EXECUTIVE AND POLICY LEAD UPDATE – July 2020

England LMC Conference – Rachel McMahon

The conference of England LMCs agenda committee have met to discuss the annual conference, which is scheduled for Friday 27th November 2020. We feel that it is essential in these unprecedented times for the voice of LMCs to be heard, and we will do everything possible to achieve this. Please **save the date of Friday 27th November 2020**, as we will be holding a conference either virtually, or in person, depending on the state of play at the time. We will be providing regular updates on our plans over the next few months and look forward to receiving motions for debate as usual (closing date noon on Friday 18th September).

GPC Wales – Phil White

In place of individual reports this is a single statement to explain activity! The executive has been in regular contact with both WG and RCGP along with the several "captains" who have been charged with sorting out the NHS during the Covid19 Crisis.

COVID-19

PPE

Still trying to ensure all are receiving the best recommended equipment for different clinical scenarios, new guidance issued. Remains an issue in some areas. New process of weekly deliveries to practices being instigated in line with need. We have clarified to WG that Hubs should not be prioritised over practices and that PPE should go to those that need it not based on hub engagement. We have been advised on variations in what LHB's are prepared to pay for under COVID19 based expenses, some won't pay for ANY PPE even that obtained before it was available e.g. eye protection.

IT

- Remote connection from home computers available.
- Video consultation enabled to allow for discussions with patients, and a separate solution for discussion with secondary care colleagues. Excellent uptake of the software across Wales. Email access for all we have been advised is up and running. However, there are two systems in common use. AccuRyx which integrates very well with practice systems, and the NWIS commissioned Attend Anywhere which does not! May have a spat about which programme should be commissioned in future.
- Concerns about increased workload generated by secondary care remote consultations generating need for primary care blood tests and prescribing at a time when Covid precautions have caused saturation of appointments. Unfunded additional work cannot be undertaken without resource.
- Control of Patient Information (COPI) regs relaxed due to pandemic which means NHS can access patient level records easier. We are monitoring IG and will ensure return to pre-pandemic rules when appropriate.
- Urgent need for e-prescribing to be introduced in Wales to overcome the difficulties we have been experiencing with reduced pharmacy access, and to enable direct secondary care prescribing.

Locum Work

- A new salaried contract for locums, from 4 hours and upwards has been issued. It may benefit a number of sessional doctors. However, please note that while we have taken the opportunity to improve elements of it, is not a co-badged agreed contract with GPCW. Death in service remains a major issue as doctors coming out of retirement, those who have taken their pension or who are on a pension holiday remain uncovered. There is a proposed flat rate benefit proposed by the UK Treasury, whereas Scottish Government have committed to cover this for all healthcare workers during COVID-19. We have written to WG asking for the Scottish route to be considered.

- GP Wales introduced – the locum register has been incorporated into a new website that enables GPs to show availability to practices, and to enable online booking. Should enable recording of income for tax purposes. We have sought a legal opinion as it now appears to be compulsory to be on this locum website (which has been commissioned by Welsh Government with an unclear tendering process) to qualify for indemnity. This is beyond what was originally described, where merely registering as a locum on the Welsh register was enough.

Sickness reimbursement

- Ensuring swab tests for GPs / Family members. Remains rather patchy across Wales. Test turnover time remains and issue and is hampering test and trace. Confusion about antibody testing as a diagnostic rather than screening tool.
- Ensuring business continuity plans in place in the event of practice having to self-isolate as a result of test and trace.

Cluster working

- Ensuring that clusters make decisions based on local need rather than top down solutions. Some cluster leads felt bullied. Cluster funds and staff being diverted into what could be considered secondary care developments. Proposal by one HB that only half of excess expenditure due to Covid19 will be covered by cluster funds. We are pushing for central reimbursement that covers all excess Covid19 expenditure for all practices.

Appraisal and Revalidation

- Suspended in Wales until further notice

Death Certification

- Relaxation in regulations, remote viewing of a body now acceptable.
- UK wide and subject to individual coronial and cremation officer attitude and beliefs. New guidelines on the way – BMA and RCGP
- Single signature Cremation Certificates
- Emailing coroners and Registrars
- Confirmation of life extinct remains problematic – training in place as the law states anyone can verify life extinct. Remote consultation with video helping.

Firearms Licencing / HGV / PSV Medicals

Suspended but some Police Forces are insisting that renewals of licences are being processed. Others have suspended this process.

Bank Holiday Opt-in Enhanced Service

Good response for Easter, weekend mornings not offered by all HBs. We have requested a sooner decision for May Bank Holidays. Many HBs not commissioning May Bank Holiday work. Enhanced Service remains in place and could be reactivated for future Bank Holidays.

Hospital Referrals

Clarity from NHS Wales Director, secondary care not to reject. Recent attempts by a local CMHT to refuse referrals and discharge patients on grounds of convenience has been centrally rebuffed.

Care Homes

High Covid death rate in Care Homes has triggered a knee jerk reaction at WG and they are attempting to rejig the Care Home Des, putting additional work on GPs and requesting in depth death reviews for all deaths. Following negotiations, we now have an acceptable agreement over Care Home care, remembering that it was the homes that imposed lockdown, not us refusing to visit. Active from 1st. July 2020.

Flu vaccination programme

Great concerns here as we have calculated it will take three times longer to vaccinate each patient due to infection control measures. Average practice does about 1500+ immunisations during the season. Requesting a Covid funding supplement as it may need weekend working by a substantial number of additional staff.

Reintroduction of Services in General Practice

This will be introduced from 1st July 2020 with appropriate claims submitted, though practices will remain fully reimbursed at last year's level, unless that is exceeded in some way. Post Payment Verification will recommence on the 1st. October 2020. Practices have been given Government Guidelines on premises.

Contract Negotiation including Enhanced Service Review

All negotiations currently suspended for obvious reasons. Guarantee that no practice will be at a financial loss due pandemic is now in place. Agreement that there will be a gradual introduction of additional and enhanced services from 1st. July with Post Payment Verification from 1st. October assuming that there is not a second wave of infection. QOF / QUAIF funding hiatus partially resolved, with measurement day moving to September 2021, allowing practices to establish services despite the Covid pandemic. Some contract review discussions starting this month.

IT Re-procurement

In commercial confidence and not for further sharing with committees or constituents.
Given the Covid19 emergency, no procurement process will be undertaken, and all practices remain with their current suppliers until January 2021 at the earliest. There will be costs to the GMS budget overall, but we have accepted these as the priority is to ensure practices have a functioning system during the pandemic. We will continue to push for choice of functioning systems when the procurement process recommences.

Dispensing policy group – David Bailey

Very little to update on dispensing due to the Covid crisis other than the ability of dispensing practices to provide P medications where there were patient access problems was confirmed under emergency legislation (in England only, Welsh regs don't contain this flexibility).

Although enacted by parliament by enabling legislation, many practices were frustrated that their regional offices did not allow practices to use this option, even when the local pharmacy was closed over the May bank holidays.

Priorities on reimbursement – possibly with a common policy with community pharmacy (which has been delayed) and EPS4 remain as before but sadly no progress on either. EPS4 remains a significant issue, after the NHS encouraged its use and that of repeat dispensing, but has not moved on its position over funding. We are pushing for it to be funded as part of the core GP IT futures programme. Sadly, no progress on either.

Although FMD has mostly gone quiet since its implementation, the possibility of a hard Brexit in December appears to have grown over the lockdown. GPC has included our position on funding in a briefing on the Medicines and Medical Devices Bill, currently going through Parliament.

A delivery service, similar to that provided by community pharmacy has been resourced with payments for delivery, and this has been extended until 31 July 2020.

We are aware that some practices will have been negatively impacted by cashflow problems at the start of the covid lockdown, and we regret that a national scheme was not announced at the same time as community pharmacy received funding advances.

We are also aware of continued medicine shortages, which are multifactorial, but not helped by covid.

GP Trainees Committee – Sandesh Gulhane and Lynn Hryhorskyj

CCT

GPT has worked alongside HEE, GMC, RCGP and devolved nations leads to secure a remote alternative for the CSA exams: the RCA. The first sitting of this is being marked now, and it will be due for a full evaluation after the second sitting in August.

GPT has also worked to secure social distancing measures for the AKT exams, but talks about testing shielding trainees are ongoing.

There are concerns that the wait for RCA exam results may delay trainees ability to CCT, causing a potential loss of earnings. This is being followed up with the relevant organisations.

Mileage

GPT continues to work with PCS to try to resolve this issue.

Tower Hamlets pilot

GPT has met with Sir Sam Everington about the proposed Tower Hamlets GP traineeship pilot, which is to be launched this year. GPT have been working with JDC to address a few outstanding questions regarding this ahead of its implementation.

Sessional GP Committee – Ben Molyneux

The committee continues to work to address COVID-19's impact on the sessional workforce and weekly meetings with GPC/SGP and NHSE continue.

Sessional representation

SGP continue to lobby for appropriate representation within the BMA structures. Following a second meeting with the organisation committee, their recommendation is to approach individual committee to request admittance. As a result, SGP attended the Strategic Reference Group with Richard Vautrey to directly request a seat at the group for the SGP Chair. A decision for this is currently awaited. SGP plans to approach council to make a similar request in due course. If acceptance is declined, then alternative solutions will need further discussion.

Parental leave

SGP and GPC reps have met with Ed Waller, NHSE, to discuss enhanced parental leave for salaried GPs (as agreed in the 2019/20 GP contract). Modelling for this is very complicated, but costs are expected to be modest and the principle was agreed by both parties. NHSE has expressed a desire to make this reform part of a larger package of action to address inequality and the gender pay gap. BMA leads will meet with NHSE again in August to further this work.

Locums GPs

SGP have been concerned with the treatment of locum GPs throughout the pandemic, who have been put in a precarious position. The committee continues to engage via regular newsletters and direct responses to members, and webinar participation. Remote working and IT/digital solutions are a particular barrier for SGPs and so regular meetings with NHSX about digital solutions continue. Solutions to enable locums to access remote working opportunities (including through Virtual Desktop Infrastructure, or VDI), are in train. SGP have consulted with GP trainees committee, ETW and GPC Exec about the best way to help these GPs. Additionally, meetings with NHSE continue about the particular need to support locums due to COVID-19, and also specifically about the locum support scheme which was agreed as part of last year's contract discussions.
The committee is also mindful of the potential extension of CCAS/CAS to deal with non-COVID-19 issues, which would require negotiation to ensure standardised terms and conditions are implemented.

Urgent care reforms

The committee continues discussions with Cliff Mann, Director of Urgent and Emergency Care NHSE, about how proposed reforms to urgent care will impact primary care both in and out of hours.

Pay

SGP are working with the BMA pay and contracts team on strategic response ahead of DDRB recommendation publication, and reviewing the historic salaried GP pay scale and its ongoing fitness for purpose.

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

Since the last report in March 2020, the policy group has been somewhat limited what they could do due to the **COVID-19 pandemic** in terms of meetings being cancelled (e.g. CPCS and measures and indicators), but has been feeding in to some COVID related work streams.
The policy group has created a workspace called 'Slack', to **collate rapidly changing guidance during COVID** and convened a meeting of the group to discuss ideas as how best we can help the profession.

In April, we published the attached **guide to the management of long term conditions using remote consultations**, in order to support patients with long term conditions during the pandemic (whilst QOF was suspended).

A **draft guidance on remote intimate examination (see below)** has been formulated by NHS England and the Royal College of GPs, with input from the clinical and prescribing policy group, and IT policy group, and is due for imminent publication.

The Priority prescribing clinical working group is planning a major piece of work through CCGs aimed at reducing the prescribing of drugs associated with dependence and withdrawal. While we recognise the importance of this subject this work must not go ahead until the workload issues arising from COVID-19 have been addressed, along with the provision of functioning services both to help patients withdraw from these medications, and to provide alternatives to prescriptions.

We have fed into NICE consultation on proposal new QOF indicators (deadline was 15 July).

The policy group has also responded to **Lung health checks** and **Primary Care Network briefings** for strategy group review

We have written to NHSE/I asking for **an update on Arrangements for caring and prescribing for gender dysphoria patients,** in particular the provision of services for this group of patients during the COVID-19 pandemic. We are awaiting their response.

Remote review of long term conditions

With social distancing arrangements in place and the increased number of patients with symptoms of or patients and staff possibly harbouring COVID-19, all patient contact should be via remote contact when possible. This particularly applies to consultations for routine long term condition annual reviews

These can be carried out using telephone or video consultation and now most commonly used video technologies are acceptable to use.

The duration of the current pandemic is hard to predict, and therefore it is very likely that patients with long term conditions will need to be followed up and assessed remotely to ensure these patients receive relevant and appropriate clinical support. Practices should do what they can, alongside

managing other more acute priorities related to COVID-19, to help patients manage their long term condition to reduce avoidable deterioration. Whilst doing remote reviews in the next few months will be easier with more patients staying at home it may also establish new ways of working that could be used for future reviews and patient contacts, as is appropriate for individual patients.

Most conditions lend themselves well to remote assessments and could be enhanced through this method, not least in the easier opportunity to share care plans, information and guidance through links to websites and shared documents. These could also include agenda setting for long term conditions so that, in advance of future reviews, a patient can share what their goals of treatment would be.

Hypertension

This can be monitored by patients using their own home monitors and results fed into the patient's record electronically or by telephone. This may lead to a reduction in white coat hypertension and enable better control.

COPD

The review could be carried out remotely but would benefit from a video consultation to be able to see the patient and observe their respiratory rate and function. Spirometry will not be able to be completed and should not be attempted during the COVD-19 pandemic. Indicators in QOF 20/21 have changed to include the following -

Patients could have a review including smoking status, a record made of the number of exacerbations in the last year, as well as MRC dyspnoea scale completion. Patients could have medication reviews and altered if control has altered significantly over the year.

Asthma

A remote review is possible for this group of patients. The practice could consider online assessments including inhaler technique using video assessment. Patients who do not already have a peak flow meter a home could be prescribed one. In line with QOF 20/21 the patient should have an assessment of control using a validated asthma control questionnaire, recording of number of exacerbations and a personalised written plan. The plan could be sent electronically, and the control and exacerbation could be collated using an online self-assessment

Heart failure

Practices could consider remote review of shielded patients first including a functional review and medication review to ensure dose optimisation. Home blood pressure monitoring could be done when medication is titrated upwards.

Diabetes Mellitus

Practices could consider remote review and complete most aspects of the annual review this way. Consideration needs to be given to those patients that would most benefit from checking their HBA1c, reducing this physical contact to the minimum. A partial foot assessment could be done via video, looking for signs of ulceration and reviewing their risk status. This could be carried out using video techniques.

Serious mental illness

Patients with serious mental illness should be reviewed remotely were possible and with the support of mental health services when relevant. Many of these patients may need additional psychological support during the current pandemic.

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

Contracts and Regulation – Julius Parker

The main policy activities currently involve:

Liaising with CQC as they discuss their current and evolving approach to regulating General Practice since the Covid19 incident was declared

Liaising with NHSE in relation to their approach to GP appraisal and revalidation, again against the backdrop of the impact of Covid19 on General Practitioners

There is also on-going work in relation to the Regulations that will be introduced in October 2020 to implement those elements of the Contract Agreement agreed for that date

Commissioning and Working at Scale Group – Chandra Kanneganti

Write a paper on the commissioning of care home enhanced service across England.

From October 2020, care home enhanced service will be part of the PCN specification, and a care home premium payment will be made available.

The policy group is considering writing a paper on how various CCGs across England have already started to commission this care home enhanced service.

Collaboration with ETW policy group

Both policy leads from the CSD and ETW policy group have agreed to increase collaboration in order to discuss and progress on PCN workforce workstreams.

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

Premises and practice finance – Gaurav Gupta

NHS Property Services legal case and update

As you know, 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 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. BMA guidance is clear that practices should engage with NHSPS, identify areas where there is a dispute, and pay undisputed amounts. Practices should not be forced into any agreement which places the viability of the practice at risk and solutions must be sustainable. Practices should be mindful that the BMA are proceeding with legal action to address historical charges and should ensure that in reaching any agreement independently of this they do not put themselves at risk of any future liability or compromise their future position.

NHSPS and Community Health Partnerships engagements

While the court case progresses, we have continued to engage with NHSPS with a view toward resolving ongoing issues, particularly where these are exacerbated by COVID-19. In April we wrote to NHSPS, expressing our concerns about attempts to pressure practices to pay disputed service charges during the pandemic. We then met with the CEO and COO of NHSPS to demand that it take a more reasonable approach. During our engagement we also sought and received assurances that some

non-urgent operational policies (such as routine asbestos survey visits) would be relaxed for the duration of the pandemic.

We have also been in regular contact with Community Health Partnerships (CHP) regarding unreasonable service charges affecting their practices. We have escalated several specific examples of this to CHP chief officers, and have since secured agreement that the COO will personally oversee the resolution of these practices' concerns.

We continue to advise practices who are unable to resolve these disputes with NHSPS or CHP to escalate via their LMC in the first instance.

NHSE – Premises review and COVID-19 considerations

In May we met with NHSE officials, seeking an update on progress made on the Premises Review and to discuss next steps in light of COVID-19. We were informed that workstreams requiring capital (e.g., the assignment of leases) are contingent on the completion of the Comprehensive Spending Review, which is anticipated in October. NHSE also agreed to share a full list of Premises Review workstreams and agree priorities going forward with the BMA. NSHE also advised that it has suspended physical inspections of Primary Care Premises by District Valuer Services (DVS) in light of COVID-19, and that valuations will now take place via desktop review. DVS will be in touch with instructing CCG or local NHS England teams to confirm arrangements on a case by case basis.

PCSE Task and Finish group – Ian Hume

The task and finish group continue to engage with PCSE on both operational and transformation issues. NHSE feel that PCSE services have managed the impact of Covid-19 reasonably well, adopting new technology appropriately. The fact that several elements of the transformation involve self-service is serendipity. Most transformation and business as usual work is being delivered through the period. Exceptions are the suspension of data quality work and list cleansing activity, which will restart soon, and cervical screening invitations. The latter restarted on 8 June and will take several months to catch up.

Performers List

Performers list activity is now all conducted via the PCSE online portal. Individual GP performers (partners/ salaried/ locums) can log on and make changes to their status. We encourage them to do this because we know some errors have passed from the old system, and it also means that they can choose if they are happy for data sharing with local medical committees. There have been twice as many online updates than on the old system. 40% of GPs have checked and changed their PCSE Online entry, and there will be a reach out to GPs on this imminently.

Around 6,400 practices now have at least one account manager. 95% are signed up and verified, but 400-500 practices still need to follow up.

The launch of the new public-facing performers' list website went live at the end of June 2020. We have identified an error in one of the data fields, which we hope will be rectified rapidly. The new performer list provides limited details to the public about performers. This new site will feed the data which will be supplied to local medical committees, and we have been assured that the information, (including contact details) on new joiners and leavers to practices will be provided to LMCs every month. There is one more information governance hurdle to clear, so all I can say is that the data is imminent.

We have however been told there are some more complex information governance issues around the release of locum data and we have raised this with NHS England. Still, it may be that we can release the practice-based data and continue to work on the locum data issues.

We are keen to keep an eye on the situation of GPs who have been fast-tracked but still need to complete the formalities of the NPL1 process. PCSE do not anticipate problems but will discuss and ensure that is the case.

We have also received formal notification from NHS England and NHS Improvement that confirms the joint agreement with Health Education England that GPRs due to start training in August 2020 are exempt from the requirement to be included in the England Medical Performers List.

Exeter System/PCSE Portal

The Exeter system (NHAIS) is being decommissioned, and all GP payments and pensions will be visible and managed via the PCSE online portal. Covid-19 has had a detrimental impact on PCSE's ability to go-live in June due to limited availability of crucial NHSE, NHSD & NHSP to engage with the project and support implementation. Technical and business go-live dates have moved to September to allow PCSE to meet the October global sum run.

There has been ongoing work to ensure that payments are accurate and reliable. During trial runs, the gap in payments between NHAIS and PDS has been reduced from an initial £70million to £22 million and in the last quarter available (April 2020) down to £7.7 million. Further data and list cleansing work is being done to ensure complete accuracy, and we continue to engage with NHSE on this matter. PCSE is working with about 210 individual practices, and further data cleansing will focus on those practices. The main driving factor is the registered list. Some practices are merged, but with different lists, and others are atypical practices, e.g. violent patient schemes. The differences are only the global sum payments, not other payments.

Recent system demonstration for several stakeholders went well, and constructive comments are being considered. A number of LMCs have requested to have sight of the system ahead of it going live to be able to support practices. PCSE have confirmed that they plan for this to happen closer to the date.

Medical records

There remain some issues with the medical record, mainly when there are data discrepancies, and some notes are looping around the system, either because of a data error or because a patient is moving around rapidly. There is a significant improvement of old records appearing back in circulation and now joining up at the appropriate location. We are agreed that local solutions are not the answer to looping records issues and that there needs to be a national approach. There is significant work being done by NHS Digital at digitalising the medical record. The BMA is continuing to monitor any issues.

LMCs have expressed frustration at the resources and time that goes into the preparation and printing of deceased patients' records. NHSE has confirmed that the digital transfer of these records is now being prioritised.

Escalation process

There is some continuing disquiet that the withdrawal of the PCSE regional engagement managers means that there is no route for LMCs to escalate long-term unresolved issues. GPC staff can escalate some of these once the agreed routes have been exhausted, but it is a 'hit-and-miss' approach. We have now been provided with this process which we can use on behalf of LMCs once the standard processes have been exhausted.

Information Management and Technology Governance – Anu Rao

Pillar 1 test result flow

Uncoded Pillar 1 test results have been flowing to suppliers destined for GP records. GPC is in discussion with NHSD, E and I to ensure the flow is stopped until a suitable solution can be found that ensures no additional burden is placed on GPs receiving test results.

Pillar 2 test result flow

Following extensive consultation with GPC, NHSD have created a solution to facilitate flow of Pillar 2 test results into GP records. The solution was sought to enable bulk flow of historic results and ongoing flow of live results.

GP IT futures

The GP IT Futures expert advisory group is reconvening and will ensure BMA and others have a meaningful voice in shaping this. GPC has engaged to help set the terms of reference for this group and ensure it is efficient and clinically led.

Contact tracing app

Discussions over the implementation of a contact tracing app are ongoing. We expect to meet with the new team in charge of a developing an app based on the framework provided by Google/Apple (rather than NHSX) in the coming weeks and will work to ensure that any new app has the confidence of patients and the public and collects only as much data as is necessary.

Remote consultation guidance

Updated guidance on remote consultations will be published w/c 13th July, this outline clearly what are and are not contractual obligations and will bring together a number of different streams of information that have been published by national bodies.

NHSE/I redaction guidance

GPC has written to NHSE raising concerns over proposed guidance on redaction of patient records. GPC has requested, as a minimum, that plans to widen patient access to records are postponed until patient safety can be ensured and effective and necessary redaction carried out without additional burden on GPs.

GPES extract for COVID19 planning and research

Over 95% of practices registered to upload patient data via GPES to be held and licensed by NHSD. GPC has oversight of any requests for this data and NHSD have already licensed it to researchers working on COVID19.

Digitisation of Lloyd George records

GPC received an update via the Joint GP IT Committee that NHSX is developing a dynamic purchasing framework for GPs to purchase digitisation services, with additional guidance expected from NHSX in the coming months.

Definition of appointments

GPC is in dialogue with NHSE/I about how appointments in general practice are defined. GPC is current awaiting revised guidance on this and remains committed to ensuring all activity carried out in general practice is recognised and reflected in relevant statistics.