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| **Chief Executive’s Report** | 2018/01Jan/Mar 2018 | U:\Marketing and Communications\Marketing Literature\SSLMCs logo\lmcs NEW REV logo generic.jpg |

1. **LMC (UK) Conference**

This was held in Liverpool on 9th March; I hope all SSLMCs delegates found it helpful and I enclose with this report the LMC Conference news, which includes Conference resolutions passed and lost.

1. **Contract Negotiations and GPC Submission to the DDRB [Doctors and Dentists Pay Review Body]**

Unfortunately, final details of the GP Contract Agreement 2018/19 are not yet available and at the GPC Roadshow a general discussion only could be held: this did make clear that GPC has been looking for contractual stability; although there is an NHS England review of QOF underway, this is not expected to report until after April and so this will delay any substantive QOF changes until April 2019 – accordingly no change in indicators or thresholds is the most likely outcome. Colleagues are also aware of the very significant Indemnity negotiations underway: these will not be implemented until, probably, April 2019 and the current 2017/18 indemnity inflation uplift re-imbursement mechanism is thus likely to continue into 2018/19. In addition, the final version of the Premises Cost Directions should be announced with this Contract Agreement.

For the last two years GPC believed it could obtain a better outcome in terms of expenses costs by negotiating with NHS England, rather than via the DDRB directly but although this has had its successes, such as the Indemnity Funding and CQC fees reimbursement, the core contract uplift has been fixed at 1%, as part of the Government public sector pay cap, although total core contract uplift has risen by more because of Global Sum recycling, particularly of DESs, which has also meant less work. This year the GPC has submitted [as part of the BMA’s submission] to the DDRB requesting an RPI + 2% uplift, noting the effects of pay deflation, employment costs, and additional likely in-year expenses, such as those associated with the GDPR. The BMA’s submission is available at: <https://www.bma.org.uk/collective-voice/influence/key-negotiations/doctors-pay/annual-pay-review-from-the-ddrb>

NHS England’s submissions continues to state a 1% budget uplift but acknowledges the need for flexibility and problems with GP recruitment and retention. It is now unlikely the DDRB Report will be published before the end of March and the DH response to it may be delayed perhaps until after the local election period, although any Award will be backdated until 1st April 2018.

1. **Flu Vaccine Orders for 2018/19**

After some prevarication NHS England have now circulated guidance for all GPs [and Community

Contractors] in terms of flu ordering for next year’s season, which can be summarised as:

* Those 65 and over years, adjuvanted trivalent vaccine (Fluad)
* Those adults under 65, quadrivalent vaccine

The suppliers (of which there is only one for Fluad) have indicated providing orders are made by 29th March, there are sufficient supplies, and NHS England have confirmed reimbursement for both vaccine types.

The LMC notes there are no arrangements to reimburse any costs associated with cancelled or changed orders, however, suppliers are in discussion with NHS England and given the very clear messaging in the FAQs regarding only giving indicated vaccinations, it is not expected practices will incur these fees.

NHS England have asked practices to contact their local teams if there are any difficulties and I have asked practices to also copy in the LMC if they need to do so.

1. **General Data Protection Regulations (GDPR)**

The GPC has now published guidance on the implications for GP practices of the GDPR. This is available at: <https://www.bma.org.uk/advice/employment/ethics/confidentiality-and-health-records/gps-as-data-controllers>

The LMC will be providing more detailed guidance to practices, but the key changes for practices under GDPR are:

* Practices must actively demonstrate compliance with the GPDR; thus, for example:
	+ they must keep and maintain up-to-date records of the data flows from practices and the legal basis for these flows
	+ have data protection policies and procedures in place such as ‘fair processing notices’
* Designation of Data Protection Officers (DPOs)
* Practices will not be able to change patients for access to medical records
* A legal requirement to report certain data breaches.
* Increased financial penalties for breaches and non-compliance.
1. **GPC Workload Control Strategy**

The GPC have released a report on approaches to workload control and this was discussed at the LMC Conference last week. As colleagues will be aware the intimately linked pressures of rising patient demand, inadequate investment, and a falling number of GPs is producing a toxic challenge nationally, and whilst individually many practices are managing to provide excellent patient care, this is usually only because of the goodwill, commitment and professionalism of all GP colleagues.

The recent survey demonstrating satisfaction with General Practitioner services falling to 65%, its lowest level ever, and with a precipitate year-on-year fall of 7%, demonstrates that it is impossible to fulfil patient expectations within the restrictions of current service resources, in its widest sense, and by which I mean money, workload and workforce.

GPC wish to introduce quantitative limits to individual GP’s workload, described individual; as by doing so this then quantifies limits within General Practice and allows system ‘alerts’ to be issued. Colleagues will be aware this very controversial and there are no provisions within the current Regulations that allow this; the only approximation being to apply to close the GP List.

One substantial issue is that there is no agreed definition of a “safe” GP workload and GPs have very different work patterns. In addition, one other concern is that there is no obvious alternative destination to which patients can be diverted, unless ‘Primary Care Hubs’ can fulfil this role, as “overspill” centres for practices who need this support. Clearly, too, practices in more rural areas simply do not have appropriate access to substitute services for their patients.

The NHS current uses the OPEL (Operational Pressure Escalation Levels) Framework as an alert system, but it requires quantitative data to allow it to work.

Self-evidently as was discussed at Conference these proposals are controversial: many GP colleagues feel this approach will undermine their independence and autonomy and hasten an integration that will damage continuity of care and our patients’ advocacy role. In addition, the current system allows unresourced shifting of [additional] work onto General Practice and although commissioners are in the main sympathetic to the challenges within General Practice, this approach would close off a key ‘safety valve’, from a commissioner perspective.

To some extent this mirrors the uncertainty about the role of ‘Freedom to ‘Speak-up Guardians’ ’ in Primary Care I noted in my last report: what is the value of reporting issues of system safety or indeed issuing alerts, unless something can be done about them, and it is entirely unclear what such Guardians would be able to do.

1. **Responsibility for prescribing between Primary and Secondary/Tertiary Care**

This guidance has just been published by NHS England and replaces the original 1991 guidance document.

There are extensive references to the Hospital Standard Contract within the guidance, and also to the principles of shared care arrangements. I will circulate this to all practice, but it will also assist Medicines Management Teams within CCGs.

1. **Working for online GP providers**

The GPC has published guidance for those GPs thinking of working for an online provider, whether in the NHS or privately; this covers such issues as indemnity, appraisal, employment and sources of professional support.

1. **Pre-registration for prisoners about to be released**

Colleagues will recall that changes in the 2017/18 contract amended the Regulations to allow

prisoners to “pre-register” with appropriate practices, to encourage continuity of care and treatment, which is recognised as being a substantial barrier on prisoner release. In Spring 2018, this process is being trailed in northern England, with the intention that by 2020 this will be standard practice.

1. **‘Third Next Appointment’ collection from General Practice**

This month (March) NHS England is repeating its October 2017 telephone survey of practices to

identify the third next available routine appointment. This will be by a phone call which should last no longer than three to four minutes.

The LMC supports this approach as it gives data which will support the concerns about pressures in General Practice. The third next appointment available relates to a GP appointment; if your appointment system does not offer routine appointments with a doctor, you should explain this as it means the question cannot be answered.



Dr Julius Parker

**Chief Executive**