GPC Newsletter

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Friday 19 September 2014 **Issue 5**

Content

GPC meeting

The GPC held its meeting on Thursday 18 July and this newsletter provides a summary of the main items discussed.

The GP Earnings and Expenses Enquiry Report 2012/13 and Investment in general practice 2009/10 to 2013/14

This morning the Health and Social Care Information Group has published the GP Earnings and Expenses Enquiry Report 2012/13 along with Investment in general practice 2009/10 to 2013/14. Both reports may be viewed on the HSCIC website.

The main figure used in the EEQ report is now that of the average of combined GPs (contractor and salaried), rather than that for contractor GPs which has been the case formerly.

The mean income before tax for combined GPs (contractor and salaried) in the UK in 2012/13 was £92,900 for those GPs working in either a GMS or PMS (GPMS) practice (compared to £94,200 in 2011/12, a decrease of 1.4% which is statistically significant).

The median income before tax for combined GPs in the UK in 2012/13 was £89,300 compared to £91,200 in 2011/12, a decrease of 2.0%.

Pressures in general practice

The GPC has undertaken a considerable amount of work over the summer to raise awareness of the crisis currently facing general practice. The main focus of this has been a set of urgent proposals which includes action on workforce, practice infrastructure, reducing bureaucracy, resolving financial anomalies putting practices at risk, making best use of existing funds, promotion of general practice, and empowering patients to manage their own care. These are being discussed at the highest level with politicians, the Department of Health, and NHS England and the outcome of these discussions will be reported in due course.

In addition there have been productive discussions with key stakeholder organisations, with a view to joint working arising from their response to the Your GP Cares campaign. There will be a further report on phase two of the campaign shortly. In the meantime the GPC will be well represented at the forthcoming Party conferences at which events have been organised to discuss the campaign and the current crisis.

As part of the wider project on the future of general practice, regional events have been held to gather the views of broader groups of GPs, including a forthcoming event specifically aimed at sessional GPs and GP trainees to be held in Leeds shortly (details of this event are below). Patient engagement events are also about to be held and there will be a survey of the whole profession at a later stage.

The GPC and RCGP have recently held a high level discussion on the pressures in general practice and have agreed a number of joint actions aimed at alleviating these pressures. We recognise that these problems will not be resolved immediately but with the concerted effort of all parties we believe that considerable help could be available in the short term, while longer term solutions are developed.

Prescribing of unlicensed medicines

The GMC has confirmed that under European law, it is unlawful to prescribe an unlicensed or off-license medication in preference to a licensed one on the grounds of cost. Prescribers should ensure that when prescribing such a medication they are content that there are clinical rather than financial reasons for the prescribing decision. Where unlicensed or off-license medicines appear in an agreed patient pathway their position must be determined purely by their clinical properties, and licensed medicines should on no account be changed to unlicensed ones for financial reasons.

Changes to NHS Availability of erectile dysfunction treatments - Changing prescribing restrictions for Sildenafil

As of 1 August 2014, the amended regulations on erectile dysfunction treatments have come in to force. This means that Sildenafil, Apomorphine Hydrochloride, Moxisylyte Hydrochloride and Thymoxamine Hydrochloride are no longer restricted for the treatment of erectile dysfunction (ED). In-patent and branded products for the treatment of ED will continue to be restricted, including the new addition of Avanafil.

The regulations are available online.

The consultation document, together with the Department of Health's formal response document is available online.

Update from the RCGP on resources to support doctors in appraisal and revalidation

The RCGP has recently developed a number of new revalidation resources and updated some of its existing resources. These include Version 9 of the *RCGP Guide to the Revalidation of General Practitioners* (the 'Guide'), a number of mini-guides ('toolkits') designed to augment the Guide, an updated version of *The Principles of GP Appraisal for Revalidation* - originally published in 2008, and a revision to the Revalidation e-learning module.

Version 9 of the Guide clarifies aspects of revalidation, including: variations in process between the four countries of the UK, the function of 'suitable persons' and the patient and colleague feedback process. Additionally the Review of Practice section has been significantly developed.

The RCGP Revalidation Toolkits look in greater detail at the following elements of revalidation:

- Colleague and Patient Feedback
- Personal Development Plans
- Significant Event Analysis
- Complaints
- Quality Improvement
- Impact Credits.

The above resources are accessible via the RCGP's Revalidation Guidance for GPs and CPD Credits and appraisal web pages, and signposted from the newly launched Clarity & RCGP Appraisal Toolkit for GPs.

The RCGP can answer revalidation queries at revalidation@rcgp.org.uk.

Vaccine update newsletter - England only

We would like to remind practices that they can subscribe, free of charge, to Public Health England's 'Vaccine Update' newsletter. This is published monthly and contains useful updates on the latest developments in vaccines, and vaccination policies and procedures in England. The September issue

is available on the Public Health England website - to subscribe just click on the link within the newsletter itself.

Care Quality Commission

Nigel Sparrow, CQC's Senior National GP Advisor, has drafted a number of guidance notes, some of which have already been published in GPC News, which are aimed at tackling some of the common myths about CQC inspections of GP and out-of-hours services. The guidance notes covering clinical audit, curtains, carpets and hand washing can be found at appendix I.

The GPC remains seriously concerned about the burden CQC inspections place on practices and is involved in active dialogue on this as part of the vital work to address the pressures in general practice.

Prescription direction guidance

The GPC recently met with the Pharmaceutical Service Negotiating Committee (PSNC) and Pharmacy Voice to discuss issues in relation to prescription direction and would like to remind practices about our joint guidance which is available on our website. Prescription direction occurs where a patient is being directed by their GP practice to a certain pharmacy to have their prescription dispensed, or where practices have preferential arrangements for certain pharmacies, these would be seen as a breach of good practice.

Conference for people considering a career in general practice

The GPC's GP trainees subcommittee is organising a conference called "**Thinking about a career in general practice?"**

The conference will provide information and support to foundation trainees who are considering applying to GP specialty training programmes and will include:

- practical information and tips on the training application process
- advice on how to get through assessments
- valuable information on how to manage finances as a GP trainee
- opinions and advice from speakers who have taken a variety of different career paths within general practice.

The conference will take place on 19 November 2014 at BMA House. Please see the BMA website for more information and the full programme.

Please forward this on to anyone who may be interested.

Sessional GP Conference

The GPC sessional GPs subcommittee is holding a conference called "Sessional GPs - Future Proofing Your Career".

The conference will offer expert advice, practical information and guidance to support all sessional GPs in making the most of their careers, now and in the future.

The conference programme includes topics such as:

- influencing your future as a sessional GP
- appraisal and revalidation
- employment rights
- pensions
- working as a locum GP.

The conference will take place on 14th November 2014 at BMA House. Please see the BMA website for further information and a full programme.

Please forward this on to anyone who may be interested in attending.

Consultative event for sessional GPs, GP trainees and newly qualified GPs

The GPC is holding a consultative workshop, hosted by Leeds LMC, for sessional GPs, GP trainees and newly qualified GPs as part of its work on the future of general practice. This event will provide attendees with an opportunity to share their views with the GPC and will cover a number of areas including:

- aspirations and career opportunities
- the developing and changing role of GPs, GP practices and primary care, and the role of both sessional and future qualified GPs in this change
- working within larger networks of practices or federations
- the role of CCGs in the future of general practice, including the relationship between CCGs and both sessional and future qualified GPs
- finding a balance between access and continuity.

The event is taking place on Tuesday 23rd September, at **6:45pm** for refreshments with the meeting starting at **7:30pm.** It will be held at Weetwood Hall Conference Centre and Hotel in Leeds. The event is **free of charge** to attendees and **travel expenses will also be reimbursed**. Those wishing to attend or who want further information should contact Leeds LMC at mail@leedslmc.org.

Representing prison GPs conference - 6 November 2014

Representing prison GPs is a one day conference giving a comprehensive update on key issues for prison GPs.

This conference will be of interest to all doctors performing primary medical services in prisons, including salaried GPs and independent GP contractors and is open to both BMA members and non-members to attend.

Confirmed speakers include:

Nigel Newcomen CBE, the Prisons and Probation Ombudsman, and Kate Davies OBE, Head of Public Health, Armed Forces and their Families and Health and Justice Commissioning, NHS England.

For more information, please visit the BMA website.

LMCs – change of details

If there are any changes to LMC personnel, addresses and other contact details, please can you email Karen Day with the changes at kday@bma.org.uk.

The GPC next meets on 16 October 2014, and LMCs are invited to submit items for discussion. You may like to review these, beforehand, with the representatives in your area who serve on the GPC. The closing date for items is 8 October 2014. It would be helpful if items could be emailed to Nadia Kalam at nkalam@bma.org.uk. You may also like to use the GPC's listservers to exchange views and ideas.

GPC News

LMCs are reminded that their regional representatives can provide more detailed information about the issues covered in GPC News, and other matters. Other members of the GPC would also be pleased to accept invitations to LMC meetings wherever possible. Their names and addresses are in the GPC Yearbook. The secretariat can also provide a written background brief if required, but it would be helpful to have such requests well in advance of your meetings.

Finally, if LMCs require assistance on local issues, they can also contact the BMA's local offices: addresses are on page 3 of the GPC's yearbook.

This newsletter has been sent to:

Secretaries of LMCs and LMC offices
Members of the GPC
Members of the GP trainees subcommittee
Members of the sessional GPs subcommittee

Appendix 1

Clinical Audit - England only

Practices can demonstrate ongoing quality improvement and effective care through completed clinical audit cycles. All GPs will do a 2 cycle audit for their revalidation portfolios. As long as the audit relates to the practice and has been discussed, evaluated and change instituted within the practice, then this can be used as supporting information within the effective domain for a CQC inspection.

What is Clinical Audit?

Clinical Audit as defined by HQIP and endorsed by NICE is:

> '…. a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change.'

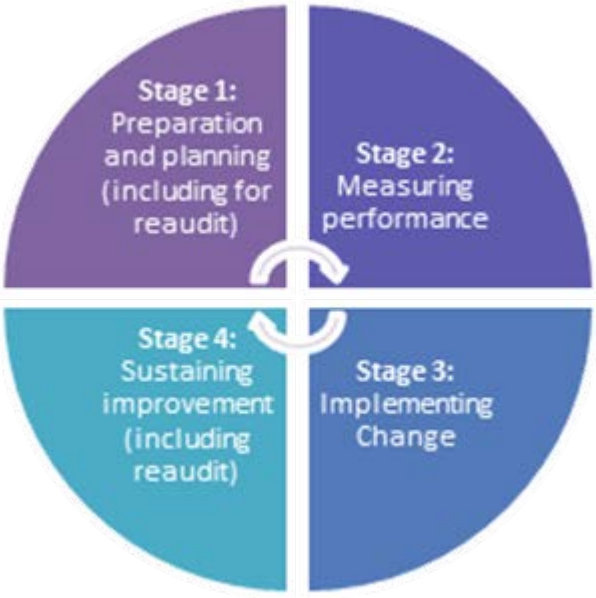
Clinical Audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. This is done by measuring the care and services provided against evidence base standards, changes are implemented to narrow the gap between existing practice and what is known to be best practice. Ideally, a clinical audit is a continuous cycle that is continuously measured with improvements made after each cycle.

Good medical practice for general practitioners states that as part of keeping up to date, and maintaining and improving your performance

> 'All healthcare professionals should take part in regular and systematic clinical audit, both quantitative audits of the care of groups of patients against defined criteria (with re-audit to demonstrate change)'

As part of revalidation all general practitioners should have one clinical audit or quality improvement project in one revalidation cycle. This is a baseline requirement. A practice as a whole should have a minimum of 2 clinical audits per year; this can be shared between multiple GPs.

The clinical audit cycle:



Stage 1: Preparation and Planning (including for re-audit)
The topic of the clinical audit is selected, ensuring that it is a priority agreed by those involved in the audit. The standards by which the current practice is being measured needs to be measurable against best practice which is evidence based. A clear, structured project plan needs to be in place at this stage.

Stage 2: Measuring performance
A detailed methodology and data collection process is designed and tested, including a sufficient sample size and a clear and concise data set. Data is analysed and communicated to all stakeholders. This can be within the practice or shared more widely.

Stage 3: Implementing Change
Once the results of the audit and recommendations for change have been communicated, an action plan should be produced to monitor implementation of these recommendations.

Stage 4: Sustaining improvement (including reaudit)
After an agreed period, the audit should be repeated. The same methodology should be used to ensure comparability. The re-audit should demonstrate that the changes have been implemented and that improvements have been made. Further changes may then be required, leading to additional re-audits.

What to look for in an inspection?
During an inspection, we are looking for evidence that all the 4 stages above have taken place, this can come from written records and discussions with staff. All GP practices should be conducting clinical audits; practices should aim to demonstrate an ongoing audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit.

There should be at least 2 cycles of a clinical audit, this may not necessarily be the case for newly opened practices.

It is worth noting that the data used in a clinical audit does not have to be bespoke data, collected explicitly for the purpose of audit. The data can be extracted from the practice's information system if it relates to current best practice or NICE guidance; the data can be a retrospective audit e.g. looking at past cases of patients with a particular illness or condition or it can be a prospective audit – where a time period and an agreed number of cases are reviewed.

Further information around Clinical Audit:

www.nice.org.uk/media/796/23/BestPracticeClinicalAudit.pdf
www.rcgp.org.uk/clinical-and-research/clinical-resources/clinical-audit/audit-guidance.aspx

Curtains guidance - England only

We have had several questions from practices and inspectors about curtains around examination couches. Do we have to replace material curtains with paper curtains? Answer – No

The CQC does not specifically have guidance to cover curtains in a GP practice, our guidance states that a practice should follow The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance.

Within the code of practice, it states that GP practices should: *"Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections." The code of practice goes on to state, "The environmental cleaning and decontamination policy should specify how to clean all areas, fixtures and fittings."*

These are the parts which relate to curtains. The guidance also points towards NPSA guidance on infection control which states that,

"Curtains/blinds should be visibly clean with no blood or body substances, dust, dirt, debris, stains or spillages." The guidance also states that curtains and blinds should be cleaned or changed 6 monthly.

Guidelines by the Infection Control Nurses Association state *"there should be a procedure in place for regular decontamination of curtains"*.

There is no guidance which states that a GP practice must have disposable paper curtains. During a CQC inspection, we are looking for curtains which appear visibly clean and that there is a system in place to ensure that curtains are cleaned or changed at least once every 6 months.

Simple pragmatic guidance based on the evidence is:

- if disposable curtains are used, the date should be clearly entered and they should be replaced six monthly
- if re-usable curtains used, they should be taken down and cleaned at 60 degrees at least six monthly and immediately when soiled
- they should be vacuumed weekly as part of the general cleaning schedule
- they should be well maintained, free of tears and clear of the floor.

Mythbuster #5 - Guidance on carpets in GP practices

There have been a lot of questions from practices about whether surgeries can have carpets.

Carpets should not be used in treatment and minor surgery rooms. The flooring in clinical areas should be seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant. This also applies to all areas where frequent spillage is anticipated. Spillage can occur in all clinical areas, corridors and entrances.

Carpets can be used in areas where the risk of spillage is lower, such as consulting rooms, waiting area, dispensing areas and administrative/storage/meeting rooms.

Where carpets are used in a GP practice, there should be consideration to needs. This includes having appropriate maintenance and cleaning programmes in place. Carpets, including all edges and corners, should be visibly clean, with no blood and body fluids, dust, dirt, debris or spillages. Floors should have a uniform appearance and an even colour with no stains or watermarks. In the event of spillage, the practice should have the appropriate equipment and protocol in place to clean the affected area.

More information can be found online.

Hand washing signs - England only

Do practices need to have signs to instruct people to wash hands? Answer – No

CQC does not stipulate that there must be laminated hand washing signs at all hand basins. Where there is no guidance from CQC, we would look towards national guidance. There is no national guidance that states hand washing signs should be in place above hand basins.

What CQC would look for in relation to hand hygiene during an inspection is that:

- there is adequate hand washing facilities available and easily accessible to all staff
- practice staff should notify the practice manager of any lack of hand hygiene products (hand gels, soap or hand towels), or obstruction of to ensure that these remain available at all times and are not obstructed by bins or equipment
- all clinical staff are trained in hand washing techniques
- the practice has thought about risks of inadequate hand hygiene and processes are in place to prevent poor hand hygiene.