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| **Chief Executive’s Report** | 2017/05Sept/Oct 2017 | U:\Marketing and Communications\Marketing Literature\SSLMCs logo\lmcs NEW REV logo generic.jpg |

1. **State GP Indemnity Scheme**

In what may prove to be a pivotal policy decision for General Practice, the Secretary of State has announced the Government will establish a state supported GP indemnity Scheme to provide medical negligence cover for GP practices (and OOHs and Integrated Primary Care Services) working under NHS Contracts. This will be in place within 12 – 18 months, hopefully therefore by January or April 2019.

There are many details yet to be agreed, and it is likely these will be included in both the next rounds of the GP Contract Agreements: the annual inflationary uplift for indemnity costs already agreed is in place for 2017/18.

It can already be anticipated, by analogy with the hospital colleagues CNST (Central Negligence Scheme for Trusts) arrangement, this indemnity cover will not include non-NHS practice, or NHS England or GMC performance processes, for which legal representation may be required, and so GPs will need to maintain cover for these issues at a minimum.

The funding of the scheme, who will operate it, and how contractors may have to contribute towards it, are all unknown.

The other significant development is the response from the MDU, MPS and MDDUS. As I noted in my letter, the MDU announced an approximately 50% reduction in GP subscription rates from November 2017, on the back of the commitment to establish a stated supported GP indemnity scheme. The two other main indemnity organisations have instead not so subtly criticised the MDU both for a premature announcement, before more details of the new scheme are available, and also because the Transitional Benefit package announced by the MDU moves membership benefits to a claims based rather than occurrence based system: normally medical indemnity is occurrence based, providing reassurances to doctors when claims can arise some years after the adverse incident, or even after retirement.

The scope of any new state GP indemnity scheme is as yet unknown and it is not clear if it will cover all claims notified after the commencement of the scheme. This did occur when the CNST was established in 1990. If this approach is adopted, clearly the MDU’s future liabilities will be significantly reduced. If it does not, MDU members will be able to purchase ‘run-off cover’ (the MDU refers to this as Extended Benefits Rights) but all Indemnity Organisations will be in difficulty as they will have future liabilities but no continuing adequate subscription base. This will have to be addressed in negotiations between the IOs and Government over the next year.

All GPs must maintain adequate liability for the present, until the new scheme comes into operation, and it is likely the MPS and MDDUS will introduce some form of transitional arrangements over the next year.

1. **New GMS1 forms**

All practices should by now have received new GMS1 forms for use from October 2017. These include supplementary questions to be completed by overseas visitors, who hold a non-UK issued European Health Insurance Form [EHIC], a Provisional Replacement Certificate [PRC] [which is a temporary replacement for a mislaid EHIC] or an S1 form, available to those in receipt of a UK old age State pension but who live abroad.

It is important to note practice staff are not responsible for trying to identify overseas visitors or checking the accuracy or veracity of completed forms. NHS England has a leaflet available to provide additional information for overseas visitors about the NHS.

Under the 2017/18 GP Contract Agreement, GP practices must, for those patients who self-declare they hold a non-UK EHIC, PRC or S1

* Enter this information into the medical record, the only coding currently available relates to holders of European EHIC cards
* Send a copy of the completed GMS1 form to either NHS Digital [EHIC or PRC] or DWP [S1]

on an approximately weekly basis.

GP practices have been given a Global Sum uplift to fund this additional administrative work.

It is important to note that all eligible patients can register with an NHS GP, whether or not they have identified themselves as an overseas visitor.

If practices use a web based registration process or a bespoke application form, as long as this is updated to include the new questions and guidance, then these approaches can continue.

The LMC has sent a more detailed guide to all practices, together with an update based on practice queries and further information provided by GPC and PCSE.

1. **GP Earnings and Expenses Estimates 2015/16**

NHS Digital has now published its analysis (based on HMRC data) for GP income in 2015/16.

In summary:

* Average pre-tax GMS Contractor income was £99,500, compared with £97,700 in 2014/15, an increase of 1.8%.
* Average pre-tax PMS Contractor income was £106,000, compared with £108,000 in 2014/15, a decrease of 1.9%.
* As a consequence, the average GMS/PMS Contractor income was virtually unchanged at £101,300 (<0.05%).
* Average gross earnings for GP Contractors was £288,200 compared with £283,100 in 2014/15, an increase of 1.8%.
* Average total expenses for GP Contractors was £186,900, compared with £181,800 in 2014/15, an increase of 2.8%.
* As a result, the expenses to earnings ratio in 2015/16 was 64.9%, having been 64.2% in 2014/15.
* The average pre-tax income for dispensing GP Contractors was £114,800, an increase of 1.3% compared with 2014/15, and for non-dispensing GP Contractors the figure was £98,900, a decrease of 0.3%.
* Average pre-tax income for salaried GPs working in GMS/PMS practices was £55,800 in 2015/16, compared with £56,600 in 2014/15, a decrease of 1.5%.
* Average GMS/PMS Contractor income by country for 2015/16 was:

England £104,900

Scotland £89,500

Wales £93,400

Northern Ireland £92,000

Salaried GPs who did not complete a self-assessment tax return, and GPs who work solely as locums, would not be included in this analysis.

The HMRC sample was of 19,250 returns, which is statistically significant.

The average NHS superannuable income for GMS/PMS Contractors was 94.8% in 2013/14, the latest year for which this figure is available, giving an indication of the private income proportion.

These figures do not differentiate in terms of hours worked.

It is important to note the figures are presented in cash and not real terms.

Full details of the report are available at:

<http://digital.nhs.uk/catalogue/PUB30072>

This information is used in negotiations with the DDRB, although GPC now negotiates directly with NHS Employers (NHS England) in relation to direct practice expenses.

1. **DDRB Submission by BMA**

There has been considerable publicity about the ‘Scrap the Cap’ campaign and the joint decision by the Agenda for Change (AfC) Trade Unions asking for an RPI plus £800 uplift in the forthcoming public sector pay negotiating round.

The BMA did not join the other AfC Unions for a number of reasons including:

* The BMA submits to a separate pay review body (the DDRB) compared with other AfC Unions.
* The £800 claim is on average a 2% rise for AfC members, but not for many doctors.
* The AfC Unions wanted to announce their claim prior to the BMA finalising its DDRB submission.

The BMA has supported the campaign against the 1% public sector pay cap now in place for seven years.

1. **Patient Referral Leaflet**

In conjunction with the National Association of Patient Participation (NAPP) the BMA and NHS England have developed a patient leaflet designed to explain to patients what they can expect to happen when they are referred to see a specialist in a hospital or community centre.

The significance of this letter is it is based on the requirements of the NHS Standard Contract 2017-2019 for hospitals; this means issues such as prescribing, test and investigation arrangements and results, and Fit Notes (Med3s) are all outlined in a way compliant with the Contract.

I have alerted all hospitals and CCGs to this letter; clearly the onus is on CCGs, as commissioners, to ensure all Trusts are aware of and compliant with their contract, but it may well be a worthwhile investment for all practices to ensure patients receive this leaflet when they are referred, and I have written to all practices to highlight this leaflet. It has also been tweeted.

1. **Peer Review of GP Referrals**

Arvind Madan, NHS England Director of Primary Care, has written to all CCGs to confirm there is no expectation that all GP referrals, from all practices, must be the subject of peer review.

Instead NHS England asks CCGs to take a targeted approach, taking into account the CCGs growth rate of GP referrals and any local variation unsupported by clinical evidence.

The LMC is clear that any additional workload for practices or GP colleagues must be appropriately resourced, and in fact this issue is unlikely to be a high priority given other pressures on NHS service delivery.

1. **Frailty: Guidance on Batch Coding**

The LMC has written to all practices to clarify the expectations of the 2017/18 GP Contract Agreement to identify frail patients. I know colleagues will be pleased to read that NHS England wishes General Practitioners to use their clinical judgement, taking into account an individual patient’s complete clinical picture, before making a diagnosis of frailty. Therefore, although a number of GP systems are configured to convert the eFI (Electronic Frailty Index) result directly into a Read (or other) coded diagnosis within the Health Record, NHS England is concerned that batch-coding cohorts of patients in this way effectively automates the process of clinical diagnosis, and therefore recommends against batch-coding. GPs are not expected to call/recall patients, but to opportunistically assess patients using the eFI result and also their clinical assessment to decide whether a diagnosis of mild, moderate or severe frailty would be appropriate.

For patients identified via the above as being severely frail the practice should:

* Offer an annual medication review.
* Ask, if clinically appropriate, whether the patient has had a fall in the previous twelve months, and
* Promote and seek consent for an enhanced SCR, if the patient does not already have one.

These coded actions and the coding, if appropriate, of moderate and severe frailty, are the only data extractions required.

1. **CQRS Data Extraction Requests**

All practices should have received a number of CQRS data extraction requests and the LMC Office, having received several queries about them, has written to all practices.

The notices come from NHS Digital, which undertakes data collection on behalf of NHS England, the data is being collected under provisions of Section 259 of the Health and Social Care Act 2012, and so this is a request practices cannot legally refuse.

There are two significant collections:

* A Workload information collection, which includes the Third Next Available Appointment which GPC and LMC support as it may help emphasise the pressures within General Practice.
* An Individual GP Level Data Collection, which is a pilot exercise to collect data related to patients’ usual GP; this includes personally identifiable information and looks at ten clinical areas including flu immunisation, dementia reviews and Emergency Admissions. There will be two data collections, in October 2017 and January 2018, and the analysed data will be returned to GP practices with an attempt made to relate the patient care data to their usual GP, as a proxy for their ‘named accountable GP’. Comparative CCG data will also be available.

As I am sure colleagues will appreciate, the validity and relevance of the Individual GP Level Data Collection is likely to be tenuous at best; however, NHS England, having analysed the October 2017 data, are planning to advise practices how best to utilise such information when it is returned to them; this should make for interesting reading.

Data is also being collected in relation to the 2017/18 GP Contract Agreement (frailty) as noted above and, for example, over 75 Health Checks.

1. **GMS/PMS Mandatory Variation Notices**

GMS Contractor practices should have received a letter from either their CCG or NHS England describing variations within their contract, including in relation to electronic signatures and prescribing.

The GMS Regulations allow for a mandatory variation in the contract in order to ensure it is compliant with new, relevant, legislative changes. Accordingly, practices should confirm their acceptance to this Variation Notice.

PMS Regulations also allow for a mandatory variation to ensure compliance in the same circumstances.

1. **National Spirometry Register**

The NHS is establishing a National Register of Certified Healthcare Professionals to assure the competence of those who undertake and interpret diagnostic spirometry in adults.

This will only become mandatory by March 2021, and will from then involve three-yearly certification. This will apply in primary and secondary care. However, GPs who diagnose and treat patients after spirometry has been undertaken and the results interpreted will not need to be on the Register. There are ‘grandfather’ clauses to enable those already undertaking such work to be initially accepted onto the Register.

This will apply to a number of respiratory LCSs, and the training and certification requirements and associated costs are being incorporated into LCSs.

I have written to all practices giving further information about the Register.

1. **CQC Inspections**

There has been further still unfortunately however relatively high-level information provided about the CQC inspection regime from November 2017, and I have written to all practices outlining this.

The planned CQC:LMC roadshows have been deferred until the New Year.

1. **New SSLMCs website**

I am pleased to say the new SSLMCs website has now gone live; this is being delivered by 14fish, who already support our Training and meeting websites and administration.

This is designed to be easier to use, and allow colleagues to more easily access the information and advice they require.

Any comments and suggestions can be sent to any of the LMC, or to Sandra Rodbourne Sandra.rodbourne@sslmcs.co.uk who has spent a very long time preparing for the new site.

Dr Julius Parker

**Chief Executive**