning disability	Eu815	XaQZ4
[X]Profound learning disability	Eu817	XaREu
On learning disability register	918e.	XaKYb
Specific learning disability	Eu818	XaaiS

Table 2: Learning Disabilities Read Codes Health Check Codes

	Read v2	Read CTV3
Learning disability health examination	69DB.	XaPx2
Learning disability health action plan completed	9HB4.	XaJsd
Learning disability health action plan reviewed	9HB2.	XaJWA.
Learning disability health action plan declined	9HB0.	XaJW9

Please see the bottom of this email for a learning difficulties questionniare termplate.

3. Wessex Survey of GP trainees

Newly qualified GPs share their thoughts

General Practice is in crisis. This latest national survey of GP trainees confirms that the crisis has not spared younger doctors.

The national survey conducted by Wessex LMCs was sent to 9000 GPs in training across Britain. There were over 2000 responses in total with over 700 trainees responding in the cohort qualifying this summer as GPs.

Of the final year GP trainees:

- 12% are intending to leave the country within the next 12 months.
- Only 15% wanted to look for a partnership in the current climate
- 77% are opting for locum or salaried work as their initial preference.
- In 5 years' time 47% would be considering partnership as their preferred option.
- When commenting on reasons for their choice; flexibility, seeking variety and a dislike for commitment were the top themes.
- 25% of those questioned intended to take a career break out of UK General Practice at some point in their career for more than 2 years.
- Burn out or exhaustion was already mentioned in 5% of comments.
- Of 200 comments on their 1 year plans just under 50% cited children or family commitments as influencing their choice of working.
- In 5 years' time 40% intend to be combining General Practice with a special interest such as education or a clinical specialist interest.
- 83% of comments made about their impression of General Practice were negative.

On factors that would attract them to a post in a practice, the top themes were a good, cohesive team, friendliness, pay, work-life balance and a supportive atmosphere.

The ambitions for 5 years' time see more hoping for partnership, but still less than 50% aspire to this with many citing political uncertainty and long working hours at high intensity as unfriendly to family life.

There were also many comments relating to the uncertainty about where OOH care will be and concern that this was pushing doctors away.

Dr Nigel Watson, CEO of Wessex LMCs said: "*These results confirm what we are seeing locally. It is sad to see younger doctors becoming disillusioned before they have really commenced their career - disillusioned doctors leaving General Practice means ultimately less appointments for patients and increasingly overstretched services. General Practice is a fantastic career – we need to work hard to re-establish General Practice as an appealing and positive career choice.*"

The majority of GPs are instead focussing on developing a career blending clinical care with another aspect of being a General Practitioner – a so called 'portfolio career'. Many commented that they wished to include a hospital specialty or education.

When all trainees were asked what might reverse the trend in recruitment there were over 1,400 suggestions. Top themes were:

- stopping the constant negative media and government attention
- secondary care colleagues being more understanding and respectful
- more funding for General Practice and better working conditions
- more emphasis on General Practice and its advantages in medical school
- more foundation placements in General Practice

There were also calls that budding surgeons and medics should spend time in General Practice to understand the different roles and challenges we each face.

Survey Comments:

"I'm afraid most trainees are running away - going abroad or getting out of General Practice after they qualify - I am not sure if it is only the workload but maybe the general lack of appreciation for GPs and pressure put on them by policies."

"At the moment I cannot understand why anyone would want to choose to be a GP as a career. Working in my practice leaves me so exhausted and demoralised, I cannot function in the rest of my life. The prospect of feeling like this for the rest of my career is unbearable."

"A profession in crisis in the UK and on the brink of collapse. Funding shortfalls, low morale, lack of support, increasing complaints culture, litigation, early retirement and a shift of work from secondary care to primary care without the necessary shift of resources = impending crisis."

"I enjoy seeing patients, however, there is too little time to do justice to patients with multiple problems, and there is too much administration - 3 hours per day or more."

"I think that FY2 posts in General Practice are really influential - that was how I came to apply for General Practice over Obstetrics and Gynaecology."

"I think a lot of people are put off by the expectation and workload, but these aren't solely GP problems. I think giving out a positive message about working in GP to medical students and foundation doctors is key. They are easily swayed by what they hear regarding a post and things like hours, seniors, workload and the work itself are all factors."

"Happy patients equals happy doctors which means better job satisfaction. The increasingly high expectations of patients with less funding in GP means that quality of care is suffering."

"I want to be able to see my patients in a realistic way in a realistic time frame and provide an optimal quality of care. I think in general many GPs at the moment feel overworked and underappreciated."

"Try to focus on some positive elements of General Practice. Unfortunately the media seem to focus on certain areas that can make General Practice seem unappealing. GP trainees do tend to do 'filler' jobs in their ST1/2 years. Six month posts can be too long I feel in certain specialities. There should be mandatory weeks in ophthalmology, ENT, dermatology- a lot of what we see in General Practice."

"Clearly changing the effects of the current government policies might help but is not an attainable goal. It may be more effective to educate medical students and junior trainees about the flexibility and the broad range of options for work in General Practice. Some of these could include portfolio careers or marketing GP as a part-time career rather than full-time so GP could be coupled with a variety of other options: eg: regular part-time in specific specialities of interest in secondary care (i.e. the best of GP married with the best of hospital medicine (still few nights or weekends), part-time research or teaching, or family life."

"Stop hospital doctors from criticising GPs continually. I didn't apply when I should have done as people saw it as a 'tragedy' to "waste" a good doctor to General Practice."

"Often in the press we are seen as bad doctors, made out to seem lazy, when often we work longer hours than hospital doctors, and can deal with many people in a day. However knowing your patients is very rewarding, seeing them growing up, get better or looking after them at the end of life is rewarding. Also you will often see things that challenge you and push the boundaries of your knowledge – you should allow more FY1/2s to spend a placement in GP as many people do not know what working in General Practice entails."

"It is a top down problem; everyone can see that General Practice is under a lot of pressure from the government & criticised a huge amount in the media. The suggestion that GPs need to provide 12 hr day & 7 day a week working is another negative for trainees. Based on all this negativity, it is understandable that junior doctors are not attracted to a career in General Practice. Although you can have GPs giving personal accounts of primary care experiences, I feel that for General Practice to be more attractive, especially to the high quality trainees, improvements need to be from a top RCGP and government level."

"More secondary care clinics and speciality services should be offered in GP practice I think a lot of the problems can come from misconceptions grown in hospitals and a reputation from a

handful of GPs that aren't as good, whereas good GPs work hard to keep their patients at home and manage them in the community where possible. We need to change these ideas and have less negative comments from senior hospital staff. Good training programmes with jobs relevant to General Practice rather than just filling a post."

"Respect for GPs in secondary care can be poor. There is a culture to criticise GP referrals amongst junior doctors and nursing staff, resulting in potential shame to admit that you would like to or are training as a GP. I'm not sure how you address this apart from ensuring that medical students & junior doctors get valuable experiences working in well run GP practices and witness the good care that takes place."

"I think a rotation in GP in foundation training should be made compulsory as should A&E. This would be the only way that GP bashing can be reduced as it allows a real appreciation of the difficulties faced in the community and the limitations in managing patients in primary care. The clinicians that I have met who started off as GPs or have done placements in GP have a real understanding of the role of a GP which allows patients to be managed better and information to be appropriately relayed to GPs upon discharge from secondary care. I started off wanting to do hospital medicine and GP was the last on the list of career options. It is because of the lifestyle and variety of cases seen in General Practice that I have made this career choice. It's a shame that all trainees do not have exposure to this at an early stage in their careers."

"When I was a house officer a lot of my colleagues were put off GP as they thought they would lose team banter that you get in hospital - so perhaps work on team spirit in GP."

"I think that more opportunities should be available for GPs to be dual qualified for example in palliative care or public health or child health."

"There should be more advertisement of the ability to have specialist interests, to try to change the impression of General Practice as a back-up plan rather than a career choice."

"Consider 1 session per week as a trainee sitting in on community clinics - eg heart failure specialist nurses/diabetes specialist nurses/dermatology clinic/paeds A+E etc etc, in order to give us more varied experience."

"The impression of GPs given by the media is harming recruitment at the moment. Why would anyone go into such a tough job that seemingly has such little respect by the media and politicians and therefore the public as a whole?"

"Currently there is too much uncertainty about GP hours, whether OOH/weekends will be brought back as compulsory - this needs to be confirmed."

"I chose GP to be patient focused, but time constraints and red tape stop this."

4. Deprivation of Liberty Safeguarding (DoLS)

The Mental Capacity Act was introduced in 2005. As part of this act consideration was given to Deprivation of Liberty Safeguards (MCA DOLS) and this provides a legal framework around the deprivation of liberty.

The safeguards are designed to protect the interests of an extremely vulnerable group of individuals and to:

- Ensure people can be given the care they need in the least restrictive regimes.
- Prevent arbitrary decisions that deprive vulnerable people of their liberty.
- Provide them with rights of challenge against unlawful detention.
- Avoid unnecessary bureaucracy.

The MCA DOLS apply to anyone:

- Aged 18 and over
- Who has a mental disorder

- Who lacks capacity to consent to the arrangements made for their care or treatment in either a hospital or a care home (registered under the Care Standards Act 2000)
- For whom a deprivation of liberty may be necessary in their best interests to protect them from harm
- Where detention under the Mental Health Act 1983 is not appropriate at that time.

One important issue is that if a person who is resident in a care home and lacks capacity to consent to remain in the care home, then by definition they are part of this group.

An issue has caused some legal challenge recently, that now requires a death in a care home where a person lacks capacity to consent to remain in the care home, therefore cover by DoLS, the death should be reported to the Coroner.

A death under these circumstances, has the same status as a death in Police custody.

5. Safeguarding – Children

This is a topic that the LMC receives more questions about than almost any other.

It will come as no surprise that safeguarding remains a priority for all, partly because of some high profile cases such as Victoria Climbie and Baby P but also the frequency and severity of reported cases mean that it is constantly in the public's awareness.

Updated Guidance

Recently there has been new guidance published by the Royal College of Paediatricians supported by a large number of organisations including the Royal College of GPs.

As GPs we will need to comply with this guidance and the full text can be found via the link below:

Safeguarding children and young people: Roles and competencies for health care staff, Intercollegiate document 2014.

As GPs we have a broader responsibility as contract holders as well as our individual responsibilities as determined by our registration with the GMC. As a contract holder (PMS, GMS or APMS) we are responsible in ensuring all our staff have the relevant training.

The Dummies Guide to Safeguarding Children!

Level 1: All non-clinical staff must have some training about safeguarding children – this would include all staff that work in a practice.

What does level 1 included?

- Recognition of the various forms of abuse
  - Physical
  - Emotional
  - Sexual

- Understanding the impact on the child when a parent has physical or mental health problems.
- To understand the risks of the internet, social networking and understanding children's rights.
- To know how to take appropriate actions or where to seek advice if they have concerns.
- Know what the term a "looked after child" means (the term is generally used to refer to a

child who is looked after by the State).

Level 2: All non-clinical and clinical staff who come into contact with children and young people.

What does level 2 include?

The competencies as defined for level one and:

- An awareness of normal child development and the impact that abuse or neglect has on this.
- Understand the additional needs of “looked after children”, young offenders and also the increased risk of further maltreatment.
- Aware of the issues surrounding data sharing both in terms of the legal and ethical duties.
- Ability to document concerns.

Level 3: All GPs now need to be trained and have the skills detailed below.

What does level 3 include?

The competencies as defined for level one, two and:

- Documents reports and concerns, can take a history and examine a child in a manner that is appropriate for safeguarding/child protection and the legal process.
- Will contribute to the interagency collecting of information and assessment of risk.
- Undertakes regular review of their own safeguarding practice as appropriate to their role.
- Understands the role of the Local Safeguarding Children’s Board (LSCB), and how child protetion boards work.
- Has a core knowledge of the court and criminal justice system, the roles of different courts, the burden of proof, and the role of expert witnesses.
- Understands the role of multi-agency audits and the role of the GP in this process.
- Understands the assessment of risk and harm.
- Knows the issues around misdiagnosis of safeguarding and the effective management of diagnostic uncertainty and risk.
- Understands fabricated or induced illness.
- Understands the emerging evidence on child sexual exploitation and female genital mutilation.
- Understands the procedures for proactively following up children who do not attend OPD appointments or parents who have mental health problems who do not attend follow up appointments.

Education and Training Requirements

The document has a section on education and training and makes a number of recommendations. It would be unwise of any healthcare professional or practice to ignore these.

It is expected in future that the GMC and the Nursing and Midwifery Council, through revalidation, will require evidence of training to the expected level and then also ongoing refreshing and updating core skills.

It will be expected that all staff have training **every three years** as a minimum requirement and this should be tailored to the role they fulfil.

E-Learning is an appropriate method of education and training for level 1 and 2 and can be used for level 3 but at level 3 there should be some team based learning.

In addition, safeguarding leads should circulate regular updates in a written format, for example changes in legislation, local procedures etc.

Clinicians should be involved in case based discussions, significant event reviews etc. where

relevant to children and young people.

Recommendations from the National Guidance:

- A mandatory 30 min session should be included in the induction of all new staff to take place within the first 6 weeks. This should include various aspects of abuse, broad principles of safeguarding and how and where to seek help.
- **Level 1** – over a 3 year period all staff should have 2 hours training as a minimum. This should include the types of abuse and maltreatment, and appropriate action to take.
- **Level 2** – over a 3 year period all staff should have 3-4 hours training as a minimum. This should include multi-disciplinary training and scenario based discussions.
- **Level 3** – over a 3 year period all staff should have 6 hours of training as a minimum or 2 hours per year. This should include multi-agency training and can be internal or external.

What does this mean for you and your practice?

The LMC has been a strong advocate of the principles of safeguarding and has worked closely with the various safeguarding teams to try and ensure that GP and practice staff are aware of the issues and are able to seek the appropriate help and advice. We have recommended:

1. All practices have a named safeguarding lead GP.
2. The named GP should attend an external update at least every 3 years.
3. All GPs should have regular updates that could be cascaded training, e-learning etc.
4. Practices should hold regular safeguarding meetings to discuss children and families who are at risk.
5. All practice staff should have a basic understanding of safeguarding.

Although the Intercollegiate Guidance is simply that and not enshrined in regulations we would be unwise to ignore this. I am sure the GMC, NMC and CQC will use it as their standard so we would be better off being ahead of the game and start preparing for this.

How does this change our recommendations?

1. All practices should have a named safeguarding lead GP.
2. The named safeguarding GP should work with the practice manager to ensure all clinical and non-clinical staff are appropriately trained and have regular updates.
3. The safeguarding GP should attend a ½ day update at least every 3 years and this should be inter-agency and multi professional if possible.
4. All staff should have as part of their annual training an update on safeguarding. This could be delivered via the safeguarding lead GP, using e-learning or an external trainer.

- All practices have an education and training programme for their staff. If you don't you need one, as CQC may wish to see this. Record your individual staff and what training they have completed on an annual basis. Within this include the topics that you believe are mandatory.
- As part of your regular staff training include an update on safeguarding. This could be by using an e-learning module as individuals or as a resource used to help discussion in a meeting.

5. Practices should have a regular clinical meeting (minimum of 6 monthly and preferably quarterly) to discuss children at risk, looked after children, etc. and as part of this meeting the opportunity should be taken to cascade information and update skills and knowledge

6. There should be a mandatory module for all new staff that covers safeguarding.

You could use the LMC's lunch and learn. This will provide you with Level 1 training for both adult and children's safeguarding.

The e-learning for healthcare has a number of safeguarding modules available on the e-LfH

website. The modules for Level 1 are excellent (I have done this module this morning – takes about 30 min). The main problem is you have to register as an individual and it can be a bit difficult to find how to access the module.

The RCGP have some excellent training resources available on their website

The BMA also has some excellent resources on their website

What can the LMC do to help you and your practice?

1. Provide advice, guidance and resources on our website.
2. Provide updates when this changes.
3. Provide a safeguarding lunch and learn to help with in-house training.
4. Convert national guidance into easy to understand information.
5. Advise what is required now and what may be required in the future.

What is the LMC considering?

1. Working with safeguarding teams to produce an App that will be of use to GPs.
2. Providing relevant updates that can be discussed and cascaded through practices.
3. Separate the lunch and learn to provide a level 1 entry module for new staff.
4. Produced in partnership with safeguarding leads, some fictitious cases for case based discussions which suggest outcomes that would be appropriate.

6. GMS Contract Changes – Version 4

NHS Employers has published version four of the technical requirements for 2014/15 GMS contract changes. Version four includes additional information about the 'avoiding unplanned admissions enhanced service' as well as the technical detail supporting the 'childhood seasonal influenza' and 'routine seasonal influenza and pneumococcal' vaccination programmes, including Read codes.

7. Acute Kidney Injury (AKI)

Below is some advice produced by the North of England Strategic Renal Clinical Network that I thought would be useful to disseminate to all GPs.

The clinical advice may not be new to you but it is clear that Acute Kidney Injury (AKI) will become more relevant to GPs as hospitals will start reporting AKI when a renal function test shows a significant increase in creatinine from the baseline.

I thought acute kidney injury what when you got kicked in the loin area and started peeing blood, but apparently it has a new definition.

I shall add this to my CPD file, hopefully we will be able to share a locally produced protocol that you could implement in your practice as this would count as a quality improvement activity for revalidation.

The guidance states:

"You will know that Acute Kidney Injury (AKI – previously known as acute renal failure) is currently a high clinical priority as it is associated with poor clinical outcomes and is very costly to the NHS. There is therefore heightened awareness that AKI needs to be prevented where possible.

A common causal factor in many cases of AKI, both in the community and in hospital settings, is that many patients are taking angiotensin converting enzyme inhibitors (ACEi) or angiotensin receptor blockers (ARB's) when they become ill.

An audit of AKI in acute assessment units in the North East of England, published by NHS Kidney Care in March 2013, showed that 41% of patients admitted with AKI were taking either an ACEi or ARB.

It is possible that in many cases the AKI could have been prevented by greater awareness in the use of these drugs in patients at high risk of developing AKI.

We are aware that GPs are overwhelmed with guidelines and recommendations, some of which may be conflicting. An example of this is that use of ACEi and ARB's in patients with chronic kidney disease (CKD) is a QOF target: many nephrologists question the clinical benefit or necessity of this QOF.

As a consequence, there may be overuse of these drugs, particularly in frail elderly patients with CKD who are most at risk of developing AKI. We appreciate this may lead to discrepancy between national targets and local advice, but we feel patient safety over-rides targets.

The Northern Clinical Network Renal Advisory Group has therefore developed some advice for GPs with regard to the safe prescription of ACEi and ARB's, which we have enclosed as an attachment. The advice is not mandatory or prescriptive, and is not designed to limit a GP's ability to prescribe drugs that he or she deems clinically appropriate. This is pragmatic advice developed by nephrologists across the Northern region who deal with CKD and AKI on a daily basis, and regularly advise GPs and other clinicians about AKI and use of these drugs."

Advice for GPs about using ACE-inhibitors (ACEi) and Angiotensin Receptor Blockers (ARBs) in Chronic Kidney Disease

ACEi and ARBs have potent effects on renal vasculature and, within the first 6-8 weeks of commencement, may cause a modest rise in serum creatinine (sCr) of up to 25-30% above the baseline sCr.

In high risk patients the rise in sCr can be severe, leading to Acute Kidney Injury (AKI) and hyperkalaemia. Approximately half of the patients with AKI requiring dialysis will have been taking either an ACEi or ARB, and in many instances the AKI may have been predictable and avoidable.

High risk patients include:

- Frail elderly patients
- Patients who become volume depleted
- Patients with suspected bilateral renal artery stenosis
- Hypotensive patients
- Patients taking other drugs that affect kidney function

Does the patient really need to be on an ACEi or ARB?

Care should always be taken with the frail elderly. ACEi and ARBs have no renoprotective effects over other anti-hypertensives unless the patient has type 1 diabetes or hypertension and significant proteinuria (i.e. PCR >100mg/mmol or ACR >70mg/mmol).

ACEi or ARBs are only specifically indicated in patients with CKD if they have hypertension and significant proteinuria.

Measure Serum Creatinine and Potassium.

A rise in sCr of up to 25% above baseline is acceptable. A rise in potassium up to 6mmol/L is safe. If the potassium is >6mmol/L: review all drugs; reduce or stop the ACEi or ARB; give appropriate dietary advice which will be available from your local renal unit.

Avoid Excessive Hypotension

For most elderly patients (>80 years old) a systolic blood pressure of around 150/90mmHg is probably acceptable.

Suspected Renal Artery Stenosis (RAS)

Patients at risk of RAS are those with widespread vascular disease, are usually severely hypertensive and may have had episodes of flash pulmonary oedema. A very large rise in sCr (sCr rising by more than 50% of baseline) in high risk patients may signify RAS. If this occurs stop the ACEi or ARB and discuss with a nephrologist.

Avoid Other Nephrotoxic Drugs

Specifically **NSAIDs, trimethoprim and potassium sparing diuretics**. A small number of patients do benefit from combinations of all of the above with ACEi or ARBs, but usually only in exceptional circumstances and after discussion with the appropriate specialist. Patients should be warned about NSAIDs bought over the counter.

“Sick Day Rules”

Patients should be advised to seek medical or nursing advice early if they develop a severe dehydrating illness or symptoms of hypotension. Interrupting the ACEi or ARB for a few days may prevent avoidable AKI.

Re-introduction of ACEi/ARBs

Where ACEi or ARBs are essential (e.g. in cardiac failure) and need to be re-introduced after being stopped, it is advisable to recommence with a low dose and titrate up as clinically indicated.

Best wishes

Nigel

Dr Nigel Watson

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Attached file: LD-Questionnaire.doc LD - Learning Difficulties Questionnaire

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We represent GPs and practices across the counties of Dorset, Hampshire & the Isle of Wight , Wiltshire, BaNES and Swindon whilst also providing services to the Islands of Jersey and Guernsey.

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