General practice 2017/18

BMA

Chaand Nagpaul, chair GPC

Manchester LMCs

1 March, 2017

Overview

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- Response to challenges facing general practice
- 2017/18 contract negotiations
- Current issues
- General Practice Forward View
- Primary/secondary care interface
- Multi-specialty Community Providers (MCPs)
- Working together at scale
- GPC/LMC partnership

Response to challenges

BMA

- Financial context: Crisis across whole of NHS and social care, impacting on GPs
  - 5YFV: £8b investment (reality £4.5b?); £22m funding cuts
  - Crisis across general practice, community, hospitals, social care
  - **All authoritative opinion- operating on inadequate NHS funding:** Health select committee letter to PM; NHS E Chief exec Simon Stevens
  - No imminent government plan for increased funding: Brexit, Autumn statement no mention NHS
- 2017/18 national contract negotiations
- Ensure commitments and funding in GPFV delivered and not be limited by it; UPGP
- BMA GP survey – solutions for general practice must be cognisant of diversity of profession and aspirations, environment outside the core contract

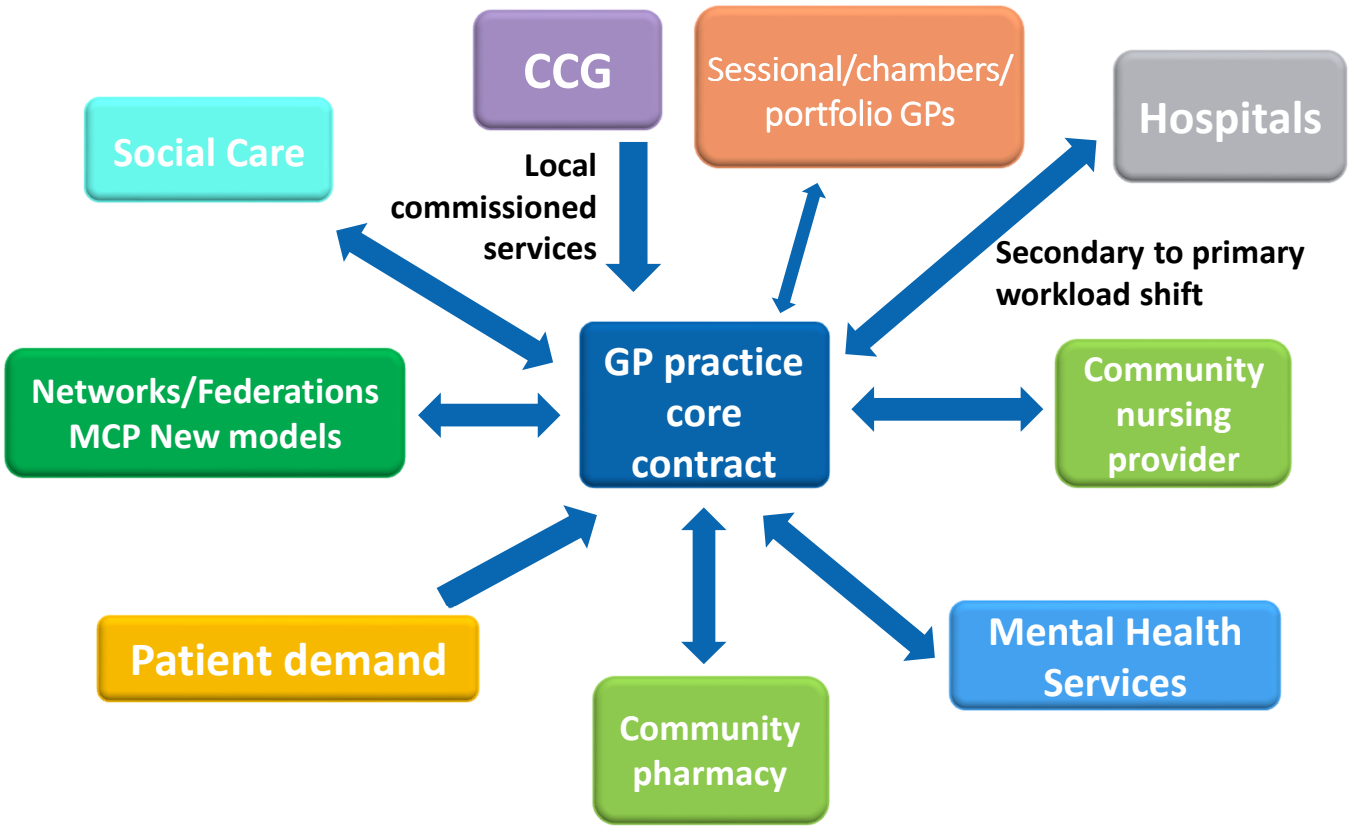
Contract overview

BMA

- Annual revision to contract; limited to scope of contract
- Call for stability (LMC conference)
- Will not sort out the overall problems for general practice
- Local commissioned services can have greater financial impact on practices
- Unresourced workload ***outside*** contract remains important area to address
- GPC will not accept any contractual change to extending GP opening hours

The GP contract as part of a wider environment

BMA



Avoiding Unplanned Admissions DES

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- **Discontinued** with **£156.7m** added to global sum
- Replaced with focus on identifying the **severely frail** using appropriate tool (e.g. eFI)
- Will apply to approx. 3% of over 65s (0.5% of practice population - current AUA DES is 2%)
- Annual review to include medication review and post-fall review, where clinically appropriate **– no care plans**
- Promoting consent for enriched SCR
- Data extraction on med reviews/falls/SCR consent, and numbers with moderate frailty
- Not to be used for performance management or benchmarking

Expenses

BMA

- CQC fees full re-imbursement
  - System of direct reimbursement – unweighted
  - Practice will pay and then send invoice to NHS England for reimbursement
  - Embeds system to have future increases funded
  - £15m will be taken off agreement this year to account for funding put into global sum last year

- Funding to cover annual rise in indemnity costs
  - £30m scheme to cover average increase
  - Separate SFE based payment – unweighted

Other new funding

BMA

- Expenses funded to deliver 1% pay uplift
- Primary Care Support England services (Capita) - £2m for increased practice workload as a result of changes
- Workforce census – £1.5 m to cover completion - contractual requirement
- Superannuation increases – £3.8m to cover 0.08% pension admin charges
- Overseas visitors changes - £5m to cover admin workload involved
- Business improvement district levies reimbursement - £1m
- Learning Disabilities ES - increase from £116 to £140 per health check
- £238.6 million additional investment into the contract for 2017/18
- Global Sum increase of 5.9% - £80.59 to £85.35 per head

Sickness and maternity reimbursement

BMA

- Sickness cover reimbursement
  - Discretionary status removed
  - List size criteria removed
  - Cover to start after two weeks sickness
  - Existing GPs in practice can be used to cover - mirroring maternity arrangements
  - Amount payable uplift in line with maternity – up to £1734.18 per week
  - Will reduce practice out of pocket locum expenses and locum insurance costs
  - Should improve terms for salaried GP sickness absence

- Maternity payments
  - Not be subject to pro-rata system
  - Practices will submit invoice - full amount or maximum payable under the SFE will be paid

Overseas visitors

BMA

- Covers patients with a non-UK issued EHIC or S1 form
- Country of origin will be charged, not patient
- Practices will be provided with patient information leaflet (hard copies)
- Amendment to GMS1 form – patients from overseas will **self declare**
- Practice will scan and email/post form to NHS Digital
- £5m will be added to contract on recurrent basis

Data collection

BMA

- INLIQ and retired enhanced services
  - Will be mandatory extraction of agreed indicators

- National diabetes audit
  - Will be mandatory
  - Joint letter will be sent to system suppliers to put pressure on enabling fully automated system

Opening hours

BMA

- National Audit Office report and recommendations: 700+ practices regularly close for one ½ day per week;
- GPC committed to working with NHS England to ensure locally responsive, safe and appropriate access during core hours (focus on weekly half day closing)
- Local Medical Committees will be integral partners in local discussion
- Changes to the qualifying criteria for the Extended Hours DES; excludes practices with weekly half day(s) closing as of October 2017

-

QOF

BMA

- Increase to QOF point value in line with CPI adjustment
- No changes to indicators for this year
- Commitment to work on replacement system for 2018/19
- Ongoing discussions on any replacement or distribution of funding
- Difficult issues due to change in funding distribution if moved to global sum and risk of potential new work required using QOF funding

Other areas of agreement

BMA

- Registration of prisoners immediately prior to their release
- Vaccination and immunisation
  - Minor amendments to existing programmes
  - £6.2 million to include morbidly obese in eligible cohort for influenza vaccinations
  - No new programmes
- New GP retainer scheme
- Dispensing negotiations to be conducted by separate group
- Expenses methodology survey to be undertaken

IT– all non contractual

BMA

- practice compliance with National Data Guardian Security Review
- practice completion of the NHS Digital Information Governance toolkit
- an increased uptake of electronic repeat prescriptions to 25% (with reference to pharmacy)
- an increased uptake of electronic referrals to 90% where this is enabled by secondary care
- continued uptake of electronic repeat dispensing with reference to CCG use of medicines management and co-ordination with community pharmacy
- uptake of patient use of one or more online service to 20% including, where possible, apps to access those services and increased access to clinical correspondence online
- better sharing of data and patient records at local level, between practices and between primary and secondary care

Current issues – SBS, TPP QRISK and Capita

BMA

- SBS note transfer failure – negotiated compensation
  - LMCs have been notified
  - Practices should now have received copies of correspondence and details of how to claim for workload
- TPP and QRISK
  - Issue of compensation being addressed and hope to announce soon
- PCSE/Capita – compensation being addressed; workload of labelling and bagging records in contract 2017/18

Recent news coverage – fighting your corner

BMA

BBC NEWS
Health
GPs being made scapegoats for A&E pressures, says BMA
14 January 2017 | Health
Share
Dr Chaand Nagpaul, BMA: "It's an insult"

BBC NEWS
Health
GPs urged to commit to seven-day service or lose funding
14 January 2017 | Health
Share
Chaand Nagpaul, BMA: "It's an insult"

itv NEWS
ITV REPORT 14 January 2017 at 6:36pm
Doctors reject Theresa May's demand for GP surgeries to open seven days a week

EXPRESS
Furious doctors reject Theresa May's demand for GPs to stay open seven days a week
DOCTORS' leaders have rejected a demand by Theresa May for GP surgeries to open seven days a week, saying they are already struggling to cope.

Theresa May must stop scapegoating GPs and tac
funding crisis in the NHS
The Prime Minister has no understanding how GPs work, writes Dr Kailash Chand

GPs hit back after Theresa May demands extended opening hours

The doctors
England sca
Date 05 January 2017
Page 9
NLA eClips

NHS is paying millions to private firms to scrutinise patient referrals
HEALTH
By Padraic Flanagan

PULSE
We need to stand up to Government hyperbole
Dr Mark Sanford-Wood

200 shut practices
HEALTH FEAR 2
ALMOST 200 GP practices shut last year.
Tables published by NHS Digital list just 7,532 open across England, down by 181.
Seven practices closed in Brighton over two years, affecting more than 30,000 patients.
The British Medical Association fears closures are at record levels due to increased workloads and lack of funding.
Last month Helen Stokes-Lampard, chair of the Royal College of GPs, said patients face waiting a month to see a family doctor as surgeries struggle with demand.

GP Forward View

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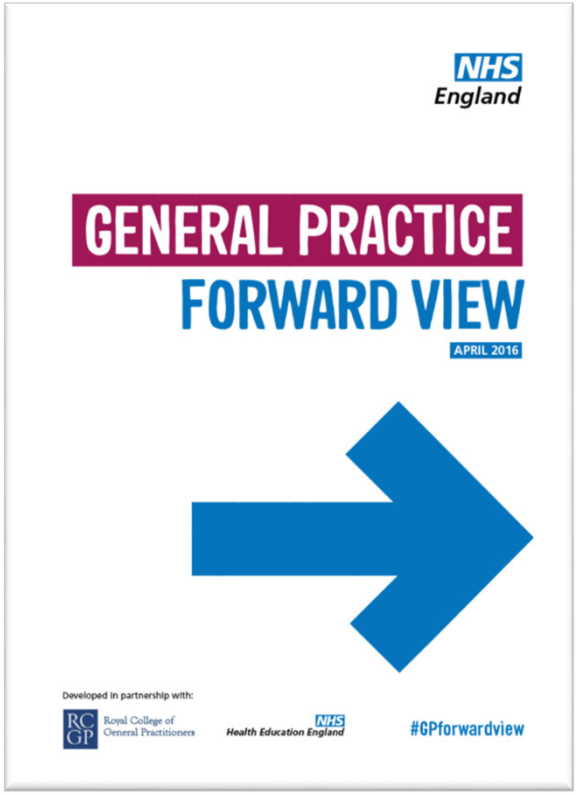
- Announced 21st April 2016
- 5 year support programme
- £2.4 billion extra **recurrent** funding by 2020/21 (14 vs 8%)
- **£506 million** over 5 years for Sustainability & transformation **non-recurrent**
- **>10% NHS budget by 2020/21; CCG investment on top**
- Result of GPC UP lobbying
- Change in tone by NHSE
- What NI GPC are campaigning for



GPFV headline areas and progress (1)

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- **Practice resilience** programme (£40m) -2016/7: £16m – *needs to be given to practices by 30 March*
- **Indemnity fees increase** reimbursement – *2017/18 contract negotiations, OOH – 2016/17 winter indemnity scheme; longer term solution via GP Indemnity Review Group*
- **CQC expense rise** *recompense – contract negotiat*ions
- Support for **burnout and stress** (£16m)- *just gone live*
- **GP Development Fund** to manage workload/shape demand (£96m) *–started this year*
- **Transformation monies 17/18 onwards** for working at scale (£171m) – *to go live April 2017 onwards*
- Review **mandatory training** – *working with RCGP*
- Commitment **national self-care programme** – *discussions with NHSE*

GPFV headline areas and progress (2)

BMA

- GP access monies:
  - £500m recurrent by 2020/21
  - Phased investment- all areas to receive £6 per head by 2019
  - No requirement for 8-8 7 days; local determination for weekend access hours
  - Can be used to support in-hours GP capacity
  - Can be for urgent appointments, and integrated with urgent care/GP OOH
  - Can be delivered via locality hubs
  - *Need to use to support current GP pressures; overflow work*

GPFV: Primary-secondary care interface

BMA

- **Hospital standard contract changes** to reduce inappropriate secondary care shift – went live 1 April 2016

Issue	2016/17
Referrals	- Hospitals to stop asking GPs to re-refer DNA appointments - Hospital to make internal referrals for related problem and not ask GP to re-refer
Communication with the patient and fit notes	- Hospital to follow up investigations and inform patient
Discharge summaries	- Discharge summaries within 24 hours
Clinic letters	- Clinic letters within 14 days
Drugs	- Adequate supply drugs on discharge

BMA

Home › Our collective voice › Our committees › General Practitioners Committee UK (GPC UK) › GPC current issues › NHS England standard hospital contract guidance

England | General practitioner | General Practitioners Committee

Last updated: 04 October 2016

NHS England standard hospital contract guidance

Template letters by topic for practices

1. Template response for missed appointment
2. Template response for delayed discharge summaries
3. Template response for delayed clinic letters
4. Template response for onward referral
5. Template response for provision of medication following discharge
6. Template response for follow-up of results and investigations
7. Template letter from practices to CCG, informing them of the breach by the provider

Template letters by topic for LMCs

We have produced template letters for LMCs (which can be locally adapted) to send to CCGs and hospital Trusts to hold them to account to meet these requirements:

- Template letter from LMC to Trusts asking them for a report on what arrangements have been made to implement the changes set out in the new standard hospital contract.
- Template letter from LMC to CCGs reminding them of the changes to the standard hospital contract and asking them what measures they have put in place to ensure that Trusts implement these, and to hold CCGs to account for their commissioning responsibilities.

GPFV Primary-secondary care interface (2)

BMA

Dedicated **GPFV primary-secondary care interface group** to address interface problems and workload shift – **Urgent Prescription priorities**

Issue	2017/18
Communication with the patient and fit notes	- Hospital to put in place arrangements for handling patient queries (from patients and GPs) - Hospital to issue fit notes to patients where needed
Discharge summaries	- Discharge summaries from A&E within 24 hrs and direct electronic transmission from Oct 2018
Clinic letters	- Clinic letters within 10 days (April 2017) and 7 days (April 2018) and move to electronic transmission using structured clinical headings (Oct 2018)
Prescribing	- Dedicated prescribing interface group. Outpatient and specialist prescriptions, share care arrangements, use of hospital FP10s and developing hospital EPS, hospital monitoring of specialist medications

GPFV General Practice Development Programme

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- Releasing Time for Care – 10 high impact areas (£30m) 67 groups (2,000 practices signed up)
- Training for reception and administrative staff (signposting, handling incoming clinical correspondence) (£45m)
- Practice manager development (£6m)
- Online consultation systems (£45m) – e.g. Askmy GP, WebGP or smartphone apps – available April 2017 onwards
- Need LMC/practice and CCG awareness – ***small amounts of money will stretch much further with groups of practices***

GPFV progress: workforce

BMA

- GP recruitment and retention:
  - *Induction and Refresher Scheme*
  - *GP Targeted training programme*
  - *Improved retainer scheme*
  - *International doctors recruitment*
  - *GP mental health service (to prevent burnout)*
  - *20k bursary in under-doctored areas*
  - *GP career plus pilot scheme*
- Practice based pharmacists (£112m ;1 pharmacist/30,000 pts) –just announced
- 1000 PAs, 3000 practice based mental health workers (1 per 2- 3 practices)
- Extended scope practitioners; enhanced nurses, paramedics, physios
- Training funds for practice managers (£6m) , nurse development (£15m), reception staff training & clinical admin support (£45m)
- Medical assistant pilots

GPFV: GP Health Service

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- Launched end January 2017 – based on model operating in London
- Free, confidential service for GPs suffering with mental health or addiction issues
- Self referral only

Contact details:

Opening hours: 8.00 – 20.00 weekdays and 8.00 – 14.00 Saturdays

Website: **www.england.nhs.uk/gphealthservice**

Tel: **0300 0303 300** Email: **gp.health@nhs.net**

LMCs vital to ensure local implementation delivery

- GPC: **GPFV implementation policy group**; central pressure and oversight; NHSE GPFV advisory group
- GPFV delivered locally; CCG plans 23.12.2016
- **LMC role** – monitor, influence, ensure commitments and spend delivered
- **LMC reference group** for GPFV set up – direct engagement with NHS England; real time- feedback
- Guidance to LMCs with **LMC checklist** for CCGs GPFV plans (December 2016) and **monitoring template** (January 2017)

GPFV LMC engagement (1)

BMA House
Tavistock Square
London WC1H 9JP

BMA

December 2016

Dear LMC,

By the 23rd December 2016 each CCG will need to submit a GPFV plan to NHS England setting out how they will translate the aims and key local elements of the GPFV into their more detailed local operational plans.

Many LMCs are already working with CCGs to help them prepare these plans for submission.

These plans will need to reflect local circumstances, but must – at a minimum – set out:

- How access to general practice will be improved
- How funds for practice transformational support will be created and deployed to support general practice
- How ring-fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed.

The guidance in this letter about CCGs proposed plans is for all LMCs. The table attached to this letter is a checklist which LMC's may find useful to check their respective CCG's plans.

It highlights key elements to look out for in your CCG's plans and we would encourage you to engage with your CCG as they draw up their plans to ensure their GPFV plan and wider operational plan reflects the pressures on and challenges for general practice in your local area.

For further information on what CCGs have been asked to consider please also see Annex 6 of the NHS Operational Planning and Contracting Guidance for 2017/19, which can be accessed here.

If you have any further questions about the GPFV or feedback about how it is being implemented on the ground then please do email Chandra Kanneganti (Chandra.Kanneganti@northstaffs.nhs.uk), who will be leading on LMC engagement for the GPC.

Kind Regards

Chaand

Chair, BMA GPs Committee

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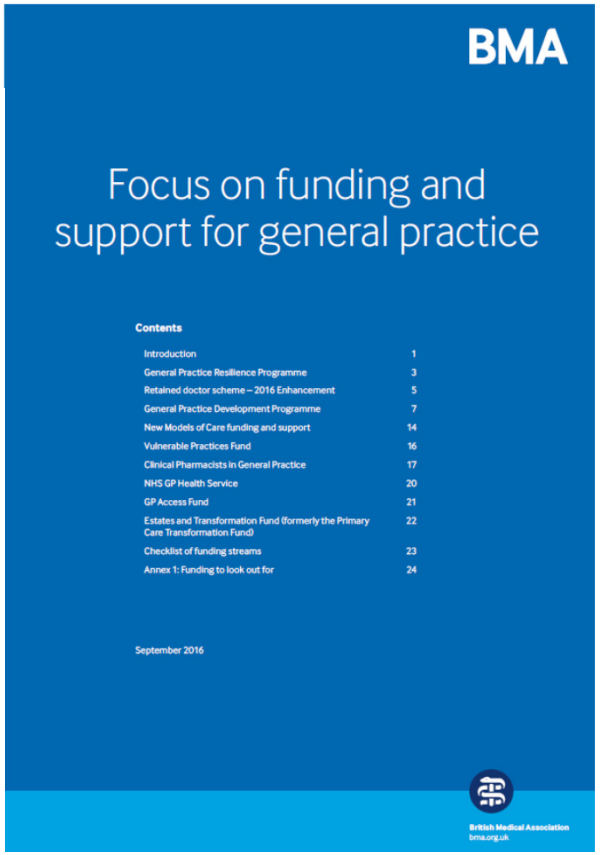
	Funding	Scheme	Detail	Check list
1	£171 million non-recurrent	Transformational support 2017/18 and 2018/19 from CCG allocations. The investment is designed to be used to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions to free up GP time, and secure sustainability of general practice. CCGs will need to find this funding from within NHS England allocations for CCG core services.	CCGs should plan to spend £3 per head as a one-off non-recurrent investment commencing in 2017/18. This could for example be £3 split between 2017/18 and 2018/19 (e.g. £1.50 in 2017/18 and £1.50 in 2018/19) or £3 in one of these years (i.e. either £3 in 2017/18 or £3 in 2018/19), or other scenarios.	
2	£45 million over 3 years	A fund to contribute towards the costs of purchasing online consultation systems, improving access and making best use of clinicians' time. Examples of types of schemes NHS England is looking for is here.	CCGs to get a share of £15 million available nationally in 2017/18 and £20 million in 2018/19 (£10 million will be available in 2019/20, but this financial year is beyond the two year planning horizon of CCGs two year plans). For detail on your CCGs's exact allocation please see page 30 of the NHS planning guidance.	
3	£45 million over 5 years	Funding for reception and clerical staff training to play a greater role in navigation of patients and handling clinical paperwork.	£10 million available nationally in 2017/18 and £10 million in 2018/19, with £5 million already allocated in 2016/17. Funding will be devolved to NHS local teams or delegated CCGs based on their share of registered patients as a percentage of the England total. Further detail on your CCGs allocation can be found on page 31 of the NHS planning guidance.	
4	£40 million over 4 years	General practice resilience programme	Funding in 2017/18 at a national level is £8 million, with a further £8 million in 2018/19, with £16 million already allocated in 2016/17. This funding is delegated to NHSE local teams on a fair shares basis, and NHSE	

GPFV LMC engagement (2)

BMA

The following table sets out the different elements of the GPFV. When completing the questions please indicate any examples of how funding or support have been used or if any difficulties have been experienced accessing the schemes and associated funding or support.

GPFV element	Funding or support	Timeframe	Availability	LMC action	Questions for LMCs
Workload					
Time for Care programme **(1 out of 5 under the general practice development programme)**	Tailored support programme for groups of practices (overall £30 million for this programme)	From 2016/17 with expressions of interest cut off August 2018	National resources and expertise will be available for groups of practices within a CCG to have a 9-12 month programme of workshops and learning sessions to plan and implement changes as part of their own Time for Care programme. This will help practices to use proven innovations from the Ten High Impact Actions quickly, safely and sustainably. The programme can be tailored to meet local interests and plans. Expressions of interest can be submitted to NHS England: https://www.engage.england.nhs.uk/consultation/time-for-care-programme-eoi/	LMCs to promote the programme to practices and signpost how to apply. Engage with CCGs – they should have clear plans on how they will support the delivery of a local Time for Care plan.	• Have any practices applied for this? • What is the status of the application? If possible, include dates of application and feedback etc. • Has any support been received? If so please include details. • Have any improvements been seen as a result of the support?



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GPFV: premises

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Awaiting updated Premises Cost Directions

- Includes 100% funding for premises grants in certain circumstances

NHSPS lease agreed

- Support for practices signing the lease within two years of release:
  - Stamp Duty Land tax covered
  - Legal fees paid (up to £1000+VAT)

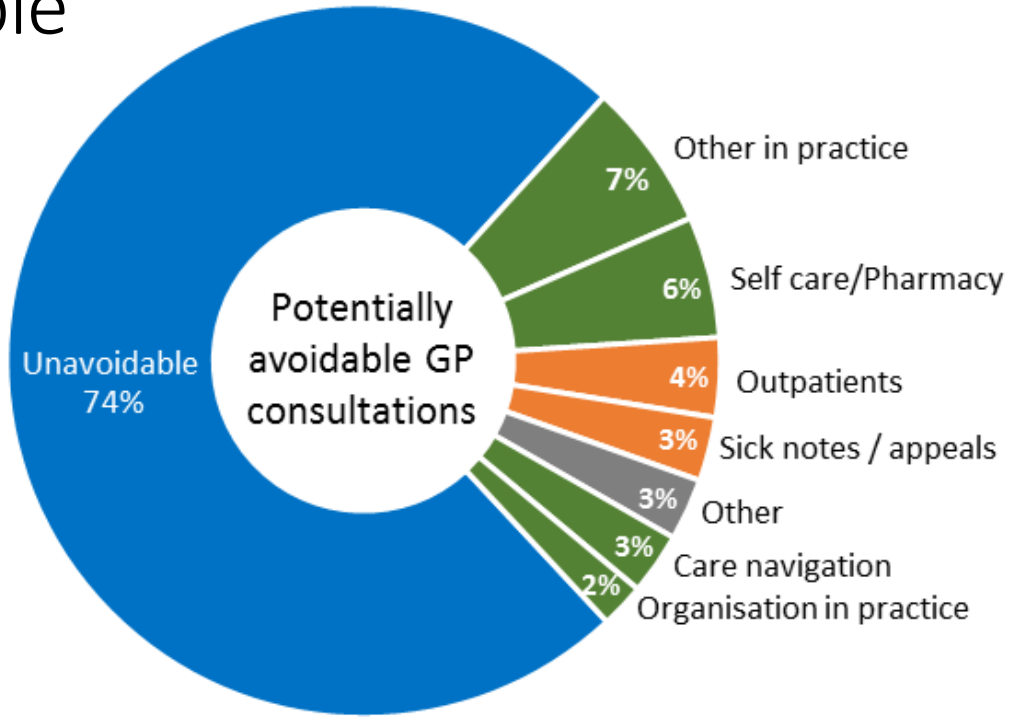
Service charges transitional support – discussions ongoing

- Any NHS PS or CHP premises will receive transitional support if their service charges have risen recently
  - Two years of NHS England automatic support (i.e. no need to claim, will automatically be done between NHS England and NHSPS/CHP, and identifiable on the invoice)

Managing Workload and demand: potentially avoidable GP consultations

1 in 4 GP appointments potentially avoidable

"Making Time in General Practice" report – NHS Alliance/Primary Care Foundation



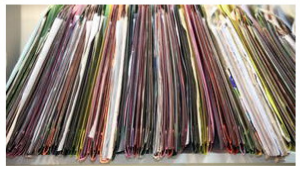
Quality First website (www.bma.org.uk/qualityfirst) BMA

Quality first: delivering safe patient care

Created: 16 June 2016

Welcome to Quality first - an interactive web portal providing you with practical support to manage your daily work and examples of different ways of working under pressure and at scale.

On these pages you will find guidance, resources, case studies and more, to support your day to day working.



Manage inappropriate workload

Accepting inappropriate work from elsewhere risks undermining the quality of care for your patients. Practices which act to reduce this work must ensure that measures are in place to ensure patient safety.

GP networks, federations and clusters

Guidance on establishing or joining a GP network or federation. We also have guidance on:

- Clusters in Wales
- Federations in Northern Ireland
- Clusters in Scotland

Manage inappropriate workload

Created: 16 June 2016

The GPC guidance Quality first: managing workload to deliver safe patient care is intended to help practices ensure that the safe provision of core services to patients remain GPs overriding core priority.

GPC Guidance

Read or download the full guidance - Quality first: managing workload to deliver safe patient care.

Template letters (Word)

Template letters to help practices manage workload. Adapt for local use as appropriate. Download the PDF version

BMA GP survey – some key findings (1)

BMA

- GP partners under greatest pressure
  - *6% partners feel work manageable c.f. 12% salaried GPs, 34% locums*
  - *Only 1 in 5 partners content with current job; 1 in 3 looking for alternative work*
  - *Just under half GPs (47%) want to work as partners in the next 5 years*
  - *79% GPs believe there should be incentives to work as partners*
- GPs want varying career options, willing to consider other models – 32% willing to work in new care models, 19% employed in MCPs
- Measures to reduce workload: self-care/management and increased community nurses and skill-mix most popular
- New funding in general practice – highest responses for increased community nurse and skill-mix support (46%), 28% wanted all investment in global sum

BMA survey: action to reduce workload

BMA

Q2.	Which of the following would you consider doing in order to safely manage practice workload?
Withdrawal of wider non-contractual services that GPs voluntarily provide	60.7 %
Restricting clinical work to contractual essential services, and increased use of external referral for non-core services	40.9 %
Withdrawal from local CCG meetings and activities	35.2 %
Temporary suspension of new patient registrations	34.1 %
Withdrawal from enhanced services, such as the provision for minor surgery, extended hours	34.0 %
Working at scale	33.6 %
Application to reduce practice boundary and remove patients from the list	26.0 %
Withdrawal from the quality and outcomes framework	23.4 %
Withdrawal from additional services, such as the provision of contraceptive services	14.2 %
I don't need to take any further measures to manage workload	6.2 %
Other	23.8 %

The list of items provided is the list from the briefing on industrial action of possible actions that could be taken

Working together to sustain general practice

BMA

- Individual GP practices vulnerable
- Working collaboratively to support each other
- BMA GP survey: One model no longer fits all

- 49.6% believe ICM should be supported to work in networks/collaboration (c.f 47.2% supporting ICM as prime model)
- 32% support multi-professional collaborative model including MCPs
- Prime reasons for collaborative working : reduce bureaucracy, workload, extended access; security and sustainability of practices within a larger organisation

MCPs (multispecialty community providers)

BMA

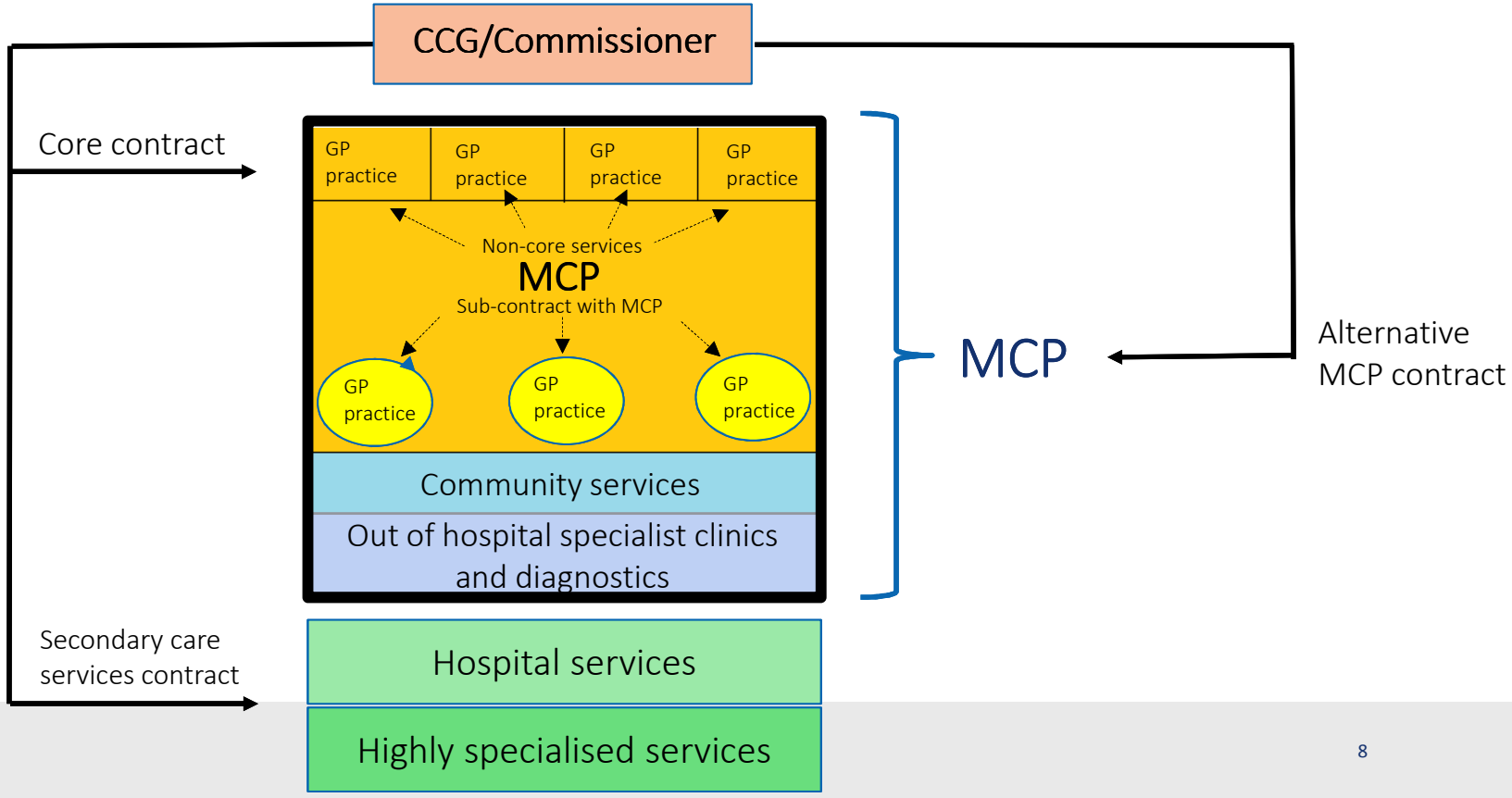
- Scale 30,000+ population, groups of practices
- 6 pilot sites 2017/18
- MCP contract advisory group
- 3 contractual options-**practices can retain G/PMS**
- 10-15 year contract with MCPs; unified capitated population budget
- Practices can have alternative subcontracts in MCPs, “right to return” (logistics?)
- GPs can be employed by MCP
- VOLUNTARY – practices can be part of MCPs by retaining current national contract

Alternative voluntary contracts being developed

Virtual MCP	Partially integrated MCP	Fully integrated MCP
• Alliance agreement • No change to current contractual arrangements	• G/PMS for core general practice • MCP contract for all other services	• Single MCP contract for all primary care and community services

Contracts and services within an MCP

BMA



Move away from national contracting

BMA

- Undermines a consistent standard of national and equitable care to patients
- Local GP contracts: Loss of national protections and T&Cs; increased bureaucracy in local negotiations
- QOF achievement will still be monitored and performance managed (NHS E primary care web tool, CQC)
- New performance pay to replace QOF? Net increase workload?
- A significant move towards a locally determined contract would undermine the collective bargaining rights for remaining GMS practices.
- Locally determined employment models would undermine national model contract for salaried GPs.
- Time – limited contracts and procurement

What practices should do now

BMA

- The MCP contract will initially affect practices in one of 6 MCP pilot sites
- Being considered in many STP plans
- Remember any MCP involvement is **voluntary** – do not feel coerced
- **GPC guidance;** can seek LMC or BMA advice
- Consider carefully: organisational;/legal/financial implications – need specialist professional advice
- **GP practices can work at scale other than in MCP arrangements with aim to support practice workload and sustainability**
- **LMCs should support practices to develop bottom-up GP owned models – offer lifeline to practices as alternative to MCPs**

GPs working at scale – emerging realities

BMA

- Emphasised in the GPFV
- Funding is available via the transformation fund (£171m) and the access fund (£500m)

Practices working collaboratively as network provider/federation

Devo-Manc and others

Development of MCPs

Primary care home

Super-practices - c.50 in England with 30,000+ patients

Acute Trusts running or contracting with GP practices

PACS/ACO development

Working at scale – supporting practices, managing workload, developing the workforce

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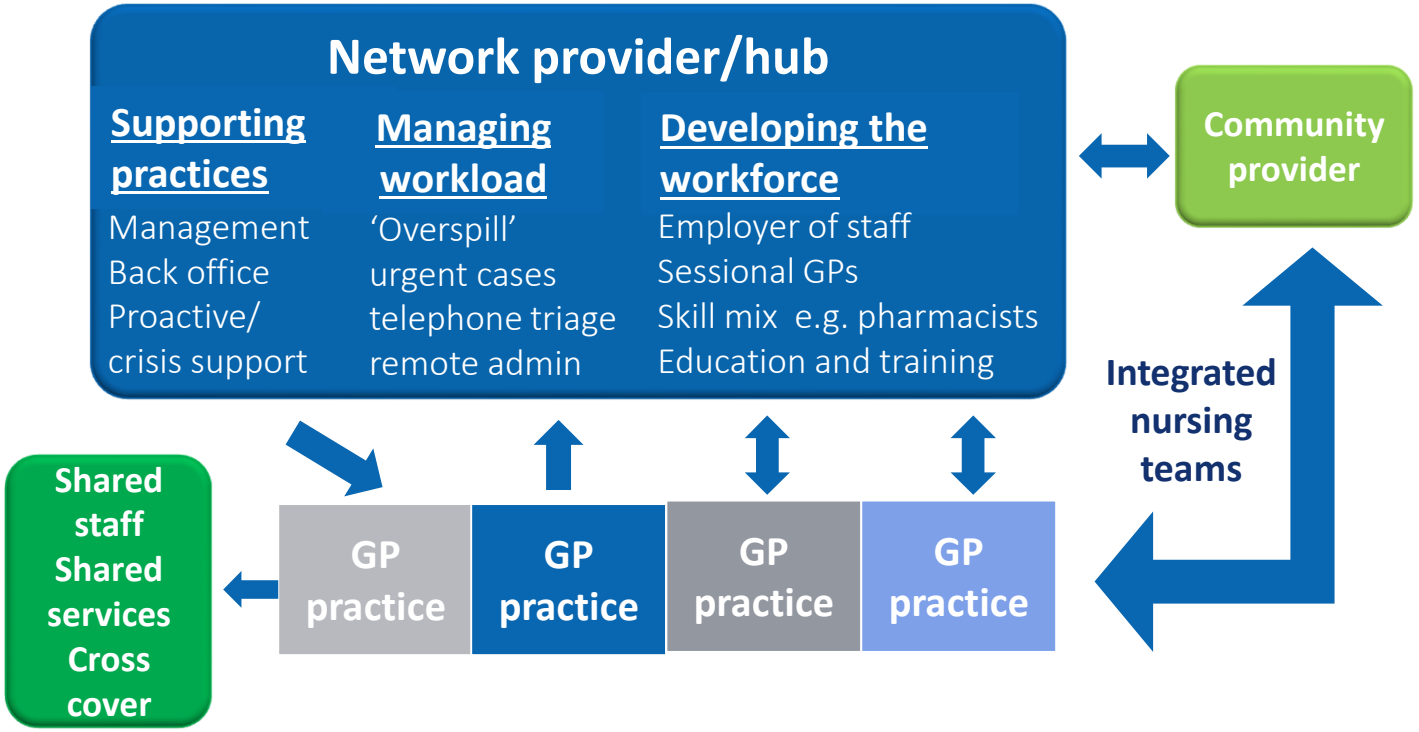

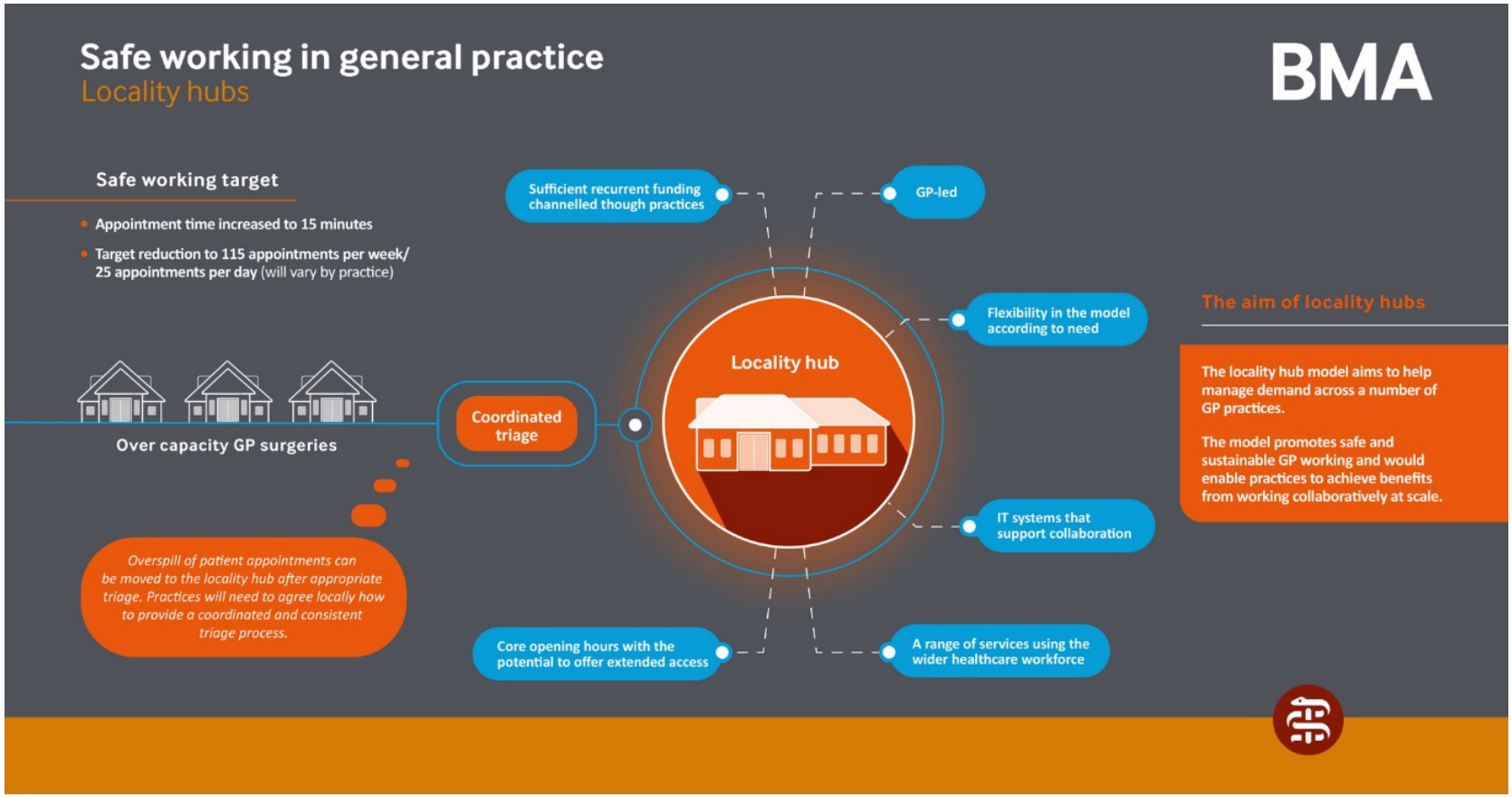

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Case Study (Federation): Essex

BMA

How it works	How it's helped
• 9 practices (50,000 patients) • Working together through a Memorandum of agreement between the practices • Agreed Care/Nursing home visits • Sharing minor illness clinics • Allocated slots depending on list size • Jointly commissioned training • Agreed pathways • Risk share agreed	• Reduced bureaucracy • Practices more sustainable • Manageable practice workload • Economies of scale

Case Study (Hub): Richmond, South West London

BMA

How it works	How it's helped
• Local GPs (28 practices) operate 4 Hubs, each based in an existing general practice surgery • Each Hub can access any patient's notes (with their permission). Read and write interoperability between GP systems so instant updates and fully-coded entries. • Practices triage calls, decide who can and should be seen at the Hub, and book the appointments. • Hub GPs see 14 patients over 4 hours at 15 minute intervals. • Practices meet regularly as localities to discuss the functioning of the Hubs, equity of access to appointments, and to develop the service. • Extending access to support a local Pharmacy First project (to encourage patients to use pharmacy for minor health care issues), and discussing integration with out of hours services.	• Hubs add another 5-8% appointments in to the system – taking some strain off local general practice • Stops extra appointment availability from driving further demand. • Extra resilience • Hubs have helped to smooth over periods of staff sickness or leave • Positive impact on A&E and urgent care numbers

Case Study (Super-partnership): Birmingham

BMA

How it works	How it's helped
• 33 practices • Population covered 290,0000 and growing with a number of practices going through "due diligence.' • Profit Centre model, common in industry, rare in medicine. • Single partnership, with original contracts held centrally in trust. • Small central corporate team paid for by levy of £2 per patient (tax deductible) • Elected board of 7 GPs from across the partnership. • Considerable local autonomy (both managerially and financially) with added advantages of being part of a very large partnership.	• Single CQC registration, with light touch inspection as per GPFV. • Practice quality and support team to reduce duplication and bureaucracy in practice. • Sustainable workforce model, starting with internal bank and Salaried Doctor pool to reduce locum costs and increase quality. • Reduction in medical indemnity costs and investment in training. • Central accounting and banking with monthly management accounts and quarterly benchmarking. • Access to buyers scheme discounts. • Increased resilience with peer support from other practices. • Opportunity for further closer merger and sharing of back office functions • Greater local and also national influence

GPC/LMC partnership

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- Increased and more timely guidance and support
- Input from lead LMCs e.g. Humberside LMC paper on GPFV funding stream; NHS property lease
- LMC reference group interface with NHS England
- More regular executive updates; planning webinars
- LMC events: "Working together to sustain general practice" conference 23 February 2017
- GPFV implementation and workload management conference planned April 2017

Supporting LMCs Guidance produced for LMCs since January 2016

BMA

- Focus on funding support from the GPFV
- Co-commissioning guidance
- GMS Contract and PMS comparison document for LMCs
- Physiotherapy guidance and cost calculator
- Focus on the publication of earnings
- Guidance on urgent prescription
- Service charges
- NHSPS lease guidance
- Gender incongruence
- Focus on the NHS England General Practice Forward View
- GP locum chambers guidance
- Template lease for GP premises, and associated guidance
- Patient registration
- Safeguarding reports and collaborative arrangements
- Focus on PMS reviews
- Focus on MCP Contract Framework
- Focus on industrial action and undated resignations
- Finances of the contract agreement
- Focus on GP funding changes
- NON-GUIDANCE: GPCE monitoring of Capita performance

In summary…

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- Operating within grossly underfunded NHS
- Successful GP contract negotiation 2017/18
- General practice as part of a wider environment
- GPFV committed resources must be spent and delivered to support general practice
- GPC/LMC partnership vital
- Empowering profession to manage workload
- Working together; to support sustainability of practices, and models to meet diverse aspirations and needs of GPs
- Political pressure/lobbying – general practice needs larger proportion of a larger NHS pot –political choice