# EXECUTIVE AND POLICY LEAD UPDATE – MARCH 2018

## GP trainee subcommittee – Tom Micklewright

### Rostering and annual leave guidance

We have been developing an annual leave guidance paper with NHS Employers. They have agreed to include the principle that GP Trainees, as supernumerary staff in a practice, should **not** be declined leave. The final paper is yet to be agreed though.

### Review of 2016 Terms and conditions

We are working with JDC and NHS Employers to re-establish a formal negotiating process for the 2018 review of the junior doctor contract in England. This would be the framework that would govern our engagement with NHS Employers under a collective bargaining relationship.

### NHS Employers

We met with NHS Employers to discuss a number of contractual areas which are still unclear from the current terms and conditions. These include whether or not GP VTS teaching should be deducted from the study leave allowance, re-imbursement of home visit travel expenses, and the publication of work schedule templates that include OOH shifts. As the Employers team was relatively new, they have asked to return to their reference group to put these questions to them before we meet again in the next couple of months.

### Dr Bawa-Garba and the GMC

Along with JDC and other stakeholders, we met with the GMC as part of a roundtable discussion to discuss learning and action points following the Dr Bawa-Garba case. The GMC made a number of pledges, including that they would never ask a trainee for their reflections as part of an investigation into their fitness to practice. Their other commitments can be found here.

### StHK Lead Employer

We have discussed with Lead Employer that across the 4 regions under their care, GP Trainees and trainers do not have access to or training in using allocate to exception report. St Helen's and Knowsley (StHK) Lead Employer will be sending further emails and guidance out soon and I have drafted a statement which will be co-signed by HENW and StHK to encourage trainers to support ER. This statement, once approved will be shared nationally with the hope it can be used as a template for changing the ER culture in GP.

### GP Out of Hours (OOH)

We have been working COGPED as part of a review of GP OOH training. Key features of the current proposals include: a move from hours-worked to a competency-based model for assessing when sufficient training in OOH has been completed for ARCP; diversifying the settings in which OOH competencies can be acquired; and clarifying expected levels of supervision at different stages of training and competence in GP OOH. We still have concerns about these proposals including the

lack of objective measures of competence and the risks to patients and doctors of remote supervision in OOH. We will continue meeting with COGPED, and the UK GP OOH Leads groups to influence this work.

We also conducted a survey of GP OOH Training. The data from this has helped us to feed into the COGPED OOH review, but has also enabled us to secure a statement from HEE outlining that, where OOH shifts are allocated to trainees, they must have at least 6 weeks notice of these shifts. HEE will be monitoring adherence to this. The statement and key findings from our survey can be found here: https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/gp-trainee-minimum-notice-of-shifts We will continue to apply pressure to the devolved nations to bring their policies in line with this from HEE.

**RCGP exam fees**

We have met with the RCGP Treasurer to discuss plans to provide a trainee-friendly breakdown of examination fees.

**LMC-Trainee handbook and sessional/trainees survey**

Using the information from the sessionals/trainees LMC Survey, we have created a guide to support LMCs and GP Trainees working more closely together. We intend to release this at LMC UK Conference.

**Academic GP Working Group**

In order to better understand current career and pay structures for GP Academics post-CCT, we have been speaking with MASC and JATS about setting up a virtual working group for GP Academic to share and collect data on current practice. We have created a consultation scope document which we will be submitting to MASC for their views.

**Devolved nations update**

In Scotland, we have been robustly rejecting proposals from Scottish Government for a 3+1 model of GP Training, whereby a post-CCT year would be spent undertaking additional training, for instance in psychiatry or paediatrics. With have been liaising with the RCGP and SGPC to reject these proposals. Additionally, from August 2018, NES will take over as the Lead Employer of Junior Doctors, including GP Trainees, in Scotland.

In Northern Ireland, our main focus has been in contributing towards a junior doctor survey, the results of which have informed our decision to build a campaign, with NIJDC, informing junior doctors of their working rights during training.

In Wales, we have been pressing for the Wales Deanery to approve ‘compensatory rest’, or time off in lieu, the morning following an OOH shift. This means that trainees can attend a full OOH shift whilst still being compliant with the European Working Time Directive rest requirements. Sadly however, this has been rejected and will be the focus of more work going forward.

**Sessional GP subcommittee – Zoe Norris**

**Model locum T&Cs**

We have been working on these in conjunction with Richard Vautrey and Justin Quinton from BMA Law. The second draft is being circulated for comment, then will go to the SSC in the first instance. We are hopeful this will provide a solution to the most common problems for locums and practices during bookings, and provide equal protection to both sides. It will have versions for use across the whole UK. Timeline will depend on amendments, and the accompanying guidance document which is being put together. Aiming for the summer with appropriate publicity to inform LMCs and locums.

**PCSE/Pensions**

Krishan remains involved in the ongoing T&F group. As a subcommittee we have grave concerns about the ongoing financial impact of the current situation, and are exploring all options to protect sessional GPs. Please continue to direct queries from sessionals to the subcommittee. We are able to signpost to some of the extensive guidance written for them, but detailed pension queries which need input from the BMA team will obviously need membership. We will continue with regular blogs and advice which – although aimed at sessionals – I would encourage you all to look at on the new website bma.org/sessionals

**Web page**

The sessional subcommittee were asked to be one of the first committees to work with the BMA web team to redesign our web pages. Pooja Arora has done an amazing job, and the sessional pages and now MUCH more user friendly, with a huge increase in hits and traffic as a result. Please do have a look, and direct colleagues there as the first point of call for all sessional information.

**Newsletter**

We continue to send out our monthly sessional newsletter, both to BMA and non-BMA members as well as LMCs. There is now a "subscribe" button so non-members can complete their details to get the newsletter directly once they have seen a copy.

We have a section on alternative careers and would welcome anyone on GPC who does something outside "normal" general practice to write a short blog for us. Please email Zoe if you're interested.

**e-Consulting/Online providers**

Ben continues to lead of providing guidance in this area, having produced the document on Sessional GPs working in New Models of care. He has spoken to most online providers, as well as colleagues working for them, and we hope this will be another helpful resource.

**Member Relations**

We appointed a dedicated exec member to liaise with BMA member relations, a role which Matt has been undertaking. This has vastly improved the information shared between the SSC and MR team, and we are supporting them in terms of the advice and guidance being offered by MR and the First Point of Contact. We continue to get reports via email and social media where things haven't gone

so well for sessionals who have contacted MR, and please do direct them to either myself or Matt if you come across this.

As a committee elected by all sessional GPs, whether BMA members or not, we continue to try and get the balance between ensuring equity of information to all those we represent. The newsletter has been part of that, as has the support given regarding Capita and pension queries by Krishan. We continue to respond to many emails and queries on social media to reach as many colleagues as possible.

**Membership Challenge – sessionals**

A number of SSC members have been invited to join myself and Krishan in a discussion about the BMAs offering and services for sessionals. This was cancelled due to the bad weather but we are looking forward to it being rearranged.

**LMC Sessional/trainees survey**

We have had a good response to the brief survey we sent to LMCs as a joint project with the GP trainees subcommittee. This looked at engagement and representation of both groups with LMCs, and at examples from LMCs of what ideas had (and hadn't) worked when trying to improve this. I will be presenting some of the key findings in my speech at LMC conference.

**CCG FOI**

We submitted a Freedom of Information request to all CCGs in England looking at sessional representation on their boards and governing bodies. This was in response to widespread concerns over the lack of sessional input, some CCGs whose constitutions barred sessional doctors from being involved at all, and the knock on effect this is having at STP level and in ACS's.

We are reviewing the results and will publish a specific report summarising these and our proposed solutions.

**Low Volume Appraisal Work**

Paula Wright has worked alongside colleagues from ETW and Contracts & Regs, led by MSW, to input into the process for appraising GPs who are doing fewer sessions in general practice. This is an increasing occurrence as the popularity of portfolio careers grows, and effects everyone from GPC members, to newly qualified, academic and older GPs. Reaching a balance between ensuring that ROs and NHSE are satisfied with the evidence providing, and not further increasing the burden of appraisal and revalidation has required a huge amount of work, but we are nearly there.

**DDRB Submission**

The BMAs DDRB submission has been submitted and is now publicly available. I have been involved in working alongside Evita in the secretariat on the section providing evidence on sessional GPs, particularly with a focus on salaried GPs and the increasing number of these. Any uplift recommended by DDRB will be backdated to April 2018, and the SSC will produce template letters for sessionals to remind practices that this should be passed on.

**Indemnity funds GPFV**

Matt has written template letters for both salaried, and locum GPs to use to highlight the additional GPFV indemnity funding which practices will be receiving from April. This will help salaried GPs calculate their proportion of the funds clearly for practices, and provide locums with an explanation for price rises which will result from this. We would ask for GPCs ongoing support – the distribution of this funding is very far from ideal, but it is for GPs of all contractual status and the onus is on all members and LMCs to ensure its fair distribution.

Any queries, please check the new website or email myself zoe.norris@nhs.net

**Representation – Bruce Hughes**

**Policy Lead selection process**

The review of the UK Policy Lead selection process led by Pete Horvath-Howard is in final draft and being presented at GPC UK on the 15th March.

**Gender Diversity**

The Task and finish group led by Rachel Ali is making good progress and will shortly be sending surveys to both LMCs and GPC members. We would appreciate your support in both responding and encouraging participation in this import work.

**Living Our Values (LOV)**

The policy group will be involved in evaluating the LOV work which took place in the GPC England meeting. Fay Wilson is leading with the kind help of the facilitators of the group work and Secretariat. We will be keen to here from the devolved Nations regarding their approach to LOV.

**Policy Group Engagement**

We are exploring the mechanisms whereby the appropriate engagement takes place with representatives of the Devolved Nations in UK wide Policy Groups.

**Speaker of the House**

The group will help evaluate the Speaker of the House pilot being run in GPC England.

**Regional Elections**

These have now been completed successfully in advance of the LMC UK conference this year.

**Prison GP Representative Election**

The election for this relatively newly created position is also in progress.

**Webpage**

We are in the process of developing a webpage.

**Dispensing policy group – David Bailey**

Little new to report since last update in November. We have met PSNC again along with colleagues from DDA and agreed we need to consider some more joint working as our interests all seem to be far more aligned than perhaps they were previously.

All sides are keen to progress work on fairer reimbursement and a better engagement with the department about the Drug Tariff and also around pharmacy schemes to tackle minor ailments. On the latter point we will be working with clinical and prescribing and make representations that any scheme to limit access on prescription to non-POM drugs not only has implications as described by Andy Green on the current terms of service but also risks being discriminatory against rural communities unless dispensing doctors can also provide P and GSL drugs for sale to their patients. We are hoping to meet separately about this with the pharmacists and C&P reps but have already set up a meeting in March with PSNC and DDA to start work on a proposal for reimbursing drugs to put to the department.

Contractual remuneration of course remains a part of overall negotiations via the plenary process and will be dependent this year on agreement to include it within this year's negotiations.

## RECURRENT AND SUSTAINABLE FUNDING AND RESOURCES

**General Practice Forward View – Chandra Kanneganti**

**CCG commissioning gaps in England**

- Many practices have highlighted that there is a current commissioning gap for enhanced services.
- The BMA Health Policy team have issued FOI requests to all CCGs to identify the current funding they are providing in their areas across England. CCGs have started to feedback with their responses, with funding broken down for each service provided.
- Once we have this information, we will be able to determine, based on the variation, how we present our findings.

**Practice Manager Development**

- NHS England have informed GPC that funding will be available for practice manager development, where 2017/18 funding has not already been allocated by NHS England for delivery of practice manager activities, the funding will be carried over to 2018/19. This will not prejudice funding already identified for 2018/9 within the GPFV. Regional teams and LMCs therefore have longer to confirm the plans for local work and to agree contracts. Although we welcome this funding, there is concern around the funding stream and variations in areas. Local NHS England teams are now speaking to CCGs about the fudning stream process. We will be following this closely. It may help if we could look to provide suggestions around providing local solutions, as it is vital that this funding continues for general practice.
- We have also sent NHS England a letter asking them to provide further clarification around the process for the local funding of practice manager training and if there is any scope for making changes to the outline or wording of the programme assessment set out in the in the NHS Operational and Contracting Guidance. NHS England have confirmed that they are aware of this issue.

**Recurrent vs non-recurrent funding**

- We have written to NHS England to ask for clarification on what recurrent and non-recurrent GPFV funding has been spent so far and what is planned to be spent.
- This will identify if GPFV is on track to deliver the recurrent funding it has committed.
- The BMA Health Policy team have followed up on the letter. NHS England have confirmed that they are finalising the response, and that we will receive the information this week.

**GPFV two years on monitoring report**

- The BMA Health Policy team have sent out a survey to LMCs to collate feedback on the progress of GPFV funded services after two years since its implementation. We have received only a few responses so far.
- We are currently collating case studies on the progress of GPFV from a few practices in England to include in our Two Years On monitoring report.
- We intend on publishing the GPFV: two years on monitoring report in April 2018.

**GPs providing care to nursing homes**

- NHS England are keen to understand and hear more about initiatives that support the care of people in nursing and care homes, including end of life care. To help feedback, we have asked LMCs to provide examples of good practice where GPs have provided proactive care to homes. Specifically they asked for examples of where they have also been value for money.
- We will be producing a discussion paper based on our findings over the next month, to feedback to NHS England and publish.

**International funding models for general practice**

- The BMA Health Policy team have now published the International funding models for general practice report on the BMA website and will promote it further with the support of the communications team.

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

**Education, Training and Workforce – Helena McKeown**

**GP Retention Scheme**

NHSE's recent request for comments on the GP Retention Scheme literature, they have no published the minor updates they have made - https://www.england.nhs.uk/gp/gpfv/workforce/retaining-the-current-medical-workforce/retained-doctors/

The scheme information on the BMA website points to the NHS England page

**Clinical Pharmacists in general practice**

Including the pilots, around 580 clinical pharmacists are working in general practice. Following approval to fund more posts in recent application waves, this will increase to over 1,100 CPs across over 3,200 GP practices. This means that over 40 per cent of surgeries in the country – a population of nearly 34 million patients – will have access to the expertise that CPs offer in disease and medicines

management, with more to follow later in the programme. The overall commitment is for an additional 2000 CPs in GP by 2020/21, representing over £100m of investment.

Further information about the pilot can be found at:

https://www.england.nhs.uk/gp/gpfv/workforce/building-the-general-practice-workforce/cp-gp/

Evaluation of Phase 2 Clinical Pharmacists in General Practice Programme is underway by NHSE and we are contributing.

From ETW's point of view:

1. The current clinical pharmacist scheme is a poorly funded workforce substitution initiative. This does not reflect that increasing demand in general practice and what we actually need is a comprehensively funded GP workforce expansion programme in line with what we have mentioned in our SGP.
2. The workforce support initiatives (sickness benefits, maternity benefits, GPH programme) are all aimed at GPs. But the reality is that the number of GPs is falling and there is a push to expand the team. In that scenario, it makes no sense to offer the workforce support initiatives only to GPs. We therefore need to push for these initiatives to be applicable to all of the GP workforce.
3. Funding. The level of funding on offer is not enough, end of. We need to look at getting funding for it which is recurrent and sustainable, and incorporated it in to the SFEs. Whilst pushing for a fully funded model like they have an NI would be the point to start, a return to the old red book 70/30 funding would not be a bad outcome either.

We are working with Clinical and Prescribing on this for a complimentary workforce expansion paper and the clinical pharmacist paper(s).

**Working with Sessional subcommittee**

We are working with the Sessionals as a significant part of our workforce and Helena meet with Zoe Norris to discuss mutual strategy with other stakeholders and dialogue included the Model locum T&Cs

**Web page**

**We have begun work on our updated webpage.** Shabana Alam-Zahir is writing a short guide for newly qualified GPs for the new ETW website, something along the lines of -

"I've qualified as a GP, now what?"

- the admin process - RCGP / GMC / performers list / indemnity - including timelines

- creating your working week - things to consider

- post CCT opportunities inc fellowships

- where and how to job hunt - sites, agencies

- mentoring

- signposting to useful resources

**Low Volume Appraisal Work**

Vicky Weeks and Helena have worked alongside colleagues from Sessionals and Contracts & Regs, led by Mark, to input into the process for appraising GPs who are doing fewer sessions in general practice and we are near reaching an agreement.

**GP Health Service**

Helena who was our GPC rep when this service was commissioned attends the strategic implementation group and attended the 1 year on review meeting.

**GPSAC (Specialty Advisory Committee) Meeting**

Sarah Matthews attends GMC have recently rejected the RCGP's curriculum submission as they felt that the Accredited Transfer of Competencies Framework was too restrictive – this will continue to be debated. RCGP are also reviewing guidance on who can complete workplace-based assessments.

**RCGP Trainee ePortfolio**

We understand a new e-portfolio platform will be launched in August 2019 and we intend to be inputting.

**Targeted GP Training (TGTP)**

Plans to support some doctors who want to re-enter GP training were announced by HEE last week today, we were working with them on this. We are positive about this, although more needs to be done such as pushing for more routes into TCTP. Helena will attend a joint meeting with HEE and the RCGP on the next steps on 8th March. The GP trainees who passed their Work Place Based Assessments 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 will be given the chance to resume their training thanks to Health Education England's Targeted GP Training scheme. The focus is on providing a re-entry route for those who were progressing in training but were unable to pass one of the exam components of the Membership of the Royal College of General Practitioners (MRCGP) qualification in the time available, whilst maintaining the high standards of the assessment process. We have championed the increase in available extensions to training for GP trainees as previously it was capped at only 6-months extensions. The introduction in January 2018 of up to a year has meant that we don't end up losing trainees simply because they needed a little bit of extra time on one of the components of training. To be eligible trainees must meet all the following criteria: Be a previous GP national training number (NTN) holder

- Have left GP training between August 2010 and January 2018
- Have passed one of either Applied Knowledge Test (AKT) or Clinical Skills Assessment (CSA)
- Have had satisfactory work place based assessments (WPBA)
- Have taken but not passed the other exam
- Have current General Medical Council (GMC) registration with a licence to practise
- Have been in medical practise within the last two years.

Applications will follow the National Recruitment process and be open from August 2018 to February 2021, subject to GMC approval of the exam changes.

Please see the GPNRO website for application details.

### Statement on GP trainee minimum notice of shifts

One of the ten targeted issues that have come under review by the Enhancing Junior Doctors' Working Lives group, made up of the BMA, HEE, GMC, NHS Employers and the Academy of Medical Royal Colleges, was that of difficulties arising from late rota notification. In response, the Code of Practice was developed to ensure trainees are informed of their final rota with six weeks' notice. However, in GP training, where GP out of hours shifts are allocated rather than chosen by the trainee, many trainees are given less than four weeks' notice of their shifts. With the GP Trainees and HEE we issued an agreed statement on the minimum notice Trainees can expect to reive of out-of-hours shifts. The BMA and HEE strongly encourage systems that allow GP trainees to choose out of hours shifts flexibly themselves, but where this is not possible trainees must be given at least six weeks' notice of their out of hours shifts in line with the Code of Practice. Where this has not been achieved, trainees are encouraged to contact their training programme director or their local HEE out of hours lead so that HEE can monitor compliance and investigate further if necessary.

**Exception reporting issues for GP Trainees**

Helena attended a cross-BMA meeting in Exception reporting to represent the ETW view on 7th March. There are a number of challenges, particular to GP trainees, with respect to exception reporting. These include:

- **Professional culture.** A common complaint that we hear is that GPs feel that working hours limits and contractual safeguards of the 2016 T&Cs do not adequately prepare GP Trainees for work post-CCT. Unlike in other settings, in general practice, the educational supervisor is the 'host', the trainer, and in some areas, the employer too. This means that unless the professional culture changes to support ER, trainees will worry that ER might bring them into conflict with their supervisor, which might have implications for their training.
- **Fear of reprisal.** Anecdotally, trainers are concerned about being fined or having trainees removed from their practice as a result of exception reporting.
- **Cost implications.** NHS Employers have made clear that if trainees and trainers agree to payment for additional hours worked, HEE will **not** reimburse these costs; the host practice would need to meet them. Many practices are therefore apprehensive about this, but TOIL (time off in lieu) would be an appropriate alternative also, and likely more suitable for a GP environment.
- **OOH.** Should an exception report be made for work in an OOH setting, there is very little that a trainer could do to address this, as the issue relates to another provider.
- **Split shifts.** The new contract makes it impossible for trainees to work split shifts without being paid for the time in between shifts. As this has historically been a model for working in a handful of practices, this has been an issue of contention for some.
- **Exception Reporting (ER) Software.** Whilst GP Trainees in most deaneries have access to exception reporting software now, we are unsure how many GP Trainers have been given log in details or training in using the software. We suspect this figure is extremely low and yet, without trainers accessing the software, exception reporting is meaningless for trainees.
- **Guardians.** There has been a delay in appointing some GP Guardians of Safe Working and in Wessex, Thames Valley and Yorkshire and Humber, the GP Guardian is a TPD, appointed by HEE, as an interim measure. When Guardians are also responsible for local training, there

exists a potential conflict of interests and whilst these appointments are temporary and subject to change, formal exception reporting processes have yet to be established.

**International GP Recruitment Programme**

NHS England have invited us to support the process for interviewing international GPs as part of the International GP Recruitment Programme.

**NHS England regional steering groups on GP nursing**

Mike Parks is going to join the group in London, but we need GP representatives on the groups in the North (usually meet in Leeds), Midlands and East and the South. There hasn't been any ETW input into this work stream to date, so it's important we can get GP representatives on these groups so they can start influencing each regional GP nurse programme.

**National leadership development reference group**

Samira attended the meeting on 27 February 2018 and argued our corner for medicopoliticians and Helena will be at the future meetings.

## A SUSTAINABLE, LONG -TERM INDEMNITY PACKAGE FOR GENERAL PRACTICE

### Indemnity

Following the announcement of the DR change last February we entered into detailed discussions with DH culminating in Jeremy Hunt's commitment made at the RCGP Conference to a state backed indemnity scheme for GPs to begin in April 2019. Discussions are ongoing and we plan to be able to announce in May the full scope and coverage of the new scheme. Significant detailed work on the operational mechanics of the new scheme will continue throughout the coming year in preparation for its launch next April.

## 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

Work since the last report has been largely a continuation of previously begun projects. In particular, work on both the QOF Review and the QOF Technical Working Group continues to take up considerable time. The aim remains unaltered, to retain QOF but to make it more clinically relevant to today's patients, with more focus on individualised care, but within current workloads.

The consultation on NHS provision of 'over the counter' products is about to end, and our message has been consistent, if drugs are ineffective blacklist them; if they are effective then we should encourage self-care but under existing regulations we cannot refuse an FP10 if asked for one for a drug we have recommended. We have also been involved with the discussion about prescribing of Gluten Free products, and have pressed for the exclusion of prescriptions from the process.

The Primary/Secondary Care Interface group is about to publish two documents, one on interface prescribing and one on consultant to consultant referrals.

There has been a meeting with the NHSE FGM lead to discuss the FGM Information Sharing Initiative. The concept is that whenever a family history of FGM is identified a marker will be placed on the spine which will be integrated with clinical systems to alert any clinician to this fact, so that when an event occurs which would not ordinarily raise concerns, such as travel vaccinations to an African country, the clinician is aware of this and can take appropriate action. We are working with the IT policy group as well as BMA Ethics to address remaining concerns.

A meeting of the All-Party Parliamentary Group on Prescribed Drug Dependence was timed to coincide with the announcement that PHE has been commissioned to conduct a review into drugs associated with dependence or withdrawal symptoms. This will cover Benzos, z drugs, opioid analgesics for non-cancer pain, and gabapentin/pregabalin. This is often not an easy meeting, though my presence alone does seem to have a bit of a moderating influence. My other function has been to try to steer them away from the benzos-are-the-only-problem viewpoint to one of focussing more attention on the pregabalin and opioid issue, which is undoubtedly huge and probably our generation's legacy as barbiturates and benzos have been those of our predecessors.

I met with the British Lung Foundation who wanted to know what barriers are in place for the provision of therapy smoking services, and also about why prescriptions for treatment have been falling in recent years. I met Prof Collins who is the NHSE Self-care Director, the work on encouraging self-care for minor illness had been seen to be ineffective, and in future the work of NHSE was going to be more focussed on measures to improve patient activation, trying to get patients more engaged with actions they can do to improve their problems, rather than rely on being the recipients of actions form health care professionals and the administration of drugs.

NHSE caused great confusion with a circular which seemed to imply GPs had to check the qualifications of online gender identity services before prescribing. An angry letter has produced clarification that the intention was to enable GPs to decline to prescribe in these circumstances rather than compel them to check.

There was a meeting into the initiation and withdrawal of Clinically Assisted Nutrition and Hydration in patients with Disorders of Consciousness. Recent court cases had made this a difficult area for clinicians and it was decided that definitive guidance would be helpful and the BMA, RCP, Law Society and GMC are therefore working together to try to do this. Guidance has now been produced here **https://www.bma.org.uk/advice/employment/ethics/mental-capacity/clinically-assisted-nutrition-and-hydration**

The seemingly moribund but very worthwhile initiative to provide all prescribers with unique prescribing numbers received an unexpected resuscitation courtesy of the SoS's Individual GP Data project, and now looks as if it might come to fruition, we will continue to push.

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

### Contracts and Regulation – Bob Morley

- Robust challenge to NHS England document on meeting reasonable needs and core hours subcontracting; GPC guidance published in response
- QC advice sought on registration/treatment of inpatients; revised guidance has been drafted and expected to be published imminently
- Contribution to briefing on ACOs and legal guidance on ACO contracts

- Responding to concerns on and implications of GP at Hand Practice /Babylon; advising on regulations re subcontracting arrangements
- Meeting with NHS England and RCGP to seek solutions for issues over collaborative payments for safeguarding work
- Continuing work and meetings with meeting with NHS England and RCGP on regulation of "low volume" of clinical work; agreed policy being developed
- With BMA's Professional Fees Committee seeking meeting with Chief Coroner to discuss issues of concern; LMCs have been asked to provide examples of problems
- Ongoing work with Sessional SC AND BMA Committee of Medical Managers on investigating issues with the contractual arrangements for GPs working in out- of practice roles
- Liaison meetings with CQC and consultation over its plans for its new phase of general practice regulation including provider information collection and methodology for more focused inspections of practices; also bringing individual practice/LMC concerns and queries to CQC attention
- Setting up meeting with CQC head of registration to discuss the many concerns over their processes
- Ongoing responses to requests for advice on C and R issues via listserver, direct queries from LMCs and direct queries from individual GPs via BMA
- Progressing action on UK and England Conference resolutions

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

**ACOs & STPs**

Policy lead has fed into a new member briefing on ACOs (accountable care organisations), which was published at the end of February. It explains the different models and the background to their development, before exploring some of the key contractual, financial and regulatory issues, and setting out the BMA's key concerns. Finally, it provides some advice on what BMA members can do and where they can access further guidance and support. Policy lead has also fed into legal guidance on the ACO contract itself which was published alongside the briefing.

Other BMA-wide activity on ACOs and STPs is continuing. The Chair of Council wrote to the Secretary of State highlighting our concerns. In January we submitted written evidence to the House of Commons Health Select Committee inquiry into STPs, highlighting our concerns regarding their development so far. Chaand Nagpaul was then invited to give oral evidence to the committee on 27th February, during which he set out the BMA's position on STPs, the need for greater levels of funding, and the potential risks ACOs may present to the NHS and, more specifically, to general practice. This was also covered in BMA News. In addition, the BMA is continuing to engage with NHS England in the run-up to the ACO consultation (expected mid to late March).

**Commissioning gaps**

We recently sent an FOI request to all CCGs in England, asking for the amount of funding they provide for each enhanced service in their area. With this data, we will be to ascertain the current funding gaps throughout England, as currently some general practices are missing out on the same levels of funding due 'pot luck' scenario that is occurring.

**Roadshows**

Following on from the 'Our profession, our future' event in Leeds, exploring the challenges and opportunities of working at scale, the presentation was incorporated into the national GPC contract roadshows in England. The policy lead and deputy policy lead presented this section at some of the roadshows. We are planning to use this content, and feedback from the roadshow discussion, to develop a 'lunchtime learning' webinar for GPs. This will give GPs an opportunity to join live and ask questions, but the recording will also provide an ongoing resource for members.

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

### Premises and practice finance – Ian Hume

**Premises Cost Directions (for England)**

GPC have now reached agreement with NHS England on the policy intentions of the update of the PCDs, after negotiating since April. Lawyers from Department of Health are now drafting the updated directions, and we are waiting to hear back on timeline for when that will be ready. We are also chasing up NHS England on the joint guidance and have started drafting our focus on documents too.

**NHSPS/CHP**

Since the last meeting, we have met with NHSPS in an attempt to reach a negotiated agreement on the current service charge issue. It is clear that NHSPS have significant debt from GP practices and that they are looking to resolve this issue. The need to involve commissioners in these discussions was acknowledged and both sides agreed to some action points from the meeting. There will be a meeting to discuss this with NHSPS and NHS England in May.

We continue to explore other options for challenging these charges, but this information is confidential for the time being.

**PCSE**

In the past few weeks, we have been in discussions with NHS England about the future of Capita's contract to provide primary care support services to GP practices in England, following reports on Capita's share price and NHS England announcing that it will be removing its resolution team from within Capita. We have followed up again on the need for a plan B if services do not improve. In spite of these developments, NHS England confirmed that Capita is committed to the PCSE contract and that they are in the process of producing an action plan to improve all service lines which we are expecting to input into. More details will be available in due course.

We have been working to improve the support we are given practices, we are continuing our efforts to develop resources which will assist practices in resolving their outstanding issues, and have recently published further advice on the website such as on statutory demand templates, SAR forms and template letters. We have also sent two FOI requests relating to the compensation scheme having received reports from LMCs that this is not as effective as we were led to believe, as well as, an FOI relating to practitioners pensions.