# EXECUTIVE AND POLICY LEAD UPDATE – November 2018

## GP trainee subcommittee – Zoe Greaves and Sandesh Gulhane

At its meeting on 19 September, Zoe Greaves and Sandesh Gulhane were elected co-chairs of the subcommittee and Marie-Estelle McVeigh was elected deputy chair. The full executive will meet for the first time this month and is comprised of:

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| **Co-chairs:** | Zoe Greaves and Sandesh Gulhane |
| **Deputy chair:** | Marie-Estelle McVeigh |
| **Northern Ireland:** | Dearbhla McManus |
| **Scotland:** | TBC |
| **Wales:** | Paul Mitchell |
| **Education and training lead:** | Lynn Hryhorskyj |
| **Terms and Conditions lead:** | Justin Copitch |

### 2018 junior doctor contract review in England

The 2018 review of the junior doctor contract in England began over the summer. The five working groups based around the key themes of the review - Less than full-time, flexible working and equalities; pay structure and transitional arrangements; safety and wellbeing; workforce; and training and education - have begun to commission data which will ultimately underpin the development of evidence-based objectives for improving the contract. Within the workforce issues group there will be a specific section titled "*non - hospital setting"* which will focus on GP trainees, amongst others. The evidence gathering stage is due to end in December. The full terms of the review are available on the BMA website:

https://www.bma.org.uk/collective-voice/influence/key-negotiations/terms-and-conditions/junior-doctor-contract-negotiations/junior-doctor-contract-review-2018

Members of the GP trainee subcommittee have until 12 November to apply to be on the Junior Doctor Committee's negotiation team. Negotiators are appointed rather than elected and are currently open to any member of the JDC, GPTSC, JATs, PHMRC and the LTFT forum. GP trainee subcommittee has oversight of the process by being a member of the JDC exec and JDC contract review steering group.

### COGPED review of OOH guidance

Over the past year, the subcommittee and the education and training policy group have been providing feedback on a revised *COGPED Position Paper: Supporting the Educational Attainment of Urgent and Unscheduled Care Capabilities in General Specialty Training 2018*. We are extremely disappointed that recommendations around encouraging remote supervision remain in the

document despite our repeated concerns about this in relation to the safety of patients and trainees. We have written to COGPED to ask them to reconsider their proposals.

**Future of GP training**

The GP trainee exec committee are meeting with Dr Will Owen, a GP trainee and National Medical Director Clinical Fellow who is working with the RCGP AiT Committee to develop a trainee-led position paper outlining a vision for the future GP Training.

**RCGP exam fees**

The subcommittee has continued to work with RCGP to develop communications to trainees about how exam and membership fees are spent. This has been a longstanding issue which the subcommittee has been trying to address over a number of years. While we have had a good working relationship and developed infographics in relation to this, we have written to the college to request a further meeting as the level of detail around how money is spent has not been sufficient.

**GP trainee newsletter**

The latest GP trainees newsletter is available here.

**Sessional GP subcommittee – Zoe Norris**

**Sessional GP subcommittee**

**Locum terms and conditions – Zoe Norris** has been working with GPC England exec and BMA Law to finalise model locum terms and conditions. These have been put together to provide a common set of terms that locums and practices can use and are intended to provide clarity around work that will be done, expectations and to reduce the chance of disputes occurring.

**DHSC partnership model review – Zoe Norris** has also continued to represent GPC England with Krishna Kasaraneni at the partnership review working group meetings. The interim report of the review was discussed at the last subcommittee meeting and that discussion will feed in to wider GPC engagement with the review.

**Annualisation – Krishan Aggarwal** has been working with the BMA pensions department to launch a legal challenge in to pension annualisation on the grounds of discrimination. Under the current interpretation of the rules, those who have transitioned to the 2015 scheme and who have taken breaks within the pension scheme year may have to tier their pension contributions at a higher rate based on their annualised earnings, rather than their actual earnings. Further information on annualisation and other pension advice for sessional GPs is available on the BMA website.

**Atypical contracts – Ben Molyneux** has been working with contract and regs and the BMA pay and contract team to develop guidance for salaried doctors working in non-standard roles.

**Sessional GP engagement in commissioning structures – Ben Molyneux** has also been working to follow up on the FOI of CCGs we submitted earlier in the year about sessional GP engagement in commissioning structures. We identified 16 CCGs that reported barriers to sessional GP representation in their CCG structures. We have written to them to say their practice is inconsistent

with the majority of CCGs and asked them to consider removing the barriers to sessional GPs engagement. We have also submitted an FOI request to STPs to understand sessional engagement in their structures, but due to different arrangements, it might be difficult to get a clear picture of engagement across STPs.

**Indemnity – Matt Mayer** has worked with Mark Sanford-Wood to publish FAQs about what we know so far about the state backed indemnity arrangements. Matt has also blogged about the winter indemnity scheme.

**Locum revalidation guidance –** NHS England have published new guidance for locums and doctors in short terms placements. This clarifies that locums do not need to list every practice that they work as part of their appraisal supporting information. It also provides guidance on induction processes for locums.

**Sessional GP newsletter** – the November issue of the sessional GP newsletter is here. If you don't automatically receive the newsletter, you can subscribe here.

**Representation – Bruce Hughes**

**Policy Groups**

The allocation process is complete and the "Roles and Responsibilities" document adopted. We are compiling a short paper in order to explain what each Policy group does to enable a more informed choice for new members of GPC UK and the subcommittees.

**Policy Group Deputy Elections**

Elections have taken place and each Policy Group now has a Deputy Lead (and in some cases two)

**Gender Diversity**

The Task and finish group led by Rachel Ali met recently and work on the final paper has begun. The timeline for reporting is to GPC UK in March 2019.

**Multi-member Constituencies**

The group discussed the pros and cons of multi-member constituencies for Regional Representatives to GPC UK. There was no clear consensus and so a working group led by our Deputy Lead Rob Barnett will examine this further.

**Dispensing policy group – David Bailey**

Two main workstreams at present.

The first is a joint project with the Pharmaceutical Services Negotiating Committee (PSNC) and the Dispensing Doctors Association (DDA) on a paper to the DH on revising the mechanisms for reimbursing dispensed drugs. There is increasing disparity in cost and reimbursement what with category M, branded generics and zero discount drugs this is impacting on financial planning and profits for both community pharmacy and dispensing doctors leading to what is a unique

cooperation between the professions to try and regularise medicines dispensing for all patients by both professions.

Profit on medicines is part of the contractual reimbursement for pharmacists and indirectly for dispensing doctors and the sheer volatility of the current situation makes this impossible to plan and cost for both the professions and the government.

One of the biggest drivers for volatility which ultimately costs the NHS money as agreed contractual envelopes have to be honoured by government is the widespread use of software such as Scriptswitch which in addition to its legitimate and helpful role in promoting prescribing safety is used by many CCGs and LHBs as a way of promoting switches of branded generics to save pennies but often at the expense of the community pharmacist and ultimately the NHS as a consequence of contractual retained profit. One of the proposals therefore which will affect all doctors is a return to proper generic prescribing with benefits for patient safety and ease of governance.

A common reimbursement system would promote more even spread of profit less dependent on varying prescribing minimise dispensing at a loss, mitigate against artificial shortages and look at the financial interests of the whole NHS rather than individual reasons and be safer and easier to understand for patients if true generic prescribing was promoted. For all these reasons of course it's likely to be very difficult to agree but we are committed to trying.

The second main work stream is around the Falsifying Medicines Directive.

It's fair to say that this has been somewhat troubled in its implementation and we are informed that in the event of a No-deal Brexit it might not be able to proceed at all.

The FMD is due to become law across Europe in February 2019 although only about 15% of medicines production will be able to be included. The process is intended to stop counterfeit medicines getting to patients by having official 2D barcodes on every package with an anti tamper device. These packs will then be decommissioned by a 2D barcode reader at the point of dispensing – community pharmacist, dispensing doctor, **and every GP practice in England and Wales (and probably NI and Scotland too)** because of personally administered medicines (immunisations etc.) so this is not a minority interest.

Currently only 5% of medicine packs have the anti-tamper and the barcode and few if any GP practices have the barcode readers. It is broadly agreed that government will have to fund the readers as part of GPSOC but there is no integrated software as yet although it is on the radar of IT futures so there is virtually no capacity to deliver FMD in three months' time although government is committed to making a start.

Our principle concern is the potential extra administrative workload for practices and also the slowing down of the consultation – particularly immunisation campaigns unless batch decommissioning is permitted (there is a relatively short window between decommissioning and having to dispense the items so in general this won't be possible at present).

Given the lack of preparation across the system governments seem relaxed that there won't be universal roll out in February but equally there is an obligation on them to start rolling out the

process with all its likely inefficiencies for the service. We will continue in discussions to try and mitigate the effects on practice workload as much as possible.

The only other current dispensing issue of note is the problem with the fee scale caused by differential pay rises in England and Wales but this will fall to GPC Wales to resolve.

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

### Education, Training and Workforce – Helena McKeown

**Targeted Enhanced Recruitment Scheme (TERS)**

We've continued dealing with members' concerns regarding advertising and allocation of £20,000 (pre-tax) incentive to support recruitment in areas to which it has traditionally been hard to recruit. Following the launch of the £20,000 TERS in England in January 2016, 105 GP Trainees accepted posts in seven hard to recruit to areas. The scheme was repeated in 2017 with an increase in the number of training places to 144, and applications for these places are now being accepted. Foundation doctors in both Scotland and Wales could also apply to the scheme in certain regions.

- HE East Midlands – Lincolnshire
- HE East Midlands - Sherwood Forest
- HE East of England - Kings Lynn
- HE East of England - Great Yarmouth
- North West Lancashire (Blackpool)
- East Cumbria
- West Lakes
- Lincolnshire
- North and North East Lincolnshire
- Isle of Wight

With TERS being given the go-ahead for another year we are pressing HEE to ensure that all local allocation processes are transparent, clearly linked to specific geographies and not a reward for attainment. This year several members have raised concerns about misleading information on local HEE websites and problems with the process for allocation.

HEE have now confirmed that for 2019 local GP directors will be more specific about the locations involved, and that TERS programmes will be separate preferences in Oriel, ensuring that applicants will be able to make informed choices around their preferred destinations.

**Targeted GP Training (TGPT)**

TGPT began this year, with the applications for the first cohort of applicants opening in July and closing in August. This group of applicants will form a pilot of these proposals, which will be evaluated in due course. GPC England has been involved with these proposals since their inception, and will continue to be involved as the pilot, and TGPT as a whole, is evaluated.

LMC Update

**GP Nursing strategy**

We have drafted a GP Nursing strategy position paper. The paper looks at how we can ensure GP nursing is sustainable and how general practice needs to be adequately resourced to invest in the recruitment and retention of GPNs. The paper has initially been circulated to the ETW policy group and comments are being incorporated. Following this we will share the paper with GPC England to agree and position the direction of travel.

**Retention**

We remain in contact with NHS England regarding concerns raised by members about CCGs refusing to commission GP retention scheme places. It is clear, however, that the problems are localised and that on the whole the scheme continues to grow in strength, with nearly 500 GPs working as GP retainers according the latest HEE figures (please note that official NHS Digital figures show considerably fewer, but this is almost certainly due to practices recording GPRs as 'salaried GPs' on their WMDS (Workforce Minimum Data Set) responses.

**Long Term Plan**

We have contributed views on workforce to the Long-Term Plan, which is likely to be released early December.

**GP Partnership Review**

Nigel Watson sought views on

- Medical Students – to spend more time during their training in general practice and ensure that this is a good experience. General practice to be paid at the same rate as placements with other providers.
- Foundation Training – all doctors to spend some time working in a practice or in a Primary Care Network.
- GP Training – more time is spent working in community placements – such as Diabetes, Frailty, Palliative Care, Urgent care, etc.
- Specialist in training should spend a period working in a Primary Care Network.
- Primary Care Networks become education and training hubs for multiple professionals.
- Appraisals – this process to be simplified and made more consistent so that both the quality and contents is the same wherever you have your appraisal.

**Clinical Skills Assessment (CSA) Exam Board**

We continue our oversight role on behalf of members regarding the MRCGP Exam – in particular if there has been an issue in an exam such as a complaint about an actor, which needs an objective judgement. The agenda is highly confidential, but we also attend an annual AKT standard setting meeting – which from my previous attendance can put the GPC attendee's knowledge to test!

**GP Registrars' OOH Supervision**

Alongside the GPTrainees subcommittee we are continuing to try and ensure the safety of our patients and Registrars in an ongoing dialogue regarding the level of supervision of Trainees OOH

and the responsibilities Trainers are being expected to take on in being asked to commit to their Registrars being safe to be remotely supervised.

**RCGP Curriculum Consultation**

The BMA GPC (led by the GPTS) submitted a response to the RCGP's curriculum consultation that took place over summer. A number of comments were received from GPC and GPTS, and this included the highlighting of some existing BMA policies in response to the curriculum. You can find the letter that was sent in response to the curriculum here.

**Health and wellbeing/occupational health**

Last month, the BMA published a UK report 'supporting health and wellbeing at work' which sets out the physical and mental health challenges faced by doctors, the barriers to accessing support services, the lack of consistency of OH provision and funding across the UK, and makes recommendations for improvements. These include a comprehensive/confidential occupational health services for staff and greater emphasis on preventing and tackling the causes of ill-health earlier.

## 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

Since September's report two new workstreams have been added to the group's activity. There is to be a **NICE review of QOF indicators for Asthma, COPD and Heart Failure.** These are to follow the same format as last year's review of the diabetes domain, which was well received. I understand that the drivers for reform will be the same, namely that ways should be found to reward individualisation of care appropriate with the patient's stage of life. This is to be welcomed and will probably be the area of our work over the next twelve months which will have the biggest impact on GPs and our patients. One of the outcomes of last year's QOF review was the suggestion that **quality improvement activities** could be introduced into a reformed scheme, and we will be providing input in to the development of possible modules.

We have made a major contribution to NHSE's consultation on **Evidence Based Interventions**, we have already made representations to Nikki Kanani about this, and will be part of the pan-BMA team meeting NSHE to express our concerns. Although this is about surgical interventions it is inevitable that GPs will be left dealing with the fall-out. Our priorities will be to press for CCGs being obliged to commission up to the level of intervention that NHSE has deemed appropriate, that monitoring should be achieved by existing clinical governance procedures and not through individual funding requests, and that the rights of patients to a specialist opinion for advice where their GP believes this to be appropriate are respected. This will link into planned work on a **Focus on referral** document which is in its early stages.

A meeting with NSHE about Jeremey Hunt's project on **GP level individual data** concluded, unsurprisingly, that it did not yield useful information and, subject to approval by his successor, has been paused.

Work has continued on **Low Priority Medicines** with NHSE, and on the **PHE review of drugs associated with dependence or withdrawal syndromes**.

We will also be writing to NHS England again regarding the **Interim arrangements for prescribing for gender dysphoria patients.**

**Workload – Matt Mayer**

The Workload Management policy group has the following pieces of work ongoing:

- Triage Systems
    - Following our break out group discussion at last GPC-UK in September, we are gathering data on work practices have done in Northern Ireland to manage demand
    - We will be gathering data from across the country on use of total triage
    - Produce guidance document on how to implement such a system, pitfalls, pros/cons
    - Guidance on appropriate utilisation of 111 and IUC systems as first point of access
- Child Safeguarding Reports
    - Working with Professional Fees Committee (PFC) re: collaborative arrangements of child safeguarding reports and how these should be funded
- Hub Working – Producing examples of hub working for website from around the UK
- Social Prescribing & Self Care
    - Work ongoing with NHS Confederation regarding promotion of self-care
    - Public-facing document being drafted for circulation during Self-Care Week
- Appointment Data Gathering – Being handled at GPC England Exec level currently

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

**Contracts and Regulation – Bob Morley**

- Further meeting and ongoing work with NHS England seeking to reach a national solution to safeguarding and collaborative fees payments

- Follow-up meeting with chief coroner arranged for further discussions on issues of concern flagged up by LMCs

- Continued C and R input from Krishan Aggarwal into work with PCSE on performers list transformation

- Continuing to challenge and work with NHS England to ensure that its contract with Capita and policy on out of area patient removal at practice request complies with the regulations

- Consulted on revised and appropriately-worded NHS England protocol complying with SFE for parental and sick leave locum reimbursements, particularly in respect of phased return from sickness; ensured that where a practice is not automatically entitled to re-imbursement for a salaried GP under SFE NHS England has instructed CCGs that they must make discretionary payments on the same basis as partner absence; protocol publication imminent and guidance to CCGs already published on NHS Employers website

- Ongoing work with C and P policy group and BMA legal team and continuing to challenge NHS England to ensure appropriate commissioning arrangements put in place nationally for GP prescribing for gender dysphoria

- Supporting exec team with advice on contractual issues and implications on challenges to the GP at Hand practice arrangements and subcontracting to Babylon

- Support to LMC and escalation to NHS England over CCG threatening inappropriate contractual action on practices not fully open throughout core hours

- Guidance issued to LMCs in response to a CCG request for information from practices re implementation of Lampard Review recommendations

- With Commissioning policy group met with NHS England on consultation over its plans to overhaul procurement processes for APMS and practice caretaking

- Contributed to BMA response to NHS England consultation on ICP contract

- Meeting arranged with ombudsman to discuss concerns over introduction of new clinical standard

- Contributing to guidance on contracts for GPs working in " non-standard" roles.

- Ongoing engagement with CQC through regular liaison meetings with it and RCGP and through other fora including GP stakeholder and cross-sector events, continuing to robustly support and defend the position of general practice. Proactively discussing the implementation of the new annual Provider Information Collection and the interim arrangements whilst it's being developed to ensure the process is as fit for purpose as possible. Continue to challenge CQC over concerns raised by practices and LMCs.

- Working with ETW policy group and Sessional SC to ensure that all local appraisal processes for locum GPs are reasonable and proportionate in respect of the need to list work placements

- Continued work with ETW policy group, and Sessional SC, NHS England and RCGP on regulation and performers list status of GPs leaving the UK

- Ongoing responses and provision of guidance to varied and numerous C and R issues raised by LMCs and BMA members

**Commissioning and Working at Scale Group – Simon Poole**

*NHS England monitoring and delivery update*

- The BMA published their analysis of general practice investment in England based on the latest data from NHS Digital. This showed that £10.2 billion was invested in general practice

(excluding drug reimbursement) in 2017/18. This represents 8.1% of the NHS budget and therefore falls £3.6 billion short of our target level of investment.

- We have written to NHS England to confirm what funding is available for practices in 2018/19. However, they have been unable to provide this information. We will continue to push them for this so we can inform LMCs of what practices are entitled to this year.
- NHS England feedback at the LMC reference group meeting on 1 November confirmed recognition of inconsistency in the implementation of funding streams across the country. They are also looking to streamline funding streams to make them easier to access and more aligned with primary care networks.

*Working at scale update*

- The policy lead for Working at scale and Contracts and Regulations attended a meeting at BMA House with representative from NHSE in charge of the development of the new Pseudo Dynamic Purchasing System (PDPS). The PDPS was presented as an online purchasing vehicle for GP and Caretaker GP services which should help to make the procurement process for APMS contracts more dynamic. The policy leads expressed their concerns regarding this new procurement system which large commercial organisations are much more likely to benefit from. GP practices are resource limited and not incentivised to register on an online procurement platform unless something arises in their area. The policy leads also indicated that the new system risked excluding local practices often best-placed to provide emergency/urgent care taking in their local area/region with the support of LMCs and often best resolved without the need for APMS contract.

- The policy lead on Working at Scale is continuing to work on the negotiations with NHSE on the Primary Care Networks agenda, with the ambition to agree on its main aims and objectives.

- The policy lead contributed to the BMA's response to NHSE's recent public consultation on the proposed ICP contract.

- The policy group had a useful meeting on the same day of the last meeting of GPC UK in September. The discussions focused on issues relating to primary care funding for the NHS long-term plan, primary care networks, the independent GP partnership review, updates on progress with STPs in local areas and the LMC conference motions relevant to the work of the policy group.

- The policy lead for working at scale attended a meeting with NHS Clinical Commissioners in October. The discussions focused on Evidence Based Interventions, the NHS long term plan, the Independent GP partnership review and the ICP contract.

## 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 on the policy intentions for the Premises Cost Directions. This was agreed in March 2018, since then the DHSC lawyers have been working on the drafting. We received the draft directions back in August 2018 and worked intensively on them with our legal department to ensure that they reflected the policy agreement. There were a significant number of changes within the document, so this took longer than expected, but undertaking due diligence is vital. We are not renegotiating the directions, merely ensuring that the policy agreement is translated correctly into the directions. We have returned our comments and have a further meeting with NHS England in the diary to discuss progress. We are disappointed with the lengthy delays in publishing the premises cost directions which are outside our control. We are acutely aware of the difficulties that failure to issue the premises cost directions is having on GP developments which is particularly frustrating for those with ETTF bids.

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 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 a hundred percent of the 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 specific options and clarity for practices that have received 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 concerning grants in our negotiations but have been continuing to discuss individual cases with NHS England to find ways of progressing schemes and utilising ETTF funding. We are committed to seeing full utilisation of the ETTF.

We are drafting guidance which can be released at the same time as the publication of the premises cost directions.

**Premises Review**

As part of the 2018 contract deal, GPC England 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’. These have been analysed, and NHS England has come up with a shortlist of initiatives, focused on achieving solutions which will address our fundamental concerns. We are shortly meeting to discuss

this in more detail. We have also launched the BMA premises survey, to build on surveys undertaken in previous years and provide up-to-date data on the current picture concerning GP premises, which will also be used to feed into the review. We have set up our own internal stakeholder group and will share details of the discussion with the policy group and stakeholder group. Some of the outcomes from the review will dovetail with the partnership review, particularly issues regarding funding and risk. 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 have now concluded some detailed legal work with the Scottish government. The Scottish model is not necessarily transferable to England because of the different landscape, but the lessons learned are invaluable informing our ongoing discussions and premises review.

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 options, but ultimately, we hope to reach a negotiated settlement. Further meetings are being arranged, and we are all hopeful that we reach a negotiated settlement. We are reviewing our guidance on the website to ensure that it remains consistent and relevant.

We recently met with Londonwide LMC and listened to some of the particular concerns they have in London. This included how capital funding is being distributed, and the role of STP is in setting the direction of Estates strategy particularly for primary care. We respond to a wide range of premises queries from several LMCs.

**Primary care support England**

Over the summer the National Audit Office released its report and senior members of NHS England and Capita have been called in front of the Public 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 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 scutinising the content and appearance of the new electronic forms. We are inching 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 and Information Governance – Paul Cundy**

**IT Futures**

The replacement for GP Systems of Choice (GPSoC). We continue to have input into the specifications for the functionalities of the next generation GP systems.

**GPES replacement, re run of Care.data**

Discussions on a GP friendly single data extract to replace all the ad hoc local and other national extracts.

**GDPR**

SARs continue to be the major problem. GPC England recently conducted a survey on the impact SARs are having. We have agreed with the ICO that we can develop a Code of Conduct that will see the default response to a SAR being an offer to the patient to set up access to their records via the NHS Patient On-line functionalities. This is not always going to be satisfactory but it is the best we can achieve in the current legal environment.

Data Sharing Agreements.

We are seeing suggestions and in some cases demands that practices sign DSAs for what is individual direct patient care. Whilst understandings and terms of engagements might be gold standard data processing under GDPR for GPs is lawfully justified under Article 6(1)(e) and 9(2)(h) and therefore no DSAs are needed. I am seeking conformation of this from the ICO.

**IG Toolkit**

We have fed back on the replacement IG toolkit.

**EPS**

EPS for CDs has begun to be deployed and Phase 4 is about to be piloted. Phase 4 is the fully paperless(sic) version where no pharmacy is nominated and the patient can call down the script to any pharmacy anywhere. Practices will still provide a bar coded token that the patient will collect but no signature will be necessary. A printed token will only be produced where the patient does not wish to nominate a pharmacy, or where a patient choses for a particular script not to be sent to their nominated pharmacy. The option of an electronic token should be available in the long term. Changes to legislation are needed but are said to be imminent.

**PRSB**

We have established links and formal input into the Professional Records Standards Board. This is a board managed by the RCP regularly commissioned by NHS Digital to develop standards regarding the content and use of clinical and other information flows in the NHS. Many of these are likely to be sent directly or mirrored to the patient's GP. Our aim is to ensure GPs are not bombarded with unnecessary and unhelpful information

**ERS**

Since the 1/10/18 deadline we have had very few ERS related problems brought to our attention.

LMC Update

**IT failures**

We continue to push for a process by which practices are compensated for work created by external events. We are in discussions with NHSE regarding various recent mishaps including the Docman issue.

**GP@Hand**

We continue to monitor the impact of the IT side of this service. It remains our view that all practices should be provided with this functionality.

**BioBank and consent**

Practices are receiving letters from BioBank about data extracts for their patients. We believe the consenting process is GDPR compliant. Via JGPCIT we have raised some questions with BioBank directly regarding other GDPR aspects of the extraction proposal.

**TPP**

We have now completed the work to enable TPP's SystemOne software to offer the functionalities GPs needed to meet their GDPR and DPA2018 responsibilities.

**GP2GP**

NHSE has described GP2GP as business as usual but we have made the point that it is not and that further work will be needed before it is universal and universally used.

**NHS App**

The NHS app is being piloted and with our input via JGPCIT is shaping up to be a potentially useful tool.