General Practice Forward View

Executive Summary

The publication of the GP Forward View (AKA the “rescue package for general practices”) has been long awaited. The headline figures of an additional investment of £2.4bn in general practice services has been largely welcomed and many of the issues that have been raised by the profession have been referenced to, but as yet there are few details and a lack of assurance that the programme will be delivered in full.

Summary of plans:

- By 2020 there will be an additional £2.4bn invested per year in GP services.
- The investment in general practice services will increase from £9.6bn per year in 2015/16 to over £12bn by 2020/21.
- There will be capital investment of £900m over the next 5 years.
- There will be an additional £500m “turn around” funding made available through CCGs to invest in transformation and working at scale.
- The will be a sustainability and transformation package (STP) of £500m to support struggling practices, develop the workforce and stimulate service redesign.
  - £56m for a practice resilience programme and an offer of a specialist service for GPs with burn out and stress.
  - £206m for workforce measures to grow the medical and non-medical workforce.
  - £246m to support practices in redesigning services; CCGs will be required to provide around £171m of practice transitional support and a new national £30m development programme for general practice.
- The will be a new funding formula that better reflects practice workload, including deprivation and rurality.
- There will also be a consultation on new proposals to tackle the problem of ‘indemnity costs’ in general practice.

- Better Care Fund - From April 2016 CCGs, Local Authorities and NHS England could pool budgets and jointly commission expanded services including:
  - Additional nurses in a GP setting to provide a co-ordination role in the management of long-term conditions.
  - GPs providing services in a nursing home setting.
  - Providing a ‘mental health specialist’ in a practice setting.
Hosting a social worker in a GP surgery.

- To increase the number of training places in general practice by 2020 so that there are an additional 5000 doctors working in general practice compared to 2014.
- A major international recruitment campaign to attract 500 appropriately qualified doctors from overseas.
- A £20,000 bursary targeted in areas where it is hardest to recruit GP trainees.
- There will be 250 new ‘post-certificate of completion of training (CCT)’ fellowships to provide further training opportunities in the poorest areas of GP recruitment.
- Attract and retain at least an extra 500 GPs back to English general practice, through:
  - Simplifying the return to work routes, with new portfolio route, and other measures to reduce the length of time.
  - Targeted financial incentives to return to work in areas of greatest need.
- Investment in an extra 3,000 mental health therapists.
- A further 1,500 pharmacists in general practice by 2020.
- Support the training of current receptionists and clerical staff to play a greater role in the navigation of patients and handling clinical paperwork to free up GP time.
- 1,000 Physicians Assistants to support general practice.
- £6m investment in Practice Manager development, alongside access for Practice Managers to the new national development programme.
- A further £3.5m investment in multi-disciplinary training hubs in every part of England to support the wider workforce within general practice.
- There will be £16m additional investment in specialist mental health services to support GPs suffering from stress and burn out, support the retention of GPs, in addition to the £3.5m already announced.
- The will be £19.5m invested in services to support GPs and to gain better access to mental health services. The service will be put out to procurement in June and should be in place by December 2016.
- Major £30 million ‘Releasing Time for Patients’ development programme to help release capacity within general practice.
- Move to maximum interval of five yearly CQC inspections for good and outstanding practices.
- Streamlining of payment processes for practices and automation of common tasks.
- In September 2016 there will be a national support programme for practices to help with support for people living with long term conditions with self-care.
- In 2015 NHS England committed £10m to support vulnerable practices, a further £40 million will now be committed to develop a ‘practice resilience programme’, starting with a £16 million boost in 2016/17.
• New standard contract measures for hospitals to stop work shifting at the hospital/general practice interface. These changes include:
  
  o **Local Access Policies:**
    
    Hospitals will not be able to discharge patients who have DNA’d an OPD appointment back to general practice. The hospital policy will need to be agreed with local general practice.
  
  o **Onward Referral:**
    
    Re-referral for GP approval is only required for onward referral of non-urgent, unrelated conditions.
  
  o **Discharge Summaries**
    
    Hospitals will be required to send discharge summaries by direct electronic or email transmission for inpatient, day case or A&E care within 24 hours.
  
  o **Results and Treatments**
    
    This specifically includes a requirement for hospitals to notify patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner, for example telephone the patient.
  
  o **Medication on Discharge:**
    
    There is a new requirement on providers to supply patients with medication following discharge from inpatient or day case care.

    Medication must be supplied for the period established in local practice or protocols, but must be for a minimum of seven days (unless a shorter period is clinically necessary).

• Streamlining Care Quality Commission (CQC) practice oversight: The proposals are that if practices are good or outstanding (87% of practices inspected so far) will move to a maximum interval of five years for inspection visits rather than annual visits.

• New streamlined approach to inspection for new care models and federated or super-partnerships practices.

• A successor to the Quality and Outcomes Framework (QOF).

• Reporting requirements and information, and streamlining of the payment system.

• There will be a simplified system for how GP data and information is requested and shared across NHS England, CQC and GMC.

• **Mandatory training**

  Practices and GPs are frequently told that there are a number of training requirements that are mandatory.

  Examples include: basic life support, safeguarding, information governance, health and safety, complaints handling, fire safety, fridge procedures. NHS England is going to work with relevant bodies to review and reduce these requirements to ensure a far more proportionate approach is taken.

  There is a commitment also…..
Greater use of technology to enhance patient care and experience, as well as streamlined practice processes:

- Over 18 percent increase in allocations to CCGs for provision of IT services and technology for general practice.

- £45 million national programme to stimulate uptake of online consultations systems for every practice by 2017/18.

- Online access for patients to accredited clinical triage systems to help patients when they feel unwell.

- Development of an approved ‘Apps library’ to support clinicians and patients.

- Actions to support practices offer patients more online self-care and self-management services.

Actions to make it easier for practices to work collaboratively, including achievement of full interoperability across IT systems.

Wi-Fi services in GP practices for staff and patients. Funding will be made available to cover the hardware, implementation and service costs from April 2017.

A nationally accredited catalogue and buying framework for IT products and services, supported by a network of local procurement hubs offering advice and guidance.

Work with the supplier market to create a wider and more innovative choice of digital services for general practice.

Completion of the roll out of access to the ‘summary care record’ to community pharmacy by March 2017.

Core GP information technology (IT) services: NHS England is introducing a greater range of core requirements for technology services to be provided by vendors to general practice through the CCG-controlled GPIT budget.

During 2016/17, services should include:

- the ability to access digital patient records both inside and outside the practice premises, for example, on home visits;

- specialist support including services for information governance, IT and cyber security, data quality, clinical system training and optimisation, clinical (systems) safety and annual practice IT review;

- outbound electronic messaging (for example, SMS) from the practice for direct individual patient clinical communication;

- the ability for patients to transact with the practice through online appointment management, repeat prescription requests and access to their detailed record and test results, with the aim that at least 10 per cent of patients will be using one or more online services by the end of this year;

- the ability for electronic discharge letters/summaries from secondary care to be transmitted directly into GP clinical systems – from June 2016; and

- Specialist guidance and advice for practices on information sharing agreements and consent based record sharing – from December.
**Background**

The current challenges that face general practice are well documented. There are very few practices that are not reflecting the voice of the many. Many GPs report that they feel that they have lost control of their working day. The workload has increased to such an extent that it is almost impossible to deliver all the care that is needed to the patients let alone all that is wanted.

The reason for this is the population is ageing, more people have a long-term condition, many have 3 or more long-term conditions. As hospitals and social care struggle to cope, more and more work has been pushed into general practice (a significant percentage of it is inappropriate). Added to this general practice has seen little increase in resources over the last 6-7 years as most of the growing resource in the NHS has been invested in the Acute Sector. The cost of indemnity is rising at a faster pace than income and costly and excessive regulation as delivered by CQC add to these problems.

The move towards equity, with the recycling of MPIG and the PMS premium have also caused some significant issues in many areas.

It is therefore not surprising that medical students and younger doctors do not want to train to be GPs, those who have completed their GP training do not want to become partners in a practice or, for some, do not even want to take a salaried role and GPs in the 50+ age group are closely looking at their pensions and deciding the best time to retire.

Despite all of the above, many of us still find the contact with our patients and the use of our experience and skills as a GP to be a worthwhile and rewarding profession. It is the system that has not supported the individual or the practice well over recent years.

So the question has to be, does the future look any brighter in April 2016 than it did in April 2015?

My answer to that is “yes”, things are beginning to happen which allows me to see light at the end of the tunnel.

The Contract GMS /changes for 2016/17:

- A £220m investment in the GMS and PMS contract.
- Recognition of the increase in expenses caused by rises in CQC fees, indemnity costs, NI contributions, superannuation and other expenses (hence the £220m uplift).
- This is intended to give a 1% pay uplift for GPs.
- A 28% increase in vaccination and immunisation fees.
- The Dementia DES has ended and the funding has gone into the global sum.
- QoF has remained the same with no changes to the various components or increase in thresholds.
- There is a commitment to explore the ending of QoF and the Avoiding Unplanned Admission enhanced service for 2017/18.

These changes are welcomed but by themselves will not address the challenges that general practice faces.

There was an announcement a couple of months ago that there would be a sustainability package for general practice (some started referring to this as a “rescue package”).

There was a report in Pulse a few weeks ago that stated that the “rescue package" was £100m and this was widely condemned as being woefully short of what was needed.
NHS England have recently published a document called “General Practice, Forward View”. This details the action that will be taken over the next 5 years to invest and transform Primary Care.

This document contains lots of information but lacks detail. The devil will be in the detail.

There is recognition of the central part that general practice makes to the NHS and states that “if general practice fails the NHS will fail”.

Over the last 10 years the share of NHS funding for primary care has fallen and the number of hospital specialists has grown three times faster than general practice. This document recognises these facts and details how this will be addressed.

There is a commitment that by 2020/21 there will be an additional £2.4bn per year invested in general practice services. This will increase the share of the NHS budget that primary care receives. There will be an additional £500m “turn around” package.

The investment will be in staff, technology, premises and action on indemnity and red tape.

**Investment**

- The investment in general practice services will increase from £9.6bn per year in 2015/16 to over £12bn by 2020/21.

  **LMC Comment:** This figure is confusing as much of the additional funding is not coming to general practice but to the wider primary care. The document states the increased £2.4b will go into “general practice services”.

- This will be delivered through national funding and it is expected that this will increase with additional investment from CCGs by a shift of funding from secondary to primary care.

  **LMC Comment:** What happens when CCGs are facing financial deficits? Experience shows that hospital funding is protected at the expense of investment into general practice.

- There will be capital investment of £900m over the next 5 years.

  **LMC Comment:** This is not new money but was announced last year. Addressing premises is critical to the transformation agenda.

- The will be a sustainability and transformation package (STP) of £500m to support struggling practices, develop the workforce and stimulate service redesign.

  **LMC Comment:** Great news but need to see the details.

- There will also be a consultation on new proposals to tackle the problem of indemnity costs in general practice.

  **LMC Comment:** This is critical.

The current investment in general practice is about 7.4% this package of measures should increase this to over 10%.

There is a £508m STP package for general practice which includes:
• £56m for a ‘practice resilience programme’ and an offer of a specialist service for GPs with burn out and stress.

• £206m for workforce measures to grow the medical and non-medical workforce.

• £246m to support practices in redesigning services; CCGs will be required to provide around £171m of practice transitional support and a new national £30m development programme for general practice.

Carr Hill formula – most would agree the formula does not adequately reflect workload or complexity. There needs to be greater weighting given to workload, deprivation and age. The BMA is working with NHS England to try to improve the formula.

**Tackling the rising costs of indemnity**

This whole area is being looked at and it is hoped some solutions will be published in the summer. The rising costs of medical indemnity are one of the major issues that have an adverse impact on GPs both young and old.

This could include new structures, such as the Multiple Speciality Community Provider (MCP), which could provide corporate indemnity for general practice.

**Better Care Fund (BCF)**

The BCF requires CCGs and the Local Authorities to pool some budgets and to jointly agree how to invest this in the integration of services. In 2016/17 this fund nationally is about £3.9bn.

From April 2016 CCGs, Local Authorities and NHS England could pool budgets and jointly commission expanded services including:

• Additional nurses in a GP setting to provide a co-ordination role in the management of long-term conditions.

• GPs providing services in a nursing home setting.

• Providing a mental health specialist in a practice setting.

• Hosting a social worker in a GP surgery.

*LMC Comment: These all seem initiatives that many practices would like to see, as yet it is unclear how this could be achieved as I am sure most GPs would have no idea what the BCF does and how much, if any, investment provides front line services in their area.*

**Workforce**

You cannot deliver a good quality service to patients unless there is an adequate workforce. It is recognised that the General Practice Forward View cannot be delivered without an adequate workforce. The primary care workforce therefore needs to be expanded. NHS England and Health Education England are committed to expand the workforce backed by and additional £206m as part of the STP.

The plan is intended:

• To increase the number of training places in general practice by 2020 so that there are an additional 5,000 doctors working in general practice compared to 2014.

*LMC Comment: This was promised before and there has been great difficulty in filling the existing GP training places let alone the additional ones and there is a real issue about where the funding will be to pay for the additional workforce. A critical factor here is we have to make general practice a better place to work to encourage the next generation.*
• There is going to be a national recruitment campaign to attract more doctors to become GPs, supported by 35 ambassadors and advocates promoting the GP role.

  **LMC Comment:** Anything that can promote general practice as a career has to be welcomed but it will only have impact if there are good jobs with career progression available.

• A major international recruitment campaign to attract 500 appropriately qualified doctors from overseas.

  **LMC Comment:** There needs to an expanded workforce, so this may fill places that currently remain unfilled but these doctors will not stay unless in-posts are ones where the workload is reduced and the role is one that people want to do. The document recognises that general practice in this country is under far greater pressure than its counterparts around the world.

• A £20,000 bursary targeted in areas where it is hardest to recruit GP trainees.

  **LMC Comment:** We know that the majority of GP trainees will end up working close to where they trained. The Isle of Wight was unable to attract any GP trainees for a couple of years. The new bursary has meant that this year most, if not all, of the posts available have been filled.

• There will be 250 new post-certificate of completion of training (CCT) fellowships to provide further training opportunities in the poorest areas of GP recruitment.

  **LMC Comment:** This will be helpful if these posts are ones that are of good quality and there is a focus on service delivery in the wider areas of general practice such as diabetes, respiratory care, care of the elderly etc.

This document focuses on the delivery of care outside of the hospital environment and therefore general practice is the major provider, co-ordinators and leaders of this care. It is a shame that the GP fellowships are not made more widely available because this is what many younger doctors want for 2-3 years post CCT. If this were combined with the sort of roles mentioned above there would be an expansion of the capacity in the community to manage the rising tide of long-term conditions and well as helping with the transformation agenda.

• Attract and retain at least an extra 500 GPs back to English general practice, through:
  - Simplifying the return to work routes, with new portfolio route, and other measures to reduce the length of time.
  - Targeted financial incentives to return to work in areas of greatest need.

  **LMC Comment:** Any initiative to help GPs who want to return to work is most welcomed. The LMC has tried to help a number of GPs in the past who have found the system of returning to general practice after a period of time out of practice (through illness, family commitments or having worked abroad) very difficult despite the help provided by the Deanery. The problem we have now is to define where the most need is because I believe most of the country is struggling and unless we expand the workforce significantly we may be in danger of helping one area at the expense of others.

If there are not enough GPs we need to consider other healthcare professionals who could work in general practice and the community who could support general practice by taking some of the workload. Most would agree the target of 5,000 new GPs was one that would probably not be met but were unclear about the commitment to recruit 5,000 other staff who would be working in general practice by 2020/21. This 5 year programme has been announced:

• Investment in an extra 3,000 mental health therapists to work in primary care by 2020, which is an average of a full-time therapist for every 2-3 typically sized practices.
LMC Comment: These therapists, will be a great asset in the management of mental health in the community, especially as they will be fully funded. Many questions remain about the level of training these therapist will have and how they will be professionally supervised.

- Current investment of £31m to pilot 470 clinical pharmacists in over 700 practices to be supplemented by new central investment of £112m to extend the programme by a pharmacist per 30,000 population for all practices not in the initial pilot – leading to a further 1,500 pharmacists in general practice by 2020.

LMC Comment: This is good news as the pharmacists can really help in general practice with repeat prescribing, medication reviews, discharges from hospital, reducing polypharmacy, improving compliance, reducing wastage and in the management of long-term conditions.

There is benefit to the workload of individual practices but equality there are potentially greater gains to the system in terms of the cost of prescribing and the reduction of the number of medications taken especially in the elderly and the work needed with care homes.

These posts should either be fully funded or 70% of the costs should be met by the system. The current pilot funds part of the post which then tappers so ultimately the practice picks up the full cost.

- Introduction of a new Pharmacy Integration Fund.

LMC Comment: It is very unclear what this fund is or is aiming to achieve.

- A general practice nurse development strategy, with an extra £15m national investment including improving the training capacity in general practice, increasing the number of pre-registration nurses, measures to improve retention of existing nursing workforce and support for return to work schemes for practice nurses.

LMC Comment: Practice nursing is often the forgotten branch of nursing. If we have more pre-registration nurses in general practice hopefully more will think of practice nursing as a positive career option, rather than most who believe you work in hospital and only move to practice nursing when working is hospitals proves to be too difficult. My practice has now had two pre-registration nurses and this has been a positive experience for the nurses and the practice. Helped by the fact the practice is now paid for the placement which was not the case until recently.

National investment of £45m benefitting every practice to support the training of current receptionists and clerical staff to play a greater role in the navigation of patients and handling clinical paperwork to free up GP time. This will enable receptionists and clerical staff to play a greater role in care navigation, sign posting patients and handling clinical paperwork to free up GP time.

LMC Comment: Our staff are one of our most valuable resources so this invest is probably overdue and welcomed. We need to ensure the training is widely available, of good quality and provides value for money.

- Investment by Health Education England to train 1,000 Physicians Assistants to support general practice.

LMC Comment: Additional help must be welcomed by general practice. I remain to be convinced of the cost effectiveness of these roles in general practice and cannot see the advantage over advanced nurse practitioners. I am sure more evidence will be forthcoming as these roles become more numerous.

- £6m investment in Practice Manager development, alongside access for Practice Managers to the new national development programme.
LMC Comment: There has been a focus on the plight of GPs within the context of the pressure that general practice faces. All too often we forget our Practice Managers who work tirelessly to ensure patients receive the high quality service that British general practice has an international reputation for. As practices struggle with recruitment, retention and excess workload our Practice Managers job becomes ever more demanding so it is most welcomed that this role is recognised and supported in this way. But more detail is needed and urgently.

- A further £3.5m investment in multi-disciplinary training hubs in every part of England to support the wider workforce within general practice.

**LMC Comment: This is welcomed but must be local to have the impact required.**

Health and Wellbeing

- There will be £16m additional investment in specialist mental health services to support GPs suffering from stress and burn out, support the retention of GPs, in addition to the £3.5m already announced.

**LMC Comment: This announcement is much needed and therefore most welcomed.**

But prevention is better than cure so we need to address the causes of stress and burnout which includes excessive workload, an imbalance between demand and supply and the dumping of work on general practice.

- There needs to be an improvement in the number of medical students that choose to join general practice. In a recent survey some medical schools had less than 20% of students saying they wanted to be GPs, yet we know this figure needs to be closer to 50%. It is not helped, as reported last year, that some medical schools have the culture that you need to work hard to succeed because if you don’t you will have to become a GP.

A report is due by the summer to address this important issue and to put a greater focus at promoting general practice as a speciality.

**LMC Comment: GPs are the expert generalist and this needs to be recognised by our hospital colleagues. In a couple of areas in Wessex we have established an informal scheme whereby a GP can spend a day or part of a day shadowing a consultant in hospital and then the consultant shadows a GP in their surgery. This has proven to be very successful in breaking the barriers down between general practice and hospital based consultants.**

- As part of the workforce development there will be a pilot of the new medical assistant roles that help support doctors.

There will also be a pilot of the role of a primary care physiotherapy service.

**LMC Comment: In addition to the national investment the document puts some emphasis on local solutions and it is expected that there will be local workforce plans and investment.**

The model of independent contractor status and partnership has proved a valuable foundation for general practice. Partners provide leadership and continuity, and in recent years this has been invaluable as general practice has come under pressure.

Over the last 2 years it has become increasingly difficult to recruit partners and more recently practices have found difficulty in recruiting salaried GPs; there has therefore become an over reliance on the locum which could lead to instability in general practice.

In the future we need a more flexible workforce. NHS England is committed to work with the profession to introduce new measures entitling GPs who want flexible working but who can commit to working in a practice or an area for a period of time, additional benefits relative to undertaking a rolling series of short term locum roles.
**Promoting health and wellbeing to combat burnout**

The will be £19.5m invested in services to support GPs and to gain better access to mental health services. The service will be put out to procurement in June and should be in place by December 2016.

**Workload**

To help with workload there needs to be action on the diversion of unnecessary work and a reduction in bureaucracy.

As part of this initiative there will be:

- Major £30 million ‘Releasing Time for Patients’ development programme to help release capacity within general practice.
- New standard contract measures for hospitals to stop work shifting at the hospital/general practice interface.
- New four year £40 million practice resilience programme, starting in 2016.
- Move to maximum interval of five yearly CQC inspections for good and outstanding practices.
- Introduction of a simplified system across NHS England, CQC and GMC.
- Streamlining of payment processes for practices and automation of common tasks.

In September 2016, there will be a national support programme for practices to help support people living with long term conditions to self-care.

**LMC Comment: This needs far more detail to understand how this will be effective.**

- In 2015 NHS England committed £10m to support vulnerable practices.

**LMC Comment: The LMC is involved with the Area Team to develop this support for practices.**

- In addition, a further £40 million will now be committed to develop a practice resilience programme, starting with a £16 million boost in 2016/17.

**LMC Comment: It is unclear what this programme will entail again more details are needed.**

**New standards for outpatient appointments and interactions with other providers**

A number of new legal requirements have been added to the standard NHS contracts for hospitals in relation to the general practice/hospital interface from April 2016.

These changes include:

- **Local Access Policies:**

Hospitals will not be able to discharge patients who have DNA’d an OPD appointment back to general practice. The hospital policy will need to be agreed with local general practice.

**LMC Comment: This is something the LMC has been asking for and we will be shortly writing to all CCGs and hospitals to ensure this is put in place immediately.**
Onward Referral:

Unless a CCG requests otherwise, for a non-urgent condition related to the original referral, onward referral to another professional within the same hospital is permitted, and there is no requirement to refer back to the GP. Re-referral for GP approval is only required for onward referral of non-urgent, unrelated conditions.

LMC Comment: This is another policy supported by the LMC and again we will write to all CCGs and hospitals to ensure this is put in place immediately.

Discharge Summaries

Hospitals will be required to send discharge summaries by direct electronic or email transmission for inpatient, day case or A&E care within 24 hours, with local standards being set for discharge summaries from other settings. Furthermore, the hospital should provide summaries in the standardised format agreed by the Academy of Medical Royal Colleges, so GPs can find key information in the summary more easily.

LMC Comments: We have been working with the hospitals to improve the discharge summaries with some effect. With this instruction we will be working with local hospitals to implement this asap.

Results and Treatments

There will be a new overarching requirement on hospitals to organise the different steps in a care pathway promptly and to communicate clearly with patients and GPs. This specifically includes a requirement for hospitals to notify patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner, for example telephone the patient.

LMC Comment: This can be a major cause of hassle for practices so this intervention will be welcomed.

Medication on Discharge:

There is a new requirement on providers to supply patients with medication following discharge from inpatient or day case care.

Medication must be supplied for the period established in local practices or protocols, but must be for a minimum of seven days (unless a shorter period is clinically necessary).

LMC Comment: Most of our local hospitals provide 28 days of medication on discharge and we would hope that this requirement will continue.

NHS England has established a Rapid Testing Programme in three sites across the country to review ways of better managing outpatient demand. This will include assessment of the practical application of a consultant hotline and advice services, enabling GPs to get rapid advice rather than referring the patient. In light of the outcome of this programme, the most effective measures will be rolled out for use by CCGs from late summer 2016 onwards.

New software to automate common tasks

Clinicians are frequently required to undertake a series of tasks on the computer when putting a care plan in place or responding to incoming correspondence. NHS England will work with innovative practices, federations and software suppliers to develop, test and implement the technical requirements for a new task automation solution to reduce workload. It is expected that practices will have access to the new automation function in 2017/18.

Streamlining Care Quality Commission (CQC) practice oversight: The proposals are that if practices are good or outstanding (87% of practices inspected so far) will move to a maximum interval of five years for inspection visits rather than annual visits.
New streamlined approach to inspection for new care models and federated or super-partnerships practices.

CQC will continue to develop the way it inspects to take account of changes to the way the sector is organised and delivered, for example, through new models of care or federated practices – with a focus on the leadership, governance and learning culture of the provider, not necessarily on inspecting every single site.

LMC Comments: Having less frequent visits would be welcomed. The massive increase in CQC fees also needs to be addressed. The excessive funding increase in CQC fees is mentioned but it is unclear if the reduction in visits will result in a reduction in fee structure.

A successor to the Quality and Outcomes Framework (QOF)

NHS England has agreed to undertake a review of QOF with the GPC in the coming year to address these issues, whilst recognising that it is one of the best public health databases in the world and, done right, can support population-based healthcare.

LMC Comment: QoF has outlived its usefulness and the funding should become part of core GMS funding. There are important aspects of QoF which could be simplified and should be disconnected from the funding.

Reporting requirements and information, and streamlining the payment system

There will be a simplified system for how GP data and information is requested and shared across NHS England, CQC and GMC.

It is recognised that it is unacceptable for hard-pressed practices to have to waste time chasing or reconciling payments.

LMC Comments: I am sure that all practice managers would welcome this development and want it to be implemented ASAP.

Mandatory training

Practices and GPs are frequently told that there are a number of training requirements that are mandatory.

Examples include basic life support, safeguarding, information governance, health and safety, complaints handling, fire safety, fridge procedures. NHS England is going to work with relevant bodies to review and reduce these requirements to ensure a far more proportionate approach is taken.

There is a commitment to explore the impact of appraisal and revalidation requirements in the analysis.

Practice Infrastructure

- Investment for general practice estates and infrastructure – supported by continued public sector capital investment, estimated to reach over £900 million over the course of the next five years. This will be backed with measures to speed up delivery of capital projects.

- New rules on premises costs to enable NHS England to fund up to 100 percent of the costs for premises developments, up from a previous cap on NHS England funding of 66 percent (with a proposed date of introduction of September 2016).

- New offer for practices who are tenants of NHS Property Services for NHS England to fund Stamp Duty Land Tax for practices signing leases from May 2016 until the end of October 2017, and compensate VAT where the ultimate landlord has chosen to charge VAT.

- New funding routes for transitional funding support for practices seeing significant rises in facilities management costs in the next 18 months, in leases held with NHS Property Services and Community Health Partnerships.
Greater use of technology to enhance patient care and experience, as well as streamlined practice processes:

- Over 18 percent increase in allocations to CCGs for provision of IT services and technology for general practice.

- £45 million national programme to stimulate uptake of online consultation systems for every practice by 2017/8.

- Online access for patients to accredited clinical triage systems to help patients when they feel unwell.

- Development of an approved ‘Apps library’ to support clinicians and patients.

- Actions to support the reduction of workload in practices and achieve a paper-free NHS by 2020.

- Actions to support practices offering patients more online self-care and self-management services.

- Actions to make it easier for practices to work collaboratively, including achievement of full interoperability across IT systems.

- Wi-Fi services in GP practices for staff and patients. Funding will be made available to cover the hardware, implementation and service costs from April 2017.

- A nationally accredited catalogue and buying framework for IT products and services, supported by a network of local procurement hubs offering advice and guidance.

- Work with the supplier market to create a wider and more innovative choice of digital services for general practice.

- Completion of the roll out of access to the summary care record to community pharmacy, by March 2017.

**Core GP Information Technology (IT) Services**

NHS England is introducing a greater range of core requirements for technology services to be provided by vendors to general practice through the CCG-controlled GPIT budget.

During 2016/17, services should include:

- the ability to access digital patient records both inside and outside the practice premises, for example, on home visits;

- specialist support including services for information governance, IT and cyber security, data quality, clinical system training and optimisation, clinical (systems) safety and annual practice IT review;

- outbound electronic messaging (for example, SMS) from the practice for direct individual patient clinical communication;

- the ability for patients to transact with the practice through online appointment management, repeat prescription requests and access to their detailed record and test results, with the aim that at least 10 percent of patients will be using one or more online services by the end of this year;
the ability for electronic discharge letters/summaries from secondary care to be transmitted directly into GP clinical systems – from June 2016; and

Specialist guidance and advice for practices on information sharing agreements and consent based record sharing – from December 2016.

**LMC Comment: Two important areas for practices are premises and IT. These initiatives should help with premises development and the greater investment in primary care are welcomed.**

**In the New Models of Care the utilisation of Web–GP has had some positive results. The creation of a common health record at a local level has been important in the creation of closer working with community staff. To help people manage their own health the development of web based tools and apps could be very useful.**

**Care Re-design**

Support to strengthen and redesign general practice:

- Commissioning and funding of services to provide extra primary care capacity across every part of England, backed by over £500 million of recurrent funding by 2020/21. This forms part of the proposed increase in recurrent funding of £2.4 billion by 2020/21.

- Integration of extended access with out of hours and urgent care services, including reformed 111 and local Clinical Hubs.

- £171 million one-off investment by CCGs starting in 2017/18, for practice transformational support.

- Introduction of a new voluntary Multi-speciality Community Provider contract from April 2017 to integrate general practice services with community services and wider healthcare services.

A new national three year ‘Releasing Time for Patients’ programme to reach every practice in the country to free up to 10 percent of GPs’ time.

- Building on recent NHS England and BMA roadshows, spread the best innovations across the country, helping all practices use 10 High Impact Actions to release capacity.

- Learn from the GP Access Fund and vanguard sites to support mainstreaming of proven service improvements across all practices.

- Fund local collaboratives to support practices to make implementation new ways of working.

- Provide free training and coaching for clinicians and managers to support practice redesign.

The Primary Care Access Fund (also called the Prime Minister’s Challenge Fund) has now expanded to cover over 18m patients and has attracted over £150m in the last 2 years to provide additional access over a 7 day period from 8am to 8pm. The investment will increase to £500m over the period from 2014/15 to 2020/21 and expand to cover the whole population.

There are 4 key elements to this:

1. **Self care and direct access to other services.**

   This can include online access such as Web-GP (now called e-consultation). There is also a system of signposting to other services.

2. **Workforce**

   Services have used a wider workforce including advanced nurse practitioners, pharmacists, physiotherapist.
3. Technology

This includes apps connecting patients to their surgeries, phone and email consultations and webcam links to care homes.

4. Primary Care Access Hubs

These offer additional clinical capacity across a group of practices. Patients are referred there by the local practices, often after some degree of triage process to ensure they are suited. They are then seen and managed at the hub, often by a local GP or nurse, with the benefit of access to the patient’s medical record.

LMC Comment: The LMC has repeatedly stated that a 7 day service operating 8am to 8pm cannot be delivered at the level of the practice and could only be achieved with additional funding and there should be no requirement for individual GPs to provide this service. With a mixture of routine and urgent appointments there must be a link to the urgent care strategy and link with NHS 111 and Out of Hours.

A new Multi-speciality Community Provider (MCP) Contract

As part of the New Models of Care programme (also called Vanguards) there are 14 MCPs. One of these is located in Southern Hampshire. This is about creating a new relationship between general practice and community based services; the integration of services and developing the ability to hold a population based budget which is based on a registered list.

Armed with that larger budget and the flexibility to deploy it, the job of the MCP is to focus on better population health management, to suit different groups of the population, and get away from the treadmill of the ‘one size fits all’ 10 minute consultation followed by outpatient referral or prescription. This means:

- a stronger focus on population health, prevention, and supporting and mobilising patients and communities;

- more integrated urgent care as part of a reformed urgent and emergency care system;

- integrated community based teams of GPs and physicians, nurses, pharmacists, therapists, with access to step up and down beds, in reach into hospitals, for example, redesigning outpatients, geriatric care, and diagnostics as part of extended community based teams.

There are 6 of the MCPs working with NHS England to develop the MCP Contract, one of these areas is Southern Hampshire.

To hold a budget for all of these services will need to be a provider organisation that is a legal entity. This could be an LLP, a community interest company (CIC), a company limited by shares or guarantee or could be part of a Foundation Trust.

An MCP Contract holder could replace QoF and simplify enhanced services. The MCP could provide corporate indemnity and could be a single registered body in terms of CQC.

The MCP could offer a new employment contract as an equity partnership or as an employed model. Practices could retain their GMS or PMS contracts but could hold a “dormant” contract and be fully integrated within the MCP.

There are two major risks to modern general practice which are premises (either as owners or as lease holders) and as employers. The MCP structure has the potential to mitigate this risk.

This development will be potentially one of the most significant developments in general practice in the last 50 years.
The MCP Contract will be voluntary and developed during 2016/17 and will be evaluated in selected sites during 2017/18.

**National three year ‘Releasing Time for Patients’ development programme**

It is acknowledged that general practice has not enjoyed the same level of improvement support offers that other parts of the NHS has received.

There will be £30m investment in general practice to support transformation. The main components will be:

- **Innovation Spread**

  The national programme to gather and disseminate successful examples and measure impact. This will include support on implementation of the Ten High Impact Actions, and a specific focus on addressing inequalities in the experience of accessing services, where there are national trends

- **Service Redesigns**

  There will be locally hosted action learning programmes with expert input, supporting practices and federations to implement high impact innovations which release capacity

- **Capability Building**

  There will be investment and practical support to build change leadership capabilities in practices and federations, enabling providers to improve quality, introduce care innovations and establish new arrangements for the future.

**LMC Conclusion**

This is a very important document in terms of the future of general practice.

There is broad agreement from Politicians, to senior NHS Managers that General Practice has lacked investment over the last 5-10 years, with additional NHS funding largely invested in hospital based care. This policy document commits to addressing the major challenges that the NHS faces by investing significant sums of additional funds in “General Practice Services” but not directly into General Practice.

Some believe that the additional funds as detailed in this policy are but an empty promise and will not be delivered. If the additional investment is not forthcoming in full General Practice specifically, and the NHS in general, will see a further decline in services as the recruitment and retention crisis will get progressively worse and hospitals will need to start seeing more and more general practice type problems as there will not be the GPs available to provide the services that the patients need.

The headlines are important with a commitment to investing over £2.4bn of additional funding in general practice services by 2020/21. There is an acknowledgement that the percentage of the NHS budget invested in general practice needs to increase to over 10% from the current 7.4%.

Although this announcement has RCGP support some are questioning whether this is new money or recycled promises and there is little in the way of real detail.

There is also a question as to how CCGs will commit additional funds for general practice when they are facing a financial deficit.

It will be important that the profession has active input into the implementation both via the GPC at a national level and LMCs at the local level.

Action is needed now and early implementation is essential for the future of the NHS.