LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

15 December 2022

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

Dear Colleagues

Re: LLR LMC Board meeting 14 December 2022

The following items were discussed:

1) Can we Fix It?
2) Paediatric Respiratory Hub
3) Safe Working in general practice

In addition, please see reports from other workstreams:

1) LMC and ICB meeting regarding Primary Care Funding Model (PCFM) and Transferring Care Safely (TCS)
2) EMAS reporting deaths to the Coroner

As usual, the LMC is happy to receive any comments or questions about anything in this letter.

Can We Fix It?

Working as part of an LMC can feel like playing Whack a Mole – you think a problem has been resolved, only for it to recur.

We have agreed that at each Board meeting we will identify one or two bugbears for general practice and work until the problem has been resolved (or if not, a clear understanding of the blocks).

This month, we have agreed to look at midwife generated blood tests. These cause confusion and often duplication of work. Once solved we will report back!

Please feed you ideas for what we could tackle next to the LMC Office or me.

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Paediatric Respiratory Hub

There was a cautious welcome for this proposal by Board Members. The LMC has gained confirmation that the responsibility of referring wheezy children for a 48-hour post-discharge review lies with the hospital. If your practice is asked to do this, please contact the hospital to advise them to refer, and consider reporting via TCS.

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Our particular concern was regarding having only one hub for the whole of LLR, and whether parents will be willing to travel for these reviews. Please feed back to the LMC office if you experience any negative, or positive experiences about this service.

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Safe Working in general practice

We had a long discussion at the Board meeting with varying views. There was a feeling that there was a balance between our contractual and professional responsibilities to see any patient that has a health need against GPs not having an infinite capacity to provide healthcare safely.

The BMA advises that GPs should provide a maximum of 25 patients contacts a day, and that risk of error/unsafe working increases over this. The think tank 'Policy Exhange' produced a document 'At your Service[1]' which had an introduction by the then Secretary of State (Sajid Javid) and concluded that 28 was the maximum safe number of contacts.

A survey of GP services in other EU countries found that the maximum number of contacts per day was 25 per GP[2].

LLR LMC has agreed with the ICB that is a practice is providing 75 appointments per 1000 patients per week then this demonstrates that the practice is providing a level of service that meets the reasonable needs of their registered patients. The NHSE advise 72 appointments per 1000 patients following work they commissioned from McKinsey.

The BMA's England GP committee (GPCE) has generated a guide to enable practices to prioritise safe patient care, within the present bounds of the GMS contract[3]. The GPCE is currently working on a Toolkit to assist practices.

The LMC advises practices to consider what actions they need to take to provide a safe service at present and if there is a further increase or peak in demand. As part of this the LMC discussed whether practices should now consider developing waiting lists for non-urgent services. Although we could not reach a consensus view on this, my personal view is that will soon become inevitable.

If practices are struggling due to increase in demand or decrease in capacity due to illness, locum not turning up etc, we would encourage practices to report this using the OPEL system: https://forms.office.com/r/akCygYHwnS. The LMC has met with the OPEL team and have been discussing them how to make this system more GP friendly. They provided examples where they have been able to arrange significant help for individual practices, as well as they also escalate the (anonymised) level of problems in general practice regionally which then get reported nationally.

The LMC will continue to consider this crucial area, and would welcome comments and suggestions about this.

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[1] At-Your-Service.pdf (policyexchange.org.uk)
[2] Mary McCarthy: Would fewer than 25 consultations a day be a safer model for GPs? - The BMJ
[3] Safe working in general practice (bma.org.uk)

LMC and ICB meeting regarding Primary Care Funding Model (PCFM) and Transferring Care Safely (TCS).

The LMC met with the ICB to discuss these two crucial topics.

The LMC noted their concern about the development process and has requested further clarity regarding the PCFM. We have also expressed our view that the 'levelling up' component should not include any activity and those services should be transferred to either Harmonisation or the Basket of Services.

We will continue to work with the ICB to reach a solution acceptable to everyone.

There was universal agreement that the Transferring Care Safely process is not working. The main issue appears to be that each event raised, even when an apology is forthcoming, does not result in an ongoing change in process of the provider. This has a significant impact on practices. Extrapolating from a survey carried out by Kent LMC, providers passing unfunded/uncontracted work to general practices costs 131,000 appointments, £3.4million, and is the equivalent to tying up 13 WTE GPs each year in LLR.

The LMC will continue to work with the ICB to look at alternatives, but in the interim the LMC has contacted UHL and requested that we discuss interface issues directly.

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EMAS reporting all deaths to the Coroner

A local oddity I came across when moving to work in Leicester, was that if EMAS is called to a deceased patient, even if a non-suspicious or expected death, then as well as informing the GP practice they also always inform the coroner leading to a coroner's officer contacting practices for more information.

This causes additional work for practices and the coroner, and avoidable confusion and distress for relatives, friends, or carers.

The Coroner invited me to a meeting and it was agreed for this process to stop with effect from January 2023.

Of course, if there is any concern about the death, then EMAS will still report to the Coroner.

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Wishing everyone seasonal greetings, and expressing our gratitude to those working over the Christmas and New Year period.

Yours faithfully

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