The Humberside Group of Local Medical Committees Ltd

Newsletter: 29 May 2015

The LMC Newsletter is a round-up of interesting news and information for GPs and Practice Managers in Hull, East Yorkshire, North Lincolnshire and North East Lincolnshire. You can read from top to bottom or alternatively, use the contents section to jump to items of interest. Items marked with a * and in orange on the content list are highlighted either because of their importance or because they contain information you may not yet have seen elsewhere.

CONTENT

CQC & INSPECTION

Guidance for Dispensing Practices Regarding Prescriptions

It has come to the LMC's attention that there have been some issues picked up by CQC inspectors in relation to the way that prescriptions are issued in dispensing practices.

We wanted to draw your attention to the CQC Mythbuster that deals with this issue, which is reproduced below in full and may help avoid issues arising during an inspection.

CQC Mythbuster 11 – Prescriptions in Dispensing Practices

We have been asked a question about dispensing practices where during a consultation, the GP sends a prescription to the dispensary for printing, which is then dispensed before it's signed.

We have agreed the following with the Dispensing Doctors Association and the British Medical Association.

Although potentially this does not comply with regulations, sending a prescription to the dispensary electronically is in keeping with modern good practice. It's safe, liked by patients – and has the great advantage that we know that the prescription has been collected.

The prescriber takes responsibility for the medicine being provided to the patient. This function is provided in the consultation by the prescriber (as opposed to a dispenser) pressing the 'issue' button, much as letters can now be electronically 'signed'. All IT systems have an audit trail that records exactly when this took place. So in many ways this is more robust than a paper signature.

Background

Practices need to have robust systems in place to ensure that prescriptions are produced and signed in accordance with the current regulations.

Schedule 2 of the National Health Service (pharmaceutical) Regulation and the associated paragraph 39(3) of Schedule 6 to the GMS Regulations

In circumstances where paragraph 3 does not apply and subject to the following provisions of this Schedule, where a dispensing doctor is authorised or required by virtue of Part 5 of these Regulations to provide a drug or appliance to a person –

(a) he shall record an order for the provision of any drugs or appliances which are needed for the treatment of the patient on –

  (i) a prescription form completed in accordance with the term of a contract which gives effect to paragraph 39(3) of Schedule 6 to the GMS Regulations or an equivalent provision applying in relation to that contract, or

  (ii) if paragraph 39A(1) of Schedule 6 to the GMS Regulations applies, an electronic prescription form;

Schedule 2 of the National Health Service (pharmaceutical) Regulation 2005

(3) In issuing any such prescription form or repeatable prescription the prescriber shall himself sign the prescription form or repeatable prescription in ink with his initials, or forenames, and surname in his own handwriting and not by means of a stamp and shall so sign only after particulars of the order have been inserted in the prescription form or repeatable prescription, and –

(a) the prescription form or repeatable prescription shall not refer to any previous prescription form or repeatable prescription; and

(b) a separate prescription form or repeatable prescription shall be used for each patient, except where a bulk prescription is issued for a school or institution under paragraph 44.

Paragraph 39(3) of Schedule 6 to the GMS Regulations 2004

Dispensing Doctors Association (DDA) guidance

DDA guidance to its members is clear that prescriptions should be signed before they are dispensed. This has been included in their publications for the past four years.

Dispensing practices should be able to demonstrate that they are aware all prescriptions should be signed before being dispensed. If they do not sign prescriptions before they are dispensed they should be able to demonstrate that they have risk-assessed this and put a process in place that minimises risk.

Pragmatic approach

Acute/consultation prescriptions
Ideally prescriptions should be printed in the consultation room and signed at the time. If this is not the case, there needs to be a robust process in place to ensure that prescriptions are usually signed at the end of the same day. There should also be a robust system to verify the accuracy of the supply. This will be acceptable – even though it's not in strict compliance with the terms of the regulations. This would not apply to those prescriptions for Controlled Drugs that should be signed before being dispensed except in an emergency situation.

Repeat prescriptions
These should be signed before medicines or appliances are supplied to the patient – and ideally before the dispensing takes place. There needs to be a robust process around this. There may be occasions where this is not possible, but the procedure to follow for these occasions should be covered by the practice protocol. On these occasions there would also need to be a clear audit trail.

Last updated: 11 December 2014

CQC Guidance on Registration Requirements for GP Federations

This guidance will help groups of registered providers who wish to form a federation to understand their duties and responsibilities around CQC registration. CQC has summarised the issues that federations should consider and provided case studies to illustrate different registration scenarios.

CQC Obligations on the retirement or admission of a GP Partner

You might have thought there were already enough hoops to jump through when dealing with the admission or retirement of a partner – but the CQC Regulations added yet another!

Failure to deal with CQC requirements within the appropriate timeframe can result in plans having to be re-scheduled, often at the 11th hour.

The procedure to follow to ensure your Partnership CQC Registration is up to date and compliant will depend upon whether your partnership was registered with the CQC pre or post 04 February 2013.

Hempsons have recently produced a really helpful guide to see practices through the process.

CLINICAL ISSUES

Patient Group Directions and Patient Specific Directions Guidance – Updated May 2015

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.

Influenza Season 2014/15 – Prescribing and Supply of Antiviral Medicines

The most recent surveillance data, which has been assessed by Public Health England (PHE), demonstrates that the circulation of influenza in the community has returned to baseline levels and, in the view of PHE, below the level at which the National Institute of Health and Clinical Excellence (NICE) guidance on the use of antiviral medicines is triggered.

GPs and non-medical prescribers should no longer prescribe, at NHS expense, antiviral medicines for the prophylaxis and treatment of influenza in primary care, in accordance with NICE guidance and Schedule 2 to the National Health Service (General Medical Services Contracts) (Prescription of drugs etc) Regulations 2004), commonly known as the Grey List or Selected List Scheme (SLS). This stands until the Department of Health writes again when the use of antivirals is next triggered.

In the event of an out of season outbreak of flu among at risk people living in long term care homes, GPs and other local prescribers should seek advice from their local PHE centre staff. However, hospital clinicians may continue to prescribe antivirals for patients whose illness is confirmed, or strongly suspected, to be due to flu and whose condition requires hospital care.

Further information

The full NICE guidance on the use of antiviral medicines can be accessed at: http://guidance.nice.org.uk/TA168 for treatment, and http://guidance.nice.org.uk/TA158 for prophylaxis .

Reports from PHE on influenza activity can be found on the GOV.UK website: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SeasonalInfluenza/EpidemiologicalData/03influsweeklyreportpdfonly/

Fit For Work Scheme – Guidance for GPs

The Government's Fit for Work service was launched in December 2014 and is intended to be a patient referral service for GPs. The scheme is now live in the Humber region and GPs can start referring their patients.

The Government is clear that the introduction of the scheme is aimed at tackling the significant number of days lost to sickness every year. However, as the scheme also aims to help support patients to move back into work sooner, one possible benefit to GPs could be that they will be called on less frequently to issue repeat fit notes.

Health Management Limited has been appointed as the supplier to deliver Fit for Work in England and Wales.

The Department for Work and Pensions has issued guidance for GPs.

The BMA has produced the following information and advice regarding the Fit for Work scheme.

The Fit for Work scheme has two elements:

Advice

This element is relatively uncontroversial; offering patients or their employers advice to help patients, for example, when their health condition is affecting their job.

This might involve providing help with issue identification, information on the type of adjustments which could help patients stay in or return to work, or more general work related health advice. This will be available online and through a phone service.

The advice service is targeted at employees, employers and GPs.

Referral for an occupational health assessment

This element will provide GPs with a referral route to access a supportive health assessment for patients who they judge could be absent from work for four weeks or more. Patients will be contacted within two working days of a referral by a case manager and they will receive a 'holistic biopsychosocial assessment', which will usually take place over the telephone.

The Fit for Work case manager will seek to identify the obstacles preventing the patient from returning to work and agree a plan designed to address each obstacle to enable a safe and sustained return to work.

This 'Return to Work Plan' will reflect the assessment and provide work-focussed advice and recommendations which have been discussed with the patient to help them return to work more quickly. The Return to Work Plan will be sent via email or post (where appropriate) to the GP, the patient and the patient's employer, subject to the patient's consent.

It should be noted that there are likely to be few face to face interviews and that most assessments will take place over the telephone, which may be of concern to some patients.

What does GPC think?

GPC has some concerns about the occupational health referral element. In particular the word 'occupational' appearing in front of health assessment or health advisor as we believe it is

potentially misleading.

We have argued strongly that it should just say 'specially trained' health professional and had previously received assurances from the Government that the service would not be presented as a comprehensive occupational health service.

The guidance reflects some of our concerns, but we do not believe it goes far enough to avoid being misinterpreted.

FAQs on the new Fit for Work Scheme

Do GPs have to refer patients to this service?
No - there is no contractual or mandatory requirement for GPs to refer patients to this service, but DWP guidance urges GPs to refer all patients that are eligible for the service.

What are the criteria for referring patients?

- patients of any age in paid employment
- the patient is likely to be absent from work for four weeks or more
- the patient has a reasonable prospect of returning to work
- the patient has not already been referred within the last 12 months and has not received a Return to Work Plan
- the patient consents to the referral

How do GPs refer patients to the service?

For England and Wales GPs can phone 0800 032 6235 or visit www.fitforwork.org

Is it only GPs who can refer?

- No - employers can refer too, separate guidance has been issued for them by the DWP
- Employees cannot self refer

Why would employers be willing to refer?

- Not only would their employee be potentially able to return to work more quickly but they also get a financial contribution to addressing any issues identified
- From 1st January 2015 the Government introduced a tax exemption of up to £500 (per year, per employee) on medical treatments recommended to help their employees return to work. This will be applicable to treatments recommended by health professionals within Fit for Work and health professionals within employer-arranged occupational health services

How quickly does the service respond?

Fit for Work will contact the patient to conduct a telephone assessment at a convenient time for them (within two working days of receipt of referral or five working days for a face to face consultation if it is deemed appropriate)

Are DWP going to be monitoring use of the scheme?

Short contact will be made with patients, employers and GPs to provide feedback about the service;

this follow up takes place following discharge of a patient from Fit for Work. This will take the form of a questionnaire conducted via email or telephone. This will help support continuous improvement and evaluation of the assessment service.

TRAINING, EVENTS & OPPORTUNITIES

LMC Essential Event - Good Practice Data Management Workshop

Hallmark Hotel, Ferriby High Road, Hull, HU14 3LG
Thursday 2 July 2015, 9.30am – 3.30pm

Data Protection and Information Governance are concepts of fundamental importance to every GP and Practice Manager. Practices make decisions every day about the collection, storage and sharing of confidential data and yet it is a complex area, fraught with potential complications and pitfalls.

This full day workshop has been designed specifically to address the needs of GP Practices. It is practical, interactive and includes real life scenarios taken from general practice. Basically, it's so useful and relevant that you can't afford to miss it!

Who should attend?
GPs, Practice and Business Managers, other practice staff involved in data management decisions

What will the session cover?
The session will cover:

- Data Protection Act basics & myth busting
- Understanding civil monetary penalties
- Investigating a potential personal data breach
- Group activities looking at practice specific scenarios
- Opportunities to ask questions and obtain advice from ICO staff
- How to implement ICO guidance

Who is the speaker?
This event will be presented by a team of 3 people from the Good Practice department of the Information Commissioner's Office – Kai Winterbottom, Claire Chadwick and Maria Dominey. Experts in their field, they recently ran a similar workshop for GP Practices in Devon and received outstanding feedback.

We are expecting this event to be very popular so please book early as places will be limited.

How much does it cost?
There is a £50 charge to cover venue, catering and administration costs. The ICO are kindly offering their expertise free of charge which allows us to offer this full day training event at such reasonable cost.

Lunch and refreshments throughout the day will be included. CPD certificates will be issued to participants.

Click here to book

Feedback from previous LMC events:

Excellent, very practical, highly useful. THANKYOU!
Very professional, excellent content.
Excellent event with lots of take home value.

Research Grants for General Practice & Prize Essays

The LMC encourages GPs and GP Registrars to consider undertaking research that will have a benefit for the management of patients in general practice. Among the many agencies that will provide resources for research up to £3,000 is the Claire Wand Fund. Full details can be found at: http://www.clairewand.org/criteria-grants

GPs and registrars who might like to write an essay relevant to musculoskeletal disorders should consider entering for the annual Trevor Silver Memorial Essay Prize. Three prizes from £750 to £250. Full details can be found at:
http://www.clairewand.org/trevor-silver-memorial-essay-prize

ECG Made GPeasy – HYMS Short Course

LARC Building, York Teaching Hospital, 16 June 2.00 pm - 5.00 pm

Being able to identify normal and abnormal ECG findings is an essential skill in primary care but is something that can feel more challenging as time elapses after hospital training posts. This interactive half-day session led by a cardiologist and open to GPs, ANPs and practice nurses will provide an opportunity to update and re-invigorate confidence in interpreting 12 lead ECGs in primary care as well as providing advice on subsequent management. During the afternoon there will be scope to re-visit the practicalities of actually doing an ECG as a further aid to understanding and interpreting them.

Costs

£70 GPs
£65 RCGP members/HYMS tutors
£55 Practice nurses/ANPs

Click here for online booking for this event.

Practices Wanted to Host Student Nurses – East Riding of Yorkshire CCG

ERY Practices are being asked if they would be willing to host a Hull University based student nurse for 30 days works experience in primary care starting in July 2015 by mutual agreement. The practices will receive a bursary of £1600.00 to cover the employment of the student over 30 days agreed between the practice and the student in a six month period. They will be employed at the minimum wage. Practices employing students over 21 years of age will receive, on application, the appropriate additional costs. The student will be employed according to agreed competencies including reception duties, note summarising and administrative tasks.

ERY CCG has agreed 5 nursing student bursaries for 2015. If there are more than five practices interested then the first five will be chosen by lot. The University will support practices to promote the opportunity to suitable student groups. Once practices have been matched to the selected

students then a suitable start date will be arrived at by mutual consent and the CCG will be informed. The practice will invoice the CCG for bursary one week before the student commences. If for any reason the student should not complete the work experience then unspent money may be recovered by the CCG depending upon the circumstances.

Closing Date 19th June 2015
Practices who wish to take part should email their contact details to: sarah.powell5@nhs.net
If you have any further questions please email Dr Craig Dobson at: craigdobson@nhs.net

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Hull CCG Practice Manager Modular Development Programme – New Dates

Hull CCG has confirmed 2 further dates for their Practice Manager development modules.

The modules are aimed at busy Practice Managers and support practice staff who wish to develop or enhance their knowledge. Practice managers can pick as many or as few modules from a wide range of topics. Each module lasts for six hours, and will provide learning that can instantly be put into practice.

Thursday 10th September 9.30 – 4pm - Newland Group practice (Alexandra HC) Report Writing
Tutor: Emma Wilson
Struggling to get your point across at work? Got to write a formal report but never done one before? Want to improve your persuasion and negotiating skills? Then this day is for you.

Tuesday 29th September 9.30am – 4pm – Newland Group practice (Alexandra HC) Finance
Tutor: Richard Apps Baker Tilley
This course is intended for managers or finance partners in GP practice partnerships. It is designed to cover all aspects of GP practice finance and should appeal equally to new practice managers and those already experienced in management

Email ebutters@nhs.net to book a place.

PRACTICE MANAGEMENT

Important action required: 2014/15 NHS complaints procedure – KO41b

The NHS collects service wide data on complaints in order to spot any significant trends and show that services are being responsive to patient feedback. Primary care providers are required, like all other service providers, to provide brief details of complaints associated with NHS work and submit a K041b return.

The 2014/15 K041b complaints data return for general practice will be collected by the NHS England Primary Care Website www.primarycare.nhs.uk .

The collection period is now open and available to complete a submission between: 27th May 2015 and 8th July 2015.

Your practice will have received a letter from NHS England with further details about the collection. Practice staff who have the permission to submit the annual practice declaration to NHS England will inherit the permissions and ability to be able to submit the K041b. Guidance is also available on the HSCIC website: http://www.hscic.gov.uk/datacollections/ko41b .

It is a statutory and contractual requirement for practices to declare complaints information.

If you need further help about K041b please contact your NHS England regional team.

GP Browser – Important Information for all users (Hull & East Yorks)

As you will be aware, HEY Trust are replacing their current electronic patient record system – Patient Centre with Lorenzo. The agreed Go-Live date is now 08th June 2015.

After June 2015, GP Practices who have signed up to the Data Sharing Agreement will be able to view Lorenzo via a desk top shortcut to view their Patient's details. GP Browser will only be maintained to view Historical information after this time.

The Trust is in discussions with CSU regarding installation of access to Lorenzo and ongoing support to Practices. Practices WILL have to sign a Data Sharing Agreement before access is given. Initially there will only be limited access to nominated Practice staff and not all Practice employees will have access to view Lorenzo.
GP Practices in Hull and East Yorkshire that currently use GP Browser must be on-board with the Lorenzo Click-In project if they still wish to access their patients' details after June 2015.

Read the full GP Browser newsletter for more information, FAQs and contact details.

Redirection of Clinical Information – Effective 1 June 2015

Primary Care Support (PCS) Services bases currently redirecting confidential information on behalf of GP surgeries will cease this practice on 31st May 2015. These changes have been discussed with the BMA and the RCGP.

You will be aware that GP practices regularly receive confidential information about patients that are not registered to them. Up until this point some practices have forwarded this information on to their local PCS base, where access to the NHAIS system has enabled us to redirect it to the patient's correct GP practice.

PCS has been informed that this current practice does not comply with NHS England information governance or current legislation, and the correct procedure for a GP should be to mark the envelope 'return to sender' and the information sent back (in bulk/ batches if necessary) to the provider who sent it initially.

PCS has created a template that can be adapted by your practice to assist you in implementing this procedure after 31st May 2015. The PCS Services will also be notifying regional Caldicott Guardians of this decision so that they can advise local acute providers of this change and allow them to prepare accordingly.

GMS Ready Reckoner

NHS Employers has published a GMS ready reckoner for 2015/16.

The ready reckoner is a spreadsheet intended to provide an indication of the changes in income steams that may affect a GMS practice in 2015/16.

It focuses on changes to funding steams announced through the GMS contract negotiations for 2015/16, including:

- Minimum Practice Income Guarantee (MPIG) Correction Factor payments which are being eroded by 1/7th from the 2013/14 baseline in 2015/16.
- The Patient Participation and Alcohol Directed Enhanced services which are being abolished in 2015/16.
- Global Sum payments, which are increasing a result of resources from the above funding streams being reinvested into Global Sum payments plus an uplift following recommendations from DDRB. The increase is from £73.56 in 2014/15 to £75.77 from 1 April 2015 to 30 September, 2015: please see the note below.
- The Quality & Outcomes Framework (QOF), for which the £ per point has been uplifted from £156.92 in 2014/15 to £160.15 in 2015/16.
- At the same time, the Out of Hours (OOH) per cent adjustment is being reduced from 5.46 per cent to 5.39 per cent, with the net effect being that practices receive the income reinvested into Global Sum from (ii) and (iii), above, as if the 2014/15 OOH deduction had not been applied to this additional funding.

Please note - the Global Sum figure of £75.77 is due to change from 1 October 2015 when Seniority payments start to be reduced and the funding reinvested into Global Sum payments

GUIDANCE & RESOURCES

Duty of candour for GPs

The duty of candour was introduced for NHS bodies in England from 27 November 2014 as a direct response to recommendation 181 of the Francis enquiry report. The key principle of the duty of candour is that care organisations have a general duty to act in an open and transparent way in relation to care provided to patients. **The statutory duty applies to organisations**, not individuals.

The duty, which was introduced by the government through regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, already applies to NHS organisations such as trusts and foundation trusts – but from 1 April 2015 it applies to all health care providers **including GP practices**, dental practices and care homes.

How it affects you

Under the terms of the new duty, you need to make sure that your practice acts in an open and transparent way:

- With relevant people
- In relation to care and treatment provided
- To service users
- In performing a regulated activity[1]

After becoming aware that a notifiable safety incident has occurred, you must:

- Notify the relevant person as soon as is reasonably practicable (CQC guidance refers to the ten days required by the NHS standard contract)
- Provide reasonable support, such as providing an interpreter for any discussions, or giving emotional support to the patient.

Your notification must:

- Be given in person by at least one representative of the practice involved, and then followed by a written notification
- Provide a true and accurate account of the incident
- Provide advice on what further enquiries into the incident are required
- Include an apology
- Be recorded in a written record, which should be kept securely.

What is a notifiable safety incident?

The regulation states that there are two meanings of a notifiable safety incident; one for a health service body, the other for registered persons – registered persons being GPs and primary care dental practitioners. According to the regulation: "In relation to a registered person who is not a health service body, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional:

1. Appears to have resulted in

i. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,
ii. an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,
iii. changes to the structure of the service user's body,
iv. the service user experiencing prolonged pain or prolonged psychological harm, or
v. the shortening of the life expectancy of the service user;

2. Requires treatment by a health care professional in order to prevent

i. the death of the service user, or
ii. any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

What is harm?

"Harm", as listed above, is further defined in the regulation as:

Prolonged psychological harm - means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Prolonged pain – means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

CQC inspections

CQC inspectors will check that providers have robust systems in place to meet this regulation. This may include training on notifiable safety incidents, incident reporting, duty of candour notification, and support for staff when they notify people that something has gone wrong, oversight and assurance.

Further information
The Care Quality Commission, Regulation 20: Duty of candour. Issues for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare (March 2015)

[1] "Regulated activity" is defined by the Safeguarding Vulnerable Groups Act 2006

QOF Resource Disk

Dr Simon Clay, a GP in North Birmingham, produces a "QOF Resource Disk" annually which is available for practices to purchase at a cost of £30.

The LMC has not had sight of this of the disk so cannot comment on its content. However, it has had ringing endorsement from a number of quarters including from Peter Holden, GPC Regional Representative for Notts & Derbyshire LMCs who is quoted as saying:

"Simon. This is brilliant, Well done! I was one of the 8 who negotiated the 2004 Contract and helped invent the QoF. You have done what I have asked all along - that it all be put in one place, because sure as hell if I can't find it then 100s of others won't."

As well as working as a GP, Dr Clay also works for PRIMIS, the Medical Informatics Company at the University of Nottingham, and intermittently for the Information Centre in Leeds. He has spent several years doing QOF talks around the country and at National conferences & writing articles on the QOF changes for Pulse etc.

The aim of the disk is to collate many useful QOF resources into one place, for easy access when required. This includes:

- A PowerPoint of QOF changes including areas that are frequently not understood that lose practices points year after year.
- A second version of the above presentation with a recorded narration that can be played as a slideshow to members of the practice team.
- Both presentations cover both the Read2 Codes and the CTV3 codes used by SysmOne.
- A Powerpoint covering QOF Basics which may be useful for new Partners, Nurses, Healthcare Assistants or GP Registrars.
- PDF Summary Spreadsheet summarising every QOF disease, indicator by indicator
- PDF Exception Code Spreadsheet containing every valid Exception Code on 2 sides of A4 (these are also duplicated for Read2 & CTV3 codes for SystmOne Practices). These can be printed off and given to clinicians.
- The complete QOF Business Rules for England
- The two official Blue Book Guidance documents from NHS England which cover QOF, Enhanced Services, Global Sum uplift, named accountable GP requirements, publication of net earnings, seniority changes, maternity/paternity/adoption leave, alcohol related risk reduction, patient participation and patient online.

- Documents covering the vaccination changes this year.
- A suite of Word & Pdf explanatory documents covering areas of the QOF that regularly cause confusion e.g. Lithium, dementia, cancer, exception coding and osteoporosis.
- Details of a group of free downloadable resources that practices can use to help them manage various diseases like AF, heart failure, COPD, diabetes & asthma.

More information, recommendations and an order form can be accessed at:
www.tinyurl.com/qofdisc

Responding to Freedom of Information Requests – Advice for Practices

From time to time practices receive Freedom of Information (FOI) Requests from journalists. One freelance journalist has been approaching a number of practices across the UK requesting information under the FOI in relation to DNAs.

The LMC has obtained guidance from LMC Law on this issue:

- A public body (which for these purposes includes a GP practice), is only obliged to provide information that is recorded or held by that practice.
- As a rule of thumb, if information can be extracted from electronic files or can be obtained using software etc. then it could be deemed to be "held" by that practice for the purposes of FOIA. If the practice doesn't have that information and it cannot be extracted from anywhere within its records then it does not have to be disclosed.
- If a practice informs a journalist that the information requested is not held, then if the journalist complaints to the ICO, the practice must be able to give a good explanation as to why the information is not held. For example, the practice could say that there is no genuine business need to record it or that it is not part of their responsibilities under their contract to record it. Another legitimate explanation is that the information is simply not held on any system or file so cannot be extracted for the purposes of FOI. (Note: just because information is not neatly stored or compiled into one document, it may still be disclosable if it can be assembled or extracted from various different sources.)
- If you do hold the requested information or it can be extracted, then it must be disclosed.
- If practices hold information they believe to be inaccurate, they must still disclose it.
- Practices have 20 working days in which to respond to an FOI request.

Sharing Information for Adult Safeguarding

The information below is the most up to date information which has been issued since the Care Act was implemented on 1st April 2015. It sets out what practices should do if a person in an adult safeguarding situation does not want you to share their information.

It may be useful for Safeguarding Leads for each practice to attach it to their Adult Safeguarding files.

<u>What if a person does not want you to share their information?</u>

Frontline workers and volunteers should always share safeguarding concerns in line with their organisation's policy, usually with their line manager or safeguarding lead in the first instance, except in emergency situations. As long as it does not increase the risk to the individual, the member

of staff should explain to them that it is their duty to share their concern with their manager. The safeguarding principle of proportionality should underpin decisions about sharing information without consent, and decisions should be on a case-by-case basis.

Individuals may not give their consent to the sharing of safeguarding information for a number of reasons. For example, they may be frightened of reprisals, they may fear losing control, they may not trust social services or other partners or they may fear that their relationship with the abuser will be damaged. Reassurance and appropriate support along with gentle persuasion may help to change their view on whether it is best to share information.

If a person refuses intervention to support them with a safeguarding concern, or requests that information about them is not shared with other safeguarding partners, their wishes should be respected. However, there are a number of circumstances where the practitioner can reasonably override such a decision, including:

- the person lacks the mental capacity to make that decision – this must be properly explored and recorded in line with the Mental Capacity Act
- other people are, or may be, at risk, including children
- sharing the information could prevent a crime
- the alleged abuser has care and support needs and may also be at risk
- a serious crime has been committed
- staff are implicated
- the person has the mental capacity to make that decision but they may be under duress or being coerced
- the risk is unreasonably high and meets the criteria for a multi-agency risk assessment conference referral
- a court order or other legal authority has requested the information.

If none of the above apply and the decision is not to share safeguarding information with other safeguarding partners, or not to intervene to safeguard the person:

- support the person to weigh up the risks and benefits of different options ensure they are aware of the level of risk and possible outcomes
- offer to arrange for them to have an advocate or peer supporter
- offer support for them to build confidence and self-esteem
- if necessary agree on and record the level of risk the person is taking record the reasons for not intervening or sharing information
- regularly review the situation try to build trust and use gentle persuasion to enable the person to better protect themselves.

If it is necessary to share information outside the organisation:

- explore the reasons for the person's objections – what are they worried about?

- explain the concern and why you think it is important to share the information
- tell them the person who you would like to share the information with and why
- explain the benefits, to them or others, of sharing information – could they access better help and support?
- discuss the consequences of not sharing the information – could someone come to harm?
- reassure them that the information will not be shared with anyone who does not need to know reassure them that they are not alone and that support is available to them.

If the person cannot be persuaded to give their consent then, unless it is considered dangerous to do so, it should be explained to them that the information will be shared without consent. The reasons should be given and recorded.

If it is not clear that information should be shared outside the organisation, a conversation can be had with safeguarding partners in the police or local authority without disclosing the identity of the person in the first instance. They can then advise on whether full disclosure is necessary without the consent of the person concerned.

It is very important that the risk of sharing information is also considered. In some cases, such as domestic violence or hate crime, it is possible that sharing information could increase the risk to the individual. Safeguarding partners need to work jointly to provide advice, support and protection to the individual in order to minimise the possibility of worsening the relationship or triggering retribution from the abuser.

Domestic abuse cases should be assessed following the CAADA-DASH risk assessment and referred to a multi-agency risk assessment conference where appropriate. Cases of domestic abuse should also be referred to local specialist domestic abuse services.

The above is from the SCIE Information Sharing Guidance that is post Care Act Statutory Guidance and is clear that only for the reasons stated above can you go against the persons wishes not to share information.

[With thanks to Dr Elisabeth Alston, Named Doctor for Adult Safeguarding on behalf of ERYCCG, who recently circulated this information]

GP Retirement Guide

Research suggests that as many as one third of practising GPs are intending to retire within the next five years. If you are one of them, and whether you are single handed or in partnership, you may be looking for some guidance on how to navigate the retirement process as easily as possible.

Retirement, particularly for a single hander, is not as simple as setting the date and walking away. As an owner of the business there are many liabilities which could follow you into retirement, both clinical and commercial – and it is essential to follow the appropriate path to ensure these are correctly handled.

Hempsons have produced a useful guide for retiring GPs which covers:

- The retirement of a Partner either with or without a Partnership Deed
- The retirement of a single handed GP
- The implications of holding either a GMS Contract or a PMS Agreement
- Steps to be taken to deal with your surgery premises
- A check list of parties to be notified.

GENERAL NEWS

Hull and East Yorkshire Hospitals NHS Trust's Chief Medical Officer moves on

Chief Medical Officer, Professor Ian Philp has accepted another Medical Director post within the NHS and is returning home to the West Midlands after two years with the Trust.

He will stand down from his post on Friday 5 June 2015.

LMC Conference 2015

The purpose of the Local Medical Committees (LMCs) conference is to create policy for future General Practitioners Committee (GPC) and BMA work throughout the following year.

The 2015 Conference took place in London on the 21 and 22 May 2015.

We are delighted that the motion presented by Dr Anne Jeffreys, Chair of the Hull & East Yorkshire LMC was carried by conference and will become GPC policy. The motion proposed:

"That conference believes that general practice is experiencing the biggest workforce crisis since its inception and calls upon the newly elected government to take action to ensure that:

(i) GP funding, recruitment and retention are addressed as its first priority for the NHS
(ii) GPs who are leaving the profession early are supported to stay in practice
(iii) all those wishing to return to the profession are fully supported and encouraged to do so
(iv) the contribution of all GPs to the delivery of NHS services is valued regardless of their contractual status
(v) general practice is supported as an integrated progressive career from medical school right through to retirement."

The LMC conference agreed that GP funding, recruitment and retention need to be addressed as a first priority for the NHS.

Dr Jeffreys illustrated the difficulties attracting doctors into general practice by sharing recruitment figures for the Yorkshire & Humber Deanery. Following Round 1, there are 100 unfilled GP training posts out of a total of 291 places. The figures show that recruitment to areas such as Scarborough, Hull and Northern Lincolnshire is particularly challenging when compared to central areas which have longstanding medical schools such as Leeds or Sheffield or are very popular areas to live such as York and Harrogate. The round 1 fill for three key areas in our region is shown below:

Scheme	Posts Advertised	Posts filled	Posts remaining
Hull	32	11	21
North Lincs - Scunthorpe	8	2	6
North Lincs - Grimsby	9	0	9

Dr Jeffreys told conference:

“It’s a never-ending battle to do a good job in ever-diminishing time. This is not the job that I went in to, nor the job that I want."

GPs also agreed that not all returning GPs needed to undergo full induction and refresher training, highlighting how many highly capable doctors were being held up by bureaucracy.

The Chair of the GPC, Dr Chaand Nagpaul gave a rousing speech which received a standing ovation from the Conference audience. Read the full speech here.

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Following a review of the work patterns of the Medical Secretaries we will aim to respond to routine emails on Tuesday, Wednesday and Thursday.