Between the lines

'Analysis and explanation of things that matter to Nottinghamshire GPs'

Oct-Dec 2014 Issue 23

'Groundhog Day' for NHS

The history of the NHS, as has often been said, is cyclical and however much the politicians seek to reorganise its structure, we often end up in a place that looks very similar to where we have been before. Nobody could have predicted, however, just how quickly the structure created by former Health Secretary, Andrew Lansley, in his controversial reforms announced in 2010 and enacted in 2012, could have been disassembled.

Senior Health Service managers and civil servants reacted with incredulity when he abolished the PCTs and SHAs and strove to fight off any suggestion of a formal, intermediate tier of management between the NHS England Board and CCGs. The Area Teams, which were eventually formed, were merely an extension of a central policy-making secretariat we were told and CCGs would embody the spirit of local accountability as both membership organisations and statutory bodies.

When, a few months ago, CCGs were invited to express an interest in *co-commissioning* of GP contracts, LMCs warned that this would weaken their membership organisation status and make them more like the PCTs they replaced but our fears that history might be about to repeat itself have been compounded by recent news that Area Teams are to be reduced in number and increased in size so that they will begin to look more like the old SHAs. These changes make it even more likely that CCGs will inherit formal responsibility for commissioning of all local contracts and be responsible for performance managing their own members, thereby recreating the gulf that existed between GP practices and PCTs.

And it may not stop there. If, as is possible, CCGs find themselves under pressure to merge with their neighbours to give them sufficient capacity to commission at the appropriate scale, we could see organisations emerge which occupy the same geographical footprint as the old health authorities, thereby turning the clock back as it were 15 years! Such is the extent which Lansley's reforms have been rolled back by his successors, we could all be forgiven for thinking that we (like the death of Bobby Ewing in Dallas) merely imagined what has happened in the last four years, or that in the film *Groundhog Day*, we have woken up only to find ourselves about to repeat the same tedious journey that we have been on before over and over again.

Chris Locke, Chief Executive, Nottinghamshire LMC Ltd

Stop Press!

Just as this newsletter was about to go to press we learnt that NHS planners were about to throw a major "curveball". Perhaps conscious of the ridicule which would accompany the announcement of an Area Team whose geographical footprint was identical to the old Trent SHA, it has been suggested that the Nottinghamshire and Derbyshire Area Team will not be merged with another in the East Midlands but instead with that of Staffordshire and Shropshire, two counties with which we have absolutely nothing in common! If this happens it will prove that NHS England has finally lost the plot. At a time when closer liaison between health and social care is at a premium and calls to federalise our government institutions in the wake of the Scottish independence referendum means that regions like the East Midlands may become more important, how typical of the NHS to opt to go in the opposite direction! (You couldn't make this up).

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NOTTINGHAMSHIRE LOCAL MEDICAL COMMITTEE (UNITED) LMC REPRESENTING AND SUPPORTING GPs

Chairman's Message

Summer has gently given way to autumn; the leaves drift down from the trees; sunrise and sunset bring a glow to either end of the day; the nights draw gently in; nature prepares for the winter ahead.

And in primary care it's all hit the fan with flu jabs, childhood fluenz and some very short expiry dates and the unplanned admissions DES are all pointing towards a "winter of discontent". We then have the continuing issues with HMC, and the certainty of another winter of attrition, and it's perhaps no wonder that morale is low as it is.

Are there any breaks in the clouds? There are little signs of change at present as the NHS is on its knees with the financial straightjacket placed around us all. But after autumn and winter comes spring and we can always hope, and work for change.

The PCDC is now up and running and we hope that training the workforce will help retention and recruitment in the medium to long term. Discussions are on-going with HEEM about the same issues with the VTS. The immediate threat to PMS Practices and defunding also appears to have been halted, but this may only be a brief respite as "the Plan" is still to achieve parity of funding in 7 years' time.

So Primary Care once more faces a winter of demand with little extra resource, of emails reminding us of hospitals on red alert, of impossible demands on an increasingly stretched service. Yet I know we have the professionalism to face these challenges, to do the best for our patients, to achieve great things although we will not be recognised for doing so. By proving our worth once more we hope to encourage resource to flow to primary care once more, and to give our patients the NHS we deserve.

Dr Greg Place

Maintaining Fitness to Practice *By Peter McKeown*

During a recruitment process you will undertake various checks. Once the recruitment process has been completed you will need to keep a continuing check on fitness to practice. In this article Peter McKeown touches upon the various tasks that should be maintained.

Some tasks are quick and simple; some not. Some tasks give "sure-fire" results; some not. Clinicians are not always aware of exactly what they have to do to maintain fitness to practice - we can't rely on others to "watch our backs".

GMC

A search on the GMC website www.gmc-uk.org/index.asp against a doctor's GMC number will tell you:

- If they are registered
- If they have a Licence to Practice
- If they are on the GP Register
- If they have Conditions, Undertakings or Warnings

An adverse entry on the first three items will mean you have to stop the doctor from working. The fourth not necessarily so.

Performers List

I don't rely on this website: www.performer.england.nhs.uk. In my experience, it's not kept up to date, neither with additions nor with removals. It seems to lack basic error-checking. I think the safest way is to email the AT and ask if a doctor is on the list. Store the reply safely. Unfortunately I believe the AT will not inform you of any changes to a doctor's list membership.

GPRs

GPRs have three months grace during which they can work/train in primary care without being on the performers list provided they submit a valid application to join the list before the commencement date of their training. What you have to watch out for is a situation where one of your GPRs is not on the register by early November, in which case you will have to stop him/her working until he/she is actually on the register.

Nurses

Nurses need to maintain NMC registration. Equally important is your own practice insurance. Nurses are employees and there is therefore the question of vicarious liability. You need insurance to cover you should a nurse consultation give rise to a serious complaint and/or litigation.

Insurance

You need to:

- Ensure that your insurance does actually cover your risks in connection with clinicians working or training at your practice.
- Ensure that you are complying with the terms of your insurance policy.
- Ensure that nurses have job descriptions or other practice policies and procedures that carefully specify what they can and cannot do as your employee. You must also be able to show that these job descriptions etc. are more than just pieces of paper but that the day to day work of the practice and the nurses in particular are actually governed by them.

Careful attention to detail is very important.

Indemnity

The various organisations have different rules. What you need to do is ensure that you receive evidence of cover on a continuing basis and as with insurance, check the fine print.

References including Appraisal

References are a one-off task in recruitment. However, doctors need to undergo revalidation, which includes appraisal. Details can be found here: www.gmc-uk.org/doctors/revalidation.asp

DBS

You might find my website www.gpsystems.org useful. If you ask for my fact sheet you will see quite a few helpful hints but one thing above all, I think, belongs in this newsletter:

It seems to me that there is no sure-fire way within the DBS system that guarantees that if you get a clear result on a certificate then you can be certain that there are no convictions. The DBS constantly emphasises the need for care and vigilance in the identification process in order that correct information appears on the certificate. Look at it this way: there is an official system at the DBS for dealing with certificates that show convictions when the applicant has no convictions at all. If they can get it wrong this way, why not the other?

Right to Work in the UK

Usually the passport is all you need. You have to take photocopies of the relevant parts and the front cover. You can get help here: www.gov.uk/check-job-applicant-right-to-work

Keeping up to date

My fact sheet has plenty of information on how you can look after the above matters. Please feel free to email me at peter@mckeown-online.com.

Staff contracts: Are they painful to touch?

Don't get your fingers burned when managing changes to staffcontracts, says Kate Nowicki, Area Director, Acas East Midlands

In recent months we have had a flurry of calls to the Acas Helpline from the primary care sector, in particular GP practices, about changes to contracts of employment. It can seem a scary business, and if you get it wrong those fears can be justified, but with a common sense approach and some sound advice behind you there's nothing to fear.

Extended hours, merging practices, changing job roles, they are changes that you are all familiar with, and at an individual level they usual mean contractual change. Practice managers can follow some straightforward principles to handle alterations to contracts of employment effectively and get a fair outcome for all involved.

But what is in that contract in the first place? It may be worth having a check-up on any paperwork that is already there. In fact just finding the paperwork can be a challenge! It is not unusual, for example, for both employer and employee to have lost any copy of a contract, especially for longer serving staff. In fact, it's not unusual for employers to believe that in the absence of any written evidence, they can do what they want because a contract doesn't exist. That is not true, of course, and a contract exists as soon as an offer of employment is accepted.

So once you know what you've got, if you do have to make changes, where do you start? Can you ask the practice nurse to start a new shift pattern next week, and change her usual day off? Well, you can certainly try, but you may not get the outcome that you want!

Consultation is the key

The changes that you are seeking need to be agreed with the staff that they affect, and that holds true both ways; staff can ask employers for contractual change, and vice versa. Here, though, I am focussing on when the employer wants to make a change, and the starting point is consultation with the staff or their representative(s). When people understand the reasons for a change they are more likely to accept it, and even better, they might be able to contribute ideas to help the situation.

When you reach agreement should you put it in writing? Well, if it affects one of the statutory terms, such as pay, hours, or holiday, then yes you should, within one month of the change taking effect. But whatever the change, I would always recommend that you write it down, and get the other party to confirm their agreement in writing, perhaps in a short email or by signing off their acceptance on a copy of your letter.

Try a different perspective

What if you struggle to agree? You can look at incentives, or 'buy outs'. They are not always going to be appropriate, but in cash or in kind they can sometimes work. Try getting a different perspective on things, and bouncing different ideas around. I know of a company where a disagreement about changes to allowances was resolved by the reintroduction of a free Christmas turkey for all staff!

But if you can't agree, and the message is 'stuff your turkeys', what next?

Into the breach

If you go ahead and impose the change you will be in breach of contract. Your employees would then have a range of potential legal challenges against you. Depending on the circumstances these could include a claim for constructive dismissal if the breach is fundamental and significant, or a claim for damages for breach of contract at a civil court or, if pay is involved, possibly a claim at an employment tribunal for unlawful deduction from wages.

As well as a legal headache, a unilateral change of contract can cause lasting damage to the trust and confidence between the manager and their staff, which can linger for years.

But we can't agree!

If you really can't reach agreement with your employees then you can serve notice to terminate the existing contract and offer re-engagement on revised terms. This is the option of last resort, after all consultation has been completed, and it is a dismissal of the employee. If you do decide to do this you must follow a fair procedure and offer the right of appeal. Your employee may make a claim to an Employment Tribunal for unfair dismissal, and it would be for the tribunal to weigh up the facts and decide whether it was fair or unfair.

Finally, if turkeys are off the negotiating table, and you need help to move things forward, give us a call, and we'll see how we can help.

Kate Nowicki
Acas East Midlands
knowicki@acas.org.uk

Acas Helpline: 0300 123 1100 (open Monday to Friday 8am-8pm and Saturday 9am-1pm). A free booklet: Varying a Contract of Employment is available from www.acas.org.uk

The Friends and Family Test

Alison Kirk, Patient Experience Manager
Area Team - Derbyshire and Nottinghamshire

NHS England in Nottinghamshire has been working in partnership with Nottinghamshire Local Medical Committee to embed the Friends and Family Test in to GP practices across the county.

From 1 December 2014, it is a contractual requirement that all GP practices undertake the NHS Friends and Family Test (FFT). The FFT is a feedback tool supporting the key principle that the people who use NHS services should be given the opportunity to provide feedback on their experience; the results from this can be used to help improve services.

The feedback tool is a questionnaire, asking whether people would recommend the services which they have used, and gives a range of responses for the person to select. The range of responses the person can choose from are: 'Extremely Likely'; 'Likely'; 'Neither likely nor unlikely'; 'Unlikely'; Extremely unlikely'; or 'Don't know'. The wording of the FFT question and responses must to be exactly as set out.

This is then combined with follow-up questions providing a process to underline both good and poor patient experience. The FFT is continuous and not a one off, traditional survey or a planned feedback tool, and the patient's responses must to be anonymous.

FFT allows practices to use the feedback received to celebrate successes and help support staff to make improvements when the member of the public's experience hasn't lived up to expectations.

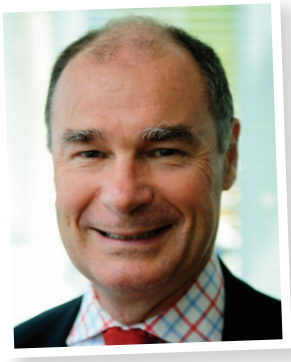
The experience of FFT shows that many of the problems it identifies are solved easily by practices, and can have an increasingly positive effect for patients' experiences. Similarly, the positive comments received through the FFT are very important for improving and sustaining the morale of hard working staff.

There are a number of key points with the FFT; one of these is that patients don't have to be asked to answer the FFT question after every appointment or interaction with practice. However, they must be made aware that the opportunity is available to those would wish to provide feedback.

After implementation of FFT, NHS England will be carrying out a review to identify any opportunities to make improvements.

You can find out more about FFT at www.england.nhs.uk/ourwork/pe/fft/ or by contacting Sarah Gec, Patient Experience Lead at NHS England Derbyshire and Nottinghamshire Area Team at sarah.gec@nhs.net.

Goodbye to Dr Andrew Parkin



It was with great sadness that partners and staff at Lombard Medical Centre said goodbye to our senior partner, Andrew Parkin after 29 years in the practice. Having travelled the world as a young doctor, Andrew settled in Newark in 1985 at what was then Lombard Street Surgeries and remained at the practice until his retirement on 30 June this year.

Andrew was committed to general practice in Newark and fought long and hard for its development. He was a founder member of CONDOR, the out of hours co-operative service for Newark and until recently, a member of the Nottinghamshire LMC. He was also a GP trainer for 15 years and headed up the recent PANNASH project in Newark & Sherwood.

Andrew was a consummate professional with an abundance of skills and know ledge which he readily imparted to others. He will be very much missed in the practice by his partners and staff and by a loyal following of patients. We all wish him a long and happy retirement.

Celebrating local GP heroes

This is the first in a series acknowledging the contributions of local GPs who have made a great impact on their communities. We begin with the late Dr David Stephens who died last year at the age of 96.

Dr Stephens practiced in Nottingham in the inner-city area of Hyson Green from the 1950s onwards and in the 1960s led a campaign in support of the development of a health centre to serve the needs of its socially deprived population. The Executive Council finally gave approval for the building of what was to become the first Mary Potter Health Centre after the LMC voted to support it in December 1964.

Dr Stephens was a prominent member of the RCGP and a respected GP trainer and one of his grateful trainees, Dr Y V S Rao, subsequently went into partnership with him. Dr Stephens held a number of medical officer posts including looking after council run residential homes and maintained a great interest in health care for the elderly. When he retired in 1987, his partner Dr Rao continued in a single-handed practice.

Following his retirement, Dr Stephens maintained his interest in medicine while pursuing hobbies including sailing, frequently taking his own boat to the continent. Dr Stephens was a graduate of Edinburgh University and, altruistic to the last, bequeathed his body to his former medical school for scientific study. His former colleagues agree that he was an exceptional man, and an exemplary GP who made a lasting and positive impact on his community and those who worked with him.

The Last Word

There can be no more perfect illustration of the administrative chaos affecting NHS primary care than the following. A couple of years ago, a combined Nottingham City and County PCT agreed to set aside some monies to fund works which certain GP practices needed to bring their buildings up to standards acceptable to the CQC. The contract to carry out the works was given to a particular building contractor and the practices were forbidden to get the works done themselves.

Many months later, after work had begun and was not yet complete, the contractor went bust just before the PCTs were disestablished and replaced by the Area Team. The Area Team identified a new contractor but soon found itself embroiled in a legal dispute with the creditors of the former contractor which meant that the unfinished work could not proceed and the CQC was asked to show forbearance to those practices falling short of the required standards while the work was waiting to be done. When the dispute was eventually settled nearly two years after the original contractor went bust, an unexpected obstacle to the signing of the contract with the new preferred contractor emerged. In common with established practice, the new contract needed to be sealed i.e. to have a company seal appended to it.

PCTs formerly had their own seals but the Area Team is not a corporate body in its own right (it is merely an extension of NHS England). So began a frantic search for an appropriate seal, which eventually extended to the bowels of Quarry House in Leeds, where cupboards and vaults were emptied and old retainers dragged out of retirement and interrogated as to where to find something that would serve the purpose. Eventually someone found a suitable seal which was capable of conferring to the contract the necessary authority. This meant that a seal of approval could finally be given a contract amounting to not more than a couple of hundred thousand pounds which could be endorsed by the body responsible for spending billions of pounds of public money each year. *Is it any wonder that the NHS is in such a mess?'*

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