KENT LOCAL MEDICAL COMMITTEE Est. 1912
Supporting list based personalised care, the partnership model and meaningful collaboration

In Touch

December 2018

In this issue.....

Kent & Medway Primary Care Board - Request for help

Dr Mike Parks, Medical Secretary

Kent and Medway Strategic and Transformation Partnership (STP), with encouragement from the LMC and support from the CCG Clinical Chairs and others, has established a Primary Care Workstream headed up by a Primary Care Board.

Fiona Armstrong, Clinical Chair, Swale CCG and I co-chair the Board. This may not seem a major step but in fact this presents a real opportunity for General Practice and Practitioners to be directly involved in planning the future of Primary Care in our patch.

As such it is obviously very important that this Board remains grounded in grassroots general practice. I believe this can be achieved by making sure that the LMC itself is key to setting the agenda and agreeing priorities.

The Board is charged with writing a Kent and Medway Primary Care Strategy. Early discussions have suggested that the following might help.

1. Workforce and workload initiatives, including workload shift from Secondary Care.
2. Kent and Medway wide Patient Offer - a comprehensive list of enhanced services that are properly funded and can be delivered by General Practice.
3. A long term investment plan that stabilises General Practice.
4. Education, Training and Support for newly qualified GPs. Helping to provide good reasons to want to work in Kent and Medway.
5. Wider more flexible employment opportunities, including some support for developing portfolio careers.
6. Ensuring that General Practice is a safe place for patients and staff.
7. Supporting the development of practice based Local Care (Out of Hospital Care).

This list is not meant to be exhaustive. So for example we also need to think about the needs of GPs in mid career and approaching retirement. Retention is obviously an important issue. So is the future of General Practice Nursing and Practice Managers.

The LMC itself has also come up with a list of potential solutions, including the better use of technology, better coordinated out of hours and extended hours services, more training on tiers of care, more funding for the 10 High Impact Actions, a properly commissioned Primary Care led frailty scheme, more work with Secondary Care in avoiding shuffling work round the system, uplifting existing Enhanced Service payments.

We are all very aware of the pressures facing General Practice. My ask of you all is that if you have some ideas or solutions that can be delivered locally I'd be very glad to hear them. I can be contacted at the office or on mike.parks@kentlmc.org. If you have more general points including suggestions that will need national implementation please also contact me and I will feed them up into the National negotiations via the GPC.

Thank you

Conference of England LMCs, November 2018: Opening Address: *Dr John Allingham, Medical Secretary*

Conference began in the traditional way with a rousing and passionate speech from the Chairman of the General Practitioners Committee (GPC), Richard Vautrey.

Richard reminded us that NHS winter pressures are now mythical and are all year round and that nothing short of a properly funded NHS built on the bedrock of General Practice will do. He congratulated the BBC on catching up with society and recognising that Doctors can be women although they don't all come from Huddersfield. In fact conference started with an entirely female podium team.

To a rallying call of 'it's about time' Richard observed that we have had 12 years of 0% pay growth and still 96% of practices are good or outstanding when CQC inspect, and that this is achieved by the hard work and goodwill of all the staff in practices.

There are some signs of improvement. The number of GP trainees is rising and £370million of new funding has come into the GMS contract. The new Secretary of State for Health, Matt Hancock, has recognised General Practice as the 'bedrock of the NHS' and that there is a need to shift the balance of resources towards primary care.

Dr Richard Vautrey, Chair of the GPC

'We are winning the argument for primary care but it means nothing without action'.

Richard gave what is becoming an annual moan about Capita. This year it followed the debacle of the failure to notify women of cervical smear results and the continuing hardship caused by the incompetent handling of our pensions. It is clear you 'cannot outsource responsibility'.

There was a call to scrap Out of Area registration regulations to prevent the cherry picking of fit and health IT savvy patients for on-line services for profit only.

The partnership review and a fair state backed indemnity scheme were seen to be positives.

Richard finished with a flourish to the 'it's about time' theme and received the customary standing ovation.

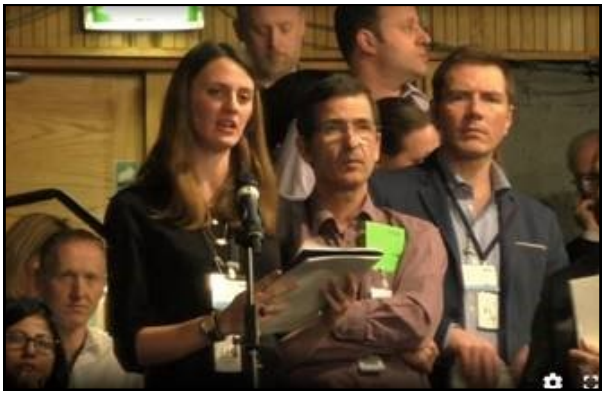
'It's about time! If hospitals are to thrive, if prevention is to happen, if we are to have a healthy future and a population with confidence in General Practice then we must invest in General Practice'.

Morning Session: *Dr John Allingham, Medical Secretary*

Conference was highly critical of the Babylon run GP at hand ser-vice with one Gerald Reissman musing whether they would ac-cept Teresa May with her Type 1 diabetes as a patient and enquir-ing what other practice gets to vet its patients before accepting them. The independent review due to be published before the end of the year was welcomed and 'dismay' was expressed with Matt Hancock flagrantly endorsing the service from Babylon Headquarters.

The rise of Alternate Primary Care providers with their potential to destabilise the local health economy were criticised and there was a call to the government to halt the roll out of these schemes until properly evaluated.

There was a tight vote carried 126 to 99 on whether the GPC should instruct all providers to deliver a full range of services, equitably, to all patient groups based on age, sex and morbidity or technical competence.

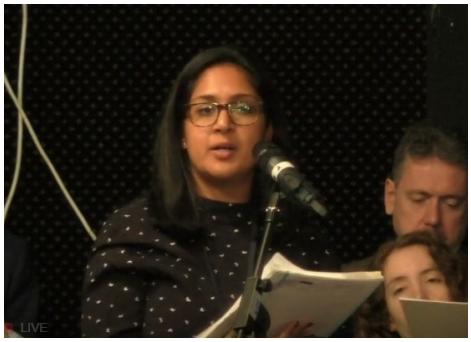


Dr Alicia Watts, Canterbury & Coastal LMC Representative, addressed Conference in the themed debate

The subject of Gender services was debated with calls to ensure no GPs were pressurised to prescribe outside their clinical competence. The same motion called for safe and effective monitoring of patients with eating disorders and for the commissioning of appropriate services for the management of substance abuse.

Referral management schemes, post code lotteries, the surfeit of templates and the general dumping of work from secondary care to GPs were soundly criticised by conference.

Conference approved a motion pointing out that general practice is not an emergency service and condemned the downgrading of ambulance calls from GP practices, called to end the diversion of GPs and their staff to deal with local emergencies and for NHS 111 to be properly evaluated. In fact one speaker called for 111 not to be evaluated but scrapped and



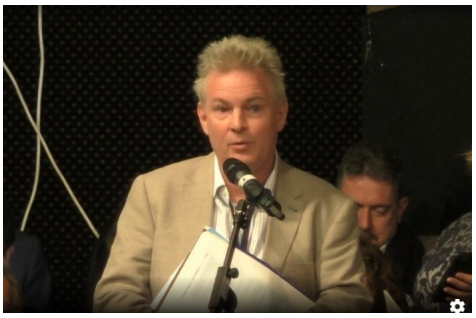
Dr Sarah Westerbeek, LMC Sessional GP Chair, spoke about Partnership Model Contracts

replaced with a clinically led system.

An hour of conference was given to a themed debate on the subject of partnership, where our Kent reps, Drs Alicia Watts, Sarah Westerbeek, Zishan Syed, Neil Potter and Gaurav Gupta were able to put 60 seconds of wisdom to conference.

The morning session continued with a debate on partnerships with calls to introduce measures to reduce the financial and property risks that discourage GPs from joining and continuing in this role.

Finally we debated working at scale and the development of Intermediate Care Systems before breaking for lunch.



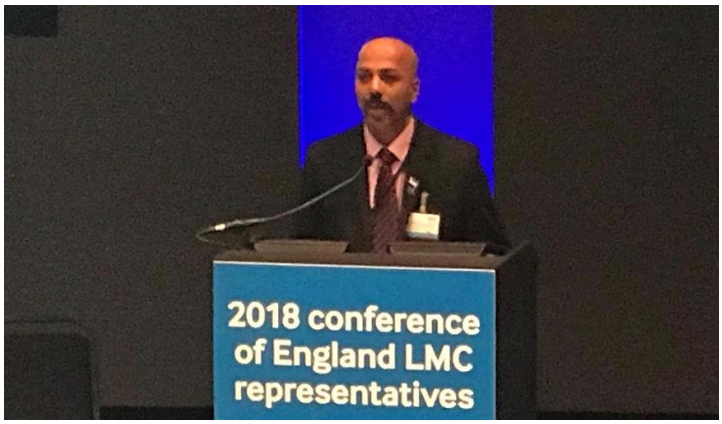
Neil Potter, West Kent LMC representative, pleads for the small practice with their high satisfaction levels.

Afternoon Session:
Dr Caroline Rickard

What an afternoon it was! Kent LMC dominated the second half with heartfelt speeches which commanded a standing ovation, singing (in tune!), and calls for conference to untether ourselves from the traditional contract and consider a co-payment model.

We started the afternoon with Regulation. This has been debated before, however, feelings are running high and many motions were approved unanimously for the GPC to move forward. Highlights of motions passed include - That Conference believes CQC visits add an unnecessary burden to the GP workload and demands a minimum interval of five years between visits for practices achieving 'good' in the last five years. Delegates spoke passionately about the negative effects of CQC inspections, the GPC responded that new approaches to inspection are more collaborative.

Zishan Syed and Gaurav Gupta spoke passionately about NHS England performance management procedures in primary care, including functions of the Performance Advisory Groups and Performers List Decision Panels. Zishan spoke of regulation in the UK being out of control and of the limited protection of vexatious complaints, the guilty until proven innocent stance of the regulators. Our Chair, Gaurav Gupta received a standing ovation following his personal reflection of the PAG process and calls for anonymity of doctors being investigated, and a more transparent process moving forward. Other delegates highlighted that there is no appeal to the PAG process and NHSE are free of scrutiny and control. With investigations being inflexible, exhaustive and performers being judged against Gold Standards. Conference calls for the process to follow clear and unambiguous rules and be transparent and accountable.



Dr Gaurav Gupta, Kent LMC Chair, received a standing ovation following his personal reflection of the PAG process

We then moved to Practice Based Contracts, Guy Watkins called for a new contract. Our Vice Chair, Richard Claxton highlighted that there is no inflationary uplift for payments for enhanced services, conference passed that payments for enhanced services should be index linked.

Dr Richard Claxton, LMC Vice-Chairman, highlighted that there is no inflationary uplift for payments for enhanced services

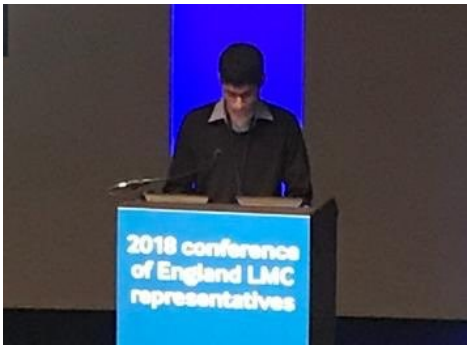
Conference heard how the challenge of excessive workload is giving even more stress to GPs. Could reducing core hours by 30 minutes or limiting the number of patients per GP be the answer? There was a very close vote against both of these from Conference. A reduction of core hours would have ramifications for core funding (reduction of 5%). Stipulating a limit of 1500 patients per full time GP could threaten the viability of the profession.

GP Retention, Kent's Neil Potter sung 'When I'm 54', we heard of the GP Career Plus scheme which has been successful in other parts of the country at retaining GPs who are towards the end of their careers. Conference called for the GPC to negotiate an incentive scheme with NHS England to acknowledge the expertise of sen-

ior doctors.

Information Management and Technology – we heard of slow IT/ Wi-Fi, Docman malfunctions, System IT failures and calls for adequate renumeration of GPs time when these failures occur.

Kent's Zishan Syed proposed the motion that Conference demands a Co-Payment Model. We heard how the five year 'backward' view is not helping General Practice in the way it was set out to do. Many areas already in the NHS have a co-payment model in place (eg. dentists, opticians). This motion was debated fiercely with some members of Conference feeling that insurance-based healthcare could be a bureaucratic nightmare. Cambridge colleagues likened the potential reduction in demand to charging for carrier bags where a 86% reduction occurred following implementation of a payment model. Following the debate delegates cast votes of 81 for and 131 against.



Dr Zishan Syed, West Kent Representative proposed the motion that Conference demands a co-payment model.

The failure of the government to implement the DDRB recommendation of a 4% award was highlighted as an insult to the profession. It was called on the government to establish a truly independent pay review body for doctors, which binds them to award the recommendations made, in the same way that applies for MP's pay.

Kent proposed the motion on premises which was passed unanimously. NHSPS, a wholly owned subsidiary of the Department of Health and Social Care is destabilising general practice through unilateral increases in service charges. NHSPS should immediately withdraw these demands, and should pay compensation to affected practices for the expense and distress caused. We heard heartfelt speeches of sleepless nights caused by service charge bills for tens of thousands of pounds appearing out of nowhere, with no justification. When asked to itemise the bill NHSPS are unable to and then randomly slash thousands off the bill with no explanation. Hardly an organisation which inspires the confidence of the profession. With motivations unclear, what is clear is that they are a threat to affected practices and are not operating in the interests of patients or the NHS estate.

State Backed Indemnity – this motion was accepted as new business since the rumours that state backed indemnity could be funded from existing GP funding. This is a red line. Conference felt strongly that this could be a death nail for the partnership model. How can it be called state-backed indemnity? If the government are genuinely serious about partnership they cannot give with one hand and take with another. They urge the Department of Health to seize the opportunity to put words into action.

Reflections from a first time attendee

"Induction for newcomers like me was extremely helpful.

Arrangement for electronic voting was useful. All the staff at Reception were only too pleased to help us all. Kent issues were raised to a flying achievement. I was pleased to see the good & the great in one place and able to raise the issues of concern to GPs.

I felt supported by our group from Kent LMC."

Dr Awadh Jha, Swale LMC Representative

Kent LMC Annual Conference 2018

Professor Sir Chris Ham, Chief Executive, Kings Fund: Integrated Care

Donna Clarke, Practice Liaison Officer

Professor Sir Chris Ham began by highlighting the Kings Fund report "Understanding pressures in general practice" which looks at issues including lack of funding and workforce and can be found on the Kings Fund website https://tinyurl.com/k46udas

He went on to say that it is widely acknowledged that general practice is the cornerstone of the NHS and he talked about the changing face of general practice and the emergence of models such as Primary Care Home, MCPs, PACS, Super partnerships etc. Kings Fund have produced various reports on the changes and also on the introduction of Sustainability and Transformation Partnerships (STPs). He commented that he has never known a time in the NHS when it was so fragmented and STPs are meant to be addressing this. There are now 14 Integrated Care Systems (ICSs) in England including our Kent and Medway STP. There is a vague national plan but no blueprint so all


Professor Sir Chris Ham, CEO, The Kings Fund

14 ICSs are being allowed to implement however they see fit.

Chris talked about the example of South Yorkshire where partnerships between hospitals, practices, community care and mental health are working on the principle that it is better to do things once than have multiple versions of the same thing e.g. developing IT and estates strategies. The whole system should benefit when everyone works together.

Wigan Healthcare are working on the premise of listening not consulting. Their ICS is led by the council and they are already seeing outcomes including the fact that Wigan has been declared the happiest place to live in Greater Manchester! There are less people being admitted to hospital with alcohol related problems. They have developed a community soccer team and a rugby league team (who are all dementia friends). This is currently being written up as a case study by Kings Fund.

He then went on to talk about Canterbury, New Zealand where they are making huge progress integrating health and social care led by GPs, Specialists, Nurses and a wide range of AHPs. They made time for GPs and Specialists to sit down and talk about pathways for the most common conditions. Together they undertook a piece of work deciding what the ideal pathways would look like for around 100 conditions, which took around 18 months. Primary care teams have been enabled to do more by being given more resource and more staff to avoid referrals to secondary care. The process has made this work, not the product – talking and renewing acquaintances with one another. All practices in Canterbury, NZ belong to a federation called "Pegasus" which was a key enabler. They could not have achieved the same results with just a few leaders sitting round the table. There are some similar examples in this country such as Manchester and Surrey Heartlands.

Chris ended by stating there is no Plan B! The whole country has to create ICSs and move away from Lord Lansley's legacy of competition.

Mr Glenn Douglas, CE, Kent & Medway Sustainability and Transformation Partnership (STP): Kent Vision

Mrs Liz Mears, Director of Operations, Kent LMC

Glenn Douglas gave an overview of what the STP is and what it is trying to achieve as one of the 44 STPs in the country.

Transforming Health and Social Care is the five year ambition. Kent and Medway have translated this into four transformation themes and work programmes:

- Care transformation
- System leadership
- Productivity
- Enablers

The Clinical and Professional Board has developed a clinical vision outlining how to deliver health and social care services in the future following extensive consultation.

Glenn described the local care model which is initially focussing on frailty and the Dorothy model. The development of the Strategic Commissioner could, to those of us who have been around long enough look like the return of the Strategic Health Authority?

The Primary Care Workstream and Board is key to help address the fragility of primary care, specifically looking at how to support practices and networks in

Mr Glenn Douglas, CE, Kent & Medway STP

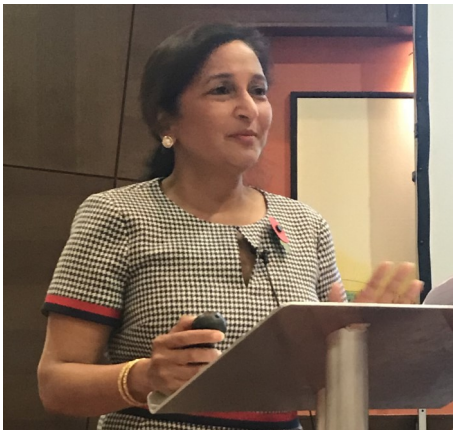
2018/19. A Workforce Strategy and Primary Care Strategy are developing well to set the direction from 2019/20 onwards.

Dr Mina Gupta, Chair, Modality Partnership: Building Partnerships

Mr Carlo Caruso, Deputy Clerk, Kent LMC

The third speaker of the day was Dr Mina Gupta. Mina is a GP and Group Clinical Chair with Modality and, following the theme from previous speakers, Mina described how general practice working at scale has impacted on the working lives of her and her colleagues, and how it has created an opportunity to work collaboratively with other parts of the health and social care system.

The trials of general practice in Birmingham were not unique. It too had to deal with the challenge of how to continue to deliver high quality and accessible care in the headwinds of increased workload and fragmentation of health services. Practices in Birmingham saw coming together as an opportunity to maintain quality, improve resilience and create economies of scale to support functions. They also introduced technologies to support service delivery and regain some control over day to day workload.



Dr Mina Gupta, Chair, Modality Partnership

The ambition for Modality came to be more than simply finding a

means of survival. Working at scale proved to be a platform for reshaping how healthcare services were delivered. Modality's vision is for general practice to be the foundation for a new community-based health and care system, with primary care providing a single point of access into a broader range of integrated community, mental health and social care services. Its projects focus on moving care into the community and reducing A&E attendance and unplanned hospital admissions.

Mina's experience reflects a vision the LMC has been promoting for a while. Collaboration, regardless of the structure, is a vehicle through which general practice can begin to address the challenges it is faced with. More than this, working together offers an opportunity to move forward.

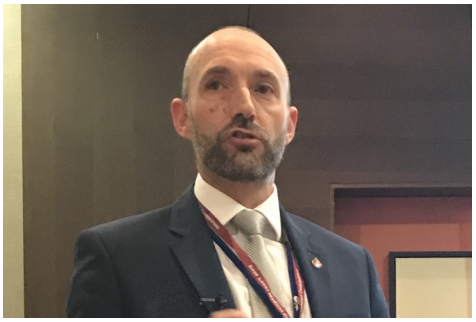
As Chris Ham had mentioned earlier, the emergence of STPs and the move away from Lansley's structure of competition to increasingly integrated systems, will result in traditionally hospital-centric services giving way to locality centred models of care. Mina offered a vision of how GPs can take the lead in the development of these new models of care.

Detective Chief Inspector Lee Whitehead, Kent Police: Sharing Information with the Police

Dr John Allingham, Medical Secretary

DCI Lee Whitehead from Kent police gave a presentation on the role and work of the MARAC (multi-agency risk assessment conference) which in our county is hosted by the force.

DCI Whitehead heads the department that deals with domestic abuse, sexual offences and similar issues. As GPs we often have information useful in the protection and management of vulnerable individuals. He reassured us about the safety of the information exchange and encouraged GPs to contribute to the MARAC process and to try and attend the meetings where relevant.



Detective Chief Inspector Lee Whitehead, Kent Police

#datasaveslives

Dr Abraham George, Consultant in Public Heath and Dr Marc Farr, Director of Information, East Kent Hospitals University NHS Foundation Trust

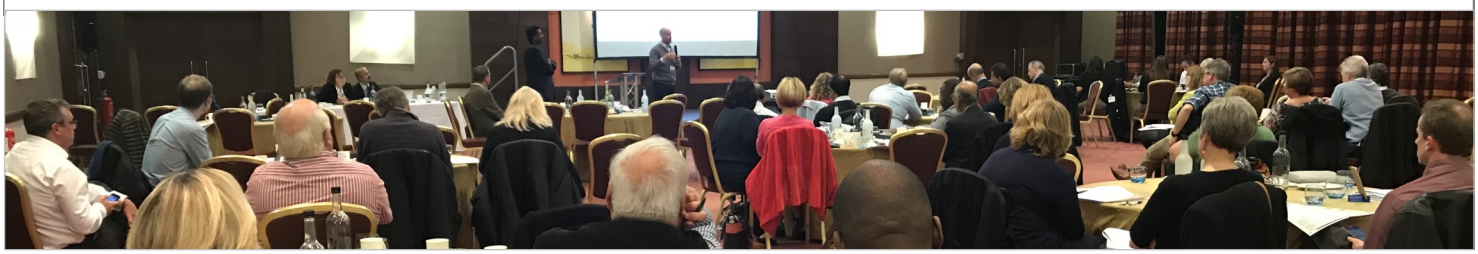
Dr Abraham George, Consultant in Public Heath and Dr Marc Farr, Director of Information, East Kent Hospitals University NHS Foundation Trust delivered a talk about how data can be used to predict events eg. MARAC and ED attendances. The data looks at what has happened in the past, what is happening now and how can this data be used to assist complex commissioning decisions.

They hope to use analysis to drive investment, especially at this time of reorganisation. Which brings me to the STP; the Shared Health Care Analytics Board are mandated to inform the planning, implementation and evaluation of population health strategy on behalf of the Kent and Medway STP Programme Board. Kent and Medway are leading the way, NHSE, NHSI and NHS Digital are looking at our achievements.

The future of KID – the existing KID by HISBi, was planned to be wound down by March 2019. CCGs have commissioned OPTUM to manage the new KID, which is designed to be a commissioner dataset for commissioning, not research. With new funding for HISBi to be agreed shortly, it is now possible to carry on with existing KID 2.0 to become a 'research database' (and real time intelligence activities) to support local provider/STP work. There is agreement in principle at STP level for both provider and commissioner data to complement each other and make data sharing smoother. The ideal would be for data to flow between the two. All data is pseudo anonymized. Drs Farr and George gave assurance that data can only be used with permission for the purposes of the health economy.

Key messages – your data already flows into linked data set and they would like this to continue. They would love to hear from GPs who may be interested in assisting with the data set and participate in the STP Shared Health Care Analytics Board.

Dr Abraham George, Consultant in Public Health & Dr Marc Farr, Director of Information, EKHUFT



Andrew Leal, Percy Gore: Making your practice financially efficient

Donna Clarke, Practice Liaison Officer

Andrew started by stating that based on his Kent practices with a total of around 500,000 patients, average profits per FTE GP predicted for 2018 are likely to show a significant increase. However, there has also been a significant increase in number of patients per partner.

So why are practices finding themselves financially unstable? He believes this is due to issues around partnership changes, locum and staff costs and PCSE issues such as superannuation errors which can have a significant impact on cash flow because superannuation is taxed in the year it is paid.

Andrew highlighted features of a stable partnership which include:

- A significant number of partners with a range of ages;
- stable profits;
- no premises issues;
- larger training practices;
- sustainable workload for partners.

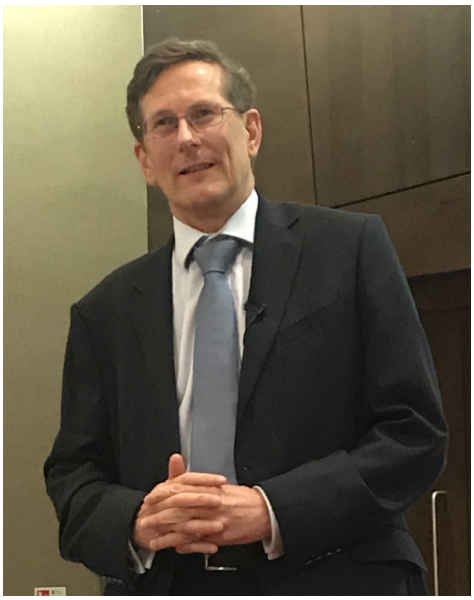
There is concern about some of the new models of working as they could mean that partner workload may become unsustainable.

Andrew is hearing 2 messages from his practices – "we have no problem recruiting" vs "we cannot recruit". Sometimes two practices in the same town have a stark difference in experience. He believes it helps to have a finance team in a practice rather than leave it all to one person.

There is also a recruitment crisis in Practice Management and less time for mentoring. In his opinion there are too many unknown unknowns for inexperienced Practice Managers such as superannuation going wrong and not being recognised and PCSE over reimbursing and not being spotted, causing significant cash flow issues.

He stated the importance of undertaking business planning citing an example of a practice where staff costs had spiralled out of control because they had been reactively dealing with problems by recruiting more staff rather than taking a long-term view. Away days and planning can help avoid this. It can also prove invaluable to collaborate and share back office functions and pool expertise.

Andrew suggested practices need to go back to basics and check that everything is correctly recorded and claimed for. He suggested asking the question who is responsible for monitoring and checking? Practices should also track activity as well as the amount of payment expected, then record what is received and tie it all up. This enables year on year comparisons. People should see Read/SNOMED codes as pound signs because if they are not right you won't get paid so take advantage of templates. Be especially careful to share information with colleagues when codes change.



Andrew Leal, Percy Gore Chartered Accountants

In summary he believes the next few years may be tough but that there is a light at the end of the tunnel because of things such as new premises cost directions which are expected to improve reimbursements, the premises review, the Partnership review, the Carr-Hill formula review, other rumoured contract changes and the new Kent medical school.

Staffing Changes within your Practice

Unfortunately the LMC do not receive updates of practice staff changes from PCSE, 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.

GP Staff Training Update

Delivering Kent & Medway GP Staff Training

GP Forward View Practice Manager Development Monies

We are pleased to announce that Invicta Health and the LMC have been successful in securing additional funding to develop practice managers throughout Kent and Medway. We are looking to develop and provide some formal training for practice managers and aspirant practice managers.

We frequently receive feedback from practice managers that there is limited opportunity to network, share best practice or develop joint projects. Some of this funding will provide an opportunity to work at cluster level. Invicta Health will be reaching out to practice managers to identify local needs and structure a programme to meet your needs.

Keep your training account!

The upgrade of the Invicta Health Learning Management System and re-registration process is now completed,

Practice Managers can now review their team training compliance at the touch of a button!

We do however have several individuals who have either not re-registered OR have partially completed their re-registration. These staff will not be able to book on training courses (or receive updates on new / available courses) OR have their training compliance included in the Practice Managers report.

If you, therefore, have not re-registered then please do so as a matter of urgency by either logging into your account and updating your profile or contacting the Learning Team via learning@invictahealth.co.uk.

Medical Secretaries / Administration Course – PM feedback

Thank you to all the Practice Managers who completed our short survey asking for feedback regarding the format of training available for Medical Secretaries or Administrators (one day v's two short days), most Practice Managers wish to keep the training to one day. However, the training to be delivered more locally. We will be looking to increase the use of local venues for our future 2019 training. If you have suitable venues at your practice which you are happy for us to use, please let us know by contacting the Learning Team via learning@invictahealth.co.uk

Save the Date - 2019 Practice Managers and Practices Nurses Conferences – Dates Confirmed

Following the very positive feedback received from this year's conferences, we have confirmed dates for 2019, please save the date:

Practice Managers Conference - Wednesday 2nd October 2019
Practice Nurse Conference - Wednesday 9th October 2019

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Kent LMC: Supporting list based personalised care, the partnership model and meaningful collaboration

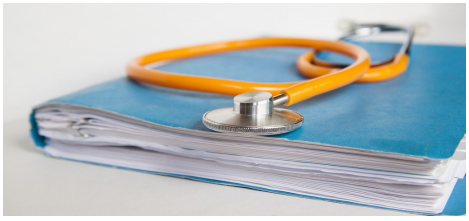
Practice Staff Vacancies

To advertise your practice staff vacancies* FREE of charge please go to the Kent LMC website.
You will need to register on the Kent LMC Website (or log in for existing users) to submit a vacancy.

*All vacancies are subject to approval by the Kent LMC and will usually appear on the website within one working day.

Police Requesting Medical Records

Dr John Allingham, Medical Secretary



I have been working with the Criminal Justice Unit in Kent to try and address the issues practices have had when the Police ask for access to medical records.

The 1998 Data Protection Act section 29.2 states 'Medical information must only be sought and disclosed if directly relevant to investigation or prosecution of offending behaviour'. It is obvious that we cannot be privy to the details of an investigation but the police should be able to reassure practices that the information is relevant and not part of a random trawl.

The consent form signed by the patient states that 'only the records that relate to the incident' will be used. Under GDPR the police can request the entire record, even though only a small amount may be relevant, with the patient's consent and unless the administration required in production is 'excessive' or it is a repeat request no charge can be levied. Nationally the police have a guidance document from the college of emergency medicine concerning access to records and provision of statements. GPs are not bound by this policy but some police officers may think we are. Similarly there is an agreement between various Kent health organisations including all hospital trusts about how requests for information will be dealt with. Some officers mistakenly believe this also applies to GPs. As GPs are independent contractors there is no organisation that has the authority to agree for all GPs to follow such a policy. It would need a change to the nationally negotiated GMS contract.

The Police policy states each request should be dealt with on a 'case by case basis'. This is sound advice and practices should consider each on its individual merits. It also states that 'concerns about confidentiality' must be considered so an awareness of the regulatory framework clinicians work under should be considered.

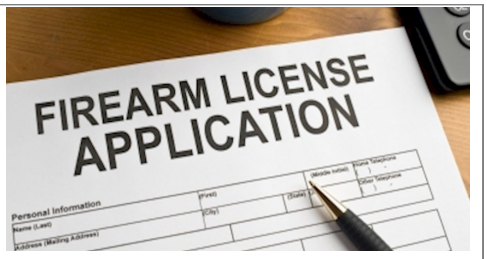
It is worth remembering that there is an exceptional circumstance where medical information can be sought without consent. This is covered by the policy, is in the data protection act and is also considered our professional guidance. In my experience the only time this occurred involved a murder!

Kent LMC have worked hard to establish connections with the Police and to improve our relationships. This has resulted in criminal justice unit staff being advised of some mis-conceptions. We will continue to help you in providing the Police with the help they need and are always happy to give telephone advice on a 'case by case' basis.

If you are still unhappy with the way the police interface with your Practice then please share the details with us and we will take it forward.

Firearms Update

Dr John Allingham, Medical Secretary



From October 1st Kent Police will be using the new process I have described here previously for renewals as well as first time applications. As a reminder it is simply a list of questions about the medical history which can be answered yes or no, apart from the final question which asks if there is any other reason why the patient should not hold a firearms licence. How you answer this is an individual preference but it does require a judgement call so answering 'I am unable to answer this question' could be reasonable.

As there are 27,000 licences in Kent and each lasts 5 years it means there will be about 5,400 renewals per year or about one a fortnight for each practice in Kent (assumes all practices same size and demography).

Licence holders get their first reminder 16 weeks before expiry, then another with 8 weeks to go and a final reminder with 4 weeks left on the licence. If a licence is not renewed the holder gets an 8 week grace period at the end of which the firearm is considered to be illegally held and will be confiscated by the police.

It is the licence holder's duty to obtain a medical report and to meet the fee levied by the GP or practice providing the service.

If this service is not provided by your practice the patient will need to find another GP who can provide the report and with consent that colleague will need to obtain the medical records via a subject access request (SAR). If you know of local colleagues who may provide this service on your behalf I suggest this fact is adver-tised via the practice website and notices in the waiting room.

KIMS HOSPITAL

We have now established regular liaison with KIMS and they have agreed to set up a generic e-mail where queries and problems can be attended to, which is

KIMS.feedback@nhs.net

How to manage subject access requests from solicitors under GDPR

Antonio Fletcher, Partner, Brachers LLP

The General Data Protection Regulation (GDPR) came into force in May 2018. Since then GPs have warned that they are under increased strain as a result of the obligations the new legislation has imposed and the increased use of Subject Access Requests (SARs).

The British Medical Association claims the additional red tape is putting extra pressure on doctors and reducing time spent with patients due to a significant increase in the number of requests made to GPs for patient notes. There is particular tension between doctors and solicitors as GP surgeries complain of being bombarded with requests – sometimes aggressively – for free copies of patient records.

The below checklist sets out what Medical Professionals need to consider and do on receiving a SAR from a solicitor on behalf of their client:

- There must be enough information in the request to identify the patient and locate the information that has been requested
- Ensure that there is valid consent from the patient. Does the patient realise exactly what they have consented to (e.g. the full set of records rather than just from a specific date)? Contact the patient, or their guardian/legal proxy, to clarify if there is any ambiguity.
- You have one month from the day after receiving the request to comply with it (save for in exceptional circumstances).
- In most cases you will not be able to charge a fee for complying with the request and providing the information. This includes not being able to charge for postage or copying.
- You will be required to redact any information that would identify third parties.
- The information supplied should be in a format that is legible and intelligible.

The two most common issues Medical Professionals have in handling SARs is in handling substantial and complex requests free of charge and also considering whether it is within the patient's best interests to do.

Consent

A patient can authorise an individual (such as a solicitor) to make a SAR on their behalf. Under section 185 of the Data Protection Act 2018 they cannot, however, be contractually compelled to (for example by an insurance company). Health Professionals releasing information to third parties acting on behalf of patients should firstly ensure that they have the patient's written consent. The consent must cover the nature and extent of the information to be disclosed under the SAR (for example, past medical history), and who might have access to it as part of the legal proceedings. If there is any ambiguity it is legitimate to check the position with the patient.

Most third parties provide the patient's signed consent when requesting information however, given the potential scope of the information that is requested, it is important that GPs are satisfied that the patient understands the following:

- Who will see the information
- What is being disclosed
- The purpose of disclosure
- The significant foreseeable consequences.

If a GP is in any doubt then they should confirm that the patient understands the nature and extent of the information disclosed and this could, in some circumstances, involve sending the records to the patient for approval before sending them to any other third party.

GPs should be satisfied that the patient has sufficient information about the scope, purpose and likely consequences of the examination and disclosure and the fact that relevant information cannot be concealed or withheld.

Fees

Under the GDPR GPs are no longer allowed to charge for copies of patient records under a first SAR.

A request can be refused or a 'reasonable' fee can be charged for a SAR if the request is manifestly unfounded or excessive. There is little explanation as to when a request might be considered as "manifestly unfounded or excessive". However, it would be prudent to assume that the threshold set here is fairly high and that accordingly requests should be refused on this basis only where the facts are particularly extreme.

Where access has been refused on this basis, the patient must in any event be given an explanation as to why access has been refused and they must also be informed that they have the right to complain to the ICO.

For many health care providers there has been a substantial impact resulting from the changes brought in by GDPR. One solution to reduce the cost of disclosure is to send out encrypted electronic copies of the records in question where possible and to speak to patients who a SAR relates to in order to ensure that they wish for the request to be complied with in the form received or whether a reduced scope would be more appropriate without putting pressure on the patient in this regard.

It is also worth noting that where any form of report or analysis of medical records is required, the rules under the Access to Medical Reports Act continue to apply.

Antimicrobial Prescribing by GPs for Odontogenic Infections

Tim Hogan, Chair of Kent LDC

It is recognised that patients will attend their GP with pain of odontogenic origin when they are best treated for this by a dentist. There are a number of reasons why patients make this decision but they may not always be truthful when asked by their GP.

It is important for GPs to appreciate that patients no longer have a registration with their dentist and once a course of treatment is finished the dentist has no legal obligation to see the patient unless there are issues arising from their last course of treatment. Dentists also have limited NHS contracts and will not be paid above or beyond the contract value that has been agreed with the Local Office.

Although dentists will normally see patients who have attended their practices within the last 2 years there may be cases when patients are refused access either because the dentist is too busy or the patient is an irregular attender. These latter patients normally have higher treatment needs and the NHS payment system is not financially conducive for dentists to see these types of patients.

In East Kent there have been 5 contracts that have been handed back to the Local Office for various reasons and overall in Kent there has been a bigger shift towards private dental care and away from the NHS. The result of these trends is that it is very likely that more patients will attend their GP in the future with pain as a result of odontogenic infections. The pain is universally caused by inflammation though the cause of the inflammation may have a bacterial involvement. As far as the management of the pain is concerned antibiotics are not indicated in the majority of cases as they will not help the pain. It would be more appropriate for the patient to take NSAIDs.

In the current climate of increasing antimicrobial resistance there is a big advertising campaign nationally both towards dentists and patients saying "antibiotics do not cure toothache". GPs should consider if they prescribe antibiotics for odontogenic infections they are medico legally liable for any adverse consequences. As there have been several cases of C.Diff and a couple of deaths following antibiotic prescriptions in dentistry, it is important in the current litigious climate that antibiotics are prescribed only when appropriate.

However, there are times when it is important for GPs to consider prescribing antibiotics even when the cause of the infection is odontogenic when there is evidence of systemic involvement or there is a safety risk to the patient. Systemic involvement is most easily determined by a raised core temperature of 38 degrees C or above. Other indications include a facial swelling that is moving towards the eye or the neck, or any swelling in the

floor of the mouth. Another indication is severe trismus. In all these cases it is very important that the patient's condition is monitored after prescribing antibiotics as any of them can lead to death. The ideal management is for active dental treatment but it is appreciated that this is not always possible.

Choice of Antibiotics

- 1st Choice is Amoxicillin 500mg TDS 5 days, review after 3 and if signs and symptoms are resolving stop
- 2nd Choice is Metronidazole 400mg TDS 5 days, review after 3 and if signs and symptoms are resolving stop
- 3rd Choice is Clarithromycin 250mg BDS 5 days, review after 3 and if signs and symptoms are resolving stop.

Please note that Erythromycin is no longer recommended in dentistry as up to 60% of odontogenic infections are now resistant to it.

Further information is available on kldc.org.uk and click on the link "antimicrobial prescribing and resistance".

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. 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/

TRUSTED TO SAVE GP PRACTICES TIME & MONEY

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

Noticeboard

A Fond Farewell
Clare Shutler

After working at the Kent LMC for nearly 6 years, due to family illness I shall be taking early retirement at the end of December 2018. I would therefore like to take this opportunity to thank everyone I have worked with within the NHS who have helped to make this my most enjoyable (and sometimes most challenging) role!

A special thank you especially to everyone at the Kent Local Medical Committee for all their support, friendship and fun – it really is a lovely place to work and I shall miss it deeply.

Plans for my replacement are in progress and I would therefore like to wish my replacement all the very best of luck and hope that whomever they may be will enjoy working for the Kent LMC as much as I have.

On behalf of the Kent LMC

We would like to wish Clare well in her retirement. Clare has carried out an excellent job, predominantly looking after the finances of the LMC. Clare even managed to navigate her way through the move from Kent Primary Care Agency to PCSE !!

We would like to thank Clare for her dedication, commitment and good humour. You will be a tough act to follow and we will all miss you.

Foundation for Essential Care

PrePITstop for Diabetes

FREE Diabetes Training

3 Day PrePITstop: Diabetes Foundation Course

The full foundation programme, suitable for clinicians keen to become more involved in diabetes services and those already involved, without a diabetes qualification.

1 Day PrePITstop: Diabetes Key Message Course

Key messages from the 3-day course, this information-packed day suits GPs not directly involved in diabetes care delivery and acts as a great update for experienced clinicians.

RCGP ACCREDITED

PrePITstop Diabetes training part of the PITstop portfolio

For more info or to book a place please contact the Learning Team via:

learning@invictahealth.co.uk or
call 03000 11 22 44 (opt 2)

Invicta health LEARNING

The LMC office will be closing on Monday 24th December 2018 and will reopen on Wednesday 2nd January 2019. 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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