LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

29 April 2023

To All General Practitioners and Practice Managers, Leicestershire, Leicester and Rutland

Dear Colleagues

Re: April Catch Up Newsletter.

This remains a busy time for general practice and the LMC:

1) Imposed GMS Contract and Arrangements for Patients Contacting a Practice
2) General Practitioners Committee Meeting 27 April 2023
3) Why Can I Never Get An Appointment With My GP
4) Pay Transparency DEADLINE 30 APRIL 2023
5) Medical Examiner Service

As usual, the LMC is happy to receive any comments or questions about anything in this letter.

1) IMPOSED GMS CONTRACT AND ARRANGEMENTS FOR PATIENTS CONTACTING A PRACTICE

Following the imposition of the national 2023/24 GP Contract on 06 March 2023, we have all been waiting for clarity regarding the full regulations from NHS England. These Regulations have now been published, and the full contractual frameworks can be accessed from the following links:

- The National Health Service (General Medical Services Contracts and Personal Medical Services Agreements) (Amendment) Regulations 2023 (legislation.gov.uk)
- NHS England » Network Contract Directed Enhanced Service (DES)

The amended GMS regulations were laid before Parliament last week and will take effect from Monday 15 May 2023, although practices are not contractually required to implement the changes until they have been served with a contract change notice and either the practice has accepted it or 14 days have passed. See the links above, and wording below:

*4.(1) The contractor **must take steps** (our emphasis) to ensure that a patient who contacts the contractor—*

(a) by attendance at the contractor's practice premises;
(b) by telephone;
(c) through the practice's online consultation system; or
(d) through any other available online system,
is provided with an appropriate response in accordance with the following sub-paragraphs.

(2) The appropriate response is that the contractor must—

(a) invite the patient for an appointment, either to attend the contractor's practice premises or to participate in a telephone or video consultation, at a time which is appropriate and reasonable having regard to all the circumstances;
(b) provide appropriate advice or care to the patient by another method;
(c) invite the patient to make use of, or direct the patient towards, appropriate services which are available to the patient, including services which the patient may access themselves; or
(d)communicate with the patient—
(i) to request further information; or

(ii) as to when and how the patient will receive further information on the services that may be provided to them, having regard to the urgency of their clinical needs and other relevant circumstances.

(3) The appropriate response must be provided—
(a) if the contact under sub-paragraph (1) is made outside core hours, during the following core hours;
(b) in any other case, during the day on which the core hours fall.

(4) The appropriate response must—
(a) not jeopardise the patient's health;
(b) be based on the clinical needs of the patient; and
(c) where appropriate, take into account the preferences of the patient."

Across the country we have lost the equivalent of over 2000 full time GPs since 2015, and LLRLMC's recent report demonstrated the effect that this has had locally, with insufficient GPs left to be able to provide a safe service, in particular due to an ever-increasing demand.

In the weeks, months and even years ahead there will be debate around what practices have to do to comply with the contract and how they may respond to these changes. Practices must realistic and pragmatic. We have adapted the FAQs below from a document created by Cambridgeshire LMC. If you have any further, unanswered questions, please send them to enquiries@llrlmc.co.uk.

"I'm not sure how it's going to even be possible for us to meet these contractual demands?"
We agree. We think it will be unlikely that many practices will be able to be fully compliant with the new Regulations. Let us take one example: the compulsory online access to patient records by 31 October 2023.

The new contract states that all patients must be given access to their prospective medical records from the end of October 2023, unless they have asked not to be given such access. The level of access that needs to be given is analogous to what must be provided should a subject access request be received. i.e. this means all incoming documents must be screened for third-party and harmful information routinely. If any such issue is noted, a duplicate must be made of the document, then physically redacted, rescanned, and only then marked suitable for patient access, with the original remaining hidden. This would represent an unfathomable increase in workload. Presently, this only needs to occur should a patient submit a subject access request. The requirement for suitable redaction tools being available has been removed from the new contract, thus the onus will be on the GP contractor to sort it out.

One of the imposed contract changes was to remove the requirement for NHS England to provide software that can redact records and attachments, I presume as they have found this too hard to deliver on.

To act safely, and within the contract, anyone at risk of harm from exposure of their records on their hand-held device(s) would need to be specifically asked prior to the end of October 2023 if they would like to decline having records access. That too, presents a phenomenal amount of work: a single appointment slot per patient for the entire population. Should GP Contractors decline to turn on access to everyone who has not explicitly declined come October 31st, they'll be in breach of contract. If practices over-redact, they'll be in breach of contract. If they under redact, they'll be in breach of the Data Protection Act.

This is why we suspect it will be hard to safely comply with the regs as written, without diverting a huge amount of work from day-to-day care and access. If others feel likewise, then contract breaches will be inevitable across the entire country.

"What *must* we do from Monday 15 May?"

Practices will only need to make changes once their individual contract has been changed.

Para 4(1) indicates that you 'must' provide patients with an appropriate response when they contact the practice via the various listed means (at the practice, via telephone, online consultation software, any other electronic methods). That means triaging their needs, and not asking them instead, to "Call back tomorrow at 8.00am."

Para (3) states that an appropriate response must be provided either "on the day" (3)(b) or if the patient contact is made outside core hours, "on the next working day" (3)(a). To avoid patient contact outside core hours, we recommend practices turn off online consultation platforms overnight and at weekends, so no response will be needed under Para (3)(a) as no applicable contacts can then be made, and patients should instead access commissioned services: NHS111 app/phone and HUC.

As per our emphasis above, the contract requires practices to "make steps" to ensure that a patient has an "appropriate response." Plain English reading of this is that as long as practices have taken appropriate steps, then they would not be in breach of contract, if they were unable to deliver on any particular day.

"What is an 'appropriate response'?"

An appropriate response may be:

1. 4(2)(a) offering the patient an appointment, either F2F, by phone, or on-line, "at a time that is appropriate and reasonable having regard for all the circumstances".

2. 4(2)(b) another option is to send patients "advice or care" (which can be interpreted as the ability to receive care, perhaps self-care information). This might include sending electronic information or reference to various NHS online resources.

3. 4(2)(c) a further option is to suggest patients are directed to use appropriate services that they can access themselves.

4. 4(2)(d) A further appropriate response may be to request more information from your patient. Should no further comment come back, you can only act on the information you have, however limited.

"What are the other 'appropriate services' that patients can access themselves?"
The addition of this clause is very significant. This represents, for the first time, an explicit recognition that practices may direct patients to other services as part of delivering their core contract. This recognises that the GP surgery does not have to be the only answer to "meet the reasonable needs" of your patients.

Other services that patients may access include local pharmacies, urgent care/treatment centres, minor injury units, extended access hubs, emergency departments, NHS.uk, the NHS app, and NHS 111.

Naturally the signposting will depend on the nature of the patient's query, and the timeframe in which they *need* to be assessed – note need, not want. Your practice may not be able to offer a timely appointment, in which case an "appropriate response" may well be to recommend the patient contacts a service they will be able to access in a more appropriate timeframe.

Paragraph 4(2)(d)(ii) "request more information" is vague and appears to suggest patients may be given further information regarding available services. These could be answer-phone messages signposting to other services (e.g., NHS111) or describing emergency scenarios where patients should not delay in accessing an Ambulance or Emergency Department attendance. It could mean information for patients on waiting lists receiving further information in due course, given that no timescales are stipulated. There may be other options too.

"What would an 'appropriate timeframe' look like?"
The regulations refer to *"a time that is appropriate and reasonable having regard for all the circumstances".*

There is no set timeframe – this will need to come down to sensible judgement depending on the clinical nature of the patient's query; any symptoms they may describe; the context of those symptoms in terms of their medical history; other significant features e.g., age or other co-morbidities.

You must also take into account the number of available appointments at the practice, and the availability of any appropriate staff. It may be that your practice will now create waiting lists for routine non-urgent health needs. Some of you do so already for e.g., joint injections; minor surgery lists; IUCD and SDI fittings; non-NHS medicals etc etc. Waiting lists may feel strange, but they are equitable, needs-based, fair, and objective. They are also very short in terms of any comparison with a hospital equivalent. TPP S1 has a button that will set them up for you automatically. EMIS may work better via additional software, e.g., AccuRx.

We appreciate the complexities in terms of holding and maintaining waiting lists. Another option is to simply have much longer timeframes in which appointments can be booked ahead - patients will need to be advised that these are based on the availability of doctors, nurses, and other clinical colleagues within the practice.

"What is classed as a 'contact'?"

We have been asked if a patient tries to telephone the surgery, but cannot get through at the first attempt, or if they receive a holding message, have they 'contacted' the surgery? Our answer is no – you cannot possibly provide an appropriate response without knowing the nature of the query, so this is not a contact as defined in paragraph 4.1.

"What should we do with our online consulting software if we are full?"

We recommend that your online consultation systems should be switched off when you are not contracted to be providing a core service, that is from 18:30 on Friday through to 08:00 on Monday, from 18:30 to 08:00 on weekdays, and during Bank Holidays – it is the responsibility of the ICB to contract for services during these hours.

Inside your core contract hours, you need to consider when safe capacity has been exceeded, and when as a practice you are unable to guarantee further safe same-day urgent care, in which case your online platform needs to be switched off until the following morning. You need to be objective in your assessment of this, and consistent in your approach. You should consider using the OPEL reporting process and specifically request your status on the local Directory of Services (DoS) to be changed to 'red.' If the ICB declines to make this change, please inform the LMC.

"What should we do if we have extreme capacity issues on a given day, beyond our control?"

If you are under extreme pressure for specific reasons, ensure you are familiar with the process to alert the ICB Primary Care Team using the OPEL system.

Consider developing communications to use in such scenarios, e.g., having a set form of words to disseminate when in extremis on AccuRx messaging, and to explain these and test them with your PPGs in advance of their use.

Para (4) states that any 'appropriate response' should be based on the clinical needs of the patient and consider the preferences of the patient 'where appropriate'. Patient need comes ahead of want, and preferences have to be balanced against the demands of other registered patients, and capacity of the practice workforce on the given day.

The Regulations say that an appropriate response "must not jeopardise the patient's health" – what does this mean in practice?

Para (4) states that the "appropriate response… must not jeopardise the patient's health". We believe this will only serve to increase the likelihood of practices making a greater number of referrals into other services, under Paragraph 4(2)(c) to reduce clinical liability if the lack of available practice capacity means an inevitable delay to the patient getting assessed in the timeframe required. We also believe that to implement this paragraph practices must implement safe working (see next FAQ) and patients must not be offered an appointment in a practice which has reached unsafe levels of working.

The Regulations determine that we deliver our essential contracted services by meeting the reasonable needs of the patients, in a manner to be determined by the GP, in consultation with the patient. This approach allows practices to act with professionalism in the patients' best interests, whilst understanding the constraints within the NHS.

This change is probably down to NHS England micro-management, but may be due to the Department of Health seeking to give an impression that it is solving a problem of its own making,

whilst doing nothing to address any of the difficulties patients face in terms of accessing GP care, or addressing GP needs.

Of course, it is likely to be both.

The result of these changes is that in 2023 the NHS itself is jeopardising the health of its patients, through its mismanagement at the very highest levels. General practice is seen as both the disease and the cure to almost every problem, but we are David to the Goliath of the rest of the system. We receive 3% of the ICS budget. 97% is spent elsewhere – remember this each time you are asked, or you choose to undertake work for another part of the system "to save time". Whose time are you saving? At whose expense?

BMA Guidance on Safe Working in General Practice

We advise all practice to implement safe working as be the BMA guidance: Safe working in general practice (bma.org.uk). Para 4 (4) (a) implies that practices must ensure their services are safe.

In a nutshell, practices should:

1. Institute 15-minute length appointments as a minimum, and longer if clinically complex.

2. Limit the total number of appointments per GP per day to a safe maximum.

3. Move away from unsafe, unlimited, uncapped 'duty doctor' systems. Keep the 'duty doctor' conductor of the practice orchestra, but ensure their own appointments are limited in number, and limited to same day urgent care needs only. Introducing such arrangements are at the discretion of the practice, and within the terms of your contract.

4. Practices may continue to operate internal triaging using their care navigators, care co-ordinators, and appropriately trained reception staff, but should introduce a cap on the number of appointments undertaken by GPs, and other clinical colleagues.

5. Para (4)(2)(c) within these new Regulations formally recognises that we are able to refer patients to other services they can access themselves; this must now be the Regulatory option practices use to secure a safe-working environment within GP practices.

6. Practices should consider stopping the provision of non-contracted/funded services, or those where the cost of provision is higher than the contracted amount.

7. Practices should look carefully at how they provide their locally commissioned services, and work together to see if scarce resources (e.g. clinicians trained in complex dressings/compression bandaging or warfarin services as examples) can be better delivered by groups of practices working together.

Conclusion

A contract imposition is hardly good news, but these new Regulations provide practices with an opportunity to proactively, and legitimately, managing their workload and demand. It is not practices fault that our government insist on pushing general practice to the brink of becoming financially unviable. This is not what practices want to deliver for our patients, but it is all our government is willing to purchase from us for our services. If we deliver more, we lose more - GPs, practice nurses, and surgeries.

The time has finally come to cut our cloth accordingly. We now have no choice but to accept that the standard of NHS General Practice that we long to provide, will not be funded by NHS England. Therefore, we should deliver the service that NHS England is choosing to resource – and this does not have infinite capacity.

Patients will need to access other services, instead of the General Practice they have previously relied upon. Meanwhile, Commissioners will have to take responsibility for any resource challenges that result from the increased patient use of such other services, which are likely to become overwhelmed, as we have done.
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2) GENERAL PRACTITIONERS COMMITTEE MEETING 27 APRIL 2023

This was an extraordinary meeting that was scheduled in response to the imposition of the changes for 2023/24 to the current five-year contractual deal. This followed the proposed contractual changes receiving no votes in favour by committee members. I attend as a representative of LLR and Northamptonshire LMCs.

The meeting was hybrid with a third of members attending remotely (I attended in person). The survey that LLRLMC carried out showing a strong appetite for industrial action was mentioned on many occasions during the day. Several other LMCs reported that they felt that whilst GPs in their area were stressed, exhausted and demoralised they were less likely to take industrial action. LMCs will have a pivotal role in providing leadership if the action is to have the impact necessary to lead to the required changes to save and reinvigorate general practice.

This meeting was scheduled as a single item meeting, with the meeting being solely dedicated to discussions around industrial action.

Below is a brief summary of the key issues discussed at the meeting that I am able to share.

Industrial Action by GPs in England

In the morning session of the meeting, the committee received a series of presentations from relevant expert members of staff and committee members.

The first of these presentations was from the committee's Alternative Action Working Group. This presentation set out what discussions the group had been having since the February meeting of GPCE. In addition, the group provided their view on the decisions that were being put to the committee at the meeting.

The second presentation was regarding what preparations are necessary to make any action as effective as possible, along with what are the key criteria that underpin effective and successful action.

The third presentation was regarding the communications and narrative considerations that the committee needed to consider in regards to any action by GPs. This presentation outlined the likely challenges that GPs will face around taking industrial action, along with outlining what impactful messaging around GPs could be, which would resonate with the public.

The fourth presentation was from Kieran Sharrock, the GPCE acting chair, who presented options to the committee around timelines for potential balloting and industrial action by GPs in England. The

committee were asked to make several key strategic considerations, which they needed to consider when deciding on the timelines for actions.

At the beginning of the afternoon session, the committee broke into roundtables to discuss the decisions required of them in the afternoon. The primary decision was around timeline for action, along with decisions around form of action and how the committee would be balloted.

Following the roundtables, group spokespeople provided feedback to the whole meeting on the views expressed during the smaller discussions, and the overall view of the groups on the decisions to be taken in the afternoon. The committee also received feedback from the Sessional GP Committee and the GP Trainee Committee on their views on potential action called for by GPC England.

There was then debate amongst the committee members over the decisions put to them today, particularly around the timeline for action. Following votes regarding the timeline for action and the form of action, the committee voted on the following motion. 98% of the committee voted in favour of the motion

> *This committee calls on the Government to agree a contract with GPC England which recognises and funds the increased workload carried out by general practices, and enables practices to provide safe patient care with freedom and trust.*
>
> *If the Government fails to do this, then this committee will ballot GPs working in England on industrial action.*

The BMA released the following press release following the passing of this motion: *GPs vote to ballot for industrial action if 'disastrous' contract changes are not renegotiated*. The outcome was also tweeted out by the BMA.

As a result, the committee and the GPC England Officer Team will accelerate preparations around balloting to ensure that the membership is fully prepared to take action if the Government does not engage meaningfully with GPC England to agree a radically improved deal for General Practice in England.

Call to Action for General Practice in England

Following discussions around industrial action, the committee discussed a Call to Action for General Practice in England. This document had been developed by the GPCE Officer Team and BMA professional staff based upon discussions at committee meetings, conference policy and debates, along with extensive engagement with LMCs, over the last 18 months.

The document sets out the key asks that the committee have of the Government for addressing the crisis in general practice, and radically improving the working conditions of GPs in England.

The Call to Action for General Practice was overwhelmingly endorsed by the committee following a formal vote.

This Call to Action will be used as the basis to lobby Government and engage the profession around our aims for the future of general practice.
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3) WHY CAN I NEVER GET AN APPOINTMENT WITH MY GP?

The LMC report that we sent out last week has had positive coverage by local press. The related summit to discuss what changes could be made locally to protect and support general practice is being held on 8 June 2023. If there are any ideas, or suggestions you would like to make, please contact the LMC Office

The document, posters and infographics are available from the home page of the LLRLMC website.

The LMC office is printing a batch of posters to distribute to those practices who have asked for them so far. We suggest that all practices use the information as a basis to discuss with your patients and PPG.

We suggest that the infographics could be used on letterheads, email signatures, and practice Twitter and Facebook accounts.

If your practice wants any posters in hard copy, please contact the LMC office.
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4) PAY TRANSPARENCY - DEADLINE 30 JUNE 2023

The LMC is greatly concerned regarding this imposed requirement. The original agreement was that everyone working in the NHS earning over the threshold would have to make a publicly available declaration, but, only GPs have been singled out for this.

The GPC guidance can be found at: Declaring GP earnings over £150,000 (bma.org.uk)

The GPC view is that:

> "It provides no benefit to GPs or their patients, but will potentially increase acts of aggression and abuse toward GPs and practices. It will be damaging to morale and wholly reduce the ability to recruit and retain GPs.
>
> GPCE has already received reports of GPs reducing their hours to remain under the threshold.
>
> As GPCE did not agree to this amendment, we consider it to have been imposed on the profession and in breach of the original agreement."

The government's purpose in forcing through this policy is to force a further rift between GPs and their patients, and provide tabloid newspapers with ammunition to continue to scapegoat GPs for the problems with the NHS caused by the government's decisions and policies. Choosing to enforce the policy for 2021/2 appears to be particularly calculating as it was the last year when many practices saw significant additional funding due to working weekend after weekend to deliver the Covid Vaccine.

This policy is likely to lead to more GPs leaving the profession or reducing their hours of work.

The most common questions from GPs are whether they must make the declaration and what could happen if they do not do so.

The declaration is a contractual requirement. If a GP earning above the limit did not make the declaration, then the practice would be in breach of contract, and could be served a remedial or breach notice.

However, in order to do this NHSE would need to know the GP's precise income. It remains the case that when HMRC and NHS Pensions share earnings data with NHSE, it is anonymised. It therefore remains unclear exactly how NHSE could 'police' this imposed regulation. There is no obvious way that the NHSE could verify the income of those who have not chosen to declare, unless identifiable data were shared. This in itself may present a case to be referred to the Information Commissioner's Office. Whilst the BMA does not know how the data could lawfully be shared, we cannot be sure that it is impossible. If any GP chooses not to declare, and is approached by their ICB or NHSE, they would have 28 days to remedy the breach in any case. Further, we would encourage them to contact the BMA, and LMC, as we would expect the ICB and NHSE to provide evidence of why they believe the individual should declare, the provenance of the information they hold, and if this has been sourced through legitimate means. If it has not, it will be open to legal challenge, and we are certain that the BMA and GPDF would move swiftly to take action through the courts in such a hypothetical scenario. I hope this is helpful.
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5) MEDICAL EXAMINER SERVICE

It has been announced that the implementation of the Medical Examiner service has been put back until April 2024. The LMC still advises practices to use the service at least on a few occasions to test it, but also so practices become accustomed how to use it before it becomes mandatory. However, in the meantime it remains voluntary whether practices wish to use the service or not.
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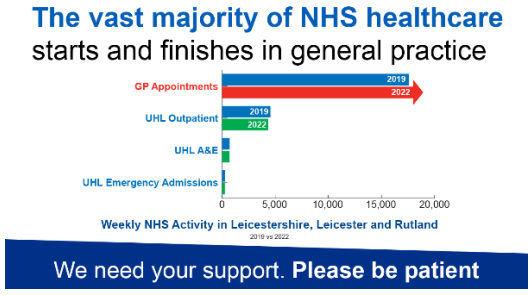
At the time of a crisis in general practice with a significant risk that a universal NHS general practice service will cease to exist within a generation, there would be a reasonable expectation that the government of the day would be working hard with GPs to reverse this. However, the current government is tone-deaf, and appears to be on a swimming holiday although unclear whether Cairo or Paris.

Yours faithfully



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