



Department
of Health

The Government Response to the House of Commons Health Select Committee Report on Primary Care (Fourth Report of Session 2015-16)



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Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

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Introduction

The Government welcomes the Committee's inquiry into current challenges in primary care in England and its particular focus on general practice, one of the great strengths of the NHS.

General practice is currently under increasing pressure due to a range of factors, including an ageing population with increasing morbidity, increasing patient expectations, difficulties with recruiting GPs in some areas; and funding has not kept pace with these rising demands. Over recent months, NHS England has worked with Health Education England (HEE), the Royal College of General Practitioners (RCGP), the Department of Health (DH) and general practice stakeholders to develop a range of measures to alleviate the pressures on general practice. The General Practice Forward View, which was published by NHS England on 21 April, sets out a comprehensive package of support for GPs, with an overall commitment to increase funding for primary medical care by £2.4 billion per year by 2020/21. This represents a real terms increase of 14% and is expected to rise further with increased investment from clinical commissioning groups (CCGs).

To boost the GP workforce, the General Practice Forward View sets out actions to increase the rate of growth in GPs, with new incentives to increase recruitment, retention and return to practice. In line with the recommendations of the Primary

Care Workforce Commission on increasing skill mix, it also sets out plans to increase numbers and make better use of the talents and skills of the wider primary care team.

On workload, the General Practice Forward View details a new practice resilience programme to support struggling practices and actions to reduce inappropriate demand on general practice. It also sets out new proposals on general practice premises, and increased investment to support greater use of technology.

These national innovations will be complemented by action at local level. For the first time, the NHS Planning Guidance, published in December 2016, made addressing the sustainability and quality of general practice one of nine 'must dos' for the NHS. In particular, local Sustainability and Transformation plans will be expected to address workload and workforce issues in general practice, supporting sustainable and transformed general practice services.

It is encouraging that the Committee has been given cause for optimism by the many examples of innovation it heard during the course of its inquiry. Many practices are forming networks and federations, working at scale to spread innovation and deliver a wider range of services to patients. The multi-specialty community provider (MCP) vanguards are leading the way in testing the new models of care set out in the NHS Five Year Forward View. A new voluntary MCP contract supporting integrated primary

and community health services will be introduced in 2017.

The Government agrees with the Committee's view that timely access to primary care services is vital and is committed to improving access to GP services as part of its plan for a seven day NHS. £175 million has been invested in the GP Access Fund to test improved and innovative access to GP services. Across the two waves of the Fund, there are 57 schemes covering over 2,500 practices, and over 18 million patients – a third of the population – have benefited from improved access and transformational change including evening and weekend appointments.

NHS England will provide over £500 million by 2020/21 to enable clinical commissioning groups (CCGs) to commission and fund extra capacity across England to ensure that, by 2020, everyone has access to sufficient routine appointments at evenings and weekends to meet local demand, alongside effective access to 24/7 urgent care services.

Achieving improved access not only benefits patients but also has the potential to create more efficient ways of working, which benefits GPs and practice staff. The GP Access Fund has shown that seven day access doesn't mean that all practices must open at evenings and weekends. GP practices have collaborated to deliver more convenient and accessible services for patients in the evenings and weekends through multiple methods including innovative use of technology, working together to provide appointments at different locations, and matching of patient needs with other health professionals such as pharmacists and nurse practitioners to release GP capacity.

Improving access to primary care

We believe that it is vital that patients have timely access to primary care services. This includes both access to urgent appointments and the ability to book routine appointments in advance. (Paragraph 25)

1. The General Practice Forward View sets out that NHS England will provide additional funding on top of current primary care allocations – over £500 million by 2020/21 – to enable CCGs to commission and fund extra capacity across England. Waves of increasing recurrent funding will be made available each year linked to CCG plans. This will ensure that, by 2020, everyone has access to GP services at evenings and weekends, including pre-bookable and same day appointments, to meet local demand. This will be alongside effective 24/7 integrated urgent care services to ensure best value for money. The General Practice Forward View is available on the NHS England website: <https://www.england.nhs.uk/ourwork/gpfv/>.

2. Through the GP Access Fund schemes (formerly known as the Prime Minister's Challenge Fund schemes), 18 million people have already benefitted from improved access, over 17 million of whom have extended access to GP services. This is largely being delivered by groups of practices working together at scale.

Evidence from the National Audit Office shows that people who work during the week would like to make use of extended hours at weekends.

We welcome the principle of improving access for people whose working lives make it very difficult to obtain appointments during the week and recognise that this was one of the Government's manifesto commitments. The Government should, however, bear in mind evidence that there may be more demand for access to GPs in the evenings or on Saturdays than on Sundays. (Paragraph 26)

3. The independent national evaluation report of the wave one GP Access Fund schemes shows that the additional hours that schemes made available for appointments during the week or on Saturday mornings were most popular with patients, with lower demand for GP appointments in most places on a Sunday. The evaluation notes the responsiveness of the schemes to meet local needs and preferences, and some schemes adjusted opening hours once the pattern of local demand was better understood. As schemes have become embedded over time, there has been a steady rise in take up of Sunday appointments and we would expect to see this continue to increase as the services become embedded in the local community. NHS England will continue to monitor utilisation of appointments to ensure that there is a meaningful service offer to patients that best meets their needs.

4. The Government and NHS England also want to see an increase in the channels of access so that patients are having their needs met in the best possible way,

including through better use of digital technology, where this adds choice and convenience for patients.

There should be a full evaluation of the pilot programmes testing the provision of routine weekend appointments before any new system is rolled out around the country. The Government's approach should be evidence based, learn from best practice and avoid unintended consequences such as damaging weekday services, continuity of care or existing urgent out-of-hours primary care services. (Paragraph 27)

5. The second national evaluation report of GP Access Fund wave one schemes will be published shortly. The evaluation has been updated with a further six months' data, which has added to the quality and depth of the outcomes.

6. The evaluation of the 37 wave two GP Access Fund schemes will be published in the autumn. As part of the wave two evaluation, NHS England has commissioned a GP appointment tool. Practices in the GP Access Fund sites are testing this automated appointment measuring interface to give them detailed information about their activity and how it varies over time. This will help practices match their supply of appointments more closely to demand. NHS England will continue to collect patient satisfaction data through the GP Patient Survey.

7. The Government and NHS England are linking extended access with the vision for developing general practice at scale, as part of a wider set of integrated services. This will happen through a supporting programme of transformational change before 2020, so that the patient offer is greatly enhanced, focusing not just on more face to face appointments, but on greater use of technology, a wider range of services and workforce, and greater enablement of self-care. To secure value for

money, it will be important that new services are procured as part of integrated 24/7 urgent care services, incorporating both NHS 111 and GP out of hours services. This will require coordinated messaging to the service and patients. This process has begun with the development of Sustainability and Transformation Plans over the summer.

8. NHS England is now building on the lessons learned from the GP Access Fund schemes with an aim to support CCGs in commissioning additional capacity more consistently across the country and in developing closer links with urgent care and out of hours services. Done well, this can lay the foundations for transforming the way in which other general practice and community services can also be delivered.

An essential component of extending primary care services to weekends should be making those patients currently disenfranchised by the existing model of care aware of improved access. Ongoing evaluation of Prime Minister's Challenge Fund backed projects should, at a local level, incorporate an analysis of patient awareness of weekend services. (Paragraph 29)

9. As services are rolled out, CCGs, as part of their specification, will need to see clear plans and evidence on how the new hours are being communicated to patients, including through notification on practice websites, and how patients can access the new appointments.

10. NHS England will keep under review the questions on patient satisfaction and access to GP services in the GP Patient Survey to ensure that they appropriately reflect the changing landscape and provision in general practice and capture patient views on these areas.

Continuity of care demands continuity of record keeping. Patient safety is compromised by inadequate access to patient records. There is greater risk of medical errors as well as the unnecessary costs of increased bureaucracy where patient records cannot be accessed and electronically updated at every point of contact. Routine appointments, especially for complex patients, without access to patient records give rise to an avoidable risk. (Paragraph 32)

It is essential, both for patient safety and to reduce bureaucracy, for patient records, accessed with their consent, to be directly accessible by all the health professionals seeing patients registered with any practice within a federation, network or out-of-hours provider. The response to this report should lay out a clear timetable for these arrangements to be in place including for shared access between primary and secondary care. Efforts should be made to ensure that such arrangements apply UK wide. (Paragraph 33)

11. As set out in the General Practice Forward View, NHS England is introducing a greater range of core requirements for technology services. 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.

12. NHS England's revised GP IT Operating Model, *Securing Excellence in GP IT Services*, 3rd Edition, 2016-18, includes a new requirement for remote access to the clinical record at the point of care for general practice. CCGs commission GP IT support services and should include the provision, maintenance and support of the necessary mobile infrastructure to support clinical

system access at the point of care, including the provision of appropriate mobile devices.

13. GP Access Fund schemes have identified interoperable requirements. From January 2017, NHS England will have tested and made available the ability to share structured GP record information across federations and other settings, integrated workflow to support appointment management across federations and the ability to task/notify across federations and care settings as part of care coordination.

14. In addition, GP systems now have the functionality to receive information on key transfers of care, removing the unnecessary burden of manual entry. There is already a requirement in the NHS Standard Contract for acute hospitals to share their discharge summary information electronically and, from December 2016, these will need to be shared in line with professionally endorsed content standards on behalf of the Academy of Medical Royal Colleges. This improves both patient safety and patient experience through the consistent sharing of information from across different organisations.

15. There is also a requirement in the NHS Standard Contract for hospitals to make services and appointment slots available on the NHS e-Referral Service to support GPs in making e-referrals. By the end of March 2018, there is an aim to achieve 80% of consultant led first outpatient referrals via the NHS e-Referral Service.

16. The Summary Care Record, which now exists for over 96% of the population and is accessed 70,000 times a week, provides key patient information to any enabled setting. By April 2017 this will have been rolled out to the majority of community pharmacies, enabling them to take a more active and informed role in clinical care.

17. There is additional work being done in conjunction with the GP IT Operating Model to provide a Digital Maturity Assessment for general practice that allows commissioners to identify core capabilities across a number of areas. This includes how they will facilitate the operation of federations, and working more closely across out of hours and with other providers.

We recommend that clinical commissioning groups, federations and networks be given the flexibility to develop local solutions for weekend access to meet the needs of those who cannot attend routine services between Monday and Friday. Clear and consistent statements affirming the Government's commitment to local flexibility are required to assist both implementation and public comprehension of the policy. Implementation of new weekend routine services must also take account of the impact on local provision of existing out of hours services for urgent primary care. We recommend that locally led design underpinned by adequate funding and resource from the centre should form the basis of the Government's implementation of its manifesto commitment to 7-day primary care services. (Paragraph 38)

18. The Government and NHS England are working with partners to set out national requirements for delivering evening and weekend access in 2016/17 and beyond. This will include local leadership of the design and implementation of services to reflect local needs.

In 2013 our predecessor committee recommended in its report on urgent and emergency services that urgent care centres providing out of hours GP services should be co-located on hospital sites where appropriate for the

local population. The future location of extended primary care provision should take this recommendation into account as part of a process of simplifying and concentrating the confusing array of urgent primary care services. Local demographics and the location of hospitals will not always make this possible, therefore local input is vital to determine the optimum locations for patient access. (Paragraph 39)

19. NHS England has encouraged the colocation of community based urgent care facilities on acute hospital sites where it makes sense to do so, and will be providing further guidance on acute facilities and community based urgent care centres in 2016/17.

Utilising Information Technology

We firmly believe that harnessing the opportunities presented by IT could improve access and quality of care. Patients expect to be able to book appointments online and practice websites should facilitate that. Whilst many patients will prefer or require a face to face consultation, for those who do not, primary care providers should facilitate telephone and eventually online consultations. (Paragraph 51)

NHS England must offer support by sharing and promoting best practice on the use of IT to facilitate remote consultations. Practice partners and managers would benefit from clear guidance and support in helping them to understand how technology can be harnessed to improve access and clinical standards of care in the most cost effective manner. We recommend that NHS England undertake research to support this objective with the aim

of formally assessing demand, risk and potential benefits. (Paragraph 52)

20. The General Practice Forward View sets out work to deliver interoperability of GP systems, enabling practices to work together at scale to deliver care to their patients by allowing access to the patient record at whichever practice the patient attended.

21. From 2017/18 NHS England will launch a new programme to offer every practice in the country support to adopt online consultation systems. There will be up to £45 million extra investment to support this.

22. The Digital Maturity Assessment tool described at paragraph 17 will enable commissioners to review progress against all IT capabilities, and will also help to support sharing of best practice.

23. In excess of 95% of GP practices in England now offer the facility to book appointments online. NHS England is providing support to GP practices to adopt this new way of working by developing guidance and resources, which are available through the NHS England and RCGP websites and via on the ground support delivered by experienced change facilitators and GPs working as Digital Clinical Champions.

24. In addition, NHS England is working with partners, such as CCGs and patient and voluntary sector organisations, to encourage uptake of online services by patients.

25. The GP Access Fund has demonstrated that enhanced access relies on working across providers and redesigning the way services are delivered, which includes greater use of digital technology. The independent national evaluation of GP Access Fund wave one schemes noted that 15 out of 20 have increased the variety of modes by which

patients can access an appointment by their GP or access their practice services.

26. For example, 12 pilots introduced telephone consultations or a GP led telephone triage service. Over 360 practices have offered this service to over 2.65 million patients. Across these pilots, the average percentage increase in telephone consultations and GP-led telephone triage being offered per week, compared with the baseline, was 10% during core working hours and 650% during extended working hours.

27. Seven pilots trialed GP e-consultations and/or online patient diagnostic tools (which include an e-consultation facility for patients who need them).

28. Seven pilots have also introduced enhanced online access features, typically online registration and booking systems, as part of their pilot programmes. These services have been enabled at more practices, or pilots have made concerted efforts to increase take-up by patients.

Variable Quality

We welcome Care Quality Commission (CQC) inspection of GP practices and the benefit which it has brought for patients. Independent regulation supported by robust inspection is a useful tool in driving improvement, ensuring quality and giving the public confidence in the services they pay for. Since the CQC's remit was extended to primary care it has played an important role in identifying failing and underperforming practices, closing some down and ensuring others improve. (Paragraph 73)

We reject the calls from the British Medical Association and the Royal

College of General Practitioners to scrap the current regulatory regime. We urge them to work constructively with the Care Quality Commission to protect the public from the small minority of dangerous practitioners and to help to turn around underperforming practices. (Paragraph 74)

We heard evidence of duplication of data requests resulting from the Care Quality Commission's (CQC) primary care inspection methodology. Like all good regulators the CQC should constantly examine its procedures and methods to avoid or minimise unnecessary burdens or duplication. NHS England, the CQC, the General Medical Council and Local Education and Training Boards must work together to agree a common framework and data set to reduce bureaucracy and unnecessary duplication. It is essential that time which should be devoted to patient care is not eroded by an excessive bureaucratic burden. (Paragraph 76)

29. NHS England, the GMC and CQC have agreed and jointly published a statement of intent to work collaboratively to reduce regulatory duplication including data requests from general practices. The statement describes the areas that will be addressed, overseen by a programme board. The statement can be found on the NHS England website at <https://www.england.nhs.uk/wp-content/uploads/2016/04/gp-reduce-dup.pdf>.

30. Work is underway to streamline the data required for both CQC regulatory visits and for NHS England's contract compliance in the annual electronic declaration, which will run for its fourth consecutive year in autumn 2016.

Improving the patient experience

Ten-minute appointments do not allow adequate time for safe practice or to address whole person care. Relentless time pressure from short appointments tends to restrict patients to discussing only one problem with their GP and clinicians to working in a reactive rather than proactive manner. Given the increasing complexity of the long term conditions that are managed in primary care, allowing time to provide safe and holistic care must be a priority. We agree with the Primary Care Workforce Commission that reshaping primary care to give patients sufficient time to discuss their conditions with health professionals should be a central aim of the new models of care. (Paragraph 83)

31. MCP and Primary and Acute Care Systems (PACS) vanguards are implementing population health models which provide more accessible, multi-professional services for patients, and more targeted, proactive approaches to patients with the highest risks and most complex needs.

32. For example, in Better Local Care (Southern Hampshire) MCP, four practices have created a Same Day Access Service, which pools the same day primary care workload and workforce for the four practices into a single service, operated from a central location at Gosport War Memorial Hospital. Patients call their own surgery and those who require same day advice or care are managed in the new service. Of 5,500 patients referred in the first six weeks of operation, 3,350 (61%) were able to have their needs met on the telephone. The remaining 2,150 patients attended a face-to-face consultation service, staffed by GPs, emergency nurse practitioners, paediatric nurses and practice nurses.

33. Separating urgent and routine general practice activity, and supplementing the same day urgent care workforce with new roles, is freeing up GP time to concentrate on those patients with more complex and chronic health needs. The key benefits of the work to date include: freed up GP sessions back in practices; better working conditions for GPs and practice staff; longer appointment slots now possible for patients with complex needs; and reduced waiting times for routine appointments in practice. The vast majority of feedback from patients is extremely positive.

Multi-disciplinary Teams

Whilst the vision for a new model of primary care and the workforce to underpin it has been established, the challenge for the Government and NHS England is to overcome the barriers to building these new teams and to implement the necessary change at scale and pace. This is especially important given the existing and worsening workforce shortfall. We are concerned that basic reforms such as widening the responsibilities of nurses, self-referral to physiotherapy and the incorporation of pharmacists into general practice teams should be enabled and accelerated. In the response to this report we would like to see a clear plan and timetable for action. (Paragraph 105)

34. The General Practice Forward View represents a step change in the level of investment and support for general practice. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates, and a national development programme to accelerate transformation of services.

35. To effectively deliver the workforce element of this programme, NHS England and HEE have established a programme to grow the non-medical wider workforce over the next 5 years. This will include £180 million for pharmacists in general practice, practice nurse development and practice support staff.

We support the objective of training physician associates to work alongside GPs within multidisciplinary teams in primary care, but as their new roles and responsibilities develop they will need careful evaluation. Attention must also be paid to the continuing professional development needs and supervision of physician associates. (Paragraph 106)

36. HEE is committed to training 1,000 physician associates to work in primary care settings by 2020. The physician associate profession continues to develop. By February 2016, there were approximately 260 qualified physician associates working in the UK and more than 550 physician associate students in training programmes, across nine course providers nationally. As many as 30 training programmes will be operational by late 2016 and annual graduate numbers will bring the total number of qualified UK physician associates to over 3,200.

37. Whilst there is considerable potential in developing this role, HEE recognises that the role will need careful evaluation and that individuals will need access to mentors and continuing professional development.

We endorse the recommendation of the Primary Care Workforce Commission that practices or groups of practices should have access to a named consultant psychiatrist and to a named mental health worker or community psychiatric nurse. We also welcome the improved access standards and

additional funding for the Improving Access to Psychological Therapies programme as an opportunity to improve access for patients in primary care to mental health therapies. (Paragraph 112)

38. The General Practice Forward View sets out plans to expand and invest in workforce capacity so that staff working in primary care will include an extra 3,000 mental health therapists to support localities to expand Improved Access to Psychological Therapies (IAPT) by 2020. In addition, local authorities and NHS England are now able to pool budgets and jointly commission expanded primary care services, for instance providing a mental health professional in a general practice setting. The requirement for access to a named consultant psychiatrist and to a named mental health worker or community psychiatric nurse would need to be determined locally, based on the needs of the population.

39. NHS England appreciates the Committee's acknowledgement of its IAPT achievements and is pleased to confirm that the most recently published national access rates are 16.47%, above the target of 15%. In addition IAPT national waiting time standards have been met with 83.85% of patients referred getting treatment within six weeks and 97.35% of patients referred getting treatment within 18 weeks.

In the response to this report we invite NHS England to explain how they will act on the Primary Care Workforce Commission's recommendation that GPs should be able to communicate routinely with specialists in secondary care by email and messaging. (Paragraph 115)

40. The New Care Models programme, established by NHS England and the

other Five Year Forward View partners, is directly supporting the development of new care models in primary care. Improved communication between GPs and specialists is a core component of the new care models being developed by the MCP and PACS vanguards.

41. For example, the Morecambe Bay PACS's Advice and Guidance service provides GPs with a direct line into specialists based in the hospital to make sure that they are appropriately dealing with the patient in primary care. GPs post their query electronically and can expect to receive guidance from a hospital specialist within five working days. The service has expanded to cover 16 specialities and rolled out across 43 GP practices.

42. Using 'Consultant Connect', Stockport MCP's GPs can, during patient appointments, call and get instant treatment advice from a specialist at the local hospital, and check whether a referral is necessary. The system connects GPs to a 'rota' of consultants and if the first is unavailable, the system automatically loops to the mobile phone of the next specialist. This has dramatically reduced referral time for GPs to consultants, from 3-4 weeks for a consultation to typically less than one minute for telephone access, benefiting the patient with timely care or advice. The system means consultants are able to spend more time with patients that need their care, as they avoid unnecessary in-person consultations. It has prevented hospital referrals in 70% of recorded cases since launching for haematology and endocrinology enquiries, has been extended to paediatrics, and there are plans to add further specialities.

43. GPs are currently able to use the NHS e-Referral service for advice and guidance to convert responses into referrals. Consultation is underway to review and update the

service in 2016 to offer enhanced advice and guidance and better decision support tools for referring GPs.

44. NHSmail2, which is planned for implementation by autumn 2016, will provide instant messaging services that can be used for individual or group communications as part of the core email service to all 840,000 active users across primary, secondary and social care.

The role of federations

Federations and networks should be formed with the primary purpose of improving care for patients. NHS England Local Area Teams, in conjunction with clinical commissioning groups, should directly support the development of new models of care envisioned by the Primary Care Workforce Commission. (Paragraph 123)

There must be assurance that federations and networks are forming with robust structures and leadership and a clear picture of how patient care and experience can be improved. We recommend that clinical commissioning groups, federations and networks also involve patient-facing charities and community organisations to help them maintain a focus on quality and local priorities for improving care. (Paragraph 124)

45. The General Practice Forward View announced a major new programme of development and improvement support for practices over the next three years. This will help groups of practices to redesign care in order to simultaneously release staff time and improve care for patients. As part of the development programme, support and advice will be provided to federations and CCGs on ways to engage patients and

voluntary and community sector groups as partners. This will help local people to shape priorities, contribute to the co-design of improved services and build assets in the community.

46. The NHS Planning Guidance for 2016/17 placed a requirement on CCGs to develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues. This is the first time specific requirements have been placed on local commissioners to support and develop general practice.

47. NHS England has also provided advice about specific ways to invest in general practice for NHS leaders as they prepare Sustainability and Transformation Plans for the future. There is a dual focus on maintaining and improving quality and access to care in existing services, while also supporting the introduction of new ways of working. Areas where support is required include: growth and diversification in the workforce; development of premises and information technology; and specific help to develop networks and federations with patient benefits at their heart.

48. NHS England provided support to the collaborations of practices which participated in the GP Access Fund. While some of these were so-called 'super-practices', most were federations. This has generated unique learning about the organisational capabilities required to deliver new services and to improve existing services in member practices. The evidence about the requirements for well governed care at scale has already led to the publication of new national guidance on information governance and patient consent models and to the creation of an expert procurement team to support IT development within federations.

This is saving money for the NHS and helping federations ensure they follow best practice.

49. Other important lessons about leading service improvement across groups of practices will be shared during 2016/17, as part of the publication of the independent evaluations into waves one and two of the GP Access Fund. This will include practical guidance for networks and federations themselves, as well as for those commissioning services from them.

50. In 2015/16, NHS England provided funding for the RCGP, in partnership with the Nuffield Trust, to establish a network of federations. This has already attracted over 400 members, and is proving a productive means to supporting peer to peer sharing of ideas and experience. It has also yielded the first national survey of practice engagement in federations, showing that over half are now involved in some form of at-scale collaboration.

51. In addition, as announced in the General Practice Forward View, NHS England will produce new resources in 2016/17 to help networks and federations identify the most appropriate ways for them to achieve economies of scale through working at scale. New work will also be commissioned to develop robust and efficient models of clinical governance for care provided at scale. This new expert guidance for federations will address a gap in current understanding of how to assure and improve standards when practices work in these new ways.

52. The New Care Models programme is providing the vanguards with practical support as part of a national package which was initially published in July 2015. This was updated in December 2015 and included the learning to date from the first 29 vanguards. Part of this assistance includes developing, with the vanguards, the different

options for organisational forms supporting the implementation of MCP and PACS care models, as well as issuing guidance on the available options and practical considerations that should be addressed for implementation.

Guarding against conflicts of interest

We believe that continued vigilance is required at national and local level to guard against conflicts of interest influencing decisions taken by clinical commissioning groups in relation to general practice. The commissioning system must operate both fairly and transparently and be seen to be operating in this way. (Paragraph 125)

53. NHS England published new statutory guidance on managing conflicts of interest for CCGs in June 2016. The key changes to the new guidance include a requirement for all CCG staff, governing body and committee members, and GP members involved in commissioning to complete mandatory online conflicts of interest training, and the introduction of a conflict of interest guardian in CCGs.

54. To support the introduction of the guidance, NHS England has also produced a series of case studies to illustrate examples of conflicts at each stage of the commissioning cycle, highlighting the risks and actions CCGs would need to consider. NHS England will also offer a programme of support for CCGs to support the implementation of the guidance.

55. England has introduced a new Improvement and Assessment Framework as part of its duty to conduct an annual assessment of every CCG. A new indicator on conflict of interest has been included,

which involves the CCG reporting on the management of conflict of interest in line with the new statutory guidance, every quarter.

56. NHS England undertook a sample audit of conflicts of interest in 2015/16. This will be repeated in 2016/17. The audit will provide another mechanism to identify compliance against the statutory guidance. The aim of the audit is to review how the safeguards set out in the statutory guidance are operating in practice, share learning and good practice and identify any areas for improvement.

Workforce planning

Ensuring there are 5,000 additional doctors in primary care by 2020 is dependent in part on attracting people to return to the profession. The induction and refresher scheme is a vital component of the efforts to do so. It should be subject to annual review to ensure that it is facilitating the return of qualified professionals as quickly as possible. (Paragraph 131)

57. The General Practice Forward View sets out a wide range of actions that NHS England and HEE are taking, in partnership with the BMA General Practitioners Committee (GPC), the RCGP and other partner organisations, to increase by 5,000 the number of doctors working in general practice, in line with the Government's ambitions. This includes measures to improve retention of existing GPs, attract more GPs to return to practice, and increase the number of doctors undertaking specialty training to become GPs. NHS England and HEE are working with the Department to develop a fuller implementation plan for these objectives.

58. HEE and NHS England have already developed a national scheme to induct and return doctors to general practice. This has seen an end to multiple policies,

with one single national policy supported website, a consistent set of written guidance to applicants and a new single point of contact, plus doctors receiving £2,300 per month from NHS England for the time they are in a supervised placement, which is a significant increase on the previous level of financial support.

59. The requirement for doctors from overseas to return to England to start the application process has also been ended. It is now possible to hold interviews via video call and sit initial assessments in countries all over the world. This has led to a doubling of pass rates in the past nine months.

60. As a direct result of these changes, there has been a significant rise in the number of doctors applying to return to general practice, with an increase of 40% in 2015/16 compared to 2014/15. Building on these improvements, NHS England will establish a more straightforward route for doctors to return to practice in England. NHS England will create a central contact point for any doctor wishing to return to English general practice, so that doctors are supported in navigating any regulatory issues and to support and guide them through the process. NHS England also plans to address delays in the Disclosure and Barring Service checks and aims to halve the time it takes a doctor to return to practice.

The Government should publish an analysis of the trends in doctors leaving the profession. This analysis should encompass their age, experience, specialism, the length of time for which doctors work abroad, the reasons for leaving the profession, and rates of return. (Paragraph 137)

61. HEE, NHS England and the Department of Health will work with NHS Digital, the BMA and RCGP to improve the coverage

and completeness of NHS workforce data to capture the workforce that is delivering services in general practice.

Selection of undergraduates

Medical schools should recognise that they have a responsibility to patients to educate and prepare half of all graduates for careers in general practice. Much greater emphasis should be placed on the teaching and promotion of general practice as a career which is as professionally and intellectually rewarding as any other specialism. Those medical schools that do not adequately teach primary care as a subject or fall behind in the number of graduates choosing GP training should be held to account by the General Medical Council. (Paragraph 144)

Medical school entry requirements should look beyond pure scientific qualifications and actively to seek out candidates who not only possess academic ability, but can also demonstrate a commitment to providing care within their own community. (Paragraph 145)

62. HEE recognises the need to raise the profile of GP careers in medical schools and has set up a working group with the Medical Schools Council, with membership comprising key stakeholders, such as the BMA, Higher Education Institutions and the RCGP. The working group will publish recommendations in autumn 2016 about recruitment and selection, finance and curriculum and the promotion of general practice as a specialty.

63. The working group is considering issues such as current selection criteria, the effect of funding distribution, promotion of

general practice careers and careers advice in schools. Recognising the importance of student engagement, HEE has held focus groups at medical schools, with both medical students and faculty members, to discuss GP career choices and influencing factors. This work will inform the recommendations that the working group put forward in the autumn.

64. A suite of associated tools and resources has been developed by HEE and NHS Employers to help embed Values Based Recruitment (VBR) in higher education institutions, in the recruitment of undergraduates, and NHS employing organisations. The purpose of HEE's VBR programme is to ensure that the workforce has the right values to support effective team working in delivering excellent patient care and experience. The University of Leeds is undertaking a longitudinal study for HEE evaluating the long term impact of VBR on patients, staff and students. The study began in April 2015 and runs for three years.

Tackling local shortages

We note that a limited scheme is already in operation whereby a bursary of £20,000 will be made to trainees who agree to work in one of 119 locations that have historically struggled to attract trainees. The success of this scheme should be kept under review to build an evidence base for the use of financial incentives in workforce planning. We recommend that the Government should assess the merits of supporting student loan repayments for newly qualified GPs and nurses working in primary care especially in areas with acute recruitment challenges, over a concurrent period of obligated service to the NHS. (Paragraph 154)

In light of the current workforce crisis we recommend that in response to this report the Government should provide a comprehensive assessment of the full range of incentives that are available to attract young primary care professionals into general practice and to encourage returners and retention in areas where the need is greatest. (Paragraph 155)

65. The measures set out in the General Practice Forward View take into account evidence from research and interviews with doctors. They include action to encourage more medical students to choose general practice as a career, an increase in GP training places, an international recruitment programme, support for non-practising GPs to come back to the service, and measures to enable experienced, older GPs to continue contributing to primary care.

66. In 2015 HEE commissioned an independent review of the GP selection process. In parallel to this it has made several changes to the recruitment process in 2016 to increase flexibility of recruitment into general practice whilst maintaining standards to ensure patient safety. The changes include twice yearly recruitment and more localised applications with proactive offer management.

67. The plans developed by the Department, NHS England and HEE for expanding the general practice workforce include specific measures to address those areas that have fewer general practice staff. As well as the offer of £20,000 to attract GP trainees to choose practices in areas of comparative GP shortages, NHS England has now introduced new targeted support for GPs to return to general practice via the induction and refresher scheme at areas with the greatest recruitment challenges. NHS England and HEE will review the impact of these new measures and will

assess the merit of introducing any further measures as appropriate.

68. The Department, NHS England and HEE will track progress against plans through a range of measures, including the bi-annual healthcare workforce statistics published by NHS Digital.

Nursing

We recommend that Health Education England, NHS England and the Royal College of Nursing develop a plan for primary care nursing akin to the 10 point plan agreed for general practice. This should include proposals to attract trainees, reform undergraduate training and ongoing professional development, establish recommended pay and conditions, and outline examples of different types of careers that can be accomplished in primary care. As well as focusing on retention of the existing workforce, greater attention should be paid to incentivising qualified nurses to return to primary care after taking career breaks or working abroad. (Paragraph 163)

69. HEE is leading on the development of a general practice nursing strategy which will report in late autumn 2016. The General Practice Forward View sets out the commitment to invest a minimum of £15 million in a general practice nurse development strategy. This will include improving training capacity in general practice, increases in the number of pre-registration nurse placements, measures to improve retention of the existing nursing workforce and support for return to work schemes for practice nurses.

Training and Education

We recommend that the Nursing and Midwifery Council urgently review nurse training curriculums with a view to increasing the exposure to primary care for healthcare professionals in training. The same principle should apply across the wider primary care team including physiotherapists and pharmacists. The education and training programme for physician associates should also be tailored in this fashion given their potential contribution to primary care and the developing nature of the profession. (Paragraph 166)

70. It is important that health professionals in training gain experience of working in primary care and many already spend significant time on placements in primary care and community care settings. HEE stands ready to support the professional regulators in taking this recommendation forward.

We recommend that the Government accelerate their work to create a payment mechanism which reflects the true cost to GP practices of teaching medical students. The objective of this work should be to ensure that reimbursement of the costs of training is not a barrier to undergraduates being able to access training in general practice. With this in mind, new proposals to replace the existing SIFT arrangements should be in place by the beginning of the 2016–17 academic year. (Paragraph 172)

71. HEE and the Department are fully committed to working together to determine the true cost to general practices of providing training for both undergraduates and postgraduate GP Registrars in order to build a solid evidence base on which to

recommend changes to service increment for training (SIFT) payments as early as is possible.

Workforce and federations

Co-commissioning of general practice services by clinical commissioning groups presents an opportunity to tailor services to patient needs by making best use of local knowledge and experience. Allied with NHS England local area teams, Clinical Commissioning Groups should use their co-commissioning powers to oversee and guide the development of federations so that patient care is central to their ambitions. We recommend that a principal element of this oversight should be a requirement for federations to develop multi-disciplinary teams focused on enhancing access to primary care and improving the quality and range of services available. (Paragraph 175)

72. As of April 2016, there were 114 CCGs with full delegation of general medical services. NHS England is encouraging the remainder of CCGs to apply for full delegation by 2017/18. Giving CCGs more control and say over primary care commissioning is part of the wider strategy to support the development of place-based commissioning. It forms part of the new deal for primary care signalled in the Five Year Forward View and is a critical step towards enabling new care models.

73. NHS England is developing a series of case studies to show the benefits and opportunities that delegated commissioning can bring. Early reported feedback from CCGs with delegated commissioning has indicated that delegated commissioning has:

- allowed the ability to develop a clearer, more joined-up vision for primary care, which is aligned to their wider system priorities;
- enabled the CCGs to commission whole pathways of care (primary, community and secondary care services) and to align their local enhanced services;
- increased clinical leadership within primary care commissioning, giving GPs greater ability to influence and shape local primary care services, and develop new ways of working;
- improved CCG insight into their GP practices and performance, giving them greater opportunities to drive improvements to quality standards and delivery of care; and
- increased public involvement in primary care commissioning.

74. The General Practice Forward View sets out how NHS England will provide support to strengthen and redesign general practice, including building capacity and capability to work at scale. Evidence from the GP Access Fund has demonstrated real transformational change is best delivered by joint working across providers and redesigning the way services are delivered. This includes working with patients, as well as making best use of the talents of the wider workforce, increasing use of digital technology, enabling self-care and direct access to other services as well as working at scale across providers. Taking such an approach can greatly enhance the patient offer and deliver the right care in the right place at the right time.

75. The General Practice Forward View recognises the need for additional support and will ask CCGs to provide £171 million of practice transformation support. One of the three calls on this money will be to stimulate

development of at scale providers for extended access delivery.

76. New care models provide an opportunity to empower and organise a wide range of staff to work in different ways, as part of new multi-disciplinary teams. Developing new care models is also a critical enabler to help with workforce recruitment and retention issues.

In order to accelerate the development of nursing roles in primary care we recommend that federations appoint a lead nurse to design and implement career pathways and continuing professional development for nurses. Health Education England should assist in setting standards and supporting federations and networks to meet them. (Paragraph 176)

77. HEE published its response to *Raising the Bar: Shape of Caring* on 18th May 2016. The response can be found on the HEE website:

<https://hee.nhs.uk/sites/default/files/documents/Raising%20the%20Bar%20-%20Shape%20of%20Caring%20-%20HEE's%20response.pdf>.

78. HEE has proposed a strategic approach with the implementation of five priority areas as follows:

- excellence in nursing practice;
- valuing and developing the care assistant workforce;
- ensuring meaningful patient and public involvement;
- flexibility in pre-registration education; and
- standards for post-registration education.

79. HEE propose to develop an overarching career and education framework aiming to bring coherence to the often fragmented pathways and multiplicity of roles that

currently feature across the caring and nursing workforce in different parts of the country.

80. In light of the recommendations set out in *Raising the Bar: Shape of Caring* and the feedback received, HEE's aim is to support and advance the quality and standards of education from Care Certificate level to PhD and beyond, including clinical academic careers. This gradual transformation will provide a career and education structure that enables the unleashing of potential. The registered nursing workforce, for instance, will be able to work at graduate level and aspire realistically to further progression. This is cost-effective and of real value to patients and the public. It is also what a motivated and skilled workforce wants and deserves.

81. NHS England recommends that federations should work together with agreed national oversight/governance to ensure an equitable approach to designing and implementing career pathways. NHS England and HEE will take forward the recommendation as part of their joint work on the primary care workforce. In addition, the Nursing and Midwifery Council (NMC) has clear guidance around continuing professional development, which forms part of their work in relation to professional revalidation requirements.

Regulation

We welcome the fact that the Royal College of Physicians now hosts a faculty which will operate the re-certifying process for physician associates, but this is not an adequate substitute for professional regulation. Regulatory change is required for the statutory regulation of physician associates to be made possible. Within 12 months we expect the Government to

have drafted proposals that will achieve the objective of professionally regulating physician associates. It is unacceptable to encourage new graduates to train as physician associates without giving the public or these new members of the primary care workforce the assurance that they will be a regulated professional group. (Paragraph 185)

82. The purpose of regulation is to protect the public by ensuring that anyone providing healthcare is doing so safely. It should be proportionate and effective, imposing the least cost and complexity, whilst securing patient safety and the confidence of service users, carers and the wider public. Whilst statutory regulation is sometimes necessary, where significant risks to patient safety cannot be mitigated in other ways, it is not always the most proportionate or effective means of assuring the safe and effective care of service users.

83. The Department of Health is currently considering how to assess when statutory regulation is appropriate and this will inform a decision on the regulation of Physician Associates in due course. As set out in the written statement, *Regulation of Health and Social Care Professionals*, made on 17 December 2015 "this Government remains committed to the principle of proportionate regulation of healthcare professionals".

GP Leadership

GP leaders have a key role to play in helping to mobilise professional support for implementing the recommendations of the Primary Care Workforce Commission, for example by emphasising the benefits not only for patients but for professional colleagues. We would welcome the RCGP and BMA taking a greater role in

helping to promote and drive forward multidisciplinary working and new models of care. (Paragraph 186)

84. The Government supports the Committee's view and welcomes the engagement of the RCGP and BMA in the work that NHS England and HEE are leading to improve recruitment, retention and return to practice in general practice.

Changing incentives in the funding system

The Government should, as a priority, evaluate the experimental projects involving capitated payment systems, with a view to extending them to primary care federations. As the vanguard projects begin to mature we expect NHS England to identify good practice and provide clinical commissioning groups with clear guidance on redesigning financial incentives to move care out of hospital, better coordinate care and, ultimately, reduce hospital admissions. (Paragraph 193)

85. Primary care is already funded largely on the basis of a whole population budget methodology, which is a simple form of capitated payment system. It is the intention of NHS England and NHS Improvement to propose that MCP and PACS services will be funded through whole population budgets.

86. The proposals also include plans to introduce a methodology for effective gain and risk sharing to improve incentives for reducing avoidable hospital activity, and a move towards outcomes based payments that incentivise improvements in quality and health outcomes.

Investing in primary care

We believe that primary care should receive a larger proportion of overall NHS spending. (Paragraph 197)

87. As set out in the General Practice Forward View, NHS England is committed to increasing the proportion of investment going into general practice services. This should reach over 10% of the NHS England healthcare budget by 2020/21 and will rise further as CCG investment in general practice also rises.

88. Overall investment to support general practice services will rise by a minimum of £2.4 billion a year by 2020/21 to over £12 billion. This represents a 14% real terms increase, almost double the 8% real terms increase for the rest of the NHS.

89. As part of its commitments on investment, the General Practice Forward View also sets out proposals to tackle the rising costs of indemnity in general practice. On 28 July 2016 NHS England announced a new Indemnity Support Scheme for practices for at least the next two years, to alleviate the immediate pressure of rising costs for GPs from indemnity.

Future Funding

It is unacceptable that financial mechanisms and a failure to coordinate health and social care continue to divert too many patients to inappropriate and more expensive secondary care. We recommend that the Government set out a clear timetable and framework for delivering the practical financial tools by which local commissioners and providers can work together to improve patient care and to reduce demand and costs elsewhere in the system. (Paragraph 199)

90. The New Care Models programme is committed to developing new voluntary contracts for MCPs and PACS. These will help create a single form of contract, where one provider is held to account under a single contract for the provision of joined up health and care services for a whole local population. The programme will be shadow testing a draft MCP contract this year, and expects to have the new contract available by December 2016 so that leading MCPs can go live under the new contract by April 2017.

91. Further, the New Care Models programme will be producing a whole population budget handbook in 2016, which will set out a detailed methodology, designed with the vanguards, to help other parts of the country introduce whole population budgets to support new care models.

92. NHS England has already made progress in a number of other areas. On urgent and emergency care, NHS England has published a financial modelling methodology guide and associated spreadsheet to support local healthcare economies in understanding the potential impact of changes arising from the Urgent and Emergency Care Review, available under the guides and documentation section at: <http://www.nhs.uk/NHSEngland/keogh-review/Documents/UEC-financial-modelling-methodology-FINAL.PDF> (guide) and <http://www.nhs.uk/NHSEngland/keogh-review/Documents/LHE-finance-template.xlsb> (spreadsheet).

93. The RightCare programme has developed a number of tools for local commissioners around spend and outcomes for health as part of a wider programme to generate value within the NHS. The Commissioning for Value Packs have recently been refreshed and they identify areas for intervention for CCGs. This is being complemented by two waves of supported

engagement with RightCare delivery partners to develop new value-based approaches to commissioning. Further details are available at: www.rightcare.nhs.uk.

94. Providers and commissioners can move away from existing payment mechanisms, should they wish to do so, and NHS England and Monitor (now part of NHS Improvement) have published high level guidance on the proposed three part payment system, specifically to support areas that are implementing changes to their urgent and emergency care pathways. Further details are available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/452925/UEC_LPE.pdf.

We recommend that by April 2017 NHS England present to Parliament a report outlining the achievements of the vanguards to date and identifying models of payment systems which produce better care for patients which can be replicated elsewhere across England. (Paragraph 202)

95. Vanguards are already making a difference for the populations they serve. Achievements are being shared, and the lessons learned from one vanguard are helping the development of new care models in other vanguards, and in other parts of the health sector. New models of payments and contracting are being developed in the vanguards, and will assist the spread of new care models across England.

96. The New Care Models programme has published the first new care model framework based on what has been learned from the MCP vanguards. Subsequent frameworks on PACS and care homes vanguards will be published in 2016. These frameworks outline the key elements of each care model, and factors for success. Where relevant, this will include models of payment systems that contribute to better care for patients.

97. As set out above, the New Care Models programme will be producing a whole population budget handbook in 2016, which will set out a detailed methodology, designed with the vanguards, to help other parts of the country introduce whole population budgets to support new care models.

98. The New Care Models programme that is supporting the vanguards is broader than NHS England; it is a Five Year Forward View programme, and involves NHS England and the other Five Year Forward View partners. The New Care Models programme will be reporting on the vanguards' achievements and lessons learned through existing channels, including reporting against the mandate to NHS England.

The costs of developing a new workforce, establishing the necessary technology and building new premises to allow for new models of care to flourish have yet to be established. By the end of 2016 we expect the Government to provide us with a full indicative costing in order for a full evaluation of the scale of this challenge to be available to the public. (Paragraph 214)

99. The New Care Models programme is supporting the development of the workforce, technology and infrastructure to support new models of care.

100. The workforce redesign workstream is supporting and enabling vanguards to design and develop a workforce that leads to a sustainable improvement in population health outcomes. The workstream will address, with vanguards, the common challenges they face in the creation of a modern, flexible workforce organised around local population needs. Three key areas of work have been identified, to support vanguards:

- workforce redesigned around care model and system-wide objectives;
- developing a new workforce culture to build local capability;
- addressing national and technical barriers to delivering the future workforce model.

101. The vanguards are being supported to deliver care using technology. The programme has supported the vanguards around the following areas:

- development of digital delivery strategies (including expertise for vanguards to produce their roadmap to interoperability) to underpin their new care model vision;
- information governance – identifying issues and building on existing work to develop tools and guides to help safe sharing of information;
- supplier engagement and procurement at scale.

102. Ongoing support will also promote digital communication and integrated IT systems, assist data sharing and analytics, and help encourage the procurement and uptake of new technology to support patient wellbeing and independence.

103. The estates workstream is supporting vanguards to realise their estate plans in support of new care models. This includes helping them to make best use of their existing estate and exploring the options available to them where they have capital requirements.

104. As well as providing practical support to the vanguards, the New Care Models programme is contributing towards their costs of transformation. The vanguards have all submitted value propositions that use existing evidence, detailed modelling, and logic mapping to describe the proposed changes, the costs involved, and their expected benefits.

105. The New Care Models programme does not expect to provide a full indicative costing of the development of workforce, technology and estates that will support new models of care. However, lessons learned and the costs of improvements in the vanguards will inform the development and implementation of new care models in the future.

We endorse the recommendations of the Primary Care Workforce Commission and believe the process of implementing a new model of primary care is a vital step in ensuring the long-term sustainability of the NHS. It is now the Government's responsibility to illustrate how it will provide the necessary investment to meet the cost of developing multi-disciplinary teams that will better meet the needs of patients. (Paragraph 215)

106. As set out in the General Practice Forward View, overall investment to support general practice services will rise by a minimum of £2.4 billion a year by 2020/21 to over £12 billion. Overall investment includes a £508 million Sustainability and Transformation package for general practices, £206 million of which will be for workforce measures to grow the medical and non-medical workforce. This includes investment to help develop multi-disciplinary teams, such as an extra 3,000 mental health therapists to work in primary care by 2020, and new investment of £112 million for pharmacists working in general practice.

107. The pharmacists in general practice commitment was developed by NHS England, HEE, RCGP and the British Medical Association's General Practitioners Committee in partnership with the Royal Pharmaceutical Society. It is part of the new multi-disciplinary team approach to improving primary care for both GPs and patients.

108. Pharmacists work as part of the general practice team to support patients with long-term conditions to better manage their medicines and consult with and treat patients directly. The main focus includes providing extra help to manage long-term conditions, advice for those on multiple medications and better access to health checks. This new way of working aims to enhance patient care by integrating pharmacists, who are medicines experts, into the practice team. Having a pharmacist in GP practices means GPs can focus their skills where they are most needed, for example on diagnosing and treating patients with complex conditions. This will help GPs manage demands on their time and increase patient access to primary care.

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