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| **Chief Executive’s Report** | 2017/04  July/Aug 2017 | U:\Marketing and Communications\Marketing Literature\SSLMCs logo\lmcs NEW REV logo generic.jpg |

**NHS England consultation on items which should not be routinely prescribed in primary care**

As I noted in my last report, NHS England has been planning a consultation on prescribing in primary care and this has now been issued. The LMC has already written to all CCGs asking them not to proceed with issuing local policies on this until the national consultation has been completed; this closes in October.

The LMC notes the NHS England consultation is in partnership with NHS Clinical Commissioners, representing CCGs, and it would therefore seem even more ironic that local CCGs are seeking to pre-empt the outcome of a consultation which is designed to provide formal guidance for CCGs to use and to ensure consistency. Issuing local policies CCG by CCG creates a piecemeal effect. The LMC also notes an NHS England consultation will create significant publicity and generate public comment, whereas CCG public consultation is necessarily limited. Additionally, only NHS England can change the GP contract wording, address the Travel Immunisation Additional Service, or add items to the Drug Tariff Part XVIIIA (‘blacklist’) which is the GPC and LMCs preferred way in which NHS prescribing of items is restricted.

Accordingly, the LMC has advised GP colleagues not to engage in local CCG policies on this issue and instead await the outcome of the national consultation; for clarity, NHS England is not yet consulting on restricting the prescribing of items which can be bought more cheaply OTC, but instead wants general views on this issue. Again, if your CCG seeks to restrict such prescribing please contact the LMC.

**GP Survey 2017**

The GP Survey is now conducted, by IPSOS Mori but commissioned by NHS England, annually, having previously been undertaken quarterly. This year’s survey has received significant publicity, and I enclose a detailed BMA briefing.

Despite colleagues’ continuing efforts, there has been a gradual deterioration in overall satisfaction with GP services. There have also been continuing trends in terms of a preference for telephone consultation, a decline in the number of patients able to see their “own” GP and a continuing decline in satisfaction with OOHs services.

It is important to note however, that most % changes are small and the BMA briefing refers to changes from 2012, that is, five years ago.

**Police requests for Medical Records**

The Professional Fees Committee of the BMA has produced guidance, adopted by GPC, for practices that receive requests from the police to view a patient’s medical records. The LMC has contacted local police services in advance of circulating this guidance and a template letter to all practices.

There have been very few queries from practices (or the Firearms Licensing Officers) since the amended guidance on Firearms Licensing was circulated; I hope this collaborative approach will help.

**Hepatitis B Vaccine Shortages**

I have written to all practices as Public Health England has introduced restrictions on the availability of Hepatitis B vaccine and also developed a prioritisation list, in the light of a global shortage of this vaccine. Supplies are unlikely to return to normal until mid to late 2018.

GSK is now the only supplier: they will no longer supply private health and occupational clinics and as agreed with GPC General Practitioners will not be able to routinely order Adult Hepatitis B vaccine; supplies will be restricted to NHS Trusts and Occupational Health Units and therefore all patients who may need vaccinations, bearing in mind the prioritisation list, would be referred either to OH or if an urgent assessment is needed to Accident and Emergency Departments, who are both aware that GPs no longer have routine access to the vaccine.

Supplies of paediatric monovalent Hepatitis B vaccines are being reserved to ensure the national programme can continue; supplies of the hexavalent vaccine due to be used in September as part of the national childhood immunisation programme are unaffected.

Further details are available at:

<https://www.gov.uk/government/publications/hepatitis-b-vaccine-recommendations-during-supply-constraints>

**Violent Patient Scheme**

In response to several queries from practices the LMC has been negotiating with NHS England in terms of the delivery of this service in Surrey and Sussex (and Kent). At present the geographical availability of the service is clearly inadequate. One complication is that this service is part of the devolved responsibility passed to delegated CCGs, with the risk of further fragmentation however locally NHSE England have agreed to co-ordinate the delivery of the service and it is likely a procurement exercise will

occur shortly. Unfortunately, the specification used by NHS England Southern Region does not comply with the Regulations, so further discussion has been needed. Any practice with difficulties in relation to this scheme or with Para 21 (Removal of Patients from the Contractors List who are Violent) are asked to contact the LMC.

**The Naylor Report**

The Naylor Report has recently been published: this tries to outline a plan for current NHS estates. Overall, and at a conservative estimate, the backlog of NHS estate maintenance is £5 billion; current STP Capital bids across England exceed £10 billion.

In terms of primary care NHSPS and CHP (relating to LIFT projects) currently own and sublease about 1500 practice buildings (out of 7600) NHSPS also owns and/or has responsibility for approximately 3500 buildings formerly owned, leased, or managed by PCTs. The major regulator of primary care estate quality is CQC. The Naylor Report does not believe current NHS England ETTF plans, and of financially much less significance, local improvement grants, are adequate to deliver GPFV plans.

The Naylor Report found no evidence to support a reduction in acute hospital capacity, which makes it all the more ironic that nearly all STP proposals are based on this premise.

The report recommends (sigh) the creation of an NHS Property Board to provide for strategic development of NHS estate; Deloitte estimates that the NHS could release land worth £1.8 billion and “estate rationalisation” could deliver approximately £1 billion savings in annual estate costs. London has 57% of land value but 33% of land ‘units’.

The Report also suggests NHS facilities management functions should be subject to competitive tendering with the private sector, which confirms suspicions first noted when NHSPS was established.

**Psychological help for those affected by a traumatic event.**

NHS England has written to all GPs to remind them of the likely symptoms to occur in patients who have experienced or been affected by a significantly traumatic event; NHS England has also produced a leaflet ‘Coping with stress following a major incident’ which is available at

<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/617321/nhs_trauma_leaflet.pdf>

**Syder and Young Training Courses**

Full details of the next six months training courses for Practice Managers and non-clinical practice staff have been sent to all practices. These courses are very competitively priced (**£**80 for a full day) and are tailored both in terms of feedback from participants and known national or CQC priorities. They represent a consistent rolling programme of training that will I believe survive all NHS reorganisation. They also represent a valuable “banner” opportunity for the LMC and turnover has risen to nearly £150k in two years.

I would encourage your Practice and Business/Training managers to review the courses on offer.

**Ballot of GP Practices**

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| **This item is included for information purposes.** |

Following the decision at the LMC Conference to pass the following motion:

‘That conference believes that the GP Forward View is failing to deliver the resources necessary to sustain general practice and demands that GPC ballot GPs as to whether they would be prepared to collectively close their lists in response to this crisis.’

The GPC was mandated to undertake a ballot of General Practitioners to test their willingness to collectively cap their lists (that is, temporarily close them to new registrations), or apply to close them. The first would constitute industrial action; the second is allowable under the Regulations although for all practices to do so for the purpose requested by the BMA would also constitute such action. All colleagues were asked to circulate the BMA’s letter and FAQs to all General Practitioners within their practice: a final decision and return to the Electoral Reform Society should be made by practice partners. There was one vote for each practice.

The GPC will use the result of this ballot to decide future negotiation strategy; as yet the results have not been shared with GPC.

The LMC advise in terms of list capping, if practices are registering too many patients to allow the continuing safe delivery of practice services to those patients who are already registered at the practice, still stands. This depends on the individual circumstances at the practice. The LMC is working with Brighton and Hove CCG to produce joint guidance for practices on this issue which if adopted could be used by their CCG.

Dr Julius Parker

**Chief Executive**

Enc. (GP Survey)