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27 November 2013

Improving general practice - a call to action

I. The RCGP welcomes the opportunity to respond to NHS England's call to action on improving general practice.

II. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 49,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

III. We gratefully acknowledge the contributions of our members in formulating this response.

RCGP response

Information, choice and control

1. **How do we go further in publishing – and getting practices to publish an increasing range of comparative public information?**

We support NHS England's commitment to greater transparency and better use of data to improve quality in the NHS. In primary care, better data - provided it is used in the right way - have the potential to empower patients, inform commissioners and clinicians, and provide a valuable resource for academic research in primary care.

However, it is critical that the data that underpin the drive for transparency are both accurate and meaningful. Poor quality data, including data that are not adequately contextualised or are misinterpreted, may be misleading and even harmful to patients, and may unfairly damage the reputation of a clinician or provider.

With this in mind, we have serious concerns about proposals to introduce aggregate 'ofsted-style' ratings for general practice. There are clear challenges, for example, around comparability of data. General practice is complex, with variation between practices in terms of the range of services offered, and practice populations differ widely across the country (for example, in terms of deprivation and/or case mix). While we recognise the merits of providing more clarity to patients, an overly simplistic ratings system could in fact mislead and render patient choice ineffective.

It is therefore imperative that NHS England and the CQC ensure that data that are published are analysed fairly and contextualised, so that any issues around comparability are clearly explained.

In order to encourage practices to publish comparative public information it will be important not only to address the concerns outlined above, but to clearly explain how the data will be used. This will help to ensure that practices are satisfied that the information that they publish will be genuinely useful to their patients and the public. In addition, while it will be important to use standardised methods for defining and applying indicators across different local health economies, these should be balanced by locally driven, peer-led approaches to quality improvement.

It is also important to acknowledge that it is almost inevitable that the publication of additional data will impose a further administrative burden on general practice. General

practice in the UK is already facing a workforce and workload crisis[1] - if practices are to publish an increasing range of public information, this will need to be backed by appropriate levels of support and resources.

2. How can we best work in partnership with CQC and the new Chief Inspector role whose inspections and ratings regime is designed to improve transparency?

We would urge NHS England to work with the CQC to avoid duplication in work between the two organisations, to streamline inspection regimes, and to rationalise the way in which data are recorded and reported in general practice so that a standard set of indicators are applied across England. In addition, NHS England and the CQC should work together to avoid creating extra 'box ticking' exercises or loading additional bureaucracy onto GPs' shoulders at a time when the profession is already struggling with a rapidly increasing workload.

Please see also our comments on aggregate ratings in question one above.

3. How do we stimulate new forms of patient involvement and insight, including introducing the Friends and Family Test in general practice?

We warmly welcome efforts to increase patient involvement in general practice. Indeed, effective patient engagement will be crucial to developing improved models of care and ensuring that services respond to local needs.

The most comprehensive data on patient experience of general practice come from the national GP Patient Survey, which was based on 971,232 responses in 2012/13. The survey provides a robust method of sampling the practice population and this should continue to be the primary means of obtaining patient insight.

We would caution against placing undue emphasis on the Friends and Family test. In our view, this will fail to provide as meaningful a measure of patient experience as the GP Patient Survey, not least as it risks making overly simplistic - and therefore misleading - comparisons between different GP providers (please see our answer to question one above on the importance of using data that are accurate and fair). Moreover, the Friends and Family test will inevitably impose an additional administrative burden on practices, and will duplicate feedback already received through the Patient Survey (the GP Patient Survey asks

[1] "The existing GP workforce has insufficient capacity to meet current and expected patient needs" - Centre for Workforce Intelligence (2013), GP in-depth review: Preliminary findings. See also: "Longer waiting times for GP appointments predicted as concerned GPs raise fears about the impact of cuts for patient care", RCGP press release, 17 August 2013.

respondents whether they would recommend their GP surgery to someone who has just moved to the area).

In order to ensure that the roll out of the Friends and Family test is as effective as possible, we would urge NHS England firstly to ensure that issues around comparability are addressed and explained, and secondly to minimise the additional bureaucracy faced by practices in implementing the test.

We would add that many practices have patient participation groups, which provide an excellent means of developing 'grassroots' patient involvement and improving communication between practice staff and patients.

4. How best do we roll out new models of patient choice?

It is difficult to respond to this question fully without understanding which particular new models of patient choice are being rolled out. We would make the general point that new models should be evidence based and piloted prior to roll out.

We recognise that patient choice of provider is one means of empowering patients and driving quality improvements. However, we feel that, in order to improve patient outcomes and deliver cost effective care, it will be more important to focus on new forms of choice that are based on the principles of prevention, shared-decision making, improved sharing of patient information, and the provision of more care in the community. Perhaps the most important example of this is care planning, which engages patients proactively in their care by working with them to set person centred goals, based on their needs and aspirations. Indeed, there is strong evidence that engaging patients in shared decision making reduces the level of surgical intervention and unscheduled hospital admissions, and leads to better health literacy, self care, and adherence to treatments.[2]

We would strongly caution against the assumption that the challenges faced by general practice are caused by a lack of competition between providers, or that the best lever to reduce perceived variability in access and/or quality would be an increase in competition. As we note below ('Workforce'), the main challenge faced by general practice is workforce capacity. The Centre for Workforce Intelligence has concluded that "the existing GP

[2] See, for example, UnitedHealth Europe (2005), Assessment of the Evercare programme in England 2003-4; Chiu W K, Newcomer R (2007): 'A Systematic review of nurse-assisted case management to improve hospital discharge transition outcomes for the elderly', Professional Case Management, vol 12, no 6, pp 330-6; Boult C, Wieland GD (2010): 'Comprehensive primary care for older patients with multiple chronic conditions', Journal of the American Medical Association, vol 304, no 17, pp 1936-43.

workforce has insufficient capacity to meet current and expected patient needs".[3] Unless more resources are invested in general practice and action is taken to increase the GP workforce there will not be sufficient capacity in some areas to allow patients to exercise choice now or in the future.

It should also be recognised that local geography can have an impact on patient choice. Patients are generally less likely to encounter a problem in switching practices in urban areas. Where there are closed lists in these areas this is likely to be because: funding is not sufficient to allow practices to expand their staffing; there are limits on premises space; or, the practice has a desire to maintain a quality service based on a defined population. Choice of GP practice may be more limited in small towns or rural areas, but in many cases it may be uneconomic and impractical to commission additional practices simply to allow choice. It is also important to recognise the potential quality benefits of reducing clinician isolation in small towns or rural areas, by encouraging partnerships rather than pushing single clinician practices purely for the purposes of choice and competition.

We feel strongly that geographically defined GP practice areas should be maintained. The abolition of practice boundaries would destabilise GP practices (as it would be far more difficult to plan to meet demand), impact adversely on continuity of care and would make it harder for GPs to deliver integrated care alongside local authorities, as these are organised on a geographical basis. Furthermore, it is likely that a number of rural practices would become unsustainable, as they would face losing significant numbers of their patients - typically younger, healthier commuters - and would be left caring for a greater proportion of patients lacking mobility and/or with complex, long-term conditions. This imbalance would rarely be sustainable in the long term and would thus ultimately reduce choice in rural communities, to the detriment of the most ill and vulnerable.

If the Government opts to proceed with the abolition of practice boundaries, it will be vital to develop safeguards to protect against possible adverse effects. The RCGP would be keen to work with NHS England to minimise the negative impact of this policy on practices and patients.

Clinical leadership and innovation

5. How can we best stimulate and create space for clinically-led innovation?

[3] Centre for Workforce Intelligence, GP in-depth review: Preliminary findings, 2013

There is significant potential for clinically-led innovation in general practice to deliver high quality, cost-effective, integrated care and improved health outcomes for patients. GPs have always found ways of adapting to change and, by nature of their generalist role, are inherently skilled at creating solutions to the new problems that they face.

However, in order to simulate innovation, GPs and practice staff need time and resources to reflect and plan. This is becoming increasingly difficult as general practice faces rising demand, workforce shortages and year on year reductions in funding.

There is an urgent need for additional investment to respond to the growing demand for general practice services and to support GPs to develop the new services that patients need in their communities. The pattern over the past decade, during which secondary care has absorbed by far the largest share of the growth in available resources, must be halted and reversed. Meanwhile, urgent action is needed to secure an increase in the general practice workforce, both in the short and long term (please see also our response on 'Workforce' below).

GPs need to be appropriately resourced and supported in order to lead innovation. For example, the RCGP's Sowerby Innovation Fellows Programme seeks to foster early-stage GP-led innovations in primary care by offering successful applicants paid sessional 'time to innovate'. Similarly, if clinician-led commissioning is to fulfil its potential to achieve locally-driven, transformational change, GPs need to be allowed time to become actively involved in their CCGs – and should be resourced for the commissioning activity they undertake.

A key objective of the RCGP's vision for general practice in the future NHS, The 2022 GP[4], is to increase academic activity in general practice to drive quality improvement and innovation. In order to achieve this, there is a need to: develop and promote approaches to care that routinely support educational activity and research utilisation in practice; increase the level of research funding; and, expand capacity and training in academic primary care.

Finally, there is scope to improve modes of dissemination – so that we can better identify, evaluate and share examples of community-based innovation and good practice.

6. How can we challenge and support local health communities, including CCGs and health and wellbeing boards, to develop more stretching ambitions for primary care?

[4] RCGP, The 2022 GP: A Vision for General Practice in the future NHS, 2013

We would propose a combination of increased resources for innovative models of care, close involvement of local clinicians in developing plans, and improved dissemination of examples of good practice across England.

When considering how to develop ‘stretching ambitions’, it is important to acknowledge that it is becoming increasingly difficult for general practice simply to stand still in the face of both rising demand, an increasing prevalence of complex and multiple long-term conditions, and workforce shortages. If general practice is to fulfil its potential to lead the delivery of high-quality, cost-effective and integrated care in the community, urgent additional investment is needed in general practice services across England to enable innovation.

7. How do we best support integration pioneers in testing new ways of commissioning and contracting for integrated primary care and community services for people with physical and mental health conditions?

Integration pioneers need to be backed by adequate resources, and must have the freedom and flexibility to test new ways of commissioning and contracting for integrated care.

NHS England can support pioneers by removing, where possible, technical or policy barriers to integration. For example, pioneers may need support to explore new payment mechanisms for care both in and out of hospital, in order to encourage integrated care across organisational settings. Pioneer areas may also need flexibility in the way that they work with their local area team – with the potential to take on delegated responsibility for commissioning primary care where appropriate.

In addition, NHS England should work with Monitor to ensure that procurement, patient choice and competition regulations do not act as a disincentive to innovative models of integrated care. In particular, it is important to address concerns – whether real or perceived – over, firstly, the need to put services out to tender and, secondly, how conflicts of interest should be managed. For example, we already know of examples where GP commissioners have been deterred from commissioning new or existing community services from general practice due to concerns over the impact of competition law. Unless greater clarity can be achieved, this inhibiting effect will damage progress in an area where there is significant potential for general practice to drive service transformation and improved patient care.

Finally, in order to place general practice at the heart of integrated out of hospital care, we urge NHS England to ensure that a significant proportion of the Integration Transformation Fund is invested in general practice services.

8. **How can we best mobilise existing improvement resource (e.g. NHS IQ) and facilitate access to other potential external support for primary care transformation?**

There is considerable potential to work with the RCGP to develop and disseminate improvement resources. For example, we are collaborating with NHS IQ, and a range of other stakeholders, on the 'Action for Long Term Conditions'. This alliance was established by the RCGP in order to support whole system change in the delivery of care for people with long term conditions, and to embed care planning and personalisation of care in general practice (please see also question 19 below).

However, much more scope exists for levering the unique reach the RCGP enjoys amongst front line GPs through partnership working, including by increasing funding to allow the RCGP to develop new quality improvement and service transformation initiatives.

Freeing up time and resources

9. **How might we develop QOF so that that we preserve its essential features but create more flexibility for practices and reduce the feel of a tick-box culture?**

It is important to retain the best that the Quality and Outcomes Framework has to offer, while ensuring that misdirected incentives do not take priority over patient needs and that QOF indicators are within the scope of GP practice influence.

The QOF contains a number of useful, evidence-based outcomes indicators - such as the percentage of diabetic patients with well controlled blood sugar - that have helped to improve patient outcomes in general practice. However, GPs need to be allowed the time to listen to their patients and the freedom to use professional clinical judgment and medical evidence to provide the best personalised care possible according to the patient's individual needs.

We therefore welcome changes to the 2014/15 contract that have removed several unhelpful QOF indicators. This is a step in the right direction, reducing unnecessary box-ticking and micromanagement and placing greater trust on the professionalism of GPs to do the right thing for their patients when it is clinically appropriate.

10. **How can we get best value from enhanced services and reduce process-oriented measures?**

There is a need for a coordinated approach between different commissioners and providers within the system – for example between out of hours services that are commissioned by CCGs and GP extended hours services. We are concerned that the new commissioning arrangements under the Health and Social Care Act may make it more difficult for GP practices to provide additional community-based services of the kind previously provided as Locally Enhanced Services (LESs). Current guidance from NHS England states that CCGs should commission such services through the NHS Standard Contract. This is a cumbersome, time-consuming and disproportionate process, particularly for small practices.

There is also a risk that CCGs may feel under increased pressure to put enhanced services contracts out to tender under the new arrangements. It is therefore vital that commissioning guidance clearly recognises that there are often distinct clinical advantages for patients when services are directly commissioned from holders of the registered patient list (i.e. the GP practice), as opposed to third party providers.

11. How should general practice IT systems develop to support more efficient and integrated working?

The lack of efficient, effective and compatible systems for the sharing of patient information is one of the biggest barriers to the integration of care.

Without this key infrastructure in place, professionals providing care will be unable to access patient information, hindering a fluid and easy transition ('seamless service') for patients and potentially compromising the safety, continuity and quality of patient care. GPs and community nurses frequently have a completely different set of notes, resulting in clear inefficiencies and risks to patient care. In addition, patients and their GPs often have to wait for a long time to receive hospital discharge letters.

A big gap is the lack of a comprehensive system of shared electronic care records. The NHS Future Forum's report on Information identified that the best way of achieving this is the development of interoperability between computer systems, rather than seeking to implement a single IT solution. Modifying general practices' existing electronic patient record systems may, however, involve additional costs that will need to be resourced. Meanwhile many hospitals continue to rely on paper based systems to record patient information.

Patients will increasingly expect to interact with their general practice team virtually, supported by mobile technology and online access to their own medical records, to electronic prescriptions and to appointment booking systems. In order to help general

practice to deliver on the government's expectations for patient online access, the RCGP has developed Patient Online: The Road Map. This provides:

- guidance and support for GP practices, and explanations of the different options available for providing Patient Online;
- potential strategies to support GP practices with the implementation of Patient Online;
- guidance about information governance and safeguarding issues;
- an overview of support, training and education tools the RCGP and partners want to develop for GPs, practice staff and patients;
- a summary of the ongoing systematic review supporting the recommendations within the Road Map;
- advice about communications relating to patient online and about an approach to market development.

12. How can we help ensure that practices are making most effective use of all practice staff, including practice nurses and practice managers?

The effective use of multi-disciplinary teams in general practice will become increasingly important as demand for GP services continues to rise, driven by the UK's growing, ageing population and an increasing prevalence of long term conditions and multi-morbidity. Indeed, it is likely that GPs will increasingly take on the role of expert advisor and leader of the multi-disciplinary team alongside their traditional role as care giver, overseeing the care of patients – particularly those with long term conditions – and ensuring that the right care is delivered by the appropriate members of the primary/community care team.

In order to facilitate this, practices need support and sufficient resources to address the training and development needs of their staff. This will help practices to develop the appropriate 'skill mix' in their teams, and thus improve efficiency. For example, GPs might delegate some patient consultations to senior nurse practitioners, in order to free up the GP's time to offer longer consultations to patients with complex needs.

We would add that many practices have already developed effective multidisciplinary teams in response to steady increases in demand for GP services over the past two decades.

Indeed, the proportion of patients seen by nurses in primary care increased from 21% in 1995 to 34% in 2008[5]. Although continuing to improve the skill mix in general practice is important, it should absolutely not be seen as a 'catch-all' solution to the workload problems that GPs are facing.

Just as the skill mix in general practice has changed to respond to changing patient needs, management in general practice has evolved as the specialty has developed from a cottage industry into a mainstream business. Traditionally, managers were promoted from reception or secretarial posts, on the assumption that an understanding of general practice was an essential prerequisite for the role. It is now generally accepted that management skills and experience are of prime importance, and it is commonplace to have practice managers who are also practice principals, usually in partnership with a group of GPs.

As practices continue to grow in size and form networked organisations, practice managers will increasingly take responsibility for strategic planning and tendering processes. Funding needs to be made available to support the training needs of practice managers and recognised training packages should be developed to make practice management a structured career choice.

13. How do we engage practice managers more effectively?

The Practice Management Network is a national community of managers in general practice and could provide a useful means of communication.

Please see also our comments above (question 13) on the need to develop recognised training packages for practice managers.

Defining practice accountabilities for high quality

14. Should we seek to develop a joint concordat with key partners that re-affirms and refreshes the core features of general practice?

It would be helpful to develop a joint statement that re-affirms and refreshes the core features of general practice. This will become increasingly relevant as the recommendations of the Shape of Training report are implemented and more doctors (including hospital specialists) begin to work within community-based teams away from hospitals. While we

[5] The Health and Social Care Information Centre, Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch® database

warmly welcome this move, it will nevertheless be important to promote and support the distinctive strengths of general practice.

The RCGP would be keen to help NHS England to develop such a concordat. Indeed, we have already done a lot of thinking about the core values of general practice and how these will be applied the future, both through the Commission on Generalism[6], which explored the importance of the 'expert medical generalist', and our vision for the future of general practice, The 2022 GP[7].

We would add that it is important that NHS England works with key partners – including the Department of Health – to reinforce the value of general practice and communicate positive messages both to the public and the profession about the centrality of general practice to the NHS. Recent negative media coverage has been damaging to morale and is likely to act as a disincentive to medical students contemplating a career in general practice.

15. How can we put general practice at the heart of more integrated out-of-hospital services and give GPs and practices greater responsibility for coordinating care for patients?

Practices already coordinate care for many patients so are ideally placed to extend this role. We suggest that the following measures would help to place general practice at the heart of integrated out of hospital services:

- Invest a greater proportion of the NHS budget in primary and community care, including a steady increase in the capacity of the primary and community workforce.
- Allow local flexibility in the contracting and commissioning of care, in order to deliver locally to a set of nationally agreed outcomes measures.
- Ensure that competition and choice regulations do not act as a barrier to integration. In order to deliver health and social care that is truly integrated, a collective approach between providers will be crucial – for example through alliance contracting. There is a real risk that if competition – rather than cooperation – is encouraged between organisations, care will become increasingly fragmented.
- Reform payment systems to remove activity-based payments for hospital services and introduce incentives to encourage acute providers to provide specialist support

[6] RCGP, Medical generalism: Why expertise in whole person medicine matters, 2012
[7] RCGP, The 2022 GP: A Vision for General Practice in the future NHS, 2013

to GPs and to work alongside them to move more services into primary care and the community.

- Work with GPs, as well as their primary, secondary and social care colleagues, to develop clinical guidelines for the provision of care to patients in community settings, including those with multiple conditions.
- Encourage and enable practices to form networked organisations or federations (please see also questions 18 and 29 below) in order to co-develop a wider range of clinical and community services.
- Develop integrated systems of information-sharing across organisations, including inter-operable IT systems.
- Give commissioners, clinicians and providers clear goals and, crucially, time and space to implement plans. Following the upheaval caused by the Health and Social Care act, local health leaders need stability in order to make sustained changes to the way in which care is delivered.

16. How should we define high quality general practice and their responsibilities/ accountabilities, through the GP contract?

Quality of care in general practice is a multi-dimensional and complex concept. To quote the King's Fund: "No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality in general practice."[8] This should be recognised and quality should not be reduced to a simplistic summary score (please see also questions 1 and 3 above).

The GP contract is one way of promoting quality care, but a far broader overall strategy is needed to define, measure and promote high quality care in general practice. The contract should focus on empowering the professionalism of GPs and true partnership with patients, in order to foster the delivery of safe, high-quality care.

17. How do we create synergy with the new system of CQC ratings and inspections to create a clearer sense of what patients can expect from good general practice?

Please see our comments on questions 1 and 2 above.

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[8] The King's Fund, Improving the quality of care in general practice: Report of an independent inquiry commissioned by The King's Fund, 2011

GP contract: incentives for outcomes

18. How far should we create stronger incentives for both inter-practice collaboration and collaboration with other primary care providers, acute, community and social care services?

Greater collaboration, both between practices and with other health and social care providers, will be key to delivering truly integrated care in the community.

In order to facilitate this, the RCGP believes that general practice teams will increasingly need to work with groups of other practices and providers - as federated or networked organisations that co-develop a range of clinical and community services. The concept of a primary care federation was first described by the RCGP in 2007, and there are now a number of innovative examples of federated or networked practices around the UK.

We outline a number of measures that would help to stimulate practices to form federated or networked organisations in answer to question 29 below. We believe that financial incentives may have a role to play in this - if properly designed. As we mention below (question 29), there is potential to refine the GMS contract to offer incentives for practices to work collaboratively. There may also be a case for designing a new contractual framework - in parallel to the GMS contract - for networked practices and similar larger-scale models.

However, it is essential to recognise that financial incentives are only one means of stimulating innovation, and may not be the most significant. Indeed, there are many different drivers of greater collaboration between practices, such as the need to improve premises or to focus on providing more comprehensive out of hours care.

It is also important to understand that there are a range of federated or networked structures - from a relatively loose alliance to formal mergers of practices. Flexibility is needed to allow models to develop that are led by GPs locally and that respond to the needs of their practice populations.

19. How can we better stimulate and recognise/reward quality of care for people with co-morbidities and complex health and care problems?

The rise in the number of people suffering from several long term conditions is one of the most important challenges faced by general practice (and indeed the NHS).

In order to better stimulate quality of care for people with co-morbidities and complex conditions, there is an urgent need address the 'inverse care law' - whereby the availability of health care varies inversely with the need for it in the population served. In other words, in areas of greatest need - and particularly areas of high deprivation - there tend to be fewer GPs per head of the population[9] [10], working with higher caseloads and sicker patients who have greater problems with self-care.

Indeed, a recent *Lancet* paper showed that the prevalence of multimorbidity increases with deprivation, with people in deprived areas having the same prevalence of multimorbidity as more affluent patients who were 10–15 years older. In particular, physical and mental health comorbidity was almost twice as common in the most deprived than in the most affluent areas.[11]

In order to meet the challenge of rising multimorbidity, GPs must be enabled to respond proportionally to need. Urgent action is therefore required to increase training capacity and recruitment in areas of undersupply (generally, areas of high deprivation). Similarly, additional financial support should be targeted at areas of highest need – as proposed by The Deep End project in Scotland[12]. This would allow GPs to offer longer consultations to patients with complex health needs, in order to tackle the many problems that might arise and provide proactive, person-centred care. Similarly, patients should have all of their chronic diseases reviewed in one visit by a clinician who has responsibility for coordinating their care, instead of attending several disease-specific clinics.[13]

We also believe that there is a pressing need to create new incentives to embed care planning and coordination across care settings and providers. Indeed, the RCGP has established the 'Action for Long Term Conditions' alliance in order to support whole system change in the delivery of care for people with long term conditions and to embed care planning and personalisation of care in general practice, such as through the 'house of care' model.

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[9] Centre for Workforce Intelligence, GP in-depth review: Preliminary findings, 2013

[10] Goddard M, Gravelle H, Hole A, Marini G. Where did all the GPs go? Increasing supply and geographical equity in England and Scotland. Journal of Health Services Research & Policy 2010; 15: 28-35.

[11] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet* 2012; published online May 10. DOI:10.1016/S0140-6736(12)60240-2.

[12] General Practitioners at the Deep End, What can NHS Scotland do to prevent and reduce health inequalities?, Proposals from General Practitioners at the Deep End, 2013

[13] Salisbury C, Multimorbidity: redesigning health care for people who use it, The Lancet, Volume 380, Issue 9836, Pages 7 - 9, 7 July 2012, doi:10.1016/S0140-6736(12)60482-6

The RCGP would be keen to work with NHS England and other stakeholders to help to better define quality of care for people with long term conditions and co-morbidities.

20. How far should we seek to reward practices for wider outcomes, such as enhancing quality of care for long term conditions and reducing avoidable emergency admissions, or reducing incidence of strokes and heart attacks, or improving patient experience of integrated care?

There is enormous potential to improve wider outcomes through better integration of community services with general practice, backed by increased investment in out-of-hospital care. However, great care would need to be taken when introducing incentives to ensure that outcomes are achievable and do not lead to geographical inequalities as a result of patient factors (such as demographics) and professional factors (such as workforce and quality of related local services).

There is also a risk that a wider outcomes based approach would have the adverse effect of incentivising providers to 'cherry pick' patients whose outcomes are likely to be better (and who will therefore be more profitable) – for example, patients who are more engaged in improving their own health, or who suffer from fewer multi-morbidities. Thought must therefore be given to minimising the unintended consequences of new outcomes based targets.

21. What is the potential future role for PMS and APMS contracts in stimulating innovative approaches or helping address particular local challenges?

PMS and APMS contracts can play a useful role in addressing particular local challenges, such as supporting practices that would not be viable under a national contractual arrangement. However, we feel that it is important to maintain a consistent national contractual framework, with the use of community (formally Local Enhanced Services) contracts and other similar mechanisms to allow local flexibility.

Safe, controlled investment

22. How can CCGs, local authorities and NHS England best collaborate to develop integrated commissioning plans for out-of-hospital services?

It is absolutely crucial that ambitions for out-of-hospital services are matched by investment in primary and community care.

There is a growing consensus that in order to meet the needs of an increasing and ageing population in a time of financial constraint, the NHS must deliver care closer to people's homes and focus more on preventing ill health rather than simply treating it. However, spending on hospital care in England has increased at a much faster rate than primary care in recent years: in real terms, PCT spending on primary care rose by 22 per cent between 2003/04 and 2011/12, while spending on secondary care jumped 40.1 per cent over the same period.[14] Meanwhile, the share of overall NHS spending that goes towards patient care in general practice in England has fallen from 10.6% in 2004/05 to 8.5% in 2011/12.[15]

NHS England should take immediate action to increase the share of the NHS budget that is invested in community and primary care, with a significant share of this investment allocated to general practice. The RCGP is calling for an increase in the share of funding that goes into general practice in England from 8.5% to 11% of the NHS budget by 2017. This investment will support innovation, transform care for patients and benefit the NHS as a whole by alleviating pressure on our hospitals and providing cost effective care closer to home.

As part of the shift of resources into out-of-hospital care, there is a need to invest in the general practice workforce (please see also our comments on 'Workforce' below), together with more community staff – such as district nurses[16] - and the additional support services required (IT, communications and training) to support an integrated service.

This investment needs to be matched by a whole-system approach to moving care out of hospital and reducing unnecessary referrals to secondary care. As we mention above (question 15), payment systems need to be reformed to remove activity-based payments for hospital services and to introduce incentives to encourage acute providers to move more services into primary care and the community. Meanwhile, it is important that savings made from reducing hospital admissions through effective community and primary care are reinvested in the community, and are not simply diverted back into secondary care.

In order to ensure that investment in community care is best allocated, we would recommend establishing common national principles, but allow flexibility in local application. We have heard anecdotal evidence, for example, that some CCGs were planning to take

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[14] Jones N, Charlesworth A, The anatomy of health spending 2011-12, Nuffield Trust, 2013
[15] RCGP press release, 15 November 2013
[16] The number of district nurses - who play a vital role in delivering care in the community - has plummeted by 40% in the past decade. National Nursing Research Unit at King's College London, District nursing – who will care in the future?, Policy +, Issue 40, September 2013

funds for the Integration Transformation Fund from community budgets, until key principles were set out in guidance by NHS England and the Local Government Association.

Health and Wellbeing Boards have a crucial role to play in holding local authorities and health bodies to account and coordinating integrated commissioning plans. Boards should be encouraged to take a proactive approach and ensure a wide representation of local providers, commissioning bodies and patient organisations. We would also suggest a review of the local Joint Strategic Needs Assessment that links back to the prevalence of long term conditions and multi-morbidity.

23. How can we support health investment analysis that allows for optimal balance of resources between acute and community services?

In order to enable commissioners to make rational decisions about investment, there is a need to improve data collection to include all the costs of services, consider the costs of services delivered in different settings, and consider different ways to make services more efficient.

As part of this, health investment analysis should review evidence – and where necessary commission new research – on the population-level gains in mortality that may be achieved through low cost interventions for both prevention and chronic disease management in primary care, including how these compare to the benefits of investing in high cost secondary care procedures for a relatively small number of people.

We would make the general point that analysis should take into account where the majority of work occurs (e.g. patient interactions); health inequalities; distribution of the workforce to ensure clinical effectiveness; consideration of hospital admission avoidance schemes; and system wide financial sustainability.

We suggest that particular attention should be paid to modelling the costs and benefits of extending and improving access to meet demand seven days a week. As part of this, we need to understand where resources that are already in the system could be best invested.

Modelling and simulation tools are also required to understand the cost of implementing care planning at scale, including the role of community staff and voluntary groups. We already have some evidence from bed status audits, such as Interqual, that could be used as part of this modelling.

24. Where commissioning plans envisage additional investment in services provided by general practice, how can CCGs and NHS England best provide assurance that any perceived conflicts of interest have been properly managed?

It is vital that concerns over conflict of interest do not act as a barrier to local innovation and investment in services in the best interests of patients. With this in mind, we would support a transparent, proportionate and realistic approach to managing real and perceived conflicts of interest.

This approach needs to recognise that GPs who are CCG members may have an interest in a health provider outside their own practice – and that, as more care is moved into the community, potential conflicts of interest are likely to increase. In order to ensure that these conflicts do not compromise the integrity of CCG decision-making, any conflict of interest should be declared at the first opportunity, and made available in an easily accessible public register. Voting rights on CCGs should take into account declarations of interest and, where a CCG member has a direct interest in a company tendering to provide services, that member should exclude themselves from the decision-making process and subsequent monitoring arrangements.

However, a proportionate approach should be taken to managing declarations of interest, in order to avoid a situation where CCG members are discouraged from bidding for a contract or renewing existing successful arrangements due to concerns about conflicts of interest, despite clear evidence of likely patient benefits.

Independent assurance processes should be put in place locally. The Health and Wellbeing Board could play an important role in reviewing investment plans, and in some instances it may be appropriate for CCGs to seek advice or oversight from the NHS England Local Area Team.

The RCGP and NHS Confederation's 2011 briefing paper on managing conflicts of interest sets out some key principles for avoiding and managing conflicts:

- Doing business properly. If CCGs get their needs assessments, consultation mechanisms, commissioning strategies and procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid or deal with, because the rationale for all decision making will be transparent and clear and should withstand scrutiny.

- Being proactive not reactive. Substantial conflicts of interest can be avoided by being clear on what is acceptable before individuals are even elected or selected to join the

CCG; by inducting members properly and ensuring they understand their obligations to declare conflicts of interest; and by agreeing in advance how a range of different situations and scenarios will be handled, rather than waiting until they arise.

- Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest. Most individuals involved in commissioning will seek to do the right thing for the right reasons, but they may not always do it the right way due to lack of awareness of rules and procedures, insufficient information about a particular situation, or lack of insight into the nature of a conflict. Rules should assume people will volunteer information about conflicts and will exclude themselves from decision making where they exist, but there should also be prompts and checks to reinforce this.

- Being balanced and proportionate. Rules should be clear and robust but not overly prescriptive or restrictive. Their intention should be to identify and manage conflicts of interest not eliminate them, and their effect should be to protect and empower people by ensuring decision making is efficient as well as transparent and fair, not to constrain people by making it overly complex or slow.

25. How do we track value from investment and adjust investment plans to reflect evidence of outcomes?

A major challenge to this approach lies in defining what constitutes a good outcome, and how to measure this. For example, there is a need to consider to what extent outcomes will be determined locally or nationally, especially where outcomes may be influenced by socio-economic factors.

All outcomes measures must be both evidence-based and designed with patients at their centre, so that metrics record outcomes that are most important to patients. We are concerned that in many cases the data needed to support an outcomes based approach is simply not yet available. Research and investment is urgently needed to develop systematic tools to gather data, including costing data and quality of patient reported outcomes [PROMs], that is both routinely collectable and forms part of an efficient feedback loop to clinicians.

We propose that one way of tracking value would be to use informatics tools that are already available to look at predicted population risk and actual subsequent use of secondary care resources. Similarly, the ‘Year of Care’ programme could provide a useful means of tracking the implication of funding a proactive approach to care planning.

It is important to review the success of investment plans in the context of the wider NHS. For example, unless activity-based payments for hospital services are reformed, it may be difficult to significantly reduce admission rates.

Finally, in order to make sustained changes to patient outcomes, local health leaders will need time to implement and assess investment plans. It is therefore essential that a long term approach is taken to tracking value.

26. How can NHS England and CCGs work together to make more effective use of existing community estates and, where necessary, allow investment in new or expanded premises?

In order to allow general practice to rise to the challenges of rising demand and the transfer of more services into community, investment is needed to fund practices to improve and expand their premises.

NHS England will need to work not only with CCGs but also local authorities, NHS Property Services, the BMA and other stakeholders in order to identify ways of accessing investment to ensure that premises are fit for purpose and able to accommodate future capacity needs.

Market management

27. How do we ensure a consistent and disciplined approach to identifying and remedying poor performance, including effective partnership with the CQC?

As we mention above (question 2), we would urge NHS England to work with the CQC to avoid duplication in work between the two organisations and to streamline inspection, quality measurement and reporting initiatives (not least as this will reduce the considerable bureaucratic burden that these myriad initiatives impose on general practice).

While it is important that a consistent approach to performance review is applied across England, it will be equally crucial to secure local involvement in performance review, with cooperation between the CCG, local area team, the CQC and local GP networks. There is considerable scope to make use of audit, quality assurance and peer-led quality review at local or practice level. Indeed, transparency and peer review may be just as effective as formal inspections in fostering quality improvement in the long-term, if not more so.

Similarly, we would urge NHS England, the CQC and other stakeholders to focus on a quality improvement agenda, rather than ‘performance management’. Good practice should be shared and celebrated, while poor performers should be offered support to improve.

Where practices continually fail to meet acceptable standards, sanctions should be applied swiftly, fairly and transparently.

28. How do we develop a more consistent and effective approach to new market entry, e.g. how far this should be targeted at areas of greater deprivation and/or lower capacity and/or limited patient choice?

As we noted in our response to Monitor's review of GP services, we would strongly caution against the assumption that the challenges faced by general practice are caused by a lack of competition, or that the best lever to reduce perceived variability in access and/or quality would be an increase in competition.

The main challenge faced by general practice is workforce capacity. The Centre for Workforce Intelligence has concluded that "the existing GP workforce has insufficient capacity to meet current and expected patient needs". In order for choice and competition to be meaningful it is necessary to have excess supply in the market; this is clearly not the case for many areas of general practice (please see also our response to question four).

In our view, it is logical to target new market entry at areas of lower capacity, which also tend to be areas of greater deprivation.[17] However, new market entry will not be sufficient in itself to address the problems faced by underdoctored and/or deprived areas. Far more urgent priorities are a sustained increase in the GP workforce and financial support for practices operating in areas of greatest need.

It is also important to understand that commissioners will often face a trade-off between choice and capacity in their approach to new market entry. We foresee that over coming years many existing practices will need either to increase in size or form networked organisations with other local practices, in order to offer better access, enhanced services and to reach the critical mass required for a comprehensive community team wrapped around the practice.

29. How might we stimulate new, innovative provider models that offer both greater quality for patients and satisfying careers for those working in general practice and primary care?

General practice should be at the heart of an integrated approach to care, with community services and social care 'wrapped around' future provider models. As part of this, we foresee

[17] Deprived areas broadly tend to have fewer GPs per head. Centre for Workforce Intelligence, GP in-depth review: Preliminary findings, 2013

a gradual move away from small independent general practice providers, towards larger regional multi-practice organisations, 'super partnerships' (large-scale single partnership structures, operating from multiple sites) and federations (groups of practices working together to share back-office functions and educational and clinical services).

Such organisations would permit smaller teams and practices to retain their identity (through the association of localism, personal care, accessibility and familiarity) but combine 'back-office' functions, provide structured career development for employees and co-develop a wider range of clinical and community services. (Please see also the RCGP's report Primary Care Federations: Putting patients first and toolkit to support the development of primary care federations.)

There is no single answer to the question of how to stimulate change of this kind, not least as different approaches will be required in different local health economies. We would suggest that a combination of the following measures could help stimulate innovation:

- GP contract. There is potential to refine the GMS contract to offer incentives for practices to work collaboratively. There may also be a case for designing a new contractual framework - in parallel to the GMS contract - for networked practices and similar larger-scale models.

- Additional funding. Specific funding could be provided for networked practices, and similar larger-scale models, to improve and expand the services they offer.

- Leadership skills. As general practice scales up, GPs will increasingly require new skills to lead and manage. Leadership and 'followership' skills need to be a core part of both GP training and continuing professional development.

- Access to organisational development and planning support.

- Local ownership. It is vital that new provider models are GP-led and that grassroots GPs feel that they 'own' the organisations to which they belong. Without the engagement of local GPs, new provider models stand little chance of success.

- Time to reflect, innovate and plan. As outlined above, GPs are under significant and increasing strain. In order to plan for the future and pioneer new provider models, GPs need to be allowed breathing space. To this end, investment is urgently needed to provide financial support for GP services and to expand the general practice workforce.

In addition to the above measures, it is essential to ensure that rules relating to competition do not act as a disincentive to innovation. Concerns over conflict of interest should not be allowed to restrain collaborative work by GP providers that is aimed at improving quality of care and developing a greater range of services. Similarly, provider models that are working effectively should be able to remain in place, without having to go out to tender to extend their contract, in order to allow providers to develop a lasting relationship with their local communities.

Finally, we would suggest that financial mechanisms should be found to encourage acute providers to provide specialist support to GPs and to work alongside them to move more services out of hospital and into primary care and the community.

30. What are the potential opportunities for 'primary care plus' contracts, built on co-commissioning between NHS England, CCGs and local authorities?

There is considerable potential to commission a wide range of additional clinical and community services from general practice (please see also our comments on networked organisations in question 29). It is important that the contracting mechanism used to do this is flexible and proportionate.

As we mention above, we are concerned that the new commissioning arrangements under the Health and Social Care Act may make it more difficult for GP practices to provide additional community-based services of the kind previously provided as Locally Enhanced Services (LESs). Current guidance from NHS England states that CCGs should commission such services through the NHS Standard Contract. This is a cumbersome, time-consuming and disproportionate process, particularly for small practices.

Workforce development

31. How can we and our national and local partners best support improvements in recruitment, retention and return to practice?

Recruitment:

We welcome the Government's target for 50% of specialty trainees to choose to enter GP specialty training, as set out in its mandate to Health Education England. We also support the recommendation of the Centre for Workforce Intelligence (CfWI), which considers that achieving and maintaining 3,250 GP trainees per annum is necessary to address future demand.

However, it appears increasingly unlikely that these targets will be hit. Worryingly, the number of GP training vacancies in England averaged only around 2,700 per year between 2009 and 2012, rising slightly to 2,850 vacancies in 2013 - significantly below the Government's target increase by 2015.

Moreover, we feel that the target of 3,250 GP trainees per annum is relatively conservative and may well underestimate future patient demand for GP services. Indeed, we note that preliminary findings from the CfWI show that three of the seven future demand scenarios modelled by the CfWI are above all of the projected supply scenarios, while five supply scenarios are below the baseline supply projection (based on achieving the 3,250 recruitment target from 2015).[18]

Urgent action is needed to recruit more medical students into general practice. As part of a strategy to achieve this, we feel strongly that there is a need for a commensurate reduction in training numbers in other specialties. Furthermore, in order to help address the recruitment problems faced by under-doctored areas (which broadly tend to be more deprived), incentives should be introduced to attract trainees to train in these areas.

Measures to attract more people into general practice should start at undergraduate level – or even in schools. We know that positive educational experiences in a GP setting, with good GP role models, are a clear factor in influencing career choices. Consequently, there is a need both to increase the number of GPs teaching in medical schools and to boost funding for primary care placements (through the undergraduate medical and dental component 'service increment for teaching' [SIFT] or other levies).

Medical schools ought to be held accountable for their success in encouraging applications in appropriate numbers into the various specialities. Consideration should be given to the question of financial incentives, so that schools are not rewarded for the failure to prioritise the need to attract more individuals into general practice. Similarly, league tables could be published to show how the different schools are performing in recruitment for under-subscribed specialties – such as general practice.

Locally and regionally, all medicals schools can collaborate with RCGP Faculties and the central Student Forum (run through RCGP Membership) to offer GP career events, recruitment advice and mentorship. RCGP groups of Associates in Training (i.e. GP registrars) and First5s (GPs in their first five years following qualification) are very well placed to assist in this, again at both a national and local level.

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[18] Centre for Workforce Intelligence, GP in-depth review: Preliminary findings, 2013

We welcome the proposal set out in the Shape of Training report for young doctors to undertake a generalist curriculum before making a final career choice. However, it is vital that these posts include general practice as a placement - both to offer an excellent breadth of clinical experience and to allow trainees to experience general practice as a career option.

In order to facilitate this, there is an urgent need to increase the capacity of postgraduate GP training and to recruit more GP trainers, particularly in areas of undersupply.

The RCGP has made the case for extended and enhanced four year training for GPs across the UK, to ensure that future GPs are equipped with the knowledge, skills and expertise they will need in the NHS of tomorrow. We believe that this will help to attract more medical students into general practice, not least as some young doctors are deterred by the complexity of general practice and want a longer training period to maximise confidence and competence. We urge NHS England to work with HEE, the Government and other stakeholders to ensure that four year postgraduate training is implemented without delay.

Retention & returners:

Given the challenges and timelines associated with recruiting and training sufficient GPs, it is critical that action is also taken to retain the existing workforce. Urgent investment is needed to provide ring-fenced funding for 'retainer' and 'return-to-practice' schemes, which should allow return from abroad, time out for health or family reasons, and breaks due to secondment to other sectors.

According to Health Education England, 20% of women who leave the GP workforce are under the age of 34.[19] Indeed, previous research suggests there is significant a pool of vocationally trained GPs that are not practising, who could be attracted to return to practice by more flexible working patterns and the availability of a re-entry courses. [20] There is therefore considerable potential for 'retainer' and 'return-to-practice' schemes to deliver a significant short-term boost in GP numbers.

As part of this, we suggest that there should be a fast track accreditation route to allow returners from aboard who have been working in equivalent settings (such as Australia) to return to general practice. There is also potential to use the appraisal and revalidation cycle to provide a structured and personalised route back into practice for returners.

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[19] BMJ Careers, GP workforce expansion efforts must begin at medical school, 10 October 2013

[20] Baker M, Williams J, Petchey R: GPs in principle but not in practice: a study of vocationally trained doctors not currently working as principals. British Medical Journal 1995, 310:1301–1304.

We are keen to engage further with NHS England, HEE and other stakeholders to develop a system that offers safe, effective and proportionate routes back into general practice for returners.

32. What are the strategic priorities for improvements in education and training to reflect the evolving role of general practice, the changing profile of the general practice workforce and the challenges facing the health service in the next ten years?

The future of general practice in the NHS will be built around the general practitioner's central role as a community-based, family-orientated, expert generalist clinician and as a coordinator and navigator of personalised, integrated healthcare. This role will be essential to improve health outcomes, reduce inequalities and to ensure the long-term sustainability of the health service.

GPs are well placed to take on an enhanced coordinating role within the teams delivering integrated healthcare services to local patients and families; they are used to working in community-based practices as part of a multidisciplinary team, which commonly includes nurses, healthcare assistants, receptionists, managers, and other staff. In the future, the community healthcare team will be expanded to include closer working with a range of other healthcare professionals, such as consultants and other specialists, health visitors, pharmacists, midwives, and social care workers. There is also scope for GPs to work across traditional organisational boundaries and to become more involved in work in hospital settings and in the pre-hospital care of acute medical cases.

GPs also provide a wide range of educational, leadership, management and academic roles in the NHS. They are increasingly responsible for local service re-design across the UK and, in England, for the commissioning of healthcare services. As more care shifts into the community, the wider NHS workforce will have to realign accordingly, and this workforce will include a greater number and diversity of trainees in community settings, including GP specialty trainees but also more undergraduate and postgraduate trainees from a range of disciplines and also more nurses and allied health professionals. This will require an expansion in the educational capacity of general practice and new approaches to how training and supervision is funded, planned and delivered.

Generalist training has historically been associated with a broad training experience early in training. Acquiring a breadth of clinical experience is an important component of generalist training, but is only a part of what is required to develop generalist competence and, beyond this, proficiency. A longitudinal development of generalist skills throughout a doctors' career

is of particular importance and this must be reflected in the design of future training and assessment programmes: to be effective, generalist clinical training must focus on themes of generalist expertise that are most relevant to the development of clinical competence and career-long flexibility. These themes must run throughout undergraduate and postgraduate training and be revisited and assessed over time, on each occasion being applied in broader and more sophisticated contexts of direct relevance to the doctor's developing role. This approach needs to start early, in medical school, and continue throughout the duration of the doctor's career.

The RCGP's educational case for a four-year integrated GP specialty training programme is based on this 'spiral' approach, where expertise in community-based generalism is built up incrementally over time. The trajectory of the spiral is intended to take the learner both higher in becoming progressively more expert and wider in being progressively more able to apply skills to wider contexts – the individual patient encounter, the team-based approach and ultimately the organisations and systems of care in which they work.

For the purposes of enhancing GP specialty training, the RCGP has identified five 'developmental themes' of key relevance to the development and assessment of generalist expertise. These themes will be represented within the curriculum and assessments and run as developmental 'threads' throughout each individual training programme, articulating conceptually with pre-programme competences (e.g. undergraduate, broad-based training, foundation) and post-licensing CPD and revalidation.

The five developmental themes are: expert medical care (e.g. first contact care, urgent care and common long-term conditions), whole person care (e.g. a holistic and person-centred approaches), complex care (e.g. multi-morbidity and comprehensive care), systems of care (e.g. quality improvement and patient safety) and relating to self and others (e.g. team-working and leadership). It would be possible to define other expert themes of relevance to generalist care and apply these to other programmes seeking to develop generalist skill – these five have been selected because of their importance in contemporary educational development and assessment of generalist competence.

Although separated for conceptual reasons, such themes would not be learnt or assessed as isolated entities but integrated as part of a developmental progression. The educational purpose of the themes is to clarify, illustrate and promote areas of professional generalist expertise that require particular focus in training as these will be critical to ensuring that tomorrow's doctors are prepared for the future NHS.

We would therefore propose that the developmental spiral approach we have developed for community-based generalist training, such as the theme-based model described here, might also serve as useful models for future undergraduate and postgraduate training more broadly. With this approach, there is potential for generalist training to be expanded to meet the training needs of not only community-based generalist practitioners but the greater numbers of doctors that will perform generalist roles within a wide range of hospital-based disciplines.

It is important to recognise that specialists working in the community will need a different skill set from that most commonly used in hospital, and that training will be required to provide this.

Enhanced and extended general practice training (summary):

The RCGP's proposals for a four-year integrated GP specialty training programme are set out in the attached document (*Enhanced GP Specialty Training - Summary of the integrated four-year curriculum, assessment and quality improvement training programme for General Practice*). In summary, the educational case proposes that future GPs should complete an enhanced four-year programme of GP training, where they would:

- Spend at least 24 months in primary care
- Receive specialist-led training opportunities in child health and mental health
- Gain experience of general practice early in their training programme to maximise the effectiveness of subsequent hospital-based training placements
- Undertake more integrated training placements in a range of relevant multi-disciplinary settings, to encourage multi-professional working and facilitate service integration
- Demonstrate leadership and service improvement skills through undertaking a practical quality improvement project, based on local service need, in the fourth training year
- Become better prepared to enter a career of independent practice through the alignment of final-year training assessment with NHS appraisal and revalidation requirements.

33. What developments would help provide more structured careers for GPs, practice nurses and other primary care practitioners?

The development of larger, networked or federated organisations of practices (please see also question 29) will allow more structured career development for employees and the opportunity for employees to be involved in a wider range of clinical and community services.

Career development should not, however, be limited to employees of larger or networked practices. Funding should be made available for practitioners to undertake training and sabbaticals at regular intervals throughout their careers, with funds following areas of need for the NHS – for example, to develop commissioning, education and quality improvement leads.

Future GP workforce planning should factor in career development needs, in order to allow capacity for training breaks and sabbaticals, and for GPs to take on management, education, commissioning and leadership roles alongside clinical work.

34. What factors are likely to promote and support good employment practice, e.g. practices providing training and development opportunities for practice nurses and practice managers?

We are concerned that there are currently no statutory national training standards for general practice nurses (GPNs); as a result, the RCGP has developed guidance on nursing standards and a competency framework for practice nurses, which are intended to be used as a benchmark by employers, GPNs, commissioning groups and primary care organisations.

We would urge NHS England to work with stakeholders - including the RCGP - to improve practice nurse training and development, through the development of national standards and establishment of mechanisms to promote greater consistency of educational provision. This needs to be supported by resources for staff training and CPD.

With regard to practice managers, funding should be made available to support the training needs of practice managers and recognised training packages should be developed to make practice management a structured career choice (please see also question 12 above).

Specific issues and questions

35. How do we ensure that people with more complex health and care needs have a named clinician with responsibility for coordinating their care? Should people with more complex needs have a named GP with responsibility for overseeing their care?

In principle we support the proposal to introduce a named accountable clinician for patients with complex needs, and recognise that GPs would be best placed to act as that named clinician. However, there is a lack of understanding over how the introduction of a named accountable clinician would differ from the current system in operation within GP surgeries. In addition, the way in which the named clinician will be held accountable and for what is not clear.

Already, when patients register with a practice they are nominally allocated to an individual GP for administrative purposes. Although patients may see a number of different GPs within a particular practice, when booking appointments, most practices will ask patients who their usual or preferred doctor is.

While GPs may be the best placed clinician to hold responsibility for patients with complex needs, their ability to ensure this will need to be underpinned by the practical systems and clinical time required to enable the effective co-ordination of care. It is therefore vital that this policy is underpinned by the provision of additional resources to enable GPs to deliver care co-ordination for the growing number of patients who need it.

In addition, there is a need to distinguish between proactive care planning and responsibility for responding to unscheduled care needs, including out of hours. While a named clinician may be able to take on responsibility for the former, it is unrealistic to expect a single person to be continuously available to deal with the latter, particularly given the growing number of GPs who work on a part-time basis.

The 2011 report of the independent commission on medical generalism, commissioned by the RCGP and the Health Foundation, concluded that "there is a clear conflict between the importance of access to medical advice and care 24 hours a day, and patients' preference for continuity of that care and advice". It stated that "it may be impractical to wish for a return to GPs' personal patient lists, as opposed to practice or group lists, and to round-the-clock access to 'your' doctor. But there is a clear case for taking steps to restore a discipline of continuity of responsibility for registered patients, seven days a week, on the part of a named team".[21]

One possible model for achieving this is the development of multi-disciplinary micro teams. These provide continuity of care to identified groups of patients such as those at the end of

[21] Independent Commission for the Royal College of General Practitioners and the Health Foundation, Guiding Patients Through Complexity: Modern Medical Generalism, 2011

life, and can involve a range of mechanisms such as buddying, job sharing, and organized handover systems.

The lack of joined up IT systems and shared patient records is likely to pose a significant barrier to the effective information sharing that would be necessary to truly realise the benefits of the named clinician proposals.[22] In addition, in order to make the concept of a named clinician effective, there will be a need for providers of secondary care to improve the way in which they communicate with surgeries concerning patients. At present, secondary care providers follow a variety of different procedures when selecting which GP to communicate with concerning a patient on a practice's list. If there is to be a named accountable clinician, it will be important to ensure that in future, they are copied into all correspondence concerning those patients for whom they have responsibility.

36. How can we strengthen general practice accountability for the quality of out-of-hours services provided to patients and ensure that OOH services are more integrated both with daytime general practice and with wider urgent care services?

Consideration of the role and design of out of hours GP services should be underpinned by the following principles:

- Patients should be able to gain timely access to the skills of an expert medical generalist when they need it, including outside core surgery hours.
- Proposals to develop out of hours GP services must be developed in the context of how they fit into the whole health and social care system, working with local councils, emergency departments and mental health services to deliver integrated, person centred care.
- Services should be designed to maximise continuity of care, with systems and processes in place to facilitate the appropriate sharing of patient information and ensure smooth and timely handover of care.
- There should be no 'one size fits all' model for the provision of out of hours services. Providers and commissioners must have the ability to develop models to reflect the context for service delivery and the needs and priorities of their populations.

[22] RCGP, General Practice and the Integration of Care, 2012

- Out of hours services must be adequately resourced. Proposals to enhance out of hours services must not come at the detriment of the ability of general practice to provide patient access in-hours.

- The quality and safety of care are paramount and all service delivery models must ensure that working patterns are safe and sustainable.

The existence of multiple services may confuse an already fragmented system. Therefore, when undertaking the design of out of hours services consideration should be given to the objectives they are intended to achieve, and how they will relate to other services within the local area. For example, there is a risk that the development of services such as walk in centres and minor injury units may lead to the emergence of new supply-induced demand, without necessarily leading to a reduction in pressures elsewhere in the healthcare system.

A key issue is what support is required from general practice during the out of hours period to support clinical decision making and the transfer of care between different parts of the healthcare system. Eighty per cent of discharges from hospital care can be classified as simple discharges, in which patients can be discharged to their own home and have simple ongoing health care needs.[23] For complex patients, it should be possible to undertake advanced planning during weekday working hours to support discharge and ensure that appropriate support is put in place, whilst if an urgent need arises for the opinion of a GP due to an unexpected deterioration in a patient's condition, it should be possible to provide this through the local out of hours GP services. In a small number of cases, it may be advantageous to be able to have out of hours input from a clinician in the patient's own practice who knows them well; however, further work is required to assess the extent and nature of the circumstances in which this might apply.

37. How do we stimulate more convenient routine access to general practice services, including ease of making appointments, speed of contact for urgent problems (whether telephone or face-to-face), ability to book less urgent appointments in advance, ability to communicate electronically (e.g. online consultations) and, particularly for working-age adults, availability of evening/weekend slots?

It is important to start by noting that patient satisfaction with access to general practice services is generally high. The 2012/13 GP Patient Survey shows that around 50% of people making a face to face appointment were able to see or speak to someone on the same day

[23] Department of Health, Achieving timely "simple" discharge from hospital: a toolkit for the multidisciplinary team, 2005

or the next day and 93% of patients said that the appointment they were offered was convenient.[24] Meanwhile, recent studies report that access to out of hours care in the UK is among the best in the world.[25]

Nevertheless, whilst satisfaction with access to general practice remains high, patient expectations are rising, particularly amongst some sections of the population (such as working-age adults). At the same time, it is becoming increasingly difficult for many practices to provide rapid access to appointments, due to the pressures of rising demand from a population with many more long-term conditions, year on year funding reductions and an overstretched general practice workforce.

In order to meet the twin challenges of offering improved access while meeting the rising demands of the frail elderly and those with long-term conditions, there is an urgent need to reverse recent real terms funding cuts for general practice. A modest increase in the proportion of the NHS budget spent on general practice would allow practices to extend their opening hours, expand their workforce, ensure that their premises are fit for purpose, and make better use of technology. At the same time, we need to see a significant and sustained increase in the capacity of the GP and wider general practice workforce (see also our comments on 'Workforce').

In addition, practices will need support to maximise the appropriate use of technologies – such as phone, internet, apps and email - to improve access and convenience for patients. Measures may include: a combination of face-to-face, telephone and online consultations; online access to appointments and health records; and models of telephone triage that facilitate self-care where appropriate. Many practices are already making use of such technologies to improve access. However, these is a need to carry out further research to develop best practice models, and to share learning across the country.

Finally, it is important to be aware that the needs of working age adults are often very different from those of frail older people and/or those with long-term conditions. For the latter, continuity of care (seeing the same doctor) and longer consultation times are likely to be of greater importance than access to evening/weekend appointments.

38. How do we stimulate general practice responsiveness to access preferences of their populations?

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[24] GP Patient Survey 2012/13

[25] The Commonwealth Fund 2013 International Health Policy Survey in Eleven Countries , Slide 13

As mentioned above (question 37), the needs of some sections of the practice population, such as working age adults, will usually differ significantly from those of other patient groups, such as people suffering from multiple long-term conditions. Similarly, the needs of practice populations vary across the country (for example, according to deprivation or location [rural or urban]). It is therefore important to avoid a 'one size fits all' approach to access and allow flexibility according to local needs.

We would suggest that the GP Patient Survey provides a useful starting point for practices to understand the needs of their populations. Practices should be encouraged to supplement this with systematic feedback from their population – for example through local patient participation groups. There may also be a role for the CCG to take a lead in exploring local preferences around access and working with practices to respond to this.

39. How far should there be a shift of resources from acute to out-of-hospital care? How far should this flow into general practice and how far into wider community services?

As we mention above (question 22), there is a growing consensus that in order to meet the needs of an increasing and ageing population in a time of financial constraint, the NHS must deliver care closer to people's homes and focus more on preventing ill health rather than simply treating it.

We know that patients with chronic conditions are already the main users of health care – in England the 30% of people who have one or more long-term condition account for £7 out of every £10 spent on health and care[26], with costs rising almost exponentially with the number of chronic disorders that an individual has[27]. Meanwhile, the number of people across the UK with three or more long-term conditions is predicted to rise significantly over coming years – in England, from 1.9 million in 2008 to 2.9 million in 2018.[28]

Managing demand, particularly among people with multiple long-term conditions, will be critical to addressing the funding pressures that the NHS is facing.[29] There is mounting evidence that, in order for the NHS to meet the twin challenges of rising demand and

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[26] NHS England, The NHS belongs to the people – a call to action, 2013
[27] Lehnert T, Heider D, Leicht H, et al. Review: health care utilization and costs of elderly persons with multiple chronic conditions. Med Care Res Rev 2011; 68: 387–420.
[28] Department of Health (2012), Long-term conditions compendium of Information: 3rd edition
[29] Roberts A, Marshall L, Charlesworth A, A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22,, Nuffield Trust, 2012

reduced resources, it will be critical to invest in good primary care, which not only delivers better health outcomes but also lower overall healthcare costs.[30] [31]

General practice is the cornerstone of the NHS – dealing with 90% of patient contacts in our health service.[32] High quality, well-led general practice leads to better and more cost-effective patient care across the NHS – with higher numbers of GPs per head of the population associated with lower death rates in hospitals.[33] GPs' skills as 'expert generalists' mean they are uniquely placed to deal with some of the most difficult challenges facing the NHS, such as the rising number of people living with multiple long term conditions. But the potential for general practice to tackle such problems, and lead the development of services that better meet the needs of patients, is being undermined by consistent underinvestment in general practice services.

Indeed, the share of overall NHS spending that goes towards patient care in general practice in England has fallen from 10.6% in 2004/05 to 8.5% in 2011/12.[34] Meanwhile, spending on hospital care in England has increased at a much faster rate than primary care in recent years: in real terms, PCT spending on primary care rose by 22 per cent between 2003/04 and 2011/12, while spending on secondary care jumped 40.1 per cent over the same period.[35]

Closely correlated to the issue of investment in general practice is that of workforce capacity. The Centre for Workforce Intelligence (CfWI) has concluded that the existing GP workforce in England has insufficient capacity to meet current and expected patient needs.[36] Yet despite steadily rising demand for GPs, the GP workforce has continued to grow more slowly over the past decade than other areas of the health service, resulting in a shift in the medical workforce away from general practice and into secondary care. Indeed, the CfWI has predicted that, if current workforce trajectories persist, there will be an over-supply of fully

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[30] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005; 83: 457– 502

[31] WHO, The World Health Report 2008: primary healthcare, now more than ever. Geneva, Switzerland: World Health Organization, 2008.

[32] The King's Fund, General practice in England: An overview, September 2009

[33] Jarman B, Gault S, Alves B, et al. Explaining differences in English hospital death rates using routinely collected data, British Medical Journal 1999; 318(7197): 1515–20

[34] RCGP press release, 15 November 2013

[35] Jones N, Charlesworth A, The anatomy of health spending 2011-12, Nuffield Trust, 2013

[36] Centre for Workforce Intelligence, GP in-depth review: Preliminary findings, 2013

trained hospital doctors in England, and by 2020 consultants' salaries (if all eligible doctors become consultants) will increase by over 50% from £3.8 billion to £6 billion.[37]

In order to put the NHS on a sustainable financial footing and deliver high quality care to our growing, ageing population, NHS England should take immediate action to increase the share of the NHS budget that is invested in community and primary care, with a significant share of this investment allocated to general practice.

The RCGP is calling for an increase in the share of funding that goes into general practice in England from 8.5% to 11% of the NHS budget by 2017. This will transform care for patients and benefit the NHS as a whole by alleviating pressure on our hospitals and providing cost effective care closer to home.

This investment needs to be matched by a whole-system approach to moving care out of hospital and reducing unnecessary referrals to secondary care. As we mention above (question 15), payment systems need to be reformed to remove activity-based payments for hospital services and to introduce incentives to encourage acute providers to move more services into primary care and the community. Meanwhile, it is important that savings made from reducing hospital admissions through effective community and primary care are reinvested in the community, and are not simply diverted back into secondary care.

The RCGP welcomes the opportunity to respond to this consultation and looks forward to further dialogue with NHS England on this subject.

Please do not hesitate to contact me if you have any questions about our response.

Yours faithfully,

Professor Nigel Mathers MD PhD FRCGP DCH Dip Ed

Honorary Secretary of Council

[37] Centre for Workforce Intelligence, Shape of the medical workforce: starting the debate on the future consultant workforce, 2012