**General Practice Forward View – LMC Reference Group**

**Wednesday 29th March, Lister-Fleming room, BMA House, 2-5pm**

**Notes**

1. **GP Resilience Programme**

* NHS England is confident that all the funding will be spent/allocated before the end of the financial year, with the benefits to be felt in the coming months
* LMC reps suggested that funds are starting to make a difference, but it is too early to see the overall outcome
* Needs of areas are different and so the solutions are varying. Some members provided examples (diagnostic tools, facilitate mergers, backfill, management support, locum cover for urgent needs, lean working support etc).
* Some practices have been saved from collapse, some have been supported through mergers. Some areas are trying to encourage collaborative working
* Further flexibility and localisation is required
* Examples are important to share good practice
* Some concern that funds are being too heavily used for diagnostics, but happy that there is some roll over time so funds can be spent appropriately
* Some concern that this programme is a sticking plaster, but more needs to be done to resolve the underlying issues.
* Support from CCGs has been variable with some management issues; LMCs and CCGs should be working and supporting each other
* Timing is key – some CCGs are already looking at 2017/18 bids, but for most this is too early
* Equally CCGs shouldn’t have to rush to spend money at the end of financial year. The funds should be spent adequately. NHS England suggested that this should improve for future years.
* Areas are looking at new ways of working such as hiring international doctors to manage shortages
* Morale seems to be improving in the areas where funding is making it through
* Some concern that section 96 will disappear as many practices are struggling and some CCGs are suggesting this resilience funding would replace S96. NHS England would reinforce this with CCGs that resilience funding is in addition to S96
* Support is needed in each practice; not all practices applied for funding which creates large variability, which needs to be reduced.
* Some LMCs have responded to the GPC survey and only some have received funding. We would like to run the survey again in May/June, we need reassurance from NHSE and monitor feedback
* London is unlike the rest of the country, North West London has not received notification let alone the funding – there are some London-specific issues which are being reviewed between the LMCs and NHS England/CCGs
* **Members were asked to provide specific examples of how the funding is being used and the difference it is making to Dan (**[**DHodgson@bma.org.uk**](mailto:DHodgson@bma.org.uk)**)**

1. **CCG plans**
2. **Transformation monies 2017/18**

* CCGs appear to be supportive of practices, however some CCGs are suggesting the funding for transformation will be taken from elsewhere within the GP funding pot
* NHS England team will be reviewing all CCG funding allocations to see where CCGs are finding the money for the £3 per patient
* This funding represents significant change to practices, as long as it is not being taken away from elsewhere in general practice
* Concern was raised that many CCGs simply do not have the funds to provide £3 per patient – some are already in deficit and need to balance their books. CCGs should not have the take funding from elsewhere in the GP funding pot, nor take it for secondary care; it should be extra funding. NHS spend as a whole, but particularly for general practice, must be increased and general practice should not be seen as here to ‘help out’ secondary care.
* Some CCG’s are diverting the funding into improving access, which is not a direct purpose of this funding. NHS England suggested that a message would be sent to CCGs regarding the appropriate use for this funding – this funding can be used to pave the way for improved access, with specific funding for access to be provided in the future
* **Members were asked to provide examples to Dan (**[**DHodgson@bma.org.uk**](mailto:DHodgson@bma.org.uk)**) – both positive and negative examples.**

1. **GP Development programme**

* This programme relates to building longer term longevity; feedback from LMCs has been good with good examples
* Cluster group funding has made a difference with good feedback from particular LMCs
* It would be good to connect CCGs so they can see what is being done in other areas
* Improvements in the north east have seen a reduction of GPs time by 30%, which they can spend on other priorities
* There appears to be variability and lack of knowledge on the work being done. Systems need to be rolled out and clarity is needed on how this funding can be spent.
* There needs to be more working together and models need to be created to encourage joint working.
* NHS England informed the group that they would be providing further guidance, but that this funding is truly for local decisions.

1. **Clinical Pharmacists in General Practice (2nd wave applications)**

* There was an example of pharmacists in each practice, which has saved each GP an hour a day. The pharmacists in this area are historically employed by the CCG.
* Some federations didn’t feel they could bid and some small practices were unsuccessful in getting a pharmacist as it is seen as a risk.
* It was agreed that GPs need more people to support them especially those in crisis, as GPs cannot do it on their own. There needs to be better communication between NHSE and practices, CCGs and federations.
* While employing a clinical pharmacist can reduce the burden on GPs, there is added workload with regard to quality management – overseeing another employee
* Some practices cannot afford to have a GP and a pharmacist and need to choose, this depends on the business models which are different and can be challenging
* There is a risk of employing a pharmacist who could possibly work for six different practices.
* NHS England are looking into the longerterm benefits of clinical pharmacists in general practice, and the benefits to secondary care, which could represent a shift in funding from secondary care to primary care – overall the prescribing budget should reduce in both primary and secondary care.

1. **GP Induction and Refresher Scheme**

* Members suggested that there is too much red tape if from outside the UK and trying to get on the performers list. Approximately 1 out of 5 applicants would be successful, and it takes a long time for those who are successful. Example provided - doctor who had been out of the country took 23 months to get back into the profession with 10 checks in 3 different places.
* Some members suggested that the retention scheme needs to be as flexible as possible to prevent GPs leaving in the first place
* Capita needs to be engaged and effective to make the process as simple as possible
* NHS England have been working to increase the pass rate, working on portfolios and video interviews
* Looking forward there are plans to make this an online form to make the process more automative and web based, which will be better and hopefully streamline the process.

1. **LMC monitoring template**

* There is a GPFV hub page now on the BMA website (<https://www.bma.org.uk/advice/employment/gp-practices/general-practice-forward-view>)
* GPC are holding a joint conference with NHS England on 26 April