September 2014

In Touch

In this issue…..

Co-commissioning of Primary Care Services

Di Tyas

In April 2013 NHS England Area Teams were tasked with commissioning, contracting and performance managing core GP Services whilst CCGs accepted devolved responsibility for commissioning local enhanced and community based services. At times the LMC has observed some confusion over the roles and responsibilities of these respective organisations as well as a degree of ambiguity over budgetary accountability.

In May 2014, CCGs were invited to submit expressions of interest to NHS England to develop new arrangements for the co-commissioning of primary care. They were invited to indicate both the scope (types of commissioning activities) as well as the nature (level of authority/ delegation) that they would be prepared to accept. CCGs in Kent and Medway we understand, consulted their member practices, some on the basis that they register an interest on the information available to them (with further decisions to be made at a later date). CCGs in Kent and Medway all expressed their interest; some were more ambitious than others to proceed at a faster pace and to consider delegated authority as opposed to joint commissioning arrangements over a wider range of responsibilities.

The LMC has given the matter some thought, having debated it at the national conference of LMC representatives in June where co-commissioning was not supported from the floor. Kent's Committee also expressed their own reservations about co-commissioning which they requested be passed on as part of our ongoing dialogue with our CCGs and the Area Team; something we see as extremely important in determining which changes to the commissioning

agenda are most likely to bring about a future we are all trying to achieve.

We are sure you will agree that the current model of General Practice has a number of strengths; not least the registered list system that does much to improve continuity of care for patients who are both familiar with and have a high level of trust in the teams that care for them. It has also seen the creation of life-long records now made widely available (in some part due to the entrepreneurial efforts of GPs and others in developing and adapting clinical systems) to inform clinically led commissioning decisions.

However you will also be very well aware that General Practice faces many challenges such as the recruitment and retention crisis as well as an increased and more complex workload with fewer resources to manage it. The national agenda indicates that care outside of hospital needs to have a stronger emphasis on the integration of health and social care systems and the delivery of primary care at scale. We believe primary care to be capable of meeting its challenges (and are aware that many of our CCGS believe this too) but this can only be achieved if the dual issues of workforce and increased resources are addressed.

The LMC believes there must be a transfer of resources between organisations and sectors to reflect a population based service outside of hospital that includes general practice (working at scale) with community nursing, social services etc. In order to achieve this we also believe that the Area Team, CCGs and Social Services must work more closely together. Our concern however is that this may result in a transfer of responsibilities in respect to contracting with general practice from the Area Team to CCGs.

Currently Area Teams are responsible for the performance management of individual GPs as well as the overall performance of practices. They also have responsibility for strategic premises decisions and contract management. The LMC would be concerned if CCGs were to hold the core practice contract because of the innate conflicts of interest that would place upon them as membership organisations. Whilst we believe that there is benefit in working in a more integrated way to ensure that decision making is better informed and more likely to lead to a better and more imaginative use of resources (e.g. decisions about premises and the future of practices) we do not believe that CCGs should be the ultimate decision makers.

Furthermore, we are concerned at the very real dangers that may arise if CCGs take on a range of new responsibilities. History shows that positive relationships forged with providers at local level suffer when organisations become large, remote entities struggling under a weight of bureaucracy (best dealt with at a much higher level). Not only is this likely to damage the sense of ownership that should be inherent in a membership organisation, but there is a very real danger that the relevant skills and resource transfers would not take place and individual CCGs would be unable to deliver a significantly increased commissioning agenda.

To summarise, whilst the LMC supports CCGs in terms of expressing an interest in co-commissioning and developing these ideas further, we firmly believe that the performance procedures for individual practitioners and performance management of general practice Contracts should remain firmly outside of CCG direct control. However, we are equally of the view that CCGs should be involved in these matters as they will clearly impact on the delivery of healthcare for their populations.

The LMC is pleased to have been invited to work with both the Area Team and Kent & Medway's CCGs in taking this work forward. We realise the importance of working together to stand the best chance of achieving a more effective commissioning model rather than just another organisational change. We are however also realistic enough to know that frequently it is only possible to influence at the edges – but that can make a big difference to individuals on the ground.

Breaking news as we prepare this article for the September In Touch, is that Area Teams are to merge (thereby becoming more remote organisations, and making it more likely that increased responsibilities will be delegated to CCGs). The more astute amongst us might recognise the new structures as akin to regional offices with PCTs?

Immunising your front line staff

Di Tyas & Mike Parks

Flu immunisation season is nearly upon us. The GMC in Good Medical Practice states "You should be immunised against common serious communicable diseases (unless otherwise contraindicated)". I believe the NMC takes a similar stance. It is obviously very important that frontline primary care staff are not an infection risk to patients. It also helpful if there is a flu epidemic that you and your staff are available to deal with it.

As you are aware flu vaccinations have been administered to front line practice staff as part of the Occupational Health Service Contract delivered by Heales Medical for many years. In order to increase access to more members of staff, the Area Team have commissioned a flu voucher scheme as opposed to a personally administered scheme. The changed process in respect to flu vouchers has resulted in an increase in numbers of staff able to access the service from 370 to 525.

We understand that Heales Medical will retain responsibility for managing the scheme and distributing the vouchers to practices who will need to apply on a **"first come, first served"** basis. Vouchers will be issued free to practice staff who will need to present their voucher at a high street pharmacy in order to receive their flu vaccination.

Healing your energy bills

Dr Mike Parks

As we all know the cost of energy seems to rise inexorably. With this in mind it is worth spending some time looking at the various green energy initiatives that are available.

Like all energy consumers, practices can benefit from the Feed in Tariff scheme which pays for electricity generated through solar panels or other renewables. This means that practices can earn money to generate electricity, use that free electricity and earn an income for exporting it to the grid.

The Renewable Heat Incentive (RHI) offers financial incentives to generate heat. Technologies such as biomass, ground and water source heat pumps also earn an income for each unit of heat generated.

Combining renewables with LED lighting, which use a fraction of the energy of traditional lamps and last many times longer without maintenance, can also significantly reduce a practice's energy costs.

Dr Caroline Jessel, the Sustainability lead at the Area Team is very happy to offer advice and guidance on the various schemes available to practices, and can be contacted on 0113 8248540 or email cjessel@nhs.net.

With thanks to Dr Caroline Jessel, Clinical Strategy Lead, Kent and Medway Area Team, Lead for Sustainability and Health, South Region NHS England, *for providing this information.*

A new Academic Primary Care Unit for Kent

Patricia Wilson, Professor of Primary & Community Care, Kent Academic Primary Care Unit

A new academic primary care unit has been set up at the University of Kent, Canterbury. With initial funding from Health Education Kent, Surrey, and Sussex, it is one of a number of initiatives led by Professor Abdol Tavabie (KSS Deanery) to address the workforce issues in primary care. The unit is headed up by Professor Patricia Wilson who has a track record of research in patient experience of primary care services, self-management in long-term conditions, and patient and public involvement.

The unit's primary aim is to attract high calibre primary care workforce including GPs into the county. From next year it will be running an intercalated BSc for medical students in Management in Primary Care. Intercalating is an attractive option for brighter students, and those that want a year out of their clinical degree to study an area in more depth. The course will be delivered in partnership with the University's Business School – one of the leading ones in the country. Couple this with the University being in the top 20 nationally for student experience and focused placements in local practices, the aim is to hook medical students into considering general practice as a career in Kent. That's obviously more a long term benefit, and in the shorter term the unit wants to attract GPs to the county through academic clinical fellowships; allowing them to develop particular research areas alongside their clinical practice.

The unit is also there to support existing GPs and other members of the primary care workforce. An MSc in Applied Health Research has been developed for those in clinical practice who want to develop their research skills alongside their work in practice. GPs can also use the unit as a source of advice for their own research ideas. The unit is also supportive of one of the other key workforce initiatives introduced by Health Education Kent, Surrey and Sussex; the Community Education Provider Network (CEPN). The CEPN provides a coordinated and resourced network to facilitate placements for multi-professional learners who will be the primary care workforce of the future. The initial focus will be on student nurse placements in general practice with the aim of presenting practice nursing as an appealing career option.

For more information about the unit go to: http://www.kent.ac.uk/chss/research/groups/primarycare.html

MSc Applied Health Research http://www.kent.ac.uk/courses/postgraduate/752/applied-health-research#!overview

Intercalated BSc http://www.kssdeanery.ac.uk/opportunity-medical-students

GMS Contract Variations October 2014

Di Tyas

Regulation 28. The small matter of registering patients from outside the practice area.

Regulation 28 is enabling legislation for which a contract variation notice has recently been issued **although the introduction of the scheme, planned to start on 1st October has now been postponed until 5th January 2015**. This regulation enables practices to register patients from outside their practice area should they wish to do so *without any obligation* on them to provide home visits or out of hours services when the patient is at home, away from, or unable to attend their registered practice.

Out of Area patients (as they are called) do remain entitled to the full range of primary medical services, however the NHSE Area Team will be responsible for ensuring they are able to access all services when they are at home and cannot attend their registered practice. It is widely expected that an Enhanced Service will be made available to allow practices to provide care for this group of patients whilst they are at home. However in the absence of further detail we cannot see how practices can register for this service when it is not clear what is expected of them or what they will be paid. Neither do we feel it can be safe for patients to be registered in this manner until there is a service commissioned for them should they feel ill at home. For this reason, whilst we understand that the Area Team requires practices to sign the Contract Variation they do so **as enabling legislation only with no obligation on practices to register out of area patients.**

Area Teams and practices now have a further 3 months to ensure arrangements are fully in place.

Patient online Services - did you know?
Also subject to the same variation notice and tucked away in the regulations (paragraph 16.5) is a requirement that practices publish a Statement of Intent by 30th September 2014 if they are unable to provide patients with access to view summary information from their records. The statement should outline the practice's plans to meet this requirement by 31st March 2015 and be displayed in the surgery premises (and on the website if applicable). Please see a summary of the regulation below.

Patient online Services
Under this regulation practices must promote and offer to its registered patients the facility for a patient to book, view, amend, cancel and print appointments online, order repeat prescriptions for drugs, medicines or appliances online and to view and print a list of any drugs, medicines or appliances in respect of which the patient has a repeat prescription in a manner which is capable of being electronically integrated with the computerised clinical systems of the practice.

Practices must also promote and offer their patients access online to summary information derived from their medical records and the ability to view online, electronically export or print any summary information derived from their medical records.

Where there is a practice website, the practice must promote and offer to its registered patients the facilities above on that practice website.

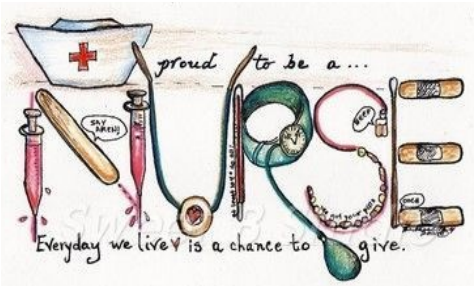
These requirements do not apply where the Contractor does not have access to computer systems and software which would enable them to offer the online services described, however as stated above, practices must publish their plans to enable them to achieve that requirement by 31st March 2015.

Introduction to Practice Nursing Course

Dr John Allingham

The Kent & Medway GP Staff Training and Education team have been sending nurses in the early stages of their careers with considerable success. The current courses have vacancies!

Please encourage your new and nearly new Practice Nurses to sign up.



Learning Points from Operation Landscape

Dr John Allingham

Operation Landscape is the code name that has been assigned to all matters pertaining to the shocking case in which a Kent GP received a six year sentence for indecent assault and for possessing and making indecent images of children.

Chaperones

The importance of the presence of chaperones and their training was highlighted. Practices should display notices in consulting rooms advertising chaperones, they should be offered for all intimate examinations and considered for many other examinations, chaperones should be trained and ideally make their own contemporaneous entry in the medical record. Practices are reminded that chaperone training is available through the Kent and Medway Staff Training team.

Photography

The use of photography in surgeries must be closely monitored and written consent obtained and kept. Cameras used should be dedicated for the purpose of medical photography and images stored only on practice computers. The use of a mobile phone to take a quick snap of something interesting is not a good idea because of the potential to transport or transmit the image without consent.

Empowerment

Practices must have whistleblowing policies so that staff are aware how to report concerns in an anonymous way so that they do not feel either threatened or it compromises them. Staff and patients should feel empowered to be able to raise concerns.

Registration of Staff

Many practices still have staff members registered with the practice as patients. The GMC good medical practice recommends that wherever possible you should not treat people with whom you have a close personal relationship. The conflict between being an employer and a medical adviser to an individual is obvious and we strongly urge practices not to have employees who are registered as patients.

Partnership Agreements

Yet again we cannot emphasise enough the importance of having an up to date partnership deed or agreement signed by all parties.

These are just some of the learning points from this event. We are planning to cover these issues and other issues in more detail in future editions of In Touch.

The Importance of Pertussis Vaccination in Pregnancy - *Dr Mike Parks*

All pregnant ladies should be offered Pertussis vaccination at between 28 and 38 weeks of pregnancy. Preferably between 28 and 32 weeks. There are no safety concerns about the use of inactivated pertussis vaccine in pregnancy although a confirmed anaphylactic reaction to a previous dose of pertussis containing vaccine or to a component of the vaccine including neomycin or polymyxin are absolute contraindications.

Vaccinating pregnant women during each pregnancy between 28 and 32 weeks will ensure that high levels of antibodies against pertussis cross the placenta from the mother to passively protect the baby when it is born. Unfortunately there has been an incident in Kent when a baby did not benefit from this protection and had to spend some of their early life in hospital. A Root Cause Analysis has been undertaken about this incident. This includes a summary of the key points, contributory factors and some recommendations and is available by contacting phst@nhs.net. Practices need to consider how they are going to make this important vaccination available.

Midwives should be reminding ladies at booking and during their care of the need to attend their GP surgeries for vaccination. Anecdotal evidence suggests this may not always occur. A good practice might be to issue a verbal reminder at the first contact with a pregnant woman and recording it in the records.

The practice responsible for the baby in this incident have set up a system which seeks to identify pregnant women and sends them a reminder letter at about the right time. This is good practice but there is no additional funding for the administrative costs.

Do I need a Water Hygiene Risk Assessment?

Rosemary Jones, Invicta Chartered Surveyors

Judging by the calls I have received from practices on the subject, there is confusion, even at CQC level, about whether surgeries need to test for legionella and, if so, what management procedures need to be in place thereafter.

The short answer to the question in the title to this article is yes. The extent of testing and management depends on the complexity of systems in a building where legionella might be present and the outcome of the risk assessment. Doctors and Practice Managers have a duty to identify and assess sources of risk, manage that risk, prevent and control it and keep records of management systems in place. As a minimum, you might simply be limited to regular testing of water temperatures and keeping written records of the sampling.

The risk from legionella exists if water temperature is between 20 and 45°C, there is a means of creating and/or spreading breathable droplets, a building has a water storage system and it is likely to contain a source of food for the organism, such as contaminants from the surroundings such as sludge, rust, scale, organic matter or biofilms.

In GP surgeries, the risks of legionella being present are most commonly located in the hot and cold water systems. Temperature control is the traditional strategy for reducing the risk of legionella. Cold water systems should be maintained, where possible, at a temperature below 20°C. Hot water should be stored at least at 60°C and distributed so that it reaches a temperature of 55°C within one minute at the outlets/taps. Other sources of contamination might be found in evaporative cooling systems, humidifiers and air washers.

There are various codes to be followed in controlling legionella in water systems and, for some (not so light) bedtime reading, you should refer to the HSE documents *L8 ACOP Legionnaires' disease: The control of Legionella bacteria in water systems* and *HSG274 Part 2 Legionnaires' disease: The control of Legionella bacteria in hot and cold water systems*. For specific guidance on GP surgeries, refer to *Health Technical Memorandum 04-01: The control of Legionella, hygiene, 'safe' hot water, cold water and drinking water systems* available to download free on www.gov.uk/dh.

Carrying out a risk assessment is the first step in meeting your duties to identify, prevent and control the spread of legionella and is your responsibility. Also bear in mind that it is likely, owing to the nature of your business, that patients and employees are more susceptible to infection due to age, illness, and a weakened immune system. You may be competent to carry out the assessment yourself but, if not, you should seek the advice of an outside consultant who is competent to undertake the work.

If you decide to employ contractors to carry out the risk assessment, water treatment or other work, it is still the responsibility of the competent person to ensure that it is carried out to the required standards. There are a number of external schemes to help source the right advice, for example, The Legionella Control Association, which holds a register of assessors (www.legionellacontrol.org.uk).

Rosemary Jones
Invicta Chartered Surveyors
www.invictasurveyors.com

Premises Lease Agreements

Di Tyas

Please remember that the NHSE Area Team will require sight of any lease agreements that you enter into prior to approving any premises schemes.

Whilst neither the NHSE Area Team nor NHS Property Services Limited are party to the lease, they are interested in the terms agreed between the parties. This is relevant in any situation where a lease rental is being negotiated as the lease terms will affect the District Valuer's Assessment. Failure to agree lease terms with the Area Team or NHSP could lead to the non-acceptance of a rental scheme or at the very least a reduced sum.

Safeguarding Training

Dr John Allingham

The online safeguarding training programmes accessed with an NHS account are currently free. It is our understanding that charges will be levied beginning sometime early in 2015.

Kent LMC Representatives

Dr Gaurav Gupta, LMC Vice-Chairman

Dr Gaurav Gupta, LMC Vice-Chairman and Canterbury & Coastal LMC Representative

Local Medical Committees, LMCs, are elected bodies which represent the interests of local GPs. The GP representatives who form the LMC are elected democratically by the local GPs. The constituency for these elections could be based on the CCG areas, geographical areas etc.

The LMCs are a great source of help and support for GPs and their practice managers in dealing with professional and partnership difficulties. The LMCs negotiate with other organisations like NHS England, CCGs, Community Health Trusts on behalf on the GPs.

The LMCs are funded by levies paid by the practices based on their list size. The LMCs in turn pay levies to the GP defence fund, GPDF, which funds the activities of the GPC. The GPC, General Practitioners Committee, negotiates nationally with the government and other organisations on behalf of all GPs.

I got involved with the Kent LMC soon after I finished my GP registrar year. I wanted to try and address the issues facing the GPs locally. I have now been an LMC representative for more than 7 years and was recently elected Vice Chair of the Kent LMC. I have found the role very exciting and interesting.

An LMC representative's main job is to represent the views and interest of their constituents. There are also opportunities to get involved in negotiations with other bodies and supporting colleagues. It gives me a chance to interact with other GPs locally and nationally, and keeps me abreast of any changes affecting the NHS and Primary Care. Kent LMC pays a sessional fee to representatives for time spent attending any meetings on behalf of the LMC.

If you are passionate about primary care and are interested in doing something to tackle the challenges faced by General Practice you will enjoy LMC work. Most of the skills you would gain working for the LMC are transferable and valuable in a GP's day to day clinical and management work. I would definitely recommend LMC work to all new and enthusiastic GPs.

If you are a Kent GP or GP trainee and want to find out more please feel free to contact me on g.gupta@nhs.net or visit the Kent LMC website at http://www.kentlmc.org.

A Sad Farewell to Debbie Burton

Di Tyas

On Friday 12th September, members of the NHS family joined the many friends and family of Debbie Burton to say a sad and premature farewell to a much respected colleague.

Debbie was the General Manager of the Kent Primary Agency for many years, working extremely hard to ensure the service provided to practices was as good as it could be. Evidence of her success in this regard could be seen when in recent times on more than one occasion, the Kent Primary Care Agency came under severe threat from a national system and Practice Managers rallied in their numbers to the support of the service and the staff that they had known and valued over many years. Always doing the best she could for her staff, Debbie was popular with her team and with all of us who came into contact with her during our working lives. I think it is true to say that even if a practice did not personally know Debbie Burton, they will have seen the results of her hard work at the KPCA over the years.

Diagnosed with Non-Hodgkin's Lymphoma in 2012, Debbie fought bravely against the disease, continuing to work for as long as she could; accepting in her last year or so an invitation to join the team advising the NHSE on the redesign of Family Health Services across the country.

Debbie became ill once again at the end of 2013 and died aged 48 in August 2014. She will be sadly missed by family, friends and colleagues alike.

Free Premises Surgery

We are pleased to inform you that Rosemary Jones, Invicta Chartered Surveyors, Edwina Farrell & Nathan East, DAC Beachcroft LLP, have agreed to run a further FREE surgery for practices on Thursday 16th October, at the LMC office, to discuss any issues you may have concerning your premises. If you would like to take advantage of this opportunity please give us a call on 01622 851197.

Noticeboard

Di Tyas

Will be retiring from the LMC at the end of October 2014

We would like to invite you to drop in for Afternoon Tea to mark this special occasion

Between 1-5pm on Tuesday 28th October 2014

At the LMC Offices, 8 Roebuck Business Park, Ashford Road, Harrietsham, Kent ME17 1AB

RSVP by 20th October 2014 to Kelly or Clare on 01622 851197 or email info@kentlmc.org

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At this time of unprecedented challenges, don't miss this opportunity to hear from keynote speakers on the future of primary care.

5th Annual Kent LMC Conference

Primary Care - A Time of Challenge!

13.30—20.00 (Refreshments and Evening Buffet included)
Ashford International Hotel, Simone Weil Avenue TN24

Wednesday 12 November 2014

Keynote Speakers

1. **Ruth Rankine**
   Deputy Chief Inspector, Primary Medical Services, CQC
   Current Challenges
2. **Julian Sheather**
   Ethics Manager *British Medical Association*
   Medical Ethics and the Mental Capacity Act
3. **Michael White**
   Assistant Editor, The *Guardian*
   A Political View
4. **Dr Neil Bacon**
   Founder & CEO, iWantGreatCare
   Making the Friends and Family Test work for you
5. **Dr Brian Balmer**
   GP Executive
   General Practitioners Committee

To book your place, please email info@kentlmc.org.

Tickets are available at a subsidised rate of £50 per person (£25 for GP trainees).

We are delighted to announce that we have now secured additional funding and are therefore in a position to offer this conference ***FREE*** *to attendees**

***Please Note:** places are available on a first come first served basis. Non-attendees will incur a charge to cover catering costs. Closing date for booking: **Wednesday 5th November 2014**

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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