LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

12 July 2024

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

Dear Colleagues

LLRLMC NEWSLETTER, JULY 2024

Welcome to our July Newsletter which includes feedback from our LMC Board meeting held on 10 July 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 JULY 2024.

The LMC met on 10 July and discussed a wide range of topics. Dr Andrew Furlong (Medical Director, UHL) attended, and we discussed various issues of mutual interest, as well as feeding back examples of where individual consultants and departments have strayed from the NHS Contract requirements and local policies. UHL are very supportive and wherever possible resolve issues without delay.

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GMS CONTRACT FOR 2024-25 / ROADSHOWS AND ONWARDS.

The GPC non-statutory **ballot** about whether GPs are willing to take industrial action is now live and closes 29 July, and if you are a BMA member and GP contractor/partner please vote now! If you are not a BMA member you can join the BMA for free for 3 months which will let you have your say.

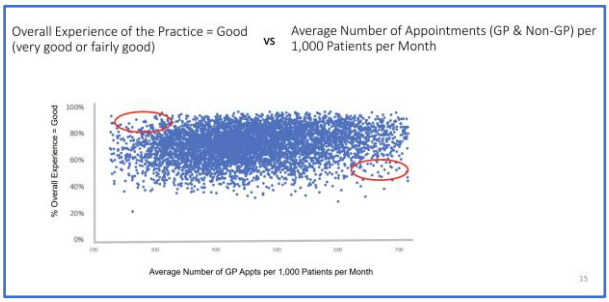
If you have not attended one of the GPC Roadshows there are still more coming up – see GP contract roadshow events 2024. These include two more 'virtual' meetings on Tuesday 23rd and Thursday 25th July. These meetings are open to all GP contractors/partners, practice managers, salaried GPs, GP registrars and practice nurses.

If the ballot is positive, then practices will be asked to take one or more of the actions in the list below. The GPC has sought legal advice that none of them involve a breach of your GMS/PMS contract. Which of the

actions taken will be up to the choice of individual practices and I have annotated our thoughts against each one.

1. Limit daily patient contacts per clinician to the UEMO recommended safe maximum of 25. Divert patients to local urgent care settings once daily maximum capacity has been reached.

   LLR LMC has been encouraging practices to consider implementing safe working, including hosting meetings for the past year. Many practices, including my own, have already started this process. Experience is that it does not lead to increased patient complaints or increased attendance at the Emergency Department. I included the graph below in my April newsletter showing that there is no relationship between number of appointments provided and patient satisfaction:



2. Stop engaging with the e-Referral Advice & Guidance pathway - unless it is a timely and clinically helpful process for you in your professional role.

   Unlike in some other areas, locally there is no requirement for GPs to use A&G for any referral pathway. However, if you are asked by any specific department to use A&G instead of a referral you should consider declining if you wish to include this activity.

3. Stop supporting the system at the expense of your business and staff - serve notice on any voluntary services currently undertaken that plug local commissioning gaps.

   The LMC has previously provided guidance on stopping services that are not funded or contracted via the core GMS/PMS contract or a local contract. Please look through this document again and considered what services you are providing without funding. Also consider any services where the funding does not cover the cost of provision.

   The LMC has worked closely with the ICB over the past year to identify 'commissioning gaps,' and services where the funding did not cover the actual cost. In LLR there are therefore fewer services affected. At present the remaining areas of contention are 48 Hour checks for Wheezy Children and Minor Surgery. There has been a proposal for commissioning the former which the LMC is discussing, and a proposal acceptable to the LMC for the latter which is passing through the ICB approval process.

4. Stop rationing referrals, investigations, and admissions
   - Refer, investigate or admit your patient for specialist care when it is clinically appropriate to do so.
   - Refer via eRS for two week wait (2WW) appointments, but outside of that write a professional referral letter where this is preferable. It is not contractual to use a local referral form/proforma – quote our guidance and sample wording

   The use of a template (PRISM or otherwise) is neither a contractual nor professional requirement. Any template should be produced in agreement with the profession (ie the LMC). Outside of the TWW templates the LMC has not agreed to any of the recent new or changed templates. The GMC requires GPs to refer where necessary in the best interest of their patients and to include relevant information

(patient's medical condition, background, PMH, current medication and any allergies). The NHS Constitution entitles patients to be referred where 'clinically appropriate.' Providers do not have the contractual right to decline referrals not using a template which has not been agreed in advance. The GPC guidance includes wording of a reply if the provider rejects your first (non-template) referral.

5. Switch off GPConnect functionality to permit the entry of coding into the GP clinical record by third-party providers.

   The majority of practices have already taken this action, if your practice has not, please consider doing so. For my comments about the NHS E shenanigans please see my comment at the end of this newsletter.

6. Withdraw permission for data sharing agreements which exclusively use data for secondary purposes (i.e. not direct care). Read our guidance on GP data sharing and GP data controllership.

   *Until and if there is change in legislation GPs are data controllers for their patient records. Despite repeated attempts to undermine this, there is no way that NHS E or the government can force practices to process patient data for other purposes. Even a change in the GMS or PMS contract does not have precedence over the legal requirement to comply with Data Protection Act, UK GDPR and Common Law Duty of Confidentiality. In their response to the Accelerated Access to GP Records the ICO reiterated that practices are able to mitigate risk to the rights and freedoms of individuals **IF** "GP practices remain in control of deciding which records are made available and retain the ability to prevent a patient record being accessed."*

7. Freeze sign-up to any new data sharing agreements or local system data sharing platforms. Read our guidance on GP data sharing and GP data controllership.

   Please see our response to 6.

8. Switch off Medicines Optimisation Software embedded by the local ICB for the purposes of system financial savings and/or rationing, rather than the clinical benefit of your patients.

   Use of OptimizeRx software is not a requirement within the Medicines Optimisation Framework part of the Community Based Services contract, and practices opting to implement this activity would disable it.

9. Practices should defer signing declarations of completion for "better digital telephony" and "simpler online requests" until further GPC England guidance.
   - Defer signing off "Better digital telephony": do not agree yet to share your call volume data metrics with NHS England.
   - Defer signing off "Simpler online requests": do not agree yet to keep your online triage tools on throughout core practice opening hours, even when you have reached your maximum safe capacity.
   -Read our guidance on this.

   These were part of the imposed 2024/25 contract. Practices will receive full funding as long as the PCN has notified the ICB before 31 March 2025. The "Better digital telephony" will provide NHS E with information which will be used to further micromanage practices, and the "Simpler online requests" could force practices to work at unsafe levels to the detriment of quality of patient care, patient safety, and staff wellbeing. The LMC advises practices not to sign declarations of completion at this stage. The GPC continues in talks with NHS E and will issue new guidance early 2025. The new government may take a more balanced patient-centred approach and change or remove these parts.

More details can be found in the BMA GP Practice Survival Toolkit. If the Ballot is successful, the LMC will provide more support and information to practices and will survey practices to understand what options they will choose.

The GPC have also developed a survey to capture the views of everyone working within general practice who is not eligible to vote in the non-statutory ballot. This can be accessed here. Please encourage as many people as you can to express their opinion.

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MINOR SURGERY.

The ICB has now shared the proposed specification for the Minor Surgery Directed Enhanced Service with the LMC. Except for a couple of minor changes the LMC is content with this. The ICB has also nominally accepted the proposed revised costings although these will need to formally pass through the ICB processes before final agreement.

The LMC Board has reminded the ICB that we have set the end date of 8 August 2024 for the revised specification and costings to be agreed.

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CBS UPDATE.

Contract

The LMC has continued to work with the ICB to finalise the CBS contract. We have now been able to agree a final wording. Regarding the quality metrics the contract now states that practices are 'recommended' to complete the quality toolkit. There is no longer any requirement to complete the Toolkit or any other quality metrics for this year. The LMC now feels that the CBS contract is fit to sign.

CBS Claims – important message for Practice Managers/Business Managers/Financial Leads to ensure correct activity is claimed.

The following advice has been kindly provided by Sarah Gibson (Practice Manager member of LLR LMC Board)

All practices should now be aware of CQRS local as the platform to claim for the Community Based Services (CBS).

When running the LLR searches it is important to note that these searches will only pull through the number of patients, and not the actual activity. If you use this figure, you will significantly underclaim for the work your practice has done.

For many of the CBS claims, patients will often attend more than once in any quarter and to get the true activity figure to be able to claim the correct amount, practices will need to break down the results, especially in areas such as **Phlebotomy** and **Wound care**. How to do this is set out below:

SystmOne

Run each search at the end of the quarter, use the breakdown feature and select to break down under "Demographics", "first name & Surname" or "NHS number" (any patient identifier option), and then under "Event Details" chose "Event Date".
The figure will then appear on the bottom left which is the true activity figure defined as "rows."

EMIS

Run the searches and select "View results", click on export and then select CSV. Save the file and then open the excel sheet and total the figures on the date bar for your activity number.

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LOCAL PRACTICE CLINICAL PROTOCOLS.

Just to remind practices that the LMC has started a database of protocols developed by local practices on our website for other practices to adapt for their own use. We already have the following uploaded:

- **HRT prescribing protocol**
- **HRT patient information leaflet**
- **HRT Form**
- **HRT Check Form**
- **Processing urine samples protocol (adults)**
- **Processing urine samples protocol (under 16s)**
- **Contraceptive pill protocol & checklist for repeat prescriptions**
- **Referral Letter for MGUS Repatriation to Haematology**
- **ECG Policy**
- **Expedite letter - awaiting first appointment**
- **Expedite letter - follow up**
- **Pill form for patients**
- **Private Providers request for reports**
- **Right to choose patient information**

The more protocols uploaded the bigger the benefit to all practices including yours! Please send copies of your clinical protocols to the LMC so good ideas can be shared, and practices can avoid reinventing the wheel.

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WHEEZY CHILDREN – 48 HOUR CHECKS.

The ICB is now actively working on commissioning a service to provide these checks. It is likely that there will still be many months before this is in place.

In the meantime, the LMC advises practices to continue sending invoices. If your practice has not already started to do this, please refer to the guidance on the LLRLMC Website.

The LMC believes that practices have a right to be paid, and we reiterate our offer, that the LMC will fund legal advice and support for practices who wish to pursue their claim, including completing the claim forms, and any back fill needed. Please let us know

If your practice has had an invoice returned for a 48-hour check and have not yet done so, please let the LMC know.

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MEDICAL EXAMINER SERVICE.

As a reminder, the process for completing Medical Certificates of Cause of Death changes from 9 September 2024, which includes the mandatory requirement to refer every death to the Medical Examiner service. The LMC guidance can be found here.

As part of the process practices must ensure that they are on the list to receive the new MCCDs by **15 July 2024** which they can check on this website.

In summary the main changes that will affect GPs are:

- To complete an APMCCD (which replaces the old MCCD) 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.
  - Consider consulting the Medical Examiners' Office if you are unsure about any of the above (Contact: 0116 258 3102/250 2946, 07814 028098 or 07815 457565).

- There is no longer any requirement for the certifying GP to have seen the deceased:
  - within **28 days** prior to death, or
  - **after death**, or
  - **face to face/in person** at any time prior to death.

- Once completed the GP **MUST** send the APMCCD to the Medical Examiner service, together with a brief summary of the events leading to the death and any other relevant information (in preference using the PRISM form, although the ME service will also accept a completed Arden's ME report template).

- After 9 September 2024, all deaths must be certified using the new APMCCD even if the death occurred before that date.

Please see the full LMC guidance here. Please consider discussing at a practice meeting and ensure that all GPs have access to the guidance. All reception staff and any admin staff who are involved in your practice processes also need to be aware of the changes.

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CELEBRATING GENERAL PRACTICE / AWARD CEREMONY.

The LMC believes that all of the good work done by general practice in LLR is rarely recognised, valued or celebrated.

UHL hold an annual awards ceremony for their own staff and teams, and they have kindly agreed to include one or two awards for general practice this year. The winners will be voted for by their peers. We believe this represents a chance to highlight general practice and show it in a positive light. We will provide more details about this as soon as they are agreed, but any suggestions regarding categories will be welcomed.

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AN LMC FIT FOR THE FUTURE

In April 2023 the LMC agreed a battery of changes to the LMC Board to improve representation, functionality and succession planning. This included:

- **Minimum of 3 sessional GPs.** To recognise that over half of the GP workforce are now sessional GPs, and the LMC have a statutory duty to represent all GPs.
- **Newly Qualified GP (within 5 years of CCT).** This post was agreed to introduce GPs to the LMC at an earlier career stage and for succession planning.
- **GP Trainee.** This post was agreed to introduce GPs to the LMC at an earlier career stage and for succession planning.
- **Practice Manager.** Practice managers have a crucial role in understanding the effect contract decisions and changes have on the day to day running of practices, and other pressures.
- **Observer.** By positively encouraging observers the LMC improves openness, understanding, and succession planning.

The LMC has already appointed a Practice Manager and Co-Opted a GP Trainee. Both of these posts have proved their value. We have also had a string of people observing Board meetings.

In addition, at our awayday last month the Board agreed on the next stage of the journey to develop and build on the LMC's previous successes. Once the Board has agreed the detail we will share it with constituents for comments.

The next elections will be held in September 2024, at which point half of the current Board posts will be up for election and we will fill the rest of the posts listed above. Details will be published closer to the time, and we will also consult on the revised constitution. If you fall within any of the groups, are thinking about whether to stand, and want to know more about what the LMC does and what is expected from Board members please contact Charlotte Woods (Operations Manager) or me (Grant Ingrams – Executive Chair).

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UPCOMING LMC EVENTS

The LMC has two more upcoming events. Book early to avoid disappointment:

LMC webinar for practices on Freedom to Speak Up – Friday 26th July 24
LMC would like to take the opportunity to invite our members to attend our Freedom to Speak Up webinar, which is scheduled to take place on Friday 26th July 2024, 1.00 - 2.00pm. This is open to all staff working within General Practice and will cover the various elements around Freedom to Speaking Up. Click here for LMC Guidance about Freedom to Speak.
For Further Information about this and other events click here, or register by emailing the LMC: enquiries@llrlmc.co.uk

New Premises Cost Directions webinar - Wednesday 17th July 24
The LMC is hosting a webinar, delivered by DR Solicitors, on the changes and updates of the NEW Premises Cost Directions 2024, which replace the 2013 Premises directions on Wednesday 17th July 2024, 1.00 - 2.00pm. A must event for PMs and GPs of any practice considering a new purchase, lease or extension.
For Further Information about this and other events click here, or register by emailing the LMC: enquiries@llrlmc.co.uk

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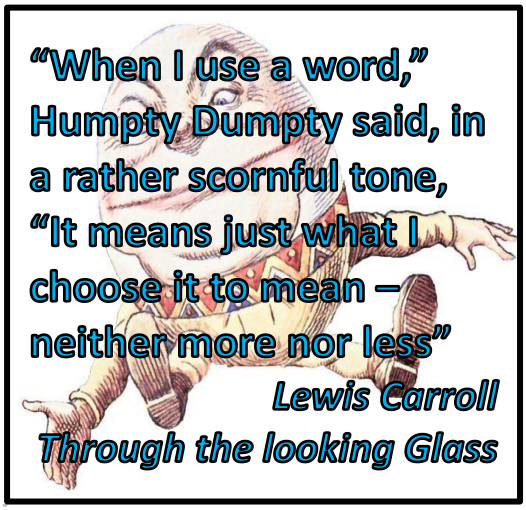
Last month I shared my thoughts about Orwellian and Kafkaesque situations in the NHS. Before my ink was (metophorically) dry Amanda Doyle provided another prime example.

The GPC had suggested that one of the actions for practices to consider if the non-statutory ballot is passed would be to turn off the ability for GP Connect to write directly into practice clinical systems. The GPC has raised concerns about the increased workload, the increased complexity in curating patient records and the risk to patient safety for many years. All SystmOne users know the problems caused by others doing this already.



The story then gets murkier. On Thursday 27 June the GPC was given a tip-off that NHS England were requiring system suppliers to disable the ability of practices to turn off this function on Monday 1 July. GP practices made heroic efforts over that weekend by the end of which I understand that 70% had made the change.

In the washup Amanda Doyle issued a letter which superficially appears to deny that the change had ever been proposed, and to criticise any suggestion of this. At the same time TPP confirmed that it had "recently received" a "request from NHS England" to remove this option. So how can both be true at the same time? The answer is in the very carefully crafted wording of Amanda Doyle's letter which states "it **is** inaccurate to suggest that there **are** any imminent changes being made to stop GPs switching off GP Connect functionality if they choose to. GP IT suppliers **are** not removing the opt-out button." By cynically using the current tense the letter can be truthful as there was no longer any planned imminent change at the time it was written, although there had been a week before.

At a time that the profession is heading towards industrial action such behaviour can only undermine what little faith GPs had left in the NHS E Board, and minimise any trust for the future. This is not how the NHS should treat the most productive part of the service which provides the bulk of patient care.

Yours faithfully

Dr Grant Ingrams
Executive Chair, LLR LMC
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