



January 2020 Edition



## **New LMC website**

**Editorial by Richard Turner**

**Communications Lead at Kernow Local Medical Committee**

Ever wondered if a particular piece of advice or guidance for general practice exists? You're probably not alone – and the likelihood is the LMC has been asked by other local GP surgeries before.

Dedicated guidance on a wide range of topics for GPs, sessional GPs and Practice Managers is one of the key features of our new enhanced LMC website, which is set to launch shortly.

We have also integrated a Google Search function on our homepage so you can search our archive of monthly updates.

So if you have a query, try searching our new website first – it might save you precious time.

The website will also offer information about the latest job vacancies and events in local general practice – and an alternative route to access pastoral support.

It also includes more information about the LMC, our role and work – and how you can get involved or raise issues with us.

The website is easy to navigate and view on all devices, such as smartphones and tablets. When it goes live it will be via the same domain name as our existing website:

[www.kernowlmc.co.uk](http://www.kernowlmc.co.uk)

We have involved some local GPs and Practice Managers in planning the website's content and design. The website will evolve and we will continue to add new features as it beds down. If you have any content suggestions, or wider feedback about the website, please email [rich@kernowlmc.co.uk](mailto:rich@kernowlmc.co.uk)

Everyone on our LMC database will shortly receive an email inviting them to sign up to access the new website and its secure areas. Registering is quick and simple and the benefits include:

- View any restricted guidance.
- Place job adverts for your practice. We are happy to post adverts for Kernow GP practices free of charge. Just complete the vacancy form.
- Upload a training event.
- Link with the LMC – if you haven't already – so we have up to date contact details for you.

## **Proposals for the service specifications for the PCN DES – position statement by Kernow LMC Executive Team**

This statement is not intended to present an exhaustive analysis of the concerns, possible opportunities and questions raised by these proposals issued by NHS England and NHS Improvement (NHSE &I).

Rather, its purpose is to provide a perspective rooted firmly in the realities of general practice in Kernow, and with the unapologetic aim of understanding how they build on the original stated intention to protect, support and improve general practice – for the practitioners working within it, as well as for their patients.

When looking through the individual specifications, there are clear concerns about the workforce capacity to undertake the extra work and it appears that much is dependent on additional staff freeing up capacity to take up the extra services and working across a range of providers. At present, it feels that a large swathe of general practice experience in the Duchy would suggest that we are not sufficiently ready for this across any part of the healthcare system, let alone within primary care.

Right now, general practice needs additional resources just to undertake the day job of core contract work. Working collaboratively is an 'apple pie' aim that few would argue against, but this takes considerable time, energy and a not inconsiderable cultural shift – none of these concepts can be expected to be mature and thriving within 12 months.

This very early introduction of new pathways against this landscape may be well-intentioned. However, it indicates a wholly concerning lack of insight into the realities of general practice and of our colleagues in allied community services, which have not substantially improved for most since the new contract was announced last year; a fact that is of no surprise to anyone working within it. It was always going to take considerable time.

At the risk of playing that same broken record once again, additional work – and these specifications are all looking to generate additional work – needs additional workforce and premises space to provide the work from; the mere existence of Primary Care Networks (PCNs), tethered to funding that can only be accessed in significant sums where recruitment can be successfully achieved, is not evidence that this has been achieved.

Alongside our LMC colleagues across many parts of England, we are extremely concerned that aspects of the core GP contract do not become eroded as a result of signing up for the PCN DES. Understandably, GP colleagues will begin to question whether they should sign up to the PCN DES in 2020/21 if it means that their national contract is going to be impacted via that DES, where NHSE&I effectively overrides that of which it disapproves within the national contract.

When the PCNs came together in July 2019 and we were told of future services that will need to be provided many of us expected that the new services would come in the form of

appropriately funded service specifications. It is of great concern that this does not appear to be NHSE&I's intention. As stated, if the key to accessing substantive funds is abundant recruitment, we have a long way still to travel along that path in Kernow. If you are expected to undertake these services while you still have vacancies across the permitted additional roles, then this will not work.

These published proposal documents generate the very real risk that relationships of trust and good faith are damaged, as between PCNs and NHSE&I. Expecting the PCNs to "sort out" resource problems across multi-provider professional boundaries when so many variables are beyond their control is unrealistic.

Now for something a little more positive ...

We are advised that the draft service specifications are intended as a starting point for future negotiations. In which case, if you have not already done so then please make your voices heard. Please respond to the NHSE &I survey. We shall certainly be doing so.

Your time is pressured and precious. By making your views known, it will provide our national General Practitioners Committee (GPC) negotiators with the volume of feedback that will help them to represent the profession at this critical juncture.

Please making your feelings known by responding to the online survey by Wednesday, 15 January 2020: <https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/consultation/intro/>

*Addendum:*

*The mood around the traps is pretty bleak. It would not make any sense for a PCN to sign up to the published draft PCN specifications in their current form. The engagement exercise has been an attempt by our negotiators to provide enough noise to make this clear to NHSE&I. Hopefully you have fed back and we continue to lobby through a multitude of channels in the hope that sense will prevail. However, before you despair and disengage, I would suggest the real risk is yet to come. In negotiating terms, the best way to get someone to agree to let you chop off their finger is to tell them that you are going to chop off their arm....after a lot of shouting you back down and the sacrifice of a finger seems like a lucky escape. In this context it is the next bit that is really important when the negotiated actual specification for the DES emerges in a watered-down form. We still should expect to keep all our fingers, or walk away.*

### **Opportunity for PPGs to lobby nationally over draft PCN service specifications**

Local Patient Participation Groups (PPGs) are encouraged to lobby the Government and NHS England and NHS Improvement (NHSE&I) about the draft Primary Care Network (PCN) service specifications.



A letter has been drafted on behalf of PPGs in Kernow and Devon – with thanks to Dr Alan Holman, a GP Partner at Roborough Surgery, in Plymouth – which you may wish to share with your PPG, if you have one, to comment on before it is sent to the Government and NHSE&I.

Comments should be fed back to the LMC this week to capture via [admin@kernowlmc.co.uk](mailto:admin@kernowlmc.co.uk) The draft letter and supporting information is available [here](#).



## Medication returns and the need for prompt action

By Nicola Davies, Practice Manager at Roseland Surgeries

At the recent Practice Managers Conference, one of our guest speakers was a GP who regaled us with some humorous (and not-so-humorous) tales of life as a GP in rural Ireland. In his recent book, this doctor had been very honest about his journey with morphine addiction, something that started in his surgery and ended with him being struck off. What was particularly sad about this story was when we learned that after being clean for 10 years, he unfortunately dipped again into full blown addiction, having got his hands on some morphine that had been brought back into the surgery by a patient whose relative had recently passed away.

This got me thinking about how we deal with medication returns in my surgery. As a dispensing practice, we unfortunately get lots of medication coming back to us – either meds have been changed, the patient has died, or it wasn't wanted. I won't bore you with my rant about the cost of this sort of drug waste, but I became anxious about those shopping bags, casually left at the surgery awaiting action and subsequent incineration.

The concern that this raises for me is if that bag contains controlled drugs (CDs), those drugs don't really 'exist' until they get booked back into the dispensary for destruction. The audit trail is there for the prescription to the patient and the dispensing of the same of course, but if drugs are sat in a bag under a desk in the dispensary, they could be there for anyone to get hold of and we wouldn't have a trail at all – because they might never get to the CD cupboard, ready for their ultimate demise.

Now, I'm not for one minute suggesting that our surgery teams are potentially in hiding waiting for illicit drugs of one sort or another to come their way. However, what are our processes for dealing with returned medications? What does my 'SOP' say (do I even have a SOP?!!!) How quickly do we action that shopping bag after it is dropped off by a well meaning relative? Is this something that CQC will ask me??

The key for me is making sure that my reception team know they need to pass that bag to the dispensary immediately it is left with us, and equally the dispensary team know they

must check it through for any CDs as soon as it gets handed to them. If there are any CDs present, these are then 'booked' in ready for destruction and locked away until such time as we can get someone from the Medicines Management team to assist with that task.

There are lots of things that happen in our surgeries that require us to do risk assessments and this cautionary tale highlights just how easy it was to get hold of drugs. As a result, I've made a point of discussing this story with each member of my team and I'm confident now we've got processes secure enough to mitigate any risk we might have.

I know it's another job to add to the never-ending-to-do list, but better safe than sorry!

### **PM Conference evaluation**

**By Nicky Sherry, Executive Administrator at Kernow Local Medical Committee**

It was lovely to see so many faces – both old and new – at the Practice Managers Conference, hosted by Kernow Local Medical Committee and Kernow Health.

Many thanks for the return of the evaluation forms, lots of very informative comments, all of which we have taken on board and where possible will be looking at for any future event of this proportion. Both praise and criticism are good because if we are not told we don't know and cannot put things right for the future.

I have put together some of the replies, which I thought you would be interested to know:

Expectations of the event by you were met, according to most of the replies, which is always good to know. Organisation of such an event to appeal to all is very difficult and if we managed to satisfy the majority then a job well done.

The venue – most of you liked the venue, but would have preferred no coffee break queue! We did also ask for suggestions of any future venue and several suggestions will be investigated. Thank you to those of you who responded to that.

Speakers – we tried to give you a variety which met with a mixed opinion. Again, we have taken on board the comments – your likes and dislikes. However, very good support for our speaker at the end of the day, Dr Krishna Kasaraneni, from the General Practitioners Committee (GPC), and many of you said that it was well worth staying to the end to listen to him.

Perhaps the biggest criticism was the time allowed for the workshops – not enough of it! Lots of you did comment on this – it was felt that there should have been fewer workshops and more time spent in each one. That said, comments on the actual content were very positive and most of you found them to be informative and well worth attending. Lots of good suggestions were made on future presentations/workshops – topics including Personal Development and HR issues, to mention but a few. The workshop that came out on top without a doubt was 'Mindful Monkeys'.



And so finally thank you for your support and attendance at this event and hopefully you found it a useful day and we will look forward to seeing you at a future event.

### **LMC levy deduction – November GMS Payment**

Local GP practices will have noticed that you had no LMC levy deducted by Shared Business Services (SBS) from your November GMS Payment. This was an omission by SBS and we are told that this will be corrected with your next payment, therefore there will be two months' levy deducted from your December GMS payment.

### **Practice Admin Staff Workshops in 2020**

**By Nicky Sherry, Executive Administrator at Kernow Local Medical Committee**

Many thanks to all of you that supported our training schedule for 2019 – most of the workshops were booked very quickly and waiting lists soon grew. I hope that we did manage to accommodate at least most of you in the end.

Our training schedule for 2020 is now available and ready for the workshops to be booked. There is a limit of 15 delegates per workshop and so early booking is recommended.

In the course of the next few months there will be others added to this, but this is for starters.

I would like to draw your attention to the booking forms. We have made a slight increase in the cost – £60 for a full day workshop and £40 for a half day workshop. The fees are payable once a booking form is received and the place confirmed back to the practice. These fees are also non-refundable.

If you need anymore information on the workshops, please email me at [admin@kernowlmc.co.uk](mailto:admin@kernowlmc.co.uk)

### **Non site specific/vague symptoms pathway briefing**

**By Sarah-Jane Davies, Transformation Project Manager (South West Cancer Alliances), South West Clinical Networks & Senate, NHS England and NHS Improvement**

NG12, the NICE guideline regarding referral criteria for suspected cancer, gives good guidance on when to refer patients with a variety of site specific symptoms. Our local hospitals provide an excellent service for patients identified as requiring investigation via these routes. In addition to patients with cancer suspected in a particular site, it is also common for GPs to suspect cancer in patients with weight loss, malaise, or other significant symptoms in the absence of clues as to the site of cancer origin. There are data to show that the presence of a 'GP hunch' for cancer has a positive predictive value of greater than 10% – far higher than the 3% threshold designed into the NG12 guidelines.

At present, none of our suspected cancer pathways serves these patients well. GPs and hospital clinicians often work creatively together to find efficient and timely diagnostic



pathways, but some patients experience multiple outpatient attendances and significant delays despite clinicians' best efforts. Some patients deteriorate clinically to the point where they are no longer able to tolerate palliative chemo or radiotherapy, or even such that they require admission. Multiple clinic attendances and unplanned admissions are costly, but above all this is a poor and anxiety provoking experience for patients and their relatives. The lost opportunity associated with avoidable delay is increasing as more modern treatments can offer significant prognostic benefit even in patients with advanced disease.

The Peninsula Cancer Alliance, in conjunction with our partners in acute trusts and the clinical commissioning groups (CCGs), has been developing a 'Non-Specific but Concerning Symptoms', or NSCS Pathway. This will give the concerned GP clear guidance as to diagnostic tests to be performed in primary care and an option to refer for urgent CT of the Thorax, Abdomen and Pelvis once these are complete. Following a scan, patients with results indicative of cancer will be referred directly to the relevant MDT. In some non-cancer cases specialist opinion may be provided without the need for further referral, and in others the care of the patient will be returned to the GP.

We expect all of our providers to be launching these services by April 2020 and will offer further communication on a more local basis as each service goes live.



### **Faecal Immunochemical Testing for Symptomatic Patients (FIT 10) – update** **Dr Joe Mays, GP Lead for Early Diagnosis for the Peninsula Cancer Alliance**

Faecal Immunochemical Testing or 'FIT 10' as an adjunct in risk stratification for patients with low risk symptoms has now been available to GPs in Cornwall and across the South West for nearly 18 months. Uptake of the test has been excellent, with 94% of all surgeries having returned at least one test during this period and over 12,000 tests completed overall.

GPs will no doubt remember that FIT 10 is a test for patients with symptoms that raise a concern of possible bowel cancer, but *do not cross the threshold for 2WW referral*. Following FIT 10 testing, NICE recommends that patients with a positive test should be referred via a suspected cancer pathway for colonoscopy, and that those with a negative test do not need endoscopic investigation. We have always been keen to emphasise that a negative test only rules out luminal pathology, and that if the patient has concerning symptoms they may still need other urgent investigation.

It is also essential to abide by the guidance that FIT 10 is not a substitute for endoscopy in patients who meet the 2WW referral criteria; the sensitivity of the test is inadequate for the purpose of excluding cancer in this higher risk group.



Interim analysis of the data gathered from our introduction of the test in the South West is highly encouraging: Around 15% of tested patients are positive – and of these around 8% have cancer. This confirms two things.

1. This patient cohort have approximately a 1% pre-test risk of cancer and it is therefore appropriate to use FIT 10 rather than 2WW endoscopy.
2. At 8% risk, patients who test positive with FIT 10 are an appropriate cohort for referral via suspected cancer (2WW) pathways.

In addition, patients diagnosed with cancer via a pathway containing FIT 10 are more likely (57 vs 48%) to be diagnosed with an early stage tumour (Stage 1 or 2) than average.

We strongly recommend that GPs continue to consider using FIT 10 for risk stratifying patients with symptoms that indicate a low risk but not no risk of bowel cancer. As an aide memoir:

- Aged 50 years and over with unexplained abdominal pain or weight loss
- Aged 50- 60 years with changes in their bowel habit or iron deficiency anaemia
- Aged 60 years and over and have anaemia – even in the absence of iron deficiency

Please bear in mind that FIT 10 is different from FIT 120. FIT 120 is the screening test used as part of the national screening programme for colorectal cancer. As the name suggests, this identifies as positive patients with a level of 120µg/g, as opposed to 10µg/g and is correspondingly less sensitive. If patients present with symptoms fitting the descriptors above, or with symptoms indicating a need for 2WW referral, the GP should not be reassured, nor offer reassurance to the patient, on the basis of a recent negative FIT 120. We recommend that the practitioner proceeds as the symptoms indicate, ignoring the recent screening result.

The Peninsula Cancer Alliance would like to thank our colleagues in laboratory, endoscopy and cancer services in the five acute trusts in the Peninsula and all of the GPs who have ordered tests. Between us we have been able to provide excellent evidence to support the routine use of FIT 10 as a cost-effective tool for the earlier diagnosis of cancer.

### **Performance Advisory Group newsletter**

The latest shared learning from the regional GP Performance Advisory Group meeting – where concerns raised about GPs are reviewed, including information from serious incidents, SEAs and complaints – is available [here](#).

### **Dementia training videos**

The South West Mental Health Clinical Network (SWMHCN) has produced a series of short training videos for GPs to build upon their existing knowledge. The videos are presented by Dr Peter Bagshaw, Clinical Lead for Dementia for the (SWMHCN), and are available [here](#).



### **Police warning after burglaries and frauds at GP practices**

Devon and Cornwall Constabulary is warning local GP practices to be vigilant after two recent burglaries and subsequent frauds in Devon.

In both incidents, someone entered a consulting room when the GP had stepped out and stole their wallet. They subsequently contacted the GPs pretending to be the bank and obtained the PINs of the stolen cards to withdraw money.

Police are advising GP practices in Kernow to also be vigilant, protect their property and challenge people they don't recognise in areas they shouldn't be in the surgery.

### **Influenza 2020/21 letter**

NHS England and NHS Improvement (NHSE&I) has published a [letter](#) based on the recommendations by Joint Committee on Vaccination and Immunisation (JCVI) which sets out the vaccines that should be offered to eligible people and the reimbursement guidance for 2020/21.

### **Schedule change to routine childhood immunisations (PCV)**

Babies born from 1 January this year will move to a new schedule for the PCV vaccination programme. They will receive one dose at 12 weeks and one booster dose at 1 year of age. This is a positive change reflecting the success of the PCV vaccine and should be well received by parents as babies will now receive only two injectable vaccines at each of the 8, 12 and 16 week appointments. Babies born before 31 December 2019 will continue to receive two primary doses (8 and 16 weeks) and one booster dose at 1 year of age. More information is available in the briefing [here](#).

### **Legal action against NHS Property Services**

The General Practitioners Committee (GPC) has issued a new briefing outlining its stance against the unrealistic financial demands that NHS Property Services is putting on GP practices leasing its estates – many have seen significant increases in service charges and facilities management costs without prior agreement, while some report being billed for services they are not receiving. Read more [here](#).

### **General Practice IT Survey**

NHS Digital provides a framework (GPSoc and from 2020 Digital Care Services) for GP practices to obtain IT systems. GP practices are asked to complete a short [survey](#) to help NHS Digital understand the benefits realised through the use of these IT systems to help shape its future strategy.

### **Pensions**

Primary Care Support England (PCSE) has provided an [update](#) about the End of Year Pension administration processes for 2020 and the Annual Benefit Statements (ABS).

### **Open Exeter update**

GP practices are reminded that Primary Care Support England (PCSE) is only replacing the payment and pension element of Open Exeter as part of the decommissioning process – it won't be reproducing all the data currently on ENHAIS.

Practices will still be able to view old data on Open Exeter but not new data once it has been decommissioned.

### **Updated BMA handbook for salaried GPs**

The General Practitioner's Committee's (GPC) Sessional GP Committee has just updated the salaried GP handbook which is written for salaried GPs and GP employers. It will also be of interest to those who are intending or about to become salaried GPs. It explains the legal entitlements of salaried GPs as employees and helps to ensure that salaried GPs are aware of their statutory and contractual rights. It also helps to prevent GP employers contravening the law unwittingly. In addition, it explains the national and local representation of salaried GPs, how to become a salaried GP and the work involved. You can access the updated handbook [here](#).

### **Electronic Prescription Service update**

The [Electronic Prescription Service](#) (EPS) allows prescribers to send prescriptions electronically to a dispenser of the patient's choice. Phase 4 of the EPS is currently being rolled out on TPP SystmOne. Read more [here](#). The General Practitioners Committee (GPC) IT policy group lead, Anu Rao, has also written a [blog](#) about EPS and the other workstreams that the group are involved in.

Currently, dispensing practices are unable to use the EPS for medicines dispensed by the practice dispensary. Further information for dispensing practices has been produced by the Dispensing Doctors' Association (DDA) and is available [here](#).

### **Best practice for remote consulting and prescribing**

The General Medical Council (GMC) has published [10 high level principles](#) describing good practice expected of healthcare professionals when consulting or prescribing remotely from the patient.

### **National General Practice Profiles: 2019 annual update**

Public Health England (PHE) has published a data tool presenting a range of GP practice-level indicators using the latest available data in the [National General Practice Profiles](#). This is designed to support GPs, clinical commissioning groups (CCGs) and local authorities to commission effective, appropriate healthcare services for their local populations. Users can search for and view data for individual GP practices and compare them with others in CCGs and across England.

### **GMC's State of Medical Education and Practice annual report**

The General Medical Council (GMC) has published its State of Medical Education and Practice [annual report](#). It notes that 45% of GPs reported working less than full time (61%



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female GPs compared with 26% male GPs), 36% have reduced their hours in the past year, and many are considering leaving the profession altogether (18% in the next year).

Increasing workloads has resulted in two thirds of GPs working over their rostered daily hours with 19% taking stress related absence over the last year. 92% of GPs reported that they felt unable to provide sufficient levels of care at times while a quarter reported witnessing patient care being compromised. Despite this, the report also notes that around half of GPs are satisfied in their work, largely driven by a sense of fulfillment.

## Information Commissioner's Office chasing unpaid data protection fees

The Information Commissioner's Office (ICO) has launched a [campaign](#) to contact organisations who have not yet paid their annual data protection fee. The data protection fee replaced the requirement to notify the ICO under the previous Data Protection Act 1998 and now organisations that act as controllers when processing personal information must pay a fee on an annual basis, unless they are exempt. For most practices, this fee will be £40 (reduced by £5 if paid by direct debit). The fee amount that needs to be paid can be checked via the [self-assessment](#) tool on the ICO website. The ICO have sent out a template letter in the post to organisations they have identified as not yet having paid their fee, warning them of the consequences of non-payment which includes fines of up to £4,000. You can pay [online](#) at the ICO website.

## Why should I pay the GPDF Voluntary levy?

This is a valid question which is asked by GPs from time to time. The General Practitioners Defence Fund (GPDF) has produced a short [briefing](#) about its role and how it uses the funds gathered from GPs via LMCs with the aim of supporting and advancing general practice.

### Latest jobs in local general practice

The latest practice vacancies – including GP and practice manager roles – are available on the [jobs page](#) of the LMC's website. Vacancies are also available on the [jobs page](#) of Kernow Health's website.

Kernow Health's Staff Bank is also now live for workers and practices to sign up. Please follow these links:

<https://cornwallcepn.co.uk/general-practice-staff-bank/>

[Bank Worker sign-up](#)

[Practice manager sign-up](#)

Lantum are supporting practices in key functions, including adding shifts and availability. If you or your practice teams would like any additional support in using the Bank, please contact [kernowhealth.workforce@nhs.net](mailto:kernowhealth.workforce@nhs.net)

### Events calendar

The LMC's [events calendar](#) provides an overview of what's taking place to support local general practice.



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Produced by Kernow Local Medical Committee. Copy submissions for the February 2020 newsletter should be emailed to Richard Turner, Communications Lead at the LMC, at [rich@kernowlmc.co.uk](mailto:rich@kernowlmc.co.uk) by Monday, 27 January please.

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