The Humberside Group of Local Medical Committees Ltd

Newsletter: 18 June 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

INSPECTION

CQC Assessment of Compliance in relation to the Duty of Candour

CQC's GP Mythbuster 32 considers the Duty of Candour and General Practice (regulation 20). The extract below (taken from the Mythbuster) may be helpful to practices as it sets out how CQC will assess compliance with the duty and gives examples of the thresholds that would trigger the duty. It also gives an example of what actions a practice might take to fulfil its duty in this regard.

(Note: an introductory guide to the Duty of Candour was given in the LMC's last newsletter so is not repeated here.)

How will CQC regulate providers' compliance with the duty of candour?

At registration

During our registration process we will test out with a provider that they understand the requirements of the regulation and ask them what systems they have in place to ensure that they will be able to meet these requirements.

The registration inspector will check that the provider has robust systems in place to meet the duty of candour regulation. This would include, but is not limited to:

- training for all staff on communicating with patients about notifiable safety incidents
- incident reporting forms which support the recording of a duty of candour notification
- support for staff when they notify patients when something has gone wrong
- oversight and assurance.

During inspection

During the inspection process, we assess whether the provider is delivering good quality care. Specific key lines of enquiry (KLOEs) under the safe and well-led questions are relevant to the duty of candour in the inspection of General Practice. These are:

- **S2: Are lessons learned and improvements made when things go wrong?**
  Prompt: Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result?
- **W3: How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality care?**
  Prompt: Does the culture encourage candour, openness and honesty, with regular meetings and a culture of challenge and debate?

Illustrative Examples for General Practice which trigger the thresholds for duty of candour

- A patient was prescribed an antibiotic by the practice which is known to interfere with warfarin levels went without INR monitoring for several weeks. The patient had an upper GI bleed and was admitted to hospital for 5 days for monitoring and follow-up. It was noted on admission that the INR was 7.
  Regulation 20 (9)(b)(i) Requires treatment by a health care professional in order to prevent the death of the service user.
- A patient who is a heavy smoker with a persistent cough is noted to have a suspicious lesion on a chest x-ray. The GP messages the practice reception to arrange an urgent appointment with the patient, although there is no answer on the patient's home telephone as he is on holiday. The message to follow up is missed. Nine months later the patient presents with shortness of breath and haemoptysis. He is admitted to hospital via MAU and is diagnosed with lung cancer.
  Regulation 20 (9)(a)(v) Shortening of the life expectancy of a service user

- A patient's discharge summary from a recent inpatient episode for pneumonia described how an x-ray showed signs of a 'suspicious lung lesion' requiring a follow-up with their GP. The GP practice carried out the appropriate further investigations – the results of which were normal. However the practice failed to follow normal processes for relaying the results to the patient and he was not informed for over one month. The patient consequently spent several weeks in a state of extreme upset, concerned about the possibility of cancer and developed symptoms of anxiety and depression which lasted more than 28 days.
  Regulation 20 (9)(a)(iv) Prolonged psychological harm
- A patient is on a repeat prescription for morphine sulphate 10mg twice a day for chronic pain. The patient requests a prescription and, in error, a prescription is issued for morphine sulphate 100mg twice a day. The medication is dispensed and the patient's wife, who looks after his medicines, gives her husband 100mg tablets of morphine sulphate. He takes 2 doses over the next day and then his wife is unable to rouse him in the morning. He is admitted to hospital where he has a cardiac arrest and dies.
  Regulation 20 (9)(a)(i) Death of a service user.

A complete narrative example of how the duty of candour could be carried out
A patient taking warfarin for stroke prevention from atrial fibrillation presented with a cough and shortness of breath and was given antibiotics for chest infection. His INR was normally stable and he only attended the warfarin clinic at the GP practice for INR monitoring on a monthly basis. 10 days passed, during which his chest symptoms recovered. He then slipped at home and hit his leg, and developed an uncomfortable haematoma. He attended the GP practice for an INR check and his INR is found to be 7.

The GP who prescribed the antibiotics explained that it was likely that the antibiotic treatment had increased the anticoagulant effect of the patient's usual warfarin dose. Although the patient had been warned of the risk of bleeding when he started treatment with warfarin several years before, the GP apologised for what had happened, The GP gave the patient vitamin K, and withheld the warfarin for that day. The patient recovered without further bleeding, but had to reattend the surgery every day for several days to recheck his INR value and modify his warfarin dose, until the INR value stabilised.

The GP invited the patient into the surgery for a meeting and reiterated his apology. He made sure that the patient understood what he had been told. The GP made a detailed note of what had been discussed in the patient's medical record.

The GP notified the practice manager responsible for duty of candour arrangements in person and followed the practice's clinical governance procedures for reporting patient safety incidents. Referring to CQC guidance, the manager and GP agreed that it was a notifiable patient safety incident, and that the discussions that had taken place were appropriate and sufficient under the statutory duty of candour obligations.

They agreed the GP would write to the patient, summarising what had happened. The GP wrote a letter to the patient, summarising all that was known about what had happened, and which repeated the earlier apologies. The GP made a final note in the clinical records of the discussion, relaying this to the manager so that the practice's notification process was complete.
See Regulation 20: Duty of candour, with related legislation and guidance.

Additional Guidance from CQC on Clinical Supervision

The LMC has been made aware of some practices receiving criticism in relation to clinical supervision of their staff and requested clarification from the CQC Regional Advisor in Primary Care for Northern England Dr Peter Davies. The response is summarised below:

The basic CQC expectation is that staff are managed well, in terms of day by day work and supervision/support and in terms of appraisals and development. Also staff should be acting within their role, and if they are taking on extended roles they should know they are doing this, and be trained for this. In a good team there's openness for asking questions, rather than for struggling on alone. The guidance around this is professional- GMC for doctors, NMC for nurses.

The key questions the CQC ask a practice is if it is safe, effective, caring, responsive and well led.

In terms of the CQC domains staffing is specifically commented on under safety (team structure). The working relationships between staff come up in safety, effectiveness and well led.

The CQC view is that in good practices the staff are well managed, have their appraisals, CPD and PDPs in place and the practice manager shows CQC training records and easily assures CQC that they have a system in place to make sure mandatory training and personal development needs are well managed. The manager often has a training matrix and knows which staff need which bits of training- whether for first time or an update. The training is scheduled properly. They pick up evidence of good team working and respectful relationships between the staff. Also outcomes such as QOF scores tend to be higher.

The CQC view is that in poorer practices they see weak supervision of staff, unmanaged and unmonitored training relying on individual initiative rather than good systems. They may find gaps in training. They may find staff working beyond their role (sometimes leaving practice nurses at risk of NMC referral). They may also find ineffective governance, lack of team discussions, lack of mutual support for each other. Often outcomes are lower as an ineffective team struggles as a group of individuals rather than as a cohesive team.

Staffing is mentioned as an underpinning of effectiveness in several places in the appendices of the CQC provider handbook which provide descriptors of what CQC are looking for.

Under outstanding practice CQC are looking to see:-

"All staff are actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and accreditation are proactively pursued. High performance is recognised by credible external bodies. The continuing development of staff skills, competence and knowledge is recognised as integral to ensuring high-quality care. Staff are proactively supported to acquire new skills and share best practice. Staff, teams and services are committed to working collaboratively, people who have complex needs are supported to receive coordinated care and there are innovative and efficient ways to deliver more joined-up care to people who use services."

Under Requires Improvement CQC note,

"Not all staff have the right qualifications, skills, knowledge and experience to do their job. The learning needs of staff are not fully understood. Staff are not always supported to participate in training and development or the opportunities that are offered do not fully meet their needs.

There are gaps in management and support arrangements for staff, such as appraisal, supervision, professional development and support for revalidation. There is limited participation in multidisciplinary working, and care is not coordinated. There may be delays or poor coordination when people are referred or discharged from other services. There are delays in sharing information about people's care, this information has some gaps or staff are not clear what information should be shared."

For further information the GP provider handbook and appendices are available at http://www.cqc.org.uk/content/provider-handbooks

What CQC want to see is good practices with well-managed, well supported, properly trained and motivated staff. When teams work well together they make work more enjoyable for themselves and they provide better service to patients. CQC state that they readily give credit to teams that are achieving this. CQC want to give encouragement to improve to those that haven't got to this yet. CQC state that they use their regulatory powers carefully- using them in proportion to the size of a problem they have observed, to secure a necessary improvement.

CLINICAL ISSUES

New Prescribing Decision Support Software for ERYCCG - OptimiseRx

Following the successful pilot and a mini-tender exercise, undertaken by YHCS on behalf of a number of CCGS, ERY CCG has approved the procurement of Optimise Rx from **1st July 2015**. Implementation will take place in current Scriptswitch users starting with SystmOne Practices first, followed by EMIS-web practices. The Medicines Management team will contact the Practice Manager regarding the new software shortly.

OptimiseRx, marketed by First Data Bank, is a prescribing decision support system similar to the current Scriptswitch software. Like Scriptswitch, Optimise Rx provides healthcare professionals with evidence based guidance and reference messages relating to best practice, safety and cost at the point of prescribing. Unlike Scriptswitch, OptimiseRx is fully integrated with the patient record and takes account of patient specific attributes to offer patient specific recommendations and alerts. A recent pilot undertaken in Walkergate Surgery, Beverley (Dr Harley - a.harley@nhs.net) and South Holderness Medical Practice (Dr Fitzsimons - david.fitzsimons@nhs.net) has demonstrated the technical compatibility of the new software and that it is significantly less intrusive during consultations. Both GPs are happy to discuss their experience of the software.

The following are seen as the key advantages to the use of this system:

- Point of prescribing guidance on local or national best practice drug choices when prescribing acutely.
- The ability to review all medications on the repeat template list with a single click.
- Guidance individualised to patients and taking account of coded information such as impaired renal function.
- Easy links to NICE or other relevant guidance.
- Ease of dissemination of new guidance and recommendations.
- Advice on long term drug supply issues with recommended alternatives

Further details on the system can be accessed at:
OptimiseRx | Medicines Optimisation | FDB (First Databank)

Forcing GPs to Prescribe Statins is the Worst Kind of Medicine

Dr Andrew Green, Chair of the GPC Clinical and Prescribing Subcommittee reflects on recent proposals by NICE….

"The proposal by NICE to introduce statin prescribing at a risk level of 10% into QOF has been met with almost universal concern from GPs, yet the group's Chair, Prof Keenan is quoted as saying that he has no idea why GPs are against the 10% statin threshold. This hard to understand as the evidence provided to his group from both the RCGP and the GPC was quite clear, and it is deeply troubling that there appears to be a fundamental misunderstanding in a powerful committee between accepting the value of a clinical intervention in some such patients, and concluding that prescribing activity measures quality of care.

There is without doubt one senior GP whose views he should take into account, and that is his boss Professor David Haslam. In an open letter to the House of Commons Select Committee Prof Haslam wrote that *'It is only if lifestyle changes on their own are not sufficient, and that other risk factors such as hypertension are also managed, that people who are at risk should be offered the opportunity to use a statin, if they want to. They don't have to and their decision should be informed by an understanding of the risks'.* If GPs are to follow this advice, it will be impossible for them to hit the proposed upper reward target of 80%, and any reward will be based on the diligence with which GPs apply exception reporting rather than any clinical factors.

Last year Professor Haslam gave oral evidence to that same committee, insisting that *'I do want to stress as well that NICE made it really clear that we are not saying we want millions more people taking statins'*, but now that same organization is proposing to penalise GPs unless they do just that; this discrepancy between statements to the House of Commons about intended policy and the subsequent recommendations of the QOF committee must be explained and one of them needs to be publically retracted, for they are mutually exclusive.

There are disturbing parallels here with the controversy regarding incentive payments for dementia diagnoses, where there was insufficient attention given to preserving the separation between the financial reward for the GP and the ability of that GP to give impartial advise in a controversial area. This policy has been widely felt to have been a mistake and it was not surprising that it was withdrawn, what is surprising is that lessons regarding the importance of avoiding tainting delicate clinical decisions with payments have not been heeded.

Equally concerning is the cavalier disregard for the impact on mental health services of forcing GPs to offer referral for talking therapies to patients with anxiousness or mood difficulties, many of whom in a less medicalised age would have sought help from non-professional sources. The suggestion that flooding overstretched services is of benefit as it will 'drive an increase in facilities' is frankly absurd in the current climate and I have never heard of this proposed as a solution to the A&E crisis or surgical waiting lists. There is a delicious irony in the fact that this was said on the same day that the Secretary of State instructed the NHS to stop asking for more money. The undoubted result of this proposal if implemented will be delays to access of those in real need with potentially fatal consequences and it is difficult to view this as anything other than irresponsible.

GPs are the risk-sink of the NHS and undertake this at the cost of great stress and a degree of personal jeopardy; we do so to protect secondary care services for those who really need them and we deserve support and praise, not criticism for performing this role.

Ultimately, these are issues of trust and respect; trust by doctors in the validity of clinical trials' data, in NICE, and in QOF; and most importantly by patients in the impartiality of their GP's advice and their trust that facilities will be available to them in times of genuine need. Trust is hard to gain and easily lost, and we can only hope that it is not too late to prevent these misguided indicators being introduced into our payment system. Those who seek to define quality must be made to appreciate that prescribing and referring is the easy bit of the job, the difficult bits, the bits for which you need training and experience, time and determination, are the consultations where you don't prescribe, and you don't refer."

North Lincolnshire - Local Outbreak of Legionnaires' Disease Associated with Cardiac Patients

(Circulated 8 June 2015 by Dr P Cowling, Director of Microbiology, Pathlinks)

There have been two confirmed cases of Legionnaires' disease admitted to Diana Princess of Wales Hospital (DPOW) and Scunthorpe General Hospital (SGH) in the past two weeks, both of whom were cared for on both Coronary Care Units at DPOW and SGH, and were transferred between both units during the incubation period of the disease. Both patients were seriously ill and required ITU care. One has since been discharged home but the second remains on ITU.

At the time of writing, there is no evidence that confirms either unit as the source of the infection. Regular surveillance monitoring of water supplies and outlets occurs throughout the hospitals including the CCUs and there have been no failures of Legionella counts on either unit. Further intensive testing is being undertaken by the Facilities Directorate and Public Health England has been involved in the investigation and control of the outbreak from the start.

GPs are urged to be alert and to identify any patient under their care who presents with flu-like symptoms or an unexpected, unexplained lower respiratory tract symptoms and signs, particularly if they have had an admission to either CCU in the past month.

If you do detect such patients, please submit a midstream urine sample to Microbiology at your local hospital and mark the request form "for Legionella Antigen testing". Results will be available on the day of laboratory receipt of the specimen.

The Duty Consultant Microbiologist will be available for advice on treatment through your local hospital switchboard.

Ebola - Five simple steps for GPs to follow

The LMC has been asked to circulate the information below on behalf of the Department of Health.

While the risk of Ebola in the UK remains low, we want to ensure that GPs remain vigilant and prepared in case someone with possible Ebola symptoms presents at their practice.

Your role is to carry out the initial verbal assessment of the patient.
If a patient telephones to say they are unwell and have visited an affected area in the past 21 days or reports a fever of 37.5°C or above or has a history of fever within the past 24 hours, don't visit or invite the patient to surgery but **follow these five simple steps:**

1. Call the patient immediately to confirm travel history and gather further clinical details.
2. Discuss the case with the local microbiologist/virologist/infectious diseases consultant and take their advice about further assessment of your patient. If they meet the criteria for possible Ebola, refer them to the local emergency department for clinical assessment.
3. Inform the emergency department so they can prepare a safe patient assessment area.
4. For the transfer to hospital, alert the ambulance service to the possibility of Ebola so they can prepare the vehicle and appropriate Personal Protective Equipment.
5. Alert the local Public Health England local health protection team.

If a patient attends your surgery, isolate them in a single side room immediately. You should then:

1. Clinically assess the patient without any physical contact.
2. Confirm travel history and/or whether the patient reports being unwell or has a fever of 37.5°C or above or history of fever within the past 24 hours.
3. **Follow the same steps as if the patient has telephoned.**

Once the patient has been transferred, any potentially contaminated areas (including the room in which the patient was isolated, any toilet they used etc.) should not be used until a diagnosis of Ebola has been excluded. This may take twelve hours. Advice on decontaminating premises can be sought from the Public Health England local health protection team.

Additonal Information:

- Clinical management and guidance for health professionals on GOV.UK:
  Ebola virus disease: managing patients who require assessment in primary care
  Ebola: infection prevention and control for primary care

- RCGP Ebola resources page for GPs and practice teams – this includes a series of index cards aimed at individual members of the GP practice team, outlining their specific responsibilities should a patient present with possible Ebola symptoms:
  http://www.rcgp.org.uk/clinical-and-research/clinical-resources/ebola.aspx

PRACTICE MANAGEMENT

Remedial action in response to the Dridex malware attack - Important action for affected practices

The Health and Social Care Information Centre (HSCIC) wrote to a number of GP practices in March and April that had been identified as being infected with malicious software known as 'Dridex', which inflects systems via macro-enabled documents and .xml attachments sent by email.

The letter from HSCIC contained advice on the actions that need to be taken by practices against this malicious software, and requested that practices confirm with the HSCIC that the necessary actions had been taken. Of 1200 GP practices affected, only around 500 so far have provided such confirmation to the HSCIC. The actions that need to be taken are relatively straightforward and do not require the installation of software.

The LMC has been asked to cascade this reminder to practices to help ensure those affected have taken these important actions. **Please note that only those practices already written to by the**

HSCIC need take action.

Where practices require further advice, they can contact the HSCIC via enquiries@hscic.gov.uk quoting 'cyber incident' in the subject line or by calling 0300 303 5678, selecting option 2.

Electronic Repeat Dispensing

Electronic Repeat Dispensing Guidance has now been published by NHS England. This will be of particular interest to practices that might want to consider repeat dispensing.

Repeat dispensing with the Electronic Prescription Service is intended to provide significant efficiency savings in general practice. Repeat dispensing used with EPS introduced new functionality and legal prescription information that differs from the paper process. This guidance enables prescribers and dispensers to use the functionality effectively.

If practices would like some support with introducing electronic repeat dispensing, the EPS team are able to assist and can be contacted through:

Joanne Lambe, Senior Implementation Manager, Electronic Prescription Service (EPS)
Health and Social Care Information Centre
joanne.lambe@hscic.gov.uk

NICE Guideline: Violence and Aggression

This guideline updates and replaces NICE guideline CG25 (published February 2005). It offers evidence-based advice on the short-term management of violence and aggression in mental health, health and community settings.

New recommendations have been added to cover a broader range of settings, including primary care. New recommendations have also been added to cover children and young people aged under 16, family members and carers.

GUIDANCE & RESOURCES

Formal Duty to Report Death of a Patient subject to DoLS

The LMC has received a number of requests for clarification regarding the duty to report the death of a patient subject to DoLS.

The formal duty to report the death is on the establishment in which they are subject to DoLS. GPs are not under a primary duty to do so.

However, the Coroner does require the GP to provide written confirmation of the medical cause of death. On the South Bank, the confirmation should be provided by letter in a form which the Coroner's office provides. On the North Bank, there is a standard form for completion which is also available from the Coroner's office.

Version 32 QOF Business Rules released June 2015

HSCIC have released a new version of the Business rules underpinning QOF. (Version 32).

Simon Clay (author of the QOF Resource Disk) has produced a Word document which lists the significant changes. The list can be accessed at:

https://dl.dropboxusercontent.com/u/10419929/Version%2032%20QOF%20Rulesets%20Significant%20changes.docx

TRAINING, EVENTS & OPPORTUNITIES

Expressions of Interest to participate in the Primary Care Clinical Healthcare Apprenticeship Scheme

Health Education Yorkshire and the Humber (HEYH) is inviting GP Practices to express an interest in participating in the **Clinical Healthcare Apprenticeship Scheme**.

General Practice is well aware of the many and varied workforce challenges that it faces; with an increasing workload, GPs retiring early, the reduced popularity of General Practice as a career choice and the huge retirement risk due to the high number of experienced nurses aged over 55.

Some Practices are starting to reshape their workforce by increasing the number of **healthcare assistants (HCAs)** to alleviate pressures on already stretched nursing teams. This is part of a wider programme of Primary Care initiatives being undertaken by HEYH that focus on the development of Physician Associates, Advanced Clinical Practitioners, Practice Nurses and Pharmacists.

HEYH is keen to promote an expansion of the HCA workforce within primary care and has developed a scheme which will enable practices to increase their Clinical Healthcare support workforce through the use of Apprenticeships. It is essential that practices have HCAs that are competent and consistently trained. Previously there has not been a dedicated training package available that is tailored to Primary Care.

The aim is to develop a **standardised regional programme** to ensure all HCAs have the knowledge and skills required to undertake the role they are delegated. The Apprenticeship training is designed as an educational development route to support HCAs and will be delivered in partnership with Education Providers. It is expected that the apprenticeship will be completed within 12 – 18 months.

Recognising that the delivery of Apprenticeships generates some additional costs, HEYH are funding a number of Clinical Apprenticeships across the region within Primary Care; this funding will include an Apprenticeship Support Grant and will cover any employer training costs that are not met by Government funding. Details of the scheme, including financial implications, will be finalised soon. Please note that practices will need to **employ** the HCA Apprentice to access the scheme.

This scheme will be locally co-ordinated to ensure consistent regional access.

Next Steps

If you are interested in taking part in the scheme, please complete the Expression of Interest Form and return to Sharon Simister sharon.simster@yh.hee.nhs.uk by **COP on 26th June 2015**.

It is hoped that the scheme will go live by Autumn 2015. High demand is anticipated and places may be limited.

Hull City Council – GPwSI in Substance Misuse

Hull City Council is seeking clinical input for their Young People's Substance Misuse Service known as ReFRESH. A GPwSI in Substance Misuse is sought to provide pharmacological approaches based on individually assessed need, with a range of clinical responses specifically for substance misuse including pharmacological approaches for detoxification, stablisation and reduction regimes with integrated psychiatric and/or psychological and physical care.

The commitment involves attending a weekly Tuesday morning Multi-Disciplinary Team meeting for hours for approximately 46 weeks per year.

The recruitment to this role is being undertaken via YORtender. Therefore any GP interested in applying for the role must be registered on the YORtender site:

https://www.yortender.co.uk/procontract/supplier.nsf/frm_home?openForm

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Information Governance & Data Management Workshop – Last chance to book!

Hallmark Hotel, Ferriby High Road, Hull, HU14 3LG
Thursday 2 July 2015, 9.30am – 3.45pm

We still have a few places available on this workshop but final numbers need to be advised by early next week so this will be your last chance to book!

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.

Book online using this link:
http://www.humbersidelmc.org.uk/seminar-booking-form-good-practice-data-management-workshop.html

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YORLMC / LMC Law Seminar for GPs and Practice Managers

1300 – 1630 Tuesday 30 June 2015
(Registration and Lunch 1300 – 1400)
Pavilions of Harrogate, Great Yorkshire Showground, Harrogate, North Yorkshire, HG2 8QZ

This event is designed for GPs and Practice/Business Managers.

Practice Mergers and Caretaking Agreements
Shanee Baker, Director of LMC Law, will advise on how to conduct a successful merger or caretaking arrangement, and highlight the potential pitfalls. This will include employment issues, what to be aware of and what to think about.

Protecting General Practice Contracts
Shanee will advise on how to protect general practice contracts, and the importance of partnership agreements. Explain why they should be kept updated to meet changing circumstances, such as practice mergers and GP federations.

Bookings will be taken on a first-come first-served basis. To secure a place at this event, please confirm your booking as quickly as possible by emailing – info@yorlmcltd.co.uk

There is a small non-refundable charge of £25 per person and bookings are required by **Friday 26 June**.

Please advise us of your method of payment when booking:

BACS payments to:
Account: YORLMC Ltd
Bank Sort Code: 40 23 12
Account Number: 62103958
Please include the name(s) of the delegate(s) in the payment reference to enable us to reconcile

Directions: http://pavilionsofharrogate.co.uk/visit-us

GENERAL NEWS

New system to monitor CCGs

A new system to hold commissioners accountable for the work they do is to be introduced.

The system will be created with help from chief executive of the King's Fund, Chris Ham, on behalf of NHS England and the government.

The performance of the clinical commissioning groups (CCGS) will be measured across five patient groups:

- People over 70
- those with long-term conditions
- those with mental ill health
- mothers and children
- the generally healthy

There will also be a metric for resilience and transformation.

Improving GP Services: Commissioners and Patient Choice

This recently published report from Monitor looks at how GP services are working for patients with a specific focus on the role of choice and competition.

Payments to GPs suspended from the Performers List 2015

This Statutory Determination by the Secretary of State for Health details when NHS England should make payments to GPs suspended from the NHS Performers List.

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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.