YORLMC Update 19 July 2022

From: Dr Brian McGregor, Medical Secretary/COVID-19 Lead, YORLMC Ltd

Dear All,

Welcome to my latest "Blog". Lots has happened since the last update, much of it covered in the LMC Newsletters, I'll try to be brief, there is a lot to cover. If you want the challenges and difficulties to be covered, read on, those looking for my opinion and outlook on current events, skip to the end!

Covid

We are currently in another wave of infections, driven by the BA.5 variant mainly, this is an omicron variant that is more infectious, numbers in hospital are steadily rising, numbers in the community have risen 4fold in a month. We are starting to see increasing staff sickness related to this putting pressure on all services, primary, community and secondary care. The BMA have called for compulsory mask wearing in health buildings to be re-introduced, all of our secondary care sites have already done this. They have also advised updating risk assessments in primary care, updating their own guidance, including links to the latest IPC guidance (unhelpful at present as it advises pre-pandemic levels of IPC and cleaning). The current BMA advice is inconsistent with the Government advice re "living with Covid", but a balance needs to be made with respect to maintaining safe services. Local figures can always be found by driving down the national website.

This week on Friday (15/7) we were treated to the usual 5 o'clockish announcement that we now have to vaccinate all 50-64 year olds for flu and covid boosters in the autumn, having had this cohort removed in the original flu vaccination announcement letter. Many will be frustrated by this, having made arrangements and cancelled them, but this is driven by events in Australia, and JCVI guidance, who are seeing one of their worst flu outbreaks ever, and we tend to follow their experiences. It is likely this cohort will be staged and run from October onwards. Children aged 7, 8, and 9 will also be included. Practices will need to review vaccine orders, consider delivery. GPC is seeking clarity on management of walk-in patients, vaccinating those from other practices (equity with pharmacy providers), coadministration appointments, and NBS functionality. There will be some complexity in managing stock levels and deliveries! PCNs should already have determined by 14th July their level of involvement following the letter re site designation and onboarding. Obviously the LES changes also highlighted a drop in payment to £10.06 (unless housebound when a £10 supplement is paid). Spring booster vaccine numbers remain less than ideal and those eligible to attend should be encouraged to do so – especially with rising numbers locally.

IT/Digital

Firearms flagging markers are appearing on selecting patients with a firearms licence, some of the diagnosis codes triggering this are bizarre ("vertigo"), they have been automatically switched off in EMIS until this is sorted but continue in TPP. The BMA has been reluctant to issue firm advice for this due to an ongoing inquest likely to last this coming week, which will likely determine future actions. GPC advised against the introduction of this measure as it was not robust, but the Home Office insisted "Something must be done" and proceeded against advice. Currently our advice is to

continue to review and charge applicants for the review, engage with the police (who will issue if you do not reply to their letters, assuming you are not against the licence) and await the inquest outcome. (The potential if BMA/GPC are not robust in the inquest is the GP practice involved will take responsibility for multiple deaths by shooting and consequences could be all future responsibility falling on GPs – not a scenario we wish to see!).

COPI notices expired on June 30th – please be aware of this as it now limits the processing of confidential information for Covid related reasons.

The NHS is developing a Federated Data Platform – this will bring together elements of data from primary and secondary care, under a single provider/data controller, the procurement is already out, GPC have concerns in regards to this, as there is an intention to include all vaccine data in this collection, which would potentially open up the way for any willing provider to be commissioned – more worrying is that a front runner is Palantir, that has links to Operose, that further links to Centene (just taken over around 60 practices in London – links directly to American managed care organisations, recently in the media for using lots of PAs and very few GPs). GPC are opposed to releasing widespread primary and secondary care data to such a company, but may not be able to influence the decision by NHSE/Digital.

Patient Access to medical records will commence universally on 1st November 2022, GPC remain concerned about inadequate redaction software, but NHSE are determined it will go ahead and state the available redaction is sufficient currently – GPC continue to work through the digital and IT committees to highlight issues and seek solutions prior to November. The list of concerns is long, not the least being the additional workload this will inevitably attract, alongside the issue of vulnerable patients withholding information, or coercive partners accessing patient records. The ultimate ambition here is to remove the need to respond to SAR requests. This will be a universal switch on of access, apparently there are currently 800 practices nationally not allowing any access at all. Practices should exercise caution when using locums based outside the UK (including online services provided via NHSE) the UK GDPR currently does not allow data to be processed abroad, and as data controllers could be liable, more information here.

Conferences

UK LMC Conference result and motions are now available online. Dr Charles Strachan, YORLMC Bradford Locality Officer, will be joining me on GPC this year as an elected member of Conference – his mandate is to ensure conference motions are delivered. I have stood for Speaker of GPC – more about that later.

The BMA Annual Representatives Meeting took place in Brighton in June, attended by myself, Dr Dougy Moederle-Lumb and other LMC members as branch of practice representatives. The GPC Report is available online. It is significantly different from other conferences, based in politics and policy for the whole BMA – only a small section is dedicated to GPs, but it drives the heart of the BMA. Junior Doctors have become incredibly organised and led a more militant approach by the BMA, hence the “pay restoration” campaign – they worked hard to gain every seat they could on BMA council, to promote favoured candidates into Senior Officer positions, and for the first time in decades, there is now no senior GP officer in the BMA. This is a concern, GPC will struggle to be heard with fewer GPs on Council (Juniors won 27 out of 65 seats), and the profession needs to be better organised and ensure it steps up to represent and vote in future BMA elections – Regional Council nominations open on 18th July, I would strongly recommend any GPs wanting to support the crisis in General Practice and influence the BMA consider standing, but also EVERY GP that is a member of the BMA needs to look out for the voting emails and ensure they support those standing. We are at risk of becoming less relevant within our Professional Body at a time of deep crisis for our profession, stepping up and speaking up is imperative for our future. As a profession, we need to organise, support, and plan, or our voice will be drowned out.

Highlights from the BMA ARM can be found online.

The significant motion for GPs was relating to PCNs and the PCN DES – the exact wording is below –

> EN Motion by LONDON REGIONAL COUNCIL: That this meeting supports GPs fighting to defend the GMS contract and NHS independent contractor status. The long-term GP patient relationship and the right for GPs to control their workload in a safe way, is essential for the future of general practice. We applaud the South Staffordshire motion passed at the 2021 LMC conference which called for GPCE to negotiate the end of the Primary Care Networks (PCNS) from 2023 as they 'pose an existential threat to independent contractor status' and this meeting:-
> i) calls on GPCE and the BMA to organise the withdrawal of GP practices from the PCNs by 2023;
> ii) calls for PCN funding to be moved into the core contract;
> iii) instructs GPC England to act upon the GP ballot of 2021 and to organise opposition to the imposition of the new contact including industrial action if necessary.
> It is an indicator of how little others understand General Practice in that part 3 is incompetent – the survey was indicative and not allowed under Trade Union legislation to be used for industrial action. However, this is now BMA policy, and GPC will be working on this to present solutions ot the profession – more re GPC later.

YORLMC continues to represent the local position that the PCN DES works well for many of our practices, we acknowledge and see the strain seen by our CD colleagues and the increasing demand, and also are aware that some PCNs feel the current IIF is not worth pursuing as the return will not justify the investment. The LMC is not part of the BMA, though we work closely with them, and BMA policy does not dictate local behaviour, given the independent nature of General Practice. The LMC works for our local GPs representing their views and as a link to national structures.

Conference of England LMCs – this will be a 2 day conference on 24th and 25th of November – anyone can submit a motion for the LMC to send to conference, guidance on writing motions is available here, and from YORLMC. Can I encourage everyone to consider what really irritates them, or what wrongs they feel need making right (including reversing previous decisions if necessary), and consider writing a motion around that topic and send to us **by the end of August**. Areas you may want to consider –

- Primary Secondary Interface
- NHS 111
- GPCE/LMC/GPDF
- NHSE/Government
- PCN DES
- Digital First
- Practice based contracts
- Workforce
- Workload
- Regulation
- Clinical/Prescribing/Dispensing
- Other

The second day in November will be dedicated to debating the future of the profession, potential "Plan Bs", GP involvement in ICSs, and the potential for collective/Industrial action. We welcome thoughts and comments from constituents with regards to these issues, we literally will be deciding the future of General Practice, so getting it right is important.

You may also want to refer to the RCGP document recently released "Fit for the future".

GPC

GPC meets next week, I have stood for the position of Speaker and the election is currently taking place, if successful, I will effectively "Chair" GPC meetings, much as the Speaker in the House of Commons. My ambition is to try and bring a disparate group of individuals together and present a united front for the profession, the next 18 months will be critical to the future of General Practice, as ICSs develop, and a new contract looms, coupled with what is very definitely a crisis in workforce and workload going forward. Now would seem an appropriate time to step up to a national role, particularly with the support of another YORLMC GP on GPC.

The GPC agenda next week has multiple written reports – Sessionals/Trainees/Rebuild GP/Chair and Officers Report, then a debate reviewing much of what will come to Conference in November, i.e. the future of General Practice, the Fuller Stocktake, and future structure of GPC going forward to increase involvement of members and collective responsibility.

ICSs

These have completed their first month of existence, and are still settling into their roles and responsibilities, YORLMC remain engaged at every level, despite some resistance in places. YORLMC is the statutory Representative Body of General Practice, speaking on behalf of all of General Practice, despite the best efforts of some to circumvent our involvement.

The Fuller Stocktake has been adopted as the blueprint for commissioning Primary Care services and specifically mentions engagement with LMCs, there are a number of recommendations, some good, some challenging. Which is what we would expect.

It calls for system leadership to drive improvement, enhancement of neighbourhood teams, new models of care and leadership, (including primary care representation at the highest level) improved estates, making PCNs central to at scale service delivery (which now sits opposite to BMA policy), General Practice support for Urgent Care, with a single, system-wide approach and a single point of contact for patients.

A phrase used repeatedly through the BMA assessment of the document is "General Practice Neighbourhood" in reference to PCNs whilst not overtly promoting the model - emphasising the importance in future commissioning plans. I would again encourage everyone to read the Fuller Stocktake, you may or may not agree with it, but it will impact on how things are done over the next 18 months and possibly beyond, depending on what is or isn't in the new contract.

Odds and Ends

National Standards of Healthcare Cleanliness 2021- some companies are offering for a fee to "upgrade" GP performance in relation to this – please read the CQC MythBusters before parting with any funding. It clarifies expectations and clearly states they inspect on regulations, not specifications, and covers expectations and common issues.

Medical Appraisal Documents have been updated and published nationally – supported by the academy of Royal Colleges, if you are unsure as to current requirements, this is a good starting place – less arduous and prescriptive, and more supportive that previous models.

Monkeypox has now been diagnosed in our region, please be aware of the latest guidance.

Freedom to speak up Guardian – YORLMC is NOT the FTSUG for primary care, it was considered by the Board and was considered inappropriate – we would be automatically conflicted if a member of staff e.g. a salaried GP came to us with issues and we were left to deal with the conflict between GP Partners and Staff. Guidance is available, and the recommendations are either to partner up with another practice or negotiate accessing an acute Trust FTSUG or NHSE management FTSUGs. Please do not name YORLMC as your Guardian in this respect.

FIT notes can now be issued by other regulated Professions – free training is available.

We continue to seek practices to step up as **TIER 2 licence employers** – this could attract a newly qualified GP to your practice and those struggling to recruit should definitely consider it. In HNYICS some support is now available to facilitate this. More information is available from NHSE. The process is straightforward and will facilitate keeping doctors trained locally staying in the area, some newly qualified GPs have been threatened with deportation if they cannot find a TIER 2 approved employer.

Pensions remain a hot topic, if you have not assessed the impact of inflation on potential annual allowance charges through the BMA Tool, please do so ASAP. A round table event of MPs has been held and it appears some of the issues are slowly being realised. AISMA have also written to the Treasury to try and highlight the issues.

A reminder, when assessing whether or not to perform additional work, and the cost is imposed, you can use the **BMA Fees calculator** to assess whether or not it would cost you as a practice (or effectively partners taking a pay cut) to provide the service (including PCN services/IIF)

Inclisiran – it has NOT been agreed to deliver this in primary care, despite what some secondary care colleagues may believe. The RCGP and BMA have a joint position statement on the proposals.

The **Rebuild GP campaign** continues and currently is under assessment as to whether it should continue until the new contract is agreed – but it would have a significant cost for the BMA and GPDF. No decision has yet been made. It has, however been successful in making inroads to negative media comments and articles, my latest appearance was on Politics North on 4th July, still available on iplayer.

Medical Examiners will be introduced from April 2023 – the system has been preparing for this for some time, when we have further information, we will share it. It will change how we certify deaths and investigate prior to cremation, is intended to streamline things, but currently few in GPC are convinced it will improve current pathways. There remain significant questions around the time and workload related to the new system, rights to access medical records, under what act (ARHA as patient is deceased seems most likely), and breadth of access – pertinent facts or full record.

Workforce figures remain less than ideal, with a drop of another 116 FTEs in a month, and the RCGP have published some concerning predictions, the BMA have similar research. For a junior Minister for Health to then say there wasn't a crisis in GP workforce at the Health Select Committee defies belief. The impact on the profession of the last 2 years and the moral injury increasing daily is steadily wearing down the profession, at the ARM there was a speech calling for the right to respite – the lack of this is leading to burnout and many cutting short careers or leaving after only 1-2 years in post. It is beholden on all of us to endeavour to make the job achievable and sustainable – this will mean challenging workload shift and learning how to collectively reject and refuse some of the additional demands. Now more than ever before we need to act together to defend our profession.

GPAS – The LMC led General Practice Alert System is now live, and already having an impact, ideally we need more practices to report, particularly larger practices, as the data provides tangible evidence in the primary/secondary workload shift debate and informs better understanding of actual workload in General Practice. Please strongly encourage your Practice Manager or administrators to take part.

Primary to Secondary Shift, Dr Danielle Hann is leading on this for the LMCs, and making excellent progress, we hope I the near future to produce a set of principles signed up to by us and secondary care Medical Directors to stop and reverse the flow of work currently being seen in practices.

Practices and PCNs may want to look at the **Healthcare Inequalities Improvement Dashboard** to help focus some of their workstreams going forward – a handy guide.

This week, the **GP Patient survey** has seen a big drop in patient satisfaction. This is not surprising given the recent difficulties with capacity not being able to meet demand, the dropping workforce numbers, the increasing workload from increased morbidity of those on secondary care waiting lists, long covid, increasing covid in the community, those who have delayed seeking care, and simply increasing patient numbers (300 per WTE in the last 5 years) with increased population numbers and reducing number of GPs, Sadly, this is only likely to increase moral injury, depression and low morale within the profession, please recognise that we continue under workload figures to be offering more appointments than ever before with the smaller workforce, in a more timely fashion. The issue is not ours to solve, there simply isn't enough capacity in General Practice to meet the demand and increasing recruitment will not solve anything quickly – retention, altering demand, and reducing workload shift to make the job achievable need to be the priorities if we want General Practice to survive and thrive.

Finally…
Which brings me to my closing paragraphs.

The LMC has had to triple the pastoral care support being offered across practices, barely a week goes by when we do not hear of another practice or GP on the edge of collapse. This is fundamentally a part of our LMC raison d'etre, but the rapid increase is becoming concerning. There are issues of "last GP standing", of partnership disputes, of disputes between practices and internally within PCNs, there are individual GPs who are struggling emotionally, with workload, with family commitments, with life generally. Current General Practice is unlike anything any of us signed up for. No-one is immune from the pressure we are all feeling. More worryingly, in recent weeks we have stumbled across GPs who have not contacted the LMC or not looked for support, unaware it was available.

Wellbeing has been our focus for the last 3 years, we have developed a suite of services via GPMplus to support all GPs and Nurses, Practice Managers, senior leaders within the practice and whole practices as well.

Please use these resources. Don't wait for things to go wrong, or until you are backed into a corner. We enjoy excellent links with our commissioners, and support can come in many guises – we will work together to maintain services and support those who are struggling.

The 1:1 pastoral support remains available, from a variety of LMC Officers, no GP should feel alone or unsupported in the YORLMC area, we are YOUR LMC, our role is to support, defend and represent every GP in our area. If you are uncertain or unsure if we can help, please ask, if we don't know the answer, we will ask of GPC Secretariat at BMA. More than ever before, we need to support each other, to ensure we are keeping an eye out for each other and remaining aware of those who are struggling.

I truly believe we stand at a crossroads for our profession, the next 18 months will determine how our services are commissioned for the next 10-15 years, how our profession is supported and our standing with the Government and colleagues within the NHS, what our new contract will look like, including the model of care, and whether or not we can create a workload that is achievable going forward.

I'm available via the office for anyone that would like to discuss anything raised in this update further. We also have a Q+A planned for Wednesday next week (change to usual day due to an LMC commitment) – you can book your place here.

Regards,

Brian McGregor
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