EXECUTIVE AND POLICY LEAD UPDATE – September 2018

Scotland

GMS National Implementation and Primary Care Development Oversight Group

An oversight group has been established with representatives from Scottish Government, SGPC, Health Boards and Integration Authorities, and held its first meetings on 24 April and 13 June. The purpose of the group is to provide broad strategic direction, scrutiny and advice on the implementation of the 2018 GMS contract, and monitor the progress of local implementation plans focussing on the development of new health board run services to reduce GP workload principally pharmacotherapy, immunisations and treatment room services. A bulletin was shared with SGPC, GP Subcommittees, Chief Officers, Chief Executives and Primary Care Leads summarising the June meeting and a regular communication post-meeting is expected. The group are next scheduled to meet on 25 September.

A separate tripartite group of Scottish Government, SGPC, Integrated Joint Boards and Health Boards will continue to meet separately for the purposes of shared working on topics that are outwith the remit of the GMS National GMS Oversight group.

GP Subcommittees

Each Health Board area has been allocated £35,000 to resource GP subcommittees directly for the additional work created by the new GP contract and the requirements of the Memorandum of Understanding. This funding is additional to any previous agreements to support the GP subcommittee except where additional support was agreed specifically for the new contract; in these cases, the additional funding may support those arrangements. Scottish Government will review the funding of GP subcommittees as the new contract progresses with a view to extending support where necessary.

Pay Award

Scottish Government announced its pay award for doctors in Scotland on 31 August. It's decision was to uplift GP pay (net of expenses) by 3%, as well as give an increase of 3% for practice staff pay and an uplift of 3% for non-staff expenses. For salaried GPs the 3% applies to those earning less than £80k, with those earning more than £80,000 receiving £1600.

For other staff groups in Scotland the decision was as follows:

- 3% increase to the national salary scales for all doctors who earn below £80,000 (full-time equivalent)
- £1,600 for medical staff earning above £80,000 (full-time equivalent)
- 3% for all junior doctors
- 3% for all Specialty Doctors and Associate Specialists who earn below £80,000 (full-time equivalent)
- Distinction Awards and Discretionary Points remain frozen

All uplifts would be backdated to 1 April 2018.

Scottish Joint GP IT Group

A Scottish Joint GP IT Group has been established in Scotland which mirrors the composition and function of the GPC/RCGP Joint GP IT Group which considers matters at a UK level. The group will

provide a coordinated approach to GP IT matters for Scotland, considering the development of IT in general practice in Scotland, training and change management issues, and providing support and guidance.

The group is composed of SGPC, RCGP Scotland, user groups, Scottish Government Primary Care Division, eHealth, NSS and NSS ISD, with observers brought into meetings with expertise on the different GP IT systems. The group is co-chaired by Carey Lunan, chair of RCGP Scotland, and Andrew Cowie, joint deputy chair of SGPC, and supported by SGPC secretariat. The group had its first meeting on 16 August and will aim to meet quarterly.

National Workforce Plan

The Scottish Government's *National Health and Social Care Workforce Plan: Part 3 Primary Care* set out plans for the development and training of GPs and the wider primary care multi-disciplinary team. The plan was published on 30 April 2018: http://www.gov.scot/Resource/0053/00534821.pdf. BMA Scotland have provided a response which can be found here: https://www.bma.org.uk/news/media-centre/press-releases/2018/april/bma-scotland-response-to-primary-care-workforce-plan

Innovative Courses To Train More GPs

Scottish Government are funding 85 additional undergraduate medical student places at the Universities of Aberdeen, Edinburgh and Glasgow.
The new courses will focus on general practice, supporting the Scottish Government's aim to increase the number of GPs by at least 800 over the next decade. A new route for experienced healthcare professionals to enter medicine will also be introduced. This was in addition to ScotGEM which is building to 60 places.

- 30 places at the University of Aberdeen: all students will undertake an enhanced GP programme, with a set minimum of teaching time and an additional range of GP options.
- 30 places at the University of Glasgow: all students will gain enhanced exposure to primary care and students can opt for intensive experience of primary care in deprived and rural settings. on the new Community Orientated Medical Experience Track ("COMET").
- 25 places at the University of Edinburgh: this innovative course will allow experienced healthcare professionals to enter medicine and combine part time study with their existing job, with large parts of the course delivered online. It is designed to target high calibre candidates who are more likely to be retained in NHS Scotland.

60 of the additional places will begin in 2019-20, 25 places will begin in 2020-21.

Wales

GMS Contract Review

The current contract review is a tripartite process involving GPC Wales, Welsh Government and Local Health Boards. We have jointly developed a memorandum of understanding, and GPCW has as also developed a vision document to help guide our negotiations.

There is a need to align this with the "Healthier Wales" strategy which is predicated on the "Primary Care Model" (previously called transformational model). This model is comprised on Multi-Disciplinary Teams working around practices and across clusters of practices delivering services and ensuring good, timely, local access to services delivered by the appropriate professional. Transformational

monies are being made available to deliver this, and the GMS contract review (and other independent contractor contract negotiations) are expected to dovetail in with this strategy.

The four work streams continue – (1) funding & minimising risk (2) workforce (3) cluster development (4) demonstrating quality. Recommendations from the work streams go to the clinical oversight group, which then agrees areas for formal negotiation.

DPO NWIS Welsh Solution

We are taking forward a solution whereby NWIS will be resourced to provide a DPO role and support to practices. The proposed service specification is available and has been distributed to practices.

The costs will be on a not for profit basis and as well as being a quality, safe, effective service for practices, it also makes sense as NWIS already keep our data in two Welsh data banks. NWIS already have an excellent track record in supporting practices in information governance responsibility through the information governance toolkit and regular updates.

We are currently at stage of evaluating the actual numbers and the resourcing of practices who wish to take it up. Sign up and payment will be co-ordinated via LMCs who will also have coverage for their responsibilities too. GPCW are currently working on securing funding for the DPO role from Welsh Government.

IT Migration

Previously highlighted some very real significant concerns regarding the ***procurement process*** within Wales for an IT system. These have been exacerbated by relatively newly identified issues with Vision necessitating a letter to all practices from GPC Wales (and separate correspondence from Vision and NWIS). All practices who have chosen Vision based on the product demonstrated at the roadshows will have the opportunity to change system.

A comprehensive ***package of support*** for migration of practices to new systems was agreed as part of our contract negotiations for 18/19. Our wants have been put forward to the stakeholder reference group tasked with working up final offer for Ministerial consideration. The initial proposal has been seen by Minister and further work will be undertaken following his response to this.

Indemnity

Welsh Government has confirmed that it will be taking on existing liabilities / claims as well as future claims. It has further been clear that those on claims only insurance policies will be expected to purchase run off cover for the time they were on a claims only policy before joining the state backed scheme.

Due diligence and negotiations with MDOs are ongoing with respect to getting requisite data on claims / funds / etc, and this is being done on a joint England / Wales basis.

We are awaiting details on funding, but assurance has been made that it will be aligned with the England scheme so that Welsh GPs are not disadvantaged.

DDRB

Announcement due hopefully on 25.9.18

OOH

Employment status of OOH GPs – GPCW are taking a legal view on the LHB interpretation that GPs are not employed for employment status yet employed for taxation purposes. Alison Edwards BMA Cymru Assistant Secretary and Justin Quinton BMA Legal have been very helpful and we have 2 GPs who have agreed to formally take this forward. The outcome of this could potentially set a very useful precedent for other parts of UK.

OOH challenges – An OOH peer review is currently looking at the challenges of OOH working and sharing good practice and potential ideas. Outcomes from this will be discussed with the various stakeholder groups including GPC Wales, RCGPW, and RCN. The outcomes may well level useful recommendations as current OOH issues are being conflated with roll out of 111. What is clear, is that the whole system is creaking!!

Model contracts – GPCW have been tasked with developing model contracts for those who want a contract with limited employment benefits (i.e. zero-hour type contract) and salaried OOH salaried contract.

Welsh Sessional Issues

There are ongoing difficulties establishing a sessional database for ease of contact. At present, ad hoc lists are around but nothing that has been validated from shared services. GDPR seems to be making this even harder for LMCs to engage with sessionals.

There is ongoing work with NWIS to enable sessional GPs to easily obtain an NHS email address.

Welsh Specialty Trainee Issues

The main issue currently is enhanced training. Our new trainee representative, Paul Mitchell, is actively involved with GPTSC Executive in trying to push this issue forward within the UK as a whole. At the last GPC Wales meeting there was support from both the committee and Deanery to take this forward. Links with HEIW (see below) will be an opportunity to see if we can progress this within Wales if a UK approach proves unsuccessful.

Health Education & Innovation Wales (HEIW)

This is a new body that has been in shadow format since last year. HEIW has responsibility for education, training, planning, leadership, careers, improvement and widening access. This is a huge programme of work, and they are also taking on all Deanery functions. One specific area of work they are looking at is the OOH workforce across MDTs.

Conflicts of Interest

GPC Wales has unanimously agreed a want to publish information on potential conflicts of interests on its web page in a spirit of complete openness and transparency like many other organisations do routinely. However, currently that is not permissible under the current BMA conflicts of interest policy. GPC Wales has written to BMA Council chair to request a review of the current policy and / or mechanisms that could allow a committee to publish this information if it decides to do so. GPC Wales has identified a few potential options for taking this forward if the BMA policy changes – e.g. a voluntary register or simple list that is reviewed annually, with a mechanism for allowing people to opt out if they do not wish to publish it.

Other matters:

A. Transgender – this is back on the agenda and it looks like the following will apply:

- ***Step 1***
  GP sees patient and refers to Welsh Gender Team – predominantly in Cardiff but there will be outreach to other areas (yet to be determined). North Wales patients may be offered a choice of London or Cardiff.

- ***Step 2***
  Welsh Gender Team see and assess the patient, identify prescribing needs, refer for surgery if needed / wanted, and devise Mx plan.

- ***Step 3***
  Local Gender Team (likely to be one in each LHB with the exception of Powys) – likely to be comprised of a special interest GP +/- sexual health doctor and may expand to nurse practitioner – will do initiation of medication and stabilisation for first year, and will manage those cases where the patient's registered practice OR linked cluster does not do prescribing.

- ***Step 4***
  An Enhanced Service is to be made available to all GP practices – LHBs will be required to offer it but obviously remains voluntary for GPs. Where a practice doesn't feel they can offer the service, they can look into a cluster solution or buddying arrangement to enable patients to have access to local timely care. The key priority is making sure there are rapid links in place to Step 3 when needed.

  The timeframe for implementation is in the new year – the agreement of Step 4 is dependent on Step 3 being in place, which in turn depends on Step 2 being in place. Also funding for the GP element is still not signed off.

B. **Hep C look back exercise** – we have had involved discussions with PHW around role of GPs in this – unsurprisingly they saw this as GP work. We have pushed back and whilst we do not mind checking off a list of patients that they can be contacted, everything else will be down to PHW and blood borne virus teams.

GPC England

Pension Reporting

Following our letter to all GP members in England and after continuing to press NHS England (NHSE) to communicate to GPs on this issue, NHSE have now informed GP practices about their sample review of pension scheme records, which has shown discrepancies between some of the pensionable earnings and contributions data which has been provided to NHS BSA. They are now going to carry out a larger review, focusing on those nearing retirement age, to identify and resolve these issues. Although NHSE have reassured us that they will deal with this problem, and all GPs will receive the correct pension due to them, if, as part of this review, GPs are asked for additional financial advice we have said that it is imperative that they are reimbursed for any expenses incurred through no fault of their own.

GDPR

ICO meeting

The BMA met with the ICO recently to discuss the Code of Conduct under Section 5 of GDPR in relation to Subject Access Requests made by solicitors, paralegals and claims management companies for access to GP held patient records. This Code was initially proposed by Paul Cundy (GPC IT lead) and was approved by GPC England. The ICO clarified that there is an ongoing process at EU level in advance of issuing further operational guidelines on how Codes of Conduct are going to be enacted, until this point they cannot accept any proposals. They did however, say they would be supportive of, although could not endorse a pilot. GPC will be discussing next steps on this issue with RCGP and NHS Digital.

SARS survey

In order to accurately quantify the full scale of the problem of SAR requests for GP practices since the introduction of GDPR, we are currently surveying all GPs across the UK to collect information on this issue.

GP trainee subcommittee – Tom Micklewright

The GP trainee subcommittee met on 19 September. Sandesh Gulhane and Zoe Greaves were elected as the subcommittee's co-chairs.

Terms and conditions

- COGPED has delayed their GP OOH training proposals, pending further review, thanks to the co-ordinated efforts of the GP Trainee Subcommittee and the RCGP AiT committee. The paper was due to be implemented in August 2018 but significant concerns remained about the safety of remote supervision in this setting. The implementation date has therefore been postponed and further work will be done to improve the proposal paper before it returns back to COGPED and the RCGP SAC to be ratified.
- The 2018 junior doctor contract review has begun with the formation of a number of joint data gathering groups with NHS Employers and JDC.
- After we learnt that the state-backed indemnity will only cover clinical negligence indemnity and would not cover professional indemnity or medico-legal services, we felt that there was a need for HEE to continue to provide and fund non-clinical indemnity cover for GP Trainees, as they have done for many years. We have therefore written to Professor Simon Gregory at HEE to ask that he confirm this will be the case.

Education and training

- The GP Trainee Subcommittee are working with Dr Will Owen, a GP trainee and National Medical Director Clinical Fellow, and with the RCGP AiT Committee to develop a trainee-led position paper outlining a vision for future GP Training. Dr Owen has conducted several focus groups as part of his research but will be supported by the GP Trainee Subcommittee to broaden this data collection and to develop the paper itself.
- The GP Trainee Subcommittee have submitted our comments on the GP Partnership Review. We have also supported Dr Nigel Watson and the review team in developing a partnership

myth-busting document to support early career GPs and GP trainees who may be considering a career as a GP Partner.

Representation

- Following changes to policy group structure within GPC, we now have GP trainee representation on all of the policy groups within GPC. Previously, trainees were disproportionately represented within the Education, Training and Workforce subcommittee but this new approach will ensure our work better aligns across the policy groups and we can ensure trainees can influence all areas of GPC work.

Sessional GP subcommittee – Zoe Norris

In addition to our ongoing work plan, recent areas of focus are:

1) Ongoing input into the GP Partnership review, alongside Krishan Kasareneni and the secretariat. Nigel Watson has shown he has a good grasp of the issues affecting the sessional workforce and how this may affect their decision to take up partnerships in the future. Zoe Norris will continue to engage with this as part of the BMA team.
2) Ben Molyneux continues his work on new models of care, atypical contracts and is acting as SSC liaison to ETW. This is a fast paced and increasingly rapid area of work, and Ben's guidance so far is well worth a read for both GPC UK members and LMCs.
3) Locum terms and conditions – timeline for this is late Autumn with the aim of sharing at the LMC-E conference.
4) We have been providing advice to colleagues in Scotland facing a variety of issues around tax and out of hours work. We continue to work alongside the SGPC to provide input when requested.
5) NHS emails – a joint project with work from colleagues all across GPC, this is coming to fruition but there remain some logistics to be sorted. The team will continue to work with NHSE to deliver this.
6) The SSC made an FOI request to all CCGs in England as the first step in looking at representation of sessional doctors at commissioner level. The results were variable and we have then followed up with those 16 CCGs who specifically excluded locum and/or salaried GPs from holding board positions. This is a longer term piece of work, the next stage being to look at STP/PCN level, and at representation in the devolved nations in conjunction with our GPC UK colleagues.
7) Low volume appraisal guidance – this joint piece of work across policy groups is now completed.
8) RCGP/NASGP/SSC liaison – a quarterly meeting with representatives from all organisations to discuss current challenges and concerns affecting sessional GPs. It continues to be a very helpful way of working towards joint aims and addressing areas of concern between us in a constructive way.
9) Indemnity – Matt Mayer in his role as a SSC exec member continues to work on this. The SSC will produce specific guidance as part of the wider comms once the details are known. There remain lots of questions and Matt will be doing a blog in the SSC newsletter on these and what we know so far.

Representation – Bruce Hughes

Policy Group Allocation

The procedure for allocating to GPC UK Policy Groups has taken place. Care has been taken to include and distribute members from the devolved nations GPCs, GPC England, and the Sessionals and Trainees subcommittees.

Policy Group Roles and Responsibilities

We have submitted a paper outlining the roles and responsibilities of various members of GPC UK, its subcommittees and devolved nation GPCs with regards to Policy Groups. This has been consulted upon widely and will be adopted for the forthcoming session. The thrust of the paper is to fully include devolved nation GPC members and subcommittee members such that the UK Policy Groups have the broadest range of skills available and that two-way communication between the GPC committees/subcommittees and the Policy Groups occurs. This paper should also help those new to GPC understand the policy group structure.

Policy Group Deputy Elections

Elections are now in progress across all Policy Groups for the Deputy Policy Lead position. These elections will take place utilising the online voting system. Several Deputy Leads have already been appointed unopposed.

Gender Diversity

The Task and finish group led by Rachel Ali continues to progress and the revised timeline for reporting is to GPC UK in March 2019.

Contractual Status Survey

The contractual status survey will be sent to all members of GPC UK soon after the September 2018 meeting.

Dispensing policy group – David Bailey

We have been in discussions with colleagues from PSNC – the community pharmacy negotiators – about a high level strategic paper regarding reimbursement of dispensed drugs for both professions.

We have had their first draft for comment and following discussions with DDA, we have sent back our first set of comments on an approach to NHS England and DH. We would hope to finalise this in the next few weeks before seeking to open negotiations.

Whilst as you might expect there is little in it to impact on most GPs one of the threads will be trying to stop branded generic substitution possibly through regulation to end the practice of recurrent changes to patients medications depending on this week's cheapest branded generic supplier undercutting the drug tariff (via Script-switch and similar) this may locally save pennies for an individual CCG or LHB in Wales but costs the NHS as a whole money - as apart from the transactional costs, because community pharmacy remuneration depends on an agreed profit margin from dispensing (agreed nationally) any undershoot has to be paid the following year ending up with a net national NHS loss. This is quite apart from the clinical governance and patient compliance risks of constant drug presentation change.

The possibility of a limited list allowing generic substitution for branded scripts by dispensing contractors (limited as some brands have bio-availability issues) is also being considered although that would require an opt out for GPs – this would of course actively save NHS money through lower drug costs.

In addition Krishna Kasaraneni and I are meeting DHSC next month to discuss ongoing concerns about the falsifying medicines directive. Agreement on fully funding required hardware is required but probably more importantly trying to find a way through the bureaucratic slow down it threatens not just for dispensing doctors and pharmacists but also all prescribing GPs in England and Wales when they personally administer vaccines. In Scotland and Northern Ireland without PA regulations the bureaucracy will hopefully all be handled at health board level. There is also the ongoing problem that this software won't be directly integrated into our systems – a real concern given the history of the NHS with IT projects

A WORKFORCE STRATEGY THAT IS RECURRENTLY FUNDED TO ENABLE EXPANSION

Education, Training and Workforce – Helena McKeown

GP Partnership Review – ETW contributed to a joint response to Nigel Watson's independent partnership review, we have yet to agree our final joint response with the workforce and innovation policy team.

GP Retention scheme guidance step-by-step guide has been updated: 29 August 2018
https://www.bma.org.uk/advice/employment/gp-practices/general-practice-forward-view/workforce/retained-doctor-scheme

Clinical Pharmacists in General Practice We are expecting a relaxation of the criteria enabling further expansion with more details on changes to the scheme presented at the National Advisory Group meeting later this month.

International GP Recruitment Programme After the last GPC England meeting we are restating our position objecting to participants being penalised financially if they move jobs from their initial geographical placement. GPC does not support the claw back mechanism and feels it is discriminatory.

Numbers are lower than expected. People in the EU are all but ready to go, but do not quite meet the language criteria. A formal survey of EEA candidates is planned to understand why they are not making the UK their first choice. NHSE have put together an attractive package to support current GPs who are about to complete their training. This package includes covering visa fees for Tier 2 (given the change in employer/sponsor) and will help match trainees to GP practices holding a sponsorship licence. NHSE is also supporting practices to get visa sponsorship licences.

We are very aware of the ethical consideration relating to international recruitment and we will not be taking doctors from areas that have a shortage of GPs.

Physician Associates (PAs) We have agreed with Health Education England (HEE) to publish a page on PAs in much the same way we have published a page on clinical pharmacists and the other national GP workforce initiatives. There are also practices in Wales training/using PAs.
This will give the GPC an opportunity to publicly re-emphasise its position on PAs and put forward the pros and cons of hiring a PA within General Practice at the same time. We are trying to get some case studies, to see how practices have made use of PAs and what their experience has been like in terms of hiring and embedding them into the practice.

GPC discussed the introduction of PAs back in September 2016 and agreed that, given GPs' changing work patterns, their desire for better flexible working options, declining GP full time equivalent numbers and the length of time it will take to train enough GPs to make up the current shortfall, PAs could become a useful part of the extended GP-led practice team, and help to tackle severe GP workload, if introduced and trained in the right way.

This would of course involve ensuring they supplement rather than replace any post within the existing workforce and that sustained funding is forthcoming so that practices can hire / engage them. NHS England's recent launch of the concept of primary care networks also suggests the transfer of care services into primary and community settings is going to gather pace in the coming months and years.

Whilst it does not explicitly represent support for MAPs, policy was passed at the 2018 ARM rejecting an attempt for the BMA to officially oppose the introduction of MAPs.

By 2023 there will be around 6000 qualified PAs within England. The vast majority of qualified PAs are currently being employed by secondary care NHS trusts at the moment.

We'd welcome any further thoughts you may have on what I've said above / the introduction of PA roles into General Practice.

Supporting the Educational Attainment of Urgent and Unscheduled Care Capabilities in General Practice Specialty Training Dan Djemal on behalf of the GPSTs and I have met with HEE to agree revisions to guidance, which are nearly finalised; the current guidance remains in place for now.

Targeted GP Training Sandesh Gulhane from the GP Trainees Subcommittee and I have been reviewing implementation of the HEE Targeted GP training scheme designed for GP trainees who passed their Work Place Based Assessment and one of the two required exams (either Applied Knowledge Test (AKT) or Clinical Skills Assessment (CSA)) but left training without passing the second exam, to re-enter GP training. The 18-month scheme is being introduced as HEE recognise that this group of trainees may not have had the equivalent opportunities for support that are available to trainees today, and sufficient time to achieve the required standards. Applications opened in July for the scheme beginning in February 2019, and will open in July 2018 on the GPNRO website.

GP Career Support Shabana Alam-Zahir has written a great blog for GPs who are/have just CCT'ed https://www.bma.org.uk/connecting-doctors/website/b/ddb/posts/i-m-ccting

NHS England High Impact Intervention Guidance for First Contact Practitioners in Primary Care There has been a delay in the publication of this scheme which we have been involved in promoting.

Apprenticeships in England Guidance has been published on apprenticeships in England https://www.bma.org.uk/advice/employment/gp-practices/gps-and-staff/apprenticeships-in-england The guidance looks at how the apprenticeship levy works, what funding is available to employers and signposts to useful resources on how to employ an apprentice.

Mental health therapists co-location guidance We were consulted on new guidance on co-location of mental health therapists which has now been published https://www.england.nhs.uk/wp-content/uploads/2018/08/guidance-co-locating-mental-health-therapists-primary-care.pdf

GP Nursing in Primary Care– we now have 4 regional LMC/GPC reps on the four steering boards for the commitment to nursing in the £15M commitment in GPFV.

There are quite a few initiatives, some currently out to procurement. e.g. Induction Template, Clinical Digital Supervision, Collaborative Platform, Blogs, Conferences, GPN Bank (backed by NHS Professionals), Nurses Voices Network, Beacon Programme supporting sustainability. All are worth keeping an eye on.

There is some work going on about T&Cs and a 'model contract'. How do we and our LMCs feel about a model contract for Practice Nurses and HCAs?

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

Thanks are due to the Cat Ohman for her diligent and often unrecognised work in keeping sections of the BMA website up to date on clinical matters, the latest updated pages deal with hepatitis B immunisations and related contract changes.

The work of the group is contributing to the ongoing **QOF reform negotiations** where are priority continues to be to ensure QOF is clinically relevant, encourages and does not disincentivise personalisation of care, and that there is stability for practices in terms of income and workload. This work is linked to the **NICE consultation on quality metrics** which (mostly) arose from the work C&P have been doing on frailty and diabetes, and it is the first time I can remember that clinical output from GPC has driven this process, previously we have been reactive to proposals of others.

We are liaising with other GPC policy groups, the DDA, and pharmacist organisations to form a common policy for **reimbursement of dispensing practices**. This reform is long overdue and best approached from a multi-professional standpoint.

We had significant input into a simulation of **Pandemic Influenza** organised by PHE. The shortest time between flu pandemics in the 20th century was 12 years, we are 9 years from our last one, so it is time to dust-off those business continuity plans. The next pandemic is likely to be the first one in the world of primary care networks, AI, digital consulting, and social media. Just as generals try to fight the next war with the tactics used in the last one, we need to be aware of and prepare for these societal changes.

The NHSE's work on **Low Value Medicines** continues, and my tactics here are to continue to engage with this group, to ensure that their actions are clinically justified, and that CCGs don't over-reach themselves with regard to implementation. Some of their future work may turn out to be of benefit to us, and there are plans to look both at 'specials' and appliances and nutrition.

Every year I attend a meeting with the **Chair of BMA Council and Chair of NICE.** It is a useful meeting to pass on the views I think you would want me to.

I have attended a meeting on the **Falsified Medicines Directive.** This EU obligation will require a fundamental change in the way we process any medicines that we give to a patient directly and will have as much impact on prescribing as dispensing doctors. This is to solve the huge problem of a whopping 0.005% of prescribed drugs being counterfeit, equating to about one prescription every day in the UK. Despite the fact that the law is coming into effect on February 1st nobody is ready for this, not least the system suppliers and drug companies, and my advice for the minute is to do nothing at practice level for now.

We have attended a meeting to discuss **medicines safety programme & metrics** based on the WHO Global Patient Safety Challenge. As ever the challenge for us is to match laudable aims with daily practicalities.

Finally, another regular source of activity for us are LMCs who have concerns, and recently we have been involved with advice on the handling of trans patients' records, follow up after bowel screening, flu vaccine delivery concerns, and the steps it is reasonable for GPs to make after issuing a prescription for an acute medication, to ensure that it is collected.

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

Contracts and Regulation – Bob Morley

- Seeking further legal advice on NHS responsibility for collaborative services payments; further meeting with NHS England arranged

- Katie Bramall-Stainer supporting Mark Stanford- Wood on with NHS England and RCGP on appraisal of GPs performing "low volume " of clinical work has been completed and policy published https://www.bma.org.uk/connecting-doctors/the_practice/b/weblog/posts/when-you-work-fewer-than-40-sessions-a-year-of-uk-general-practice-new-guidance-to-support-gps-appraisers-and-ros

- Further work with NHS England and RCGP on regulation and performers list status of GPs leaving the UK is now underway

- Consulted and commented on RCGP's draft revision of revalidation and appraisal guidance

- BMA Guidance related to coroners' issues is being updated following our meeting with chief coroner. In particular guidance on Section 28 notices is being prepared. Further joint work being planned on clearer national guidance on referrals to coroner and guidance to bring further consistency to process for verifying expected death

- Continue to engage with CQC through various fora to represent the interests of general practice; have continued to robustly raised practice concerns over the process and conduct of inspections in the new phase of regulation; attended a CQC registration issues workshop to discuss and resolve problems experienced by practices across numerous aspects of the registration process

- Letter of concern written to CQC chief inspector of hospitals over the activities of Bluecrest health screening and its implications for GPs and their patients

- Ongoing work with PCSE on performers list transformation processes; Krishan Aggarwal leading

- Successfully challenged NHS England on interpretation of regulations for removal of patients at request of practice who have moved out of area. Further challenging on still extant policy which reflects ultra vires contract with Capita

- Ongoing engagement with NHS England over local misinterpretations of SFE re phased return from sick leave; NHS has now fully conceded that SFE mandates payment for partners on phased return and that in those cases where it is not mandated for SGPs' phased return local commissioners MUST make discretionary payment; consultation on new national protocol for imminent publication. Further work on shared parental leave is ongoing.

- Contributed significantly to new NHS England national guidance on appropriate PCSE process for removal of violent patients and special allocation schemes , now published https://www.bma.org.uk/advice/employment/gp-practices/service-provision/special-allocation-scheme

- Continuing to work with C and P policy group, on issues related to absence of commissioning arrangements for GP prescribing for gender dysphoria; meeting with legal team planned to consider next steps

- Legal advice obtained confirming that limited companies cannot hold GMS contracts alongside named partners, and guidance issued on the risks of contract novation from partnership to limited company

- Commencing production of guidance for practices on Lampard Review

- Julius Parker has been re-elected as policy group deputy lead

- Forthcoming policy group meeting to discuss progress with allocated Conference resolutions and workplan for the session

Commissioning and Working at Scale Group – Simon Poole

- NHS England have issued new guidance to encourage GPs to place mental health therapists in their surgeries.
- NHS Digital have published the latest GP investment data in September which will be analysed by the health policy team.

- Simon, along with GPC England exec team, is is attending meetings with NHS England discussing primary care networks as well as feeding into the GP partnership review regarding working at scale issues.

Going forward

- The policy group will continue to focus on working at scale issues led by the chair, Simon Poole. However, the group will now also encompass a focus on NHS England delivery and monitoring, which will be led by Chandra Kanneganti.
- Some of the issues that the group will look at over the session include:
    - Monitoring the delivery of NHS England programmes such as funding for the long-term plan for primary care; access funding; funding for online consultations and practice manager funding
    - Monitoring and developing guidance on primary care networks
    - Working at scale issues addressed by the GP partnership review
    - Progress with STPs.

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

Premises and practice finance – Ian Hume

Premises Cost Directions

As part of the 2018 English contract deal with NHS England, GPC England agreed the policy intentions for the Premises Cost Directions. This was agreed in March 2018, and during the last six months NHS England's lawyers have been working on the drafting. We have now received the draft directions and have been intensively working on them with our legal department to ensure that they reflect the policy agreement. We are not renegotiating the directions, simply ensuring that the policy agreement is translated correctly into the directions. We envisage completing our review within the next few weeks and then will return them to NHS England for further refinement.

The new directions will give additional clarity and resolve some of our long-standing problems, for example:

- Rent reviews will be simplified with contractors not having to undertake their own valuation, but just show evidence of negotiation with the landlord.
- Rent reviews will not lead to varying lease terms.
- There will be more formalised arrangements for third party use of premises with no financial disadvantage to the contractors.
- Improvement grants will be permitted to purchase land to build an extension.
- Grants representing hundred percent of project cost will be allowed (currently this is only 66%).
- Amended abatement and use periods have been agreed.
- Last partner standing issues - we have more explicit options and clarity for practices that have been in receipt of a grant, and for leaseholders.
- We have greater clarity over contractual rights to reclaim overpayments.

We were not able to agree to all the conditions with regard to grants in our negotiations but have been continuing to discuss individual cases with NHS England over the summer to find ways of progressing schemes and utilising ETTF funding.

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 meeting over the summer participating in a core steering group and a wider stakeholder group. NHS England recently sent a consultative 'call for solutions'. We have just received the results and will be meeting with NHS England to discuss the next steps in the coming weeks. Further to this, we will shortly send out a BMA premises survey, to build on surveys undertaken in previous years and provide up-to-date data on the current picture with respect to GP premises, which will also be used to feed into the review. We have set up our own internal stakeholder group and will utilize members of the policy group over the coming months. The outcome of the review will be a set of recommendations for NHS England and DHSC to consider.

Other work

We have been providing support and guidance to GPC Scotland implementing the national code of practice for GP premises and working on the underpinning legal documents.

We continue interactions with NHS property services, gaining evidence about their service charge model and examining the legality of this process, pushing back on any attempts by NHS property services to bully or cajole practices by legal action. We will continue to seek appropriate legal advice and explore all option, but ultimately, we hope to reach a negotiated settlement.

Primary care support England

During the summer the National Audit Office has released its report and senior members of NHS England and Capita have been called in front of the Parliamentary Accounts Committee. This has highlighted the woeful inadequacies within NHS England's contracting process with Capita, alongside other failures. We continue regular engagement, at a senior level, meeting monthly to cover operational issues and the GPC office continues to deal with cases on an individual basis. We discuss operational issues, for example shortly NHS England will be undertaking their routine list cleansing work. We also continue to feed into the transformational projects and improvements to the performers list process, which do seem to be inching closer. The electronic format (if it works) will be a significant improvement for those who wish to change status on the performers list. A considerable amount of work has gone into testing the system and scrutinising the content and appearance of the new electronic forms. We are getting closer to agreement of how somebody would be verified to have access to the portal in order to change status. There have been issues with PCSE management of pensions and we continue to keep pressure on NHS England to rectify the problems. Finally, at some stage the Exeter system will be decommissioned, and the spine will be used as the prime source for patient registration and payment data. This is an area which is hugely important for the stability of general practice and we are insisting on a high level of diligence going into the project.

Information Management, Technology & Information Governance – Paul Cundy

IT Futures, the program that will replace GPSoC is coming to the end of the specification derivation process. The IT Policy group is being involved in signing off the final specifications for the systems that

will be available under the IT Futures contracts. These specifications will include all current functionalities as well as more recent developments in digital first patient services.

GPES, the data extraction system used for the majority of data extracts from GP systems, is also coming to a contractual end. GPES is not the only mechanism by which CCGs and others extract data from GP systems. Many of these other processes are less well regulated and assured. The proposal is to replace all of these with a system which will extract an agreed all-encompassing single dataset and then have recipients receive only the data they need, a single conduit for all data flows. We have sought and secured a wide range of protections both for the GP data controllers as well as the data itself. Discussions are ongoing but are expected to be made public by the end of the year.

GDPR, we continue to liaise on an almost daily basis with the ICO on GDPR. The most contentious issue remains SARs and their costs. Some clarity is emerging, and BMA guidance is being updated to reflect this. My own personal survey showed from 1,200 practices that 54% felt SAR requests had increased by an average of 26%. As you know building on this GPC has launched a more refined and targeted poll to collect detailed evidence for negotiations.

We have begun the process of developing a Code of Conduct for SAR extracts for GPs and the ICO has been extremely supportive of the initiative. We are liaising with stakeholders and have begun developing the necessary documentation.

Appointments data. NHS Digital has collected under a Direction from the ex SOS a large quantity of "appointments data". They are legally bound to publish data they collect. We are having discussions as to what shape and form this publication should take, NHS Digital are aware that the data is open to massive misinterpretation and will not fully reflect the GP's working day. I am concerned that one outcome will be a call for GPs to spend more time logging what they do rather than actually doing it.

Controlled drugs via EPS. We await regulatory changes to allow controlled drugs to be prescribed via EPS.

QOF cut-off date. It has recently come to light that some system suppliers apply a cut-off date for QOF data entry that is not midnight on 31st March but some hours earlier. We have asked for a contract change notice (CCN) to be issued to correct this error. This has been the situation since 2004 and the suppliers do publicise this to their users every year.

IT failures, Docman issues, allergy coding errors, delayed hospital letters. There have been a variety of system failures recently that can be traced to both software and process errors. We have made the case for practices to be resourced to deal with correcting these problems, which in some cases can amount to thousands of documents. As IT utilisation grows outside practices and we move from the universal paper post entry portal to electronic delivery, the diversity of delivery systems and mechanisms is proving difficult tricky to monitor.

PRSB, Professional Records Standards Board, a committee made up of the royal medical houses run by RCP and commissioned by NHS Digital to develop standard data content for clinical communications, has agreed to establish formal links to the JGPCIT so as to ensure that GPs have a say in what stuff is sent to us.

Section 28 Coroner's report. A coroner has ordered NHS Digital to report on an event where a patient died because medicines that might have prevented the death were not dispensed urgently. The JGPCIT has submitted wording that clarifies the GP's position and responsibility in such circumstances.

Pharmacy EPS systems not fully relaying additional patient messages sent by the GP via EPS. We have raised this issue with both the RPS and NHS Digital as it has both human behaviour and system design elements (as ever!). NHS Digital is ensuring that in future all systems will correctly, fully and intuitively deliver what is a privileged clinical communication.

TPP, data sharing. I can report that this message will be in our next GPC news;

Final statement from JGPCIT on TPP's SystemOne data sharing functionalities.

The JGPCIT has previously raised concerns regarding the sharing of patient records in TPP's SystemOne software. We have issued interim statements in March and December 2017 and earlier this year advising GPs of progress being made to address those concerns. New functionalities were deployed and implemented earlier this year and are now fully embedded. Consequently, the JGPCIT is confident that GP Data Controllers using TPP SystemOne now have the tools they need to ensure that they comply with GDPR and DPA 2018, but which also support appropriate sharing of data for care. To that end the JGPCIT is of the view that the concerns it raised have been fully answered and considers the matter closed. This is the end result of significant collaborative work between the Office of the Information Commissioner, NHS England, NHS Digital, TPP, the RCGP and ourselves over the last 2 years.

NHS App, we are involved in the latter stages development of the "NHS app". We have argued for and secured a more sensible approach to the development of its functionalities, such not having "select where you want to die" as one of its first offerings, given the likely take up target group. We would like to see it offer a consistent access to digital services throughout England.

GP@Hand, we continue to press NHSE regarding the Babylon product and its interface with the NHS via the GP at Hand service.

SNOMED, snomed is now embedded in GP systems and transition to its use as the primary coding system is under way.

EU Falsified Medicines Directive. This is on the horizon and will require kit for GPs. We have opened discussions. It will not be a big bang, more like a slow dribble. It involves every single packet of medication circulating in the EU having its own barcode passport so it can be tracked in and out of the supply chain. Practices are expected to scan them when dispensing medicines to patients, for all GP this will mean vaccines and injections but obviously the implications for dispensing doctors is quite different.

GP2GP, we continue to press for GP2GP to be taken back from being classified as "BAU" as it is still neither universal nor universally used. GP utilisation has improved markedly (well done everyone) with average receipt and import into the new GP practice running at 4 -5 days. It has been identified that 80% of transmission failures occur between two suppliers but NHS Digital has yet to allocate resources to properly investigate the issues. GP2GP will be the bedrock of a paperless NHS and we will continue to push for every bell to be polished and whistle tuned.