June 2014

In Touch

*** Special Edition ***

LMC Conference - 22nd-23rd May 2014

In this issue…..

Day 1—Morning Session
Dr Julian Spinks, LMC Chair

Day one of the conference and the Kent delegates were met by a picket line outside the conference hall. Protesters were worried about a motion on charging patients for appointments. It was all very civilised and no police escort was needed.

In the hall and the tension rose through the usual preamble about the terms of reference as Chaand Nagpaul was about to give his keynote speech.

Dr Chaand Nagpaul
Chair—BMA General Practitioners Committee (GPC)

Chaand was greeted warmly and started a speech which was persuasive and powerful. The tone was set by the opening sentences where he said that general practice, a service used 16 times more often than A&E, was in a parlous state and facing unprecedented challenges. He went on to say that he had started his chairmanship with the profession facing an imposed contract but hard negotiation had reversed most of the imposition, 238 QOF points had moved into core funding, QOF threshold increases had been stopped and the three imposed DESs had been removed. Despite these positive moves, he was concerned that the new GP responsibilities would only work if the rest of the system played its full part. He also warned that only one in five CCGs have made available the £5 per head to resource change.

Members of the public gathered outside the Conference hall to protest against charging patients for appointments.

The GPC Chairman warned of a quadruple whammy of a crisis in workload, workforce, premises and morale with GPs showing the highest levels of stress since records began. If general practice is such a jolly, why are young doctors shunning it in favour of hospitals? He warned those that continue to denigrate us that putting off potential future GPs will mean the NHS will collapse and the detractors will not have a GP in times of need.

Chaand spoke movingly about his time as a medical student and the difficulty, at the time, of getting a training position and partnership due to competition to enter the profession. He reminded

GPs the high regard in which they are held by their patients and the importance of maintaining trust. For this reason the GPC had called for the halt to the roll out of care.data.

He spoke about the need to protect practices hit by MPIG and PMS cuts and explained that the correction factor was a fifth of the money spent on a non-existent winter crisis this year. The relentless unresourced shift of work to GPs overloads our ability to care and it is also unfair to patients who face a pass-the parcel experience because CCGs fail to use their commissioning levers to shift resources. CCGs must also realise that they are membership organisations which should support their members.

Conveyer belt medicine was the next concern. The 10 minute consultation was an anachronism in a time of an ageing population and complex needs. We also need space to care and we cannot continue to practice from outdated, inadequate premises. The CQC passes judgement on poor premises, but who is providing the funds to improve them? Ultimately we need people to provide the care. We need to retain our existing doctors and staff and recruit newcomers as well as enhance the primary care team.

Chaand highlighted the 'Your GP Cares' campaign and announced an e-petition to government. The public must know of the trade-offs between seven day working and personalised care to the elderly. When money's tight, he said, businesses invest in the most cost effective services and in the NHS that is general practice. But the spend on general practice and the proportion of doctors in it has dropped over the decade. Just an increase of 2.5% of the total NHS spend would give practices a one third increase in resources. He concluded that the government needs to decide if it wants a sustainable NHS. If so, it cannot afford to fail to support, invest in and develop general practice?

The speech received a standing ovation.

It was then down to business with motions on workload and patient safety showing healthy debate and general agreement that the excessive workload was putting patients at risk and needs to be controlled.

Dr Adam Skinner, West Kent LMC Representative, proposed a motion that 'general practice no longer provides the service its patients deserve'.

Commissioning of care was next with conference agreeing that the NHS reorganisation was 'a shambles'. Co-commissioning of GP contracts by CCGs produced opposing views, with proponents suggesting it could facilitate funding shifts from secondary to primary. However the majority felt it contained dangers such as conflicts of interest which could leave the future of practices in the hands of non-clinical board members. Co-commissioning could be a disaster for already overstretched CCGs, especially given the fact that no extra staff or management funding would move with the responsibility. The conference voted to oppose co-commissioning.

Another motion proposed that general practice no longer provides the service its patients deserve. Adam Skinner opposed this in his usual rumbustious style. "What gets me going" he said, "is the phrase 'giving the people what they deserve'….many people get a far better service than they deserve!" Drunks, readers of the Daily Mail and Telegraph were all in Adam's cross hairs as were the royal colleges and the BMA due to their policy of constructive engagement. He talked about his anger and felt that Nye Bevan would be glowing in his grave from spinning so fast to see what has happened to the NHS. He finished with a quote from Heroditus "There is no more terrible pain a man can endure than to see clearly and be able to do nothing". The motion was defeated.

With Adam being towelled down in the corner, the conference moved on to regulation, monitoring and performance management. The conference carried motions deploring the CQCs new rating plans then Gaurav Gupta spoke against a motion demanding an apology from the CQC Chief Inspector.

He reminded conference that maggots had been found during an inspection… and not just the inspectors. His conclusion was that the Chief Inspector should not apologise, he should resign!

Gary Calver proposed the next motion for Kent. It believed that GP consulting rooms should be a therapeutic environment, not be a sterile operating room and should have carpets and curtains so they were cosy and comfortable. Gary reminded conference

that the consultation is 'what we do'. These motions sought to stop the move to sterility and discomfort. Comfortable surroundings are better for anxious and worried patients and there is evidence that our surroundings affect our mood. We should not impose guidelines designed for hospitals. We and our patients deserve to be comfortable and cosy. All parts were carried by conference except the call for cosy and comfortable surgeries so dig out the concrete waiting room benches.

Access to general practice was the final part of the morning, with conference rejecting routine 8-8, seven days a week and calling for any extension to hours to be accompanied by resources. It commended GPs for providing a 24/7 service. A motion was passed condemning the approach of NHS England to Christmas and New Year's Eve where GPs were expected to stay open despite minimal demand whilst NHSE staff went home early.

Dr Gary Calver, South Kent Coast LMC Representative, proposed a motion that GP consulting rooms should be a therapeutic environment

Finally the conference voted for a motion rejecting the use of GPs to assess eligibility of patients for NHS treatment.

Day 1—Afternoon Session

Robert Blundell, West Kent LMC Representative

Motion 27 was a complex debate, the crux of which was that General Practice is unsustainable in its current format and calling on the GPC to explore services that can and cannot be accessed in the NHS.

Dr Helena McKeown, although not an enthusiast for the motion, proposed it stating that charging patients would support the NHS and reduce unsustainable demand. She spoke of the risk of the loss of GPs to Australia and reminded all that the NHS is not free – but is funded through taxation.

Concern was expressed as to whether the sentiments of the motion could be misinterpreted whilst others suggested this motion might facilitate increased resources for primary care allowing the development of services. Laurence Buckman and David Wrigley from the GPC spoke against the sense of the motion with Dr Wrigley stating that the NHS was £2billion in credit at the end of the last financial year passing funds back to the Treasury.

Many stressed how this motion would damage doctor patient relationships and place GPs in the role of tax collectors for the government. It was suggested the motion was flawed in that it might lead those most in need unable to afford treatment. John Grenville, a seasoned conference attender of 30 years spoke in favour of the motion, stating that he felt that unless passed there was a risk that General Practice would die a death of attrition. Later speakers emphasised the need to balance 'want with need' but if the motion were passed in its entirety the vulnerable and needy would suffer most and portend the end not only of general practice, but of the NHS. Dr Chaand Nagpaul stressed the need for trust between patients and GPs and cited commonwealth research stating that we have greater compliance with treatment in those treated by the NHS than elsewhere. **The motion had mixed fortunes with parts 1 and 3 carried but the remainder lost - of particular note was that there was no instruction to investigate charging for GP Services.**

Motion 28 debated the effect of the loss of MPIG and PMS growth monies. Dr Julian Spinks, Chair of Kent LMC spoke opposing (v) which sought protection for ru-

Dr Julian Spinks opposed a motion which sought protection for rural practices citing that all practices had particular problems warranting protection.

ral practices citing that all practices had particular problems warranting protection. Julian followed the example of excellent and engaging Kent speakers which was necessary to lighten and enlighten discussions on occasion. He emphasised and contrasted the difficulties of urban practices which run the risk of losing LED lights to cannabis farms and postulated the development the 'ebong'. Richard Vautrey spoke of the need to ensure that Peter was not robbed to pay Paul suggesting (v) should be taken as a reference - Victory for Dr Spinks!

Motion 29 considered the imminent PMS Reviews and loss of monies. A speaker from Wakefield stated that his resources were to be decimated and urged a favourable consideration of his CV should he apply to one's Practice! **The motion was carried in all its parts.**

Proposing Motion 30, Pamela Martin from Lewisham requested that additional resources be negotiated to take account of rurality, deprivation, high levels of migrant populations, patients whose first language is not English and where there are high levels of patient turnover. Opposing speakers warned of the incomplete nature of this list - whereas other speakers listed evidence in support of cited populations. Dr Nagpaul related the limitations of formulaic funding stating that sufficient funds should be non-attributed. **All parts carried**.

Motion 31 on Pension changes was proposed by Thomas Kinloch from Mid Mersey who enumerated the excessive costs of working to 68 both to Senior GPs 28.5% (without added years) and additional tax risks and loss to younger GPs. The fact that although NHS pensions are, according to the Government's own actuaries, currently over funded, there is a real risk that a rush to early retirement could destabilise the situation. Chairman of Committee spoke of the concern that any NHS income should be optionally not superannuated. **This advice was heeded and all but part (iv) of the motion was carried.**

Motion 32 "That conference believes the absence of a scheme by which new GP Premises fit for the 21st century can be cost effectively constructed where required represents the biggest (significant) obstacle to improving the delivery of primary care in the UK". The proposer from Nottingham spoke of the need for new premises stating that GPs should not be expected to subsidise them in future. **Neil Potter (Kent LMC Rep)** stated that although premises were a problem, GPs had numerous other problems; recruitment, low morale – and if these other issues were sorted out then premises would be the biggest obstacle.
The motion was carried

Neil Potter stated that aside from premises GPs had numerous other problems including recruitment and low morale

Motion 33 about GP Pay was proposed by Gill Beck who related that in 2012 she had earned the same as in 2003 without taking account of inflation. She questioned the competence of those who calculated GP expenses. A GP trainee eloquently enumerated the increased costs facing trainees – **the motion was carried in all its parts.**

Motion 34 against the Publication of GP Pay attracted speakers in favour who spoke of the risks of publication whilst those against feared that the Government would not play fair. Dr Green suggested that if a true "like for like" comparison was made (and accountancy research on this exists) GPs would probably find their earnings in the same range as Specialty Drs. Chairman of Committee – Dr Holden urged that this be passed - as he felt it would lead to a Government Own Goal. **The motion was passed in all parts.**

Motion 35 GP Partnerships and Federations
This called on the GPC to actively support the development of GP Federations.

Speakers spoke of how federations could protect GPs and facilitate services. Dr Una Duffy spoke against the motion believing that it would lead to leaden movement, unconvinced that it would be of benefit as did the majority of subsequent speakers - one stating that they thought this would facilitate the development of corporate-led General Practice. **The motion was carried by 4 votes.**

Motion 37 asked conference to demand that NHS England ensures GPs understand the risks and challenges of remaining single-handed and appropriately encourage them to take on partners to assure general practice succession planning is in place. Dr John Caning spoke of the danger of sanctioning or seeking to encourage NHS England to be involved in structuring future General Practice. Conference listened and the motion was taken as a reference.

Motion 38 was presented as part of the fight for the NHS and discussed the increasing privatisation of NHS Services calling for increased publicity of this activity. Opposers cited the short comings of traditional NHS services – e.g. Stafford Hospital and urged GPs not to forget that they are indeed private providers. Supporters claimed that there was a plan from Mrs. Thatcher's era outlining the progression of privatisation for General Practice. **This motion was carried in all its parts.**

Motion 48 called for re-democratisation of the GMC- this was passed though the Chairman of the Committee regretted they might not be able to carry out the direction!

Day 2—Morning Session

Dr Gaurav Gupta, C&C LMC Representative

After the great dinner and speeches at the National Railway Museum the previous night, we were all looking forward to another day of stimulating debates and discussions.

The morning started with a speech from the Guest speaker Professor Chris Ham, Chief executive of the Kings Fund. He spoke on 'Investment and reform the challenges for General Practice'. He lamented on the fact that funding for primary care has flat lined while the demands and needs of the population continue to rise. He called for better funding and reform of primary care to make it better suited for the future. He called for consideration of new ways of working and quipped that consultants got the hospitals and GPs got the patients.

After this the GPC launched its 'Your GP Cares' campaign which aims to highlight the great work GPs and their teams do to keep the NHS functioning. It calls for the government to invest in primary care adequately for the improvement of GP premises and to increase the number of GPs, and practice staff. GPs can get involved by visiting the BMA website.

The first motion of the day featured a prominent theme for this year's conference. It called for the government to prioritise the workforce crisis that is threatening primary care. One of the speakers said that good family doctors can't be replaced by robots or artificial intelligence. Another invited GPs north of border, as things were more straight forward, before they closed the border. The motion was, unsurprisingly, passed unanimously.

We were then treated to the most entertaining speech of this year's conference from our very own Jim Kelly. He proposed the Kent motion calling upon the GPC to negotiate a Payments by Results based contract. He argued that the only way to future proof against ever increasing demand was a contract that paid for activity undertaken rather than the current block contract. GPs should be paid for the amount of work they do. He then burst into a brilliant rendition of 'Little less conversation and more action please' in true Elvis style. The motion was lost after a good debate.

The next motion argued for devolved nations to be able to negotiate their own contract. This led to a Great debate but the conference voted against the motion.

Soap box session this year attracted a great variety of topics including improving care mechanisms for temporary resident patients, work life balance, concerns regarding privatisation, issues with incapacity benefits system, rising cost of indemnity cover, increasing complaints due to raised expectations, increasing demand from ageing populations in nursing homes.

Professor Chris Ham, Chief Executive, Kings Fund

Dr Jim Kelly, Ashford LMC Representative proposed a motion calling upon the GPC to negotiate a payments by results based contract

The conference then moved onto the QoF section where a motion called for abolition of QoF, claiming that it has become a box ticking monster. I got the opportunity to speak against this motion and argued that QoF has led to better and uniform standards of care, and should be preserved as long as it is based on clinical priorities. The conference voted against this motion. The conference also voted against any local QoF schemes that undermine national negotiations.

One of the motions that attracted an interesting discussion called for the government to stop stoking unrealistic patient expectations. The media lies and propaganda against doctors in general and GPs in particular drew heavy criticism. Speakers called on the GPs to man and woman up to back up general practice, say no and mean it. The NHS is affordable if money isn't wasted. The motion was passed by the delegates.

There had been some discussion in the previous years calling for reforms in the LMC conference. Dr Mike Ingram, chair of LMC conference, proposed a motion which suggested trialling an alternative model of working. I stressed on the need for involving newer GPs in LMCs and at the LMC conference. The motion was passed and the GPC reaffirmed their resolve to make the conference more relevant to a larger audience.

Day 2—Afternoon Session

Dr Neil Potter, West Kent LMC Representative

The final session of conference turned out to be a more agreeable few hours where the human face of delegates and negotiators is seen. The urge to gripe, grumble and to rant has already been met.

Straight after lunch the "Ask the Negotiators" half hour allowed delegates to quiz the team on a range of issues, without warning, on issues as diverse as the future of the new DESs, closing practices, and saying "no" to non-funded services. Confidence in their abilities ran high.

Mark Ironmonger asked for recognition that dispensing does support rural services in providing core services, that EPS is not an option for these practices and called for more liaison with the DDA.
Motions followed to congratulate GPC in their negotiations of the last 12 months, and the LMCs themselves with a decision against forming a national LMC body. The BMA public relations office was also spared a castigation having efficiently launched the campaign "Your GP Cares".

Debate on Training led to calls for more places, more trainers, and early engagement of students. Training programs need to be standardised nationally and trainers should not be compelled to work OOH. Mismatch of GPs starting and leaving practice was a recurring theme of the 2 days.

Care.data was deemed "nothing short of a disaster" which gives GPs a conflict between the Data Protection and the Health and Social Care acts. We saw no need for data to be identifiable on leaving the practice.

Stephen Meech informed a lively and complex motion about SCR, GP2GP and CQRS with a call for funding to digitise all patient notes which was carried.

Further pressure on GPs from violent patients and then from rising indemnity costs drew some striking personal accounts but no one in conference was quite prepared for the impassioned proposal from Adam Skinner calling for HPV vaccination for boys as well as girls. He bravely recounted, with consent, the life-changing struggle of his son who has Laryngeal Papillomatosis, receiving a standing ovation and a unanimous vote of support.

Motions calling for robust evidence for guidelines on lipids followed and a well-received call to clarify prescribing responsibility in secondary care. Lack of funding for Occupational Health for GPs, staff and locums was then deplored at a time of unprecedented pressure. The last motion came from a "Maiden Speaker" of Essex requesting common-sense be reintroduced to the NHS.
Incredibly the whole ungainly affair finished on time and we

Dr Stephen Meech, West Kent LMC Representative called for funding to digitise patient notes to improve General Practice IT and patient care.

quickly strode the ancient flagstones to catch the southbound train. Thank you on behalf of the Kent delegates to the office for the faultless organisation and support. I can recommend the experience of attending LMC conference if you ever have the chance.

How to retire and leave the medical list and the performers list CQC registration

David Barr

Doctors deciding to retire fully from medical practice will want to remove their names from the formal Lists of General Practitioners that are held by the various regulatory authorities. It is however important to understand the role of each organisation to be sure that de-registration is done in the correct order.

If you are a single handed GP holding a GMS PMS or APMS contract and you are closing the practice and the business it is necessary to be aware that there are another set of responsibilities. Simply walking away from the practice is not an option. Please take advice from NHS England, your accountant, the LMC and your landlord well in advance of your intended retirement.

For GP partners and contract holders where business is to continue the steps you need to take are: consult with partners and give notice to retire from the practice. Many partnership agreements will require 6 months notice. Make arrangements for your pension if you have not already taken a 24 hour retirement. The practice and you will notify NHS England that your name is to be removed from the GMS or PMS agreement. Notify CQC that you will no longer be registered as responsible for the services provided by the practice.

Once these arrangements have been put into operation consider removing your name from the Performers List held by NHS England and the GMC Medical List and of course notify your medical defence organisation of the date when you will cease practicing. It is not necessary to immediately resign from the Performers List or the Medical List but there may be costs involved in remaining on the lists.

The Performers List Regulations say that if NHS England receive a notification from the GMC that a doctor's name is no longer included on the Medical List they have to act immediately to remove that doctor's name from the Performers List and to notify many other organisations that your name has been removed. You will also receive a very formal letter from NHS England advising of their action and GPs have found such letters can be upsetting. This is because the Regulations require the letter to be sent and it does not discriminate between a GP who has simply retired from one where the GMC have removed the GPs name following a fitness to practice or other decision. It is therefore advisable to always remove your name from the Performers List first. All that is needed is a simple letter addressed to NHS England Kent and Medway Area Team explaining that you have decided to retire. Once you receive confirmation that your name has been removed then remove your name from the GMC Medical List, which can be done on the GMC website by using the Voluntary Erasure procedure.

If you are a Sessional or locum GP you should also follow the above procedure and remove your name from the Performers List before seeking Voluntary Erasure from the GMC Medical List.

Please also inform the LMC.

The proposed merger of the Clarity and RCGP appraisal toolkits—*Di Tyas*

The Royal College of General Practitioners (RCGP) has just announced that they are to partner Clarity Informatics to provide a unified revalidation e-portfolio toolkit for GPs. The new enhanced system is expected to be available from late August 2014.

Current RCGP Revalidation e Portfolio users' supporting information will be transferred to the new system which will be hosted, developed and supported by Clarity Informatics, a company well known to many of Kent's GPs.

The College will contribute clinical expertise to ensure that the e Portfolio continues to be devised by GPs for GPs and draws on the experience of GPs to ensure that the new system meets their needs and complies with national guidelines. It is expected that the new tool will be reliable and easy to use through combining the best aspects of the current Revalidation e Portfolio tool with Clarity's existing system.

RCGP members currently using the revalidation e Portfolio tool will have free access to the new tool for the first 4 years after which they will receive a 25% discount to the annual subscription (currently £50). Members not using the Revalidation e Portfolio will receive a 25% discount to the annual subscription.

They emphasise that there is no need to contact the RCGP - they will be in touch with their members shortly to inform them of options and next steps.

At the time of writing there is no notified change from Clarity who also currently have an annual subscription of £50 with the offer of a group discount for 6 or more GPs. They will also no doubt make their own announcement shortly.

An Overview of Recent and Proposed Changes at the Care Quality Commission…make preparation for your visit a priority and include all the practice team

Di Tyas, Advisor

Key Messages

- *Make preparation for your visit a priority and include the whole practice team.*
- *Ring the LMC office if you would like a member of the LMC to attend as an observer.*
- *Do provide feedback to the CQC on your visit – they rely upon feedback in order to effect change.*

Changes from April 2014 Primary Medical Services Directorate.

The Primary Medical Services Directorate within CQC is concerned with general medical practice, dentistry, children and health justice, integrated care and medicines management.

Four regional deputies report to the Chief Inspector of General Practice, with a range of senior managers working with them, four of whom focus on General Practice. 28 inspection managers, accountable to the Heads of General Practice manage around 200 General Practice Inspectors.

Key Proposed Changes for GP practices from October 2014. (An evolving process that will develop and change as a consequence of pilot visits to practices from April 2014).

There are two types of inspection:

- **Comprehensive** – a review in relation to five key questions leading to a rating on each question using a four-point scale and an assessment of six population groups.
- **Focused** – follow up of a previous inspection or in response to a particular issue or concern.

CQC will inspect and rate all NHS GP practices in England between October 2014 and April 2016. Once this is completed it is likely that they will inspect services that are judged to be providing poor quality care more frequently than those that they judge to be good or outstanding. **In a minority of cases poor or unacceptable care will result in use of the full range of enforcement powers including stopping practices from providing services or prosecuting them.**

(Practices that have been inspected any time before October 2014 will be inspected again in the period from October 2014 to March 2016).

The CQC will announce which CCG area is to be visited at least four weeks before starting inspections in that area, usually giving GP practices at least two weeks' notice.

Unannounced inspections will occur if there are concerns or CQC is following up on any concerns from a previous inspection.

CQC use intelligent modelling to decide when, where and what to inspect. Inspectors use their professional judgement supported by objective measures/evidence to assess services against **five key questions:**

- **Are they safe?**
  Definition: people are protected from abuse and avoidable harm.
  Includes checking whether practices learn from safety incidents, that medicines are managed properly and adults and children are safeguarded from abuse.
- **Are they effective?**
  Definition: people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
  Includes checking people have the right diagnosis and treatment and that patients are referred appropriately. Also checks how practices prevent poor health and promote healthy living.
- **Are they caring?**
  Definition: members of staff involve and treat people with compassion, kindness, dignity and respect.
  Includes checking people are treated with compassion, dignity and respect and are involved as partners in their care.
- **Are they responsive to people's needs?**
  Definition: services are or-

ganised so that they meet people's needs.
Includes checking whether practices plan services to meet the needs of the practice population; checking to see that all patients can access appointments when they need to do so.

- **Are they well-led?**
Definition: the leadership, management and governance of the practice assures the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.
Includes checking that a practice supports its staff, provides training and supervision to make sure they are able to do a good job and has good quality governance. Also assesses how the practice proactively gets feedback from people and learns from this to improve services.

Population Groups (inspectors are finding it difficult to find evidence relating to all population groups across each of these domains during the pilot phase).

The way services are provided to the following groups will also be looked at:

- Older People
- People with long-term conditions
- Mothers, babies, children and young people
- Working-age population and those recently retired. People in vulnerable circumstances who may have poor access to primary care. (the homeless, gypsy population, sex workers etc)
- People experiencing a mental health problem.

Key Lines of enquiry (KLOEs)
Inspection teams will use a standard set of KLOEs directly related to the five key questions to focus the inspection and ensure consistency of approach – vital for reaching a credible, comparable rating. Alongside each KLOE is a description of what "good looks like" as well as a series of prompts to consider.

Evidence from four main sources will be used to answer the KLOEs:

- Information from the ongoing relationship with practice e.g. what people, carers and staff say, complaints information and stakeholder information.
- Information from intelligent monitoring e.g. patient surveys, QOF, public health data.
- Information from activity carried out during the pre-inspection phase e.g. CQC records, other stakeholders, the provider, national datasets, and service users.
- Information from the inspection visit itself e.g. what is observed, heard and what the practice tell inspectors.

Ratings will be developed and implemented from October 2014 to help people compare services and to highlight where care is **outstanding, good, requires improvement or inadequate.**

Equality and Human Rights
CQC has integrated human rights principles into KLOEs, rating characteristics, Intelligent Monitoring, inspection methods, learning and development for inspection teams and their policies around judgement making and enforcement.

Monitoring the use of the Mental Capacity Act
CQC inspects and reports on how well the service is meeting the approach required by the Code of Practice relating to the Mental Capacity Act and have reflected the importance of this in their prompts and descriptions of the ratings for safety, effectiveness and caring.

New expert teams
Inspections will be led by specialist inspectors with clinical input led by GPs. Teams usually include specialist inspectors, GPs, nurses and/or practice managers and sometimes an Expert by Experience. An inspection manager will lead the inspections across a CCG area and be the main contact with the CCG and Area Team. **Lesley Meech is the Inspection Manager for Kent.**

Workload and Costs associated with inspections
CQC will work closely with CCGs and Area Teams to share information and avoid duplication. It is anticipated that costs and workload associated with inspections may shift between these organisations, and indeed on practices themselves with those rated outstanding or good likely to have invested heavily at the outset and tailing off thereafter whilst those rated as requiring improvement or inadequate will at that stage be required to invest both time and money on improving their services and reporting to CQC.

Registration
It is proposed that the registration process be more robust for both new providers wishing to register and existing providers.

More checks will be made to ensure potential providers can provide acceptable levels of care and ensure the fitness and suitability of applicants to ensure they have the right values and motivation to provide care as well as having the right skills and experience.

NB. Remember to notify the CQC every time there is change to the partnership entity or a partner joins or leaves the partnership. It is important to allow sufficient time for new partners joining the partnership to undergo a CQC countersigned DBS check and to complete the necessary paperwork.

Do keep up to date by logging onto the CQC's website at http://www.cqc.org.uk/register and/or sign up to receive regular updates or join their online community.

Been notified of your triennial premises notional rent review?

David Barr

If you want to be sure that the rent review properly represents the market value of your premises do not just send back the PREM 1 asking for a review.

You are entitled to send attached to the PREM 1 your evidence to be taken into account when the valuation is considered by the District Valuer. The process carried out in this way is much more likely to avoid the eventual need to appeal the decision that is made. So how to collect your evidence? The best approach is to appoint a specialist Chartered Surveyor who has experience of valuing GP premises and has local knowledge. Local knowledge will ensure that the comparisons that are used are both relevant to the nature of your premises and of course will have a higher comparative rent.

Your evidence as advised by your Chartered Surveyor should give you a good idea of what action to take when you receive the District Valuer's advice to NHS England. If the DVs evidence is significantly lower then the local dispute process can be instituted, followed by an appeal to the NHS Litigation Authority if necessary. It the claim goes to the Litigation Authority your evidence and the case put by the NHS Property Services Agency on behalf of NHS England will be evaluated by an Independent Chartered Surveyor whose decision is virtually always accepted by the Litigation Authority.

If you have provided your evidence from the beginning the cost of the appeal should be minimal.

Kent LMC have negotiated agreements with 2 firms of Chartered Surveyors, details of which are on the LMC website under the Buying Group section.

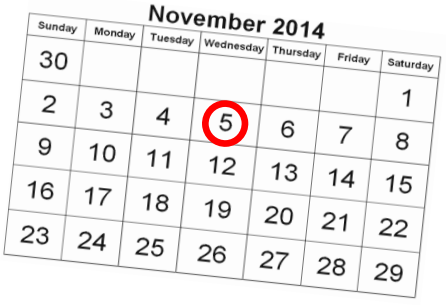
Although there is a rapid rise in residential property values this is not necessarily followed by commercial premises. However we are aware that there are practices that have not properly reviewed the valuations for some years and of course accepting a depressed value reflects in the valuations the DV advises in other nearby premises and benefits nobody.

A Date for your Diary!

The Kent Local Medical Committee have provisionally arranged their Annual Conference for

Wednesday 5th November 2014

Further details will follow shortly...



Collaborating in Kent

Dr John Allingham

We are being encouraged from all sides to work together or collaborate. The General Practitioners Committee (GPC) last year discussed co-ordinated integration in 'Developing General Practice Healthcare solutions for the future' and The Royal College of General Practitioners (RCGP) has stated that 'it believes collaborated alliances or federations will enable integrated working to become a reality'. At the national LMC conference we heard Professor Chris Ham's view of the future of General Practice which included working together in larger groups.

In Kent we have had many meetings and discussions supported or led by the LMC to help groups of practices make their own minds up whether they are strong enough to go it alone or if by collaborating can provide better services, protect existing services and preserve their own businesses.

In the Canterbury/C4 area there is a community interest company called Invicta which has existed for 5 years and has a membership of nearly every practice in the area.

More recently in South Kent Coast (SKC) the practices formed their own offshoot of Invicta sitting under the company umbrella but functioning as a separate entity. At the time of writing only 2 practices out of 31 have not joined or expressed an intention to join this organisation. The SKC Invicta was awarded £1.9m from the Prime Minister's Challenge Fund to pilot 8 to 8 working in the 8 practices in Folkestone initially before being rolled on to Dover next year. The implementation of this project is a massive challenge but the project is an example of what can be achieved through working together.

In Ashford the LMC helped practices decide between a community interest company and a company limited by shares as a vehicle to move their federation forward. The group are following the majority and forming a company limited by shares.

Gravesend and Dartford have held meetings and progress is being made to form an organisation serving the DGS area.

In Medway meetings have occurred and at the time of writing 14 practices have agreed to form a federation. Whether it will be a community interest company or a company limited by shares is still being discussed.

The LMC have helped the discussions in Tonbridge and Tunbridge Wells which was initially driven by a group of Practice Managers and a community interest company is being formed with Invicta assisting as technical advisers.

There are early discussions elsewhere in West Kent and the LMC is facilitating some of these.

In Thanet there has been a Community Interest Company for some time but it seems to be currently dormant. A small group of practices have banded together and are forming their own federation.

Swale have met and agreed to form a federation and are in the early stages of moving things forward.

One way or another most areas

of the county are coming to the conclusion that working together is a good thing and that by forming a formal entity the result of that union can hold contracts and bid for services.

The debate about Community Interest Company or Limited by Shares Company continues with advantages and disadvantages either way.

A Community Interest Company (CIC) is a cross between a charity and a profit making company that can be run so that most income from contracts held is passed to the service providers.

A company limited by shares can operate in a very similar way to a CIC but with some profit being passed to shareholders who may also be service providers. Such a vehicle is more likely to be expansionist but could also be vulnerable to takeover.

Up and down the land GPs are forming companies but there are also 'super practices' with combined contracts and lists and also some loose 'gentleman's agreement' collaborations.

Whilst it is still possible to operate alone it is becoming harder and it may be inevitable that all practices will be part of some sort of collaboration or federation in the near future.

Noticeboard

Separated Parents and Access to Children's Records

Dr John Allingham

It is common for parents post separation to mistrust the other and for the children's medical care to be part of that dispute.

One parent may ask to view the child's records or to insist on being involved in the Child's care.

Question 1
Is the child 'Gillick competent?' *(Do they understand enough to give consent for treatment?* No guidance on exactly what age but can be as young as 8 or 9)
If the child is 'Gillick competent' then records can only be disclosed with the child's instruction. This should be sought in a manner that parental coercion can be excluded and documented.
If the child is not 'Gillick competent' then...

Question 2
Does the parent requesting access have parental responsibility?
Confirm this. Either by asking the other parent for confirmation or in the event of a discrepancy by seeing the relevant documentation.

The children's act sets out who has parental responsibility and includes;

- Holding a custody or residence order
- Holding an emergency protection order
- Having adopted the child
- Being the father and having been married to the mother when the child was conceived or at some time thereafter.

In the event that a father was not married to the child's mother when the child was born he can have parental responsibility if;

- He has a residence order
- Has a parental responsibility order
- Has made a parental responsibility agreement with the child's mother
- Has since married the child's mother
- Since Dec 2003 is registered as the father under the Births and Deaths registration act.

If the parent has parental responsibility then the records can be disclosed, taking in to account the child's best interests and removing any references to third parties who may not have consented.

If the parent does not have responsibility then there is no duty to disclose although there may be circumstances when it is considered in the child's best interest.

Does a parent have the right to be updated every time a child attends the surgery?
It is reasonable for a parent to access the records at reasonable intervals but there is no requirement on GPs to agree to such requests.To be informed after every visit is fraught with practical difficulties. What if a visit is forgotten, it is not in the child's best interests or the child becomes Gillick competent. The best solution to this request is to encourage the parents to share information.

Who can consent to treatment?
Generally either parent can consent to treatment, but if there is a dispute it is best to attempt to reach agreement. If that is not possible and the GP feels that it is in the best interests of the child for the treatment to go ahead for example childhood imms and vacs then it is for the dissenting parent to seek legal recourse to stop it. If the treatment is irreversible or controversial then it is unwise to proceed without a court order.

KENT LMC Buying Group

The LMC Buying Group exists to save their member practices money on goods and services which they purchase. The Federation helps them do this by identifying suppliers with whom they have negotiated significant discounts over what practices would otherwise pay for goods and services.

For information on our current offers from our suppliers please go to:

www.kentlmc.org

and click on the blue box on the bottom right hand side of the screen.

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