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| **Chief Executive’s Report** | 2017/01Jan/Feb 2017 | U:\Marketing and Communications\Marketing Literature\SSLMCs logo\lmcs NEW REV logo generic.jpg |

**GPFV (GP Forward View)**

As an update, all CCGs were required to submit their plans for parts of the GPFV to NHS England by 23rd December 2016, which, along with other Surrey and Sussex CCGs, West Sussex CCGs have done. The LMC is in the process of analysing these on the basis of an evaluation template developed by GPC, to try to ensure the monies devolved to CCGs within the GPFV are translated into tangible investment in General Practice. This particularly relates to the GP Access Funding, and baseline investment allocation guidance CCGs have received from NHS England. Obviously, there are other elements of GPFV investment being held centrally by NHS England. Locally significant progress is being made to support delivery of the Practice Resilience Programme.

**Publication of MCP (Multi-Speciality Community Provider)** **Contract Guidance**

NHS England have now published the proposed MCP NHS Standard Contract, although they are still consulting on some details and so this and the associated guidance (from GPC and LMCs) cannot be definitive.

The LMC has now circulated guidance to colleagues which makes it clear that a full-integrated MCP model would be a step completely outside the partnership, independent contract, list-based delivery of primary medical services. There could be no return ticket in the commonly understood meaning of this phrase, and which did genuinely apply to PMC Contractors. The virtual MCP simply involves GP practices and/or other local stakeholders, including CCGs and other community service providers, agreeing to work more closely together: there would in such circumstances be no MCP contract, and no change in GP core-contract, QOF, and other revenue streams.

One concern must be that in the absence of anything else to say, many STPs have suggested that an MCP contract may be used to deliver integrated community services, indeed this was being suggested well before any indication of what an MCP contract might represent was available. Now it is known, it would seem unlikely many GP colleagues will wish to fall on their swords for a completely unevidenced future vision of the NHS.

**Patients presenting with Dental Symptoms**

The GPC has published updated guidance in relation to patients who present to General Practice (and OOHs services) with symptoms suggesting a dental illness. Essentially if after an assessment (which need not be face to face but is required) it is thought the patient does have a dental illness, they should be referred to a Dental Practitioner, and GPs should not initiate treatment as they are unlikely to be indemnified for doing so.

If the patient does not have a regular NHS dentist, or no private dentist, noting that NHS dentists do not have registered lists, or cannot access one, they should be referred to the CCG and it will be helpful for practices to have access to this number to provide to patients. The CCG is responsible for commissioning arrangements, which includes publicising access to NHS dental services both in and OOHs. Most assessments OOHs are undertaken by dental triage nurses or 111, and both should have access to emergency dental clinic appointments.

I have circulated this guidance to all practices.

**Indemnity Issues**

The GPC negotiating group for indemnity issues has now met and there is an agreed workplan covering:

* ‘winter’ indemnity scheme OOHs
* Indemnity arrangements in new models of care, such as PMCF/MCP and if indemnity is provided by organisations (rather than centrally via the Trusts CNST) what happens to run-off indemnity if such organisations go out of business or fail to win or retain contracts.
* The rising cost of indemnity itself, costs are increasing twice as fast in unscheduled work as in-hours, which is creating a significant recruitment and retention bottleneck of the required workforce
* Developing support tailored to individual groups, such as GP registrars, returners/retainees and those close to retirement. The difficulty is avoiding tax-based support but not shifting costs and so differentially burdening subsections of the workforce.

The other current issue that may have implications for indemnity costs is the consultation on the personal injury discount rate. There has been further information about this issued by the MDU.

Although it may sound an obscure point, any changes in the personal injury discount % rate would have an impact on Court Awards because a higher award would be necessary to adjust to a lower expected long term investment return for that award. Consequently, indemnity costs would rise to fund higher awards. The current discount rate is 2.5% and it may fall to 1%, as it has done in the Republic of Ireland in 2014. The Lord Chancellor is due to make a final announcement by the end of January 2017, following a consultation exercise that began in 2012.

Clearly any substantial increase in GP indemnity costs will further exacerbate the workforce issues with which NHS England are currently grappling.

**Pearson Review of Revalidation (‘Taking Revalidation Forward’)**

Sir Keith Pearson’s two-year review of the process of revalidation, which became compulsory for GMC licensed doctors in 2012, has been published: the full report is available at:

<http://www.gmc-uk.org/Taking_revalidation_forward___Improving_the_process_of_relicensing_for_doctors.pdf_68683704.pdf>

As colleagues know many GPs have gained positive benefits from their appraisals, but the integration of the annual appraisal process with the five-year revalidation decision has caused some concerns as what was essentially designed as a formative process has been integrated with one that has a summative outcome.

In their response, the GMC have identified a number of priority areas for action:

* **Making revalidation more accessible to patients and the public.**

This could simply involve changing the terminology; thus, changing the term ‘revalidation’ to ‘relicensing’ already describes what many of the public think is happening already. ‘Real-time’ feedback is already available (iwantgreatcare) and the Pearson Review recommends looking at other systems which would allow this.

* **Reducing unnecessary burdens and bureaucracy for doctors**.

As colleagues know, particularly at a time of excessive workload, the perceived burden of appraisal is significant and feedback from GPs lead to the Royal College issuing very helpful guidance regarding Revalidation in December. The LMC also wrote to the GMC about this issue last year and I am circulating the response I received, which as you will note covered many concerns the LMC has received from GPs, all of which are noted in the Pearson Review. The GPC is already working on separating out ‘mandatory training’ requirements which are primarily related to Health and Safety and Safeguarding expectations, including those required by CQC, from the professional evidence that should be considered at an appraisal NHS England is also being asked to improve and invest in suitable IT to support the appraisal process.

* **Increasing oversight, and support for, doctors in short-term locum positions**.

This was almost entirely focused on locum doctors working in secondary care: the existence of the Medical Performers list for GPs provides a significant layer of reassurance in terms of identifying and supporting locum GP colleagues that is absent from secondary care and independent practice arrangements.

* **Measuring and evaluating the impact of revalidation (on doctors’ professional development and the safety and quality of the care they provide).**

Clearly this should be positive, but detailed academic research is needed; this is being undertaken but will not be published until 2018.

**CQC**

I noted the increase in CQC fees in my last report; I can confirm the GPC discussions on the current contract Negotiations for 2017/18 place as one of the highest priorities obtaining increases in expenses reimbursement. This has already been achieved, in terms of average costs, for GPs in terms of indemnity for 2017/18 and 2018/19 although this will be paid outside the Contract Agreement. The next phase of CQC Inspections will not commence until October 2017; the CQC will be publishing a consultation document regarding its new ‘primary medical service provider’ Inspection process in March 2017; this will run for two months.

The CQC locally will complete all first inspections by January 2017; after then it will undertake practices that have requirement or enforcement notices within six to twelve months after publication of the relevant Inspection Report, depending on the nature of breach. There are some clear straws in the wind; the GPFV has confirmed that any practice with a good or outstanding rating can expect to have an inspection once over the next five years. The CQC is trying to reduce the burden of inspection and so will be more likely to contact practices initially if a concern is raised for example, by using data in the public domain, or received from patients or other stakeholders.

**NHS Shared Business Services (SBS) documents received by practices.**

The LMC has written to all practices who may have received correspondence from SBS following a Significant Event in which it was identified substantial numbers of documents were not transferred by SBS to practices over a period of years.

A central clinical review of all these documents has already occurred, and so, in the great majority of cases, there will be no patient care implications. These documents should be reviewed, however, and both payment and, if necessary, a reporting and investigation process have been agreed by NHS England.

**Indicator No Longer in QOF**

I have written to all practices who have been contacted by NHS England or the HSCIC inviting practices to permit extraction of indicators under CQRS which have been retired from QOF. On this point, for the reasons outlined in my letter, SSLMCs does not support the wording of the 2016/17 or in fact the 2017/18 ,GP Contract Agreement, which encourages practices to facilitate this reporting, and therefore whilst it is certainly appropriate for colleagues to continue to undertake clinically appropriate work, and code this to ensure optimal patient care, the LMC has advised practices it is not mandatory to permit CQRS of INLIQ in 2016/17.

**Surrey and Sussex LMC Twitter**

This account is now being managed by Dr Clare Sieber, and benefits from her being the only LMC Director who actually knows what the process involves; we currently have 158 followers, though there may be more by the time you read this report; the account is available at: @SSLMCS

The aim is to provide a seamless link between LMC guidance sent to practices, guidance available on the website, events facilitated and supported by SSLMCs, and also to tie into GPC support for both LMCs and practices.

**BMA Junior Members Forum**

I have circulated a flyer to all practices, requesting colleagues’ attention is drawn to this free conference on the weekend 25th/26th February, open to all GP trainers and those within 12 years of qualification.

There are a limited number of places.

**NHS Medical Advice App**

As GP colleagues will soon be working 24/7/365 I realised you would be one of those groups within the community who find it particularly difficult to access your own GP, and so may be more encouraged than most at the news that NHS England is developing a new app to provide medical advice. Given we are now in a post-truth world I thought I should access the Sun newspaper to provide an update for my Report (<https://www.thesun.co.uk/news/2548383/nhs-medical-advice-smartphone-app-111-helpline/>)

It is claimed that the ‘chatbox’ will require around 12 texts, responding to various questions, before then searching a database of symptoms and advising the patient to see a GP, go to hospital, visit a pharmacy or stay at home. The app is being piloted over a six-month period in North London, including Islington; I have also sourced various quotes, including:

 Patient Concern: ‘The whole idea is scary’

 Dr Chaand Nagpaul: ‘This app leaves no room for clinical interpretation’

President Trump: “This was me, it was my idea; if you listen to me you don’t need to go to real doctors”

Dr Julius Parker

**Chief Executive**