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

June 2016

In Touch

In this issue…..

LMC Conference 2016: Day One

Liz Mears

Dr Guy Watkins welcomed everyone to the 2016 Conference of LMCs and outlined the changes to the conference structure.

Dr Chaand Nagpaul, Chair of the GPC, delivered an excellent speech, talking in detail about the crisis in general practice. He highlighted that the urgent prescription for general practice campaign penetrated the media far and wide, with a total of 663 mentions across broadsheets and national and regional media. He commented that the GPC would shortly be hosting a Parliament event in Westminster to enable MPs to confront the harsh realities of general practice with their LMC constituents.

Chaand noted that the 2016/17 Contract agreement does not include any clinical changes, and that any positive changes to the contract are drowned by the relentless demand outside of the core contract.

Heeded as an environment in which it feels like the profession are set up to fail, with an expanding population and unresourced work, Chaand highlighted the importance of ensuring solutions have to reflect diverse career aspirations, different contractual options and must be inclusive of all GPs that make up the broad profession.

The GPC has put together the Urgent Prescription rescue plan in an attempt to stabilise the current unsafe state of the profession and further create a platform for future sustainability.

Chaand stated that the Government finally responded with NHS England's GP Forward View (GPFV), which clearly cited that GPs suffer greater workload and stress than their international counterparts, and damns a decade of disinvestment in general practice, resulting in GP numbers rising by one third of that of hospital consultants. The GPFV has 108 commitments and various funding pots, and after a decade of declining funding, general practice will finally see an upturn of investment and an increased share of the NHS budget. Although positive, it is tempered by the fact that general practice endured gross disinvestment at a time of plenty.

Dr Chaand Nagpaul, GPC Chairman

Chaand talked at length about the GPFV, and reported that after much lobbying, routine 7 days GP service does not appear in the document. He stated that the Urgent Prescription is clear that the immediate priority must be to provide stability to vulnerable practices, and that it should be a significant untoward incident if a contract fails. He talked about the rescue plan, which at its heart must tackle the unmanageable workload, and either reduce demand or increase capacity or ideally both.

The importance of managing demand was highlighted, with the GPFV estimating that ¼ of GP appointments are

potentially avoidable, and that avoidable waste must be stopped.

Chaand welcomed the amended standard hospital contract, which stops hospitals sending patients who have missed appointments back to their GPs. GPs having to re-refer to a related speciality or chase up hospital results will also cease, with responsibility falling upon the requesting clinician. These changes need to take effect now, and that the Urgent Prescription goes much further in proposing to end the raft of examples of secondary to primary shift, from inappropriate transfer of specialist prescriptions to ending GPs chasing up hospital follow ups.

The forward view heeds the call for a national patient self-care campaign scheduled for September, which should deliver an unequivocal public facing message about the pressures facing general practice, highlighting the need to use GP appointments wisely and empowering patients to self-care for both minor ailments and as experts in their chronic disease or signpost them to other services.

The Urgent Prescription supports GPs working together in collaborative arrangements. Chaand conveyed the need for development funding for an in hours' co-operative movement, and to pull together as one GP profession.

Fundamental to any rescue package is the ability to limit workload, and that the current unsustainable reality of GPs working to unsafe and open-ended demands must cease. The Urgent Prescription proposes maximum workload limits, with the creation of overflow hubs to support practices when limits have been reached. GPs should not be forced to manage patients with complex multiple problems within a 10-minute appointment, and should be given longer consultation times in the

interests of safe care, even if it means creating a waiting list.

Chaand raised the thorny issue of indemnity, with the need for NHS England to urgently address crippling costs which are directly reducing workforce, the necessity to embrace skill mix to support the profession, along with the need for recurrent funding for a true skill mix, with the flexibility to meet the needs of practices, rather than political initiatives.

Chaand called for a replacement for CQC, with a system that is proportionate, targeted, understands context and supports practices rather than threatens them. A judicial review, challenging CQCs processes within a system which has recently been exposed where the rating of a practice is associated with the level of funding.

The GPC is on the national oversight group of the Forward View, and an LMC reference group is to be established to ensure high level ideas are translated into reality on the ground. The GPC will Fight to implement the proposals in their urgent prescription.

Chaand stated that woefully inadequate funding must be addressed, whilst general practice will finally get a larger slice of the NHS cake, it remains a cake that is woefully too small to feed the needs of the population.

Chaand's final message to conference was that the GPC remain determined to rescue the profession, and they will not give up until success is achieved. He received a standing ovation.

The Conference format was very different this year to enable more delegates to get more opportunities to have their say. The rest of the morning was dedicated to themed debates around:

- Funding of General Practice
- Workload in General Practice
- General Practice Workforce
- Empowering the Profession

The majority of our reps were called to voice their concerns and opinions directly to the GPC, albeit very succinctly in one minute!

This included Caroline Rickard speaking passionately about spiralling indemnity costs and the impact this is having on the workforce and its availability, and Zishan Syed speaking to express his grave concerns that skill mixing to try and replace GPs with non-GPs will not give you a suitable replacement. Where does the liability sit? I was amazed at just how well they did this, and with the support from the rest of the conference delegates.

For the majority of the rest of the afternoon the delegates attended 3 of 9 parallel discussion groups:

Dr Caroline Rickard, Ashford LMC Representative

- Training and support for a new GP workforce
- Listening to and learning from our diverse workforce
- Mitigating risk in funding and developing GP Premises
- How devolution in Manchester has radically changed thinking
- Experience of creating an extended primary care team in Wessex
- Professionally supported regulation – Preparing for a post-CQC world
- Helping GPs to work at the top of their game
- GP networks – promoting sustainable practice through collaboration
- Responding to new contractual initiatives in New Models of care.

Day Two (Morning Session):
Carlo Caruso

The day began with John Allingham, Caroline Rickard and I deciding to work off the conference meal from the previous evening by walking the 2 miles to The Mermaid, where the conference was being held. On the way we wondered what the response of the profession might be to the General Practice Forward View (GPFV). Would it be seen as the panacea to the crisis surrounding general practice, or would it lead to industrial action.

Chaand Nagpaul opened the session with an overview of the document. It has some of the right ingredients, particularly the investment of up to £2.4b assumed to go into core general practice funding by 2021. A number of other initiatives from the GPC's Urgent Prescription had made its way into the GPVF. Workload transfer issues from secondary care have now been addressed via the NHS Standard Contract for 2016/17.

There was support for developing the workforce and help for vulnerable practices. There was support for premises development via the Primary Care Transformation Fund. This still fell short of the GPC's Urgent Prescription for General Practice. However, this was not enough. The GPFV had many of the right ingredients but it was not the rescue package. It alone will not save general practice and more work needed to be done.

The tone of the speeches were similarly sceptical about the GPFV. Much of the funding was short term when what the profession called for was the stabilisation of the core contract. The core contract needed a large increase in funding now, not by 2021! The Primary Care Transformation Fund was replete with hold ups and ever changing rules making it difficult to access. There was doubt about whether there would be the 1000s of promised physician's associates when there were only 30 currently working in the UK. The Clinical Pharmacist scheme only ran for 3 years after which the funding disappeared. The document was full of uncertainty when the profession needed cast-iron certainty in order to be able to secure a sustainable future.

Gaurav Gupta gave a passionate speech on motion S20, echoing the general consensus amongst LMC representatives from across the country. It was time for the GPC to stop prevaricating. The profession knows that the GPFV is underwhelming. It is now time for the GPC to deliver on its mandate from the Special Conference in January 2016. Gaurav finished by giving Chaand an undated letter of support. The profession wanted the GPC to take action, to take it now and it did not want to return in 12 months to have the same debate.

Dr Gaurav Gupta, LMC Vice-Chair and Representative for Canterbury & Coastal CCG handed Chaand an undated letter of support

Gaurav also proposed motion 13, that NHS Property Services Ltd was not fit for purpose. He spoke woefully of his experiences of being a NHS PS tenant, sentiments which were clearly shared by the audience, many of whom have probably directly or indirectly experienced similar accounts to Gaurav's. The auditorium carried all parts of the motion, with parts (iii) and (iv) carried unanimously.

The Soapbox sessions provided Caroline, John and Zishan an op-

Motion S20

8. That conference does not accept the General Practice Forward View is an adequate response to the GPCs statement of need within the BMAs Urgent Prescription for General Practice, and considering this to be sufficient grounds for a trade dispute, unless the government agrees to accept the Urgent Prescription within 3 months of this conference, the GPC should ask the BMA to:

(i) ballot the profession on their willingness to sign undated resignations

(ii) ballot the profession on their willingness to take industrial action

(iii) ballot the profession as to what forms of industrial action they are prepared to take

(iv) produce a report to practices on the options for taking industrial action that doesn't breach their contract

portunity to speak.

Caroline spoke about giving the right to Limited Liability Partnerships to hold GMS contracts, protecting partners against the risk of last man standing.

John spoke for creating a new staff grade post, giving ST3s that have failed MRCGP the opportunity to continue to contribute to the workforce by working in general practice in a supervised capacity, and eventually giving them another opportunity to take the exam.

Zishan expressed his concern about the need to enable GPs to have their reflections protected from legal scrutiny, encouraging them to learn from incidents and become better and safer doctors.

Motion 13:
That conference believes that NHS Property Services is not fit for purpose and has:
i) failed in its mandate 'to provide a quality service to its tenants'
ii) failed in its core value 'caring – helping the NHS to deliver better and more sustainable clinical care and services'
iii) not been made accountable for its mismanagement and lack of action
iv) demanded charges that are unrealistic, unaffordable and destabilising to practices.

Day Two (Afternoon): *Dr Mike Parks*

A quick lunch was taken and then back to the Mermaid for the final furlong and a wide ranging debate on motions selected by conference.

Buckinghamshire proposed a motion seeking to remove the right of the public to have direct access to a GP. Whilst many understood the desperation GPs feel this motion was defeated. However a motion calling for contingency planning by NHS England for the large numbers of patients being left without a general practitioner at very short notice was supported.

The Kent motion:

KENT: That conference insists that the GPC:
(i) secure a commitment from government that spending on primary care increases to at least 12% of the total NHS spend
(ii) secures an agreement to suspend all further PMS redistribution and MPIG erosion
(iii) produces a nationally agreed and costed menu of 'GMS plus' services
(iv) act on its mandate to seek a new national core contract which links payment to activity

was passionately proposed by our own inimitable Jim Kelly and was passed except for (iv). Last year a motion calling from an activity based motion was passed by a small majority. This year asking the GPC to act on this mandate was narrowly defeated. What this means for the GPC going forward is not clear as the previous motion should still constitute GPC policy.


Dr Jim Kelly, Ashford LMC Representative

Jim made a series of hard hitting points. As usual he was very persuasive and did a splendid job and was even congratulated by Richard Vautrey, Deputy Chair of the GPC for persistence.

The following motion focused on the need for deprivation to be included in the review of the Carr -Hill formula. What was most interesting to me was the fact that deprivation brings forward the onset of long term conditions. I guess we probably all know this. This means that a deprived 60 year old will have similar morbidity to a prosperous 80 year old and that this is not accounted for in Carr-Hill. Tinkering with the weighting of patient lists will of course have to done very carefully so as to avoid the production of a whole lot of practices who lose out.

Further debate demonstrated strong support for continuity of care.

For some time, the concept of limiting GP workload in a way that makes practicing medicine safe has been in the headlines. Somerset successfully proposed that the GPC open negotiations to;

i. Define the contents and scope of the core primary care contract
ii. Acknowledge that additional work will require additional resources
iii. Consider how public demand for health care can be better managed.

Allied to this was a request that the GPC publish a list of procedures and services that are not part of contracted essential and additional service. This has, in fact, in part, been done and more information can be accessed at the GPC website (search for Quality First).

Mark Ironmonger spoke very well to a motion about Firearm certification. Conference and we feel that the new system is not acceptable and needs revision.

John Allingham has covered where we are with this in a separate article. Believe it or not there are 750,000 firearm licences in England and Wales!

LMC Conference: Personal Reflections

Dr Zishan Syed, West Kent LMC Representative

Dr Zishan Syed, West Kent LMC Representative

Having initially attended the emergency LMC conference earlier this year I was keen to attend again months later for review of progress. I once again reiterated my concerns that employing non-doctors in doctor roles under the guise of 'skills mix' is fundamentally wrong especially if doctors are blamed when things inevitably go wrong with such flawed systems of practice.

There was a lot of frustration vented in the previous conference and I do feel that the GPC has failed to respond adequately to the dire condition of General Practice. At least there was agreement from the GPC that the Five Year Forward Plan is inadequate but that was the only positive recollection I can take away from the conference. This is not, however, enough and I left the conference feeling rather disappointed for my fellow GPs. There is considerable disquiet amongst GPs that the GPC appears to be appeasing the government and has lost direction. I really hope the GPC will find its true purpose and momentum. I certainly will continue to do my best to represent grassroot GPs as best as I can.

Donna Clarke, soon to be Practice Liaison Officer, Kent LMC

I am shortly to take up a new post within the LMC office and was invited along to the conference to get a flavour of the LMC from within! I currently work as a Practice Business Manager at a practice in Swale and I am also Swale CCG's Practice Manager Governing Body Member so have had a fair amount of contact with the LMC over the years but from a different perspective.

The Thursday before the conference I attended the pre-meeting with the GPs who were going and we poured over the conference agenda. It was the largest agenda I have ever seen in my life – a whole A4 ring bound book with details of all the submitted motions from LMCs all over the country as well as the timetables and debate themes. I am happy to report that I was not the only one suffering from a little confusion as the format had been changed this year and everyone was uncertain of how it would work. It was great to meet everyone beforehand.
The conference venue had changed at the last minute due to Health and Safety issues, which meant either an 11 stop tube journey in the rush hour or a 1.9 mile walk across London. I opted for the walk and found myself walking with 4 long legged men who I am quite sure would normally have walked at twice the pace but were very gentlemanly in sticking to what my rather shorter legs could manage!

The Kent contingent sat together and suddenly everything made sense as GPs started to get up and wait to have their 1 minute say on the issues listed. It was fascinating and very fast moving so you didn't have time to get bored.

After a well earned lunch we were back for the afternoon sessions. These were three parallel breakout sessions – each session on related topics. I went to one looking at MCPs (Multispeciality Community Provider contracts) – much trumpeted as the way forward in Simon Steven's General Practice Forward View but which leaves many GPs still to be convinced. The speakers were Dr Nigel Watson from Wessex LMC who are piloting what sounds like a very successful MCP in Gosport and he is obviously a convert who truly believes this is the way General Practice needs to go to be sustainable. We then had a session which he led with Chaand Nagpaul expanding on the topic. Finally Dr Tracey Vell from "Devolution Manchester" spoke, rather less convincingly in my opinion, about the benefits of a pooled Health and wellbeing budget. I think the jury is still out until we see some evidence of the patient outcomes from these pilots.

Unfortunately I had to miss the Friday because of a CCG Board meeting, but I thoroughly enjoyed my first experience of the conference and look forward to being at the whole thing next year. I would also like to thank everyone for making me feel so welcome.

Dr Mark Ironmonger, West Kent LMC Representative

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The agenda committee had clearly noted the discontent shown by LMC reps at the emergency conference earlier in the year that was a highly controlled top down affair, with much formal intervention and irritability from those in charge, where process seemed to trump content.

This produced a flurry of red emergency speaker slips from delegates who felt they had a point to make but no means of airing it. On this occasion there was a better atmosphere and it felt more inclusive, the conclusions drew out the passion that the LMC delegates felt about the perilous state of our profession and the need for immediate support to sustain it.

As usual, the Kent LMC team was fantastically well organised, leaving only myself failing to notice the difference between Euston and Euston Square tube stations, meaning that I arrived with only one minute to spare on day 2.

Dr Richard Claxton, West Kent LMC Representative

In general I was a bit uncertain of what to expect of the LMC conference this year. I wasn't sure if the general feeling of anger, frustration and desperation voiced by so many delegates at the Special Conference in January was going to have been diluted by the GP Forward View published in April. Like many of my colleagues, I was pleased that the Forward View had at long last raised awareness of the crisis around GP workforce and workload in a public debate - although I was also aware of how short the window of publicity it received had been (a bit longer than the length of the Today Programme) and also how scant the detail was within the document. How would Practices and Localities actually receive the investment, resources and political goodwill promised?

It seems I was not alone. I detected in the hall a decidedly lukewarm response to Chaand Nagpaul's speech/manifest by the shorter length of applause at the end and the definite lack of unanimity in the standing ovation he received. That said, when the Forward View was debated, strong feelings about the inadequacy of its promises were voiced, and many times the hollow promise of jam tomorrow was rejected - with Practices clearly in need of bread today.

The format had changed a bit this time: some of the debates were structured around a theme rather than a motion. This was a welcome change for me as it avoided the opportunity for somewhat pedantic focus on the minutiae and wording in a motion; gave more speakers the chance to speak (albeit for a shorter 1 minute slot) and did away with the need for prospective speakers to play games with their speaker slips (such as joining a minority of people speaking against a motion - but in fact only speaking against because they felt that the motion did not go far enough!). As a result it was more mature, and easier for anyone to gauge the feeling in the room as a whole: a great improvement.

Meanwhile, from the Parallel Sessions I attended, two stand out in my memory:

I learnt about a scheme in Wessex where practices under a Vanguard project had got together as a collective provider. This had had some success; they are looking in the future to a reversion to block contracts - geographical, population and outcome (not tariff/activity) based contracts for their commissioners to consider. This warmed the Frank Dobson inclined cockles of my heart. I was particularly impressed that they didn't use the F (for Federation) word once!

I also heard a talk about how in Glasgow they are looking to help GPs work at the "top of their game". It was very positive with lots of words like "mastery", "autonomy" "engagement" and talk of making time for training, enhancing GPs' self -esteem and allowing them to be leaders of the community health team. I was so inspired and enthused that I went home full of grand plans to move to Scotland. I'd often lamented on the right to vote for Nicola Sturgeon so far having been denied me in Maidstone and the Weald. Mrs Claxton was less impressed, and has emphatically vetoed the move North of the border. I will watch the Calcutta cup next year in silence brooding at what might have been…

In the end, I left the conference feeling a bit cynical about how in the current landscape such Scottish aspirations may come to fruition in *this* home nation. What will come next for the Forward View and the GPC? One clue may be found in the initial email response from Maureen Baker, who sounded regretful at the wariness and disappointment voiced at the Conference to the Forward View. Certainly it seems to me that the opportunity for divide and rule by Government, given the tension between the RCGP and the GPC, cannot have gone unnoticed in Whitehall.

There are difficult days ahead for the GPC negotiators: one senses that they are part emboldened by the Junior Doctors' success in their unity and the public support they received. However, they should also be very wary of just how much of an appetite there really is for the threat of industrial action from this most patient-friendly group of Doctors. When push comes to shove, I suspect that the majority of GPs will not vote with their feet, but remain in their swivel chairs.

Anyone for Haggis?

Managing Workload: List Management

Dr John Allingham

As the pressures on Practices rise more and more are looking at ways of controlling workload and so the office is frequently asked how to manage lists.

The article below was originally published in 'In Touch' a few years ago and is available on our website. The advice remains pertinent and the regulations unchanged so it is reproduced to help all practices thinking of list management as a means to control workload.

List Management

Dr John Allingham

Many practices are struggling to cope with the escalating workload demands and are constrained by premises and or difficulty recruiting. One way of easing the workload is to manage the number of patients on the practice's registered list using the regulations carefully.

Formal List Closure:
Application to formally close the list involves an assessment process and results in closure for a period of time up to a maximum of 12 months. This requires the approval of NHS England which is not necessarily granted.

Informal List Closure:
Many practices are now managing their lists by using paragraph 171 of the General Medical Services Contract which states 'The Contractor MAY accept an application for inclusion in its list'. Note the word MAY not MUST!

The regulations continue to state an application to join the list 'shall only be refused if the contractor has reasonable grounds that do not relate to race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.' Within 14 days the practice must notify an applicant in writing of the refusal to accept an application to join the list and the reasons for this.

A lack of capacity is a 'reasonable ground' and a practice can produce a standard letter for reception staff to provide to applicants.

Practices must keep a written record of such refusals and be prepared to make it available to NHS England on request. A computer log or record book accessible to reception staff and updated as each applicant is declined should be maintained.

Practical Considerations in operating an 'informal list closure'

- *Staff need to understand exactly what is required and not deviate from the rules. No exceptions.*
- *The simplest way to be non-discriminatory is to decline all applications to join the list.*
- *The only exceptions might be newborn babies or applicants who join an existing household eg returning students, new partners.*
- *The decision to operate an informal list closure should be recorded in the minutes of a practice meeting and reviewed on a regular basis possibly monthly.*
- *The letter to the patients should be honest and include statements to reflect that the decision remains under review and may be reversed if the situation changes. It must be reasonable, transparent and justifiable.*
- *Practices should have a written policy that all relevant staff have read and ideally signed.*

Some practices maintain their lists at a level by taking on the same number of patients a month as left the list the previous month. This is within the regulations as outlined here.

In January 2015 the BMA published 'Quality First: Managing workload to deliver safe patient care'. This is available on the BMA website and includes other advice such as reducing the size of a practice area.

The LMC can be contacted for advice or clarification.

Welcome to Donna Clarke, Practice Liaison Officer

Liz Mears

We are really pleased to announce the appointment of Donna Clarke as Practice Liaison Officer for the LMC two days per week.

Donna will be starting with us at the end of July 2016 and will be working on Mondays and Thursdays. This is a key appointment to the LMC office team and will provide a practice management perspective to the work of the LMC.

Donna will be looking to establish a Practice Manager network to help with the work with members of the Secretariat, LMC representatives, and constituent GPs to facilitate the development of Primary Care and General Practice.

The New Firearms Forms

Dr John Allingham

Under the new arrangements the practice will receive a communication from the police asking the practice to:

1. add a read code to the patients records. This was advice we gave a few years ago simply on the basis that we felt knowing who held a firearm was useful information for personal and patient safety.
2. To respond to a request for information about medical concerns or problems.

If a GP is happy to respond to the request he/she has 21 days to do so and the police will not pay a fee for provision of the information. The work involved in this is substantial and the GP may feel it should be funded and can negotiate a fee with the patient for this work. If negotiating such a fee and carrying out the work will take more than 21 days then the Police should be informed.

If a GP feels unable to participate and this could be because he/she has a conscientious objection to anyone holding a firearm or because they feel unable to provide the information they should inform the police immediately.

One response that has been suggested by another LMC is to reply as follows:

'Dear Police Firearms and Explosives Licensing Unit

Thank you for your request for a medical report on the above patient. You have asked me if I have any concerns regarding the issuing of a firearms licence to this individual, and you therefore seek my professional opinion rather than a simple report of the medical facts.

It is widely accepted that the major clinical issue giving rise to the improper use of firearms is the presence of a personality disorder. To give a professional opinion on such a diagnosis one would need to conduct a specific examination for personality disorder and have special expertise. Such expertise would, at a minimum, require approval under section 12 of the Mental Health Act 1983 (as amended 2007).

I regret to inform you that I am not approved under sec 12 MHA, nor have I conducted an examination appropriate for the diagnosis of personality disorder in this person. I am therefore not qualified to offer the expert professional opinion you seek and would suggest that you approach an appropriately qualified psychiatrist who may be able to help you in this regard.

Yours Faithfully
Dr Kent GP'

The issue of coding the notes to indicate the holding of a firearms licence carries with it potential obligations under 'Good Medical Practice' but these could be argued to be no different to those created by the receipt of a letter and filing it in the clinical record.

- Where a patient is mentally unwell to the extent that a GP knows them to be a danger to society there is a clear duty to inform the police.
- If a patient is expressing suicidal ideation it may be advisable to arrange for the firearm (or the ammunition) to be placed out of harm's way but how we make such an assessment is a vexed issue.
- If a GP is called to visit a patient who is confused or disturbed and a firearms licence holder should an approach be effected to ensure personal safety? What would be reasonable? Would turning up with a police escort to an elderly farmer confused by a UTI be reasonable?

These questions do not have easy answers and whilst the new licensing process is probably an improvement on what went before it does raise a whole load of additional questions and dilemmas.

Discussions about this new approach to firearms certification are ongoing nationally and this guidance may be amended so expect some of this article to be subject to amendment in the future.

The Meldrum Report
Dr Mike Parks

The very final part of the LMC Conference focused on the future of the GPC, the future of LMC Conference and how the funding flows. Many will find this supremely uninteresting so may wish to stop reading at this point. For those who are interested I have summarised the main points.

Hamish Meldrum, past chair of the GPC and BMA Council was asked together with a team of the great and good to review the role and structure of the GPC, the role of the LMC Conference and the funding mechanism (via the General Practitioner Defence Fund).

In March the 'Report of the GPC reform task group' was published and some elements of this were discussed and then voted on at the LMC Conference. Rather than a binary vote i.e. Yes/No a system of graduated voting was used with a range of 1 (do not support) to 6 (fully support) was used.

The results of these votes are as follows:

- The resuscitation of GPC England to mirror the GPCs in the devolved administrations was strongly supported.
- The creation of larger multi-member constituencies rather than the existing regional constituencies (in our case Kent constitutes a single regional constituency) was mainly supported.
- A change of the electorate from all voluntary levy paying GPs to LMC representatives (a very controversial issue). No majority view expressed.
- The members of the GPC (England) Executive other than the Chair to be appointed rather than elected was mainly supported.
- The GPDF to release funding to support development of LMC was supported.
- A one day (rather than two day) annual LMC UK conference with a separate one day LMC (England) conference held in the autumn was supported.

Hamish Meldrum speaking at the Annual Conference of LMCs 2016

(Note- the 2017 conference in Edinburgh will not be affected by this decision).

- The majority wanted to retain the annual LMC Conference dinner.
- The voting members of the GPDF to transfer from the members of the GPC (the main beneficiaries) to LMCs was supported.

The other main issues covered in the debate relate to an urgent need to improve communication between the GPC, LMCs and GPs with a particular focus on a more imaginative use of social media.

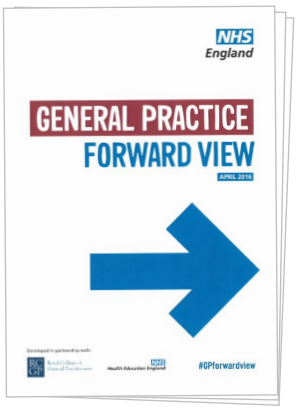
An Update from the Kent Academic Primary Care Unit (KAPCU)
Liz Mears

Based at the University of Kent, KAPCU was set up 2 years ago and is the hub for a growing array of GP led primary care research. The unit supports GPs interested in developing their research and now has 5 GPs attached as fellows, associates and PhD students.

Their research areas include GP resilience, mindfulness for GPs, end of life care in COPD, primary care education and renal. Dr Vanessa Short was appointed in 2015 as the KAPCU GP Clinical Research Fellow. A PhD study on community acquired AKI takes up some of her time, and she is also the research lead for Encompass; the Faversham, Whitstable and Canterbury Vanguard. KAPCU will play a key role in developing research themes within Encompass. KAPCU also runs an annual programme of research seminars and clinical updates. On April 21st KAPCU hosts an AKI afternoon in Medway, June 23rd sees a Canterbury based afternoon on primary care physician associates, and on November 24th there is a respiratory focused afternoon in Canterbury.

If you would like more information on KAPCU, the programme of activities or any research ideas please contact Professor Patricia Wilson p.m.wilson@kent.ac.uk

General Practice Forward View and the changes to the NHS Standard Contract—*Carlo Caruso*



The General Practice Forward View has quite rightly, for a whole variety of reasons, received a very mixed reception. However, one success I think we can all agree on are the changes that have been introduced to the NHS Standard Contract for 2016/17. For those that are with it, the Standard Contract is the contract CCGs are mandated to use when commissioning any healthcare services other than primary care.

The changes relate to hospital/general practice interface by providing some clarity on the division of labour between the two with the intention of relieving general practice of some unnecessary workload burdens. In all reasonableness it may take some time for secondary care to adapt its systems and processes to conform with these new requirements. Should this continue in your area then you can inform the provider and your CCG of this using template letters that can be found in the Guidance section of our website (www.kentlmc.org), under the sub-section on Workload.

Local Access Policies
Hospitals will no longer be able to adopt blanket policies under which patients are automatically discharged back to their GP for referral after missing an outpatient clinic appointment. This change should mean less appointments needlessly wasted that could ordinarily be used for a patient that actually needs to see their GP.

Hospitals will need to publish their Local Access Policies and listen to GP feedback when considering service redevelopment and redesign.

Onward Referral
Unless your CCG has specified so, secondary care specialists can make an onward referral to another professional within the same hospital without having to refer back to the GP. GPs will only be required to make another referral in the case of non-urgent unrelated conditions.

Discharge Summaries
Will now have to follow the format agreed by the Academy of Medical Royal Colleges making it easier for GPs to identify key information.

Outpatient Clinic Letters
Hospitals now have to promptly and clearly communicate with GPs no later than 14 days following an outpatient clinic appointment. This will be strengthened in 2017/18 by requiring electronic transmission within 24 hours of appointment.

Results and Treatments
Hospitals are now required to notify patients of the results of clinical investigations and treatments in an appropriate and cost effective manner by, for example, telephoning the patient.

Medication on Discharge
Providers now need to supply their patients with medication following discharge from inpatient or day case care. Medication will be provided for a minimum of 7 days (your CCG will have a specific policy about this).

The changes in the Standard Contract clarify some of the grey areas between general practice and secondary care. Do not think turning down this work is a negative act. It is clarifying the role of general practice in relation to secondary care. Taking on work that you are not funded for gives you less time to look after yourselves and your patients.

Dates for your Diary!

A Practical Guide to GP Survival
7th Annual Kent LMC Conference

Thursday 3rd November 2016

12.45-18.30 (Buffet lunch & refreshments included)
Ashford International Hotel, Simone Weil Avenue, TN24 8UX

Look out for further details on our website!

Merger Workshops

Following the success of the recent workshop, the LMC have arrange two further dates:

30th June 2016 - 1.30-4.45pm (Village Hotel, Maidstone)
28th September 2016 - 1.30-4.45pm (Ashford International Hotel)

Speakers include CWJ Solicitors, Percy Gore Accountants, a Chartered Surveyor and a practice who have recently merged to give the potential reality of merger. The workshops are open to all GPs and Practice Managers. Please see the calendar on the LMC Website for agendas and further information.

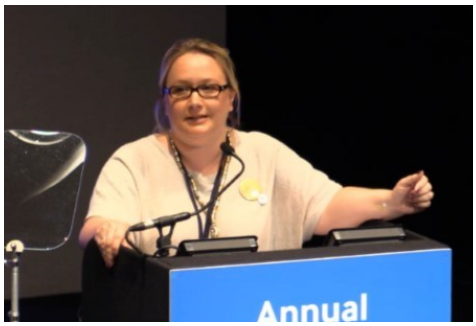
GPC Regional Representative Elections
Liz Mears

We were very pleased to see that there were two candidates for the Kent GPC Regional Representative position.

After an election process the GPC counted votes and announced that Dr Mike Parks was successful and will continue on the GPC as the Regional Representative for Kent.

The GPC held two elections at the LMC Conference this year. One position for a GP within their first five years of practice and another as the 7th seat elected at Conference.

Our representatives were keen to put themselves forward for Conference GPC seats. After an election process held during the conference we are extremely please to announce that Dr Stephanie De Giorgio was successfully elected.



Dr Stephanie De Giorgio, LMC Representative for South Kent Coast, was successfully elected as a GPC Representative.

Managing Workload: 'You have been Referred' Leaflet—*Dr John Allingham*

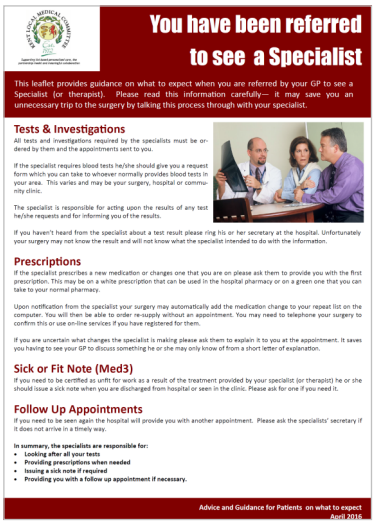
Following discussions with the full LMC committee the office produced a simple leaflet that can be given to patients telling them what they can expect from the hospital in the hope it will reduce some of the secondary to primary care workload shift.

We sent drafts of the leaflet to all CCGs and Hospital Trusts in Kent to try and facilitate a joint approach but none of them replied!

Since we produced this leaflet the GP Forward View has been published and some of the issues will be in the National Contract and thus unavoidably the responsibility of secondary care.

The leaflet can be edited or rebadged if you choose to use it but we have produced it with the Kent LMC logo to try and make it a countywide initiative.

The leaflet was e-mailed to all practices and is also available to download from the LMC website.


You have been referred to see a Specialist

This leaflet provides guidance on what to expect when you are referred by your GP to see a Specialist (or therapist). Please read this information carefully— it may save you an unnecessary trip to the surgery by talking this process through with your specialist.

Tests & Investigations

All tests and investigations required by the specialists must be ordered by them and the appointments sent to you.

If the specialist requires blood tests he/she should give you a request form which you can take to whoever normally provides blood tests in your area. This varies and may be your surgery, hospital or community clinic.

The specialist is responsible for acting upon the results of any test he/she requests and for informing you of the results.

If you haven't heard from the specialist about a test result please ring his or her secretary at the hospital. Unfortunately your surgery may not know the result and will not know what the specialist intended to do with the information.

Prescriptions

If the specialist prescribes a new medication or changes one that you are on please ask them to provide you with the first prescription. This may be on a white prescription that can be used in the hospital pharmacy or on a green one that you can take to your normal pharmacy.

Upon notification from the specialist your surgery may automatically add the medication change to your repeat list on the computer. You will then be able to order re-supply without an appointment. You may need to telephone your surgery to confirm this or use on-line services if you have registered for them.

If you are uncertain what changes the specialist is making please ask them to explain it to you at the appointment. It saves you having to see your GP to discuss something he or she may only know of from a short letter of explanation.

Sick or Fit Note (Med3)

If you need to be certified as unfit for work as a result of the treatment provided by your specialist (or therapist) he or she should issue a sick note when you are discharged from hospital or seen in the clinic. Please ask for one if you need it.

Follow Up Appointments

If you need to be seen again the hospital will provide you with another appointment. Please ask the specialists' secretary if it does not arrive in a timely way.

In summary, the specialists are responsible for:

- Looking after all your tests
- Providing prescriptions when needed
- Issuing a sick note if required
- Providing you with a follow up appointment if necessary.

Advice and Guidance for Patients on what to expect April 2016

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

NHS England

Primary Care Support England

Dear Practice Manager

For those who I haven't met at your local practice manager meetings recently, I am your Local Training Manager for Kent, and part of the National Engagement Team for the South East. I previously worked for the Kent Primary Care Agency for 22 years, and take my knowledge and experience going forward to help support you. In my new role I am here to answer questions you may have, and to provide hands-on support around the new processes that you will need to use to access services. I will also be carrying out the face to face identification meetings with any new Performer List applicant in the area, now that KPCA has closed.

All practices have received a letter from Primary Care Support England (PCSE) confirming the contact information going forward following the closure of KPCA. Further changes are planned to modernise the GP Payments service including the ability to manage your payments online and also introduce an online application for Performer List. These changes are not expected until April – June 2017, in the meantime please use the contact details provided.

The PCSE will continue to communicate to the main users registered onto the portal giving weekly updates regarding the movement of medical records and ordering supplies. We are currently in Phase 1 of the national medical record solution and practices are bagging their medical records in individual shipping bags and City Sprint will continuing to visit each practice every week. Phase 2 will see the implementation of barcode tracking labels for individual records and you will be informed of the timetable when this has been agreed. In the meantime please release your Medical Record Envelopes to City Sprint, packed in the new shipping bags for processing to avoid any back log at a later date. Understandably there has been some reluctance to hand over the records to the new courier without the tracking labels however this has a knock on effect all over the country with fewer notes being delivered.

It is a requirement for all City Sprint couriers to be DBS checked and carry ID. All drivers have been issued with a briefing statement detailing the level of service expected from them. Please do seek confirmation of ID if you're unsure before handing over medical records.

Any questions, please let me know

Kind Regards

Julie

Mrs Julie Gibson
Kent Local Training Manager, National Engagement Team
Email: julie.gibson3@nhs.net

Kent Local Medical Committee

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