LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

NEWS FROM YOUR LOCAL MEDICAL COMMITTEE

Welcome to our April 2018 Newsletter

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REGIONAL:

A. WEIGHING SCALES

The LMC is aware that the Trading Standards Inspector has been visiting practices stipulating that all practices need to adhere to his interpretation of the regulations.

British Medical Association have confirmed that there is no legal mandate for practices to use Class III or Class IV weighing scales and we have outlined why this is the case from a legal view point but more importantly from a medical safety and quality aspect.

The LMC does not believe that the trading standards regulations which has been quoted apply to the use of weighing scales within GP practices. As such, trading standards have no legal authority to mandate any such regulations on practices. As well as pointing out, general practice has all their equipment including weighing machines calibrated in accordance to CQC.

The more important fact that we need to look at is how we use our resources in a financially strapped heath economy and the question is does use of class III weighing scales improve both quality and safety of patient care? Fluctuation in a person's weight happens throughout the day depending on a variety of reasons like loading of bowel/ bladder and to get accurate weights one must be weighed without clothes with empty bowels and bladder. However, there is no medical need in practices to use such methods for accurate weights because weight measurements are required only for monitoring purposes for which we need to look at trends rather than every day weights. In the case of medications, we are always given a range of weight on which dosage should be based. Hence there is no clinical evidence that weighing patients to the Nth gram is either required or makes any difference to management of their health conditions.

The LMC would view this matter as closed and if Trading Standards issue any penalties to practices, the LMC will fully support the practices until the matter is resolved.

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B. DR VICKRUM BOLARUM CO OPTED ONTO LMC BOARD

We are happy to confirm that Dr Vikram Bolarum has been co-opted onto the LMC Board, as a West representative, following Dr Nick Simpson stepping down.

We look forward to welcoming Dr Bolarum and his first LMC board meeting, Wednesday 4th April.

C. EAST MIDLANDS LEADERSHIP ACADEMY

Members can sign up to any of the courses presented on this website- follow the link below to see the full scheduled courses for 2018.

http://www.leadershipeastmidlands.nhs.uk/

D. GDPR

As members will be aware, the LMC hosted a GDPR event on the evening of 11th April 2018. This event was very well received.

We understand the presentation may raise more questions than answers.

We want to ensure practices that the LMC is having ongoing discussions with Federations and CCG's in how it can support practices to implement GDPR.

E. LMC COMPLAINTS WORKSHOP - WEDNESDAY 9TH MAY 2018

As highlighted in our March newsletter, the LMC is pleased to confirm that on Wednesday 9th May 2018, we will be running a Complaints workshop in conjunction with NHS England. The lead facilitators will be Cathie Cunnington, Senior Complaints Lead and Kimberley Kingsley, Deputy Director, Nursing and Quality at NHS England and will be Chaired by Dr Anu Rao (LMC, Vice-Chair).

This is a free event and is open to all LLR GP's and Practice Managers.

Programme:

- Central Midlands Complaints Team Structure
- NHS England Complaints – Tiers 1, 2 & 3
- Role of LMC during complaints
- Central Midlands Complaints Process
- Practical Session – What does a good complaint response look like?
- Obtaining Independent Clinical Reviews
- Central Midlands Assurance Process / Sharing Lessons Learnt
- Questions and Answer Session

Email invitations have now been circulated to members, to book your place please email enquiries@llrlmc.co.uk

F. UPCOMING LMC EVENTS

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The LMC is looking to deliver the following events during 2018 for our members:

- CQC inspections seminar – date tbc
- GMC representative workshop on key areas
- Finding of the HCB findings of the case from the criminal perspective and review (TBC, June)

SHARED LEARNING:

SUBLETTING CONSULTANCY ROOMS WITHIN GENERAL PRACTICE

The LMC has received the following guidance from the BMA on sub-letting following a couple of queries raised by members, so thought it would be good to share.

Generally, if the practice is receiving rent from those subletting, then it would be reasonable for the notional rent to abated. However, if this is not the case and the room is being used to provide services that are supporting the delivery of Primary care (such as the ones you describe) this would not be the case, though it is a little bit of a grey area! The BMA have written to NHS England for clarity on this issue previously and have received the below response and said that anything that is not clear from this is up for commissioner discretion. The new PCDs will clarify the process when they are published.

Overview

The NHS funds GP premises costs under the terms of their GMS contract. Locally, these terms are equally applied to PMS contracts and some APMS contracts where GMS services are commissioned. The contract provides for recurrent premises costs to be reimbursed to Contractors, all of which are detailed within the National Health Service (General Medical Services - Premises Costs) (England) Directions 2004/2013, more commonly referred to as the 'Premises Directions'.

The commissioning of services by Clinical Commissioning Groups means that additional services can often be hosted within GP surgeries. This leads to questions regarding the premises payments linked to these arrangements.

In brief:

1. There is an expectation that the floor area approved for reimbursement under the Directions is used for the delivery of GMS services.

2. Where there is the hosting of ad-hoc sessions of other primary/secondary/community care services, this can generally be accepted without the need for adjustment to the premises costs. However, where the hosting arrangements see the hosted Service(s) occupy space within a surgery effectively full time (8-10 sessions per week), then the NHS reserves the right to abate the premises payments made to Contractors.

Questions are often raised in terms of what premises costs can be passed to these Tenants:

3.There is an expectation that a formal Agreement will be in place between the Practice and any other Service Provider / Tenant. This Agreement will lay down the terms of occupancy, to include the space occupied, length of agreement, notice period and any costs that may be related to that space. Both parties will agree and sign the document, each holding a copy. A further copy will be passed to the Commissioner.

4.Where the NHS funds practice premises costs in full (100%), to include Current Market Rent (Notional, Actual or Cost Rent), Business Rates, Water charges and Clinical Waste the Contractor may not seek to cover those costs a second time through direct invoicing to that Tenant.

5. A GP contractor is entitled to a triennial Current Market Rent review under the Directions. The CMR assessment takes into account the Tenants liabilities. This will typically include internal maintenance and decoration (and in many cases, external maintenance and decoration), insurance and other general maintenance items. Where covered by the Commissioner, these cannot be recharged. This CMR assessment is subject to triennial reviews under the terms of the Contract and Premises Directions 2004/13.

6.Where the NHS funds practice premises costs only in part, agreement needs to be sought from the Commissioner to ensure that the area supported by the NHS can de delineated on a floor plan with the area excluded from support clearly defined. Agreement for direct charges to be levied against that area can then be offered by NHS England.

7.There is an expectation that any charges made are reasonable. This will mean that Rental charges (where properly incurred) are in line with the Current Market Rent assessment for the property and that utility and service costs are valid and can be supported with evidence. Such charges may include cleaning, consumables, telephony and in some instances, reception and admin support where this is directly offered by the Practice.

8.Often the simplest way to determine charges is to take the full year liability/cost for each element (where it can be charged) and pro-rata that cost according to space/time occupied. Given the vast variation in the type of buildings, age and current market rent assessments it is not possible to determine an average rent or an average utility cost either.

The NHS will look to support such hosting arrangements; however, it must be clear that this must not be to the detriment of the delivery of GMS contracted services. GPs are commissioned to deliver their core contracted and Enhanced services and the premises costs awarded are to deliver those services. Where it is possible to host additional primary/secondary/community-based clinics, this must be reasonable and not require the need for additional investment/extensions to practice premises, or force practices to relocate in order to support hosting arrangements.

NATIONAL:

G. GP CONTRACT ANNOUCEMENT 2018/19

GPC England has concluded negotiations with NHS Employers for amendments to the 2018/19 GMS (and PMS) contract.

The agreement reached will provide some stability to GMS/PMS contractors, securing £256m of funding to address practice pressures, including practice expenses and a long-overdue pay increase.

Contract changes - in summary:

- Interim uplift of 1% for pay and in line with inflation for expenses, which would be increased further following any uplift secured through the DDRB process
- Increase in indemnity costs covered
- Uplift in line with inflation for those vaccination and immunisations in the SFE

- Uplift to reimbursements of locum cover for sickness and maternity/paternity/adoption leave
- Fixed-term contracted salaried GP's for sickness/parental leave will be reimbursed (in line with locum cover)
- Minor amendments to clinical aspects of vaccinations and immunisations
- Significant resources and support for implementation of the electronic referral service
- QOF point value to be uplifted to reflect population increase
- New regulations to support practices in the removal of violent patients
- New premises cost directions

There are updates on some main points such as:

GP pay and expenses

The GPC have not agreed to accept a further pay uplift of 1% this year. Instead they have agreed that from 1 April 2018, an interim payment for GP pay and expenses will be made whilst they await the outcome of the DDRB process. Therefore, pay will be initially uplifted by 1% and expenses funding will be uplifted in line with Consumers Prices Index. This will mean that, together with the annual recycling of correction factor and seniority payments, global sum with initially rise from £85.35 to £87.92.

The BMA's submission to the DDRB calls for a significant uplift to GP pay and expenses, of Retail Prices Index plus 2%. Any increased uplift secured through the DDRB process will be back-dated to 1st April 2018.

Indemnity increase cover

The GPC have agreed a sum of £60m to cover the average uplift in indemnity for the last two years. This will both be paid to practices in 2018/19 on a per-patient (unweighted) basis. Extra £30m nationally to cover increased Indemnity costs for 2017/18. This with the increase last year will mean that Practices will receive £1.017 per patient, to be paid in March 2018. Practices should ensure that an appropriate equivalent amount is passed on to any salaried GP and/or partner that pays for some or all their indemnity cover. For 17-18 this was 51.6p/patient

Amendments to reimbursements for locum cover for parental and sickness leave

The GPC have agreed that these payments should both be increased to avoid their value eroding with inflation. Parental leave payments will increase from £1,131.74 to £1,143.06 for the first week and £1,734.18 to £1,751.52 for subsequent weeks and the upper amount for sickness payments will increase from £1734.18 to £1751.52.

In addition to this, the GPC have clarified the rules for locum cover reimbursement such that from 1 April 2018, if a contractor chooses to employ a salaried GP on a fixed-term contract to provide cover, NHS England will

reimburse the cost of that cover to the same level as provided for locum cover, or a performer or partner already employed or engaged by the contractor.

Electronic referral service

From October 2018 hospitals will only receive payment for standard referrals if they are made through e-RS.It is expected that CCGs to work with LMCs and practices to resolve local system issues.

While it will be a contractual requirement to use e-RS for all GP practice referrals to 1st consultant led outpatient appointments, agreement has been reached with NHS England that they will take a supportive not punitive approach where circumstance dictates that practices are unable to realise this. Guidance will be clear that this does not mean that individual GPs have to use the e-RS system themselves. There are a variety of models that practices could adopt, and it is for practices to determine how much of the e-RS process is done by administrative staff. The GPC have secured £10m investment into the contract this year to ensure practices are financially supported to implement the system. NHS England and GPC England have also agreed guidance for practices. There are many issues that need to be resolved to ensure practices have a better referral system in the future than they currently do now including:

- IT infrastructure,
- inadequate bandwidth,
- local contingency processes,
- appropriate referral pathways,
- delays in hospitals dealing with referrals and
- inappropriately declining referrals

The GPC admitted there is still much to do and continue to work with NHS England and other agencies on further workforce initiatives.

H. GPC UK MEETING, 15TH MARCH 2018

The GPC representatives for Leicester, Leicestershire and Rutland are, Dr Anu Rao and Johnathan Ireland (Chair of Northampton LMC). On Thursday 15th of March 2018, the GPC entered discussion on GMS contract negotiations.

A summary of the main issues discussed at the meeting:

- Reports were given from all devolved nation GPC Chairs
- Securing official recognition of GPs as specialists
- BMA report on international models of general practice
- BMA report on safe workload limits and the recommendations voted on during the themed debate at the LMC UK conference
- Gross negligence manslaughter relating to healthcare and planned BMA work to support doctors under pressure

The main points highlighted by Dr Anu Rao and Johnathan Ireland following the meeting were:

- Workload comparisons paper highlighted the huge discrepancy in high workload that UK GP's work with compared with others, though many countries GP's feel stressed by lower level of workload.
- Presentations from Wales, NI and Scotland. The stress of leading discussions within the different areas was at times clear. There is much

admiration and discussion around the Scottish agreement and how England is behind in some regards. In NI the situation sounds very precarious, but they are determined to support the partnership model. Income per patient in NI is lower than England, though of course there is a range and many of our local practices are considerably under the mean. To provide the service with this is very difficult.

- As at the LMC conference in March, there was considerable support for the partnership model and the dangers of fragmentation with many models being adopted including overflow hubs. These do not provide a coherent service to patients and may be inherently riskier. There was a clear message that at national government level there is recognition of this and that loss of partner led practices is likely to lead to further problems within the health economy. The working at scale federated arrangements may help but there needs to be tangible support for partnerships directly.

The next meeting of GPC England will take place on Thursday 17 May 2018.

I. RESPONSIBILITY FOR PRESCRIBING BETWEEN PRIMARY & SECONDARY/ TERTIARY CARE

This guidance was led by Dr Andrew Green, the GPC prescribing lead and Dr Gary Wannan of the Consultants Committee. This guidance aims to provide clarity on the responsibilities of professionals involves in commissioning and prescribing. Some key points from this work are as follows:

- Legal responsibility for prescribing lies with the doctor or health professional who signs the prescription and it is the responsibility of the individual prescriber to prescribe within their own level of competence
- GPs would only be obliged to provide treatment consistent with current contract requirements.
- The provision of shared care prescribing guidelines does not necessarily mean that the GP has to agree to and accept clinical and legal responsibility for prescribing; they should only do so if they feel clinically confident in managing that condition.

J. BRIEFING ON THE DR BAWA-GARBA CASE

This case has caused a lot of anxiety amongst GP's and at the GPC meeting a clear message was shown that medical negligence manslaughter should demand a very high degree of proof, probably greater than in the case in question.

Dr Bawa-Garba was sentenced to two years imprisonment, suspended for two years. On 29 November 2016 the Court of Appeal Criminal Division refused her leave to appeal against her conviction.

Wider implications of the case:

- The GMC has confirmed to the BMA that it will never ask a doctor to provide their reflective statements when investigating a concern about them (although it is legally permitted to do so). A doctor may provide their reflections as part of

their defence at the tribunal, for example to demonstrate that they have shown insight, but this is up to them.

- BMA guidance has been updated to address any confusion among doctors about what should and should not be recorded by referring them to the 2015 guidance from the Academy of Medical Royal Colleges (and recent update), and from the medical defence organisations, such as the MDU.

The LMC are currently in discussion with Michael Devlin of the MDU to hold an event into gross negligence manslaughter for our members in the summer. Further details to follow in due course.

K. GUIDANCE ON NHS PRIMARY CARE MEDICAL SERVICES IN INSTITUTUONS AND CARE HOMES IN THE UK

This guidance published on the BMA website outlines the responsibilities of practices deciding whether they need to register such patients, and if so, what services they are required to provide. Such as:

- Registration of hospitals inpatients
- Provision of services
- Obligation to carry out a visit
- Indicators of whether GPs are responsible for patient care
- Providing primary care services to patients in secondary care institutions
- Providing care to patients in non-hospital institutions or care homes.

When GPs provide services to patients residing in institutions and care homes, there is often confusion over who is clinically responsible for their care, which may present a risk to patient safety. GPs must not be forced to accept clinical responsibility for aspects of the care of patients in secondary care institutions, nor for those in any setting where the clinical needs of the patient fall outside the normal skills and contractual requirements of GPs.

L. SURVEY OF GP'S TO HELP INFORM THE DEVELOPMENT OF THE NEW STATE-BACKED INDEMNITY SCHEME.

Recently, the LMC's in England have been approached by the BMA stating that their Colleague Ipsos Mori (Department of health and social care) is continuing to survey GP's to help inform the development of the new state-backed indemnity scheme. This is due to commence in April 2019. This survey has already been completed by many GP's they do require additional responses to make sure the data recorded accurately represents front line staff.

If our members are contacted in the upcoming days, the department would encourage them to take part and appreciates the time GPs will give up assisting with this work.

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