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

January 2016

In Touch

In this issue…..

Reflections from the Special LMC Conference—30th January 2016—*Dr John Allingham*

'Conference instructs GPC that should negotiations with government for a rescue package for general practice not be concluded successfully within 6 months of the end of this conference the GPC should canvass GPs on their willingness to submit undated resignations.'

This was the final motion of the special conference and the one we all left discussing and considering. The debate before an almost unanimous vote was lively and passionate with speaker after speaker endorsing the sentiments behind it. Kent's Gaurav Gupta dared to oppose the motion on the basis that action was needed now and not in 6 months time. You will have read of this motion in Pulse and maybe the national press and that 80% of GPs surveyed prior to the last election supported the sentiment. If the time comes when this nuclear weapon needs deployment it is crucial that we stand united as our junior doctor colleagues have.

The Morning Session

If the day ended with dynamite it began with a few fireworks too. John Canning, Treasurer of the GPDF, radically opposed the agenda threatening to send conference into disarray and Kent's Jim Kelly used an emergency speaker slip creatively to try and promote his own motion on an activity based contract onto the agenda. The agenda was approved and although many shared John Canning's view that it was heavily watered down, business began.

Chaand Nagpaul gave a forceful 'State of Emergency' address which was widely distributed and even available on line before he delivered it. He suggested CQC should be put in special measures,

Dr Chaand Nagpaul, GPC Chairman

that £136 per year per patient for all GP care is a bargain and less than 1 visit to Out Patients, that it is not safe to see complex patients in 10 minutes or to have up to 70 consultations per day. Chaand was interrupted by applause on numerous occasions and received his customary standing ovation.

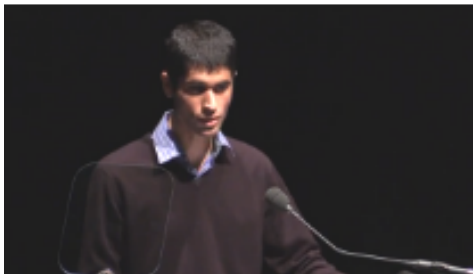
The first section of motions concerned workload and those carried included the pursuit of 15 minute consultations, restriction of the total number of patient contacts in a day, alternative contractual arrangements for home visits and for medical certificates. No Kent representative was called to speak in this section. Stephen Kuelter from Bucks left us with an interesting thought when he said 'we are funded like a food bank but the public are told to treat us like an all you can eat diner.'

Business then moved on to workforce and began with a motion asking GPC to explore all contractual options including moving away from independent contractor status. Kent's Caroline Rickard spoke as a young salaried GP who does not want to see the end of partnerships and included in her speech the comment that 'she was repeatedly disappointed by the size of Jeremy Hunt's package' which was not only well re-

ceived in the hall but also on social media with retweets from Maureen Baker and Roy Lilley!

Dr Caroline Rickard, LMC Representative (Ashford)

There was strong opposition to the suggestion that physicians assistants (associates-error in the agenda) will be a lifeline to general practice before Kent's Zishan Syed spoke passionately to a motion about training highlighting 'the pointless reflective exercises of the trainee e-portfolio', the cost of the CSA exam (£1642) and the 'irrelevance of the AKT to the modern working day'.



Dr Zishan Syed, LMC Representative (West Kent)

The Afternoon Session

Maureen Baker current Chair of the RCGP gave the keynote address that kicked off the afternoon. Much of what she said echoed Chaand's speech. She pointed out that we need In and Out of hours investment, an end to the constant drive for 7 day access when there is no appetite for routine Sunday appointments and she too spoke of an inspection regime that is not fit for purpose and which demotivates and de-professionalises.

Business began with a call for a commission to report on the form, function and funding of the NHS in the 21st Century and moved on to a motion on new models of care which talked of cherishing and building on the independent contractor status. Kent's Mark Ironmonger became one of many to hijack business with an emergency speaker slip on the basis that he wanted to be cherished now and not in the future.

Conference moved on to the issue of regulation with a powerful motion opposing CQC. It was interesting to note that although GPs are accountable to all and sundry including CQC, the CQC is only accountable to Jeremy Hunt and no one else!

Finally we came to the only motion that Kent had succeeded in proposing and Stephanie De Giorgio spoke as an appraiser calling for appraisal to be simplified, returned to a formative rather than a summative process, reduced to every other year and for revalidation to be suspended. Stephanie asked for an end to navel gazing to satisfy the data gathering spreadsheet fiends. The proposal was well received with only a narrow defeat to the call for revalidation to be suspended spoiling the show.

Dr Stephanie De Giorgio, LMC Representative (SKC)

The debate on premises was enlivened by Gaurav Gupta mocking the use of the word 'services' after NHS Property as their service includes random and unexplained price increases. He suggested they do not understand the meaning of the words 'debt' or 'recovery' on their own or when assembled together. This motion approved the concept of 'a buyer of last resort' to prevent the last man standing in a practice holding a toxic premises asset and for accelerated development of premises for practices.

The funding debate drew the familiar analogies between the cost of pet care and a year of general practice care. Even a year's pet insurance for a tortoise exceeds the funding from the NHS of a year's care with a GP.

Kent's Richard Claxton opposed the suggestion that care should be priced at £200 a year pointing out that this was not 'ring fenced'.

A Waltham Forest motion calling for an end to annual negotiations, for contracts to last the length of a parliament and for independent financial review of such was approved with the proposer suggesting the current arrangements were 'like negotiating with a teenage daughter'.

Jim Kelly opposed the call for the proper reimbursement of GP expenses on the basis that if we were 'paid a fair days pay for a fair days work' it would be unnecessary as income would cover all. Taking a contrary view Peter Holden pointed out that the expenses mechanism of the old red book had worked for 45 years and the current policy was 'to work you to death and then starve you out'.

As the afternoon dragged towards evening and conference grew impatient for the resignation debate the issue of indemnity came up and a proposal to push for 'crown indemnity' was approved. I spoke half-heartedly against the motion on the basis that it is only part of the solution and will leave non contract, voluntary and good Samaritan acts unsupported.

This was the 6th LMC conference I have had the pleasure to attend and it was by a long way the most lively and passionate.

I hope Jeremy Hunt heeds our call and that all of you tearing your hair out at the coalface stand shoulder to shoulder with your representatives in the LMCs and GPC.

United we stand! Divided we fall!

Special Conference: Personal Reflections

Dr Zishan Syed, LMC Representative, West Kent

I am delighted to have had an opportunity to speak at a historic event in General Practice. It was good to see some representation from the younger generation as we are the future of General Practice. I emphasised in my speech that it really is time the GPC started prioritising the welfare of GP trainees and medical students rather than the welfare of pharmacists and physician associates.

However, I do feel that the hope of undated resignations needs to be translated into firm action. The consensus and force behind this is monumental and the GPC needs to act now. More needs to be done: I am moved by the speeches of some of my Kent LMC colleagues who point out quite rightly that perfectly reasonable solutions to the present crisis are not being implemented by the GPC even when supported in motions. This makes me feel uneasy and I am sure there are many GPs who like myself are looking for the GPC to act with the courage of our junior doctors who have not hesitated to stand up to this government.

The GPC cannot afford to delay action. A unique precedent has been established to challenge the CQC. The constant negative drip feeding of comments regarding General Practice by this body is causing tremendous damage in public confidence. Following Steve Field's (Chief Inspector) deplorable comments about General Practice, now the CQC plans to impose more regulations/ monitoring on GP antibiotic prescribing.

These actions are happening at a time when people freely purchase antibiotics over the counter in other countries. Why does the CQC hate GPs so much and what will the GPC do to combat this?

Dr Amit Kumar, LMC Representative, Dartford, Gravesham & Swanley

LMC special conference was a great national event to attend. It provided us with the opportunity to raise matters of serious concern and share with colleagues from all over the UK.

Conference was well conducted. There were quite a few first time attenders and first time speakers who were taken care of. For those attending for the first time, a helpful introduction was given prior to the start of the conference by a couple of GPC members.

A barnstorming speech by Dr Chaand Nagpaul fetched standing ovation. Although it was considered as overstretched and full of emotions by some, it definitely brought life into the conference. This was followed by agenda items of variable appeal factors.

I did not have the opportunity to propose my agenda item because of the time constraints, however overall it was good to see that first time speakers were generally encouraged and supported well by the Chairperson. Overall the discussions and arguments provided me with an insight into the prevailing problems in General Practice and sense of relief that we do share some common ground of concerns which should help bring necessary changes to our current over pressurised NHS primary care.

I would like to think that the message of our solidarity has gone across to the policymakers. If not, then I suppose we have to persevere! I quote these lines by Bob Marley- ''Get up, stand up, stand up for your right. Get up, stand up, don't give up the fight''.

Dr Caroline Rickard, LMC Representative, Ashford

There is a fire in the belly of General Practice. The anger was palpable. The movement to instigate positive change has started.

This will be just the first step with a further 2 days of conferences to go this year.

We should follow the lead set by our junior colleagues as momentum builds to change General Practice for the better.

Our strength is in unity, it's time to put aside our differences and support the GPC.

Premises/CCG Estates Strategy

Liz Mears

The Primary Care Transformation Fund is a £1billon investment programme to help general practice make premises and IT improvements. In January 2015 bids were invited from GP practices to make much needed improvements in access to clinical services by extending existing GP premises. A number of bids were approved in different waves.

In October 2015 CCGs were invited to put forward proposals for investment in primary care infrastructure in future years, submissions for investment in premises and technology which will increase the capacity of general practice and out of hospital care. Detailed guidance on criteria will be published at the end of February with proposals being submitted from CCGs in April 2016.

Each CCG has developed a draft Estates Strategy (December 2015) including primary care. These estates plans will take account of the services that are required and planned for the future. CCGs should be gathering provider and stakeholder views. Bids will only be considered via CCGs so you must contact your CCG if you have plans to discuss.

Merger Workshop

Liz Mears

The LMC held a pilot workshop on the 14th January around practice merger. Delegates who were in or about to enter into serious practice merger discussions were invited. This pilot was to test out if this would be something worthwhile re-running for practices considering merger.

The afternoon looked at the HR implications and partnership agreements with Judith Curran and Pritti Bajaria from Clarkson, Wright & Jakes Solicitors. Andrew Leal, Percy Gore Accountants and Rosemary Jones, Chartered Surveyor provided financial and premises considerations and I provided details on the NHS England contractual requirements. The workshop was rounded off by a very interesting view from Dr Gaurav Gupta who had recently merged two practices.

Key messages from the workshop were:

- Communication
- Planning
- Partnership Agreement

- Property Lease
- Take appropriate professional advice.

Feedback from the delegates has been extremely good and something that the LMC will be looking to run again this year.

Latest Guidance on Zika Virus

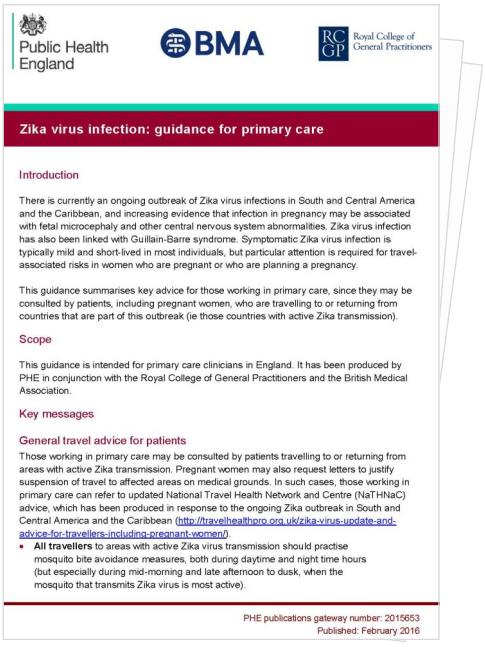
Dr Mike Parks

There is currently an ongoing outbreak of Zika virus infections in South and Central America and the Caribbean, and increasing evidence that infection in pregnancy may be associated with fetal microcephaly and other central nervous system abnormalities.

On 4th February Public Health England, the British Medical Association and The Royal College of General Practitioners published detailed advice for Primary Care on Zika Virus.

This guidance summarises key advice for those working in primary care, since they may be consulted by patients, including pregnant women, who are travelling to or returning from countries that are part of this outbreak (ie those countries with active Zika transmission).

The guidance should have been received by practices through the usual routes, is on the LMC website and is also available on: http://tinyurl.com/hgncbx6



Public Health England | BMA | Royal College of General Practitioners

Zika virus infection: guidance for primary care

Introduction

There is currently an ongoing outbreak of Zika virus infections in South and Central America and the Caribbean, and increasing evidence that infection in pregnancy may be associated with fetal microcephaly and other central nervous system abnormalities. Zika virus infection has also been linked with Guillain-Barre syndrome. Symptomatic Zika virus infection is typically mild and short-lived in most individuals, but particular attention is required for travel-associated risks in women who are pregnant or who are planning a pregnancy.

This guidance summarises key advice for those working in primary care, since they may be consulted by patients, including pregnant women, who are travelling to or returning from countries that are part of this outbreak (ie those countries with active Zika transmission).

Scope

This guidance is intended for primary care clinicians in England. It has been produced by PHE in conjunction with the Royal College of General Practitioners and the British Medical Association.

Key messages

General travel advice for patients

Those working in primary care may be consulted by patients travelling to or returning from areas with active Zika transmission. Pregnant women may also request letters to justify suspension of travel to affected areas on medical grounds. In such cases, those working in primary care can refer to updated National Travel Health Network and Centre (NaTHNaC) advice, which has been produced in response to the ongoing Zika outbreak in South and Central America and the Caribbean (http://travelhealthpro.org.uk/zika-virus-update-and-advice-for-travellers-including-pregnant-women/).

- **All travellers** to areas with active Zika virus transmission should practise mosquito bite avoidance measures, both during daytime and night time hours (but especially during mid-morning and late afternoon to dusk, when the mosquito that transmits Zika virus is most active).

PHE publications gateway number: 2015653
Published: February 2016

Kent Primary Care Agency

Liz Mears

NHS England
Primary Care Support England

As many of you know that following a national procurement process for the services that have traditionally been provided locally by the Kent Primary Care Agency, a contract has been awarded to Capita. Capita took over the contract to be known as Primary Care Support England (PCSE) from the 1st September 2015 and significant changes are imminent:

Parkwood Distribution Centre
The local distribution centre which predominantly dealt with processing all medical records and distributing orders for NHS free forms and prescriptions will be closing at the end of March 2016 and all the services provided there will transfer to Capita's Darlington site. Capita have appointed Citysprint as their national courier partner.

Patient Notes
There will be a national system for managing notes and you would have been written to recently to help with the trialling of the proposed service. With the local distribution centre closing so soon Kent and Medway will be near the front of areas to be included in the national system for distributing patient notes. You will be sent details on how to register for the Capita portal to manage patient notes and supplies. Practices should register on the portal as soon as possible so that they are able to use the service when it goes live at the end of March. We want to understand if this will be an additional burden on practices.

Faith House Staff
The team based at Faith House will be made redundant at the end of May 2016 when the office is scheduled to close. Sadly all that experience in both Faith House and the distribution centre will be lost. Many staff have worked there all their careers.

Vacancies
If any of you are looking for new staff for the practice, particularly in the West Kent and Medway areas please do ensure that you put the vacancy details on our website as the staff from KPCA will be looking for work over the coming months. It would be a real shame if their primary care experience was not put to good use.

Payments
With arrangements moving to a national system we would strongly urge that you ensure that all matters associated with payments are processed at the earliest convenience. We are all used to a knowledgeable and responsive local service and we don't know what the new service will be like particularly in the early days. Sorting out payment queries will be much simpler before the team are disbanded.

For GP retirements, especially ill-health and 24 hour retirements, let all three teams at Faith House know as soon as possible via their team email accounts, as these will continue to be monitored after the office closes:

kent-pca.superannuation@nhs.net
kent-pca.pladmin@nhs.net
kent-pca.doctorspremises@nhs.net

Please note that VAT is not reimbursable on water rates and claims for reimbursement should go to:
kent-pca.doctorspremises@nhs.net

Do you really need to make an Individual Funding Request (IFR)?

Andrea Chait, Principal Associate – IFR, South East CSU

SOUTH EAST/CSU

Although the vast majority of treatments that patients need are routinely offered by the NHS, you will occasionally have patients who request low priority and restricted-access treatments. But this does not necessarily mean that you should complete an IFR application for these requests:

First, check the *Referral and Treatment Criteria* available on any Kent & Medway CCG website, e.g. http://www.ashfordccg.nhs.uk/about-us/individual-funding-requests for criteria and access thresholds for commonly requested treatments.

If your patient **meets** criteria, there is no need to apply for funding; you are able to refer without review.

However, if your patient does not meet criteria or the treatment is unavailable, you would only apply for funding if you can propose exceptionality or rarity. To demonstrate exceptionality you would need to show how the patient is significantly different to ***and*** more likely to benefit as compared to the cohort. Rarity is where something is so unusual that no policy has been warranted.

It should actually be quite unusual to complete a funding application form. The form is currently being whittled down to be more user-friendly for primary care, but in the general course of events, you only need to complete one if you truly have a rare or exceptional case to propose.

Patient Online – prepare now for next year's contractual deadline

Dr Chris Frith, Digital Clinical Champion *& Ruth Adekoya, Implementation Lead, NHS England*

As you know, promoting the use of online appointment booking and online repeat prescription ordering are contractual requirements for Patient Online. These are routinely offered to patients in Kent and Medway.

From 1 April 2016 practices are expected to fulfil the current contractual requirement to provide patients with online access to their GP records. Online access will be extended from the current access to repeat prescriptions, allergies and adverse reactions to access to all **coded data** within a patient's record. **The inclusion of free text is not a contractual requirement** but may be useful in certain circumstances (explaining test results out of range for example).

EMIS and TPP's latest releases now provide the functionality to support the contractual requirements. It is expected that INPS and Microtest releases will be available in time to allow practices to meet these obligations. Practices will not be expected to fulfil this contractual requirement if they do not have access to computer systems and software which would enable them to offer the online services.

A statement from the Patient on Line team confirms:-

"GPSoC has assured the Detailed Coded Record elements from the Framework Requirements in EMIS Release 5.5 to 5.8 and TPP Release MR 116 for clinical safety, information governance and functionality. These elements have been confirmed by NHS England to meet the GMS contractual requirements for 2015/16.

HSCIC and NHS England are continuing to work with INPS and Microtest to secure timely delivery of system functionality for access to detailed coded records."

You will need time and help to understand the practicalities and the implications of this. Currently NHS England's (NHSE) Patient Online programme (https://www.england.nhs.uk/ourwork/pe/patient-online/) is providing support to practices to understand and deliver these commitments. Support for Kent and Medway is provided by Implementation Lead, Ruth Adekoya, and Digital Clinical Champion, retired GP, Dr Chris Frith.

It is a good idea to contact your system provider now to find out more information on how to deliver online access to patient records in a safe and consistent way.

NHS England are currently hosting additional webinar sessions to provide advice on how you can benefit from providing online services to patients. The webinars are interactive and provide an opportunity to ask questions, learn from other practices and find out how to access support locally. Visit the NHS England website (http://tinyurl.com/zskpt5o) for further information.

There is also a contractual requirement for practices to issue a **statement of intent** (http://tinyurl.com/jztn46z) in relation to these new services. **This should be done as soon as possible**.
If you have any queries, or would like to discuss Patient Online in more detail, please contact Ruth Adekoya (Implementation Lead): ruth.adekoya@nhs.net, Dr Chris Frith (Digital Clinical Champion): chris.frith@nhs.net.

Further information is also available on the following links:

Patient Online Interactive Resource and Support Guide:
http://tinyurl.com/nn97ecd

RCGP Guidance
http://tinyurl.com/jyvzj4p

Outstanding Payments

Liz Mears

With the advent of co-commissioning in 5 out of our 8 CCGs from the 1st April and the departure of KPCA from May 2016 where there will be a significant loss of local knowledge and historical information. **We strongly urge that any payment issues are addressed asap.**

Having been part of many NHS reorganisations in my previous life where every effort is made to pass on the historical information but for some reason it is not always the case!

We are concerned that practices might find it even more difficult than it currently is now to seek resolution on outstanding invoices after April 2016.
Please ensure that all matters associated with payments are processed at the earliest opportunity but before the end of March 2016. Sorting out payment queries will be much simpler before the team are disbanded.

Contract Changes for 2015/16

Liz Mears

You may wonder why the LMC is writing an article regarding contract changes for 2015/16 with only 2 months to go but there are a couple of changes that we would like to remind you of just in case you do not have them on your radar:-

1. **Named GP for all patients**
   By 31 March 2016 all practices must include on their website reference to the fact that all patients (including children) have been allocated a named accountable GP (Partner or Salaried).

2. **Publication of GP earnings**
   By 31 March 2016 all practices are contractually obliged to publish on their website mean net earnings that relate to the GMS contract for GPs in your practice (contractor and salaried) relating to 2014/15 alongside the number of full and part time GPs associated with the published figure.

Some detailed guidance was published but it is rather confusing and open to interpretation. We understand this may change for next year, but not this year. This information when published is likely to attract media interest. We would recommend that you seek advice from your accountant before publishing.

Police Requesting Access to Medical Records

John Allingham

Mike Parks and I met with representatives from Kent Police to discuss the continuing issues with the Police requesting access to medical records and we hope to be able to come back with a definitive 'agreed by Kent LMC' policy.

At present Kent police are continuing to mix the Access to Health Records Act 1990 and the Data Protection Act 1998 with confusing consequences when seeking evidence from GP practices.

It is current practice in Kent for the police to send a form signed by a patient giving consent to release their records under 'Section 3 of the Access to Health Records Act 1990'. This act states clearly that expenses can be claimed in providing copies. The second form that Kent Police send is a request to release the data under Sections 28(1) or 29(3) of the Data Protection Act 1998. In accordance with Kent Police policy this must be authorised by an officer of the rank of Inspector or above. If it is only signed by a Constable or Sergeant please return it for the appropriate higher authority.

The Data Protection Act 1998 allows data to be released for the 'prevention or detection of crime' and for the 'apprehension or prosecution of offenders' and as this is considered to be in the interests of 'National Security' it does not require consent and no expenses can be claimed.

The Information Commissioner who oversees the Data Protection Act states that the requests should be reasonable and proportionate. There is personal experience of Police 'fishing for evidence' and as the Data Controllers GPs can refuse access to such Data.

The police are restricted by their need to determine if a prosecution is likely to occur for the Crown Prosecution Service to proceed. Our records can contain information that supports or weakens the patient's credibility as a witness or their ability to have perpetrated a crime.

How Data is accessed is up to the Data Controller and as there are no expenses payable costs can be minimised by not providing copies but allowing the investigating officer to view the relevant records under supervision in the practice. There is also experience of the Police asking for all the data relevant to a particular condition eg erectile impotence for a patient accused of a sexual assault. To provide this data involves trawling through the records to extract the relevant entries and making a decision on what is and isn't relevant. This constitutes both professional opinion and an extract from the records both of which should command a fee and are outside the scope of the Data Protection Act 1998. GPs can refuse to present data in this way without an agreement to pay fees or expenses. Hopefully this will be further clarified in due course.

To further complicate issues the Police have an agreement with the Kent hospital trusts that evidence and statements will be provided free of charge. Kent LMC have made it clear that agreements with hospital trusts or even CCGs or NHS England are not relevant to GPs.

We will solve this but in the meantime suggest GPs consider carefully when the police request data what they are asking for, why they are asking for it and to then decide whether to grant access and how to do it.

No two cases are the same. The office are happy to answer and advise when needed.

Managing Military Veterans Health Needs

Maj (Rtd) John Allingham, Ex RAMC

Every surgery has military veterans on their lists be they the elderly who did their bit in World War 2 or recent returnees from Iraq or Afghanistan. All veterans may have health needs related to their service. The physical trauma of conflict may be obvious but the more subtle signs of Post -traumatic stress disorder and increased use of alcohol are harder to spot.

Many Veterans struggle to adapt to 'civvie street' and may have social, housing or family problems. They often struggle to relate their issues to civvies but by asking the open questions as we have all been trained to do it can lead to useful information being shared.

There are Read codes for 'Military Veteran' and 'Current Reservist' to help identify them on your computer system and there is help in supporting these patients available at www.armedforcesnetwork.org.

The RCGP has an on line training module in veteran's health and there is a workshop planned for ST3s (GP Registrars for April).

The Kent lead for the Armed Forces Network is Dr David Chesover (david.chesover@nhs.net).

Cold Chain—Tips and Updates

Jayne Ford, Screening & Immunisation Coordinator, Public Health England (South East)

Ordering

- Order when you have two to four weeks' worth of stock left
- Order small amounts regularly
- If vaccines come in multi-dose packs, ensure you order the correct number of doses

Stocking your fridge

- Check expiry dates regularly
- Ensure the fridge plug cannot be turned off accidentally
- Keep vaccines in their original packaging in the main part of the fridge
- Keep your fridge door locked at all times
- Use a maximum-minimum thermometer and keep a daily record of the temperatures
- Remember to RESET fridge once the temperature has been recorded
- Ensure fridge is serviced and defrosted according to the manufacturer's recommendations
- Position the fridge away from heat sources
- Best practice recommends regular fridge audits – (Vaccine Storage Audit tool, available from Screening & Immunisation Team, Public Health England)
- Remember the Four R's: Read - Record - Reset - React

Receiving your order

- Ensure **ALL** staff are aware of the importance of the cold chain upon delivery and receipt of vaccines
- Check your order thoroughly when it arrives and refrigerate it as soon as possible
- Ensure stock is rotated so that it does not become out of date
- Do not over fill the fridge as this restricts airflow

Cold chain incident

- Report all cold chain incidents to Screening & Immunisation Team (PHE) by completing an incident form, also report stock loss to ImmForm
- Contact Manufacturers for advice regarding the stability of the vaccine

Cost of stock loss due to avoidable cold chain incidents (i.e. incidents not due to external power loss)

- In Quarter 2 July - September 2015 there were a total of **10 incidents** that included the loss of 1062 vaccines at a total cost of **£30,152.96**

Is Healthy Start yet another GANFYD?

John Allingham

Women who are at least 10 weeks pregnant and with children under 4 can get vouchers which can be spent on milk, fruit or veg if they are on Jobseekers, Income support, employment support or Child Tax Credit. However the claim form has to be countersigned by a health professional who may be a GP (or a midwife or health visitor). Part B of the form requires confirmation that the countersigner has given advice on breast feeding and healthy eating.

The guidance states that 'health professional should not charge for signing applications' and that it is helpful if GPs do sign the form 'during a routine appointment on a related matter'. If they prefer not to sign the forms they should signpost applicants to their midwife or health visitor. It is recommended that reception staff are aware of the GPs position on signing these forms and the simplest way is to have a practice policy that all GPs adhere to.

It is important to note that health professionals are not expected to check that an applicant is in receipt of a qualifying benefit.

As you know Kent LMC and our national colleagues are campaigning to reduce bureaucracy

and whilst this scheme is laudable it is yet another GANFYD (get a note from your doctor)!

Legal Aspects of GP Practice Mergers

Brachers LLP

Brachers law

Mergers between GP practices are increasingly common as small practices face ever increasing challenges such as a squeeze on funding and/or partners retiring. Nationally, there has been a sharp rise in practice mergers in recent years with approximately 200 mergers taking place in the last year. This is compared to 80 or so in previous years.

For those readers that are considering a merger and are wondering what exactly is involved, an overview of the five key stages is set out below.

Once you have moved passed initial discussions with another practice, the first stage is to agree heads of terms. Heads of terms are a non-legally binding summary of the terms of the proposed merger, such as what assets are going to be transferred by each party, how those assets will be valued and any conditions to the merger.

The second stage is due diligence. This is a two-way process that enables the parties to understand their future partners' viability and standing (as each practice will have its own clinical and trading history and its own contracts, employees, liabilities and issues). Due diligence is split into three parts: legal, financial and commercial. The process can be arduous and document heavy but by undertaking due diligence and identifying any risks associated with the merger, each practice will be able to make an informed decision about whether to proceed.

The third stage is notifying NHS England of the proposed merger and obtaining its approval. It is highly advisable to involve NHS England in the process at an early stage. The type of notification, approval or variation required will depend on the type of clinical contract(s) held by the merging practices.

The fourth stage is the agreement of the legal documents for the new, merged practice. This will include a new partnership agreement for the merged practice (or a deed of adherence and variation to an existing partnership agreement), leases of the practice premises and asset transfer agreements to transfer the non-property assets of the individual practices into the new, merged practice.

The fifth and final stage is implementation of the new management structures and practices. This stage is the most important stage and yet it is the one that is most easily forgotten in the lull after completion. It is important that partners have a clear plan for any changes they wish to make post-merger as changes are most likely to be successfully implemented during the first 90 days. Completion of a merger is in many respects the beginning and not the end of the process!

For further information please contact Matthew Simmonds, a partner at Brachers LLP, at matthewsimmonds@brachers.co.uk.

Display Energy Certificates

Carlo Caruso

In October 2008 buildings occupied by a public authority where the total useful floor area equals or exceeds 1,000 square metres (m^2) and which is frequently visited by the public have been required to display a Display Energy Certificate (DEC) and to have in their possession or control a valid Advisory Report (AR).

In February 2013 regulations were changed by the Department for Communities and Local Government requiring public buildings with a total useful floor area of over 500sqm to display a DEC and to hold an AR.

This remained the case until July 2015 when the regulation was changed again to include public buildings in which the useful floor area exceeds 250sqm.

What is a Display Energy Certificate (DEC)?

A DEC shows the energy performance of a building based on actual energy consumption as recorded over the last 12 months within the validity period of the DEC (the operational rating which is a numerical indicator of the actual carbon dioxide emissions from the building). The rating is shown on a scale from A to G where A is the lowest.

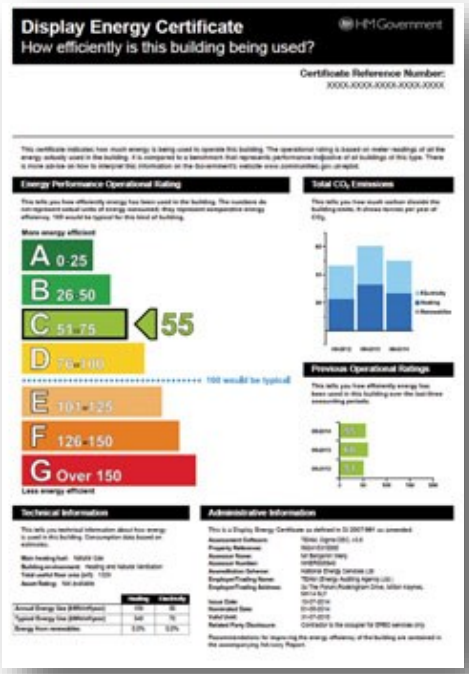
A DEC must be lodged by an accredited energy assessor - suitably accredited energy assessors can be identified at www.ndepcregister.com. We are also aware that the LMCs Buying Group provider, ASI Environmental (http://tinyurl.com/hrxn98h) can provide DECs for practices.

Does this apply to practices? Clearly the question arises as to whether this regulation applies to practice premises. The GPC's legal department has advised that the crux of whether a GP practice would be required to display a DEC lies in all of the following being applicable to a practice:

- It has a total floor area of over 250sqm.
- It is at least partially occupied by a public authority or an institution providing public services (whilst practices are not usually seen as "public authorities" they are in receipt of public funds and provide a public service to large numbers of people who visit regularly).
- It is frequently visited by the public (true for all practices).

Then there is the question of what constitutes a "total useful floor area" and who is responsible in a building, is it the landlord or the tenant? What is a large number of people? Some of these questions are answered in the Department for Communities and Local Government's own Guidance "Improving the energy efficiency of our buildings" issued in December 2012 and available on: www.gov.uk/dclg.

Their definition of a building is "a roofed construction having walls, for which energy is used to condition the indoor climate; a building may refer to the building as a whole or parts thereof that have been designed or altered to be used separately". They describe the "total useful floor area" as the gross floor area as measured in accordance with the Building Regulations; i.e. the area of sloping surfaces such as staircases should be taken as their area on a plan and areas not enclosed e.g. balconies, covered ways are excluded.



Landlord or tenant's responsibility?

The GPC's lawyers have weighed the evidence and in their opinion it would be for the occupier of a building, rather than the owner to arrange the DEC (the use of the building will usually be dictated by the occupier so it would make sense for them to arrange the same if the remainder of the criteria applied to them).

The guidance states that where there is doubt over whether a DEC is needed it is good practice to obtain one (Guide to Display Energy Certificates and Advisory reports for Public Buildings).

Penalties for not having a DEC

There is also the small matter of fines – a local authority can issue a penalty charge of £500 for failing to display a DEC at all times in a prominent place clearly visible to the public and £1,000 for failing to possess or have in your control a valid ad-

visory report.

When DECs are required?

If you are an occupier of a building requiring a DEC you should display a DEC and have in your possession or control a valid advisory report.

If you are a new occupier or have been in occupation for less than 15 months you may not have the previous 12 months of meter readings available that are required for an operational rating. The legislation makes provisions for calculation over the period of occupation in these cases.

Validity period of DECs

Where the building has total useful floor area of between 250sqm and 1,000sqm both the DEC and AR are valid for 10 years. If the building is greater than 1,000sqm the DEC is valid for 12 months. The accompanying advisory report is valid for 7 years.

Is there any good news?

Potentially there are benefits from having a DEC. They enable landlords and occupiers to see where energy could be saved. Reducing energy consumption will result in lower utility bill costs and save money in the long run.

Please do read the guidance (http://tinyurl.com/jmqa9js).
Overall the GPC's lawyers suggest that these regulations do apply to those practices for whom the three bullet points in paragraph 3 apply.

Kent & Medway GP Staff Training Team Update

Liz Mears

As you are aware the GPSTT have undergone yet another review brought on by NHS England questioning their continuance of the funding they provide for the administration of the GPSTT. Funding that has been provided by the NHS traceable through the various predecessor organisations to 1990! However, NHS England have recently declared that they are no longer prepared to provide this funding.

As a reminder the NHS has traditionally funded the administration of the team and General Practices have funded the 'top slice' which pays for the actual training that is delivered.

NHS England has written to CCGs to ask them to consider funding the administration going forwards.

Basically we need to find a solution of who can fund the administration and who can host the GPSTT. In the meantime the GPSTT's hands are tied. They are not able to commission any training from April 2016 whilst these talks are going on. Obviously this is not ideal! Any training that has already been booked by the team is in place and longer courses that run past the 1st April will continue to be supported.

None of us want to see a reduction in staff training, and therefore we are urgently working to find a solution with the CCGs.

The LMC Buying Groups Federation comprises 53 LMC Buying Groups across England, Wales and Northern Ireland that have been set up to help GP practices save money on the products and services they regularly buy. The Federation was established in 2009 by PSS (Notts) Ltd, a subsidiary of Nottinghamshire LMC Ltd. Each of the groups has been based on the model of the Nottinghamshire LMC Buying Group which has been operating successfully for over 15 years.

LMC BUYING GROUPS FEDERATION

"Saving practices time and money"

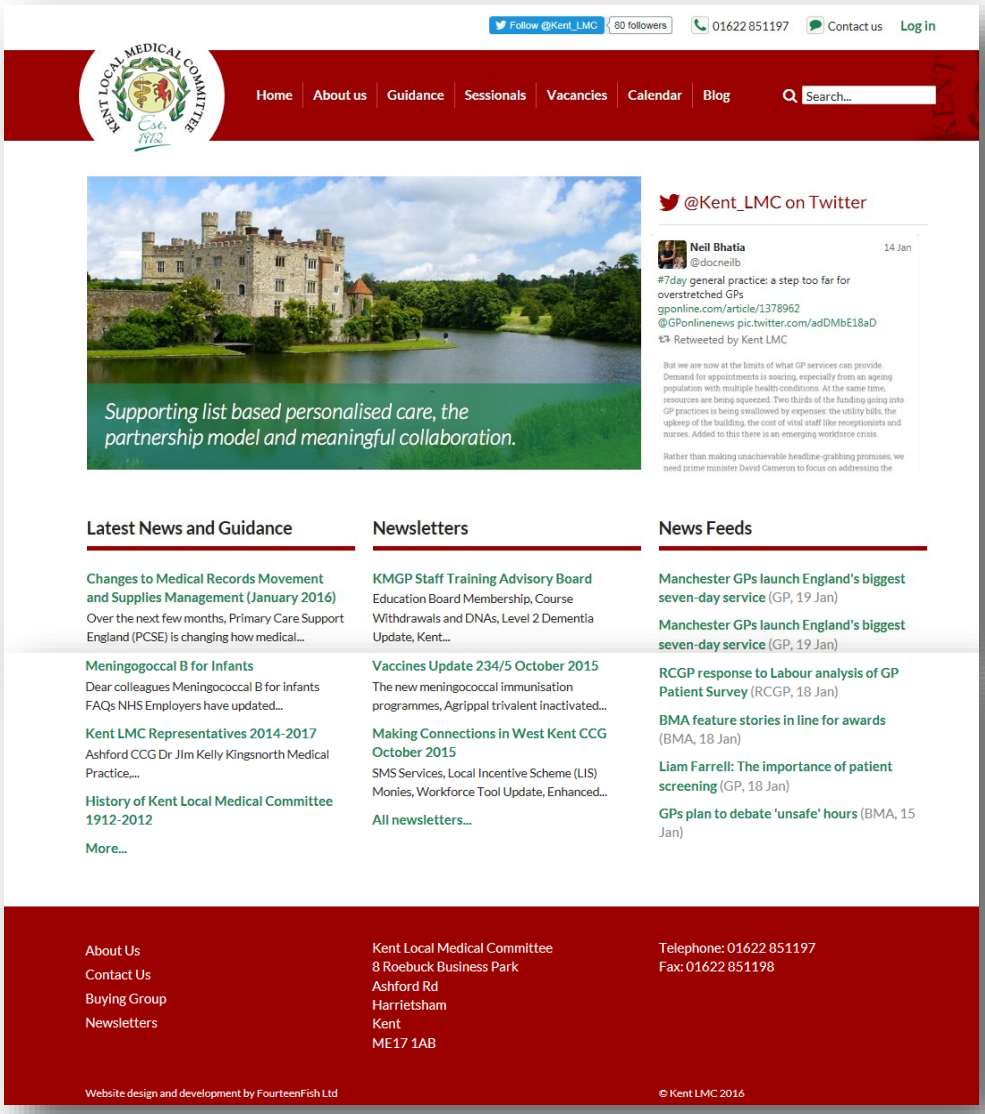
Why choose us?

- No membership fee
- Excellent negotiated discounts from a range of suppliers
- Quality products and services
- Free cost analysis for members
- No need to 'shop around' any more – we've done the hard work already!

We have 6300+ GP practice members which means we have been able to negotiate excellent discounts on a wide range of products/services from our approved suppliers. Our suppliers won't just offer you a great price one week and then ramp up the price the next so you can be assured that if you order from our suppliers you'll get a great price every time you shop meaning you don't have to 'shop around' to find the best deal every month anymore.
Membership is completely free and there is no compulsion to use all our suppliers and no minimum spend. We cover our running costs through small commissions from our suppliers. For further information and details of suppliers please look on the Kent LMC Website: http://www.kentlmc.org/kentlmc/website10.nsf/pages/buyinggroup/

Noticeboard

Introducing the NEW Kent LMC Website
www.kentlmc.org



We are pleased to announce that we will be launching the new Kent LMC website at the end of February 2016. New features include an improved search facility and vacancies section, news and twitter feeds and a blog. Development is ongoing, and we anticipate introducing a members area and the facility to book events in the future. We would welcome feedback—if you have any comments or suggestions please email kelly.brown@kentlmc.org.

Kent Local Medical Committee

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