LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

14 September 2023

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

Dear Colleagues

# LLRLMC NEWSLETTER SEPTEMBER 2023

The summer is always quieter for news and developments, although the LMC has kept busy working on ongoing problems and challenges.

Topics in this newsletter:



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

# LMC MEETING SEPTEMBER 2023

The main discussion was around the PCFM. Whilst the LMC remains in agreement with the principle of distributing additional funding to try and reverse part of the deficiencies of the Carr-Hill formula, there needs to be more transparency, and stability of funding.

In addition, the LMC continues to work with the ICB to ensure that every other element within the PCFM is properly costed. It is inappropriate for the ICB to expect GP partners to continue to subsidise NHS healthcare.

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# REINFORCED AERATED AUTOCLAVED CONCRETE (RAAC)

The significant problem that the use of RAAC in buildings has been highlighted again recently following further collapses of walls and ceilings within schools.

Guidance was sent out in January 2023 to practices providing advice that practices should ensure that they are aware whether their building contains RAAC or not.

GP contractors occupying their owned estate are advised to engage the services of an experienced estate/maintenance manager or a professionally registered structural engineer or surveyor to identify if RAAC is present.

GP contractors occupying leasehold buildings are advised to seek assurances from their landlord subject to lease terms, that they have undertaken a desktop exercise to identify if the building may contain RAAC.

If any buildings are identified that may contain RAAC, GP contractors may wish to undertake an independent review of the processes being used by the landlord to gain assurance that RAAC and the associated risks are being managed in accordance with current guidance.

The LMC believes that the recent email from the ICB was excessive, implying that every GP practice needs to have a detailed survey. For example, if your building has been built in the past 25 years then RAAC will not have been used in the construction.

The LMC advises that all practices should ensure that they are aware of whether the premises that they work from are free from RAAC or not. If you rent your premises, ask your landlord for an assurance whether RAAC has been used in the construction or not.

If you own your premises and are unsure, you will need to arrange a survey to check.

If you have RAAC in the structure of your premises you need to contact the ICB Estates Department to discuss next steps. The LMC believe that the NHS should fund any remedial work, and the GPC has written to Government calling on them to provide central funding for practices where RAAC is found.

Last week Dr Gaurav Gupta, GPC premises lead, was quoted in GP Online: "It's important to remember that general practice premises are already in poor shape due to a chronic lack of investment and planning from the government. Ultimately issues with RAAC have the potential to completely destabilise general practice if GP premises are found to be at risk, regardless of ownership. Therefore, the government must find a solution which means patients can continue to be treated in buildings which are fit for purpose and it provides a fully centrally-funded solution to the RAAC issue which covers all NHS buildings, including all general practice estate."

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## MINOR SURGERY

The LMC has received a mandate from a large number of practices to negotiate an increase in minor surgery fees. We have contacted the ICB to formally commence the process.

The LMC will directly contact the remaining practices who have not provided a mandate to give a final chance to join this process.

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## CORONER PORTAL AND RELATED ISSUES

The Coroner procured and implemented the portal without prior discussion with the LMC. We worked with the coroner to try and improve useability, but is has become clear that the current version is not fit for purpose. We are advised that the portal is now being revised and we have requested to assess it before it goes live.

The Coroner and Registrars have raised an issue regarding where the cause of death is an injury or disease that may be related to a current or previous occupation. There is a tick box on the MCCD, but if the death is related to an occupation this must be reported to the coroner.[1] To avoid confusion it would also be helpful to have this discussion with the relative who will be registering the death oif possible.

Finally, a reminder, that it is the responsibility of the doctor who has been involved in the deceased's care to report the death to the coroner if required and not EMAS. EMAS will only report deaths which are clearly unnatural, but they will not know whether the GP will be able to issue an MCCD or not.

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## PLANNED SWITCH ON OF AUTOMATED ACCESS TO PROSPECTIVE PATIENT RECORDS.

The LMC remains very concerned about this project, and the risks both to patient safety and to practices.

The GPC has recently met with Neil O'Brien OBE MP (Parliamentary Under-Secretary of State for Primary Care and Public Health) to raise the profession's concerns.

The requirement for the provision of competent redaction software has been removed from the regulations and the risk that this proposes has been highlighted with the minister, and the GPC are also discussing this issue with the ICO.

In line with previous calls from our LMC, the GPC is now also calling that errors due to this process must be covered by the CNSGP central indemnity scheme.

[1] Guidance for registered medical practitioners on the Notification of Deaths Regulations (publishing.service.gov.uk)

The change in the regulations is poorly written, and I was shocked to find out that, unlike in the past when I chaired the GPC IT Subcommittee, NHS E no longer consults with the GPC about revised wordings of the regulations to ensure they are competent. As written, the only grounds that access can be declined by a practice is if the patient requests this in writing. NHS England more recently has been suggesting a more balanced approach[2] and are advising that practices can take into account safeguarding issues.[3]

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## HOME VISITS FOR REGISTERED PATIENTS FROM OUTSIDE OF PRACTICE AREA

GMS[4] and PMS Practices can register a patient who resides outside of the practice area, and specify that they will not provide home visits.

It has become clear recently that the ICB currently does not have an agreement in place who provides any required home visits in these circumstances. The ICB are considering this, but in the interim, the LMC would suggest that practices advise patients to call 111.

If a patient's clinical needs who is registered under this regulation change and they will require home visits the practice may terminate the registration due to this reason [Regulation 30(4)(b)(aa)]

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## 6% PAY INCREASE FOR STAFF.

The DDRB advised an uplift of 6% in salary for Salaried GPs. If a Salaried GP's contract says that they will receive any DDRB increase (as per the model contract) then practices should give this increase backdated to April 2023. If a Salaried GP contract does not specify that DDRB increases will be honoured, the GPC still advises practices to give Salaried GPs the same increase.

The DHSC advised that all other staff (except ARRS) should receive the 6% uplift. The GPC continues in negotiation with the DHSC for an additional increase in the Global Sum for 2023/4 to include this uplift. There is no contractual requirement to pay this uplift but the LMC would encourage practices to honour it once the additional payment has been received.

[2] NHS England » Offering patients digital access to GP health records
[3] Safeguarding patients from harm or distress - NHS Digital
[4] Regulation 30 of The NHS (GMS Contracts) Regulations 2915 as amended

For ARRS staff there is an agreement that they should receive a 5% uplift in salary for 2023/4. The total ARRS envelope has not been increased to recognise this, but the maximum reimbursable amount for each role has been increased.

If a practice has already given an uplift, then the 5% or 6% is not on top of this. For staff where practices have agreed to pay these national advised uplifts they should pay the difference. For example, if you have already given your Practice Nurses a 2.1% increase, once you have the additional funding, you would give an additional 3.9% increase.

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## COMPLETING DVLA MEDICAL FORMS

The LMC has become aware of a case in another area where a patient is suing a GP as the information given in a DVLA form led to them losing their driving licence. The main issue is that the GP's Medical Defence Organisation has declined to support them during the court case.

We would remind GPs that when deciding what to charge for DVLA and other non-NHS forms that they should include an element to cover the cost of defence or insurance fees, as well as potential legal costs. Also, we advise GPs to check whether their current MDO would cover them in such circumstances.

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I hope you have found the contents of this and previous newsletters useful. Any and all feedback is welcome!

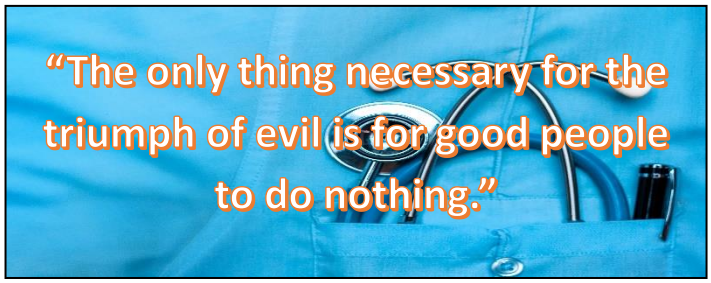
I have campaigned for many years to change the culture within the BMA to no longer be the misogynistic, discriminatory organisation that it was when I first became involved in the early 1990s. Including this year, at BMA Annual Representative Meetings I have successfully proposed further incremental changes in BMA processes to highlight and tackle this problem. I was therefore saddened at the letter from a retired anaesthetist in The Times opining that young doctors should just toughen up and accept sexually inappropriate comments and bullying as just being part of the job, and also the survey that almost a third of British female surgeons had been sexually assaulted over the past 5 years. I would like to think that this would not happen in general practice, but if it happens to you, please speak up. Please use your Freedom To Speak Up guardian (the LMC will provide this service free to any constituent practice) or contact the LMC for support. The BMA provides a complete list of support services for doctors and medical students which can be found here.

The NHS Winter Resilience plan includes no additional funding for general practice and no schemes to off load general practice workload. Indeed, the NHS England page on winter resilience does not mention general practices at all, despite the facts that we continue to provide the majority of healthcare in the NHS, have experienced the greatest increase in workload, and the number of fully

trained GPs continues to fall.[5] You cannot help coming to the conclusion that either DHSC and NHS England just do not care about general practice or just hate us.

Senior figures in the DHSC and NHS England sometimes do praise general practices, but, I suppose, you need to get fully behind someone to stab them in the back …

The LMC will continue to campaign for general practice to get proper recognition and appropriate funding locally.




Yours faithfully

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[5] General Practice Workforce, 31 July 2023 - NHS Digital