Kent Local Medical Committee Est. 1912
Supporting list based personalised care, the partnership model and meaningful collaboration

# In Touch

May 2019

In this issue…..



## Developing a Primary Care Network (PCN): Some General Principles—*Dr Mike Parks & Donna Clarke*

During April we sent out an email containing general principles for consideration when setting up your PCN. The following is a slightly revised version of those principles:

### Taking Time

Although applications need to be in by 15th May, and approved by the end of May what is required for the application is clearly set out in the Guidance. Forming and agreeing the membership of your PCN should in most cases be relatively straight forward. The more difficult bit is agreeing and signing the network agreement. We can help you with this and have run some workshops and telephone surgeries during April and May. It is important to recognise that the first year of a PCN is meant to be focusing on establishment rather than wholesale change.

### Practices are in charge

The PCN process is intended to be empowering for practices. Once you have agreed the membership, you will need to decide what structure you prefer and who you want to work with. If this is with a Federation or other provider, then you need to determine what you wish to purchase and on what terms. Useful information to help you with this can be found in the BMA PCN Handbook which can be found on the BMA website at: https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-england/gp-contract-agreement-england/primary-care-networks

### The right size

The guidance is clear that 30,000 to 50,000 is the optimum size. Of course, this won't suit all settings, but this does need to be borne in mind. The right size is probably the right size to enable community services to be successfully configured around the membership of the PCN. Very large PCNs will be expected to operate a locality/neighbourhood structure. Some thought needs to be put into whether it is better to be two or more PCNs or a single large PCN with two or more localities/neighbourhoods. Which gives the greatest advantage in reconfiguring services to the benefit of both patients and practices? Which is more practical in your healthcare community?

### Avoiding competition

Competition between PCNs or between PCNs and Federations is unlikely to be productive. This needs to be considered when setting the relationship between PCNs and their most likely supporter, Federations. Care needs to be taken in making sure that these relationships are constructive and productive.

### Supporting Clinical Directors

A key appointment that must be from within the clinical workforce of a PCN. In most cases this will be a GP. The role is defined in the Network Contract DES specification but remains a bit vague. We are very keen to support this group and hope that establishing a peer support group will be helpful. A provisional date for the first meeting of this peer support group has been arranged for the evening of Tuesday 21st May. We will be contacting Clinical Directors directly to arrange this. There is a lot to be gained by working together, both locally and across Kent and Medway, in sharing experiences and good practice, in learning together and avoiding professional isolation.

### Delivering a Strong and Influential Primary Care Voice

Clinical Directors, whilst accountable to the PCN membership, will be a key part of the development of both Integrated Care Partnerships (ICPs) and the Integrated Care System (ICS). Both of these need strong consistent input from Primary Care. This needs to be as close as possible to grass roots General Practice.

### Gaining CCG Approval

We believe that the CCGs will only be able to approve/confirm PCN applications once they have received all the applications in their area. This is in order to be able to confirm that there is 100% coverage, that the applications make geographical sense and that it is practical to reconfigure community services around their geography. The LMC will be helping the CCGs to resolve any problems to enable a comprehensive and sensible solution.

As well as sending out this information we have been attending PLTs and initial PCN meetings across the county to provide whatever support and information we can. As a result of this we have picked up on the following common queries:

**Is there any separate funding for admin support or backfill for PCNs?**
Unfortunately, no. You will look to fund PCN needs using the £1.50 Network DES payment and £1.76 Practice Engagement Payment. You will also need to consider the 30% part of the additional roles costs that are not reimbursed. If the PCN finds the £1.50 is not sufficient there will need to be an agreement about how practices contribute from their £1.76 if deemed necessary. It is worth pointing out that both the £1.50 and £1.76 will be backdated to 1st April 2019 with the backdated amount being paid at the end of July 2019.

**Will we need legal/financial advice?**
The likelihood is that you will in order to complete the schedules to your PCN agreement. This will be a legally binding document and will contain details of how PCN workforce will be shared, governance, financial details etc.

**What happens to a practice with sites in 2 different PCN areas?**
There is no definitive guidance on this but there is a possibility that such a practice may have to belong to 2 PCNs as long as the population of each site can be easily identified in order for payments to be split accordingly. If you suspect you may have this issue we would urge you to talk to your CCG as soon as possible to work on the right solution for your patients.

**What happens if a practice does not want to join a PCN?**
Joining a PCN is optional. The LMC will provide support to any practice who opts not to join a PCN. If a practice does take this option they will not receive their £1.76 Network Engagement Payment and that payment will not be given to anyone else. Therefore the PCN that provides Network services to the patients of the opted out practice will have to manage with the PCN funding.

# Conference of UK LMCs, March 2019: Opening afternoon session: *Dr John Burke, West Kent LMC Representative*

Kent LMC's 12-strong delegation gathered with hundreds of other attendees at International Convention Centre in Belfast for this year's BMA-hosted annual conference. Dr Mark Corcoran (chairing) welcomed all to the capacious auditorium as cameras captured the proceedings for online webcast. General Practice Committee (GPC) Chair Dr Richard Vautrey began in full voice about how the GPC has delivered for general practice, encouraged the government to invest in primary care and of the strengths of GPs as expert medical generalists. Conference later heard how GPs don't wish to be undermined by digital services and the government was urged to manage healthcare demand.

Local GPC Chair Dr Alan Stout spoke of the history of Northern Ireland (NI), the mental health legacy of the Troubles and the lack of a health minister or government given NI's political impasse.

To a silent auditorium, Dr Lucy Henshaw (Suffolk LMC) opened the debates with a moving account of the loss by suicide of a male university student friend and fellow GP, adding that female doctors have a fourfold higher risk of suicide than the UK general female population. She drew a parallel with fallen soldiers 'under relentless hostile fire' and called for better prevention, understanding and support. Conference fell silent as a mark of respect to past GP colleagues lost to suicide and a standing ovation followed what was a moving start to the afternoon's seven motion debates.

Kent LMC's Dr Sarah Westerbeek joined the call for better GP support and for all removable suicide risk factors to be addressed. The motion was carried.


Dr Richard Vautrey, Chair of the GPC

All conference debates and resolutions are available online and via BMA webcast.

The next debate addressed issues relating to private health screening and whether NHS GPs or private providers should be obliged to provide follow-up appointments. Delegates voted in favour of the need for the latter provision and for approval of the UK National Screening Committee for such activity.

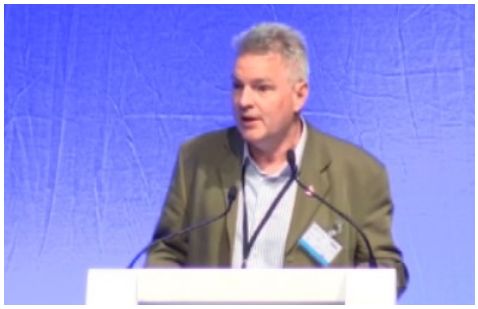

*Dr Sarah Westerbeek, Kent LMC Sessional GP Chair called for better GP support and for all removable suicide risk factors to be addressed*

Three motions followed, all addressing IT aspects of primary care: the resources and risks involved in the role of data controller, the impact of GDPR on practice workload and a call for national-level consideration of legal and ethical aspects of Data Sharing Agreements. Regarding patient access to information under GDPR, one speaker said that almost all requests come from solicitors. Another GP called for the Health Secretary to ensure equitable provision high speed broadband in rural areas rather than focussing on apps and virtual consultations - this rural GP's more complex patient notes reportedly taking 15 minutes to download.

Dr Zoe Norris (sessional GPC member) gave a resonant Sessional Sub-Committee report that marked the end of her three year term. She called for the provision of NHS email addresses for all locum GPs nationally and outlined features of the new BMA locum

practice agreement (available online). Its aim is to minimise common disputes between practices and locum GPs. She spoke of professional fairness and GP co-working, whether in hubs, out-of-hours or virtual care. Sessional practice was then debated, conference resolving to ask the GPC to recognise the plurality of sessional roles, demanding improved representation and negotiation.

There followed a debate about overhauling GP trainees education and training. One speaker called for more training in 'being a GP,' including business, leadership and management skills. Another spoke highly of the range of traditional hospital posts, and that any change should not be at the expense of valuable hospital experience. Conference voted for a push for GP trainees to be predominantly based in general practice with set time to attend secondary care for learning opportunities.



*Dr Neil Potter, West Kent LMC Representative called for clarification on e.g. the level and type of mandatory/required CPD.*

The final debate of the afternoon concerned appraisal and revalidation. Dr Neil Potter declared to the auditorium that he is trying not to fall into that high percentage of GPs he feels wish to retire soon, and called for clarification on e.g. the level and type of mandatory/required CPD. Another speaker advocated a return to formative appraisals and shifting emphasis from information gathering to pastoral care and mentorship of GPs. Such motions passed, but another to extend appraisals to three-yearly and revalidation to six-yearly did not.

After a stimulating afternoon, delegates retired first to their hotels and later to some fine Irish hospitality at Titanic Belfast.

*Titanic, Belfast: Drs John Burke, Neil Potter, Mike Parks, Mrs Liz Mears, Drs Caroline Rickard, Sarah Westerbeek, Andy Parkin, Richard Claxton, Thilla Rajasekar and Gaurav Gupta*

## Wednesday Morning Session:
### *Dr John Allingham, Medical Secretary*

The Wednesday morning session began with a depressing update on the effects of Brexit and the preparations being made by the BMA's European Union Public Affairs Manager.

This was followed by a section on prescribing where Kent's self-appointed 'dispensing dinosaur' Neil Potter defended the importance of the service to rural patients and the need for it to be adequately funded.

During the contract negotiations section concerns were raised about the changes to the GMS1 registration form effectively turning GPs into agents of the Home Office in the pursuit of immigration status.

There was a debate that followed a report from the Chair of the General Practitioners Defence Fund which funds conference about how the payment streams for GPC and BMA work should flow. The GPDF has undergone reform and is repositioning itself.

This session ended with speakers representing all 4 of the nations describing different solutions and models being employed in their areas to the current pressures facing General Practice.

There were then break out sessions on a variety of related topics that the Kent contingent were scattered through.

## Wednesday Afternoon Session:
### *Dr Thilla Rajasekar, Ashford LMC Representative*

The afternoon session on Wednesday started after a filling and tasty lunch at the Tedfords, for the Kent delegation. The afternoon session was kicked off with a motion proposed by the conference of England LMCs. This was about continuity of care. There was widespread frustration at how extended hours and improved access was being pushed and promoted, taking over local priorities to the detriment of patient access and continuity of care. This point was made resoundingly by many delegates from across the country and forcefully by some very angry delegates from the Cambridge LMC.

The next motion was proposed by colleagues from Leicestershire. The GP delegate who wrote the motion was unable to attend the conference due to personal commitments. Instead the motion was moved by his local colleague who made some very important and notable points about the hasty push for working at scale in its present fashionable name of PCNs. It appeared that generally most GPs were sanguine about the push for PCNs. But our Leicestershire colleagues did raise some very important points about how PCNs may be short sighted, a threat to the long term viability of the present model of primary care led by partners and how we are being lead headlong into a blind alleyway by the hasty and reckless enthusiasm on the part of the BMA and GPC who agreed this at the last contract negotiations. The motion was defeated soundly, though most GP colleagues were left contemplating the somewhat gloomy prophesy of our Leicestershire colleagues.

The next motion was moved by our colleagues from Oxfordshire who lamented the lack of coordination and understanding by secondary care which pushes work towards primary care inappropriately to the detriment of our patients. This motion was widely and almost unanimously supported by many of our colleagues and was passed without much ado.

The next motion was regarding online access of GP services which was moved by our colleagues from Hull. Again this was supported widely and almost unanimously with the health secretary Matt Hancock coming in for some much deserved flak for his uncritical approach to online services and GP access apps creating an uneven field for GP colleagues. Again passed without much ado.

In the midst of all the interesting motions discussed and passed, it was announced that our dear colleague Sarah Westerbeek has been elected for the GPC role. This excellent news was greeted with immense happiness by the Kent delegation, thrilled to have another local voice representing Kent in the GPC.

This was followed by another widely supported motion proposed by our colleagues in Bedford who wanted GPC to represent the widespread consternation and anger at the appalling situation where GPs were made to act as paramedics or when ambulance priorities were downgraded due to the presence of GPs on the scene. Again, this motion was passed with almost unanimous support imploring the government to resource ambulance services appropriately.

This was followed by GPC reports from the chairs of the Wales and Scotland chapters of GPC. These reports and speeches were well received, especially from Dr Charlotte Jones of Wales who was stepping down from her role. She gave an emotional speech describing the exhausting demands of her GPC role and the difficulty balancing her professional roles.

This was followed by another important motion which was moved by our sessional colleagues from Devon who demanded that the GPC negotiated on behalf of our locum colleagues who were being treated unfairly by the pension scheme. Our own Kent colleague Dr Andy Parkin spoke in support of the motion, making a very emotive yet light-hearted speech which was thought provoking and was picked up by GP press who quoted his speech for the online press. This motion was moved unanimously.

The final motion was moved by our Scottish colleagues from across the border about the need for transparency and protection for our colleagues who whistle blow or raise impertinent questions about lack of resources and poor practice in care without fear of reprisals. Again this motion was moved unanimously by the conference.

The conference then concluded, hopeful that the important motions passed will be forcefully negotiated by the GPC bringing about important changes to the care of our patients and to our working lives.

KENT
A DIFFERENT VIEW
Jobs in health and social care

# Take a Different view – the Kent attraction

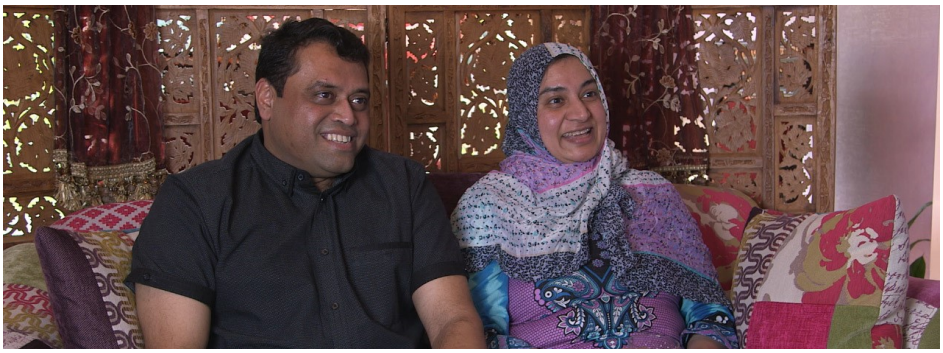
**Health and Social Care Trusts across Kent and Medway have joined forces to promote Kent as a great place to live and work for health professionals.**

The 'Take A Different View' campaign was launched in March 2018, and aims to showcase the best of what living and working in Kent has to offer.

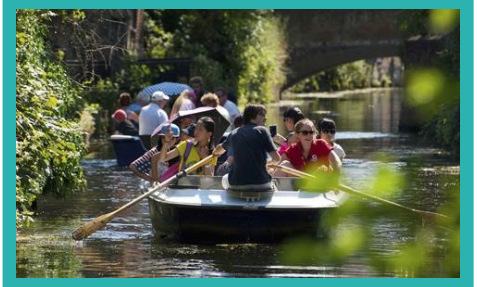
The campaign has a website: www.takeadifferentview.co.uk and is supported by several social media channels (Facebook, Twitter and LinkedIn). The website has had more than 9,000 users and 15,000 visits. The Facebook page has more than 2000 followers and a reach of 15,000 people per month.

Trusts can post jobs directly to the website via their resourcing team (posted jobs will appear automatically on the twitter feed).

Dr Mo Sohail, A GP from the Bethesda Practice in Margate, appears as a case study on the site.



Mo says: *"It was a treat moving to live and work in Thanet as I am not a great fan of traffic congestion! I was living in Dagenham in east London, so you can well imagine doing a mile in 45 minutes was not my cup of tea, and getting stuck behind buses every five minutes was no fun. Margate on the other hand provided me with a totally different perspective. It reminded me of my home town – Karachi in Pakistan, which is also by the seaside. House prices were a real eyeopener compared to London, and we quickly decided this is where we wanted to live, raise our children, grow old and retire. My lovely wife is a doctor as well and she works at the local hospital as a staff grade. We have no regrets about moving here whatsoever. We have raised our children here and have benefited from quality schools and the great outdoors. There is no other place you can work and make a difference for your patients, while at the same time feel like you're on holiday every day. Kent is an amazing place to live and work."*




IF YOU'RE A QUALIFIED HEALTH OR SOCIAL CARE PROFESSIONAL,
TAKE A DIFFERENT VIEW OF KENT

# Registration Lapses

## *Dr Caroline Rickard, Medical Secretary*

It is a requirement for health professionals such as Paramedics, Nurses and Doctors to be registered with their relevant professional body. This provides assurance that the person has achieved the appropriate standard of competence and suitability.

Health professionals are personally responsible for ensuring that they remain registered with their regulatory body. Not all lapses in registration are problematic, for example if a person voluntarily leaves the workforce through retirement. However registration lapse can cause problems if they are due to a failure of the professional to renew and pay their registration fees, a failure to take part in the regulators continuing professional development or a failure to engage in the renewal process.

There are several issues for practices if a staff member's registration lapses, the main problem being that it is illegal for a person to use a protected title or carry out certain functions if they are not on the relevant register. The second problem would be that indemnity cover may not be available if negligence occurs.

If the registrant has lapsed through non-compliance with renewal or payment requirement they are unable to work until their registration is renewed. This has impact on practice service delivery while the member of staff is unable to work.

With the increase of allied health professionals in General Practice the monitoring of registration status of staff is getting more complex, with different professions covered by different regulators.

The following details the regulator and frequency of renewal:

| REGULATOR | FREQUENCY OF RENEWAL | LAPSING RATE (% OF REGISTER/CYCLE) | Profession |
|---|---|---|---|
| General Medical Council | Annual | 1.1 | Doctors |
| General Pharmaceutical Council | Annual | 1.1 | Pharmacists and Pharmacist Technicians |
| Nursing Midwifery Council | Annual | 7.6 | Nurses and Midwives |
| Health and Care Professions Council | Every 2 years at a set date by profession | 6.2 | Paramedics, Physiotherapists, Occupational Therapists, Social Workers and more |

It is up to your organisation to know when members of staffs' registration are due for renewal, and check it either electronically or with the production of the relevant certificate. A process should be in place for prompting renewals when they are due and checking all their professionals' registration status on a regular basis.

# Treating Patients who are out of the UK

## *Dr John Allingham, Medical Secretary*

Modern technology makes it easy for patients with medical issues to contact their GP from anywhere in the world. With the increase in on line and video consultations this issue can be expected to grow.

The NHS is only responsible for the care of patients within the UK and thus providing international advice is not something GPs have ever been contractually obliged to do.

However a recent addition of one of the Medical Defence Organisation's (MDO) bulletins pointed out that there is an additional risk in the event of an error or claim arising from this activity if the patient takes legal action within the country in which they were located at the time of the incident. It is possible that the MDO may be unwilling or unable to support the GP. Furthermore if a GP was acting outside of the GMS contract requirements then some personal liability may ensue.
Having recently been misled by a patient on a mobile phone who was in Spain I am now very careful to determine exactly where patients are when I talk to them.

**Treating patients in UK hospitals who are not entitled to NHS treatment**
As GPs we can treat anyone who is resident in our practice area irrespective of their immigration status.
The same is not true in secondary care but they have significant issues identifying those who are not entitled to free NHS treatment.

Our hospital trusts are working on processes to tighten up on the charging of overseas patients which may have some effect on practices.

We may see some patients we have referred being rejected as they can-

not or will not pay and it is considered that they have a condition they can live with. No one in need of urgent care should be rejected.

Although hospital trusts would love to receive the soft intelligence GPs may have regarding patients in referral letters there is no contractual duty to provide it.

If a patient is being referred who may need to pay it may be kind to consider warning them.

At the time of writing the EHIC card issued to EU citizens allows treatment to be free at the point of contact and to be reclaimed from their government. What happens in the future and how fast it happens is unknown.

## Primary Care Quality Standard (PCQS) - Unifying Enhanced Services across Kent—*Dr John Allingham, Medical Secretary*

For several years Kent LMC have been working with the 8 Kent CCGs to try and ensure all GPs across the county receive the same remuneration for the same services.

There are considerable differences in prices for what is often an identical or very similar service. There are services that are funded in some areas whilst in other places GPs are expected to deliver them and swallow the associated expenses without recompense.

The starting principle has been to achieve commonality in service specification and price. The aspiration is to level up and align with the highest price offered in Kent for the same specification.

There will have to be some transitional arrangements as there are one or two services where the highest price lies outside the range of others and this could pose a financial challenge.

We are working to unify the specifications for these services. The discrepancies are usually of a minor nature and it has provided an opportunity for updates in line with current guidance. The first services being reviewed in this way are: Community ECG; Treatment Room; Ambulatory BP monitoring; Phlebotomy; Women's Health; Complex Wound Care and 24/48-hour/7-day Ambulatory ECG.

The approvals for these changes are working their way through the relevant CCG committees during Spring and early Summer.

Additional services have been proposed for future phases from 2020. The long term aspiration is to be able to 'bundle' all the services together for a single price and for them to be delivered at practice or PCN level depending on local arrangements.

## Indemnity—What the new Scheme covers

*Donna Clarke, Practice Liaison Officer*

2019/20 sees the introduction of the Clinical Negligence Scheme for GPs (CNSGP) provided automatically by NHS Resolution. We have received several enquiries about what/who is or is not covered by the scheme. Basically, anyone working in a GMS/PMS/APMS practice providing NHS services is covered for clinical negligence under the scheme.

The key things you need to consider therefore are:

### Professional Negligence/ Performance Issues

CNSGP does not cover these, so you will need to take out an amount of indemnity for this purpose. It is worth shopping around as we are seeing a significant variation between the MDOs.
Similarly, you will need to consider whether the practice pays for such cover for nursing staff, many of whom have benefitted in the past from Practice Group schemes and are now receiving demands for this cover of several hundred pounds. This will be an internal matter for practices to decide and then negotiate with your staff. It would also be worth exploring cover that comes with RCN membership and whether that will be sufficient.

### Private Work

Private work is not covered under CNSGP. This will include things such as writing medical reports, cremation forms, travel services that are not included under NHS services etc. It could also impact your nursing staff if they are involved in travel clinics and as with the professional cover above you will need to consider who pays for the additional indemnity required.

### Further Information

There is now fully comprehensive guidance available on the NHS Resolution website which can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-general-practice/

There is also advice and guidance on the BMA website at:
https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-england/gp-contract-agreement-england/gp-indemnity-overview

Noticeboard

## Welcome to Loraine Kay

We are delighted to welcome Loraine Kay to the LMC team. Loraine joined us in February as our Senior Administrative Officer (Finance). By way of introduction we asked Loraine to share some interesting information about herself...

*I moved to Harrietsham in 2005 buying the local pub that had been converted to residential accommodation. We still have the beer/ale pipes running through our cellar but sadly for our hopeful Villagers we are not planning on re opening it as a pub!*

*Having worked and lived in London for most of my career, in Banking and Financial Services, moving to the country was a big transition. I soon learnt, after crossing a very muddy field to get to the station, that city heels and attire do not meet country requirements – I soon Bought Wellies and a Barbour! I commuted to London for two years after the move but decided, with long working hours and the commute, my home/Life balance needed adjusting. I took voluntary redundancy and worked locally in Ashford for the NHS Trust for two years. I have since had various contracts and roles working in finance across many sectors.*

*Outside of work I have two grown up step children and two lovely grandchildren, 2 and 4 years old, who I love spending time with.*

*I am active person and love running, boxing and yoga which probably marries well with my love for cooking and entertaining!*

*I also love singing and had singing lessons for many years, originally operatically trained and then later classical training. I even sung with a Jazz band on my Wedding day!*

Kent LMC joined the LMC Buying Groups Federation in 2008 to deliver savings to practices without creating any additional work or inconvenience.

Membership entitles practices to discounts on products and services provided by the Buying Group's suppliers.

TRUSTED TO SAVE GP PRACTICES TIME & MONEY

Membership is free and there is no obligation on practices to use all the suppliers. However, practices can save thousands of pounds a year just by switching to Buying Group suppliers. To view the pricing and discounts on offer you need to log-in to the Members section of the Buying Group website: https://www.lmcbuyinggroups.co.uk/

***Not convinced the Buying Group can save your practice money?*** Well... why not challenge them to do just that?

The Buying Group offers a free cost analysis service that aims to show member practices how much money they could save just by swapping to buying group suppliers. They can also provide this service for groups of practices working together. For more information, contact the Buying Group on 0115 979 6910 or email info@lmcbuyinggroups.co.uk


***Photo: Kent Messenger Group***
*Team Kana are cycling London to Brighton 16/6/19 for British Heart Foundation*

## Would you consider sponsoring us to raise funds for the British Heart Foundation?

When my phone started ringing late the evening of Wednesday December 19th it triggered a feeling of dread. On this occasion I was being called to be told that my GP colleague had collapsed and died at home.

We'd been thinking for some time that as a Practice we might want to re-enter a Team to cycle the London to Brighton Bike ride (raising funds for the British Heart Foundation) and the realisation that it was 20 years since I'd last cycled this and "Dr Kana" had been part of that team sealed the decision.

So on Sunday June 16th a team of 17 who work for or are associated with the Whitstable Medical practice will be cycling forth as "Team Kana".

Would you consider helping us in our endeavours to raise as much money as we can for the BHF by sponsoring us?

Below are the links for an article that appeared in last week's Whitstable Gazette and our JustGiving link.
Thank you for taking the time to read this.
Sandra Chandler (Dr)

https://www.kentonline.co.uk/whitstable/news/charity-bike-ride-in-memory-of-much-loved-gp-203375/

https://www.justgiving.com/fundraising/Team-Kana2019

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