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| **Chief Executive’s Report** | 2018/03July/September 2018 | U:\Marketing and Communications\Marketing Literature\SSLMCs logo\lmcs NEW REV logo generic.jpg |

1. **Resignation of NHS England Director of Primary Care**

I am sure that most colleagues will be aware that the NHS England Director of Primary Care, Dr Arvind Madan has resigned. This appears related to two issues; the first being his comments that GPs should be ‘pleased’ when small practices closed, which is a gross disservice to the many colleagues and practice staff who work in “small” practices providing a high quality of care to patients, with higher than average patient experience statistics, and secondly the discovery that Dr Madan had been anonymously contributing comments to Pulse articles under the pseudonym ‘Devil’s Advocate’, which appears at the least an unusual occupational activity for NHS England’s Director of Primary Care, and certainly undermines his credibility.

 Dr Madan will presumably return to partnership working at the Hurley Group, whose business model would appear to be predicated in part on the ‘failure’ of small practices, or at least their acquisition.

NHS England, in Dr Madan’s judgement, includes those who are “dedicated to supporting General Practice and wider primary care”. His interim successor is the current NHS England Medical Director of Primary Care, Dr Nikki Kanari, a substantive appointment will be made in the Autumn.

1. **GP Earnings and Expenses Report**

The 2016/17 GP Earnings and Expenses Report has now been published; the full Report is available at: ( <https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2016-17> )

but highlights of the report are as follows; colleagues should note these figures are based on anonymised aggregated tax returns and are not linked to working hours. Figures also exclude GPs who hold more than one contract.

**Average 2016/17 income, before tax in England:**

* For GP Contracts (either GMS/PMS Contracts) was £109,600 compared with £104,900 in 2015/16, an increase of 4.6%
* For salaried GPs employed by GMS/PMS Contractors was £56,500, compared to £55,900 in 2015/16, an increase of 1.2%
* The expenses/earnings ratio is 67.6%; expenses have grown at a faster rate than income before tax for contractor GPs since 2005/06

However, although earnings have risen, there has be4en a fall in the number of FTE GPs, and therefore a significant proportion of the apparent rise in contractor income may be accounted for by the falling workforce.

The expenses/earnings ratio continues to rise inexorably, indicating GP partners are investing in their practices but facing increasing cost pressures in doing so.

**UK figures, before tax when relevant**

* The average GMS Contractor income before tax was £103,700 compared with £111,500 for a PMS Contractor. The earnings/expenses ratio for PMS contractors is also higher, being 64.9% (🡩 1.3%) for GMS and 68.6% (🡩 0.9%) for PMS Contractors
* The NHS superannuable proportion was 94% in 2014/15, the latest year such pension information is available
* There has been a statistically significant increase in GMS/PMS non-dispensing practice income [4.5%] compared with GMS/PMS dispensing practice income [2%]
* GMS/PMS contractor income remains the highest in England, compared with the devolved nations.
* 60.5% of salaried GPs had employment only income, a % which has risen steadily from 48.5% in 2012/13, suggesting the proportion of salaried GPs who have employment income only is rising significantly.
* For the first time since 2012/13 rural GP income before tax has fallen slightly below that of practices clarified as urban [UK figures] although this is also affected by the proportion of GMS/PMS practices which are dispensing [41.4$ rural practices and 6.3% in urban] although there has been a significant fall in rural dispensing practices, from 55.5% in 2011/12
* For the first year, earnings in relation to list size information is available, as below:



* There is no correlation between salaried GPs income and the size of their practices registered patient list; however, there is a significant correlation between list size and the proportion of GP contractors to salaried GPs, as below:

**Table 4.20: Count of practices and contractor to salaried GP ratio in each practice registered patient list size band, UK, 2016/17**

**Contractor**

**Practice Patient List Size           Count of to salaried practices GP ratio**



**Fewer than 5,000**          2,314                 3.4

**5,000 to fewer than 10,000**         3,179                 3.1

**10,000 to fewer than 15,000**        1,477                 2.5

**15,000 to fewer than 20,000**           334                 2.3

**20,000 and over**             102                 1.6

Over time UK GMS/PMS earnings and expenses have changed as below:



1. **Trends in General Practice to 2017**

NHS Digital has published a further description of General Practice trends, this time to 2017, as part of the on-going work of the Technical Steering Committee, which includes representation from the DHSC, NHS England, NHS Digital and the BMA. It plays an influential role in professional contract negotiations. The full publication is available at:

 <https://digital.nhs.uk/data-and-information/publications/statistical/general-practice-trends-in-the-uk/general-practice-trends-in-the-uk-2017>

Highlights of the report include:

* The number of GP practices in England continues to decline, falling to 7361 (7527 in 2016 and 8261 in 2007)
* The number of GP contractors is also declining, although this does not translate into an FTE headcount. There were 22919 in 2017 (23937 in 2016 and 27342 in 2007).
* The number of “other GPs” has risen to 11497 in 2017 (10988 in 2016 and 6022 in 2007). These figures exclude registrars, retainers and locums.

* The England registered GP practice population has risen from 53588 in 2007 to 58675 in 2017
* The average patient list per practice has risen from 6847 in 2007 to 7971 in 2017.
* The practice demographic has changed significantly over the past decade, as below: -

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient list size |  |  |  |  |  |  |  |  |  | Percentage |
|  | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|  |  |  |  |  |  |  |  |  |  |  |  |
| England |  |  |  |  |  |  |  |  |  |  |  |
| 0 to 2,999 | 20.8 | 20.3 | 20.9 | 21.2 | 20.6 | 18.4 | 17.1 | 15.9 | 13.9 | 12.3 | 10.4 |
| 3,000 to 5,999 | 32.1 | 31.8 | 31.3 | 30.6 | 30.5 | 30.9 | 31.0 | 30.6 | 30.3 | 30.1 | 29.5 |
| 6,000 to 8,999 | 22.8 | 22.8 | 22.2 | 22.3 | 22.5 | 23.0 | 23.3 | 24.0 | 24.3 | 24.6 | 24.9 |
| 9,000 to 11,999 | 14.6 | 15.0 | 15.2 | 15.1 | 15.3 | 15.9 | 16.4 | 16.4 | 17.0 | 17.2 | 17.7 |
| 12,000 to 14,999 | 6.6 | 6.8 | 7.0 | 7.2 | 7.3 | 7.5 | 7.8 | 8.3 | 8.9 | 9.4 | 9.7 |
| 15,000 + | 3.1 | 3.3 | 3.4 | 3.6 | 3.9 | 4.3 | 4.5 | 4.9 | 5.6 | 6.4 | 7.8 |

* Approximately 43.5% of GP partners are female, with 73% of ‘other GP’ and 48.6% of locums.
* Practice staff numbers have fallen in recent years, from a recorded high of 139352 in 2014, to 131705 in 2017 (being 117375 in 2007) with this trend being mirrored for both clinical and non-clinical staff within practices.
* The proportion of GP practices holding GMS contracts has risen significantly since 2013 as the nationally mandated PMS Contract Reviews occurred, rising from 55% in 2009 to 69% in 2007. In addition, a disproportionate number of PMS contracts are now held within NHS England (London).
* The number of APMS contracts has risen only slowly, from 173 in 2009 to 224 in 2017, now representing 3% of the total number of practices.
1. **GP Patient Survey**

The annual Ipsos Mori GP patient survey has been published against the backdrop of the many challenges also noted in this Report, it describes a service still delivering high quality care for the great majority of NHS patients. Over 750k responses were received. The headline findings include:

* 83.8% reported a good overall experience with their GP practice, dipping slightly from 84.8% in 2017
* 96% had confidence and trust in the healthcare professional they saw, (this, as was widely reported at the time, dipped to 92% in 2017), and
* 95% felt their needs were met at their last appointment.

In terms of access to appointments: -

* 70% found it easy to get through to their practice by phone, with
* 62% who accepted an appointment saw or spoke to someone at a time they wanted to or sooner, and
* 66% who wanted a same day appointment and accepted one, received one.
* 54% of patients have a GP they prefer to see (other studies confirm this expression of a preference is statistically higher in the >65s and those with an LTC) and 50% of these always, or much of the time, see their preferred GP when they would like to.
* Overall 74% were satisfied with the type of appointment offered, and accepted it
* 10% of patients now book appointments on-line (up from 7.9% in 2016) with 78.5% by phone (down from 85.6% in 2016)

Care at their last appointment:

* 89% of patients reported being involved as much as they wanted to be, with
* 87% saying the healthcare professional had listened to them, given them enough time, and treated them with care and concern.

In terms of awareness and use of on-line services:

* 41% were aware of a system for booking appointments on-line and 13% had done so
* 38% were aware of a system for ordering repeat prescriptions on-line and 14% had done so
* 13% were aware of a system for accessing medical records-on-line and 3% had done so, and
* overall, 78% reported finding using their GP practice’s website easy.

Planning care:

* 40% of those with an LTC had spoken to a healthcare professional about managing it, and
* 79% said they had received enough support from local services/organisations

Of the 5.8% of patients who did not take an offered appointment:

28% didn’t subsequently see or speak to anyone

22% contacted their practice at another time

14% got an appointment on another day

11% looked for information on-line

11% went to an Accident and Emergency Department

11% contacted or went to another NHS service (OOHs, WIC, MIU)

11% spoke to a friend or family member

10% spoke to a pharmacist

 7% rang 111

with some doing more than one of these alternatives.

Further details of the 2018 GP Survey are available at: - <https://gp-patient.co.uk/surveysandreports>

1. **Central Alerting System (CAS) notice about Docman software (Version 7) with Electronic Document Transfer (EDT) enabled.**

I wrote to all practices about this issue following the identification of a serious incident in which practices using the current (or historic) Docman configuration as above may have “unprocessed folders” in which patient related correspondence may exist which has not been successfully transferred to an identified patient record. NHS England believe they have identified all practices to whom this applies and have contacted them asking to check whether such unprocessed folders exist, and, if so, the number. NHS England have provided software which will enable practices to eliminate duplicate unprocessed folders. As a second step practices are being asked to review such folders and identify and categorise any incidents in which patients may have come to harm. However, as will be apparent to colleagues, this process may require more clinical support than is available: the LMC recommends practices in this situation (or who experience any IT difficulties) contact their CCG Lead for advice, as well as the LMC.

A second, more limited issue has arisen with TPP SystmOne in which practices using this provider system have been advised not all medication allergies/sensitivities have been properly recorded. This has now been addressed, but practices were provided with a list of patient records to review.

It will be apparent that GP practices are facing workload implications as a result of IT or other organisational errors: GPC have agreed with NHS England to identify the scale of work involved, in relation to the Docman issue, and use this as a template to calculate appropriate remuneration.

However, GPCs IT Lead has also used relevant extracts from GMC’s ‘Good Medical Practice’ to indicate, once GPs are aware of this problem, they have a professional responsibility to address it. The LMC will provide further advice on this.

1. **Dr Bawa-Garba Appeal**

I am sure many colleagues will be aware that following Dr Bawa-Garba’s appeal, supported by the BMA as an ‘interested party’, the Court of Appeal has overturned the High Court decision to erase her from the Medical Register and has reinstated the original MPTS Tribunal decision to suspend her for twelve months: the BMA has strongly supported the MPTS role as the right regulatory body to make final decisions on doctors’ futures, as only they have the opportunity to hear and consider all the evidence involved.

The decision has placed a spot-light on the GMC’s reputation amongst the medical profession with the Government accepting the view that the GMC’s right to appeal MPTS decisions should be removed.

1. **Pensions Contributions Review**

I have circulated to all practices a recent announcement that, following an NHS England quality assurance review, a small sample of cases revealed discrepancies in PCSE submissions of GP pension contributions to the NHS Business Services Authority (which administrates NHS Pensions). As a result of this a wider review will take place, focussing initially on GPs close to retirement (age 56 and over), those who have recently retired, and those who have died in service.

If any discrepancies are identified, the individual doctor will be contacted.

Clearly, as NHS England and PCSE are aware, this is a significant reputational issue that has the potential to further undermine GP morale, and an external expert is supporting the PCSE review.

1. **DDRB Announcement**

As Colleagues will be aware, the DDRB has finally reported and the Government has announced pay awards for staff covered by the DDRB. I have written to all practices outlining this and also the concerns associated with the outcome.

In summary, a further 1% uplift is being added to the Global Sum, which will rise to £88.96 with the OOHs deduction remaining at 4.87% (£4.33). The previous formula uplift, which distributed a DDRB Award within the three national contract reimbursements (Global Sum, QOF and DESs) has not been applied and the GPC has, contrary to verbal discussion at the time, not veered a portion of the DDRB award to uplift non SFE contract immunisation payments. There are phased increases to the salaried doctors pay scale (2%), trainers grant (3%) and appraisers fees (3%).

The DDRB Report clearly accepted the concerns expressed about GP workload, recruitment and retention and NHS England’s apparent expectations of General Practice, and recommended a 4% uplift net of expenses.

The new SoS did offer a further 1% uplift in 2019/20 depending on contract negotiations; however, this is contingent on, at present, the unknown.

1. **SARs**

The LMC has been advised the original expectations that GDPR would preclude solicitors asking for SARs was incorrect; having taken legal advice, the BMA has advised that solicitors [and third-party claims and notes review intermediaries] can submit SARs which must be treated by practices as if they were submitted by the patient directly. That the underlying purpose of the SAR, in such a case, is to support a legal claim rather than to obtain a copy of electronically held records and verify it accuracy and completeness, cannot be considered. This is causing significant difficulties to practices and the GPC regards this as an increasing and unfunded workload. A comprehensive survey of practices about this issue is to be circulated soon.

1. **NHS England Consultation on ‘Digital-First’ primary care and QOF**

NHS England have published two consultations relating to the GP Contract and I have written to all practices giving a summary of these.

In terms of QOF, the consultation follows an NHS England QOF review, at which GPC was present, but which reported too late to be included within the 2018/19 Contract Negotiations; consequently, QOF was unchanged during 2018/19. QOF remains one of the largest ‘pay-for-performance’ schemes in the world, with a budget of nearly £700 million in 2016/17.

There were multiple caveats around the need for any change to be incremental and negotiated, but possible developments include:

* modification of indicators to better target the population cohorts to which they apply
* ‘rebranding’ exception reporting as ‘personalised care adjustment’ operating at an individual rather than domain level
* Introduction of a ‘quality improvement domain, based on national/local priority areas, but with a recognition that most GP/CCG experience of the 2011-14 QOF ‘Quality and Productivity indicators was poor.

Although there are no plans to reduce the overall value of QOF, the only way to produce financial “headroom” would be to retire indicators, perhaps 25% of the total. The INLIQ experience demonstrates a gradual decline in data recording with increased variance amongst practices, but it is unclear if this reflects any change in the appropriate quality of care provided to patients.

There is also a discussion of QOF changes in Scotland and in the few CCGs that did negotiate changes, prior to NHS England halting this.

The consultation means QOF will be changed for the 2019/20 GP Contract Agreement, but cautiously, with the consultation making it clear changing QOF significantly would take years and a substantial element of clinical indicators will remain.

The second consultation relates to recent ‘digital consultations’ developments and NHS England’s belief that such NHS consultations will increase in numbers over time. NHS England therefore argue the following elements of the GP payment structure should be reviewed.

**The London Adjustment [London Weighting]**

This is a flat rate non Carr-Hill Formula capitation payment of £2.18 paid to all practices based within London, to all registered patients, whether living in London or not. It is paid in addition to a higher MFF (Market Forces Factor) paid to London practices to adjust for higher metropolitan costs.

NHS England’s suggestion is to apply the London weighting only to London-resident patients, not just paid it to GP practices who are based in London.

**The Out-of-Area Registration Payment**

Currently practices receive the same fee for patients registered ‘normally’ and under the ‘out-of-area’ registration arrangements, even though they do not need to provide Home Visits to the latter. At the time the scheme was introduced, in 2015, NHS England accepted this anomaly would need to be reviewed, and the number of ‘out-of-area’ registrations has only slowly increased. However, the ‘digital-first’ offer may lead to a surge in such numbers. Accordingly, and based on an analysis of the frequency of home visits, NHS England have suggested the Global Sum payment for out-of-area patients may need to be reduced by about 20%. NHS England wish to continue the out-of-area registration option. The difficulty of commissioning an in-hours home-visiting service in most areas is also recognised.

**The Rurality Index**

This is a niche interest; it is an additional payment made to practices with a higher than average distance between patients’ homes and the practice. 90% of practices’ have an average distance between 0.8 – 3.9 km. However, if the proportion of out-of-area registrations rise, then, because these and normal registration are not distinguished in terms of the rurality index, then practices will appear more ‘rural’ than they really are. Physical distance obviously has a significant impact in terms of delivering GP services but is irrelevant to a ‘digital-first’ consultation. However, any such changes in the index will have no impact on over 7000 practices.

In terms of consultation responses, obviously GPC will be providing a full response; individual GPs can do so, and/or I can response on behalf of SSLMCs in relation to particularly those issues of most interest to our area.

1. **Local IT Issues**
2. **Incomplete episodes of care at St Georges Hospital**

I hope all practices with patients identified as being involved in this incident have now received an invitation from the CCG to review such patients and advise St George’s if any action is needed. I am grateful to Londonwide LMCs for undertaking the initial negotiations on this issue.

1. **Unprocessed Docman folders**

Again, originally in Londonwide’s area but perhaps affecting many SW London practices, an issue has been identified in which unprocessed Docman folders contain multiple documents which have arrived at the practice but not been uploaded into the patient’s file. It is difficult to know what the scale of this problem will be, and so NHS England has contacted all practices seeking to identify whether they have such unprocessed files, but not requesting any action to be taken yet. A significant incident investigation involving Docman is underway but as yet no further details are available.

1. **The Potentially Avoidable Appointment Audit**

Supported by NHS England, the Primary Care Foundation has developed an audit to look at current practice appointments, based on initial research suggesting up to 27% of appointments in General Practice were potentially avoidable if other services and support were in place. There is no cost to practices.

Information about the audit, which over 1000 GPs from over 400 practices have so far undertaken, results so far, changes, and case studies are available at: -

<https://pcfaudit.co.uk/login>

1. **NHS App**

As a 70th Birthday present for the NHS, the Government has announced that an app will be available across England by December 2018; this will give patients safe and secure access to their GP record – or at least that is what it says within the current publicity – and allow patients to order repeat prescriptions, book appointments – assuming they are available – and state preferences such as data-sharing (via the National Data-Opt-out) and organ donation. This is an element of ‘digital-first primary care’ of which colleagues will hear much more……..

1. **Supporting General Practitioners who undertake a low volume of NHS General Practice clinical work in one or more appraisal cycles**.

Whilst there is no formal requirement in terms of the number of sessions that have to be fulfilled annually to remain on the Performers List, NHS England have responded to concerns expressed by appraisers and Responsible Officers (ROs) that GPs with a very limited commitment to Clinical General Practice are at risk of disengagement from, and increasing inexperience in, patient care.

After some discussion NHS England’s guidance to ROs is that General Practitioners undertaking 40 or less clinical sessions per year have to complete a Structured Reflective Template aimed at addressing perceived risks; and encouraging the GP to reflect on these.

By way of comparison, the current Retainer Scheme supports up to four weekly sessions, so this will apply to relatively few colleagues.



Dr Julius Parker

**Chief Executive**