Kent Local Medical Committee Est. 1912
Supporting list based personalised care, the partnership model and meaningful collaboration

December 2019

In Touch

In this issue.....

Conference of England LMCs: GP Home Visits

Liz Mears, Clerk

Dr Andy Parkin presented the most controversial motion of the conference:

That conference believes that GPs no longer have the capacity to offer home visits and instructs GPC England to:

i. Remove anachronism of home visits from core contract work
ii. Negotiate a separate acute service for urgent visits
iii. Demand any change in service is widely advertised to patients

In proposing at Conference Dr Parkin was quick to highlight that this motion was not to disadvantage vulnerable, frail or palliative care patients.

Dr Parkin added:

*"moving away from routine day-to-day contacts would actually improve care. All our patients will benefit, by gaining us that most precious and rare commodity in general practice, **time.** Home visits take up the most time of anything we do. Two to three hours a day for the majority. They cause the most friction, complaints and litigation. You have the most highly trained, endangered, and in-demand people in primary care driving around 25 square miles to see two patients an hour, and in the case of rural colleagues, maybe only one."*

This proposed motion fuelled conference into a passionate debate about the merits of home visits and looking after patients who are potentially vulnerable or near the end of life.

Many GPs stepped forward to try and put their points across before the conference delegates voted. The debate highlights the purpose of Conference as an opportunity for grass root GPs to present their opinions and be heard nationally.


Dr Andrew Parkin
Kent

54% of GPs voted in favour of the motion and 46% against.

Kent LMC released the following statement:

This motion is not intended to remove the ability of GPs to perform home visits. More complex, vulnerable and palliative patients are best served by their GP visiting them when needed.

In Kent we have pockets of home visiting services where members of the multi disciplinary team such as paramedic and nurse practitioners attend to patients at home. Currently there is no universal consistency for patients. Increasing demand and falling GP numbers are further compounding pressures in general practice, September 2019 saw 26,400,000 appointments take place in general practice, a rise of 9.7% when compared to September 2018.

The NHS is in a cycle of transformation. Kent LMC are asking for a home visiting service that is properly resourced and delivered to our patients.

Annual Conference of England LMCs: 22nd November 2019:

Morning Session, Dr Thilla Rajasekar, Ashford LMC Representative

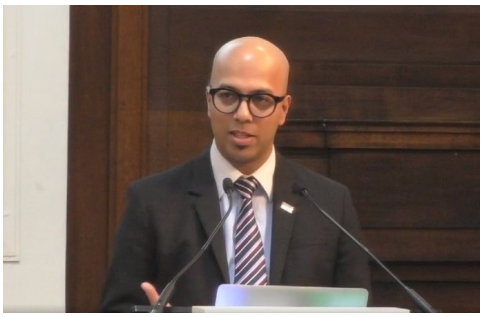
The morning session of the 22nd November English LMC Conference started with a rousing speech by the chair of English GPC who spoke about the achievements and also about the ongoing talks to solve the pension crises engulfing NHS.

The first motion proposed was moved by the Leicester LMC which condemned the broadbrush tainting of GPs by NHS England who misrepresented and exaggerated fraud in primary care. This was well supported and passed with clear mandate given to GPC to take NHS England to task over these unsubstantiated claims.

The next motion was moved by Shropshire LMC about the risk of medicine shortages in the past few months which has affected patients as well as GP workload. Again this was passed with overwhelming support.

Then at 10:40 came what must be described as the most sensational motion to be proposed in recent LMC history from our own Dr Andy Parkin. He spoke in support of the ''unspeakable'' imploring to reconsider home visits which was becoming increasingly untenable for GPs. After a passionate and often emotional debate the points were all passed with a surprisingly high level of support among the attending delegates.

After this momentous motion, delegates raised questions to the various panel members of BMA and GPC.



Dr Gaurav Gupta, Kent LMC Chair fielded questions on premises

Our chairman Dr Gaurav Gupta fielded questions on premises.

Then it was the turn of Dr S Westerbeek to propose a motion to advance the rights of sessional GPs and parental leave entitlement. Again this motion was passed without a murmur.

Then the next important motion discussed was on pensions issue which was moved by the Liverpool LMC again passed with overwhelming support after which we broke for a well deserved lunch.

Conference of England LMCs

Afternoon Session—Dr Sarah Westerbeek, Kent LMC GP Sub-Committee Chair

The early afternoon was focused around the development of PCNs and the issues that many are facing since their formation.

A themed debate allowed numerous individuals to speak about their experiences and a recurrent theme was that Clinical Directors were being asked to do more than they are able to do within the funding that has been given for PCNs and the time that they had allocated to do the work.

There was displeasure at the fact that PCNs were being expected to "mop up" extra work that could not be managed by normal general practice. There was also concern expressed that the additional staff being employed at PCN level with 70% reimbursement, may well be asked to do additional work, rather than taking work away from general practice, which does not provide significant benefit for GPs.

Motion 19 specifically focused on the inability of PCNs to tackle workload, workforce issues and called for GPCE to reject this model of care. Zishan Syed from Kent gave an impassioned speech detailing why his practice had decided not to join a PCN, after seeking financial advice that indicated it would not be viable in terms of taking on new staff. Dr Richard Vautrey replied by stating that PCNs had funding attached to them and unless practices participated in this DES that this funding would not be available to them and the risk is that this would then be lost to General Practice. Conferences voted in favour of the

fact that they did not have faith that PCNs would reduce workload or deal with workforce issues, but they did not vote in favour of GPC rejecting the model of care.

Motion 20 discussed the proliferation of clinical guidelines and the negative impact that they can have on patient care.

Dr Thilla Rajasekar spoke about importance of guidelines in helping

to plan the financial implications of clinical decisions for practices. Gaurav Gupta spoke in favour of any changes to guidelines needing to be passed through LMCs prior to approval. The motion was carried.

The following motion raised the issue of PDLD meetings and it was voted for unanimously that trained LMC nominees should be mandated to be at each of these meetings as the practice specific practitioner. Continuing the theme of supporting individuals who had GMC or NHSE conditions placed on them, conference voted in favour of enabling them to join the Induction and Refresher scheme.

Debate was then had around accountability of CCG spending and ensuring that CCGs have to prove that funding had been allocated to practices as promised. Then conference voted in favour of a motion holding secondary care to account for not fulfilling their contractual requirements with regards to work that is being dumped on primary care.

To conclude the afternoon three chosen motions were debated, the first being that the improved access scheme should be scrapped, which was unanimously voted through.

The second motion was an emotive one, calling on GPC to make a plan of action with a designated timeline for implementing the recommendations made by the Romney Report into sexual harassment and bullying within the BMA. Several women gave emotional speeches on the importance of putting the recommendations into place in order to improve the culture and behaviours within the BMA and GPC specifically. The motion was unsurprisingly carried unanimously.

The final motion of the day was around concerns about CCG mergers and the negative effect this may have on practices and representation of them.

It was a long day, filled with excellent balanced debate and particularly by Kent LMC representatives who were heavily involved in debate throughout the day!

Conference of England LMCs: Personal Reflections

Dr Richard Claxton, LMC Vice-Chair & West Kent Representative

Funny old game these conferences, the more I go to them the less I can make sense of the processes involved. Just when you think you've got your head around the procedures and know how things are likely to play out; along comes a motion that swings the other way - based on the mood in the room - or a particularly powerful and emotive speech.

Take the headline motion at this conference on Home visits. I remember this being debated and rejected a few years ago by the UK conference. We knew it was going to be controversial and I'd even had patients raising their concerns about it in conversation in the last week or so. I'm not sure how slim the odds a bookie would have given you on it being passed, but like most people I spoke to I fully expected it to be defeated once again.

Personally I am concerned that it will damage the profession; home visits are time consuming but hugely important for our most vulnerable patients, and a keystone in the place of GP's holistic and patient-centred role within the NHS. I'm worried that using a current workload and recruitment crisis to make changes such as this one is shortsighted. Undermining the traditional model of family medicine which so appealed to me in my career aspiration to become a GP may negatively impact our recruitment appeal for future generations. Moreover this will add to the multitude of threats currently circulating which threaten continuity of care.

Indeed I'd prepared a speech against it - but wasn't chosen to speak. There were plenty of delegates wanting to speak, and four of us (all against) were not chosen, possibly because the chair considered the likelihood of it passing small. As it was ably proposed by our very own Andy Parkin and supported by Zishan Syed - as well as several others, the mood in the room and their eloquence carried the motion. This led to a flurry of activity for the BMA Press office - as headlines were written in the National Press. The message being put out that the motion was more a public indication of the crisis in workload we currently face.

Another key motion for me was 207, the chosen motion (one of three supplementary ones included at the last minute after a ballot of delegates pre-conference) calling for the end to Improved Access. This was carried - almost unanimously and hopefully will be such an important strand of policy for the GPC going forward that it was a wonder to me that it hadn't been included by right in the main agenda.

The last key debate and standout vote for me was on the value of the new PCNs. The feeling in the room and the subsequent vote was pretty damning on the impact they'll have on GP workload, recruitment. This was the first time any LMC conference had had the chance to comment on this new DES - clearly seen by the GPC and NHSE as a

key foundation on which to build a new shape for primary care.

Richard Vautrey was rightly admonished for using his role as an impartial policy lead in commenting on the debate in a biased way - effectively speaking against the motion (and in favour of PCNs). So it's back to the drawing board for the GPC on that one. I don't envy them.

Conference of England LMCs: Personal Reflections from a first time attendee

Dr Siva Nathan, DGS LMC Representative

It was a privilege to attend my first LMC England Conference with colleagues from Kent LMC.

As joint Clinical Director of my PCN, this year has added a massive new dimension of workload. The most tangible effect of PCNs thus far appears to be multiple meetings. Most of these to extend late into the evenings, are of very variable usefulness and often with more than one per week……I was therefore eager to participate in the Conference and hear opinions of GPs from across England.

I had a slightly stressful journey, to the Friends House Conference Centre Venue in Euston, with my wife away in Sheffield and having to drop my ill daughter with grandparents followed by closures on the Jubilee line.

Setting the scene for the Conference was the opening speech by Dr Richard Vautrey (BMA General Practitioners' Committee Chair). The tone was somewhat optimistic but with healthy measures of realism in regard to unsustainable workload and other challenges. There was a passionate defence of the Partnership Model with acknowledgement of the solutions needed regarding pensions, premises, morale and GP numbers.

Of note was Dr Vautrey's opinions regarding the eminent position of LMCs to support General Practice across the UK.

Next followed the motions, all of which mirrored the discussions that we GPs have on a daily basis.

First off were well argued motions regarding medication shortages (which seems to be an even more irritating problem outside Dartford!!) and condemnation of language used in an NHS England strategy document.

Unsurprisingly the bulk of both motions were carried unanimously and served as warm up acts for the main talking point from the conference: Kent LMC's proposed motion regarding Home Visiting.

This was the most polarising and stimulating event of the day. Speakers from across England put forward detailed debate for and against the motion. Interestingly, I found myself in agreement with most of the points made by both sides.

I find that providing home visit support for terminally ill patients and their families is one of the most satisfying and effective aspects of General Practice. It is also a role that sets us apart from other specialties and enhances our importance to the NHS. However, the rationale for the motion is hopefully obvious to all concerned.

I can recall two routine visits to 'housebound' patients over the summer who incidentally had examination signs of marked sunburn when visited. Both had been on holiday, far from Dartford, and then requested a non-urgent GP home visit, less than a mile from the surgery, on their return. Following the conference, much of the debate in GP circles has acknowledged that there needs to be change to how home visits are requested. Including the issue of visit requests where transport to the surgery is not straightforward. Let's hope the incoming Secretary of State for Health has sense to address this and all of the other motions which were passed…..

Debt & Mental Health

Dr John Allingham

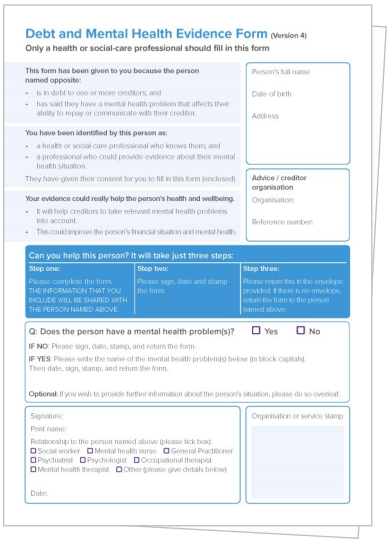
On October 1st 2019 the BMA announced that patients will no longer have to pay for medical evidence to support a diagnosis of a mental health condition when seeking advice or liaising with creditors about personal debt. This change comes as a result of changes in the new 5 year contract agreed earlier in 2019.

Creditors or Advisers should trust customers own accounts of their health issues.

If evidence is needed a prescription, appointment card or letter concerning benefits should be accepted.

If evidence is unavailable then a GP can be required to complete a Debt and Mental Health Form.

The agreement is that all that is required is to tick a box confirming existence of a mental health problem and to write the named diagnosis on the form. Any additional information is voluntary but there is a box to allow for this.



Debt and Mental Health Evidence Form (Version 4)

Only a health or social-care professional should fill in this form

This form has been given to you because the person named opposite:

- is in debt to one or more creditors; and
- has said they have a mental health problem that affects their ability to repay or communicate with their creditor.

You have been identified by this person as:

- a health or social-care professional who knows them; and
- a professional who could provide evidence about their mental health situation.

They have given their consent for you to fill in this form (enclosed)

Your evidence could really help the person's health and wellbeing.

- It will help creditors to take relevant mental health problems into account.
- This could improve the person's financial situation and mental health.

Person's full name

Date of birth

Address

Advice / creditor organisation

Organisation:

Reference number:

Can you help this person? It will take just three steps:

Step one: Please complete the form. THE INFORMATION THAT YOU INCLUDE WILL BE SHARED WITH THE PERSON NAMED ABOVE

Step two: Please sign, date and stamp the form.

Step three: Please return this in the envelope provided. If there is no envelope, return the form to the person named above.

Q: Does the person have a mental health problem(s)? ☐ Yes ☐ No

IF NO: Please sign, date, stamp, and return the form.

IF YES: Please write the name of the mental health problem(s) below (in block capitals). Then date, sign, stamp, and return the form.

Optional: If you wish to provide further information about the person's situation, please do so overleaf.

Signature:

Print name:

Relationship to the person named above (please tick box):

☐ Social worker ☐ Mental health nurse ☐ General Practitioner ☐ Psychiatrist ☐ Psychologist ☐ Occupational therapist ☐ Mental health therapist ☐ Other (please give details below)

Date:

Organisation or service stamp

WE NEED YOU!

Kent LMC Elections EARLY JAN 2020

As a GP are you keen and able to contribute to and influence events in your local area?

NOW is the time to become an LMC representative.

Phone the office on 01622 851197 or email info@kentlmc.org for an informal discussion or further information

What is a Local Medical Committee?

The LMC is the only body that has a statutory duty to represent GPs at a local level. This statutory duty was first enshrined in Law in 1911 and has been included in the various NHS Acts and is included in the 2012 Health and Social Care Act. The LMC has a constitution that ensures it is representative of GPs, this is updated regularly following consultation with GPs. In every area of the country there is a local representative committee called a Local Medical Committee whereby, GPs are nominated by their peers and elections to these roles take place regularly (in Kent every 3 years). The committee also ensures there is a balance in terms of representation (75% contract holders and 25% sessional (salaried/locum) GPs).

Whilst recognised by statute and having statutory functions, unlike CCGs, LMCs are NOT themselves statutory bodies, they are independent. It is this unique status as independent representative bodies recognised by statute that allows them to be so effective in standing up for and supporting their GPs. They are accountable to the GPs they represent, unlike CCGs who are answerable to NHS England and the Department of Health leaving LMCs free to speak up on behalf of GPs, practices and their patients when others cannot.

The Health and Social Care Act reinforces the requirement for NHS Bodies to consult with the LMC on issues that relate to general practice. It is important to understand that the LMC is not a trade union and cannot act as such, this is the role of the British Medical Association (BMA). The LMC therefore considers itself the voice of general practice at a local level. Kent LMC works for and supports individual GPs and practices and are also the wider professional voice of general practice.

The LMC in the wider context

Kent LMC represents local GPs views nationally through representation on and to the General Practitioners Committee (GPC) and by submitting proposals to the England and UK Conferences of LMCs.

GPC membership consists of 51 GPs elected from regional seats and the Annual Conference of England LMCs. The GPC is responsible for advising the Secretary of State, the Department for Health and NHS Employers with whom it negotiates, GPs terms and conditions. It is guided by policy decisions determined at the Annual Conference of LMCs England.

The Annual LMC Conferences are the main policy-making event where representatives from LMCs nationally attend to debate motions that reflect local GP concerns and objectives. The LMC Conference is the body to which the GPC is directly accountable. In Kent we are currently represented on the GPC by Drs Gaurav Gupta and Sarah Westerbeek.

How are we Funded?

The LMC is funded from Statutory & National Levies. We raise levies to cover the expenses of the office function as below:

The Statutory Levy

This sum, collected from all practices based on a number of pence per patient, and is reviewed annually. This ensures LMC independence from any other NHS body and enables us to represent and work neutrally on behalf of our GP constituents. This funding is used exclusively for the running of the local LMC office and its functioning.

The Voluntary Levy

A separate levy, called the Voluntary Levy, is collected to contribute Kent's share of the cost of the operation of the national negotiating committee and the GP Defence Fund. The rate is set by the GP Defence Fund, based on an amount per patient and reviewed annually. Access to services funded from this levy will be made available to those who contribute. In Kent this levy has an additional price per patient for the delivery of GP staff training and the Employment Law helpline.

The 6 main functions of the LMC

Body Recognised by Statute	Has rights and responsibilities defined in the NHS Acts & Regulations and serves as the local representative committee for all NHS GPs
An Independent Body	Represents the interests of general practice solely and acts as its advocate, remains independent from political constraints and the need to satisfy other interests
A Professional Body	Promotes quality and maintains standards of professional practice through support and demonstration in collaboration with other professional and educational bodies
A Representative Body	Listens, debates and responds to feedback and represents the majority view of its GPs to NHS England, CCGs and other national and local organisations
A Democratic Body	Elected by and consisting of local GPs who represent their local and diverse interests
A Resource	Provides advice and support to all GPs in all matters relating to their professional lives and actions.

Supporting Individual GPs and Practices

LMC links with other bodies

- ☑ Integrated Care Provider (ICP) and Integrated Care System (ICS)
- ☑ Clinical Commissioning Groups
- ☑ NHS England

- ☑ Public Health England
- ☑ Social Services
- ☑ Patient representative bodies
- ☑ Local Authorities
- ☑ The national press
- ☑ Other LMCs
- ☑ BMA General Practitioners Committee (GPC)
- ☑ Royal College of General Practitioners (RCGP)
- ☑ National Association of Primary Care
- ☑ NHS Alliance
- ☑ Members of Parliament
- ☑ Dispensing Doctors Association
- ☑ Local Pharmaceutical/Dental/Optical Committees
- ☑ Hospital & Community Trusts
- ☑ CQC
- ☑ STP
- ☑ Others

Why should you become a Kent LMC Representative?

LMCs represent **all** GPs, both sessional and contract holders. Any issues that you or your peers are facing locally, such as issues with contracts, can be raised through the LMC and can be taken forward on your behalf. Also, if you are experiencing difficulties that affect GPs at a national level these can be fed up through the LMC to the GPC to take forward. Recent examples include PCSE issues, pensions annualisation, NHS Property Services, indemnity cover and model locum terms and conditions.

In terms of commitment, if you join Kent LMC there will be five full LMC meetings per year and quarterly Local Constituency Committee meetings. Renumeration for these are currently offered at a rate of £335 per meeting (£210 for short meetings of up to two hours). It's not a major time commitment but, as with everything, the more energy you put into it the more you get out of it.

Being part of Kent LMC can be an interesting way to get to know about and become involved in tackling local issues affecting GPs.

If you have a passion for contributing to and influencing local issues and policies then joining Kent Local Medical Committee is the perfect way of doing that.

The current term of office of the members of the Kent Local Medical Committee expires on 31st March 2020, and the Election process for members to the new Committee for the term of office from 1st April 2020 – 31st March 2023 will start in early January. We will be seeking 30 Contract Holding GP Representatives and 10 Sessional GP Representatives.

All GPs who are on the Performers list are eligible to stand for election, regardless of any positions they may hold with other organisations, eg. Clinical Directors/CCG Boards/Federations.
Further information on the election process is available on our website: www.kentlmc.org.

Kent LMC Annual Conference: The Evolution of Primary Care
31st October 2019

Hot Topics: Jamie Kaffash, Editor, Pulse Magazine
Dr John Allingham, Medical Secretary

Jamie Kaffash the editor of Pulse opened conference with a different and entertaining run through how the publication approaches stories.

Jamie is an engaging speaker who told the 'back story' and chronology some of the big stories which were subsequently picked up by the national media outlets. How an eminent national GP was caught out commenting on Pulse Stories under a pseudonym and the interesting way the public relations fall out from the issue was handled gave a deep insight into the sensitivity with which stories are handled.

Jamie described the dilemma when a story can be seen as critical of or conflicts with the interests of advertisers. He described how the companies criticised in a story about 'heart age' were all advertisers and how the owners of the magazine could have been concerned about the publicity.

Overall it was reassuring to understand that Pulse is the GPs magazine. We are the readers and the source of the stories so overall it is on our side and seeks to support our endeavours.

ICS/Primary Care Board Update: Beckie Burn, Head of Programmes & Dr Fiona Armstrong, Co-Chair Primary Care Strategy Board, Kent & Medway STP
Liz Mears, Clerk

Dr Fiona Armstrong (STP Co-Chair Primary Care Board) and Beckie Burn (STP Head of Programmes) presented the final draft of the Kent and Medway Primary Care Strategy.

Fiona described the work of the Primary Care Board and in collaboration with the LMC the development of the Kent and Medway Primary Care Strategy.

Why have a primary care strategy?
Primary Care is the bedrock of the NHS and if primary care fails, then so does the whole of the NHS. With the shortage of GPs in Kent and Medway there are significant challenges and in partnership we need to have a plan for the next 5 years and beyond. Fiona described that following significant engagement and liaison with all stakeholders priority themes have been banded into 8 areas: Care redesign, workforce/workload, digital, estates, finance and contracts, communications and engagement, PCN's and implementation plans.

Development of the PCNs is key and so is creating a consistent support offer. Funding for PCNs for leadership development, PCT development and service improvement has been identified.

In 5 year's time what will it look like? What is the impact on individuals, colleagues and communities? The strategy is ambitious and it should be, but there is a sense of realism that the basics need sorting and this is very apparent for example, with primary care digital.

In 2019/20 there are many deliverables and the focus will be on PCN development. Looking at local care and primary care and identifying the overlaps and what is actually needed to deliver. Other priorities around the workforce plan, pilot of digital first and data and analytical support and implementation of the Primary Care Quality Scheme (PCQS).

The next step is for the primary care strategy to be submitted nationally and to work through carefully the priorities and identify the gaps, including the funding impact. There is general agreement that no unfunded work will be passed onto general practice.

Some searching questions from the delegates around the STP supporting the 30% contribution towards additional PCN staffing. The LMC confirming that practices need to be able to see a 30% reduction in associated workload. Confirmation given by the STP that PCN development plans are an indication of where we are in Kent and will not be used for performance management. £450k is identified for service improvement and there is not full consensus yet with the PCNs on how this will be used. There was concern that the good aspirations will be stifled by the mismatch we have with primary care out of hospital and the primary care infrastructure and IT. The STP and Primary Care Board recognise these significant challenges and want strong focus on getting the basics right.

Working at Scale: Dr Paul Bowen, General Practitioner, Medical Director & Partner, Middlewood Partnership & PCN—*Carlo Caruso, Deputy Clerk*

Paul Bowen, a GP, from Poynton in Cheshire, gave the audience a refreshing account of how a moment of crisis led to transformative change, benefitting the day to day working life of him and his colleagues.

Paul gave a rather phlegmatic account of the travails he and his colleagues went through. Many readers, I'm sure, find the account familiar. He joined a partnership in 2006. He was the youngest of the 4 partners and together they looked after a list of 6,000 patients. Things were very sta-

ble until the first partner retired at the age of 55. The practice was unable to recruit a replacement, but the remaining partners persevered. Sometime later another partner retired and despite their efforts they were unable to recruit a replacement, leaving only 2 partners holding the contract

They did what they could, implementing the same "list of doom", such as the 10 high impact actions and increasing skill mix. Although these were important and beneficial changes, they did not help to address the fundamental issue which was that the remaining partners were working harder and longer than ever before just to stand still.

Things hit crisis when, while his partner was ill and off work, Paul was struck down by the Norovirus. Although they were able to find a locum at short notice to see patients, they only had cover for 24 appointments which was not enough to meet the routine demand. Paul and his partner did what they could, with Paul triaging calls whilst confined to his bathroom, and his partner logged onto the clinical system remotely issuing prescriptions.

The crisis lasted for a further day, but the lessons learned from the experience gave way to some rather simple but profound changes. Having a GP triaging patients was initially meant to be a compromise response to a moment of crisis, but the benefits were so significant it became business as usual. It made a significant impact on workload, returning a sense of control and making clinical work feel safe again. Secondly, GPs would regularly spend time sat in the reception area doing admin work whilst assisting the reception team with triage. This helped to strengthen comradery and the GPs also learned what crisps could be eaten silently whilst on the phone!

Perhaps, the greatest impact was how it transformed working days. these were now divided into 3 2.5-hour sessions, or 4 if it included cover for a colleague. Each session would be taken up with one activity, admin

whilst sat in with the reception team, face to face consultations, or home visits. Clinicians sat in with reception would also support the team, taking the phone, issuing prescriptions or fit notes, and ensuring appointments are used appropriately.

Over 4 years since the changes were introduced things at the practice have changed significantly. The partners worked less hard than comparable practices or they had done previously; they have fewer clinicians per 1000 patients; work shorter days; have higher QOF and income from enhanced services; and most importantly, there was stability and the practice became a "happier place psychologically".

Primary Care Quality Standard: Bill Millar, Director of Primary Care, East Kent CCGs *Liz Mears, Clerk*

Bill started by thanking Gail Arnold, Tracy Rouse, Natalie Rennie and Clare White from the CCGs as well as members of the LMC for their hard work on this project.

Historically there has been significant variation in Local Enhanced Services available to practices across Kent and Medway. Bill explained how the CCGs, together with the LMC have developed PCQS in order to improve equity across the county and help start to create more certainty of future funding for General Practice. In some CCG areas it will not be possible to bring in all the services immediately because of the nature of existing contracts with other providers, e.g. Medway CCG contracting arrangements mean they cannot commence PCQS until sometime in the new year.

Bill talked about the principles applied to ensure that all practices have the potential to provide the services either individually or in collaboration with other practices. They also intend to make the data collection as easy and the monitoring as light touch as possible.

PCQS will be rolled out in three phases with Phase 1 including 24/48 hour Ambulatory Blood Pressure Monitoring, Phlebotomy, Community ECGs, Treatment Room (including common nursing work such as ear syringing and suture removal), Complex Wound Care and Women's Health (IUS/Ring pessaries insertion, checking and removal).

On 16th August all practices in Kent (except Medway) received details of the scheme and were asked to advise their CCG how ready they are to provide each of these services. The responses demonstrated a variation in readiness and some of this reflects the historic differences in arrangements across the 8 CCGs. Phase 2 is intended to commence around April 2020 and is likely to include PSA monitoring, Respiratory/Spirometry and Shared Care Drug Monitoring. Draft specifications are currently being developed in conjunction with the LMC.

Work is progressing on automated data extraction to reduce the bureaucratic burden on practices. Templates are also being written for Vision and EMIS for ease of data entry and to ensure correct codes are used for the data extraction for payment and monitoring.

Bill went on to say that there is recognition that this is a small start, but they believe strongly that working with practices on a common set of services provides an opportunity for practices. Dr Gaurav Gupta added that overall this is a positive move to maintain income in General Practice as well as reducing variation across the county.

Dr John Allingham stated that the discussions for the next phases include an extensive wish list especially in respect of what might be included under Shared Care prescribing and monitoring. Dr Richard Claxton requested that the scheme is flexible enough to allow inclusion of odd rare drugs that would not be named in the

spec but could be agreed on a case by case basis. Bill agreed that this could be considered if practicable.

It was noted that the clinical systems practices use are not all able to share patient records yet and that will need to be urgently addressed to enable collaboration between practices. Dr Gupta finished by saying that PCQS is being rolled out in some CCG areas now and that practices should ensure they are coding activity in Phase 1 now to ensure it can be extracted for payment.

Appraisal & Revalidation Update: Dr Jonty West, Clinical Appraisal Lead, NHS England—*Caroline Rickard, Medical Secretary*

We heard about how our 210 appraisers are supporting our colleagues in Kent and Medway. Key points include the changes in appraisal over the last year, 'The Soft Re-boot', GMC – The Reflective Practitioner, NHSE ROANS and Structured Reflective Template for practitioners who undertake low volume clinical work.

Appraisal has changed over the last year. No longer are you expected to reflect on every hour of CPD. The process is now moving to being more formative and supportive to appraisees. There is a joint publication for practitioners who undertake low volume work (less than 40 sessions a year) to assist them with appraisal and the reflective template to be discussed at appraisal: https://www.kentlmc.org/nhsguidancesupportingdoctorswhoundertakealowvolumeofnhsgeneralpracticeclinicalwork

CPD remains unchanged, 50 hours per year, total 250 hours over the revalidation cycle. CPD for additional roles is in addition to this. These additional roles must be discussed at appraisal. Quality Improvement Activities – the RCGP outlines recommendations. Audit is no longer mandatory.

MSF/PSQ – the GMC has guidance on how to do these to achieve anonymity and objective results. You must use the standard questionnaire that has been validated and independently administered. Complaints – appraisees must declare and discuss all formal complaints that they have been named in over the appraisal year. This should include your insight and learning from complaints. Don't forget compliments!

Our website has links on it to useful resources to support you with your appraisal which can be found here https://www.kentlmc.org/usefulresourcesfromthenhsappraisalteamseptember2019

Kent & Medway Medical School (KMMS) Update: Professor Chris Holland, Dean KMMS—Caroline Rickard, Medical Secretary

Chris Holland, Founding Dean KMMS, updated us. Students will study on both the Canterbury Christ Church University and University of Kent Canterbury campuses.

At Christ Church they will study in the Science, Technology, Health, Engineering and Medicine building. This houses a high-fidelity hospital simulation suite and an anatomy learning centre and at Kent the building features a GP simulation suite. There are learning and study spaces on both sites. Both buildings are on track to open in the summer.

The first cohort of 100 students will join in September 2020 – they had 1537 applications for these places with 12% coming from Kent and Medway.

A large-scale fundraising campaign has already secured several scholarships including Medway Council who are offering to fully fund tuition fees for a student from Medway.

Noticeboard

Kent LMC joined the LMC Buying Groups Federation in 2008 to deliver savings to practices without creating any additional work or inconvenience.

Membership entitles practices to discounts on products and services provided by the Buying Group's suppliers.

Membership is free and there is no obligation on practices to use all the suppliers.

BUYING GROUPS LMC FEDERATION

TRUSTED TO SAVE GP PRACTICES TIME & MONEY

However, practices can save thousands of pounds a year just by switching to Buying Group suppliers. To view the pricing and discounts on offer you need to log-in to the Members section of the Buying Group website:

https://www.lmcbuyinggroups.co.uk/

Not convinced the Buying Group can save your practice money? Well... why not challenge them to do just that?

The Buying Group offers a free cost analysis service that aims to show member practices how much money they could save just by swapping to buying group suppliers. They can also provide this service for groups of practices working together.

For more information, contact the Buying Group on 0115 979 6910 or email info@lmcbuyinggroups.co.uk

Practice Staffing Changes

Sophie Webb
Office Administrator

Since PCSE took over from KPCA, the LMC no longer receive updates of any staff changes within practices. This means that, unfortunately, our records are not always 100% accurate, which can result in Practice Managers and GPs not receiving important news, updates and guidance from us.

We understand how busy all practices are, but we ask, where possible, please would you update us on any GP or Practice Manager changes at:

info@kentlmc.org

This will help us maintain up-to-date records and ensure that important information and updates are sent to the right people.

The LMC office will be closing on Tuesday 24th December 2019 and will reopen on Thursday 2nd January 2020.
Please note calls will be monitored during this period.

Wishing you all a Merry Christmas and a Healthy New Year from all at the LMC Office

Kent Local Medical Committee

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