British Medical Association (BMA) Proposed Collective Action

Sheffield LMC

GUIDANCE FOR SHEFFIELD GPS

August 2024

INTRODUCTION

The paramount messages from any forms of action that practices may want to take from the BMA list are:

- As long as you follow the current BMA proposed actions they will not breach core contract activity.
- Practices may choose to engage in all, some or none of the proposed actions.
- Integrated Care Board (ICB) systems are aware of the potential impacts of actions and are making contingency plans.
- Although suggested action is from 1 August 2024, this is collective action, rather than industrial action, so there are no set timeframes for engagement.
- Patient safety is a paramount consideration, but that is dependent on workforce health and wellbeing.
- Sheffield LMC is not a Trade Union, so cannot direct practices what action to take, although we are happy to discuss any queries.

ACTION 1

Limit daily patient contacts per clinician to the European Union of General Practitioners (UEMO) recommended safe maximum of 25.

Practices must offer a service that "...meets the reasonable needs of patients."

There has been a recommended safe number of contacts since 2016. This is a recommended maximum, and targets may be lower to allow for on-the-day urgent contacts as well. The target is about safe working for clinicians, whilst still meeting the reasonable needs of patients, and improving decision-making and continuity for patients, which both have health benefits.

Use of the wider practice, Primary Care Network (PCN) or Community team for appropriate patient management can reduce demand on GPs. Once capacity is reached practices can consider diverting patients to 111, Walk-in Centres, Minor Injury Units, Overflow hubs and A&E as appropriate.

Practices are contractually obliged to provide 111 appointments at a rate of 1 per 3000 patients for direct booking. Patients may be redirected to practices from 111 with a timeframe for action. This is a timeframe for the practice to re-triage the patient (not to see them) and then advise the patient on appropriate health action. We have been seeking an offer from Sheffield Place of the ICB to remove practices from the 111-disposal directory when they are experiencing OPEL 3/4 level reporting. This is linked to the Primary Care Capacity and Demand (PCCAD) reporting in the Quality Contract Locally Commissioned Service (LCS), for which we want some active actions to support practices.

ACTION 2

Stop engaging with the e-referral Advice and Guidance (A&G) pathway.

General practice has reported a significant increase in workload being transferred from secondary care through the use of A&G, telephone consultations and outsourcing to private providers.

GPs not only have a role in treating their patients appropriately within their skillset, but also to be the patient's advocate when other services need to be involved. If a GP considers A&G is appropriate, then that is a request that should be made. However, a GP should not accept A&G if they consider a secondary care appointment is more appropriate.

There is no contractual obligation on practices to accept A&G, even if secondary care has targets to reach. This might include telephone advice from secondary care mental health teams to change medication doses in complex mental health patients. The responsibility for medication rests with the prescriber and, if you consider it is beyond your skillset, you should not be putting your General Medical Council (GMC) registration at risk. We have fought to retain this by-pass ability within the Clinical Assessments, Services, Education and Support (CASES) system so that it does not become a referral management tool.

The BMA provided guidance and letters to push back on secondary care workload after the 2017/18 hospital contracts. Locally, if GPs consider they have received an inappropriate workload request from secondary care they can make senior clinicians aware by emailing sth.lmpagsheffield@nhs.net. This inbox is monitored on a weekly basis, so cannot be used for specific cases that require a direct, time sensitive response / resolution. These should be passed back to the requesting clinician without delay. If practices wish an LMC opinion they can email manager@sheffieldlmc.org.uk, but we can only receive patient anonymised information.

ACTION 3

Stop supporting the system at the expense of your business and staff.

It is important to understand what GPs are commissioned to provide, either through the core contract or through LCSs. The Clinical Negligence Scheme for GPs (CNSGP) is very clear that it will cover activity where there is an NHS contract in place. It is less clear about cover for services which are not directly commissioned and likely to require a case-by-case assessment. For example, Prostate Specific Antigen monitoring requests from secondary care for prostate cancer surveillance is covered in the "Over and Above LCS" , however, monitoring of Monoclonal Gammopathy of Uncertain Significance (MGUS) is not.

The uplift in value of LCSs has fallen far behind the levels of inflation for many years. It is, therefore, sensible for practices to evaluate the cost-benefit value of these contracts to the business. To this end, we will be issuing updates on all LCSs available in Sheffield, including a Ready Reckoner to calculate practice costs for delivering these and personally administered items.

ACTION 4

Stop rationing referrals, investigations and admissions.

As mentioned before, GPs need to meet "...the reasonable needs..." of their patients. If the GP considers patients need investigations, referral or admission, then it is important that you seek these on behalf of your patients. We are well aware that there are always going to be financial constraints on health service delivery, but that should not limit GPs working in the best interests of their patients.

You will note from the recently published Quality Contract that Standard 1 - Transforming Elective Care includes the use of CASES and the Electronic Referral Service (eRS) where available, including local proformas. We have tried to ensure as many of these as possible will pre-populate for ease of completion.

We recently confirmed that Morelife will still accept Dashboard referral forms, as well as forms on their own portal, although there may be some delay in evaluating the Dashboard generated forms.

If practices sign up to the Quality Contract they may follow BMA guidance on eRS referrals, but there will be a financial penalty in not attempting all sections of the Quality Contract. Practices can still use the CASES service but, if they consider that an appointment is more appropriate than being given advice, they can still then refer directly to the department with reasoning.

ACTION 5

Switch off GP Connect update record functionality.

Concerns have been raised about coded data being entered into GP records through Pharmacy First, without the GP being aware or alerted to them. Although the system allows smoother transfer of data between Pharmacy and GP records there are implications for GP practices.

Coded data or alerts may not trigger action until searches are done, increasing the workload on practices. If actions are missed because GPs have not been alerted to the data in their systems, they may then need to do a review of data processing within the practice, taking more time.

GPs are the data controllers and so will be responsible for any problems relating to data management.

The sharing of health care records with other providers for management of care needs is considered best practice and in line with Good Medical Practice.

ACTIONS 6, 7, 8

Data Sharing Agreements (DSA)

Practices are reminded that they are the data controllers and any request to share data is their responsibility. Practices need to consider whether any DSA is in the best interests of their patients' health needs, who is managing raw data and pseudonymised data, and what are the mechanisms that allow change in data use without recourse to asking the data controller. More detailed guidance on these considerations can be found here.

National opt-outs will be incorporated, but practices may want to inform patients before they sign any new DSAs, so patients are aware of what their data is being used for. Local opt outs are also being considered.

For any data sharing with the ICB we are pushing for any advisory committee that oversees the pseudonymised data to have significant GP input and veto on any new uses of data if not considered to be in patients' interests, and to protect GPs as data controllers. We have not received such reassurances yet.

Any complaints, Subject Access Requests or Freedom of Information requests received by the data processors may be passed back to the practice and increase workload.

OptimiseRx is a tool used to alert clinicians to potential drug interactions, but also has a financial saving element built into it. Again, patient safety is paramount, so practices need to consider whether they have adequate warning systems in place to prevent unintentional drug interactions before withdrawing consent from this package.

Withdrawing from OptimiseRx or Eclipse packages may impact on ability to achieve Prescribing Quality Improvement Scheme (PQIS) targets. The ICB's Medicines Management Team is aware that if practices do not renew their DSA for Eclipse then the ICB will need to find alternative methods to allow data collection.

ACTION 9

Better digital telephony and simpler online requests.

There will be a contract update in October 2024 that allows data from digital telephony systems to be collected and analysed by NHS England (NHSE). Concerns are that this data will be used to vilify general practice, rather than use the data to identify gaps and establish how to address these. We have always maintained that the issue of waiting times on telephones and for appointments is one of capacity, not access.

The core general practice contract has seen significant underinvestment for years, alongside high inflation rates and near 10% increase in minimum wage for the last 2 years. This has made staffing increases within the funding envelope very difficult, and it is now anticipated that 60-80% of GPs qualifying this August will be unemployed.

We have already distributed patient-facing information to practices to support this rhetoric and counter some of the expected negative press. The information has been updated and put into poster form, which can be downloaded here.

Online requests.

Concerns have recently been raised about risks and patient care associated with online communications and consultations. However, NHSE continues to push this mode of patient access. General Practitioners Committee (GPC) England has said to await further updates on their response to this.

ACTION 10

Defer making any decisions to accept local or national NHSE Pilot programmes whilst we explore opportunities with the new Government.

SUMMARY

We recognise that practices may want to take time to review and consider what actions to take. There is not an expectation that all actions should be in place by 1 August, and we expect uptake to be gradual and incremental.

The issues raised by these suggestions may also encourage GP surgeries and PCNs to consider future contract offers. The BMA has already highlighted concerns about the autumn Flu/COVID vaccination campaign and the reduced funding for COVID vaccination co-administered with 'flu. We are seeking further clarification of funding and timing of the autumn/winter 2024/25 vaccination programme.

Practices may also wish to evaluate the cost effectiveness of buying-in certain medications for delivery by the practice (Personally Administered Items) compared to issuing an FP10 and then administering the medication.

We hope you find this information useful. If you have any questions about any of the actions please do not hesitate to contact the LMC Office via chair@sheffieldlmc.org.uk.