18 January 2024

To All Leicester, Leicestershire, and Rutland General Practitioners and Practice Managers,

Dear Colleagues

LLRLMC NEWSLETTER JANUARY 2024

Welcome to our January Newsletter which includes feedback from our LMC Board meeting held on 10 January 2024, and other current issues.

Topics in this newsletter:

As always if you have any comments, questions, or suggestions please contact the LMC

LMC MEETING JANUARY 2024

As usual the 'weightier' agenda items are discussed individually below.

Richard Mitchell (Chief Executive Officer UHL) attended the meeting. We raised with him various issues including individual consultants insisting GPs jump through higher and higher hoops before referring a patient. If you have any individual problem that could be solved by raising directly with Richard please contact the LMC.

Richard is keen to continue to develop a close relationship with the LMC which will benefit the hospital, GPs, and our mutual patients.

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LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

UNDERFUNDED SERVICES/NOTICE TO QUIT

I would like to thank all those practices that provided the LMC with Notices to Quit. This made a significant difference to the outcome of discussions with the ICB, not only for this occasion but also for future discussions.

I hope you have had the opportunity to look at the email from Nisha Patel and Dr Tony Bentley (Subject: GP Funding 2024/25 Update) with costings agreed by the ICB, and the update sent on Monday 8 January. I would like to thank the ICB for constructively working with the LMC.

There are ongoing active discussions and we have recently written to Dr Caroline Trevithick (Chief Executive Officer LLR ICB) to outline the outstanding issues that need to be resolved as part of this year's discussions, that include:

- Minor Surgery costings.
- Escalation process for wound care which must include the LMC.
- That practices must be able to 'opt out' from providing one or more of the 'Community Based Services' (CBS) with no cost or risk to the practice, in recognition that not all practices will be able to perform all services. At times this is due to circumstances beyond the practice's control, including lack of investment and therefore capacity within premises.

We have also asked the ICB to consider providing one off support for practices taking on a new service, for example:

- Funding for one off costs not covered by the costings (for example repurposing rooms, recruitment costs etc.
- Project management support to commence a new service
- Training
- Ability to commence most services either from 1/4/2024 or from 1/10/2024, but for phlebotomy for children 12 to 16 to join in a phased manner relating to training capacity.

Finally we have asked the ICB to agree a process to ensure an annual review of contracts and to avoid remuneration of contracts falling behind actual costs again in the future.

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MEDICAL EXAMINER SERVICE.

The proposed implementation of the Medical Examiner service is still most likely to happen in April 2024, although we are advised that it is now more likely to be the end rather than the beginning.

We cannot publish definitive local guidance yet until the legislation and national guidance have been finalised and published. However, to let you know what the process is likely to be like, please see our draft guidance at Annex One.

If you and/or your practice have not yet trialled the Medical Examiner service I recommend that you try it out whilst it is voluntary rather than wait for when it has gone live as a mandatory service.

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EMAS – CHANGE OF PRACTICE EMAIL ADDRESS.

EMAS have raised an incident where they had informed a practice of the death of a patient, but the practice had not received it as they had changed their email address.

Although it is rare for a practice to change their email address, if this happens, please remember to let EMAS know by emailing your new address to eprfteam@emas.nhs.uk.

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SUCESSION/RETIREMENT PLANNING WEBINAR.

The LMC will be hosting a lunchtime webinar on succession/retirement planning for practices presented by BW Healthcare Surveyors on Thursday 25th January 12.30 - 1.30pm

Succession/retirement planning: What to do with your premises?

This webinar will be performed by an expert speaker in the field of primary care who is involved with supporting practices with all their premises related issues nationwide.

They will explore the main premises options to consider when beginning GP practice succession and retirement planning; how to avoid common costly pitfalls and how a robust succession plan can even help alleviate partnership recruitment problems.

When you consider a significant proportion of GP Partners are within five years of the average retirement age of 58, putting a succession plan in place has never been so important.

The details are below:

- Thursday 25th January 2024
- 12.30 - 1.30pm
- Teams link sent on registration
- To register, email enquiries@llrlmc.co.uk

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INCLISIRAN.

Inclisiran is a medication given by subcutaneous injection that is administered by a clinician, with the aim of reducing blood levels of Cholesterol. We have received several emails from practices about this medication.

New medications are discussed by the Leicester, Leicestershire and Rutland Area Prescribing Committee, which has representatives from both Primary and Secondary care, with a resulting local formulary stating if a drug is "Red", "Amber" or "Green" to prescribe. We understand all local area prescribing committees were uniquely advised by NHS England to designate this medication as Green, rather than discuss this in the usual way.

The LMSG prescribing guidelines, in the section on Inclisiran, give it a 'Green' status, but add that the guidelines are "for prescribers who feel competent to use this medication.[1]"

General medical practitioners are independent registered practitioners who take full responsibility for any prescription they sign. The General Medical Council requires registered doctors to prescribe only when they "are satisfied that the medicine or treatment serve the patient's needs." When prescribing based on the recommendation of another doctor the GMC further requires that "you must be satisfied that the prescription is needed, appropriate for the patient and within the limits of your competence."

Inclisiran is a relatively new and novel drug, that many GPs advise they do not feel competent to prescribe. We note that an editorial in the British Medical Journal called on the National Institute for Clinical Excellence to reconsider their guidance on Inclisiran as the "recommendation is premature without data on cardiovascular outcomes.[2]" The British Medical Association and Royal College of General Practitioners have produced a joint statement advising a cautious approach to prescribing by general practitioners.[3]

Since Inclisiran is a black triangle drug, if you do decide to prescribe it before the long-term outcome and safety data is realised, please ensure you:

- Undertake shared decision making with your patients, ensuring a full and detailed informed consent is taken, documenting the lack of long-term evidence and unknown long term safety profile of this new and novel medication,
- Encourage your patients to report all side effects to you, however minor, ensuring you fill in a MHRA "yellow card" when they are reported to you and
- Report any potential drug interactions or concerns of your own at the earliest opportunity

The LMC view is that it is up to individual clinicians to decide whether they wish to prescribe this medication, given the above guidance and the responsibility that come with it. You may wish to develop a practice view on this and factors such as your competence and confidence as a prescribing clinician, practice workforce capacity and costs involved in the recall process might inform this.

There was initially £10 available to practices, per patient, if ordered as a personally administered medication. This has now reduced to £5, and we understand will reduce to zero at the end of the 23/24 financial year. Practices will need to decide if this adequately covers the costs of providing the medication when factors such as GP time to counsel prior to initiation, consultations about any side effects, clinician time to administer and staff training are considered. There are also wider financial considerations including the cost of maintaining a long-term recall system with an unknown future level of income, along with the impact of tax and current inflationary pressures. The LMC view is that

[1] Leicester, Leicestershire and Rutland Area Prescribing Committee: Inclisiran
[2] NICE guidance on inclisiran should be reconsidered | The BMJ
[3] Inclisiran position statement (rcgp.org.uk)

the provision of Inclisiran injections must be commissioned as a specific, appropriately funded service.

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AGM – THE HIGHS AND THE LOWS

BOOK NOW TO AVOID DISAPPOINTMENT

Join us at our next LLR LMC Annual General Meeting

Date: **21st March 2024**
Time: **6.30pm**
Venue: **Hilton Leicester Hotel, 21 Junction Approach, Leicester, LE19 1WQ**

This year we have TWO very special guests, Katie Bramall-Stainer the current chair of the BMA's General Practitioners Committee, and Adam Kay. If you would like to reserve a place, please let us know. Spaces will be limited due to capacity of venue.

AGENDA

6.30 - 7.30pm: Arrival, Dinner & Networking

7.30 – 7.50pm: Formal meeting - opening remarks and questions from members on annual report from Dr Grant Ingrams, LLR LMC Executive Chair

7.50 – 8.30pm: Dr Katie Bramall-Stainer - Chair, GP Committee England - BMA

Katie qualified from UCL in 2003 and completed her GP training in North London in 2008. She spent seven years in partnership from 2010-2016 before taking on LMC roles. Katie was elected Chair of GPC England in August 2023 following chairing the UK Conference of LMCs in 2022 and 2023. She is a firm advocate of the unarguable economic case for GP-led holistic expert-generalism from cradle to grave and suffers from an almost maniacal sense of duty to protect general practices, their amazing staff, and GPs themselves.

8.30 – 9.00pm: Adam Kay

Adam is a BAFTA-winning author, TV writer, comedian and former junior doctor. His first book, This is Going to Hurt, spent over a year at number one in the Sunday Times bestseller list, was translated into 37 languages, won numerous awards, and sold over three million copies. He is also one of the country's bestselling children's authors, with titles including Kay's Anatomy, the fastest selling kids' non-fiction book of the decade.

Adam's numerous accolades for TV writing include a BAFTA award, a Writers Guild award and a Broadcast award for his BBC/AMC adaptation of This is Going to Hurt. As a live performer, Adam has sold out several West End seasons and UK tours. His tour of This is Going to Hurt was attended by over 250,000 people. He has innumerable TV credits, and his unique stories from the wards have made him one of the UK's most in-demand performers for

corporate and private events. His latest show, *Undoctored,* was the biggest-selling show of the 2023 Edinburgh Fringe, and was followed by a sell-out West End season. It will be touring throughout 2024. Adam is a proud patron of the Laura Hyde Foundation, Doctors in Distress and The Lullaby Trust.

RESERVE YOUR SPACE

All LLR GPs and Practice Managers are welcome to attend the LLR LMC Annual General Meeting and there is no cost, we just ask you confirm your attending by emailing enquiries@llrlmc.co.uk in advanced of the session.

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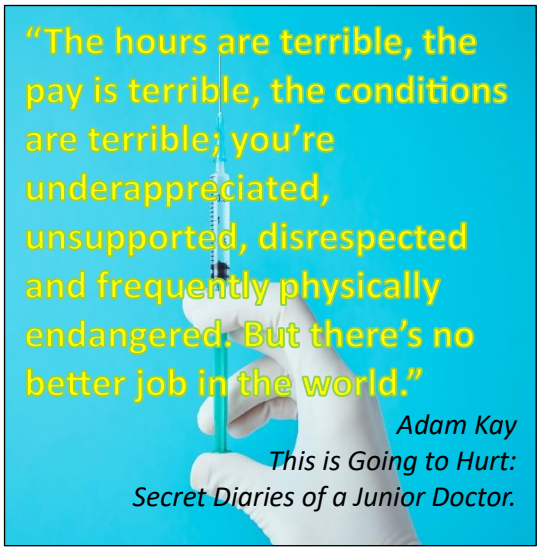
Your LMC wishes all GPs, Practice Managers and Practice Staff a Happy New Year.

We cannot predict what 2024 will bring, but the LMC is starting to agree a workplan, and what we should focus on next. If you have any ideas or views let us know.

If you want to know what the interim GP contact for 2024/5 will be about, and what the new, revised GP contract for 2025 onwards is likely to look like, then join us to listen to and question the current Chair of the GPC who is leading these negotiations at our AGM. Following this be entertained by the talented Adam Kay who is the son of an old friend and colleague, Dr Stuart Kay, who was for many years a GP in London and GPC member.



Yours faithfully

Dr Grant Ingrams
Executive Chair, LLR LMC
Grant.Ingrams@llrlmc.co.uk

ANNEX ONE: Draft Death Processes and The Medical Examiner Service from April 2024

PLEASE NOTE THAT THIS IS **DRAFT GUIDANCE**, AND THERE MAY BE CHANGES PRIOR TO GOING LIVE AS SOME LEGISLATION AND SUPPORTING NATIONAL GUIDANCE IS STILL IN DRAFT FORM.

1) The processes to be followed after death will be changing significantly in 2024. Although it is expected to be implemented during April 2024 it may be delayed until later in the year. This short guide for GPs has been written with the kind input from the Senior Coroner, Senior Medical Examiner, Senior Registrar and a Funeral Director.

2) The main changes that will affect GPs are:
   2.1) To complete an MCCD/APC you will need to:
   - Have 'attended' the deceased before death.
   - Know 'to the best of your knowledge and belief' the cause of death.
   - Know that there is no requirement to report the death to the coroner (Annex C).
   - Consider consulting the Medical Examiners' Office if you are unsure about any of the above (Contact: 0116 258 3102/250 2945 or 07814 028098 or 07815 457565).

   2.2) There is no longer any requirement for the deceased to be seen within **28 days prior to death**, or **after death** by the certifying GP.

   2.3) Once completed the GP **MUST** send the MCCD/APC to the Medical Examiner service, together with the deceased's person's relevant health records and any other relevant information (in preference using the PRISM form).

3) Please find attached the Following Annexes:

Annex A	Flow chart of death process for GPs.
Annex B	Frequently Asked Questions.
Annex C	Notifiable Causes of Death.

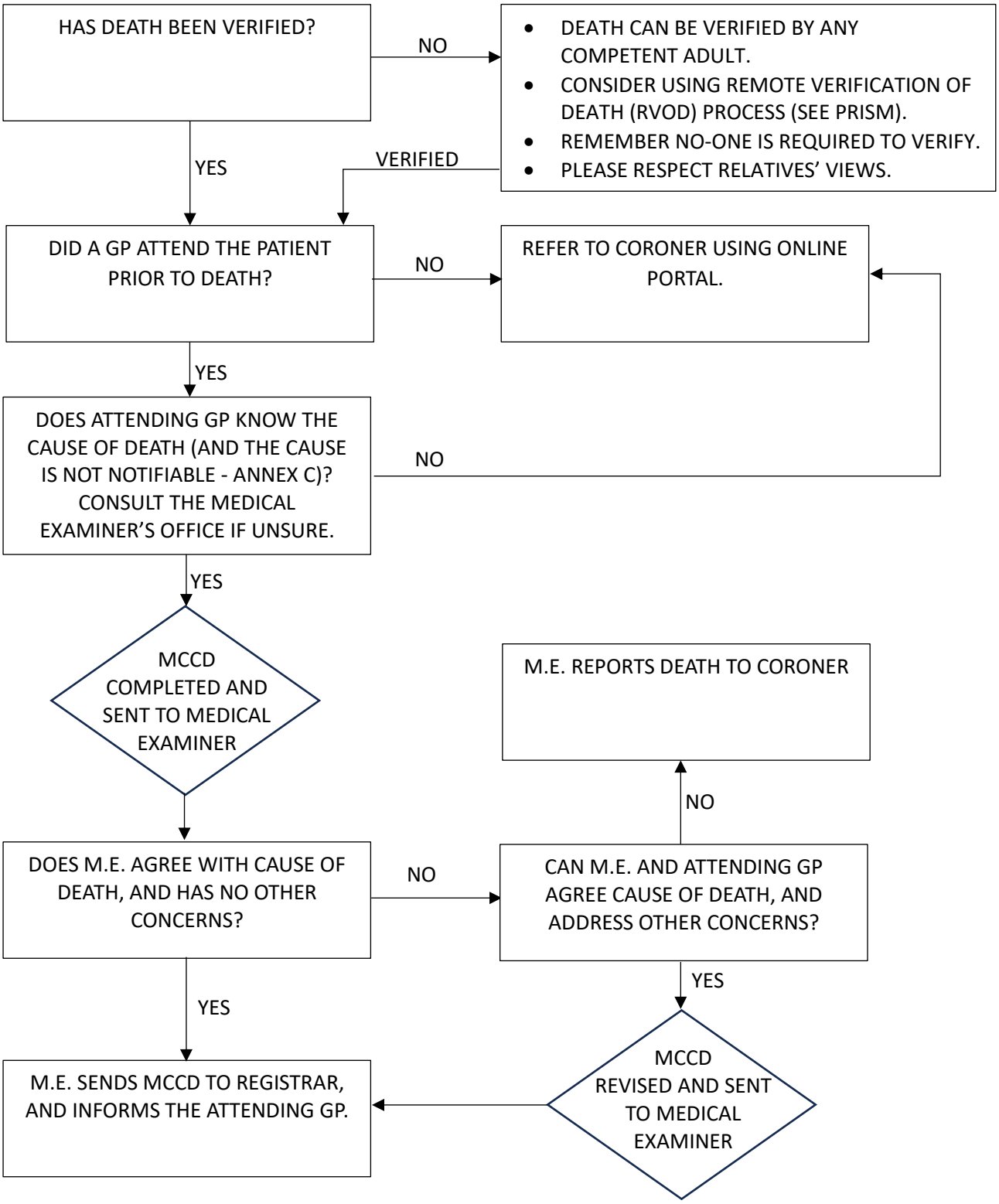
4) This guidance is accurate at the time of writing but refers to draft legislation so may be subject to change.

LLRLMC
January 2024

LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

ANNEX A:

FLOW CHART FOR PROCESS AFTER DEATH FROM 1 APRIL 2024



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ANNEX B

Frequently Asked Questions (FAQs)

Who Can Verify Death?

Under current law, any competent adult can verify death. The GP should assure themselves that the person who has verified death has been able to correctly identify them.

Although any competent adult can verify death there is no requirement on anyone to do so. This puts a GP in a potentially difficult position as you cannot consider whether to issue an MCCD/APC unless you are sure of the identity of the person and that they have died.

Consider using the Remote Verification of Death Process (available via PRISM) which enables a GP to verify a death by video or phone if there is a willing adult present. Please respect the views of relatives or carers if they do not wish to be part of the process as they may find the process too distressing.

Funeral Directors will not remove a body unless verified as dead.

What is the underpinning legislation?

Primary Legislation:

- Coroners and Justice Act 2009, Sections 19, 20 and 21
- Health and Care Act 2022 Section 169

Regulations (draft)

- The Medical Examiners (England) Regulations 2024
- The Medical Certificate of Cause of Death Regulation 2024
- The National Medical Examiner (Additional Functions) Regulations 2024

Other legislation which will be amended:

- Birth and Deaths Registration Act 1953
- Human Tissue Act 2004
- Access to Health Records Act 1990

Other Regulations where the amendments are not yet available even in draft.

- Notification of Death Regulations 2019
- The Registration of Births and Deaths Regulations 1987
- Cremation (England and Wales) Regulations 2008

Who should a GP inform if a patient dies who, as far as the GP knows, has no next of kin, or anyone to make arrangements with a funeral director?

The GP should inform the Coroner's Officer by phone during office hours or otherwise the Police.

What is an Attending Practitioner's Certificate?

The Medical Certificate of Cause of Death (MCCD) is referred to as an 'Attending Practitioner's Certificate' (APC) in the The Medical Certificate of Cause of Death Regulation 2024 and the two terms are used interchangeably.

Who can complete an MCCD/APC?
Any medical practitioner who attended the deceased before their death and can propose a cause of death to the best of their knowledge and belief **must** complete an MCCD/APC.

What is the definition of 'attended' in relation to a GP completing an MCCD/APC?
There has never been a clear legal definition of what 'attended' means, and the BMA and local senior coroner supports leaving this up to the discretion of the certifying GP. This has allowsed the meaning to change with changing work practices.

The current government guidance says that 'attended' is generally accepted to mean "*a doctor who has cared for the patient during the illness that led to death and so is familiar with the patient's medical history, investigations and treatment. The certifying doctor should also have access to relevant medical records and the results of investigations. This could include, for example, a GP who has been involved with talking to the patient and/or relatives and liaising with the palliative care specialist nurses regarding medication and other care, even if the GP has never seen the patient in person.*"

There is no provision under current legislation to delegate this statutory duty to any non-medical staff.

Does a GP need to have seen the deceased 28 days before death?
No, there is no longer any requirement for this from April 2024.

Does a GP need to have seen the deceased after death, if not see within 28 days before death?
No, there is no longer any requirement for this from April 2024.

Having completed an MCCD/APC is there a legal requirement for a GP to share it with a Medical Examiner?
Yes, together with relevant medical records and other relevant information. In preference, please use the PRISM form.

Does a reporting GP have a duty to respond to enquiries from an ME?
The Medical Certificate of Cause of Death Regulation 2024 says that reporting GP must be available, ***as far as reasonably practicable***, to respond to any enquiries that the medical examiner may have in connection with the attending practitioner's certificate (MCCD/APC).

If the medical examiner has a query and cannot contact the certifying GP, then the MCCD/APC you have provided cannot be used to register the death. Please give details of how and when you can be contacted, in preference by personal mobile phone so a text message can be sent if unavailable at that time, or a 'back door' number for the practice. Please avoid, where possible, the main reception number, as it is unreasonable to expect the Medical Examiner Office to spend an excessive time trying to contact you.

What happens if the ME disagrees with the cause of death?
The Medical Certificate of Cause of Death Regulation 2024 advises that if the ME is unable to 'confirm the cause of death' as written on the MCCD/APC, they 'must' refer the death to the senior coroner.

In LLR we have agreed the pragmatic view that if the original cause of death does not meet the relevant guidance (or example using the term 'old age' for a deceased patient under the age of 80, or referring to mode of death instead of cause) then it is reasonable, following discussion, for the ME to request the attending GP to consider issuing a revised MCCD/APC.

Will a new MCCD/APC be provided?
The aim is to provide an electronic MCCD/APC, but this will not be available until later in 2024. In the interim a new paper version of the MCCD/APC, and a PDF version will be distributed.

There will remain two MCCD/APC forms:

- for deaths within 28 days of life, and
- for deaths after 28 days of life.

The revised MCCD/APC has not yet been published, but will include the following changes:

- Details of the ME who scrutinised the death.
- Ethnicity, as self-declared by the deceased during their life (or otherwise mark as 'unknown'). Relatives or other representative of the deceased should not be asked for this.
- If the deceased was pregnant.
- An additional line (1d) for cause of death.
- Record of medical devices and implants.

What happens if a registrar is given information (by the informant who applies to register the death) which suggests that the cause of death on the MCCD/APC is wrong?
The registrar must consult with an ME, who, if they agree that the cause of death should be changed, can 'invite' the GP to issue a revised MCCD/APC. If the attending practitioner declines, the ME informs the registrar.

What happens if there is no attending GP, or all attending GPs are not available with a reasonable time?
In these circumstances the practice should refer the death to the coroner using the online portal.

The coroner can decide not to investigate and refer to the Medical Examiner, who, in this case, can complete an MCCD/APC, if there is a clear natural cause of death.

If a GP has reported a death to the coroner, do they also have to inform the ME?
No

At what stage is a registrar informed of a death, and registration of the death occur?
The ME (or coroner) will notify the registrar of the cause of death (the GP no longer should do this). the 5-day statutory time frame to register the death will start on the day of this notification.

How is the GP informed that the MCCD/APC and cause of death has been accepted by the ME?
The ME is required to inform the GP 'without reasonable delay' when they have sent the MCCD/APC to the registrar. This will normally be via email to your practice, unless you have asked to be informed in person (and have provided a means to do so).

Will the GP also need to complete a form Cremation 4?
From April 2024 GPs will no longer need to complete a form Cremation 4. Scrutiny by the medical examiner will in the future be regarded as sufficient. Crematorium referees will remain in position initially but are likely to be removed from the process in the future.

Will the GP still need to provide information about medical devices (eg pacemaker) and implants in the body of the deceased?
Yes, this will be included as a question on the revised MCCD/APC. Items that should be included are listed in The Cremation (England and Wales) Regulations 2008 Guidance to medical practitioners completing form Cremation 4 (publishing.service.gov.uk):

- Pacemakers
- Implantable Cardioverter Defibrillators (ICDs)
- Cardiac resynchronization therapy devices (CRTDs)
- Implantable loop recorders
- Ventricular assist devices (VADs): Left ventricular assist devices (LVADs), Right ventricular assist devices (RVADs), or Biventricular assist devices BiVADs)
- Implantable drug pumps including intrathecal pumps
- Neurostimulators (including for pain & Functional Electrical Stimulation) Bone growth stimulators
- Hydrocephalus programmable shunts
- Fixion nails
- Any other battery powered or pressurised implant
- Radioactive implants
- Radiopharmaceutical treatment (via injection)

What is the legal basis for an ME to access the records of a deceased person?
The Access to Health Records Act 1990 has been amended to insert a new subsection 3(1)(g), giving a Medical Examiner scrutinising a death the "Right of access" to the health records.

When should a GP notify a death to the coroner?
The reasons are set out in The Notification of Deaths Regulations 2019, and included as Annex C.

Is there a requirement for the certifying GP to have seen the patient in person/face to face at any time during their lifetime?
The current draft guidance and legislation does not require this. However, until the new MCCD/APC has been finalised we will not know if there is any expectation for this.

LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

Annex C

Circumstances in which there is a duty to inform the coroner of a death

(Extract from Notification of Death Regulations 2019 ***with additional comments in italics)***

1) The registered medical practitioner suspects that that the person's death was due to:
   (i) poisoning, including by an otherwise benign substance;
   (ii) exposure to or contact with a toxic substance;
   (iii) the use of a medicinal product, controlled drug or psychoactive substance;
   (iv) violence;
   (v) trauma or injury;
   (vi) self-harm;
   (vii) neglect, including self-neglect;
   (viii) the person undergoing a treatment or procedure of a medical or similar nature; or
   (ix) an injury or disease attributable to any employment held by the person during the person's lifetime;

   [Referral is necessary if any of the conditions above significantly contributed to the cause of death. They do not need to be the main cause. If in doubt, the Medical Examiner's Office can advise on the current practice of the Senior Coroner.]

2) The registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);

3) The registered medical practitioner—
   (i) is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person; but
   (ii) despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown;

   [Where the reporting GP considers the cause of death to be known, then this should be included in the referral]

4) The registered medical practitioner suspects that the person died while in custody or otherwise in state detention (For the definition of "state detention", see section 48 of the Coroners and Justice Act 2009.);

5) The registered medical practitioner reasonably believes that there is no attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person;

6) The registered medical practitioner reasonably believes that—
   (i) an attending medical practitioner is required to sign a certificate of cause of death in relation to the deceased person; but
   (ii) the attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death;

7) The registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.