DDA 2024 conference transcript of discussion between
DDA chairman Dr Richard West and GPC deputy chair Dr Julius Parker

Dr Richard West (RW) I'd like to start by saying we've had a very good year with the GPC in terms of structured conversations around where we would like to see dispensing going and how to develop the new contract. So, perhaps, we can start with collective action in August, and where we are in the process of developing new contracts?

Dispensing contract negotiations

Dr Julius Parker (JP): It's important to realise that this is a twin track process, because we'll still be negotiating the 25-26 contract, even if we get a commitment from the government, which is what we're seeking, for a renegotiation of the national contract. [Currently], we're preparing for 25-26 but we haven't had a mandate yet from NHS England, so those discussions haven't started yet - but some of it will be going back to what we were hoping to achieve in 24-25 which has sort of emerged over the year. We're seeking commitment for a renegotiation for the national contract, because we recognise that what was in place in 2004 isn't now fit for purpose in 2024 and I can't say to you that we've got that commitment yet, but that's what the government know we're looking for. So that's where we are with both in

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RW: In terms of the dispensing contract - where does that fit within the process? Obviously, we've had discussions, and one of [GPCE's] aims is to include dispensing as part of these contract negotiations. But, do you see this as part of this year's contract, or in a later iteration?

JP: At last year's conference, I was concerned that there was a definite feeling amongst the audience and from the DDA that, perhaps, you hadn't had the sort of engagement with GPC England that you should have had. And I came away from the conference and I said: This is going to change. Since then, we've been having structured meetings to look at the dispensing contract specifically. My stance is that as long as it doesn't negatively impinge on non-dispensing practices, I look to the DDA to shape what you want from the dispensing contract. My preferred option is to start on that as soon as possible before the national contract negotiations. But you and I both know there are some things that even the DDA is not in control of, and nor am I, and that is the remit from government in terms of what they will negotiate about. Colleagues will know from the 24-25 contract round that sometimes NHS England will just say: We will not talk about that, and obviously a negotiation requires both parties.
However, we have been able to demonstrate the parlous state of general practice. While we can also demonstrate the parlous state of dispensing and dispensing practices, it's an extra issue – but we believe we are making progress. Now we've got a new administration and they're still finding their feet and they have a set of competing priorities. We do need to make sure that dispensing is one of those. And as you know, Richard, I've been doing that.

Collective action

RW: How is [collective action] going nationally in terms of collective action. Are things happening? How do you see that process sort of moving forward?

JP: With 6,500 practices, it's very difficult to get a coordinated response. And also, some aspects of collective action are not really negotiating levers, for example, safe working guidance - because we're not going to say: All right, we've got what we wanted, so we'll go back to doing things unsafely. A lot of collective action is about saying to the government: Look, you are relying on the goodwill of general practitioners and their teams, and you can't go on relying on that without resourcing it appropriately. It's about saying to the government, look at all these things we do. We shouldn't be doing them, or we should be resourced to do them. Some actions are designed to disrupt things and are the negotiating lever, ie medicines optimisation as ICBs rely on that to accrue at least some money for their deficit. There is a heat map to show where collective action is taking place and what's happening in different geographical areas and that's going to be fed back to general practice. It's important not to feel that

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you're the only one doing something. I'm expecting a variation across the country, and I'm also expecting things to take time, because collective action is not about damaging you financially, and it's not about getting breach notices. What we want to do is to make NHS England realise that they can't go on pretending general practice is an endless dumping ground for work and a sort of free gift to the NHS. We are a gift to the NHS, but we have to be resourced.
Talking to the DDA, we do know that there are specific challenges in rural areas, particularly in signposting your patients to somewhere else. From feedback from rural practices, GPs still have a more personal relationship with the patients than in [urban areas] so we have to tailor things. But on the other hand, if we don't do something we are looking at the terminal decline of general practice as we want to do [it].

Pharmacy First service

RW: My personal opinion is that we need to look at [Pharmacy First] and try to create a similar resource for rural patients to access whether that is provided by rural practices or by others. My fear is that [the dispensing contract] will just roll over into [more of the same] just because of infrastructure differences.

JP: I'm going to confine myself to saying yes, because I agree. However, the BMA is not involved in negotiating the pharmacy contract.

Dispensing fee

RW: Traditionally, the DDA has seen the dispensing fee before it is published. However, the DDA hasn't seen it this year.

JP: I asked [the DHSC/NHSE] if I could share it, and they said no.

RW: I do have concerns around this because it's a very technical document, and last year, I and several other board members spent a long time with the BMA statisticians going over it line by line, because it's very difficult to interpret and from time to time, there can be errors. This is the first year that there has been a slight tweak to try to stop the yo-yo effect and I'm disappointed that [DHSC/NHSE] didn't feel able to share, and we weren't able to test it properly.

JP: I hope next year it will be a different environment. However, [DHSC/NHSE] are quite sensitive at the moment. I think what the government thought was that with the 7.4 per cent increase in global sum aggregated this year, [the BMA] would probably say: Okay, we'll cool off collective action. But that

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wouldn't have been the right thing to do, because collective action isn't about just negotiating a particular outcome. It's about protecting our profession and our practices and, ultimately, to make sure that patients get a better service… so, maybe they do feel a bit unhappy with us. But we know that if we don't change things, things are going to get worse, and we know that collective action is the best way to achieve this. For GP partners, a strike will simply lead to breach notices, which are not protected by a strike mandate.

RW: At the beginning of this year, 6 per cent was promised to just about everybody, and in my view that includes dispensing staff. The dispensing contract has very much been standalone, and in my opinion the 6 per cent for the dispensing staff should end up in a pot that looks at dispensing, not in a general pot. Are we anywhere near that position? Is there any chance of getting anywhere near that position? In Scotland it is acknowledged that dispensing income subsidises the extra costs of rural services, so having the GMS 'pot' cross subsidise dispensing is not a tenable proposition. Have we got anywhere?

JP: No, I don't anticipate it in this year's financial settlements. I don't think that specific element of the uplift will be possible.

RW: We very much recognise some of these things are not within your gift but having said that the funding [for dispensing] needs to stand on his own two legs. To suggest that cross subsidy works from GMS into dispensing will likely [take] practices the way of post offices and banks and other institutions which used to be in rural areas. As a society we can't afford to let that happen to rural general practice.

JP: I agree with you, Richard, and that's one reason why we sat down after the DDA conference last year and said: we need to put this on the proper footing. Our rural colleagues need recognition for the support you uniquely provide patients and that shouldn't be cross subsidised by the GMS contract. Absolutely, it should be standing alone. It's difficult for me to say we haven't achieved that, but I think you've got to look at the context of everything else that we have been able to negotiate (statement of financial entitlements claims) which does benefit dispensing practices as well.

RW: All practices want to be good employers and they want to protect and help their staff as much as they can. Putting us in this invidious position is not helpful.

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JP: I do understand. I'm completely committed to recognising that you need a better dispensing contract. [The lack of dispenser pay uplift] hasn't landed well, but I don't think there's anything I can do about it in this financial year.

RW: In Wales they are moving to two- or three-monthly prescriptions rather than monthly. Are there any discussions or thoughts in England around that sort of change? From an economic view, I can see that where you're losing pharmacies, to try to decrease their workload a bit might be something that's being thought about.

JP: I've heard absolutely nothing nationally on that line. I think it's much more likely to be discussed at a local ICB level through your pharmacy optimisation teams.

Flu vaccines

RW: There are rumors in the market of centrally purchased vaccines moving forward. While this does remove some of the financial risk, it also takes out the reward - profit that pays for a nurse for a year. The other thing that I'd just like to reflect on is the Covid vaccine campaign. Practices achieved vaccination rates of 95 per cent, yet the direction of travel appears to be [away from that setting]. Most rural practices provide a really good vaccination service really cost effectively, and any move away from that, I think, threatens public health. Do you have any news on central procurement?

JP: I've got no indication at all that they're planning to move to central procurement for flu during the next financial year. All the focus of our discussions with the immunisation team at NHS England has been the item of service and we've asked them to justify in terms of their own calculations: how £10.06 is a viable economic proposition. We don't think it is okay. General Practice delivers absolutely the best service for public health, and they need to be fair. I think they recognise that. We want to see an increase in the item service fee and they point blank have refused to discuss it. I can't say to you it won't happen in terms of central procurement, but we think they recognise that [to do that] is likely to lead to a further sort of attrition in general practice. My personal view is that eventually NHS England and the DHSC will realise that the current fee is untenable.

Reimbursement

RW: It's been a tough year [for reimbursement] in terms of recouping your spend on drugs. The

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reasons for that include the increased number of zero discount items as well as generics priced higher at the wholesaler than the reimbursement. And then we have the clawback added on top of it. Has there been any [word] from the other side that they recognise this as a problem and may want to discuss a possible solution?

JP: Part of the purpose of our regular meetings is to ensure that we get specialist input. From DHSC and NHS England it's pretty much radio silence so our work is to prepare for the best possible negotiating position when we can embark on that. We have to try and create a negotiating position that is tenable, that is deliverable, and that gives you all the best outcome you can for your services. And that's what we're trying to do.

RW: In terms of the audience here if they can put a little bit of pressure on their politicians and their ICB to encourage them to think that negotiation is easier than not negotiating, then that will be extremely helpful in order to try to move this process forward. But in terms of expectation management, there's nothing that's going to suddenly appear.

JP: The pressure that you bring as an organisation, but even more powerfully, as individual GPs - not just sending a prescriptive letter, but actually discussing what it's really like - is really important, particularly in the context of the sort of administration we've got now. We've got a lot of Labour MPs in more rural areas, which isn't, traditionally, how people have voted in the past, and they are more alive to the specific issues that their constituencies have in rural areas than they had in the past. Pressure that you can bring - that's the way to make people realise that there's a problem, and, you know, politicians will only do something if they recognise it's a problem.

Questions

Q: Is there any scope for the BMA to negotiate private income streams for GPs?

JP: I don't think [private income streams] will form part of the 25-26 negotiations. But [a question] I would ask this audience is: do we think the state, on its own, can fund the sort of general practice we want? If the answer is no, we need another income stream. There's lots of ways in which you can expand the [income] beyond just NHS income, but I think any changes in the regulations related to your ability to conduct private practice are going to await the national contract negotiation.

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Q: Regarding vaccine reimbursement, the Government has set out there three priorities, one of which is prevention. So surely, if you want to prevent disease, you will need fund that?

JP: We absolutely want to increase the vaccination item service fee. As an individual, there's no reason why you can't write to your Member of Parliament to ask why, if prevention is one of your priorities, why are you not properly investing in it to do it? If you costed up increasing the item service fee to, £12.28 to take inflation into account, it isn't a huge amount of money in terms of the NHS spend. But I think there's an ideological barrier and we are in a funding 'envelope', and what we don't want to happen is for this fee to go up and for another to go down and the envelope remain the same. What we need to happen is for that fee to go up and be added as an extra item to the overall envelope.

Q: My practice comes under pressure from ICB medicines management in terms of forcing through medicines optimisation frameworks, which they seem to be aligning with PCN funding, saying that if you don't achieve it, not only will your practice not get the money, the whole PCN will not get the money. I feel that we need some help and support from BMA and GPC in terms of that.

JP:That sounds like contractual bundling, and this is something that your LMC should really strongly challenge.

Q: Dispenser pay. It's going to be very difficult to say that we're not going to not give a 6% pay uplift to our dispensing staff. This hits partner profits at a very, very difficult time for practices generally. Could the BMA put out a statement to say that you have tried to achieve the 6 per cent uplift for dispensers, but that the negotiators won't negotiate with us? That will make it easier for us to be able to explain to our staff and explain to our patients that the BMA are trying to negotiate on our behalf – but that we've been discriminated against. That would be really helpful.

JP: I think that's a very reasonable request. It would be totally inappropriate for you to distinguish between your premises or your practice staff, and dispensary staff, because they're one and the same in a dispensing practice.

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