Email update from the LMC

Date sent: Thursday 28 July 2016

Email sent by Wessex LMCs, on 28th July 2016

The summer has finally arrived, the world of general practice used to go through a quieter spell before the winter infections returned. I don’t know what it is like in your practice but in mine we are certainly not seeing any slackening of the pace!

My practice recently had our CQC Inspection which proved to be an interesting day! The anticipation from the staff was palpable and there was a certain fear factor but most of all people seemed to have a pride in their practice and did not want to let the team down. Nothing could have been further from the truth as all the people interviewed from patients, the Patient Participation Group (PPG), members of staff and even the partners all did well and provided a true insight into the practice which I am very proud to be part of.

As the registered manager, I did a short presentation about the practice and then was interviewed about everything from formularies, safeguarding, significant events, Vanguards and even what we do for Veterans Health. My interview went on for close to 4 hours, the discussion amongst the GPs was whether I was being given a hard time and grilled ++ or was I talking them to death

I have added some reflections below.

I believe the next 12 months will be critical for the future of general practice - it will be a turning point as I believe that a number of initiatives that will increase the resources available to general practice, the greater flexibility that will come with policies such as the New Models of Care and the realisation of commissioners, hospitals and NHS Managers that if there is no general practice, the rest of the system will not be able to cope.

We all need to invest in our future, that goes from the GP Trainees through to the older GPs. We all need to pull together supported by action (rather than words) delivered by the Government, NHS England and the CCGs.

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1. The current state of general practice

This gives you some information about the response to the special conference of LMCs in January and the national conference in May. From this the “urgent prescription for general practice” was developed and we now have the GP Forward View. Is this enough? Do you want to come to a meeting in September to hear more about the GP Forward View?

2. Indemnity

An update on the national discussions on the increased cost of Indemnity.
3. MCP Voluntary contract

Does this contract replace GMS or PMS - the answer is no, but when will it be available and will it help us?

4. Practice nurses

We have over 700 practice nurses on our database working in Wessex. The LMC has employed a Practice Nurse advisor - see what Helene has brought to our team and follow the link to her first newsletter.

5. Cremation and death certification

Some months ago I told you about the different requirements in terms of the permitted causes of death that GPs are able to use depending on whether they are covered under the rules that are associated with death certification or cremation - read this interesting update. Some evidence of the power the LMC has to change GP behaviour!!!

6. Sessional GPs

Here is the latest update from the GPC’s Sessional Subcommittee

7. Primary care support services

An update on the current issues with Capita.

8. CQC - my personal experience

A summary of some lessons I have learned from the process.

9. TTP and QRisk2

Have you corrected the incorrect advice that might have been given to your patients when there was an error in the calculator for QRisk2?

10. Revised BMA guidance on firearms

This is an area that has recently caused lots of concerns from GPs.

1. The current state of general practice

In January of this year there was an emergency “Special Conference” of LMCs - the day was spent discussing the problems that general practice faces and reflected on the fact that many practices were unable to recruit and retain GPs and some were coming to the point where they felt that they had little choice but to resign their contract. The conference concluded that there needed to be a substantial rise in the investment in general practice and that this needed to occur within the next 6 months and that if this did not take place the profession should be surveyed as to whether they would be prepared to submit Undated Resignations or take Industrial Action.

In May the National Conference of LMCs took place regarding the ‘rescue package’ for general practice, and the government’s acceptance of GPC’s urgent prescription proposals. Click here for the urgent prescription for general practice.

The recent GP Forward View (GPFV) has committed to invest £2.4bn over the next 4 years to support general practice. There are many strands to this as I have reported in my previous emails but very little of this money is directly invested into core funding.

Much of the urgent prescription for general practice has been included in the GPFV. NHS England is considering in detail each of the proposals in the urgent prescription that are not in
the GP Forward View (GPFV).

It is therefore important at this stage to continue working with NHS England and ensure that the commitments that have been given in the GPFV are delivered in a timely matter. Undated resignations and Industrial Action may be considered at a later date.

There will be a local meeting in September, where the national team from NHS England will give more details about the GPFV - if you have not booked your place please do so soon as places are limited.

Please note the following communication from NHSE with regard to an evening event, to be held by NHSE on the 28th September, relating to the implementation of “The General Practice Forward View”. . .

“Following the recent publication of the General Practice Forward View, it has been encouraging to note the generally positive reception for the plans to support and transform primary care. However, it is also clear that questions remain for system leaders about issues relating to the detail and timescales, particularly as CCGs and LMCs talk together about plans for stabilising and transforming primary care in their area.

Therefore, the national primary care team are proposing to hold a series of events to give local commissioners and providers the chance to quiz national and regional primary care leads about the Forward View, to hear about the implementation plans and consider the implications for yourselves. Each event will be joined by NHS England local team colleagues.

In line with the above, an evening event will be hosted for practices themselves to hear more detail about the Forward View implementation, ask questions and learn about how they can engage with the new national development programme.

At this free evening event you will hear from the regional and national primary care teams about the latest details for implementing the Forward View. You will be able to quiz the team and discuss how the new national development programme could best serve your practices.”

To register your attendance at the evening session please click here, which will direct you to NHSE’s website to register.

Where:
Novotel, 1 West Quay Road, Southampton, S015 1RA

When:
28 September 2016

Timings:
7.00pm - 9.15pm

2. Indemnity

Rising indemnity costs remain a significant concern for GPs in whatever contractual capacity they work. This is a problem for all GPs and is one of the issues that is having a major impact on the recruitment to general practice, some doctors choosing to stay in hospital medicine to avoid this expense. Out of hours GPs are experiencing a bigger increase than others.

Discussions are continuing with NHS England about how this matter can be addressed, this year an additional £33m has been added to the GMS/PMS contract to assist with the significant increases that have been experienced by GPs in recent years.

It is hoped that a more detailed solution will be published later in the summer.

There are about 32,000 whole time equivalent (WTE) GPs working in the UK, each paying on average £9 - 10,000 per year for their medical indemnity insurance. So if this was covered fully it would cost the NHS a total of £320,000,000.

Some have asked about Crown Indemnity - this does not exist. Those working in hospitals are covered by Trust Indemnity - each Trust pays to insure their staff, most consultants would also have some form of MDO cover on top of this.
I hope we will have some good news soon but we need ensure our expectation is realistic!

3. The Voluntary Multiple Community Provider Contract

In Wessex there has been a lot of work to try and develop better services for patients including the Vanguards in the Isle of Wight, North Hampshire and Farnham and in Southern Hampshire. There are other areas such as Dorset and Southampton who were not part of the initial Vanguard programme but have joined the process of transformation of services across providers.

Following the announcement at the Conservative Party Conference that there would be a new deal for general practice there has been much speculation about what this would include and how much freedom it would give practices.

For the NHS to meet the demands that it faces with an ageing population and more people who have one or more long term conditions, continuing with the over dependency on hospital based care will not only be unaffordable but will also compound the problems faced by community services and general practice.

I have told you before that the NHS needs to build on the strengths of general practice, with the registered list of patients and also, where appropriate, the unique strength of continuity of care that general practice offers, but this is not enough. There needs to be greater investment, flexibility, and joint working in the community to deliver a balanced model that is sustainable. To achieve this, general practice needs to play a lead role as we account for about 90% of the daily patient contacts.

The Voluntary Contract will be based on a defined population and will require general practice to be at the core of this work. Without the registered list this will have little impact.

The contract will need to be held by a legal entity which could be a Limited Liability Partnership (LLP), a Limited Company, a Community Interest Company (CIC) an NHS Trust or a Foundation Trust. This will be a population based contract with a defined budget giving greater freedom to the providers in terms of the design and delivery of care, breaking down the barriers between general practice and community staff.

Some have said that this contract will mean that practices will have to give up their GMS or PMS contract and therefore is a major threat to the profession.

I sit on the national advisory committee for the New Voluntary MCP Contract and Hampshire is one of the pilot sites. I can assure you that those practices who want to retain their GMS or PMS contract will be able to do so. For some, as has happened in Gosport, moving to an employed model where this is in the best interests of the practice, the option will also be available.

In addition, if a practice does not want to be part of the contract they can remain outside it but will need to accept that services for their patients will be developed at a population level. Clearly if lots of practices opt not to take part in the contract, it will not go to procurement.

More information on this contract will be published later today.

4. Practice Nurses

It has been very interesting over the last 30 years of my career as a GP how the role of the practice nurse as evolved. The practice nursing team whether they be a Health Care assistant, a nurse or an advanced nurse practitioner now for an important and significant part of the workforce in general practice.

I was very pleased recently when the LMC agreed to recruit an experience practice nurse to join our team and help us establish closer links with practice nurses and to better support them. Helene Irvine is a very experienced nurse currently working as an Advanced Nurse Practitioner
and is also a member of the RCGP team who advise practices who are in Special Measures following an inspection by CQC.

The LMC website now contains far more information that is relevant to nurses and is divided by section into HCAs, nurses and advanced nurse practitioners. For more information - click here.

Helene has now produced the first practice nurse newsletter - I was personally really impressed with the contents and thought it should be essential reading for all GPs, Practice Managers and all of your nursing team. For the Newsletter - click here.

The problem that this newsletter creates is that it makes my email updates seem somewhat inadequate so I am going to have to think how I can up my game!!

5. Cremation and death certification

In November 2015 as part of my email update I wrote about some problems with death certification and the completion of cremation forms - see below.

In a recent audit at a crematorium in Wessex, they found that there were problems with about 10% of the Cremation Forms completed.

The most common error is that the doctor does not give their full name of at least one person who nursed the deceased during their final illness, in Question 14.

Responses such as ‘nursing staff at Nursing Home’ or ‘D/N Sarah’ or ‘community nursing team’ cannot be accepted on legal forms, when the instructions in the question are quite explicit that full names and addresses are required.

The next most frequent failings relate to the cause of death. In a number of cases, the description of the symptoms and other conditions which led to the doctor’s conclusions about the cause of death, required in Question 9, are inadequate, and is often merely a re-statement of the causes of death given in Question 11.

The other significant problem is the cause of death in Question 11 being given solely as ‘Old Age’, ‘Multi-organ Failure’, or ‘Frailty of Old Age’.

Although the coroner will accept these causes for death certificate purposes, the Ministry of Justice has instructed they are unacceptable for cremation certificate purposes, in the absence of more specific pathological causes of death being given in section 1b or 1c, or, exceptionally, if the certificate is being given by the usual doctor or a partner, specific contributory causes in section 2.

Otherwise the coroner needs to confirm, in each individual case, that they do not feel the cause of death is actually unascertained, and that Old Age, Multi Organ Failure, or Frailty of Old Age is acceptable.

I often wonder how many of you read my emails but clearly they do have some impact as there has been a significant reduction in the number of cremation forms that have not been correctly completed over the last year, in particular, the number of occasions when there was a failure to give the full name of someone who nursed the deceased during the final illness has decreased very significantly. The LMC has been credited as having been responsible for this reduction.

There is still an occasional problem with the completion of the ‘cause of death’ section, mainly due to a discrepancy between what the coroner is willing to accept for death certification, and what the Ministry of Justice requires for cremation certification. This can create difficulties, particularly with new General Practitioners who are often unaware of this somewhat conflicting advice.

The Ministry of Justice has instructed “Old age’ alone is unlikely to be an acceptable cause for cremation purposes, as it must be satisfied that the cause of death has been definitely ascertained”.

Therefore, a cause of death in Question 11 of ‘Old Age’, ‘Multi-organ Failure’, or ‘Frailty of Old Age’, in the absence of more specific pathological causes of death being given in section 1b or 1c, “cannot be used where the cause of death is properly ‘unascertained’ and which should, on that account, be referred to a coroner”. As only the coroner can definitively advise on whether
this is the case or not, he should be asked to confirm, in each individual case, that he does not feel the cause of death is actually unascertained, and therefore that a cause of OA, MOF, or FOA alone is acceptable. Exceptionally, if the cremation certificate is being given by the usual doctor, or a partner with access to the medical records, OA, MOF, or FOA, as sole causes of death in section 1, are acceptable without reference to the coroner if there are specific contributory causes identified in section 2. I do understand the irritation this discrepancy between regulations can cause, but the Medical Referees at the crematoria are required to conform to the MOJ guidance, and, although we will exercise discretion and common sense where possible, we cannot ignore specific guidance."

It seems unlikely that this irrational situation will be rectified before Medical Examiners replace the current death and cremation certification process, but it seems, according to the latest on the grapevine, this will not happen until October 2017 at the earliest.

6. Sessional GPs

The Sessional GP subcommittee of the GPC has produced another excellent newsletter to read more - please click here.

7. Primary care support services - England

The current issues related to NHS England’s contract with Capita to provide primary care support services are well known to all local practices and PMs. The GPC recently passed a motion of no confidence in Capita, following the months of concerns highlighted by practices in England about the failures in patient record transfer, delivery of supplies and payment problems since NHS England handed over responsibility to Capita, as well as the very real concerns highlighted in NHS England’s plans to remove patients from practice lists.

The GPC chair had previously written to NHS England highlighting the significant concerns of the committee and the wider GP population. Capita has dramatically failed the NHS in England, disrupted general practice, and more seriously is still putting patients at risk of harm in their disastrous handling of the Primary Care Support contract. GPC representatives will be meeting with NHS England in the near future to discuss the situation.

You will have read the stories about the potential for de-registration of large numbers of patients who have not seen their GPs in the last 5 years.

This story fails to understand that general practice is not funded on an activity based contract but on a capitation basis. This means that the person who sees the GP 20 times in a year is balanced by those who never see a GP. There are also major implications of de-registering patients who see GPs less frequently in terms of health promotion and screening. For example a de-registered man of 65 will not receive an invitation for bowel screening.

There will be a update once the national discussions are concluded.

8. CQC - my personal experience

My practice was not one of the first practices to be inspected, so in effect we have had longer to prepare. Within the practice we have been having regular “CQC” meetings, using this as an opportunity to discuss and develop the practice using the expected CQC visit as a positive focus for debate.

We often used Nigel Sparrow’s myth busters as a focus for development - trying to understand what they are looking for - for more information about the myth busters please click here.

The inspection team we had were friendly, well led and very thorough. There were lots of questions and many of the statements that we made needed to be backed up by evidence.

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So for example, we have increased our bowel screening uptake from 60% to 80% by the practice sending personal letters to patients. They thought this was a good initiative but then wanted to see a copy of the letter and evidence that the uptake had been increased (fortunately we had that evidence).

They want to see how you function as a practice and assure themselves that you have robust systems in place that would make you a safe practice. So for example, does your practice receive the patient safety alerts and if so how do you record you have received the alert and actioned any relevant issues?

One issue that I am repeatedly told by CQC inspectors is that practices hugely under report what they do well; there is an assumption that the inspection team will know all about you and your practice (they won't unless you tell them). There are the Key Lines of Enquiry (KLOE) where CQC are looking to see whether your practice is safe, effective, caring, responsive and well led and then they will look at various groups such as the older person, working age people, family, children and young people, people with long term conditions, those who are vulnerable and people with poor mental health.

If you produce a table listing the groups and match this against the KLOE you will be surprised at what you do for your patients. I have attached the one we completed in my practice to give you an idea, also a document that gives greater detail for some of these areas.

I know practices find this intrusive and feel it is a waste of valuable time and resent the increase in fees but I would encourage you and your practice to use this as a tool in a positive way to celebrate the great things you do in your practice and identify what could be improved and this could be a rewarding experience!

9. TPP and QRisk2

I am sure we are all aware of the problems associated with QRisk2 and the fact that for a period of time the calculation of this within TPP was wrong. This has meant that some patients have been given advice which is now incorrect.

I don't know about you but I have become confused as to what is expected of practices.

So the error has been recognised and TPP practices can identify who these patients are and what the QRisk2 was recorded as and what the correct QRisk2 should be.

For the letter from NHS England and some sample letters you could use to inform your patients - please click here.

In my practice of 13,500 patients the searches have identified about 75 patients where the QRisk score is incorrect. For most, the error is a small QRisk2 of 7% rather than 8% or 23% rather than 25%. For these patients the clinical advice would remain the same. But for some the risk may be 12% rather than 30% or 32% rather than 9% in which case the advice would be different. My practice has 10 patients who fall into this category.

The discussions between TPP and NHS England about workload and compensation has meant that many practices have not actioned this error but are waiting to see what is going to be agreed nationally.

The LMC's advice is that as GPs we have a duty of care to our patients and we should run these reports and contact the patients where appropriate and explain how the error has been made, provide the correct advice and ensure this has been recorded.

You should act on this now if you have not done so already.

10. Revised BMA guidance on firearms

Please find below the link to the BMA's revised position and guidance on the firearms licensing process developed in light of the new policy passed at the Local Medical Committee’s Conference and ARM seeking further action and changes:
Please click here for further information.

The Home Office has also been kept informed and the BMA will continue to engage with them on seeking improvements to the current process.

Best wishes

Nigel

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Attached file: KLOE.docx

Attached file: CQC Welcome Pack v5 July 2016.docx

Attached file: CQC Matrix Discussion Notes 10-11-15.docx

Related guidance and emails...

Nursing Homes and Residential Homes
The provision of care in private hospitals and care home generates a considerable number of queries. There are a number of reasons for...

Certification - Deaths
The law requires a doctor to notify the cause of death of any patient whom he or she has attended during that patient’s last illness to...

Sudden Death on Practice Premises
Beyond the immediate clinical need of a patient - if a patient is declared dead on the premises how should you proceed? If the death is...