# GPC ENGLAND EXECUTIVE AND POLICY LEAD UPDATE – May 2019

## GP trainee subcommittee – Zoe Greaves and Sandesh Gulhane

**2018 junior doctor contract review in England**

The subcommittee continues to support the 2016 junior doctor contract in England, which is now in its final round of negotiations with NHS Employers. Key issues for GP trainees are supernumerary status being recognised in the contract, mileage allowances and safeguarding the GP trainee pay premia. The full terms of the review are available on the [BMA website](https://www.bma.org.uk/collective-voice/influence/key-negotiations/terms-and-conditions/junior-doctor-contract-negotiations/junior-doctor-contract-review-2018).

**Future of GP training**

The GP trainee exec committee met with Dr Will Owen, a GP trainee and National Medical Director Clinical Fellow who has been working with the RCGP AiT Committee and King’s Fund to develop a trainee-led position paper outlining a vision for the future GP Training. The subcommittee will continue to engage with this work.

Sir Sam Evington also attended the last committee meeting to discuss his proposal for a pilot scheme of a 5- year GP training set primarily in primary care. The scheme was still under development, with the view of launching the pilot with seven juniors across seven CCGS in London in the next few years.

GP trainees have agreed a policy position for their vision of the future of GP training.

**Targeted Enhanced Recruitment Scheme (TERS)**

The Targeted Enhanced Recruitment Scheme offered a one-off payment of £20,000 to GP trainees committed to working in a select number of training places in England that have been hard to recruit to for the past three years. The subcommittee has been working together with the education and training policy group (ETW) policy group to address the concerns around certain places were funding was not provided. A meeting is being set up with Professor Simon Gregory, HEE Deputy Medical Director, Primary and Integrated Care to discuss TERS and other education, training and workforce topics.

## Sessional GP subcommittee – Zoe Norris

**Pensions**

Krishan Aggarwal has continued to work with the BMA pensions department on pension related issues affecting sessional GPs and has continued to have regular meetings with PCSE, NHS England and NHS Pensions. Next meeting is on 8 May 2019.

**Annualisation**

Regulations that came into effect on 1 April 2019 to the 2015 NHS Pension Scheme removed the one-month concession around gaps in pensionable earnings for Type 1 and Type 2 GPs and removed the three-month concession for locum GPs. The regulations affect those members of the pension scheme who may have taken breaks within the pension year and may have to tier their pension contributions at a higher rate based on their annualised earnings, rather than their actual earnings.

The sessional subcommittee has been working with BMA Pensions and an external legal team to raise a potential legal challenge based on the discriminatory impact of annualisation on certain groups of doctors. GP locums are particularly disadvantaged by the regulations.

At the same time, the subcommittee is seeking further clarification from NHS Pension on how the new regulations are being interpreted and applied, so that new guidance can be released to support sessional GP members.

**NHS email pilot**

The sessional subcommittee has been working with Dr Farah Jameel, NHS England and NHS Digital to progress the pilot scheme which would enable locums GPs in England to get an NHS email address. The final stage of the pilot will be going live shortly. A set of 500-1000 eligible GP locums from various regions across the country will receive an email inviting them to register for an NHS Mail account.

**Death in service benefits**

Krishan Aggarwal has been liaising with BMA Pensions and the legal team on this workstream. The BMA has commenced proceedings in the High Court to challenge the Pensions Ombudsman’s interpretation of the NHS Pension Scheme Regulations and is seeking clarity of the exact meaning of ‘*in pensionable employment’* as it applies to Locum GPs who die in service. The BMA applied for permission to appeal on 27 February and awaits the Court’s decision.

**Model contract for GPs working in non-standard settings**

Following the motion passed at the LMC conference in Belfast recognising the plurality of the roles taken up by GPs across the UK, the subcommittee is exploring the provision of employment guidance and terms and conditions to support GPs working in non-standard settings, in both clinical and non- clinical roles.

**Sessional GPs and Primary Care Network**

The subcommittee has been exploring the implications and the opportunities for engagement for sessional GPs within the newly formed PCNs. A short guidance document has been published to support sessional GPs engagement and representation across PCNs.

**Locum practice agreement**

The subcommittee has worked with GPC exec and BMA Law to develop the [locum practice agreement](https://www.bma.org.uk/advice/employment/contracts/sessional-and-locum-gp-contracts/bma-locum-practice-agreement). This consists of terms and conditions and a work schedule, which together form a legal contract that can be used by locum GPs and GP practices for locum engagements. It is intended to minimise common disputes between locums and practices and clearly outline the type of work that will be undertaken by a locum when working at a practice. It is also intended to protect against locums being categorised as an employee or worker by HMRC for tax purposes or by an employment tribunal for the purposes of statutory employment protection, as well as ensure that there are appropriate arrangements in place for compliance with GDPR.

Background information and FAQs are available on the [website](https://www.bma.org.uk/advice/employment/contracts/sessional-and-locum-gp-contracts/bma-locum-practice-agreement), as well as the following downloads:

* Work schedule and model T&Cs
* Model T&Cs optional clauses
* Explanatory notes

**Elections**

A single national election is currently being held for all 16 seats on the sessional GP subcommittee. Counting rules will be applied to ensure that at least one member is appointed from each regional constituency (listed below) and at least two members are appointed from each of the professional constituencies (salaried and freelance/locum GPs). Representatives will be appointed for a three-year term (2019-20, 2020-21 and 2021-22).

**Sessional GP Newsletter**

The latest issue of the sessional GP newsletter is available [HERE](file:///C:\Users\MLasham\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\YEJFQFVN\%20https\bma-mail.org.uk\t\JVX-690CO-1BJCJOU46E\cr.aspx). If you don’t automatically receive the newsletter, you can subscribe [here](https://r1.dotmailer-surveys.com/00jvxef-632k2x2e?utm_source=The%20British%20Medical%20Association&utm_medium=email&utm_campaign=10114731_NEW16A1%20SESSIONALS%20ENEWSLETTER%20131218&utm_content=Non-member%20sign%20up%20link&dm_t=0,0,0,0,0).

## Representation – Bruce Hughes

We have been working with the Secretariat team on a paper regarding Sessional GP Representation which was presented at the next GPC meeting. We have submitted a request to change standing orders to the Organisational Committee regarding the criteria for Regional GPC elections and being an LMC levy payer. We would like to remove this, it was a recommendation from the Gender Diversity Task and Finish Group.

**Dispensing policy group – David Bailey**

As always any progress over dispensing issues has been frustratingly slow but following a series of meetings between GPC DDA and PSNC we have an agreed basis to begin discussions with DH about a cross profession framework for reimbursement and a shared written framework to discuss.

This would attempt to address problems around generic substitution, zero discount lines, branded generics and retained margins as a part of contract arrangements to drive efficiencies and avoid the future scenario of medicines being dispensed at a loss.

It is intended that these talks will precede separate negotiations about the remuneration elements of the contracts and would lead to some influence over the drug tariff and category M adjustments.

It is envisaged that negotiations would have a single agency (possibly DH) leading for the government side to arrange the structure, with a cash envelope probably agreed by NHSE with some proportionate uplift to reflect recent wider contract uplift.

We hope this would produce a much more predictable and stable environment for dispensing doctors and indeed more predictable outcomes for prescribers who use PA vaccines etc

We have had further meeting with clinicians at DH on the ongoing saga of FMD. They at least understood that the need for bar code scanners across the practice whether dispensing or prescribing was more a function of GP numbers and multiple sites than whether the practice was dispensing. Still no agreement though on payment or inclusion in core specs for GPSoC

**Indemnity Update**

The long-awaited Clinical Negligence Scheme for General practice (CNSGP) was launched on 1st April 2019 in England. A parallel scheme was launched on the same day in Wales. While the transition appears to have been reasonably smooth there have been many queries generated regarding the “wrap around” cover offered by the MDOs. There has been confusion about the exact scope and depth of the cover of CNSGP and the remedies required of MDOs as a result. There have been many anecdotal reports of inconsistent advice from MDOs and complex product structures has added to the unease. This has been a difficult time for BMA staff as we have tried to clarify matters without either promoting or criticising any particular MDO. We have been in very regular contact with all MDOs and continue to meet with NHSE, NHSR and DHSC at least fortnightly to troubleshoot implementation problems.

We welcomed the announcement by MPS that its GP members in England will benefit from government-backed protection against historic clinical negligence claims. While the MDU and the MDDUS remain in negotiations with government on this issue, all GPs can be confident that they remain fully covered both historically and going forwards.

Discussions between Health Education England (HEE) and the BMA’s GP and GP trainee representatives resulted in comprehensive personal indemnity cover for all GP trainees being funded by HEE until qualification. This vital professional protection includes, for example, support with GMC investigations and hearings, assistance with criminal proceedings, protection for Good Samaritan acts, and free medicolegal advice.

**A WORKFORCE STRATEGY THAT IS RECURRENTLY FUNDED TO ENABLE EXPANSION**

**Education, Training and Workforce – Samira Anane**

The focus for ETW has been on how we can retain **ALL GPs at ALL stages** of their careers within the GP workforce. To support this work we are looking at collecting examples of good practice that are already taking place in the country. We are especially interested in seeing how successful schemes have been evaluated and evidenced in supporting GPs in returning to and staying in work.

We are working with NHSE to develop the national offer for the **GP Fellowship scheme** involving newly qualified GPs up to two years post CCT. Liaising with our colleagues from the Sessional and Trainee subcommittees we are committed to ensuring that that the scheme is a positive offer with the emphasis on retaining newly qualified GPs through mentorship and support.

An on going priority has been the **recruitment and retention of GP trainers** to support increasing GP trainee numbers. A specific focus is the reduction of **unnecessary bureaucratic burden** to enable experienced and enthusiastic GPs to take on the role. We are working with the GP trainees subcommittee reviewing the new GP trainee prescribing assessment and inputting into a review of the **GP trainee curriculum** from a broader perspective.

Building on the **Nursing Strategy** paper from earlier this year, we are working with NHSE and HEE to support the development of the **Nurse Fellowship and Supervision schemes**, with the overarching aim of retaining Practice nurses through the provision of structured career paths and career progression.

In England the advent of PCNs will continue to entail us looking at the **wider GP led practice team** including pharmacists, first contact physiotherapists and paramedics. We have contributed to consultations on AHPs and have had regular representation at the **national primary care physician associate group**. We are keeping a close eye on the current discussions and outputs around the **regulation of PAs** and the wider **credentialing** debate working with our colleagues across the BMA and other branches of practice.

For the upcoming session we will be taking up the motions passed at the LMC UK Conference, in particular **identifying and addressing** the underlying reasons for **increased GP suicides** and lobbying for properly resourced help and support for **psychological and professional services** for GPs.

Throughout this session we have had the privilege of leading on and contributing to a huge range of work streams cutting across policy groups; and we would like to sincerely thank our **LMC and GPC colleagues and Secretariat** in helping to support our work. In particular we would like to extend a warm thanks and farewell to **Sarah Matthews the Medical Women’s Federation and Coventry LMC rep, and Mike Parks of Kent LMC and GPC regional rep**. Their valuable and hardworking contributions to ETW over the years have been very much appreciated and we wish them all the best.

**ENABLING PRACTICES TO MANAGE THEIR WORKLOAD IN ORDER TO DELIVER SAFE SERVICES AND**

# EMPOWER PATIENTS AND CAREERS AS PARTNERS IN CARE

## Clinical and Prescribing – Andrew Green

Work has continued on representing GPs on all the current threads of **prescribed drug dependence,** with an appearance before the All-Party Parliamentary Group at Westminster, liaison with the RCGP, several interviews with journalists including BBC national news, and continued input into the PHE review.

Brexit may have been delayed but the **problems with medicine supply** continue, and in March drug price concessions to pharmacies (a good measure of shortages) reached its all-time high of 96 preparations. I met with the Association of British Pharmaceutical Industries to discuss this, with no particular result beyond discovering that they were surprised that it was such a concern to us and anyway, where there were problems with generics it was of no concern of theirs.

I met with NHSE about our concerns about the **Evidence Based Interventions** initiative, in particular about the fact that many CCGs were commissioning a lower level of service than that specified, on the basis that they had previously done a consultation on these conditions and come to their own conclusions. NHSE are not unsympathetic to our view, indeed agree on principle, but feel held back by legal concerns regarding the autonomy of CCGs. They are planning to write to CCGs to encourage them to abide by the guidance but my offer of helping them write the letter does not appear to have been taken up. CCGs are required to have regard to the guidance, and my suggestion would be for LMCs to contact their CCGs and ask them how they have done this, as a CCG not doing so could be open to challenge from a patient denied a treatment recommended by NHSE. The safest way for CCGs to avoid this would be to re-run the local consultation process in the light of the new guidance.

There was a meeting with NICE and other interested parties to bottom out the suggested changes to the **Heart Failure, Asthma, and COPD QOF domains**. This has proven to be a more difficult task than last year’s diabetes review, but hopefully the proposed indicators will help towards identifying those who need most care while avoiding any appreciable increase in workload. These are currently out for consultation, as are NICE’s proposals for additions to other non-QOF indicators into which we have had no input, which raise several concerns, and to which we have responded.

The **Review of Vaccinations and Immunisations** promised in last year’s contract agreement has begun, chaired by NHSE with all the usual suspects in attendance. This is of course a hot topic at the moment with Anti-vax campaigners prominent on social media, however there is limited evidence that this is a factor in the recent slight decline in immunisation rates. The members of the working group have agreed to confidentiality prior to publication of the report but be reassured that our priority will be to try to simplify the complexities of the current system without increasing training requirements or reducing practice income.

**Workload – Siobhan Brennan**

The main work that been done has focused on Telephone triage models in the UK.

Information gathering regarding the types of models has been done vial email and social media to get a reflection of how this model of triage is undertaken, in an attempt to understand the pros and cons of this model of service delivery.

There has been a huge number of responses to Siobhan Brennan, who is currently writing up the information provided into a readable document.

A formal meeting was undertaken to look at options to practically implement this at grassroot level, to try to assist practices that are considering this option.

The role of paramedics in this mode of delivery is being researched and also evidence re delivery of this model of access by nursing colleagues is being reviewed and will be included in the document.

In summary, a document will be created to given advice about Telephone triage to help practices think around demand management in an unbiased way, to allow then to consider it in a measured fashion.

This document will be finished by early June once all the data has been reviewed. Siobhan Brennan actioning this.

**Home visit-review of practice**

A review of the role of home visits in primary care has been undertaken. The main focus has been on trying to clarify a home visit protocol that is fit for purpose but also sensible and safe for both practitioners and patients alike. The role of a commissioned home visiting service is being audited in a small demographic by SB which will provide an insight to helpfully aid PCNs going forward to think about other ways of delivering home visits to those patients that need them. Also the role of a paramedic in providing home visits is being evaluated which will be useful for PCNs going forward in 2019. This body of work will be completed by the end of June.

# THE RETENTION OF A NATIONAL CORE CONTRACT FOR GENERAL PRACTICE THAT PROVIDES A HIGH-QUALITY SERVICE FOR PATIENTS

## Contracts and Regulation – Bob Morley

* Policy group has met to discuss progress on last years conference motions and actions required from this year’s England LMCs conference motions
* Meetings have been arranged later this month with NHS England to discuss addressing concerns with professional performance procedures highlighted in conference motions
* Consulted on and provided comments on 2019/20 GMS contractual changes joint guidance
* Consulted and commented on proposed NHS England communications re follow up of Docman 7 incident actions
* Ongoing work progressing with NHS England to reach national resolution of safeguarding collaborative fees payments
* Liaising with RCGP re concerns over new guidance on safeguarding training requirements
* Further liaison meeting with CQC; agenda included the launch of the new primary care information collection telephone interviews, concerns over digital providers and issues over approach to regulation of at scale general practice; introduced to the new chief inspector of primary medical services and integrated care, Rosie Benneyworth
* Further consultation on draft changes to regulations re serious medicines shortage protocols
* Further work  with ETW policy group and sessional subcommittee, with NHS England and RCGP to finalise policy document for performers list status of GPs leaving/wishing to return from abroad.
* Continue to regularly respond and provide advice and guidance to various C and R issues raised directly by LMCs and BMA members and via list server queries

## Commissioning and Working at Scale Group – Simon Poole

*Commissioning and Service Delivery update*

* The policy lead attended a GPFV Oversight Group meeting on 25 April 2019. This meeting included; an update on the GPFV programme, an update on Primary Care Networks, and a discussion around the future role of the group. The key points from the meeting are below:
  + The group will continue to monitor the delivery of GPFV / contract funding commitments to practices. In addition, NHSE agreed to review the detail of concerns the policy lead raised around funding being used to the benefit of acute providers.
  + At the policy lead’s suggestion, the group agreed to monitor in six months’ time the involvement of PCN clinical directors on STP / ICS boards around the country.
  + The group will be renamed as the ‘Primacy Care Transformation Oversight Group’, to reflect the agreement by the group that it should expand its remit to monitoring the delivery of primary care commitments in the long term plan. The group also agreed the group’s membership should be expanded to reflect the range of stakeholders involved in the delivery of PCNs (e.g. Pharmacists, Local Authorities, Practice Managers, etc.).

*Working at scale update*

* The policy team has contributed to the guidance which provides advice and options to groups of practices looking to establish and develop a Primary Care Network (PCN).

* The policy lead has drafted a blog discussing the opportunities and challenges presented by the development of PCNs.

* The policy lead and colleagues in the policy team will contribute to the preparation of the upcoming PCN Clinical Directors’ conference which will be held at BMA House on 5th June 2019.

* The policy lead and colleagues in the policy team will use the opportunity presented by the next quarterly survey to ask for member’s feedback on their experiences of urgent care and ambulance services, NHS 111, as well as the establishment of PCNs.

# PREMISES, IT INFRASTRUCTURE AND ADMINISTRATIVE SUPPORT TO ENABLE THE DELIVERY OF QUALITY CARE

## Premises and practice finance – Ian Hume

## Premises Cost Directions

We do not have a date for publication. NHS England is still considering their position on outstanding issues; meanwhile, we await confirmation on the outcome of this and when to expect publication. This is compounded by senior officials changing role as part of the integration of NHS England and NHS improvement and the impact of Brexit. We are disappointed with any delay in publishing the premises cost directions, but unfortunately, this is outside our control.

Several LMCs have contacted us because their local offices have stated that the premise cost directions require a lease to be agreed before releasing funds from the ETTF. This is particularly affecting practices which occupy premises owned by NHS property services, and we have made the case that because NHS property services are part of the NHS, then they should as landlords be able to give NHS England suitable reassurances that the property will remain available to the NHS and providing primary medical services. We sought additional legal opinion, and the legal advice is that NHSE can refuse to give a grant where there is no security of tenure, but the absence of a written lease is not conclusive evidence of no security of tenure. The terms of the lease whether written or unwritten would need to be appropriately considered, although an unwritten lease would be extremely unlikely to have an agreed term of 5, 10 or 15 years (which is required to establish the security of tenure).

A formal lease is desirable however given the scenario between NHS property services, and their tenants with regards to the service charge dispute. We are planning to work with NHS England to see if there is a pragmatic solution for this particular cohort.

## NHS Property services

NHS England and NHS improvement have published a letter for practices who are NHSPS tenants which states their commitment to supporting a regularisation of tenancy arrangements and explains the benefits of a formal lease. They want practices to either sign up to a full lease or to a rental agreement letter, which they see as an interim measure, while they continue work on agreeing on facilities management, other services and ultimately lease terms. Where it is evident that providers are failing to engage, they may seek legal recourse. We oppose any form of intimidation, and GPC England remains committed to reaching a negotiated settlement.

Agreements between NHSPS and practices need to be reached after discussion including any commitments from previous commissioners and must be affordable. The lease regularisation programme needs to be backed up by NHS England’s prior offer of reimbursement of some legal costs and SDLT. Practices should not be forced into any agreement which places the viability of the practice at risk and solutions must be sustainable. This would adversely impact on patients.

The letter contained a line threatening legal action if practices did not engage. Advice on the BMA website is clear that practices should engage and identify areas where there is a dispute. They should pay undisputed amounts. We have assimilated evidence from several practices demonstrating the inconsistency of approach by NHS property services and using this to counter claims made by NHS property services legally.

## Premises Review

As part of the 2018 contract deal, GPC agreed that we would participate with NHS England in a premises review. We have been participating in a core steering group and a wider stakeholder group meeting throughout the winter months. NHS England sent a consultative ‘call for solutions’. These were analysed, and NHS England has come up with a shortlist of initiatives, focused on achieving solutions which will address our fundamental concerns. We are now waiting for the draft report to be shared with us.

## Primary care support England

We continue regular engagement, at a senior level, meeting monthly to cover operational issues. Following GPC writing to the chief executive of NHS England expressing its extreme concern after being made aware that a significant number of women had not received information regarding cervical cancer screening after a system error, it has been agreed that Capita will no longer be responsible for this service line and a review is being undertaken by Professor Mike Richards.

**Information Management, Technology and Information Governance policy group – report by Paul Cundy as policy lead**

**FitzGPSoC**

We continue to work with NHSE/NHSD on the replacement scheme for GPSoC, to be called IT Futures.

**IT Operating Framework**

We are still working on the draft IT Operating framework for CCGs and commissioners that will determine the priorities for local investment in GPIT. The main area of contention is the relative influence of CCGs in choice of supra practice level systems (such as a locality digital first systems). We maintain that the 2004 GMS contract provides for practice level choice for all systems including locality or area wide systems and this is ever more relevant with the advent of PCNs.

**UK BioBank and CPRD**

We raised concerns about extensions of the UK BioBank and CPRD research projects to include data from all core GP clinical systems, our concerns being that these new processing arrangements need to be GDPR compliant. We have agreed an approach with UK BioBank and we hope that they will be communicating with practices soon.

**Health Intelligence, CHIS and DESP**

We have expressed concern at NHSE’s approval of the Health Intelligence Child Health Information System product, as it would have placed 3,500 practices in breach of GDPR.

**On-line services**

We are working with NHSE on the 2019/20 contract IT commitments which remain conditional on adequate systems being available. We hope to be able to release joint system specific practical guidance as to how practices can reasonably meet the contractual requirements in relation to redaction and prospective protection of sensitive data.

**LHCREs**

We have expressed considerable concern about a variety of LHCREs that appear to have very poor IG input. It remains my view that under the principles of data protection and the specifics of GDPR and DPA2018 it is very difficult to justify anything other than access or pull on demand systems for sharing records for direct care. “Data bucket” models where every patient’s entire record is placed in a repository in an anticipatory approach cannot be justified when there are no systems that can automatically restrict access to that which is necessary, relevant and appropriate, i.e. allowing the physio to see what they need as compared to what the community psychiatrist would access. In the presence of increasingly complex interoperability and the GP Connect program I would only recommend the use of direct pull and access on demand functionality.

**PCN Data Sharing**

We are aware of draft PCN Data Sharing documents being circulated and have provided initial comments on them

**Good Practice Guidelines for GPs and EPRs (GPGs)**

The GPGs, which are referred to in the SFE, are now 8 years old. They are in need of a revision and the RCGP has been commissioned to provide a report as to how, what and when a revised set of statutory guidelines should be produced.

**NHS App**

We are in close contact with the NHS App development team. Unfortunately take up of the app has been disappointing. We hope to be able to influence its future development so that it has intuitive value for patients and practices alike. We prefer a national approach with a nation-wide NHS branded app.

**GP@Hand**

We continue to monitor the impact of GP@Hand and are reviewing the Ipso Mori report released this week.

**Secretary of State’s IT vision**

We continue to argue that what is needed are basic infrastructure upgrades, we already have pretty efficient functional systems but GPs staring at the sand timer due to connectivity delays is a dreadful waste of valuable NHS resource. This was emphasised by a BMA report which sets out doctors’ vision for IT in the NHS and is a direct response to the [Department of Health and Social Care's own vision](https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/technology-infrastructure-and-data-supporting-nhs-staff)

**SAR Code of Conduct**

The office has been working on the proposed BMA Code of Conduct for GP SAR requests and the ICO is supportive of the proposal. I am hoping a draft will soon be forthcoming.

**Digitisation of the Lloyd George records.**

There are four digitisation pilots running to gain insight into how this mammoth task should be undertaken. Until a national specification has been agreed that will support interoperability via GP2GP we recommend practices to not sign up to local schemes.

**EPS Phase 4**

JGPCIT has recently given its support for further extension of the EPS Phase 4 pilot. We should not be long before full national deployment.

**GPES replacement**

We continue to discuss the replacement for GPES and have agreed an outline approach.