

GPC England

BMA

2018 Roadshow



Content

- Contract update
- Saving general practice
- Recent developments
- Sessional GPs update
- GPFV update
- Working at Scale support

Contract negotiations - update

- Many issues facing General Practice outside contract and need to be addressed through other routes
- Minimal changes planned for 18/19
- Current contract negotiations yet to be completed
- Pay uplift and expenses via DDRB, not direct agreement, due to lifting 1% pay cap
- No changes to QOF (apart from uplift for CPI) – review for 2019/20 underway
- Seeking commitment to uplift vacs & imms IoS, sickness and paternity payments
- NHS England opposed to practices providing their patients with private minor surgery for non-NHS commissioned services

Contract update - funding

CCG allocation for 2018/19: **£188m**

NHS England can only offer within current budget:

- 1% pay uplift and expenses uplift
- Population growth uplift
- Indemnity increase cover

- GPC cannot agree to just another 1% uplift
- Approaching the DDRB for RPI + 2% uplift to pay and expenses (RPI as at Jan 2018 was 4%)

BMA DDRB submission:

- GP pay
- Staff related expenses
- Other expenses
- SFE reimbursables (locum cover, study leave, retainer scheme etc)
- Guardians of safe working
- Cybersecurity measures
- GDPR

DHSC DDRB submission:

- 1% budgeted for but need for more flexibility to address areas of skills shortage
- Acknowledged problems with GP recruitment and retention

Contract update - indemnity

- £30m uplift for indemnity for in-year rise in indemnity costs for 16/17 and £30m for 17/18
- Paid to practices on a per patient basis and not weighted
- Practice should pass on to all GPs – salaried and principals - in line with their individual payments
- Payments to individual GPs are to cover the average indemnity increase for the last two years
- Locum GPs should ensure charges reflect their costs, including any increase in indemnity costs
- Guidance and template letters will be made available to salaried GPs and locums to help them make sure they get appropriate payments
- Discussions started on state-backed indemnity scheme from April 2019

Contract update – premises cost directions

- Permit 100% improvement grants
- Explicit options for owner-occupiers who hand back core contract
- The Board can waive grant repayment for leaseholders who hand back core contract
- The Board can assign a lease to their designated property body for leaseholders who hand back core contract
- Lease terms will not be varied following a rent review
- Practices will not be at risk of being financially disadvantaged by agreeing to host a third party at the request of the commissioner
- Improved provisions for minimum standards reviews
- “Focus on premises cost directions” guidance document to be released alongside new directions
- GPC England calling for “premises commission” to look at wider issues and future arrangements

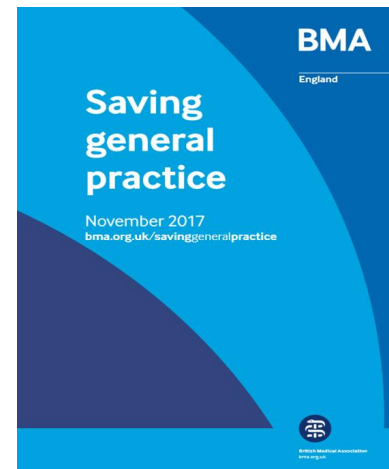
Contract update – Electronic Referral System

- NHS Standard hospital contract changed such that from October 2018, hospitals will not be paid for referrals unless received through ERS
- GPC is seeking that:
 - the ERS system will be fit for purpose
 - appropriate bandwidth for use
 - local contingency process if the system is not operational
 - resources for training and implementation
 - referral pathways developed as a result of ERS implementation agreed locally with GPs and LMCs
 - appropriate referrals received by the hospital through a non-ERS route will not be rejected on that basis, but processed internally
 - hospitals must reply to the referring GP
- Joint guidance on ERS including how responsibility/liability flows through the system

Saving General Practice

Key areas to address:

- Recurrent and sustainable funding and resources
- A workforce strategy that is recurrently funded to enable expansion
- A sustainable, long-term indemnity package for general practice
- Manage workload to deliver safe services and empower patients and carers
- Retention of a national core contract for general practice
- Premises, IT infrastructure and administrative support



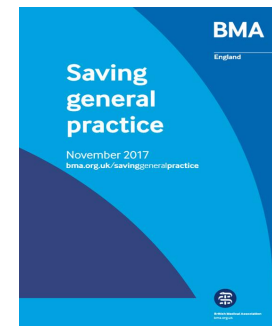
Recurrent and sustainable funding and resources **BMA**

Problem: Underinvestment while increased workload and demand

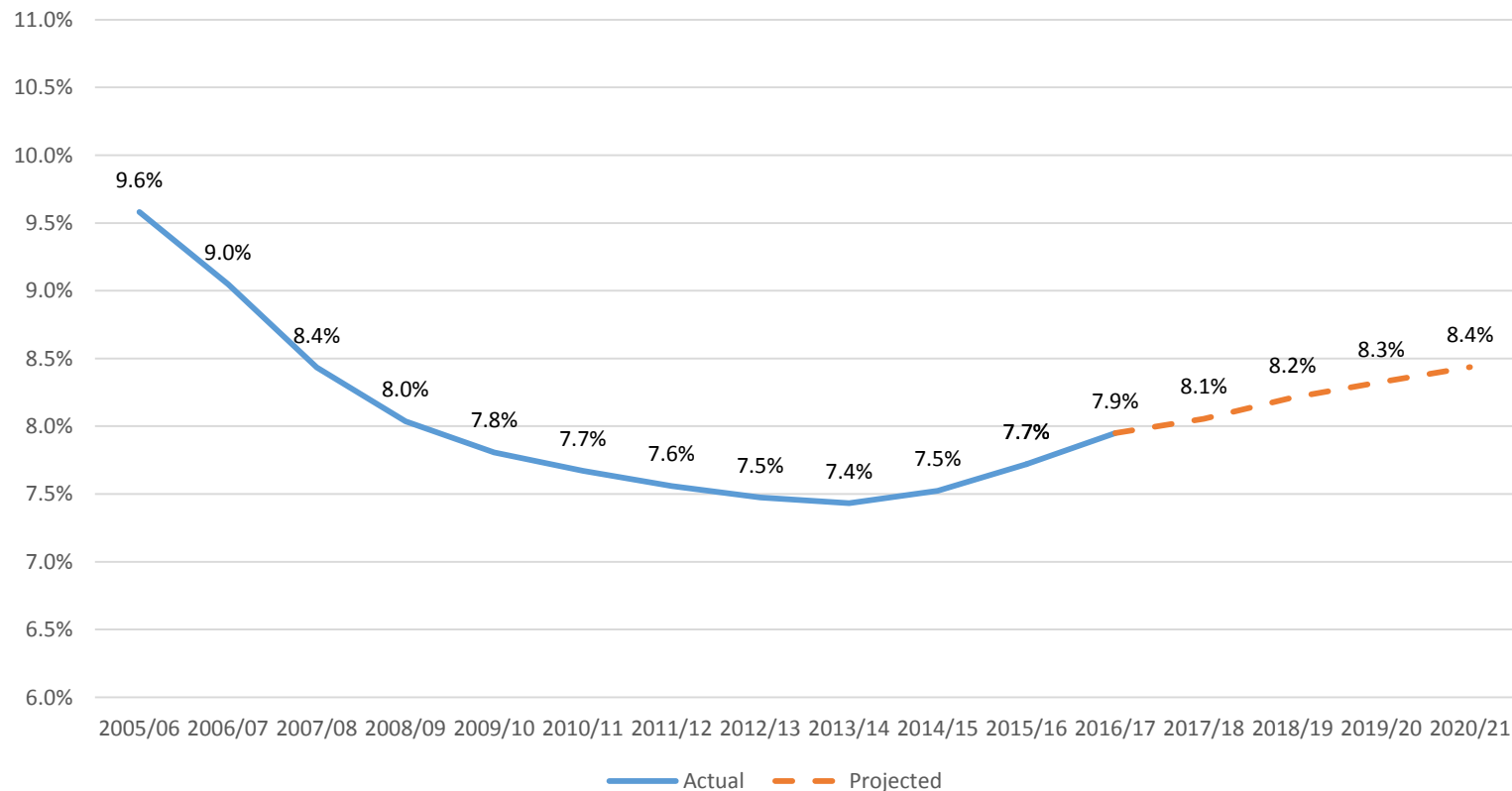
Impact: GP crisis

Solution: Increase overall proportion of NHS spend in general practice, through recurrent funding

Progress: Lobbying government, using declining workforce stats, using BMA research into European comparators; funding is slowing increasing (but not enough and not fast enough)

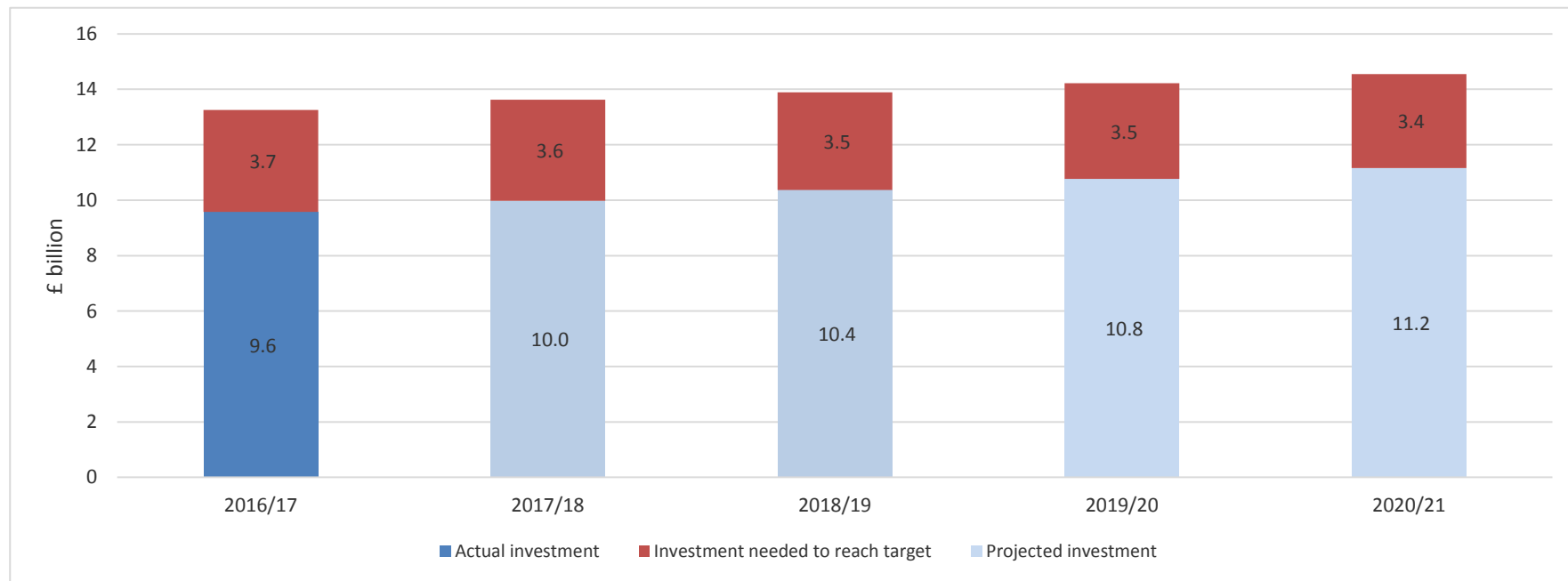


GP share of NHS budget – projected change



Funding gap to reach 11% investment target

Investment in general practice (excluding drug reimbursement)



Workforce expansion strategy, recurrently funded **BMA**

Problem: FTE GPs declining, GPs reducing time commitment or leaving, increased role substitution rather than expansion, time-limited funding

Impact: Longer appointment waits, practices unable to recruit, closing lists to new registrations or closing altogether

Solution: Genuine workforce expansion strategy, recurrently funded, flexible working initiatives, international GP recruitment, training grants, better use of funded MDT, promoting general practice positively

Progress: Medical school expansion with GP focus; 256 x £20k targeted enhanced recruitment scheme; improved induction/refresher and retainer schemes; recruiting internationally; clinical pharmacist scheme



GP Workforce - 5000 more GPs?

Current reality (excluding locums):

Dec 2016 – Dec 2017 (latest data available for GPs)

- Reduction of 346 GPs (0.9%) from 40,199 GPs to 39,853
- Reduction of 427 FTEs (1.3%) from 33,463 FTEs to 33,036

Sept 2016 – Sept 2017 (latest data available for all)

- Number of FTE GPs fell by 742 (2.2%) from 33,804 to 33,062
- Number of FTE consultants rose by 1,492 (3.4%) from 44,333 to 45,825
- Number of FTE doctors in training rose by 1,250 (2.4%) from 51,575 to 52,825

A sustainable, long-term indemnity package

BMA

- Secretary of State announced state-backed indemnity scheme for all GPs and practice staff from April 2019
- Aiming to remove burden of indemnity from all NHS GPs and practice staff
- Establish parity with hospital doctors
- GPC discussions with DH have commenced
- Potential survey shortly



Manage workload and empower patients

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Problem: workload and demand rapidly grown over last decade, population increasing, underfunded workload shifting from hospitals, bureaucracy of regulatory reporting

Impact: Doctors leaving or not joining general practice, practices suspending patient registrations or closing, GP burnout

Solution: Practices to define capacity limits; warning systems for practices reaching unsafe working limits; locality hubs managed by practices; limit registration for patient safety; reduce bureaucracy and duplication; patient empowerment; reduce GPs' role in non-NHS work; review collaborative service payments

Progress: Practice resilience programme >£17.2m (1279 practices 2016/17), £8m available in 2017/18; GP Health Service; significant changes to the standard hospital contract to reduce burden on practices; GPC defining safe workload and developing alert system



Managing and reducing workload: Primary-secondary care interface

- Changes to the standard hospital contract 2016/17 and 2017-19, for example:
 - *hospitals are responsible for providing patients with fit notes*
 - *hospitals to provide discharge summaries within 24 hours*
 - *Hospitals to stop asking GPs to re-refer DNA appointments*
- Helping practices and LMCs hold CCGs and trusts to account, by providing template letters to report and push back on breaches
- Working with NHS England to communicate changes to trusts and patients (eg new patient facing leaflet)

When seeing a specialist: your checklist

- ☐ If I need to start taking a new medicine straightaway, has the hospital provided me with a supply to last at least seven days (or less, if I need to take the medicine for a shorter period)?
- ☐ Do I understand what the medication is, how to take it and any side effects?
- ☐ If appropriate, has a Patient Information Leaflet (PIL) been supplied?
- ☐ Do I have the contact details for the specialist or the hospital?
- ☐ If I need a Fit Note, has the hospital provided me with one, and does it cover the length of time the specialist expects me to be off work?
- ☐ Do I need a hospital follow up appointment and if so, do I know how this is organised?
- ☐ If appropriate, do I have the names and contact details of organisations who can give me more information or support if I need it?

What happens when you are referred by your GP to see a specialist?

Access an electronic copy of this leaflet: www.nhs.uk/itsa/patientinformation

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages. For requests, please contact 1300 123 23 23 or email: english-england.consentments.net.

This leaflet has been developed with the help and support of NHS England, the British Medical Association and the National Association for Patient Information.

What if I need a Fit Note?
(Previously known as 'Sick Note')

If you need to be certified as unfit for work following treatment by a specialist:

- The specialist should issue you with a Fit Note.
- The Fit Note should cover the period they expect you to be unfit to work, or until your next contact with the specialist.

You should not need to see your GP to get a Fit Note following hospital treatment, unless your inability to work is unexpectedly prolonged.

What if I need a follow up appointment?

The specialist will discuss with you whether you should attend hospital for ongoing follow up care or whether you should be discharged back to your GP. If the specialist thinks you do need to be seen again, the hospital will give you another appointment or tell you when to expect this. If you do not hear anything, please contact the specialist's office, rather than your GP surgery.

What if I have any specific questions?

If you have any specific questions related to your hospital care, your specialist will be able to help you with this. It is also important that you make sure you know how you can contact your specialist's office, so that you will be able to continue to receive care from the hospital. You will be told about this at your appointment.

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Managing workload

- Enabling practices to improve quality and safety, and address recruitment and retention crisis, by agreeing safe workload limits
- Providing practices with practical tools with which to achieve workload control
- Guidance on safe working limits, by number and type of appointment
- Development of clinical hubs to transfer work when practices are at capacity
- Build on GP Access fund and urgent care plans
- Black alert system – different levels depending on severity, prompting local action to reduce pressure

Retain national core contract for general practice **BMA**

Problem: Threat of APMS and ACO contracts, doctors unwilling to commit to becoming partners due to uncertainty, impacting recruitment, retention and premises developments.

Impact: Threat to quality health service for patients, continuity of care and working with communities long-term, loss of independent advocate, risk of a costlier service that loses the support of the public

Solution: Ongoing commitment to the national contract and independent contractor status; at-scale models built on the foundation of registered lists and GMS contract; collaborative working across local healthcare systems rather than single responsible body/employer; fully funded integrated urgent care service

Progress: Investment in GMS contract through national negotiations; Secretary of State speaking of commitment to partnership model; ACO contract guidance; government review of ACOs.



Premises, IT and admin support

Problem: insufficient investment, deterioration in premises, out of date/not fit for purpose, slow IT networks, outsourcing NHS backroom function problems

Impact: practices unable to accommodate latest innovations, practices handing back contracts because of premises, difficulties with data sharing, vulnerable to cyber-attack, patients at potential risk, destabilising practice finances, exacerbating workforce crisis

Solution: IT refresh; recurrent fully funded systems; end paper records; superfast data connections; fully functioning PCSE/back office support systems; premises commission; increased recurrent investment in GP premises

Progress: PCDs updated; challenging NHS PS and CHP; extension to STD/L/VAT/legal fees programme; discussions regarding the replacement of GPSoC; GP2GP implementation progressing



Recent developments - PCSE

- Survey of GPs, practices and LMCs provides further evidence of failure of NHS England to hit December 2017 deadline with decline in services and need for resolution across the board
- Results and letter sent to Simon Stevens
- Legal template letters (statutory demands) for practices and GPs to use to recoup incorrect payments
- Exploring test cases on some service lines
- FOI to provide information as to extent of PCSE problems
- National Audit Office review of PCSE
- Subject access requests
- Writing to MPs and other political bodies

Recent developments - GP at Hand

- London based practice-commissioned App for online consultations
- Available to any patient in England, but selective outside practice boundary
- Massive increase in patient registrations – 4970 to 16,117 by January 2018
- Patients not always clear they have left their current GP to access this service
- Undermines principle of registered list and current funding model
- Inappropriate use of out of area regulations
- Data protection issues and blurring lines between NHS and private services
- GPC written to and met with NHS England, requesting suspension of current registrations to allow full review to ensure patient safety and assess impact on other practices

Recent developments - GDPR

- New EU data protection regulations from May 2018; UK data protection bill currently going through parliament so potential for more changes
- Key changes for practices:
 - Compliance must be actively demonstrated and documentation produced on request
 - More information is required in 'privacy notices' for patients
 - A legal requirement to report data breaches, and within 72 hours
 - Significantly increased financial penalties for breaches as well as non-compliance
 - Not charging patients for access to medical records (SARs) with shorter deadline for responding
 - Designation of Data Protection Officers
- NHS England and ICO very slow in assessing impact and practicalities on general practice and preparing guidance
- GPC guidance planned to be released soon

Recent developments - Scotland contract changes **BMA**

- Agreement to implement new contract from April 2018
- Emphasis on GP as expert generalist
- New funding formula
- End of QOF (already commenced)
- Minimum partner income of £80,430 (inc employers superannuation) pro rata by April 19
- Agreed income range and direct reimbursement of practice expenses in phase 2
- All vaccinations programmes to be done by Health Boards
- Pharmacotherapy service provided to support practices
- 25 year programme to move toward Health Board owned GP premises

Recent developments – GMC high court ruling

BMA

BMA in urgent meeting with GMC to address the serious concerns raised by this case:

- The GMC's appeal of the Medical Practitioners Tribunal Service decision
- The use of appraisal reflections in prosecutions

The BMA will be:

- Offering support for Dr Bawa-Garba's legal team
- Publishing guidance to doctors to protect themselves and on recording appraisal information
- Challenging unsafe working conditions

NHS pressures - your experiences:

www.bma.org.uk/reportNHSpresures

Recent developments – Sessional GPs subcommittee **BMA**

- Lobbying NHS England/Capita and relevant bodies across the UK to provide accurate performer's list data to LMCs
- Access to nhs.net email addresses for locums
- Improving sessional engagement with LMCs
- Undertaking work to understand the role of sessional GPs in NHS commissioning structures



Recent developments – Sessional GPs subcommittee **BMA**

- BMA's submission to DDRB
- Work to address the inconsistent eligibility in death in service benefits
- Employment status guidance covering issues such as OOH, IR35 and indemnity
- Model terms and conditions for locum GPs
- Focus document about T&Cs for doctors employed under new models of care

BMA

IR35 (intermediaries legislation)

This guidance has been prepared by BMA Law for the BMA. It is intended as a general overview of the law. It is recommended that specific legal advice is sought in individual cases.

What is IR35?

IR35 (also known as the 'intermediaries legislation') is an anti-tax avoidance measure introduced by the Government in April 2000. It targets individuals who attempt to avoid paying employee income tax and national insurance contributions (NIC) by supplying

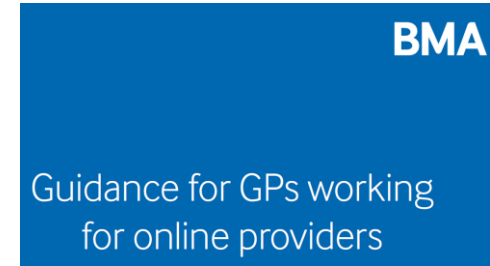
Salaried GPs working under new models of care



British Medical Association
bma.org.uk

Recent developments – Sessional GPs subcommittee **BMA**

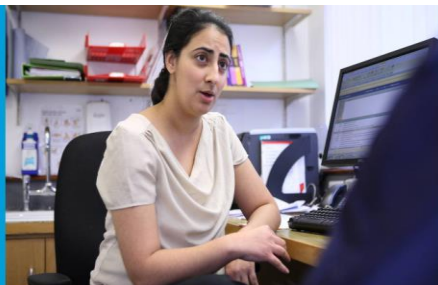
- Lobby NHS England and devolved administrations through GPC structures to reduce the financial burden of indemnity for sessional GPs in all roles.
- Continue to produce guidance on indemnity issues for sessional GPs and LMCs
- Supporting LMCs and GPs with local issues



BMA website resources for sessionals

Sessional GPs subcommittee

The sessional GPs subcommittee is part of the BMA's general practitioners committee (GPC UK). We provide national representation for all salaried and locum GPs.



Sessional GPs subcommittee

Subcommittee overview

An overview of the sessional GPs subcommittee, its priorities and meeting information

Committee membership

List of GPs on the subcommittee

Guidance for sessional GPs

Salaried GPs handbook

Locum GPs handbook

Pension blogs

BMA



Guidance for sessional GPs

Salaried GPs handbook

Locum GPs handbook

Pension blogs

Model contracts for salaried GPs

IR35 for locums

Appraisal

Job planning guidance for GPs

Minimum terms and conditions

Revalidation

Sessional GPs and LMCs

Tips for working out of hours

GPC committee

New models of care

Medical indemnity for GPs

Subcommittee guide (PDF)

GP retention scheme

GP induction and refresher scheme

Get involved with the BMA

Committee visitors scheme

Have a say in how your profession is run. Participate as a non-voting

Nominations and elections

Nominate yourself for a role in a committee, council or board.

Support schemes

A range of initiatives to help you get more involved with committee and

Monitoring GPFV funding delivery

- Information to LMCs on available funding/ support
- £3/patient CCG transformational funding for general practice
 - FOI request to CCGs on transformational funding in 2017/18 and 2018/19
 - Responses sent to LMCs
 - Follow-up action with NHS England on those not investing this funding
- Clarification with NHSE of recurrent and non-recurrent GPFV funding
- Short survey in March/ April 2018
- Second annual BMA monitoring report May 2018

Improving access to general practice

- £138 million available in 2017/18 to support better access
- CCGs with GP Access Fund sites will receive £6 per weighted patient in 2017/18 and 2018-19
- 18 transformation areas asked to accelerate extended access will receive £6 per head in 2017/18
- All other CCGs receive £3.34 per head in 2018/19
- From 2019/20 all CCGs will receive £6 per head

18 transformation areas:

Northumberland, Tyne & Wear;
Morecombe Bay; Fylde Coast; Greater Manchester; Dudley; Modality MCP;
NH Hants & Farnham; NE Hants & Farnham; Somerset; Isle of Wight;
Durham, Darlington & Tees,
Richmondshire & Whitby; Harrogate & Rural District; Wakefield; Mid Nottinghamshire; Wakefield; Erewash; Principia South Nottinghamshire; Tower Hamlets; Canterbury & Coastal; Fareham & Gosport, South Eastern Hampshire CCGs.

Other funding/ support in 2017/18

Programme	2017/18 provision
General practice resilience programme	£8 million
Online Consultation Systems	£15 million
GP Retention Scheme	Practices employing a GP in this scheme will receive £76.92 per session
GP Induction and Refresher Scheme	Practices hosting GPs in this scheme will receive a supervision fee of £8,000 per year FTE
Clinical Pharmacists in General Practice Programme	583 appointed, 587 more agreed - practices employing CPs will receive £29,000 FTE (£36,000 FTE Senior CPs) which reduces to £0 over three years
Mental Health Therapists	20 mental health pilots, 400 new IAPT therapists in primary care
International GP Recruitment Programme	Begin recruitment process for 600 doctors
Training for Reception and Clerical Staff	£10 million
Practice Manager Development	Approx. £2.5 million (of £6m)

Collaborative working

- Different shapes and sizes – no one size or model fits all
- Different threats and opportunities depending on the model:
 - sustainability , resilience and support for individual practices
 - workforce support and development
 - option to expand and integrate primary care services
 - community services delivery
- Does not resolve overall lack of resources
- Need for recurrent operating costs to be funded
- BMA not promoting any particular model, but can offer support to interested practices

Possible Opportunities and Threats?

- Strength and resilience in size
- Shared support and workload management
- Options for workforce development and flexible working
- Investment and expanded/new services
- Indemnity and governance
- Greater influence
- Reduced personal liabilities
- Decreased continuity of care
- Less autonomy for individual GPs
- Risk of transfer of contract
- Risk of failure to secure larger community contracts

Federations

- Practices working together, in a collective, legal or organisational entity
- Different organisational forms:
 - loose arrangement based on a MoU
 - company limited by shares or guarantee,
 - community interest company
 - limited liability partnership
- Different ownership, governance and management structures, to suit local aims and requirements.
- In all models individual practices remain independent organisations, but profit, contractual and pension arrangements may vary

Taurus Federation – Herefordshire

- LMC initiated
- Philosophy to support varied GP landscape (inner-city to very rural) and retain GMS
- Plans to resist pressure of ACO/vertical integration by demonstration of viable horizontal approach
- Formed an LLC (a company limited by shares), all 24 practices in Herefordshire joined
- All practices on EMIS Web, robust data sharing across the Federation
- 7 day extended services, based around 3 hubs. 53 local GPs work in the hubs
- Other developments include: a 'Zero tolerance integrated patient service' with patients seen in the hubs; joint sexual health service; joint workforce strategy and development with clinical pharmacists, Physicians Associate ambassador and apprentices.

Super-partnerships

- Practices forming a single business unit, covering multiple sites.
- For larger scale super-partnerships likely to involve a partnership agreement and a new structure, eg a company limited by shares, which can hold contracts and limit individual partner liability
- Autonomy retained by practices varies according to model (including profit sharing arrangements, retention of P/AP/GMS contracts, GPs' employment status, structure of the practice)
- Single, central structure may enable economies of scale, centralisation and sharing
- Large super-partnerships have greater capacity to bid for and deliver extended services, and potentially offer different workforce models and employment options

Our Health Partnership, Midlands and Shropshire **BMA**

- 38 practices, population covered 370,000 originating in Birmingham
- 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)
- Considerable local autonomy (both managerially and financially) within each practice
- Central functions and economies of scale (back office, central accounting, buyers scheme discounts, reduced indemnity costs, joint training, single CQC inspection)
- Shared support for practices (eg peer support, quality team, shared pool of salaried doctors, GP bank, leadership development)
- Retain partner and salaried roles, practices retain individual practice managers

Modality, Birmingham (and beyond)

- National super-partnership, originating in Birmingham, but now also operating in other regions (Sandwell, Walsall, Hull, Airedale, Wharfedale & Craven, Wokingham and East Surrey) serving 320,000+ population with 120 Partners and >850 staff
- Delivers both primary care and outpatient services
- Each region manages its own delivery (workforce and financial), supported by centralised back office support (finance, payroll, HR, communications etc)
- Joint working on population health (including but not limited to CCGs, Acute Trusts, Community Trusts, Mental Health Trusts, Voluntary Sector, GP Alliances / Federations, Local Authorities)

Primary Care Home

- Model developed by the NAPC (National Association of Primary Care)
- Combined focus on the personalisation of care with improvements in population health, using an integrated multi-disciplinary workforce
- Groupings of practices that cover 30 -50,000 people
- PCHs are expected to deliver whole population health, host community-based professionals, deliver extended access, deliver holistic, personalised care, be part of a local network delivering urgent and long-term care and reduce unwarranted variation and demand

Granta and Shelford - Cambridgeshire

- Three Granta Medical Practices (previously merged) joined with neighbouring Shelford practice to form a primary care home – 42,000 population
- Planning a John Lewis-type model of ownership with all staff having a stake in the business
- Operational executive of three partners and senior practice management with delegated authority to run the organisation
- Developments include:
 - working with local trust to second their community staff into the PCH; improved communication with the acute trust; collaborative delivery of paediatrics, ENT services and ophthalmology.
 - professional management and IT support systems; extended surgery hours and increased same day GP access (46% of patients); emergency care paramedics available for home visits; dedicated phone service with a 20-minute call back time

MCPs (multispecialty community providers)

- New care model in the Five Year Forward View
- Piloted by vanguard sites across the country
- Model potentially combining the planning, budgets and delivery of primary and community care services.
- Responsible for providing care to the whole population, based on registered lists of participating practices, covering at least 30- 50,000 people

Hampshire – Better Local Care

- Spent time building relationships between the local Trusts, GP practices and commissioners
- Developments include care navigators, fully funded clinical pharmacists in practices, data sharing and shared IT systems, eConsult, a frailty service, same-day primary care access hubs (calls are triaged by ANP or GP – 40% receive a face-to-face appointment with a GP, nurse or physiotherapist).
- Local Trust supported struggling practices in Gosport. Doctors are now employed by the trust on a permanent contract, either at partner or salaried level with indemnity covered
- All changes achieved under existing contractual arrangements
- Providers and commissioners are starting to work more collaboratively – general practice needs to be part of this

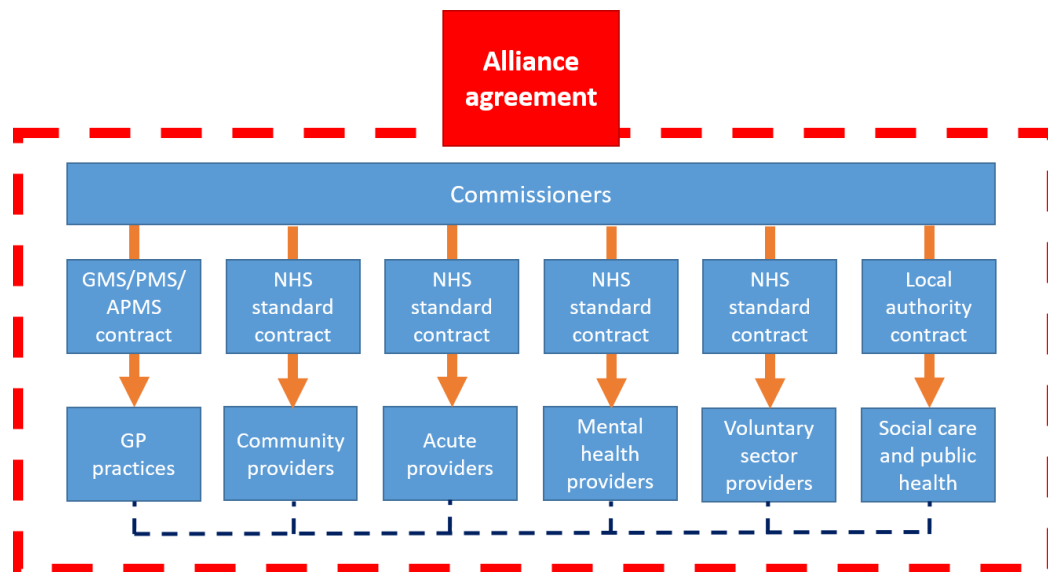
- NHS England's focus now on ACOs (accountable care organisations) – similar to MCPs but would likely include secondary care.
- Extent of general practice integration will be determined by local GPs – all new contractual options are **voluntary**.
- Key concerns: risk to GP independent contractor status; any 'right to return' unlikely to work in reality; locally negotiated employment contracts; financial accountability and risk-gain share arrangements; full contract tendering with risk of private sector winning bid; ongoing funding, workload and workforce challenges
- Possible opportunities: more integrated working; better relationships with other providers; possibility of ending of perverse incentives of PBR; clearer patient pathways

Virtually integrated

All contracts and accountabilities remain in place, but overlaid with an alliance agreement outlining how commissioners and providers will work together to create better integration of services.

Enables providers to work in collaboration under existing contracts.

Essentially an ACS (accountable care system) rather than an ACO (accountable care organisation).



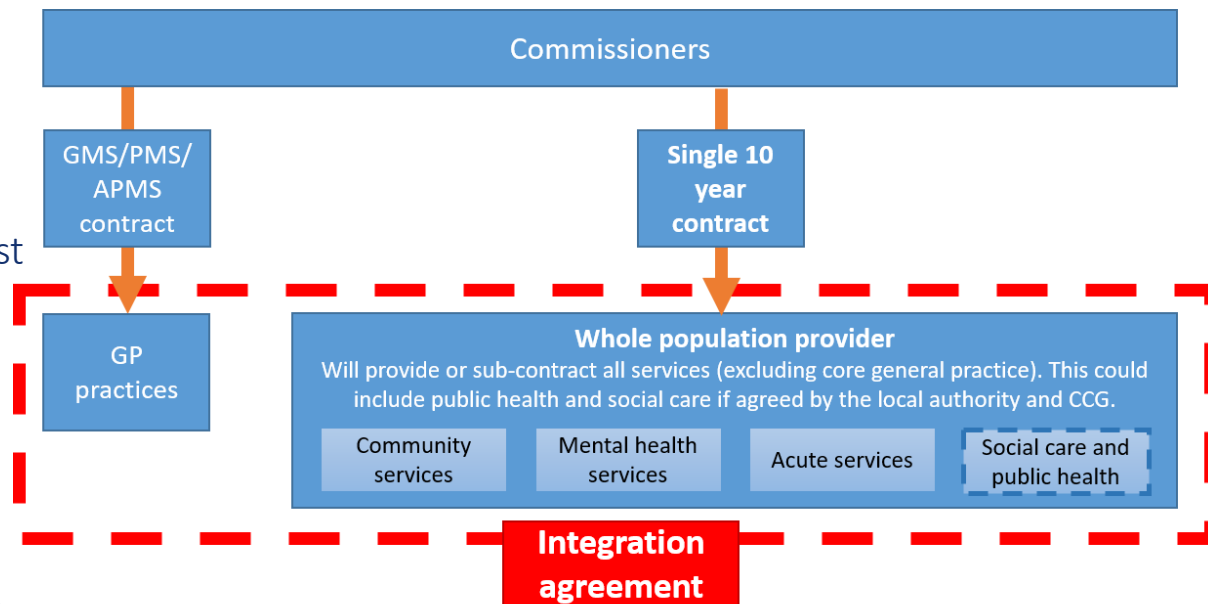
Partially integrated

Single contract held between the commissioners and providers (except core GP services).

Under procurement rules this must be put out to tender.

GP contracts remain in place.

Formal integration agreement between the whole population provider and GP practices to work together.



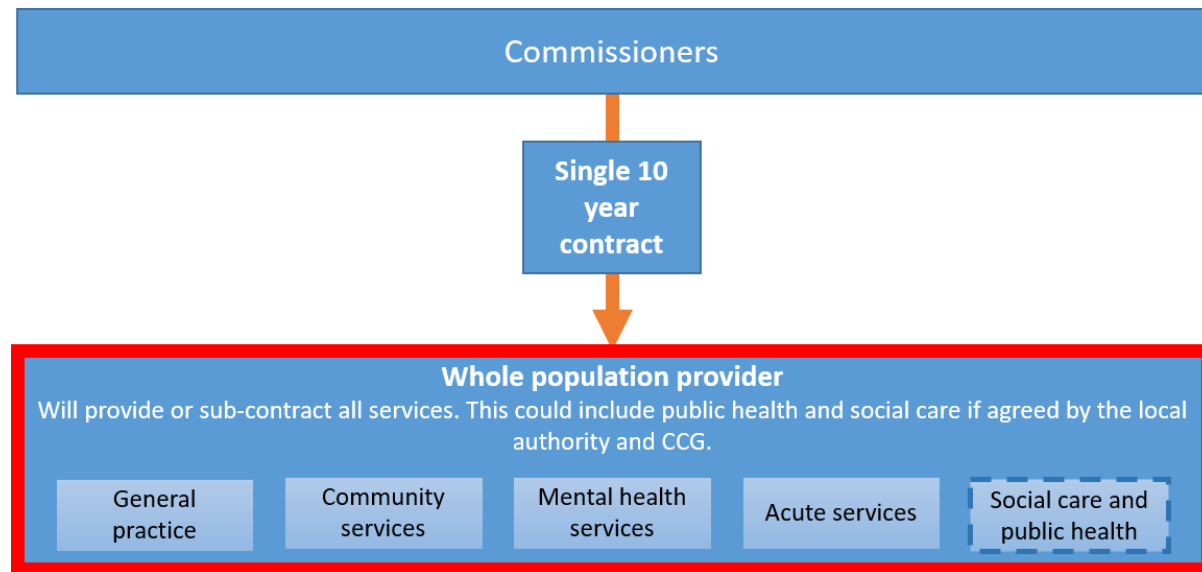
Fully integrated

A single contract between the whole population provider and the commissioners.

Under procurement rules this must be put out to tender.

Provides or sub-contracts all services

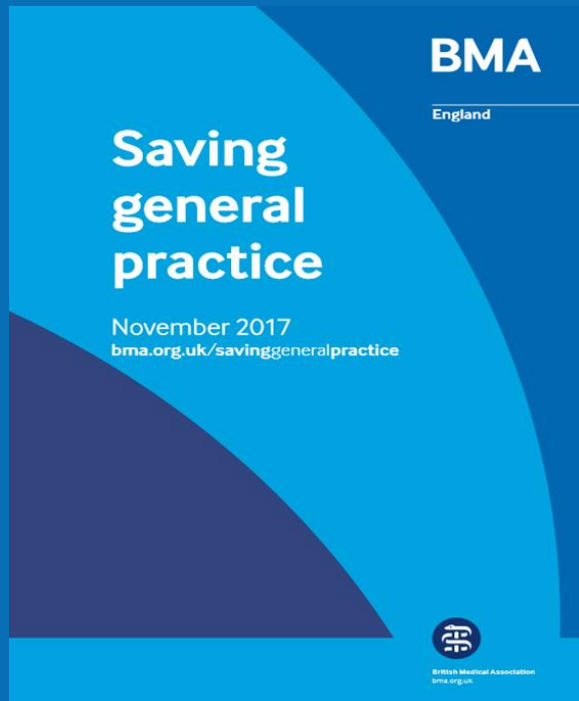
An end to GMS/PMS contract



GPC England

BMA

Questions?



Contact us:
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