To: All Practices in Surrey and Sussex LMCs

26 October 2021

Dear Colleagues

GPC England response to NHS England's plan to improve access and support to General Practice

This letter is being sent to all General Practitioners and other practice colleagues across SSLMCs.

It describes in more detail the motion passed by GPC England last week, the process whereby the BMA may move towards both Industrial and Collective Action, and some of the implications of what is happening. Not all details are yet known; I would encourage colleagues to attend the LMC Webinar planned for Thursday 28 October at 1.00pm; a flyer has been circulated to all practices.

When	Where
Thursday 28th October 2021 **13.00 – 14.00**	Microsoft Teams meeting **Join on your computer or mobile app** Click here to join the meeting **Or call in (audio only)** +44 20 4526 6282,,851491066# United Kingdom, London Phone Conference ID: 851 491 066# Find a local number | Reset PIN Learn more | Meeting options

Any colleagues who have seen and heard newspaper and other press reports over the last few days will know the current situation is being grossly misrepresented to the public: GPs are not "striking over the issue of F2F appointments". GPs are resisting NHS England's failure to address the crisis within General Practice, brought on by chronic underfunding and uncontrolled demand, which is damaging us both professionally and personally. NHS England is undermining our primary professional motivation, to provide high quality care to our patients, and is risking our future commitment to the NHS if it cannot provide a safe working environment. Many colleagues are making that decision already.

I imagine, following GPC England's Emergency Meeting last week, you will all have seen the resultant statements and publicity, including in many social media groups. **Many colleagues will be feeling anxious about the implications of these developments, and uncertain how to respond or what they might be expected to do.** There will also, naturally, be a range of reactions across the profession, but I suspect no doubt about extent of the crisis within, and challenges, facing General Practice.

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This letter will complement the LMC Webinar [details above]. The LMC will provide as much advice and support to practices, but it is only the BMA, as your Trades Union, and not the LMC, that can call for and co-ordinate Industrial and Collective Action. I will describe the legal position below.

The LMC also needs to maintain a strong on-going relationship with CCG colleagues and current joint work will continue. Any action taken by General Practitioners will have significant implications for CCGs and leads to a range of options in terms of their response; the LMC will seek to influence these situations in the best interests of the profession and patient care.

Industrial and Collective Action

In order to take **Industrial Action**, a Trades Union must declare they are in a Trade Dispute; given the nature of NHS England's recent actions, it is likely the BMA will find grounds to do so. Industrial Action involves acting outside your contract; this needs to be approved by BMA Council, who will look at the nature of the dispute, the outcome that is being sought, an identified achievable end point, and the resources needed to support such action.

Under Trades Union legislation a Union calling for industrial action must obtain the participation of at least 50% of those eligible to vote, with the additional proviso that where those involved in industrial action provide 'important public services', which would be the case for General Practice, then 40% of the electorate must vote in favour, as well as there being a majority in favour, for a mandate to be obtained.

Collective Action represents actions the BMA could encourage General Practitioners to take collectively; these would not represent a breach of contract, and do not necessarily require a Trade Dispute to be declared. It would be usual for the BMA to ballot before any collective action, to demonstrate a mandate for taking action, for example, in the context of delivering public services. The LMC will provide a separate letter about the options for Collective Action

Response of NHS England and CCGs to any breaches of contract.

If a contractor [GP Partnership] breaches their contract, it is open to a CCG to issue a Remedial or Breach Notice, under clauses within the GM/PMS Contract, which must define what contractual clauses are held to have been breached, and, in the case of Remedial Notices, how they can be set right. Successive Notices can be issued. There is no requirement to issue such Notices, although there is an expectation, and under the Regulations the LMC must be consulted before such a Notice is issued to a practice, or more than one.

The LMC will provide more information to practices on this point should a ballot for Industrial Action be called by the BMA.

Analysis of GPC England Motion

The motion passed by GPC England was:

That this committee is outraged by the deliberate, relentless denigration of GPs by Government, NHSEI and certain quarters of the media, and: (57/57 - 100% Agree)

i. rejects the plan published by NHSEI on 14th October 2021 and calls on all LMCs (local medical committees) in England to disengage from any participation with the implementation of that plan (53 agree, 2 disagree, 2 abstain)

ii. calls on all practices in England to pause all ARRS recruitment and to disengage from the demands of the PCN DES (47 agree, 8 disagree, 2 abstain)

iii. promises its full support to protect and defend any constituent GPs who refuse to engage or comply with the unreasonable contractual impositions by NHSEI of "Pay Transparency" and "Covid Medical Exemption Certification" (54 agree, 1 disagree, 2 abstain)

iv. calls on all practices in England to submit undated resignations from the PCN DES to be held by their LMCs, only to be issued on the condition that submissions by a critical mass of more than 50% of eligible practices is received (48 agree, 8 disagree, 1 abstain)

v. instructs the GPC Executive to negotiate a comprehensive new contract to replace the outdated, underfunded, unlimited, unsafe workload of the current GP contract (49 agree, 6 disagree, 2 abstain)

Clearly, GPC were unanimous in condemning the denigration of GPs by NHS England, the Government, and certain sections of the press.

Dealing with these motions in turn:

Motion 1(i) GPC has rejected NHS England's letter of 14 October 2021 and the proposals within it and called for LMCs to disengage from any participation in this plan.

LMCs are independent of GPC England, and having taken advice from many GP colleagues, SSLMCs has already, and before GPC England's meeting, clearly rejected all elements of NHS England's proposals that involve the performance management elements of that letter. The data being used is flawed, and the parameters proposed do not reflect the safe delivery of care to patients nor the quality of care provided by practice teams.

The LMC has recommended GP colleagues have nothing to do with analysing and reflecting such data and identifying a 20% cohort of practices on the basis of it. **The LMC does not support implementing NHS England proposals – including the financial investment available – if doing so is contingent on the extra-contractual performance management of 20% of practices based on this data**. However, it is possible that such investment could be available to support GP practices by other routes if agreed locally. With the caveat above, the LMC is supporting such a locally agreed approach.

Motion 1 (iii) relates to the contractual requirement, introduced in October 2021, for the GP NHS earnings 'Pay Transparency' declaration and participation in the 'Covid Medical Exemption Certification' process. As both are parts of the GMC/PMS contract, with the former being imposed on General Practice, not complying with this would be Industrial Action. The LMC's advice is that the BMA, as our Trades Union, must provide further guidance and colleagues should not take any action without considering this; the BMA is aware the 11 November deadline to submit pay declaration information is imminent.

Motions (ii) and (iv) relate to the PCN DES; these are undoubtedly the most significant parts of the motion from a strategic perspective as the formation of PCNs, and engagement of practices with the ARRS staff recruitment and deployment process, is the central plank of NHS England's 'Long Term Plan' for General Practice and, more widely, primary care. PCN Clinical Directors have also been drawn into multiple other roles, many of them unreferenced within the PCN DES.

I know many colleagues will find this an uncomfortable situation; PCN CDs have committed considerable time and energy to their roles and may be enthusiastic about the opportunities within the DES specification and collaboration with other partners. All GPs have worked with ARRS colleagues and recognise the value of their contribution to patient care and the wider team. This is an unsettling time for such colleagues.

However, the fact remains that PCNs could be developed by NHS England into a substitute for the practice model: **investment in PCNs is not investment directly into practices and properly funding the core GMS/PMS contract**. GP practices do not need PCNs to successfully collaborate, and both the ARRS scheme and the PCN DES specifications, and the Investment and Impact Fund targets, represent excessive micromanagement, and a substantial workload.

The PCN DES is voluntary, and therefore withdrawing from the DES does not constitute Industrial Action, providing it occurs by giving appropriate notice and under the arrangements within your Network Agreement, although it is Collective Action if the BMA encourages GP practices to do so. **The PCN DES is a practice-based contract, and withdrawal is a partnership decision, not one to be either made or vetoed by a PCN CD**. In addition, practices may withdraw from the PCN DES until 31st October 2021 simply by giving the CCG notice of this. The LMC is not collecting such resignations. The LMC recognises this is not a decision most practices will wish to make without carefully considering their options but **withdrawing from the PCN DES is the single action the profession could take that would most effectively challenge NHS England to change their strategy and reset their support for General Practice.** If we have a different vision for the future, this will express that aim most effectively, but as Collective Action colleagues need BMA endorsement

Recruitment of ARRS staff, whilst expected, is also not a contractual requirement as the availability of suitable staff is unpredictable. PCNs have recently submitted ARRS workforce plans, both for 2021/22 and 2022/23, but these are aspirational and not firm commitments.

Disengagement from "the demands of the PCN DES" is not further defined within the motion; the current PCN DES specifications include, for example, Enhanced Care in Care Homes MDTs and Structured Medication Reviews, often undertaken with the support of ARRS staff.

In both cases the LMC recommends GP colleagues await further BMA guidance before considering what action following motion (ii) might constitute.

The LMC will accept undated resignations from the PCN DES if practices wish to submit them. These can take effect up to 31st March 2022, if they were to be implemented. **However, the LMC is not suggesting practices need make an imminent decision on this point,** unless they have decided to withdraw unilaterally, and on an individual basis, outside the scope of current BMA/GPC action. I will write separately to all practices about this issue shortly.

If a practice resigns from the PCN DES they will no longer be paid the capitated £1.76 Network Participation Payment. The following payments [£1.50 CCG payment, Extended Hours payment, ARRS payments, and IIF achievement payments) are made to the PCN collectively. The IIF payment cannot be used as practice profit. PCN CD payments [and recent quarterly supplements] are ringfenced as financial contributions to the PCN CD role. However, in considering the financial implications of withdrawal, colleagues should carefully consider the "hidden" costs of the PCN DES. **For example, the workload associated with managing, supervising, and training ARRS colleagues is significant and is not reflected in the income practices receive from the PCN DES.** The commitments of PCN CDs and the balance between PCN workload and practice workload may not be proportionate.

After withdrawal, practices will have no responsibility to deliver the PCN DES specification but will retain a 'Duty of Co-operation' in terms of enabling patients to receive services delivered under the PCN DES, for example, by providing names/contact details of patients eligible to receive those services.

CCGs will continue to have a responsibility to deliver PCN DES services to their populations; in practice it is highly likely that if swathes of practices withdraw from the PCN DES, remaining PCNs will be unable [and unwilling] to attempt to deliver such services and a domino effect will ensue, probably occurring at well under 50% withdrawal.

Practices should note the PCN DES specification includes confirmation that if practices do not participate in the PCN DES, their ability to continue their GMS/PMS Contract is unaffected [3.1.4]
In addition, in terms of practice accrued employment liabilities should the PCN DES be handed back, this was addressed in Para. 1.20 of the Update to the GP Contract Agreement 2020/21 – 2023/24 as below:

> *Furthermore, should all the practices which comprise a PCN ever decide in the future to hand back the DES, the commissioner must arrange timely alternative provision for the same services from another provider, e.g. another PCN or NHS community provider. In these circumstances the law regarding the transfer of staff would apply as normal. The commissioner will approach the appointment of the new provider on the basis that, unless there are exceptional circumstances not to do so, 1) relevant staff will transfer from the outgoing practices) to the replacements, 2) the TUPE Regulations will apply to that transfer and 3) transferring staff will be treated no less favourably than if the TUPE Regulations had applied.*

PCN employment models vary, and undoubtedly some GP practices would wish to continue to employ, or decide to offer to newly employ, a proportion of ARRS colleagues in these circumstances as an on-going business option

The final part of the motion (v) instructs GPC to negotiate a comprehensive new contract to replace the current nGMS Contract on the basis that this is underfunded and unlimited.

The last 2004 nGMS contract took two years to negotiate against the backdrop of the Blair Government's largesse to the NHS in the early years after the millennium. Matters would be different now, but it is unlikely GP colleagues would be seeking the same type of unlimited contract this time. However, this is not an imminent action.

I hope this summary is helpful; to be clear, only the BMA can trigger a Trade Dispute, and call for Industrial and Collective Action. The BMA will provide further guidance shortly. The LMC will do what it has always sought to do, work locally with all colleagues, including from the CCGs, to support the profession in even more challenging times and provide as much advice and information as possible.

With best wishes

Dr Julius Parker
Chief Executive