EXECUTIVE AND POLICY LEAD UPDATE – JULY 2021

Conference of UK LMCs – Katie Bramall Stainer

The conference unit has confirmed the booking for the U.K. Conference of LMCs to provisionally take place at York's Barbican on 10 & 11 May 2022. Further details will come in due course. At this stage it is too early to speculate but naturally we would love to see a face to face conference next year.

The chair and deputy chair elect have had a meeting with GPDF. We have also attended the first GPC U.K. task and finish group and are building bridges with our four-nation counterpart conference officer teams. Next steps will include a wash-up meeting and new agenda committee plan for the next year once membership is confirmed after the ARM in September.

GPC Wales Committee – Phil White

Flu Vaccination Campaign
Highly successful campaign. 76.5% over 65, 51% under 65 at risk, 10,000 pregnant women
Low uptake 50-64 because of delay in introduction and vaccine supply

Additional Flu Cohort
Welsh Government announced 50 – 64 will be included next season practice supplied vaccine.

Covid Vaccination Scheme
Health Boards given responsibility for the campaign progressed at speed despite vaccine supply issues.
Mainly Oxford vaccine in General Practice but one or two took trays of Pfizer due to supply issues HB Mass Vaccination centres continue and will probably do most under 50's
Recent announcement by JCVI for a two phase Covid booster programme from September with 70 +, care home residents, care professionals, immunosuppressed over 16, and those over 16 considered extremely vulnerable.
Second phase will include all over 50, adults 16-49 in flu at risk groups and the adult contacts of the immunosuppressed.
Suggestion that there may be co-administration of flu and covid vaccines but not confirmed.
No confirmation if third covid vaccine needs to be different from primary course.

Covid Contract Suspension
Contract relaxation continues, except for Care Home DES, paediatric immunisation, and anticoagulation until the end of September. Some access targets reduced, and reduced Access DES will continue for a further 12 months unchanged.
Dementia DES can be done remotely.
Learning Difficulties ES retired until September 2021
Gradual reintroduction of cervical cytology.
CGPSAT and IG Tool completion postponed until September.
Access Targets paid at April 2020 level, active again April 2021

E-transfer of prescriptions
Top of the wish list and proposals on the Minister's desk. Vital to get GP to Community Pharmacy set up as soon as possible in order to free up hours of GP time, and enable CP to receive scrips as they are issued, rather than a bundle of several hundred signed at the end of the day. Huge workload issue for General practice.

Locum Hub / GP Wales / GMPI
Legal requirement to complete for indemnity cover
Some latitude for forgotten shifts
Scheme in Wales has Health Board named in legal action, not individual GP.

Bonus Payment
Bonus announced by Government just before election lock down
All NHS staff, including GPs and staff employed for at least 1 month 17/3/20 – 28/2/2021
Locums with 8 sessions or more worked in this period as individuals will qualify.
Designed to give £500 to basic rate taxpayer.
Paid in May to NHS Wales employed staff but will be delayed until September for contractors. This is despite practices having provided regular staff updates for over a year.
GP staff feeling like second class citizens.
Considerable disquiet amongst locums as one Health Board has erroneously applied IR35 regulations (HMRC) to all locums, effectively excluding many from receiving a bonus. Discussions continue.

Appraisal and Revalidation
Having both been suspended for 12 months there will be a reintroduction on 1st April 2021, with doctors expected to complete within their allocated quarter.
Last year will be regarded as "Approved Missed".
At present, remote meetings are the norm and will concentrate on the wellbeing of practitioners.
It is expected that many "due" revalidations may be deferred to allow time for doctors to prepare.

Death Certification Process
New system with a Medical Examiner being introduced (England and Wales)
Less than 5% of GP patient deaths likely to be stage 2 reviews for community deaths.
Agreement with Welsh Government for a simple Significant Event Analysis type process.
Further England and Wales negotiations to take place regarding the complexities of the workings of the whole scheme.

111 / OOH / GMS / ED Interface
No direct booking with GP without clinician discussion
Two-way interface
111 not yet fully rolled out nationally
Ongoing discussion

Training in General Practice
Current proposals to increase time sent by medical undergraduates in General Practice will increase demands on estate capacity, though additional funding should enable time to be allocated.
FP2 attachment to practice has proved to be a useful boost in interest in General Practice.
HEIW looking at training others in General Practice but there are considerable issues of room within buildings and GP time.

Mention of pre reg pharmacists doing 4 months, Advanced Nurse Practitioners, Physician's Associates, Pharmacists doing independent prescribing courses, Paramedics doing similar, and practice nurse training. They seem to overlook the day job and given the increasing pressures on General Practice from a workload perspective, there may need to be a major review of how to go about this additional training.

Premises Review
As mentioned above, major issues of restrictive premises as additional staff / training added to General Practice. Independent Review has been undertaken. Again, conclusion is on the minister's desk.

Remuneration Increase 2021 – 2022
Minister will consider DDRB report
Expected July?

Ongoing Contract Negotiations
Government want list and GPCW want list being prepared
Looking for a major rationalisation of the contract.
Then we crunch the two together.
Much depends on the Covid outlook

A WORKFORCE STRATEGY THAT IS RECURRENTLY FUNDED TO ENABLE EXPANSION

Education, Training and Workforce – Samira Anane

Meeting with HEE on GP retention
This month, Paula Wright and I met with HEE leads to discuss the support that they provide to GPs on the national GP retention scheme. The meeting was arranged on the back of a survey carried out by NHSE in 2020 showed that female RGPs in particular felt their support to be deficient in certain areas. The meeting was a helpful introduction to working collaboratively in this area, with HEE welcoming our input and proposing that we hold a joint meeting with their educational leads to discuss potential local improvements.

ENABLING PRACTICES TO MANAGE THEIR WORKLOAD IN ORDER TO DELIVER SAFE SERVICES AND EMPOWER PATIENTS AND CAREERS AS PARTNERS IN CARE

Clinical and Prescribing – Preeti Shukla

Weight Management Enhanced Service
The new Weight Management Enhanced Service was announced to the profession in June [17/6/21] by NHSE/I [Letter C1302]- **without BMA support.** The programme offers both digital access to weight management services and face to face support for those with obesity plus either diabetes, or hypertension, or both, accessible freely by e-referral from all general practices in England. Officially launched 1 July the programme forms part of the Government's obesity strategy.

It allocates £20m to practices for weight management referrals. This is a tiny amount of money meaning there is a cap on funding per practice - which could limit people who could benefit from it.

During negotiations earlier this year, GPC raised concerns about impact that this enhanced service would have on GP workload. Concerns were expressed about the pressure to raise the issue opportunistically with patients. Particularly the risk of driving patients away from presenting at practices for anything, for fear of being told they're obese and having a hard conversation. GPC queried the weak evidence base for the accompanying digital programme - which is based on findings from the Digital Diabetes Prevention Programme (DDPP) 2017-2020 setting out average weight loss of NDH cohort of about 3kgs at 6 months, maintained at 12 months. Our position is that the service is clinically flawed and will make little to no impact for patients. In addition to this it is overly bureaucratic and adds to workload at a time with the profession are at breaking point. Participation remains voluntary for practices.

Gender dysphoria
The policy group continue to lobby for proper services to be commissioned for gender dysphoria patients, and met with the BMA's Ethics, Equality and Inclusion, and legal team in June to discuss the

BMA's work in this area and next steps. We are in the process of updating our guidance for practices and are also working with the Ethics and Equalities teams in producing new ethical guidance following an ARM resolution last year. We have recently met with Dr Hillary Cass, chair of an independent group (Cass review) reviewing gender identity development services for children and adolescents, and we will continue to be involved in the process along with the Ethics Committee. We are meeting with the GMC on 16 July to discuss their guidance on bridging prescriptions. We are aware about concerns in relation to 'Gender GP 'and are currently working with wider BMA teams to reach a solution including raising the issue with GMC and CQC.

PrEP meeting
There have been initial discussions about what expanding PrEP accessibility could look like. As part of the BMA's public affairs activity on public health funding we have raised the lack of funding for sexual health services with MPs and other stakeholders. We discussed the need to consider digital solutions and pathways in prescribing the drug (PrEP) as well as the need to build shared care agreements between sexual health services and local GP practices to prescribe PrEP and provide more support for patients. The Policy group would formulate an internal position.

Community Pharmacy consultation service (CPCS)
Practices are slowly increasing referrals to the Community Pharmacy consultation service (CPCS) with around 2,500 referrals per week now in England. Referrals back to Practices remain at 10%.

Consultations
The policy group has responded to a consultation of RMOC shared care guidance: draft shared care protocols for Methylphenidate in adults, Lisdexamfetamine in adults and Dexamfetamine in adults. We outlined our concerns about the shared care guidance due to the lack of appropriate specialist services, and that we are worried that primary care will be inundated with requests from patients who have sought initial consult with private clinics and ongoing monitoring and handling complications will be left to NHS GPs. We also highlighted that patient safety is paramount.

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

Premises and practice finance – Gaurav Gupta

NHS Property Services – service charge disputes

Background
The BMA is supporting five test claimant GP practices who have received demands from NHS Property Services (NHSPS) to pay inflated service charges based on its "full cost recovery" approach, outlined in NHSPS' Consolidated Charging Policy ('the Policy'). These court proceedings were brought against NHSPS for a declaration that the Policy does not form part of their tenancy and therefore NHSPS cannot base their charges on it.

After years of stating otherwise in 2020 NHSPS conceded that the Charging Policy was not automatically incorporated into NHSPS tenants' occupancy arrangements. In the 16 November hearing, and subsequent judgement, the Court agreed, and established that because NHSPS has conceded the point, declarations to that effect were not necessary. Consequently, NHSPS can no longer rely on the Policy as the legal basis for demanding the payment of increasingly exorbitant service charges.

NHSPS has elected to counter-sue the five practices involved in the case. Given that it has been established that the Policy has no legal force, it now falls to NHSPS to establish alternative grounds for the levying and recovery of the disputed service charge amounts.

It is extremely unwelcome that NHSPS has chosen to sue practices in the midst of a once-in-a-lifetime pandemic, where GPs are playing the key role in the rollout of the vaccination programme

whilst also doing their best to manage an ever-growing backlog of care as a result. While we remain confident that these cases will produce a favourable outcome for the practices involved, and will demonstrate that NHSPS's approach is deeply flawed, we continue to work towards the development of non-litigative solutions to these disputes.

Update
We continue to engage (via lawyers and directly) with NHSPS to explore an Alternative Dispute Resolution as both an option to address the disputes of the five practices involved in the case, and potentially as a template for the resolution of hundreds of outstanding disputes between NHSPS and practices across England.

We are working on behalf of the 5 practices to ensure that they could access the information they need in order to consider an alternative dispute process. We continue to work with NHSPS on behalf of the practices to explore all possible solutions. If it is not possible to get an acceptable out of court settlement, then the issue will be decided by the ongoing court process.

NHS Property Services- operational engagements
We are scheduled to meet with the chief executive officer and senior staff from NHSPS to discuss business as usual matters in mid-July (whilst litigation is ongoing). By maintaining this relationship, we have been able to resolve issues as they arise, including successfully pressuring NHSPS to drop threats of legal action against several practices.

Premises Cost Directions
After almost two years of delays, in November 2020 we received a confidential full draft of the revised Premises Costs Directions (PCDs) from NHSE. In January 2019 GPC submitted its review of the draft PCDs, but by November 2019 DHSC and NSHE had returned with a further list of proposals and outstanding issues, which have been worked into this most recent iteration by DHSC lawyers in the months since. Many of the further changes sought by DHSC and NHSE are significant. The draft is currently under analysis by the BMA legal team. In early May the premises team met to review the changes and are working with legal colleagues to draft our response.

Community Health Partnerships – operational engagements
We met with the senior team at CHP in June and progressed discussions on direct payments, their dispute resolution process, and the future of premises improvements through ICSs. In July we had an introductory meeting with the new CEO of CHP Wendy Farrington-Chadd who will take over from Dr Sue O'Connell who has led the organization for 17 years. We have agreed to maintain regular meetings addressing any arising issues that practices contact us about and reflected that it has been a constructive relationship.

We were recently alerted to CHP contacting some practices to say that they will start charging the practices for services they were already providing. We escalated this with CHP, and they admitted it was a mistake. They have agreed to roll back the proposed new changes.

Capital allowances and ETTF
We have received reports from practices who have been informed by NHSEI that ETTF funding will be withheld unless GPs agree to sign clauses waiving their right to claim capital allowances- even on the funding provided by GP partners themselves. It seems that the concern is that they will receive a 'double benefit' and NHSEI feel it is incumbent on them to protect the public purse. But what it means is that a private company would be allowed to benefit from an investment where the GPs cannot. We have received legal advice on the matter and have drafted a letter which will be sent to NHSEI requesting clarity on the issue.

Primary Care Estates Ownership Reformation programme

NHSE&I has instructed Primary Care Commissioning (PCC) to lead the development of the Primary Care Estates Ownership Reformation programme. We see this as a continuation of the Primary Care Premises Review 2019, with ownership as one of the key themes.

NHSE&I are in the process of finalising the report and recommendations on Primary Care Estate Ownership. The report will be reviewed at the next Programme Board meeting, which is scheduled to take place in the next few weeks. The report is expected to be out for formal public consultation by mid-Summer 2021 for a minimum of two months when all member organisations of the advisory group will have another opportunity to comment on the proposals.

Information Management and Technology Governance – Anu Rao

NHSX Data strategy

GPC has provided feedback on the data strategy though bilateral meetings with NHSX and will be put forward its position in the BMA-wide written response.

GP Data for Planning and Research (GPDPR)

BMA remains engaged with NHSD and NHSX over this programme, its scope and scale, rollout and communication of the changes being made. We have made representations to senior members of both organisations outlining our concerns and are confident that these have been heard.

Continuity of GP Records (digitisation, GP2GP)

The programme for digitisation was handed to NHSE/I by NHSX and we understand that E/I are carrying out a review before going any further. We do not expect that the review will suggest stopping the programme, but rather how best to proceed. GPC is taking updates on GP2GP via JGPITC to better understand how to improve the service.

Vaccine status certification

The NHS app will have functionality added to it to allow users to display their vaccine status for the purposes of international travel. This data will flow directly from national stores rather than GP records.

Shared Care Records

GPC are advising on the information governance framework and structure for the expansion of Shared Care Records. We have asked for a high-level national briefing on this which we expect soon. Following this meeting we will feedback on the outcome

COVID19 vaccination programmes

GPC are continuing to receive updates on this and are relaying concerns expressed by members to relevant national teams. The focus remains ensuring that the continuation of the programme avoids placing additional burden on practices. We raise any queries received via the LMC listserver at these regular meetings

GP IT Operating Model

We hare meeting with colleagues to discuss next steps on this following written feedback on a draft document

NHS App

In light of significantly increased downloads of the NHS app due to the ability to display vaccine status, BMA is engaged with NHSX to ensure no additional burden is passed onto GPs to process new registrants to the app.

PCSE task and finish group – Ian Hume

New GP pay and pension system

By necessity, our PCSE work over the last period is focused on the new pay and pensions system (GPPP), introduced on 1 June 2021, ahead of the decommissioning of NHAIS. All GP payment and pension transactions now go through the PCSE online portal. The GPC team engaged with Capita and NHSEI throughout the process, culminating in the much-delayed launch. We were repeatedly assured that the system would not go live until it was in a fit state. We were told that extensive testing had confirmed the integrity of the GPPP portal before the go-live decision. We naturally approached the launch with caution and were told to expect some 'teething' problem early on, which would be expected in a project of this scale. To mitigate risk, we attend their early life support meetings.

Over the first six weeks of the system, it has been apparent that the myriad issues faced by GPs, practices, and accountants in using the new system cannot reasonably be described as merely 'teething' problems. The high volume of issues identified right across the system have understandably further diminished the profession's confidence in PCSE.

Overall, the portal has been described as 'clunky', 'messy' and much worse. Historical data imported into the new system has arrived with crucial information and descriptions stripped out and whole years of statements missing. Locum and solo performers have been left trying to figure out what work their statements refer to as work for different employers have been amalgamated into a single total as if there was a single employer. PCSE assure us that the data which has failed to import is not lost but, while that is likely, we have yet to see the evidence.

Practices have reported receiving payments without sufficient attendant detail to immediately know what they are for or whether they are correct and even double payments for QOF achievement. Pension deductions have been taken for the wrong GPs and not taken from the right GPs. The list goes on.

Many users then have their existing frustrations exacerbated when they try to log their issues with PCSE. We have received reports of large numbers of queries raised using the online forms not receiving replies, let alone solutions. Similarly, those who have chosen to phone in their questions find themselves talking to customer services staff who have very little understanding of the issues and bluntly say so or offer unsound advice and information.

In short, the user experience has so far been unacceptably poor. GPCE, with the Institute of General Practice Management, wrote to NHSE's Chief Commercial Officer on 21 June, setting out the many concerns and seeking assurances that swift improvements will be forthcoming. We are waiting for their reply.

We are currently meeting with PCSE and NHSE three times weekly to raise and pursue the issues we see. This is a frustrating experience increasing our concerns about their ability to grasp our agenda's relevance or importance. Some progress is being made slowly. This week, PCSE stated that 26 of approximately 100 identified functional defects had been fixed, with the expectation of around 40

more 'fixes' due to be put in place next week. Additionally, we are told that the current global sum payment run is going smoothly, and expected sums are reaching practices. PCSE appreciate that we remain skeptical until we have confirmation of a successful outcome.

We monitor the progress of issues as they come up and will continue to challenge PCSE for all the corrections necessary for as long as it takes. While we believe the system-wide 'fixes' should improve the current user experience, we fear that the 'bedding in' period will be protracted, and issues affecting individual users will continue for some time.

With this in mind, we are looking to focus on PCSE's customer services work performance. As already mentioned, this is a cause of growing concern, and there is a particular lack of transparency around that work we are challenging. We are just about to embark on a short piece of work with an LMC, which we expect to provide clear evidence of shortcomings in response times, the quality of advice being given to users, and more.

This has been an area of poor performance for PCSE long before introducing the new system, and we were continuously assured that all the necessary resources would be in place to support users as of 1 June. This is entirely at odds with PCSE now openly stating that they have been recruiting and training staff post-1 June while simultaneously telling us that levels of queries raised to the customer service centre have been considerably lower than anticipated.

The Pensions committee is due to send out a survey to GPs to capture their experiences of the system next week, and we would encourage everybody to respond to that if they can. That will be followed in the coming weeks by a similar survey for practices, likely to focus on the accuracy and timeliness of the receipt of payments. Both could be invaluable in supporting our arguments as we progress and will help inform where we take things from here.

It is still early days, but the first six weeks have shown us that PCSE has a considerable amount of work to do to get close to what the profession was promised. The GPC team will continue to challenge Capita and NHSEI to make improvements.