LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

20 May 2023

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

Dear Colleagues

Re: May Newsletter.

This month I provide an update on the May LLRLMC Board meeting, the Conference of LMCs UK, and informal list closure:

May LLRLMC Board Meeting:

1) Joint Working with UHL
2) State of General Practice report & next steps (LMC Summit)
3) Phlebotomy Contract

Conference of LMCs UK

4) Report of conference

Informal List Closure

5) How to informally Close Your Practice List

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

1) JOINT WORKING WITH UHL

Following a productive meeting between Richard Mitchell (UHL CEO), Dr Andrew Furlong, Dr Fahreen Dhanji (LLRLMC Deputy Chair) and me, we have agreed that it will be beneficial for us to work more closely, and a senior member of the UHL management team will attend each of our LMC Board meetings.

Richard Mitchell attended the May meeting. He gave an update about the situation at UHL, and the work they have been doing to improve the waiting lists. We had a useful discussion. He advised that patients will be getting confirmation regarding when a referral has been received including how long the waiting time is likely to be. In addition, he promised to confirm UHL's DNA policy and will ensure that it is implemented equally across UHL. They are also developing a new access policy which he promised to share in advance with the LMC.

Finally, UHL have offered to host a joint consultant and GP evening event. The numbers are limited due to space, but we hope this will be the first of many.

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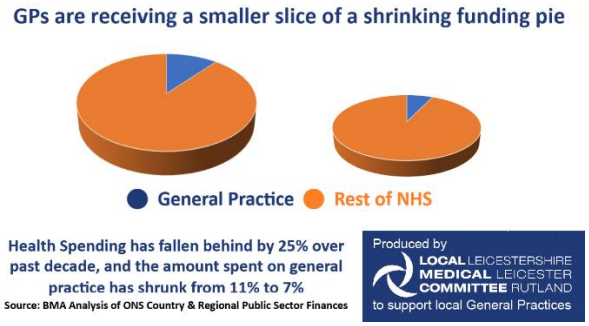
2) STATE OF GENERAL PRACTICE REPORT & NEXT STEPS (LMC SUMMIT)

Our report is still being quoted and discussed by the media (eg 1 in 5 people in England would be without a GP if practices stuck to 'safe limit' | GPonline). We hope that practices are using the posters and infographics. We have produced a new infographic (see below), but if you've have any suggestions for additional posters or infographics please let us know.



The next step is a Summit that the LMC is holding with politicians, and decision makers from health bodies on 8 June 2023. We will ensure that everyone is aware of the current situation, the risk if no improvement is achieved, and what each organisation can do to help.

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3) PHLEBOTOMY CONTRACT

The LMC discussed a presentation by the ICB regarding the phlebotomy contract.

They had undertaken a survey of practices and requested information from the laboratories, to get objective data about which grade of staff provide the service, and the number of appointments.

Although the costings are more realistic than what is currently being paid, the LMC does not believe that it includes all oncosts and has asked for these to be included. The LMC is more confident that by next financial year the pricing of this part of our contract will be more appropriate.

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4) CONFERENCE OF LMCS UK

Three members of the LMC represented LLR at this conference which was held over 2 days.

The conference was opened by an address by comedian Chris Morris who said:

> "Steve Barclay seems to have sorted out the crisis in general practice by deciding that you can't have a crisis in general practice if general practice doesn't exist.
>
> He also seems to realise that you can tell patients anything because he's not going to be here in 18 months to carry the can. In fact, Wes Streeting is going to have to do that. He's going to have to answer for a service**,** which will by that time be carried out by Superdrug and children with stethoscopes."

Although much of the informal discussion in the tea rooms was about the imposed contract in England this was not discussed as only issues affecting GPs in all 4 nations were included. There is a separate one-day Conference of LMCs England which is held in November each year.

There was a debate about industrial action. The conference unanimously supported the junior doctors action, and past by an overwhelming majority that General Practice should take the same approach to achieve pay restoration, including considering industrial action. Dr Kieran Sharrock (Acting Chair of GPC England) advised the conference that legal advice has confirmed that GP contractors can take industrial action. Another speaker pointed out that to restore general practice funding to 2006 levels would take a 57% increase in funding.

There was a long session to discuss the proposal to employ SAS doctors in primary care. Overall the feeling was that this was a policy designed more for political reasons which would not benefit general practice.

The conference also passed a motion that GPs should be able to provide private services to their patients, but rejected a motion that other health professionals should be able to complete Medical Certificates of Cause of Death.

The LMC can take 1-2 observers to these conferences (depending on space). If you would like to be considered please contact the LMC office. We would particularly consider recently qualified GPs or if considering standing for the LMC.

The motions passed form GPC UK policy.

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5) HOW TO INFORMALLY CLOSE YOUR PRACTICE LIST

The LMC has recently received questions from practices about how to informally close their practice list. We have prepared these FAQs to assist practices.

Which practices can informally close their list of registered patients?

All practices have a contractual right to decline to register any new patients without having to go through any formal processes and without needing to obtain commissioner permission. This is often referred to as an informal list closure.

Which patients can a practice refuse to register?

Practices can decide to refuse to register all patients. Practices can also devise a policy to only register particular patients, for example:

- Children born to registered patients, and/or
- First degree relatives/partners of registered patients and/or
- New residents in a care or nursing home that the practice already has registered patients and/or
- Other people living in the same residence as already registered patient(s) etc

Practices must ensure that whatever policy they adopt is non-discriminatory as per the regulations (see next FAQ).

Please note that the practice would have to accept any patient assigned to the practice by the ICB.

Which regulations allow a practice to implement informal list closure?

Section 18(1) of Schedule 3 of the National Health Service (General Medical Services) Regulations 2015 ('the regulations') as amended states "The contractor MAY [our emphasis], if the contractor's list of patients is open, accept an application for inclusion in that list made by or on behalf of any person whether or not that person is resident in the contractor's practice area or is included, at the time of the application, in the list of patients of another contractor or provider of primary medical services."

Section 21 (1) of the regulations states "The contractor may only refuse an application made under paragraph 18 or 20 if the contractor has reasonable grounds for doing so which do not relate to the applicant's age, appearance, disability or medical condition, gender or gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sexual orientation or social class."

What does a practice need to do to implement informal list closure?

When declining an application to register the practice must give notice in writing to the applicant with the grounds for the refusal (Section 21 (3) of the regulations) within 14 days of the decision, and must keep a written record of the refusals and the grounds and make these available to the ICB if requested (Section 21(4) of the regulations).

What are the reasonable grounds to decline registration?

The regulations cite the specific examples of a patient not living in the practice area or living in the outer boundary.

Other reasonable grounds could include: that the practice is unable to provide a safe service due to a GP leaving or on longterm leave and unable to recruit a replacement; part of the practice premises being temporarily unusable; due to a sudden influx of patients due to a new development or a neighbouring practice closing etc. These are only examples and is not an exhaustive list. The most important consideration is to ensure that the grounds are not discriminatory.

How long can the informal closure be for?

As this is an informal process using a practice's contractual rights there is no minimum or maximum time.

Should a practice inform the ICB when considering an informal list closure?

There is no contractual requirement for a practice to inform the ICB. However, the LMC would encourage practices to consider an OPEL report if due to a problem with capacity, or if the arrangement is likely to be ongoing to discuss it with the ICB and what support they may be able to give (in particular to consider formal list closure – see Sections 33 to 37 of the Regulations).

What checklist should a practice use when considering an informal list closure?

- Decide the non-discriminatory grounds for the informal closure.
- Decide the dates between which you will informally close your list.
- Decide whether the practice will continue to register any specific group(s) of patients.
- Ensure that a list is maintained of all declined applications.
- Write a standard letter to applicants to advise that they have been declined and the grounds.
- Consider discussing your plan with the ICB.
- Consider whether application for formal list closure would be more appropriate.

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The LMC continues to consider how to best represent your views and we welcome all feedback. We continue to consider our approach and to challenge where appropriate. General practice continues on a knife-edge, and it would not take much for it to fail. As stated in the NHS Five Year Forward View "If General Practice fails, the NHS fails."

Yours faithfully

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