# EXECUTIVE AND POLICY LEAD UPDATE – January 2021

## GPC England update on COVID-19 - GPC England Executive

### Update on activity

Since the last committee meeting in November, we have seen significant developments, with the number of cases and mortality rates exceeding those of the first wave, moving to a further national lockdown, and the launch and progress of the COVID vaccination programme. An update on the vaccination programme will be provided separate to this update.

The GPC England executive team and Chair of Sessional GP committee have continued meeting with NHSEI to discuss COVID related matters, in addition to weekly meetings to discuss the COVID vaccination programme.

We've had wide ranging discussions on topics including CCAS staffing and capacity, roll-out of the NHS111 first programme, progress of the annual flu programme and planning for next year, issues for specific types of practices, supporting practices with staff sick with long-COVID, testing for practice staff, COVID risk assessment tool, support for general practice, workload prioritisation and income protection.

### Support for general practice

Following pressure from GPCE, NHSEI launched guidance and support for university practices experiencing issues due to lack of patient registrations in the normal fashion. This advised CCGs to provide similar levels of funding to previously so that practices can maintain their existing workforce and clinical services.

In January, we secured further contractual relaxations, income protections for practices at both national and local level, and additional funding, following the announcement of the national lockdown and the need to free up practices to prioritise the COVID vaccination programme. NHSEI's letter highlighted the following measures:

- minimise local contract enforcement
- suspend any locally commissioned services, with payments maintained
- redeploy clinical CCG staff to support practices
- additional funding for clinical directors in managing the vaccination programme
- Minor Surgery DES dropped with income protected
- QI indicators dropped with income protected
- Further QOF indicators dropped with income protected
- Appraisals to be deprioritised

This is in addition to the previous relaxations, income protections, and additional £150m funding for expanding capacity.

We also updated the BMA-RCGP workload prioritisation document, to provide further guidance to practices through the national lockdown.

We have continued to update our general COVID guidance to practices, as well as the COVID vaccination guidance.

## GPC Wales – Phil White

Happy New Year to you all. Let us hope things get better in 2021, after a dreadful past 10 months.
We have been involved in discussions concerning Covid pressures on WAST, OOH and Hospitals, Covid vaccination scheme with little time for anything else!

### Flu Vaccination Campaign

Welsh General Practice can take the plaudits for being the main driver in this year's flu vaccination campaign.

For the first time, over a million doses have been given in Wales.
Uptake is at an all time high, with 75% + of over 65s being vaccinated and almost 50% of at risk under 65s.
Almost 55% of 2 – 3-year-olds have been vaccinated.
Exceptional performance in this, the most difficult of all years

## Additional Flu Cohort

Very late in the day came the announcement from Welsh Government (online rather alerting practices first) that the previously announced expansion of coverage to the 50 – 64-year-old cohort was to proceed, and the additional vaccines procured by Welsh Government centrally would be made available.

However, the late nature of the announcement meant had missed the boat, and many of those who had shown great interest at the initial expansion announcement seemed to have lost interest and were now more concerned with getting a Covid vaccine. However, we still managed an almost 34% coverage to date.

Once again, we have pleaded with Welsh Government to announce as soon as possible what they intend proposing as cohorts next year so that we can plan accordingly.

## Covid Contract Suspension

We lobbied hard on behalf of the GP Profession for reinstatement of contract relaxation as during the first wave of the pandemic (March – September). On 17 December we received a letter from Welsh Government which reverted enhanced services to the same position as during the first suspension (including payments and PPV) and suspended other areas such as the COVID QI project and some cluster activity. However, we are unclear over certain aspects and await a reply from Welsh Government to our queries. Welsh Government officials were keen to stress at the time that the suspension is purely for Covid work pressure.

We are in the process of preparing a Focus On document to explain the changes to our constituents and expect it has been issued by the time you receive this.

According to a statement made by the Minister at a press conference (11th. January 2021), Welsh Government are open to further contract relaxation to allow us to undertake Covid Vaccination Campaign. GPC Wales has relentlessly made the need for such a relaxation known to Welsh Government officials. We await further details.

## Covid Vaccination Scheme

Despite our suggestion of an Enhanced Service or a Service Level Agreement to allow us to start immunising, Welsh Government decided to commission, via Health Boards, a Primary Care Covid 19 Immunisation scheme that they hope will involve pharmacists, dentists and optometrists in addition to ourselves. This enables Health Boards to commission us to provide the service should they wish us to.

Most have now opted for GP involvement as we are recognised as the efficient vaccinators of the NHS, but there is flexibility to provide the service either as individual practices, groups of practices or clusters. The fee structure is standard across the UK, £12.58 per vaccine, but we have secured £400 per 1000 vaccines to assist with costs as we know that this work will, once again, incur additional staff costs.

It is our belief that we should enter vaccination data through our practice systems, as this is how we undertake the Flu campaign, and it is a tried and tested method. We do not feel that the Welsh Immunisation system meets our needs, but we are happy for data to be extracted for statistical purposes.

We are also encountering issues of vaccine supply but have told Welsh Government that to proceed at pace we need bulk supplies up front, and not a drip feed of small vaccine quantities.
Despite the directive that vaccines be only used for target groups, we feel it indefensible to waste left over vaccine, especially as some have managed 12 doses from a 10-dose vial. It is reasonable to use any “wasted” vaccine to cover any practice or attached staff who are not yet immunised, particularly given that they are a priority group within the JCVI cohort.

### Locum Hub / GP Wales

There has been extensive discussion with SSP regarding the abrupt introduction of this recording system as a prerequisite of providing indemnity to sessional doctors. We have an admission that it was badly handled, and that we were not fully consulted.

Currently we are attempting to reduce the bureaucracy to a minimum and extend the deadline during the Covid crisis and we await a response.

Legal opinion has confirmed that Welsh Government can apply terms and conditions to the provision of indemnity, and the tendering process appears to have been correct.
We have also raised objection to the title GP Wales as this could easily be confused with GPC Wales inadvertently.

### Appraisal and Revalidation

Both we and the RCGP Wales have been lobbying for suspension of appraisal and revalidation until the Covid Crisis is over. We are pleased that the Chief Medical Officer confirmed on the 11th January that the option for an 'approved missed' appraisal period will be extended to the end of March 2021.

## England LMC Conference – Shaba Nabi

As you know, the 2020 LMC England conference was held virtually on 27 November. You can find the link to the recording of conference here and to the final list of conference resolutions here. My thanks to all those members of GPC and LMCs who were able to find time in their incredibly busy schedules to represent their colleagues during such a difficult time for the profession.

I would also like to once again thank Rachel McMahon, the out-going chair of England LMC conference, not only for her chairing of conference on the day, but also for her leadership in delivering our first ever fully virtual conference. The many people involved in organising conference behind the scenes know just how great of an achievement that was.

I'm pleased to introduce my agenda committee for this session's conference: Elliot Singer (deputy chair), Roger Scott, Zoe Norris, Matt Mayer, Simon Minkoff, and Paul Evans.

Elliot and I, along with the rest of our agenda committee, are already in the process of thinking about what we think this session's conference will look like in collaboration with our secretariat staff team, the GPC England Executive and our elected LMC conference colleagues at UK and nation level. We will continue to keep you updated.

If you have any thoughts or ideas about the structure of conference please do drop us a line at info.lmcconference@bma.org.uk. This is very much the profession's conference and we are here to listen to you.

## Representation – Bruce Hughes

Rachel Ali had been appointed as the GPC Gender Diversity Champion. Rachel had introductory meetings with the GPC chair and the BMA's Equality Diversity and Inclusion team to start developing the role.

Aims for the 2020-21 session:

- The gender diversity champion will continue to work alongside the culture and inclusion oversight group and other BMA equalities champions and to explore gender diversity on GPC and consider encompassing other protected characteristics within the role

- Conduct a second survey via the GPC Gender task and finish group, including questions specifically related to sessional GP representation including representation in Scotland, Wales and Northern Ireland and for feedback on the multi-member constituencies paper

- Work with the Sessional GP Committee on a proposal for sessional representation on BMA committees and to evaluate the recent changes designed to improve Sessional GP representation

- Form the 'GPC UK future remit task and finish group' as per the membership outlined in the terms of reference agreed by the representation policy group

## 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

The clinical and prescribing group continue to liaise with NHS England's long COVID task force regarding the roll out of **Long COVID clinics** and the importance of communication to primary care and patients. In specific we raised the impact of long COVID on healthcare professionals and need of occupational health support.

We had a joint meeting with BMA's medical ethics with Dr Hilary Cass who is leading the review on Gender identity services for children and young people and expressed our concerns regarding lack of services and need for a special commissioned service for young people and the effect of Tavistock vs Bell judgement.

There has been another meeting with the **Priority prescribing working group** where we continued to discuss the commissioning framework for optimising prescribing of medicines which may cause dependence and withdrawal of the Public health England Prescribed Medicine Review.

There has been little push from NHS England over the past two months and very little take up for practices new to the **Community Pharmacy Consultation Service (CPCS)**. This is due to the resurgence of COVID. Numbers of referrals of patients from the pilot sites continues to rise though slower presently.

We have had discussions with the PSNC and Royal Pharmaceutical Society regarding **drug shortages should a no deal Brexit have occurred**. We have also had a meeting regarding the utilisation of **serious shortage protocols**, and other ways to reduce practices workload in this relatively common matter. A report from Department of Health and Social Care is expected soon.

We have attended a **primary secondary care interface working group**, where we discussed the RMOC (Regional Medicines Optimisation Committee) draft for a standardised shared care contract for medications, as well as the workload shift from secondary to primary care, which has increased during COVID. Out-patient transformation is also a risk to general practice as more work is taken up by GPs pre and post referral, especially with the increased use of advice and guidance pathways.

We have also attended another **measures and indicators group** – they are evaluating what measures are helpful given the pandemic.

We have published a **joint statement with RCGP on 'Cancard'**– a 'get out of jail ID card' for patients using cannabis for medicinal purposes which we would advise GPs not to sign and leave for specialist prescribers.

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

### Commissioning and Working at Scale Group – Chandra Kanneganti

#### Meeting with Ian Dodge on Primary Care representation on ICS boards.

Following their letter of 16th October, the Chair of GPC England, the policy lead, the deputy policy lead and another member of the CSD policy group met with Ian Dodge to discuss the issue around the representation of primary care providers on ICS boards.

Ian Dodge and Bill McCarthy from NHSEI announced that they were working on some proposals for ICSs and would welcome the BMA's contribution.

### NHSEI's consultation on legislative changes.

The policy group contributed to the BMA's response to NHSEI's consultation on legislative changes.

### PCN Survey

The policy group discussed the new version of the BMA's annual survey of PCN Clinical Directors. The policy group was also consulted on the results and the PCN survey report.

### Workplan

The group discussed and updated its workplan for the new year. The workplan and list of new members of the group are attached to this update.

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

## Premises and practice finance – Gaurav Gupta

### Primary Care Estates Ownership Reformation programme

NHSEI 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.

In November we were invited to take part in what PCC has characterised as "informal engagement" on a series of recommendations. Feedback from the Premises and Practice Finance Group, as well as GPC premises policy leads, emphasised that there is a need for the prioritisation and ring-fencing of funding for the primary care estate, and that any changes to the ownership framework reflect the needs of General Practice. A further series of recommendations were provided to the BMA on 23 December for consideration under the same "informal engagement" approach. Our feedback was similar to what we had to say in the November round, though we have raised significant concerns about the timing of this consultative exercise given the pandemic and pressures associated with the rollout of the COVID-19 vaccination programme. We will keep GPCE apprised of this programme as it develops, with a focus on further opportunities to comment in the forthcoming "formal" phase of engagements.

### NHS Property Services – service charge disputes

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.

In our updates in the final months of 2020, we outlined that NHSPS had, after years of stating otherwise, conceded that the Policy was not automatically incorporated into NHSPS tenants' occupancy arrangements. In the 16 November hearing, and subsequent judgement, the Chief Master of the High 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.

As noted in our previous updates, 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 of course extremely unwelcome that NHSPS has elected 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 approach is deeply flawed, we continue to work towards the development of non-litigative solutions to these disputes.

To that end, we have persisted in our efforts to engage (via lawyers and directly) with NHSPS to explore 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.

### NHS Property Services and Community Health Partnerships – operational engagements

We have continued our regular meetings with chief officers and staff from NHSPS whilst litigation is ongoing. By fostering this relationship, we have been able to resolve issues as they arise, including recently successfully pressuring NHSPS to drop threats of legal action against several practices.

Similarly, we have regularised our meetings with Community Health Partnerships (CHP) senior executive team. These engagements are consistently constructive and have enabled us to gain a better understanding of the CHP estate, policy and processes.

These meetings with NHSPS and CHP serve as valuable opportunities to work through operational issues and to escalate immediate problems faced by practices. Practices who are unable to resolve these issues with NHSPS or CHP should nevertheless escalate via their LMC in the first instance.

## Information Management and Technology Governance – Anu Rao

### National Immunisation Management Service (NIMS)

GPC have been engaging with colleagues at NHSD, X and E/I on a weekly basis to raise ongoing issues with the COVID19 immunisation campaign and consult on proposed changes. All four of the core GP IT suppliers are set to go live with clinical reporting functionality for vaccinations, however no final timescales have been given. Pinnacle continues to suffer sporadic outages, however many of these are resolved relatively quickly. Following a request from GPC via JGPITC, NHSE/I are considering what external IT and admin support they can provide to practices both at present, and in a potential scenario in which practices beyond those designated to administer vaccines are expected to begin vaccination.

### GP IT futures

The GP IT Futures expert advisory group has reconvened and includes representatives from BMA. GPC received an update on some of the strategic aims of GP IT Futures during a JGPITC Liaison committee meeting. These aims include specialised support for new market entrants and the adoption of open standards with a view to all GP IT systems being directly interoperable with one another (as opposed to via GP Connect) within about 10 years.

### Access to records

Sharing of PHRs for direct care. Looking into the governance and the various ways that this can be implemented for example GP connect. Further meetings planned to ensure the systems are streamlined and principles of data sharing is followed. Update will be provided in full at the next GPC meeting.

### GPES extract for COVID19 planning and research & GP Data for Planning and research

In January at JGPITC Liaison meeting, members of GPC held a discussions with RCGP and NHSD over proposals to unify existing extracted GP data in a single place for both direct care and secondary uses. GPC lobbies against

this and discussions are ongoing about the extent to which expanded extracts that have been taking place for COVID19 research and planning may continue post-Covid.

### GP Appointment data

GPC is in dialogue with NHSE/I about how appointments in general practice are defined. We remain committed to ensuring that appointment data that is collected is not used to 'score' practices and that data collection takes place with minimal disruption.

### GP Workload reporting tool

NHSD intend to replace the current GP workload reporting tool with one that has been designed in-house. The aim of this is both to make the process of reporting easier and to improve the range and accuracy of data that are collected in order to set a baseline against which to judge progress on conservative manifesto commitments to expand the number of available GP appointments and grow the workforce. Many questions remain about the purpose and effectiveness of replacing the existing tool. As a minimum, GPC has argued that no communications should go out to practices and no changes made until immediate pressures have subsided.

### VDI

The programme will initially rollout licenses to regions to prioritise those who need it most. There is a possibility to scale up the amount the VDIs available in the short term in a limited sense and GPC remains in discussions about how to scale up to the extent needed for national coverage.