July 2015 - Issue 16

Newsletter

North Staffordshire LOCAL MEDICAL COMMITTEE

Professional advice for General Practice

In this issue .....

Dear colleagues

Trying to write an editorial for the LMC newsletter this month is like trying to match the current weather, mainly wet and stormy.
Thinking about general practice this month is like thinking about the grieving process; grieving for what was once the cornerstone of the NHS.

•Denial - the whole DoH, MPs, newspapers and health system remain in denial about the pressures and constraints facing general practice - they are simply still not listening. How bad has it got to get? How long have the days anchored in front of a computer ploughing through docmans and bloods and delegated tasks and extras got to get? Has the service population cover got to tear? Even private providers have handed back their contracts, on to other private providers.
•Anger - very angry how colleagues are facing unfair and unsustainable workload pressures, yet continue to manage from day to day, unrecognised and belittled heroes. Very angry how public health makes central changes with no consideration for the workforce and locally thinks it can decommission a stop smoking service without prescribing cover. Very angry with the hand-cuff onerous lease arrangements for some of our properties. Very angry how the whole system wants to make us responsible for everything, but with no new resources and eroded old ones and thinks that it is a success when it manages to achieve another unfunded shift of workload! Very angry that the system has decommissioned intermediate care medical cover and hopes GPs will just do it anyway. Very angry at the current crazy 7/7 debate as if the capacity existed.
•Negotiation - locally encouraged with the establishment of our Federation board, relationships with CCGs and local links with NHS England. Uncertain where the future lies with the local trusts and how further workload shifts will be managed or supported. Uncertain where the future lies with the CCGs.
•Depression - aware that for some of us, this is a daily

GPC News

Here is the July GPC Newsletter

and Appendix 1

reality - for ourselves and our patients and that the health service currently is regressing - this now seems to be no longer a "phase."

•Acceptance - this in itself is unacceptable because the status quo is unacceptable - it is not good enough for ourselves, our staff or our patients. The system should not force early retirement, demotivate younger doctors and dis-incentivise professional ownership of service quality and delivery. Sinking to a bare-boned salaried unprofessional grind of a service is in no-one's interests, let alone watching GP access shred. Is all this deliberate privatisation creep or plain cock-up? Both are unacceptable, but it still seems to be happening to a hidden destructive political agenda.

The GPC has become aware that it has been disenfranchised from the national debate and that the true battle lines are now local.

Harald and I have discussions in the next few weeks about struggling practices and colleagues, infrastructure investment, the LIFT/CHP lease debacle, EOL and cancer commissioning, pathways and transformation, pharmacists, ESCAs and the Federation board launch. As well as the Federation, we are beginning to realise that some practices may need to merge for their own sustainability and minimum economies of scale. We are happy to discuss this and sign-point the help available. In Birmingham a group of practices have jumped past a Federation and just formed a 350,000 list practice, using accountancy savings to pay for their management structure.

We believe in the true value of what GPs and their staff do for patients day in and day out and that this is irreplaceable and vital for the sustainability of the NHS. The sooner the public and politicians realise this, the better.

I hope at some point you get a well deserved sunny holiday break this Summer, to recharge your batteries.

Regards and best wishes,
Paul Scott
Chair, North Staffs LMC

Patient Group Directions (PGD) and Patient Specific Directions (PSD) in General Practice

The GPC's guidance on Patient Group Directions (PGD) and Patient Specific Directions (PSD) in General Practice has been updated following regulatory and organisational changes within the NHS, and new NICE Guidelines.

The guidance is available on the Drugs and Prescribing page of the BMA website.

Indemnity Cover for Locum Nurses

Employers, i.e. GP practices, are expected to provide indemnity cover for nurses. Other practice staff on employment contracts are generally covered by the employer's vicarious liability.

GP practices should also, as a matter of course, check that locum staff have adequate cover before taking them on. If in doubt, practices should seek advice from their own medical defence organisation (MDO). Some MDOs may extend cover to locum nurses too.

Independent practitioners, however, should really have their own professional liability cover. Self-employed nurses can obtain cover through membership of the Royal College of Nursing. The RCN Indemnity Guidance states the following (page 7)

Working on a self-employed basis or running your own business
The RCN scheme will cover members in their own business, subject to the general conditions and exclusions, and dependent on the type of activity you are undertaking.

Even in the case of nurse locums who are provided through an agency, the locum nurse should take

responsibility for finding out whether they either receive professional indemnity cover through the practice where they will be providing locum cover, through their agency or if they are expected to arrange their own professional cover.

For further information see the NHS Employer's Professional Indemnity FAQs and the NHS Litigation Authority's guidance NHS Indemnity

The legislation requiring nurses to be covered for professional liabilities is The Health Care and Associated Professions (Indemnity Arrangements) Order 2014

New and amended meningococcal vaccination programmes for 2015-16 - England - correction

Further to the guidance from the GPC which we published in our June newsletter, the BMA have made some amendments to the vaccs and imms page on their website to clarify that the Freshers programme is now for Men ACWY rather than MenC. It should now read:

Meningococcal vaccination for University freshers

The Men C University freshers programme, which was due to start on 1 April 2015, has been on hold until the MenACWY vaccine becomes available. The MenACWY vaccination programme will now commence on 1 August 2015, which is when the vaccination programme for freshers will also commence.

Men ACWY vaccination will be offered to freshers (first time university or further education students who have received notification via UCAS to obtain the vaccine – aged 19-25) not previously vaccinated with MenC since reaching age 10 who self-present at their practice for vaccination. There is a flat fee of £7.64 for one dose.

This is a single dose programme for patients aged 19 years and over and will run from 1 August 2015 to 31 March 2016.

Further information about all these programmes is

available in the Meningococcal Table and on the BMA website Vaccs and Imms pages (see link in first paragraph of this article). The service specifications are available on the NHS England website.

Workforce Minimum Dataset (WMDS)

The GPC has advised LMCs on the Workforce Minimum Data Set (WMDS), and the actions practices were asked to undertake by the Health and Social Care Information Centre (HSCIC) in submitting this workforce data.
The GPC is aware that alternative guidance was provided to some practices. This guidance stated that although practices were required to submit the data, pressure could be exerted on NHS England and the HSCIC to prevent them from processing the data. It was recommended that practices encourage their staff to submit a notification under Section 10 of the Data Protection Act (DPA) to the HSCIC, lodging their objection to the use of their information, and asking the HSCIC to confirm they would comply with this objection and not process the data. This advice had been provided following communication with the Information Commissioner's Office (ICO).

The legal department has sought to clarify the position for practices, through further independent legal advice and correspondence with the ICO and HSCIC. Each has confirmed that data subjects do not have the right to issue a Section 10 notice under the DPA when the processing of data is being conducted pursuant to a legal obligation, as is the case with the WMDS. The legal advice also confirmed that practices could be in breach of their contractual obligations if they fail to comply with a legal requirement to provide data under direction of the Health and Social Care Act.

The GPC therefore recommend that practices continue to follow the guidance issued by them. The deadline for the initial data collection was 7 June and we understand the next collection of data will take place in November 2015. As mentioned in the GPC guidance, the GPC remains concerned about the burden placed on practices in completing this collection and will continue to take up feedback from practices with the HSCIC.

Please note that the HSCIC confirmed that they received a large number of Section 10 notices following the alternative advice provided to practices. They are in the process of responding to these applications to clarify the situation.

Where practices have queries or concerns they can contact the LMC or the GPC Secretariat at (info.gpc@bma.org.uk).

New framework set to simplify care information for disabled patients and their carers.

Disabled patients are set to benefit from improved healthcare after a new law comes into force to ensure information they receive is clear, consistent and easy to understand.

The **Accessible Information Standard** will be implemented on 31 July 2016 and aims to provide people who have a disability, impairment or sensory loss with information that they can easily read or understand. This means informing organisations how to make sure people get information in different formats, for example in large print, braille or via a British Sign Language (BSL) interpreter.

All organisations that provide NHS or adult social care are required to follow the new standard, including NHS Trusts and Foundation Trusts, and GP practices. As part of the accessible information standard, these organisations must do five things:

- Ask people if they have any information or communication needs, and find out how to meet their needs. Record those needs clearly and in a set way.
- Highlight or 'flag' the person's file or notes so it is clear that they have information or communication needs and how those needs should be met.
- Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.
- Take steps to ensure that people receive information which they can access and understand, and receive

communication support if they need it.

Further details are available here:

New £15m clinical pharmacist pilot to support GPs with significant workload pressures (England)

The NHS England Chief Executive, Simon Stevens, has recently announced the launch of a new £15m three year pilot to fund, recruit and employ clinical pharmacists in GP practices. The announcement is part of the GP workforce 10 point plan , Building the Workforce – the New Deal for General Practice, and is the result of close collaborative working between NHS England, Health Education England, the GPC, the Royal College of General Practitioners and the Royal Pharmaceutical Society.

The GPC has been heavily involved in the design of this pilot and sees this as another step in the right direction towards reducing workload pressures and improving recruitment. This scheme is of course by no means the answer, but is part of a series of initiatives that we hope will ensure struggling practices get the sustained resources they need to safely manage their workload.

The pilot will be comprehensively evaluated by an independent academic institution and NHS England plans to invest at least £350,000 in this evaluation process.

Further information about the pilot, including links to:
· the letter from Barbara Hakin, NHS England Deputy Chief Executive, to all GP practices in England
· the co-branded proposal for the scheme
· the application form
· FAQs and
· BMA press statements, online news and blogs from elected members,

are available via the BMA website

The Pilot Proposal
It will be funded for three years with an expectation that practices will continue with the role into year four and

beyond. NHS England will provide practices with match funding of 60% in the first year, 40% in the second year and 20% in the third year. It is anticipated that in the region of 250 clinical pharmacists will be involved over this period.

The focus will be on areas of greatest need where GPs are under significant pressure, and the pilot should build on the success of those GP practices already employing pharmacists in patient-facing roles. Practices working collaboratively, multi-site practices or GP networks / federations that are interested in offering patients different approaches to accessing care will be able to bid for funding from today.

The pilot proposal has two grades of clinical pharmacist working together:

· experienced clinical pharmacists who will be prescribers or working towards to prescribing qualifications and who will begin to see patients immediately, whilst developing additional skills such as leadership and change management;

· less experienced clinical pharmacists will be employed as part of the same development programme, working with and mentored by the experienced pharmacists, developing their clinical skills in the context of general practice with the intention of taking on prescribing responsibilities in the course of the programme.

Application Deadline

The deadline for applications is **Thursday 17th September** and a decision will be taken on successful bids around mid-October.

Roadshows

The partner organisations have agreed that a series of roadshows will be held throughout the application period in the eight regions with the highest levels of deprivation and the lowest GP training recruitment rates. GPC will provide further information to LMCs about this once the eight regions have been confirmed by NHS England.

In due course, LMCs and Local Pharmaceutical Committees (LPCs) will be invited to host the roadshows, and provided with funding from NHS England to do so, as LMCs/LPCs are best placed to bring together the various stakeholders who have an interest and need to be involved in this pilot, e.g. GPs, pharmacists, NHS England area teams, Local Education and Training Boards and CCGs.

Duty of care for hospital test results and drugs recommended from outpatient clinics

The joint GPC and Consultant Committee statement on hospital test results has been updated and a statement on Duty of care regarding drugs recommended from out-patient clinics has also been published – as per below and on the BMA website.

Duty of care regarding communication of investigation results

We are aware that in some areas, some hospital doctors have been instructing GPs to find out the test results which the hospital had ordered.

Both the General Practitioner Committee and the Consultants Committee of the BMA agree this practice is potentially unsafe, and that the ultimate responsibility for ensuring that results are acted upon, rests with the person requesting the test.

That responsibility can only be delegated to someone else if they accept by prior agreement. Handover of responsibility has to be a joint consensual decision between hospital team and GP. If the GP hasn't accepted that role, the person requesting the test must retain responsibility.

This advice is in line with both National Patient Safety Agency guidance and the Ionising Radiation (Medical Exposure) Regulations

Duty of care regarding drugs recommended from outpatients

Communication of prescribing recommendations from out-patient clinics to patients and their GPs is a complex area where patient safety can be compromised. We would strongly recommend that LMCs and Hospital Trusts agree policies that are publicised and adhered to by all parties. These policies should include the following general principles:

•Drugs required for urgent administration should be prescribed by the hospital doctor, and if appropriate dispensed by the hospital.
•Responsibility for the provision of a prescription for non-urgent medications should be determined and agreed locally, but must recognise that delegation of responsibility for prescribing from hospital to GP can only take place with the explicit agreement of the GP concerned.
•All communications should be in writing with the responsible doctor identified.
•Where communications are sent via the patient, there should be clear instructions to the patient regarding the time scale for completion of the prescription, and this should be in addition to and not instead of a formal communication.
•The doctor recommending a prescription should ensure that the prescription is appropriate, including carrying out any tests required to ensure safety.
•The doctor recommending a prescription should provide counselling for the patient about important side effects and precautions, including any need for ongoing monitoring, which if needed should be agreed between primary and secondary care clinicians.
•Recommendations should be in line with any agreed local formularies. Individual judgements should be made about the desirability of recommending a particular drug as opposed to a therapeutic class.
•Where a GP feels that a prescription recommendation is inappropriate, the secondary care clinician should be informed.
•Notwithstanding any of the above, all prescribers must be aware that the ultimate responsibility for the prescription lies with the prescribing doctor and cannot be delegated.

Please report any ongoing problems with this issue to the LMC.

Female Genital Mutilation Prevention Programme

Jane Ellison, Minister for Public Health, has written a **letter** which has been sent to NHS Trust Chief Executives, Directors of Public Health and Chairs of CCGs across England.

Within the letter, the Minister highlights the need for

extra vigilance across the NHS as we approach the school summer holidays, a time when female genital mutilation is often performed on young girls who are taken abroad for this purpose. She outlines the main 'warning signs' for NHS staff to look out for, and the range of support and training materials available. The letter reiterates that FGM is illegal, and that safeguarding procedures must be followed every time there are concerns.

Please also see article for The Guardian Health Professionals Network which highlights this letter.

Focus on the global sum allocation formula (Carr-Hill Formula) - England

The global sum allocation formula, or Carr-Hill Formula, has been used as the basis of core funding for GMS practices since the inception of the new GMS contract in 2004. This short explanatory paper has been produced now because the allocation formula is newly relevant to some GP practices. You can access the guidance here

Post-operative Swabs

You will be aware that hospital staff take nasal and perineal swabs when patients attend in the pre-operative assessment clinic. This is a reminder that if these swabs are found to be positive it is the hospital's responsibility to decolonise these patients. This includes informing the patient of the swab results, providing a prescription for decolonisation and advising patients how to administer this. The LMC would therefore advise practices to decline prescribing for decolonisation of MRSA in these circumstances.

Stoke City Council - requests for confirmation of medication requirements

The LMC has been contacted by GP colleagues expressing their concern about repeated requests from the Community Wellbeing Team for practices to provide confirmation of medication requirements for patients.

The LMC has reviewed the City Council's medication policy and cannot see anything in the policy which indicates that care staff are expected to obtain this information, as clearly the GP will have provided instructions on use when the prescription was issued. These unnecessary requests for information put an additional strain on an already overstretched GP workforce, and the LMC would advise practices to decline to cooperate with these requests. The LMC is awaiting clarification from the council on this subject, and has asked that carers are informed of the LMC's view.

Parachute Medical Forms

The LMC has been asked for guidance on how to deal with requests for completion of medical forms for parachute related activities. Patient should normally be expected to present with a form from The British Parachute Association, which contains a self declaration and a statement for the GP to complete. An explanatory note for GPs will normally be attached, but if need be the BPA, who are generally very helpful, can be contacted by telephone. You can access their commonly used medical forms here.

Sessional GP e-newsletter

Here is the July edition of the sessional GP e-newsletter

The Chair's message focusses on Death in Service, the e-newsletter also features top tips on working in commissioning, and some interesting blogs.

It has been sent out to all the sessional GPs on the BMA's membership database. Using the new format it is also possible to easily highlight different sections of the newsletter via social media if you use Twitter, etc.

Subject Access Requests for insurance purposes

The GPC has issued new guidance on the use of SARs which can be found here. I would encourage you to read this as you may wish to implement the recommendations into your day to day practice.

Deprivation of Liberty Safeguards (DOLS)

Guidance from the chief coroner has taken the view that those who die subject to a DOLS amount to "death in state detention". This means a coroner's inquest just like those who die in prison or police custody. The number of patients subject to DOLS increased since Baroness Hale judged that even those who make no attempt to leave are still deprived of their liberty if they would have been detained if they had made an attempt to leave.

If an attending GP finds a patient of theirs subject to a DOLS then they ought to refer the case to the coroner.

Like in other coroner cases, it is the coroner that releases the body for cremation or burial and so the GP need not write a medical certificate of cause of death or cremation form. What is different is that the coroner requests a mini-report from the GP in these cases. You will be aware that the coroner has stopping paying GP for any factual reports but the report is a similar amount of information as on the medical certificate of cause of death. Hand written and typed reports on the mail-merge template available from the coroner are acceptable.

It is a little known fact that it is the registrar's responsibility in law to report cases to the coroner rather than the GP. Custom has developed where in fact the attending doctor reports. Therefore if a registrar happens upon a medical certificate of cause of death in a case where the deceased was under a DOLS they would be duty bound to report to the coroner. This may cause distress to the bereaved family.

Practices will come to their own arrangements on how far they go in obtaining DOLS information on their patients, whether prospectively or opportunistically upon the death of care home residents by the certifying GP. The LMC knows of nothing in the GMS contract that make it a contractual obligation to hold a register of patients under DOLS for example. DOLS read codes are available as follows however.

Read Version - 9NgzG - standard authorisation of deprivation of liberty given.
Clinical Terminology Version 3 - XaZfO - standard authorisation deprivation of liberty MCA 2005 given.

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Transfer of Private Patients to NHS

We still hear stories of consultants in private practice asking GPs to transfer/refer patients to NHS care. This is NOT a GP's responsibility. If a patient has been referred to a consultant privately for a first outpatient appointment and the patient wishes to be transferred to NHS care, then it is the responsibility of the private consultant to refer the patient directly into the NHS. At this point in time, the patient will enter the 18 week pathway at the date that this decision was undertaken, not on the date that the original referral was made and patients will be subject to NHS waiting times. In addition, the surgery/treatment/diagnostics required must be routinely commissioned by the CCG.