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Executive summary

In April 2016, the RCGP welcomed NHS England’s announcement of the GP Forward View: a significant, detailed set of commitments to support general practice over the following five years. The headline pledges include increasing recurrent investment in general practice by £2.4bn by 2020/21 and to expand the general practice workforce by 5,000 full-time equivalent (FTE) doctors and 5,000 other staff in the same period. Alongside these, there are scores of further promises touching all areas of general practice. The potential impact is huge.

However, the impact is dependent on implementation, so the College committed to publishing an assessment of the progress of the GP Forward View every year. This document represents our assessment of the first year of the programme.

It is important to recognise there have been some very significant steps. Hundreds of millions of pounds of additional investment went into general practice in 2016/17, signifying that the commitment to spend an additional recurrent £2.4bn on general practice by 2020/21 is on track. This is one of the most fundamental commitments of the GP Forward View and the money will make a big difference to GPs, their teams and their patients. The number of schemes and initiatives that have been started are also demonstrative of the commitment of NHS England to taking action. Initiatives such as the new GP Health Service and the improved Induction and Refresher Scheme are already delivering excellent results.

It is also still relatively early. Some commitments have not yet started; others are in the process of being implemented but will not be felt until more time has elapsed. The first year has given GP Forward View stakeholders the opportunity to learn, which means some of these programmes can be enhanced or improved to deliver the most benefit possible. NHS England have shown a willingness to engage, learn and improve.

Nonetheless, general practice is under serious pressure right now. GPs and their teams need to receive appropriate support to offer the best service to their patients. They also need to be invested in the future of general practice and believe that this situation will improve soon. When they see programmes implemented poorly or slow progress on key pledges, they are in danger of losing trust.

There are therefore some serious areas for concern, alongside areas of good progress. The main problem lies in the number of doctors in general practice, which shows no sign of increasing. This is despite new initiatives in this area, and commitment and effort from the stakeholders involved. This should be the absolute priority for all parties working on recruitment and retention, as clearly it is one of the most difficult challenges facing general practice.

There are warning signs around the implementation of some other schemes. In some areas, such as finding a long-term solution to soaring medical indemnity costs, progress has been too slow. In other cases, while NHS England have met, or are on track to meet, a commitment, the perception amongst frontline doctors is that it is not enough to make the necessary difference. Our research suggests a gap between what some initiatives are setting out to deliver and GPs’ views on what is needed.

By identifying areas of concern at this early point, the RCGP hopes to work with NHS England and other partners to improve implementation, engage with the profession, and make changes to programmes where required. The RCGP is committed to playing its full part in this process, to ensure the benefits of the GP Forward View are realised.

Below is a summary of progress on the key commitments of the GP Forward View.
# Key commitments

## Investment

<table>
<thead>
<tr>
<th><strong>Invest a further £2.4bn a year in general practice by 2020/21.</strong> An additional £322m in primary care allocations in 2016/17.</th>
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<tbody>
<tr>
<td>NHS England are confident that the allocations for 2016/17 were made, and will be able to confirm this when figures are published in September. This would mean that recurrent investment is on track to be increased by £2.4bn by 2020/21.</td>
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<tr>
<th><strong>A sustainability and transformation package for general practice of £500m over five years.</strong></th>
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<tr>
<td>Although individual elements of this package have clearly been spent, confirmation on how much overall in the first year will come in September 2017.</td>
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<tr>
<th><strong>Proposals for reducing the costs of indemnity.</strong></th>
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<tr>
<td>Numerous short-term solutions have covered rises in indemnity costs and supported winter out-of-hours work. The Government have promised GPs that they will not feel the effects of the change in the discount rate, although confirmation is still awaited on how this protection will work. Furthermore, there have been no proposals for long-term solutions. The discount rate change has highlighted how pressing this issue is.</td>
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<tr>
<th><strong>A practice resilience programme worth £40m, with £16m assigned to the first year.</strong></th>
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<tr>
<td>After a slow start, £17.2m was invested in 2016/17, which is more than was originally promised for the year and shows how NHS England engaged with the College’s concerns about underspending. However, some members have raised issues with the support offered in their areas.</td>
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## Workforce

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<tr>
<th><strong>An additional 5,000 doctors working in general practice by 2020/21.</strong></th>
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<tr>
<td>If anything, there has been a decrease, which puts significant strain on general practice and the overall delivery of the <em>GP Forward View</em>.</td>
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<th><strong>Increase GP training recruitment to 3,250 a year.</strong></th>
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<td>In 2016/17, recruitment was increased by over 400 from the year before to 2,927 after round 2. Indications currently suggest recruitment is higher this year and it should be possible to reach the target.</td>
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<tr>
<td>Measures to improve the experience of returning to work.</td>
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<td>----------------------------------------------------------</td>
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<tr>
<td>Numerous positive changes have been made that have led to an increase of doctors on the Induction and Refresher Scheme. There are additional opportunities to improve the scheme further.</td>
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<tr>
<th>A new retainer scheme more fit for purpose by April 2017.</th>
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<tr>
<td>The new scheme is in place, though it is too early to assess its impact.</td>
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<th>An additional 5,000 other staff in general practice by 2020/21.</th>
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<tr>
<td>There was an increase of 2,896 FTE practice staff between September 2015 and September 2016, so this is doing very well.</td>
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<tr>
<th>Investment of £15m in general practice nurse development.</th>
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<td>There has not been any spending to date but a plan with spending proposals is promised during 2017/18.</td>
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<tr>
<th>An additional 1,500 pharmacists in general practice.</th>
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<tr>
<td>The target date for completion of this commitment has been shortened to the next three years (2019/20), reflecting good progress on the pilot scheme and its subsequent roll-out.</td>
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<tr>
<th>An additional 3,000 mental health therapists in general practice.</th>
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<td>More specific targets have been set, with 800 mental health therapists expected in post by March 2018.</td>
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<th>1,000 physician associates working in general practice.</th>
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<tr>
<td>The institutions offering the physician associate programme have expanded their intake from 2016. HEE believes this will enable the achievement of the goal of 1,000 physician associates in general practice.</td>
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<tr>
<th>A specialist mental health service for GPs suffering from stress and burnout.</th>
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<tr>
<td>This was launched in January 2017. There has been high demand for its services and feedback has been positive.</td>
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### Workload

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<thead>
<tr>
<th>Task</th>
<th>Details</th>
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<tbody>
<tr>
<td>Invest £30m in a development programme to help release capacity within general practice.</td>
<td>NHS England have provisionally stated that £8m was invested in 2016/17. To date 90 groups of practices have engaged, and 2,486 people have taken part in Time for Care workshops.</td>
</tr>
<tr>
<td>New contract measures to improve the interface between primary and secondary care.</td>
<td>Changes have been made to the NHS Standard Contract, but at this early point very few GPs have noticed a difference and it is unclear if these standards are being uniformly implemented by NHS Trusts.</td>
</tr>
<tr>
<td>Move to maximum interval of five yearly Care Quality Commission (CQC) inspections for good and outstanding practices.</td>
<td>This was committed to in the CQC's strategy for 2016-2021.</td>
</tr>
<tr>
<td>CQC will consult on changes to its regulatory model with the aim of reducing the regulatory burden for practices that deliver good or outstanding care.</td>
<td>A consultation is currently underway, with the window for responding closing on 8 August 2017. Many of the individual proposals look sensible but it is unclear whether they are sufficient to have a large impact on practices.</td>
</tr>
<tr>
<td>Launch a national programme to help practices support people living with long term conditions to self-care.</td>
<td>A pilot scheme has been launched across 50 sites.</td>
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## Practice infrastructure

<table>
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<th>£900m of capital investment in general practice by 2020/21.</th>
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<tr>
<td>Almost 200 projects were completed through the Estates and Technology Transformation Fund in 2016/17, but there is evidence of substantial difficulty receiving capital support in some cases and poor communication with applicants.</td>
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<tr>
<th>New rules on premises costs to enable NHS England to fund up to 100% of the costs for premises developments.</th>
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<tr>
<td>These changes have been delayed, causing problems and uncertainty for GPs.</td>
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<tr>
<th>Support for other costs such as Stamp Duty Land Tax and VAT for practices who are tenants of NHS Property Services and Community Health Partnerships.</th>
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<tr>
<td>This support is being offered, although take-up has been low so far. Work is being undertaken to understand barriers.</td>
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<tr>
<th>An 18% increase in allocations to Clinical Commissioning Groups (CCGs) for the provision of IT services in 2016/17.</th>
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<tbody>
<tr>
<td>These allocations were made to CCGs; it is currently unclear whether CCGs have fully invested the money in GP IT but will become clearer in September when investment figures are published by NHS Digital.</td>
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<th>Wi-Fi services in GP practices for staff and patients from April 2017.</th>
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<tr>
<td>The number of practices with free Wi-Fi has been increasing; all practices should have this by the end of the year, which is an excellent result.</td>
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<th>A £45m national programme to stimulate uptake of online consultation systems for every practice.</th>
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<tr>
<td>There is £15m to be invested in 2017/18, though the guidance and funding has not been released in all areas.</td>
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Care redesign

Additional recurrent funding of £500m by 2020/21 provided to enable CCGs to commission and fund extra capacity across England to improve access to general practice.

Funding will be available to some CCGs from 2017/18 and all from April 2019, although there is not enough evidence that CCGs are establishing the level of local demand for extended access.

CCGs to provide £171m of practice transformational support.

Although most CCG plans make provision for this spending, there are some plans yet to be fully assured.

Go live with a Multispecialty Community Provider (MCP) contract in April 2017.

A draft contract was published in December 2016. Publication of the version for use in 2017/18 was delayed due to the General Election, but is expected to be available soon. This revised version is usable for accountable care models generally.

Conclusion and recommendations

Despite the beginnings of some promising programmes such as the GP Health Service and good starts in areas such as overall investment, progress is still too patchy and several commitments are not yet being delivered. There has been progress on several schemes to increase the GP workforce, yet numbers are no better than the year before the GP Forward View. Some schemes are failing to have impact because they are not being implemented or communicated well enough. If this continues, there is a risk that more GPs will lose faith in the GP Forward View.

Throughout this document, the RCGP offers specific recommendations relating to the progress of individual commitments. While there are many of them, the recommendations can be considered under six categories:

Rethink

- In some areas NHS England must review their current strategy to ensure that pledges are delivered. This is particularly important for the delivery of 5,000 additional FTE GPs.

Improve

- In many areas NHS England is making progress but must take steps to ensure that the delivery of pledges is bringing meaningful benefit to practices, GPs, and patients.

Deliver

- It is not clear in some cases that funding is being delivered locally, with CCGs and NHS England local teams sometimes acting as barriers to delivery.

Communicate

- Where pledges are being delivered, NHS England must ensure that opportunities are effectively communicated to practices to make sure all GPs and practices who can, benefit.

Expand

- Some programmes which are already being delivered should be expanded.

Continue

- In some areas, we are calling for current work to continue.

The RCGP will be working to pursue and support strong implementation of the GP Forward View, and will continue its programme of monitoring and evaluation.
Introduction

It has been just over a year since the *GP Forward View* was published in April 2016. This was a landmark moment for general practice in England, with promises to invest an additional £2.4bn per year in general practice and increase its workforce by 5,000 doctors and 5,000 other members of staff by 2020/21. If the ambition of the document is realised, general practice will receive meaningful support and the crisis it has been facing may be substantially averted.

The RCGP supported the programme but in doing so promised to closely monitor the implementation of the *GP Forward View*, to ensure the benefits it promises are being seen by GPs and their patients. The College sits on working groups for *GP Forward View* workstreams as well as the Oversight Advisory Group, ensuring the views and experiences of GPs are heard as the plans progress. This report details our analysis of the status of the commitments made in the *GP Forward View* following the first year of implementation.

We published an interim assessment of the *GP Forward View* in January 2017, focusing on the commitments relating specifically to the first year, to ensure any areas of concern were highlighted in time for action to be taken. An update on the short-term commitments is integrated throughout the report alongside medium- and long-term commitments. A summary review of the commitments covered in the interim assessment can be found in Appendix A.

To support our analysis, we partnered with a research agency to survey our members in February 2017. Half (50%) indicated that they believed it to be unlikely that the *GP Forward View* will make a positive difference to general practice in England. This is a significant increase from the 39% who believed this in August 2016, only a few months after the launch. There are some understandable reasons this might be the case, including long lead times on some commitments, time needed for others to have a tangible impact, and the seasonal strain that leads winter to be a more difficult time for general practice. Nonetheless, this assessment is an opportunity to ask difficult questions about the progress of the *GP Forward View*, and highlight areas where things should be working better or that need urgent rethinking.

Overall, this project aims to contribute to a better future for GPs and their patients. The *GP Forward View* has admirable aims and the RCGP is making sure these are seen through.

Sources of information

We have based our analysis of the commitments on numerous sources:

- Publicly available data, including figures from NHS Digital and CCGs.
- Information and feedback from NHS England, Health Education England (HEE), the CQC and the British Medical Association (BMA).
- An online and telephone tracking survey among RCGP members.*
- Feedback on schemes from members in response to questions distributed through our Chair’s blog.
- In-depth telephone interviews with GPs and practice managers, conducted with those who had experience of applying for or receiving support from the *GP Forward View*.
- Reports from the RCGP regional ambassadors, who are frontline GPs working in STP footprints.

* Run by Ipsos MORI. Wave 1 was in field 1 August – 7 September 2016 (n=1,288) and the second wave was in field 27 January – 3 March 2017 (n=1,250). Results were weighted by age, gender and region to be representative of GPs working in England. Throughout this document, wave 1 will be referred to as the August survey and wave 2 will be referred to as the February survey.
Investment

Introduction

In the decade before the GP Forward View, investment in general practice as a proportion of health spend was either sinking or stagnating, leaving a vital part of the health service underfunded and struggling.

The GP Forward View’s commitments to significantly increase investment in general practice are therefore critical. It not only promises money for specific programmes to support general practice, but crucially pledges an uplift in recurrent funding.

One year on, there are promising signs that these commitments are being upheld. While delivery of funding needs improvement in some areas, and it may take some time for the effects of investment to be felt, progress is being made to ensure general practice is funded fairly.

Key investment commitments in the GP Forward View

- Invest a further £2.4bn a year in general practice by 2020/21.
- An additional £322m in primary care allocations in 2016/17.
- A sustainability and transformation package for general practice of £500m over five years.
- Proposals for reducing the costs of indemnity.
- A practice resilience programme worth £40m, with £16m assigned to the first year.

Total funding for general practice

The GP Forward View commits to invest a further £2.4bn in general practice in recurrent funding by 2020/21, compared with 2015/16. Within the GP Forward View, it is claimed this will result in general practice receiving at least 10% of the NHS budget. The RCGP’s financial analysis indicates that commitments in the GP Forward View will mean general practice receives between 10.2% and 10.6% of the health budget in England in 2021/22.1

This ongoing commitment was supported by a specific pledge to allocate an additional £322m in primary care allocations in 2016/17. Although total spend on general practice in 2016/17 will only be confirmed by audited figures released by NHS Digital later this year, NHS England are confident that these allocations were made: a promising start.

However, it may take a while before extra investment is felt after such a sustained period of underfunding. In the RCGP’s February survey, 57% of our members indicated that they think it is financially unsustainable to run a general practice (although those who knew a lot about the GP Forward View were more likely to think it was sustainable, with 39% of them thinking this compared with 34% of all respondents).

Nine in ten (88%) of those who thought it was unsustainable selected insufficient core funding as a key reason. About half the respondents thought there was less funding available centrally (49%) and locally (48%) than a year ago, while 83% thought the funding available from all sources was inadequate. Clearly investment in general practice needs to continue increasing.

Despite this, there does appear to have been a small shift in feelings about general practice funding. When members who were most pessimistic about the future of general practice were asked why, 34% cited poor funding or budget cuts, a significant decrease from 45% six months before. Similarly, 12% cited lack of or insufficient resources, decreasing from 16% in the same period. These figures remain a cause for concern but might be indicative of initial improvements that will hopefully increase as the GP Forward View continues to be implemented.

One concern that has been raised several times with the College is the feeling that money comes through lots of different schemes, rather than the core contract. This can be more arduous, as access depends on going through numerous application processes; it also means that sometimes money is specifically linked to delivering something additional rather than supporting practices as they are.
Other members have also raised concerns about the GP Forward View focusing on money going through discrete schemes or funds linked to the provision of additional services. While there is also money from the GP Forward View that goes through the contract, increases should be communicated more clearly.

Investment through CCGs

The RCGP reviewed the spending of the 114 CCGs that have delegated commissioning powers. Based on their projections as of the end of May 2017, they were forecasting a net general practice commissioning underspend of £47m in 2016/17.

NHS England believes the allocations commitment has been met, with investment elsewhere in the system making up for any CCG underspend over the last financial year. For example, £30m of indemnity relief for rises in 2016/17 went through in that financial year, rather than early in 2017/18 as originally planned. However, as more CCGs take on delegated commissioning responsibilities, it is crucial that they budget for and go on to deliver increased investment in general practice.

CCGs are also required to provide £171m over 2017/18 and 2018/19 in practice transformational support. This spend should be outlined in their plans for general practice. Currently, most CCGs have made the appropriate provision, but some plans are not fully assured at this point. NHS England say they are monitoring this closely. It is important this money is identified and that CCGs invest in general practice and transformation.

Indemnity

The cost of indemnity has been increasing dramatically for GPs. In our most recent survey, of the 57% of members who said running a general practice was unsustainable, professional indemnity costs were the second most commonly cited reason for thinking this, selected by 81%.*

The GP Forward View committed to acting on indemnity and since its publication there have been several positive steps taken:

- NHS England announced that it would offset the rising cost of GP indemnity. In March and April 2017, £30m was distributed to practices relating to rises in 2016/17, and a similar process will be undertaken by April 2018 for rises in 2017/18. In addition, £33m was distributed through the contract in 2016/17 to offset indemnity increases in 2015/16.

- NHS England announced the extension of the winter indemnity scheme for out of hours work in 2016/17, which was open from October to April and was worth £5m. This was an increase on 2015/16, when the scheme was shorter and worth £2m. NHS England have reported there was good uptake on this scheme, which meant there was more investment than the initially planned £5m. When we asked our members, 8% had received funding from the winter indemnity scheme, one of the highest levels of uptake we recorded for a scheme running under the GP Forward View. However, 42% were not aware of it, which suggests that with wider communication, even higher uptake could be achieved.

- The Department of Health has run a consultation on capping the level of recoverable costs on clinical negligence claims.² This consultation was a commitment in the GP Forward View and the College has responded to it positively. The results are currently being analysed, with a response expected later in the summer.

Although it is excellent to have some short-term support for GPs from NHS England, it is less clear whether much progress has been made in finding and implementing long-term solutions. The RCGP is disappointed at the lack of visible movement in this area, with no public consultation on potential options. It is vital that this advances soon, to reassure GPs that they will not continue to face the unpredictable and punishing burden of indemnity costs. As soon as there are options to consider, GPs should be consulted on these.

* The most commonly selected reason was insufficient core funding, chosen by 88%.
At this point, this is a matter that requires action from the Government, who must seriously engage with the building pressure indemnity costs are placing on GPs.

**Changes to the discount rate**

The Lord Chancellor announced a change to the discount rate to come into effect in March 2017. The impact of this will be to significantly increase awards to successful claimants, with the MDU (a medical defence organisation) giving an example of a case where the settlement would increase by 108%, from £8.4m to £17.5m, purely because of this change.³ It is therefore likely that this will lead to further increases in indemnity costs. The Government has given assurances that GPs will be protected from these increases. Although this demonstrates an understanding of the problem and goodwill, it is disappointing that there has been no further indication of how these costs will be covered, leaving GPs in an uncertain position. There needs to be clarity soon on how this will be done, as increases may start imminently. This is an opportunity for Government to engage with serious long-term solutions to the issue of indemnity costs, as it is clearer than ever that the rises are unsustainable for GPs.

**Resilience funding**

The **GP Forward View** committed to a £40m practice resilience programme running over four years, with £16m to be spent in 2016/17. In the College’s interim assessment, we reported that by the end of 2016, although £15.9m was committed, only £2.5m had been spent. Similarly, it was disappointing to report that only £6m of the £10m vulnerable practices funding, identified originally in December 2015, had been spent by the end of January 2017.

By the end of the financial year, the situation had been turned around, with £17.2m spent on resilience funding, £1.2m over the amount originally planned. In addition, £10.2m of the vulnerable practices funding had been spent. The College is pleased that our concerns were acknowledged and the importance of making these investments was recognised. It is excellent that additional money has gone towards supporting practices.

However, three in ten (29%) GPs in our most recent survey were unaware of the scheme. Therefore, as well as recommending the continuation of this scheme, we believe it is important to ensure practices are clear about the existence of support and how to access it. There may also be a need to expand it, given the programme funds reduce to £8m in 2017/18, despite the clear demand.

**Case study**

**Resilience funding**

The RCGP talked to a GP partner and practice manager from the East of England who had received support as part of the practice resilience programme, which they felt had not been satisfactory.

The practice originally applied for some support related to a planned project and renegotiation of their lease. They also made a joint application with the two other local practices to get a care coordinator. These applications were all refused but the three practices were offered a diagnostic review, which cost £10,800 per practice. The practice had previously refused the offer of a diagnostic review as part of the vulnerable practices funding, but now felt they would not get any further funding without partaking, so agreed.

The practice was under huge time pressure, as they were notified of this at the end of February with the instruction to have the review completed by the end of March.

For the review, a management consultancy proposed by the CCG met the practice manager twice (although not the GP partners, who had made themselves available), then delivered a report that was only 10 pages long. From the practice manager’s perspective, this primarily repeated her own words back to her. The recommendation that stood out was for the three practices to merge.

The GP felt the merger had been the plan for the diagnostic review all along. She said, “The remit is to get all…practices into practices of 30,000 patients or more in the next two years. So they’ve basically said to us if the practice fails they’re not going to rescue us. We’ll be allowed to fail so that the patients will have to be absorbed by the other practices in order to make everyone merge. But in [this town] we’re only 22,000 so even if all three practices merged we’d still need to merge with some other practice as well.”

She also felt that merging would not be the best outcome for the town’s patients: “The practices do have different flavours and emphases. The patients move around between them and have the option at the moment of choosing what sort of general practice they want.”

Aside from the recommendation to merge, the other recommendations included implementing a care coordinator, which was one of the original reasons for requesting funding.
Meanwhile, there are clearly more practices that need help. One GP in the South West told us:

“The reaction all along has been you’re doing ok, you’re coping, so even though we know that you’re financially very vulnerable, we can’t give you the support that other practices need because they are having to close because they don’t have GPs in place... we get penalised for actually coping, I think.”

Other funding streams

General practice sustainability and transformation package

There is a commitment in the GP Forward View to spend £500m on a sustainability and transformation package for general practice over 5 years, which incorporates workforce measures, the General Practice Development Programme and support for struggling practices. Although specific programmes are covered elsewhere in this document, at this stage the total amount of the package spent is unconfirmed. The figures will be available in September 2017.

PMS contract reviews

NHS England is currently in discussions with regional teams to confirm that all PMS reviews are complete and to check if there are any outstanding issues. This exercise is ongoing.

Conclusion and recommendations

Commitments on greater investment are critical. Our members are clear that this area is incredibly challenging, and for many the challenges they face are linked to the need for sustainable funding.

In many respects, the investment made following the launch of the GP Forward View has been good news for general practice. In particular, if NHS England is correct in its understanding that an additional £322m in recurrent funding was invested in 2016/17, this is a meaningful increase that is also indicative that the ultimate increase of £2.4bn by 2020/21 is on track. This is a major change from historically sinking or stagnating investment in general practice and its importance should not be underestimated.

In addition, there have been other pockets of investment. Supporting GPs by covering increases in indemnity is a
welcome short-term initiative, while the programme of resilience funding, after a slow start, has begun to support practices.

Nonetheless, there are some areas that may be cause for concern. Evidence of CCG underspending could undermine national intentions to increase investment in general practice, while the implementation of some programmes of investment has room for improvement. There is low awareness of schemes that would otherwise make a difference to GPs, and the application process can be demanding, particularly if applying to multiple programmes of support.

To address these issues and ensure continued, increasing and impactful investment in general practice, the RCGP recommends the following actions are taken:

- CCGs must ensure they are fully spending their budgets relating to general practice.
- CCGs must identify appropriate funding for practice transformational support, to ensure the commitment of £171m is met.
- The practice resilience programme should be expanded to recognise the demand.
- NHS England and CCGs should ensure that funding opportunities are widely publicised, with accessible application processes that do not take an unreasonable amount of time. This might involve processes that cover several schemes so key information does not require duplication, while ensuring that any practice aware of one scheme will also have the other schemes clearly flagged.
- The Department of Health and NHS England must continue to support GPs with rising indemnity costs while a long-term solution is being found, including urgent action to absorb the impact of the discount rate change.
- The Government must consult on and implement long-term solutions to the indemnity crisis as a matter of urgency.
- Support given to practices (such as resilience funding) should reflect a shared understanding of GP practices’ needs and the kind of support that will be most effective in meeting these.
- Management consultancies should not be contracted to deliver resilience support unless this is the explicit wish of the relevant practice.
The people who work in general practice are essential to its success and survival. When GPs and other practice staff go through challenging times, as many are currently, the sustainability of general practice is compromised as people leave the workforce. The GP Forward View is a response to this, as together the commitments should create significant improvements for people working in general practice.

Although some of the schemes proposed in the GP Forward View have been put in place and the number of GP trainees is on the up, the outlook on the first anniversary of the publication is disappointing. Crucially, there is no evidence that more doctors are working in general practice – if anything, there are fewer.

Furthermore, since the launch of the GP Forward View, new challenges to expanding the workforce have arisen. HEE budget cuts might affect GP training programmes, while the UK’s upcoming departure from the European Union means England is at risk of losing existing GPs who are EU nationals or dissuading potential GPs from the EU from relocating.

This is the most troubling area of implementation for the GP Forward View. Serious progress needs to be made or the success of the whole programme will be severely undermined. At this stage, a strategic review of the workforce workstream is needed. There are signs that this is already underway, with a significant extension of the programme of recruiting doctors internationally.

### Key workforce commitments in the GP Forward View

- An additional 5,000 doctors working in general practice by 2020/21.
- Increase GP training recruitment to 3,250 a year.
- Measures to improve the experience of returning to work.
- A new retainer scheme more fit for purpose by April 2017.
- An additional 5,000 other staff in general practice by 2020/21.
- Investment of £15m in general practice nurse development.
- An additional 1,500 pharmacists in general practice.
- An additional 3,000 mental health therapists in general practice.
- 1,000 physician associates in general practice.
- A specialist mental health service for GPs suffering from stress and burnout.

### Anticipated increase of FTE GPs (if linear) compared with actual number of FTE GPs

![Graph showing the anticipated increase of FTE GPs compared with actual number of FTE GPs.](image-url)
Doctors working in general practice

The GP Forward View commits to an additional 5,000 doctors working in general practice by 2020/21. Little progress, if any, has been made on achieving this increase.

Between September 2015 and September 2016, there was a decrease of 96 FTE GPs. Far from growing, the GP workforce is slightly contracting. There was an even greater deficit by December 2016, with a decrease of 542 FTE doctors compared with September 2015, which reflects seasonal factors but nonetheless does not inspire confidence. While it may take time for some of the GP Forward View commitments to start increasing GP numbers, this initial snapshot is discouraging.

However, there is substantial difficulty in quantifying any changes in this figure due to ongoing methodological changes by NHS Digital. In 2016, the data source changed, as well as some of the assumptions made when calculating the figures, so although estimates were made on this basis for September 2015, no earlier data is comparable. Since then, data collection has continually been adjusted to improve accuracy, which means the latest figures (March 2017) are not comparable to any figures that have come before, as locums, who were being undercounted in previous methodologies, are being recorded more reliably following guidance to practices.

Although it is clearly necessary to have workforce data that is as accurate as possible, these comparability issues will need to be addressed by NHS Digital or this commitment will prove impossible to monitor. This work needs to be done transparently to ensure that the profession maintains trust that these figures are being objectively reported.

Recruitment

Recruiting GPs remains challenging for many practices. One GP in the South West told us:

“We advertised for about 18 months through the RCGP and British Medical Journal but absolutely nothing. Our CCG did a huge drive with videos and adverts for six months — for the whole of [the local area], not just our practice...and they didn’t get a single applicant.”

This example is borne out by the survey we ran in February, which found that 71% of GPs who have been involved in recruiting for GPs in past year say it has been difficult. Meanwhile, 38% of GPs say there has been at least one GP vacancy at their surgery for more than three months – and of these, 78% say lack of applicants is the main reason for these ongoing vacancies. In the latest workforce census, practices that responded reported over 400 FTE vacancies for GPs between April to September 2016. This is based on information from only 866 practices, so the real figure is likely to be even higher.

The GP Forward View commits to increase recruitment of GPs in training to 3,250 each year. As reported in our interim assessment, numerous steps were taken by HEE and its equivalents in Scotland, Wales and Northern Ireland in 2016 to streamline the recruitment process and increase its flexibility, resulting in a fill rate of 90%, with 2,927 places filled in the first and second rounds. Although not meeting the target, this is still a substantial increase on the 2,513 places filled in 2015. More recently, there was confirmation that things are on track for delivery of 3,250 GP recruits in 2017. If so, this is very good news.

It will take a while for these GP trainees to start working in general practice, but there should be a noticeable impact when these expanded cohorts enter the workforce. However, it is important to recognise that the number of doctors starting GP training is not necessarily the number who will ultimately take up jobs in general practice.

Training places filled (Round 1 and 2)
new guidance was published for commissioners in March with details of how CCGs can apply to receive funding for the international recruitment of GPs up to 2020.

Recent comments by NHS England that they will look to significantly increase the number of doctors recruited from overseas as a way of bridging the gap before UK trained doctors enter practice, are welcome if they are able to enter the UK workforce safely and at the same standard as a doctor trained in the UK.

While it is promising to see progress on these commitments, it is clear the recruitment challenge is severe; further solutions will need to be pursued to sufficiently counter this.

Returning to practice

It is important that doctors who wish to return to general practice can do so safely and efficiently. Barriers to returning exacerbate the GP workforce crisis, as capable doctors who wish to re-enter the workforce are diverted. There are therefore several commitments in the GP Forward View focusing on this issue.

The GP Forward View aims to attract 500 returners by halving the time it takes to return to work and improving the experience. Changes include:

- a new portfolio route for GPs with previous UK experience
- an increase in the monthly bursary for doctors on the scheme from £2,300 to £3,500
- a £1,250 top up to the bursary to help with indemnity costs (until October 2018)
- removal of assessment fees for first time applicants, worth up to £1,000
- reimbursement of up to £464 to cover the costs of GMC annual fees and Disclosure and Barring Service fees (until October 2018)

There are currently 260 doctors on the Induction and Refresher scheme, with 106 GPs having successfully entered the workforce from the scheme since the GP Forward View was published. These numbers reflect an increase since the support was improved. In March 2017, a campaign was launched around returning to general practice, although this had to be paused in the run up to the election, so it has not run for very long and there has not been much time for its impact to be seen.

In terms of making the process easier, applicants now have a caseworker, meaning they have a single contact
point, which is a big step forward. However, there is still not a single portal or website where the whole application is administered.

Overall, the changes to the scheme make a big difference to returners and are a success. However, there may be further changes needed to ensure the scheme covers all those who might need it. For some doctors, the bureaucratic hurdles are too great and more could be helped if further work was done to understand individual barriers to returning. A woman from the East of England who had been a GP partner for 20 years told us of her difficulty returning to work after a period of unexpected illness; as she remains on the performers list, she is not eligible for the Induction and Refresher Scheme, which highlights a potential area for review.

As reported in our interim assessment, NHS England selected 11 pilot areas to begin developing a scheme of targeted financial incentives to return to work, in locations where workforce pressures are particularly severe. At this point, 50 practices that can evidence historical difficulties in recruiting GPs have been identified to take part. This includes recruitment support alongside up to £8,000 relocation allowances for GPs employed through the Induction and Refresher Scheme, and up to £2,000 in an education bursary. Currently, eight of the practices have managed to fill their longstanding vacancies.

Retention

Retaining current GPs is vital for the ongoing success of general practice and any future increase in workforce figures, but there are reasons to be concerned. The RCGP’s survey of its members in February indicated that 39% were unlikely to be working in general practice in England in five years, a significant increase from 32% six months earlier.

Although much of the work to address retention issues is interwoven with wider schemes to support general practice and address workload, the GP Forward View contains several commitments specific to retention. The GP retainer scheme benefited from increased financial compensation from July 2016 for doctors on the scheme and those joining until the end of the financial year. At the time of our interim assessment, it was unclear whether these changes were having an impact on the number of GPs on the scheme – this remains unclear.

Meanwhile, a new retainer scheme has been in place since April 2017, forming part of the 2017/18 GMS contract. This is aimed at doctors seriously considering leaving or who have left the general practice workforce. It is too early to assess the impact of this scheme.

The GP Forward View further committed to introduce new retention measures for GPs who want to work

Thinking about the future, how likely or unlikely are you to be working in general practice in England in each of the following time frames?

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Likely</th>
<th>Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>One year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August 2016</td>
<td>91%</td>
<td>6%</td>
</tr>
<tr>
<td>February 2017</td>
<td>89% ▼</td>
<td>8% ▲</td>
</tr>
<tr>
<td>Two years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August 2016</td>
<td>80%</td>
<td>12%</td>
</tr>
<tr>
<td>February 2017</td>
<td>76% ▼</td>
<td>16% ▲</td>
</tr>
<tr>
<td>Three years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August 2016</td>
<td>51%</td>
<td>32%</td>
</tr>
<tr>
<td>February 2017</td>
<td>46% ▼</td>
<td>39% ▲</td>
</tr>
</tbody>
</table>
flexibly but could commit to working in a practice or area for a period of time. In 2017/18, NHS England will be testing models of employing doctors in pools across a lead provider through the GP Careers Plus pilot. Pilots are underway in 11 sites across the country, with the expectation that they will have begun recruitment to their pools by the end of July 2017. This will support approximately 80 GPs to work more flexibly.

Health service for GPs

GPs are under enormous pressure, which can take a toll on their own health and wellbeing. In our recent survey, 40% said they were so stressed they felt they couldn’t cope at least once or twice a week, with 5% saying this happened every single day. As well as significantly improving the general practice environment and workload to address this, there is also a need for mental health support.

The GP Forward View committed to extra investment in specialist mental health services to support GPs suffering with burnout and stress. At the end of January 2017, this service was launched, and will be worth £19.5m in total. An RCGP regional ambassador outlined how the region has been able to increase staff levels:

“"There’s been almost universal acknowledgement: thank goodness, that’s been needed, thank god it’s here at last. The GPs on the ground are really happy to see it exists. The service was commissioned with an expectation of seeing 700—800 new GPs in England in the first 12 months. We’re just at the end of the first three months and it’s already over 250 new GP presentations within England. There was perhaps an unmet need catch up in the first few weeks — they saw a lot of people very quickly — but the need is continuing. It was anticipated that it might slow down and it hasn’t, and in some areas it’s beginning to accelerate because obviously it is a new service and awareness takes a while to trickle out.”

It is hugely positive that this service exists, and the response to it shows the need for it. It is important that GPs who may need to use it are aware of it and feel empowered to self-refer. NHS England say it will only be in a position to measure outcomes later this year.

Other practice staff

The GP Forward View commits to the employment of at least 5,000 additional other staff in general practice by 2020/21; currently, progress towards meeting this commitment is on track, ahead of where it would need to be after one year. In September 2016, there were 91,171 FTE practice staff, an increase of 2,896 on the previous year. This represents an increase of 429 FTE nurses, 860 FTE staff working in direct patient care, and 1,606 FTE admin/non-clinical staff.

An RCGP regional ambassador outlined how the region has been able to increase staff levels:

“"In Gloucestershire the £1.50 per patient at scale funding has been increased by the CCG to £1.89 and also made recurrent so has enabled employment of staff as an option. Throughout the STP as a result, with this fund we have employed: 9 clinical pharmacists, a paramedic for a home visiting service, a community matron for the frail and a visiting nurse for the elderly, also in one cluster a repeat prescriptions back office team.”

RCGP regional ambassador for Gloucestershire

The GP Forward View further committed to introducing multidisciplinary training hubs in every part of England to support the development of the wider practice workforce. There are currently 130 hubs across the country, with work ongoing by HEE to provide full coverage by March 2018, meaning all general practices will have access to the services of a training hub.

Practice nurses

Although the number of nurses has been increasing since the GP Forward View was launched, in our latest survey, almost two thirds (64%) of GPs involved in recruitment for nurses in the past year said it had been difficult to recruit, so there is clearly still an unmet need. In our interim assessment, we noted that wider roll-out of return to general practice nursing programmes was needed. Since then, the GP nursing workforce development plan has been published. The plan looks to improve training capacity in general practice, increase the number of pre-registration nurse placements, introduce measures to improve retention of the existing nursing workforce...
and support the development of return to work schemes for practice nurses. The plan incorporates the roll out of the Community and General Practice Nursing Education and Career Framework as well as the implementation of the QNI Voluntary Education and Practice Standards for District and General Practice Nursing.

Further work is underway by NHS England and HEE to formulate a plan for the £15m identified within the GP Forward View. A welcome 10-point action plan is due to be published. This plan must include a commitment to bringing forward targets for increasing nurses in general practice. Work is also starting within the training hub community to map existing work to identify areas of development nationally. HEE training hubs are required to identify funding and provide access to mentor funding for nurses as needed locally. HEE told the RCGP that initial offers of HEE funded mentorship courses have been accessed but there is less demand than anticipated, which is for a range of reasons. These include trained mentors remaining dormant due to difficulties maintaining the qualification, nurses not wishing to become mentors and nurses not being released from clinical roles to undertake the training. In some areas, there appears to be lower need for mentors than originally anticipated. HEE should actively communicate this opportunity to nurses and ensure that the barriers are addressed.

Pharmacists

The pilot scheme placing clinical pharmacists in general practice has resulted in 494 pharmacists working across 658 practices. Practices have been able to apply to access practice-based pharmacists following this pilot, with the aim of an additional 1,500 pharmacists in general practice in the next three years, which is a shorter timeframe than the original GP Forward View commitment. Following the first wave of the roll-out, 215 more FTE pharmacists have been approved across 730 practices, with a second wave expected to place an additional 300 FTE pharmacists across a further 1049 practices.

When we surveyed our members, 16% said they had received support or funding relating to the practice-based pharmacist scheme, while only 12% were unaware of this opportunity, indicating the highest awareness of any of the schemes we asked about. As the original pilot scheme launched in July 2015, with pharmacists working in general practice from early 2016, it has had longer to bed in, with more opportunities for the scheme to be communicated to practices compared with other schemes that opened later in 2016. Therefore, this could indicate the potential for younger schemes to become better known as they become more established.

Some of our members reported the benefits of having pharmacists in practice, noting how they helped to manage workload and reduce costs:

“Now a valued member of the team dealing with medication requests, medication reviews, changes following discharge from hospital and some undifferentiated patient face to face contact.”

GP, Midlands

“The pharmacist we have recruited is excellent… She has made a large difference to trying to control our costs and in particular enabling bulk changes to medication. Having failed to make our prescribing budget savings in the past we are now improving.”

GP, South West

However, others said they only received a small amount of pharmacist time, or reported that non-prescribing pharmacists were less impactful on their workload. There was a marked desire to be able to recruit more prescriber pharmacists.

In addition, some members were frustrated at their inability to secure funding:

“We have employed a practice pharmacist for many years, and asked if funding could be used to fund her time. We were told that this was not possible, meaning that we’ve effectively been punished for already doing something which is now regarded as ‘innovative’.”

GP, London

Others had been rejected as they were applying on behalf of fewer than 30,000 patients. Some were not given a reason.

There is clearly demand for pharmacists, with real benefits being seen where the scheme is working. As the scheme develops, we would expect more practices to have successful applications.
HEE leads on the educational element of this programme and are completing re-procurement for this, with the expectation that the next cohort will start in September or October 2017. Completion of the programme will take between 12 and 18 months depending on the needs of the pharmacists.

**Mental health therapists**

The *GP Forward View* commits to having an extra 3,000 mental health therapists working in primary care by 2020, and in the interim assessment we reported that NHS England had identified 22 early implementer sites, with new therapists starting to come into posts. Since then, there have been more specific short-term commitments made, with 800 mental health therapists to be in primary care by March 2018 and over 1,500 by March 2019. An additional 15 early implementer sites have been identified.

As new mental health therapists will largely be employed by existing Improving Access to Psychological Therapies (IAPT) services, it is unlikely that all or many will be based at GP practices. It is vital that therapists are properly integrated with general practice and accessible to GPs if the programme is to ease the pressure on general practice caused by common mental health problems.

**Physician associates**

The *GP Forward View* commits to “investment by HEE in the training of 1,000 physician associates to support general practice”. The institutions offering the physician associate programme have expanded their intake from 2016, with 25 universities either having opened courses or intending to do so within the next 12 months. HEE believes this will enable the achievement of the goal of 1,000 physician associates in general practice. It is important to ensure that physician associates are encouraged to work in general practice, ensuring they do not principally go towards hospital specialties.

**General Practice assistants**

There are currently two areas exploring the feasibility of the general practice assistant role: London and the South East, which is testing an administrative role, and the North West, which is using a mixed role combining administration with some low level clinical duties. The College has some concerns that it will take a couple of years for the pilots to be finished and evaluated, which therefore means it will be a long time before other regions benefit from the introduction of the role if the evaluation demonstrates that these are successful initiatives.

**Physiotherapists**

There is a commitment to pilot the role of primary care physiotherapy services. NHS England concluded the pilot in 2016 and the evaluation will be published shortly. Direct access to physiotherapist services has been rolled out in some places already, such as Suffolk.

**Practice managers**

An investment of an additional £6m in practice manager development was committed to in the *GP Forward View*. Regional networking events for practice managers were held in December 2016 and NHS England is supporting the growth of local and online networks of practice managers to accelerate the sharing of ideas, action learning and peer support. However, it is unclear how much of the investment has been made.
Conclusion and recommendations

Progress on workforce is ultimately judged on numbers, and in the year since the launch of the GP Forward View, fewer FTE doctors are working in general practice. If the target of 5,000 additional FTE doctors is not reached by 2020/21, general practice will be in severe difficulty, even if all other commitments are met.

However, the RCGP’s concern is that the existing plans for the GP workforce are not sufficient to turn the tide. The current commitments are welcome but more needs to be done. Our recommendations are:

- NHS England and HEE to work with partners to refresh their strategy to increase the number of FTE doctors working in general practice, to ensure much more progress is made. This should include a focus on retention and international recruitment.
- Review the returners scheme to make further improvements and ensure it is inclusive of those who have not practised for a while despite being on the performers list.
- Create a single website to administer applications for returning to general practice.
- Communicate schemes widely, including the returners scheme, retainers scheme, GP health service and clinical pharmacists scheme, through a national NHS England information programme advertising the opportunities and schemes to all doctors, nurses and Allied Health Professionals.
- HEE to review the reasons for lower than anticipated post-CCT fellowship numbers and take action to increase these.
- HEE should report on the number of doctors who complete GP training and work with NHS England to identify the number who take up jobs in general practice following GP training. This should inform workforce calculations and planning. If pressure points are identified, solutions should be put in place.
- NHS England and HEE’s plan for practice nursing must include a commitment to bringing forward targets for increasing nurses in general practice.
- HEE to address barriers stopping nurses from becoming mentors.
- Ensure the ‘Nothing general about general practice’ campaign has wide reach among medical students and foundation stage trainees.

There are some rays of hope. An increase in GPs in training will take time to translate into working GPs, but these GPs of the future will have a big impact when they arrive in practices. Fast progress on the Induction & Refresher scheme is seeing hundreds of GPs getting ready to return to work. There is also good movement with some other practice staff, with this group seeing a strong increase in numbers from last year.
Workload

GPs are struggling under a bigger workload: an ageing population with increasing incidence of multimorbidity, a rising administrative burden from regulatory and statutory pressures, and covering for colleagues where there are difficulties filling GP vacancies. Pressure of work is a factor in many GPs giving up full time practice and makes retention more difficult. The GP Forward View aims to address these problems by reducing the burden on practices and helping release time for GPs and their teams.

There is a potential impact on patient safety due to GP fatigue and burnout. GPs should not be too exhausted to provide safe care to their patients. The GP Forward View recognises the need for immediate action to avoid GP burnout and it is pleasing to see that some of the proposals contained in the report are being implemented. However, it is concerning that the majority of frontline GPs are not feeling the reduction in their workload that these schemes are intended to deliver, suggesting there is more to be done.

High impact actions

The three year £30m ‘Releasing time for care’ programme aims to release GP capacity by supporting practices to deliver what are known as the 10 high impact actions. These are:

- **Active signposting:** making sure the first point of contact directs patients to the most appropriate source of help.
- **New consultation types:** using communication methods such as phone and email for some consultations, reducing clinical contact time.
- **Reduce Did Not Attends (DNAs):** making changes to ensure patients remember their appointments and that it is easy for them to cancel or rearrange.
- **Develop the team:** integrating other healthcare professionals into the team.
- **Productive workflows:** introducing new ways of working.
- **Personal productivity:** training and support to enable staff to work more efficiently and improve resilience.
- **Partnership working:** creating partnerships and collaborations in the local health and social care system.
- **Social prescribing:** referral and sign-posting to non-medical services in the community.
- **Support self-care:** supporting patients to play a greater role in their own health and care.
- **Develop QI expertise:** developing a specialist team to support continuous quality improvement.

Overall, the College recognises how useful these actions could be. We also note that this plan is being delivered in several ways, including through commitments relating to workforce and care redesign as well as through the programme itself. This is a good demonstration of the way the different areas support and rely on each other’s success.
The vast majority of GPs in our recent survey indicated their practice was taking or had previously taken steps to reduce workload aligned with the high impact actions, but there were a range of responses. Almost three in five (57%) said they were managing workflows better, whereas only one in five (21%) said steps to reduce GP workload had involved increasing personal productivity through methods such as enhanced computer skills. This indicates that although most practices are already looking at ways to reduce workload, there are opportunities that the programme could highlight.

To date through this programme, there have been 90 schemes covering 115 CCGs and 3,600 practices, and 2,486 people have taken part in Time for Care workshops. Forty-one of the schemes, covering 600 practices, are participating in the Productive General Practice Quick Start scheme, which focuses on productive work flows and the development of quality improvement expertise. Although final figures are still to be released, NHS England report that around £8m was invested in the programme over 2016/17. This implies that a further £22m is to be spent over the next two years, suggesting many more practices and people working in general practice will be reached.

NHS England estimates that most practices can expect to release 10% of GP time based on feedback from those who have already taken part. However, there is currently insufficient evidence to indicate whether it will have this impact. To ensure it does, NHS England must conduct a thorough evaluation of the programme and adapt support where necessary to ensure it genuinely makes a difference to GP workload. Struggling practices should also be proactively encouraged to participate.

**Reception and clerical staff training**

There is £45m committed to training reception and clerical staff to play a greater role in navigation of patients and handling clinical paperwork to free up GP time in the *GP Forward View*. This is split so £5m was invested in 2016/17, with £10m each year following until 2020/21. Some members have reported positively on their CCG’s engagement with these initiatives:

“Our CCG is really supporting us with things like the patient navigation and training parts of the *GP Forward View*…they’ve put their support into finding an organisation that will do all our navigation training for our receptionists…so that it’s rolled out across the patch, promoting self-care and signposting.”

*GP, South West*

**Which of the following steps, if any, is your practice currently taking, or has previously taken, to try to reduce GP workload?**

<table>
<thead>
<tr>
<th>Step</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing work flows better</td>
<td>57%</td>
</tr>
<tr>
<td>Utilising new consultation methods such as over the phone or e-consultations</td>
<td>56%</td>
</tr>
<tr>
<td>Improved internal processes</td>
<td>56%</td>
</tr>
<tr>
<td>Hiring additional non-GP clinical members of staff</td>
<td>53%</td>
</tr>
<tr>
<td>Supporting self-care for patients</td>
<td>49%</td>
</tr>
<tr>
<td>Better signposting via online portals and reception navigation</td>
<td>43%</td>
</tr>
<tr>
<td>Taking measures to reduce missed appointments</td>
<td>43%</td>
</tr>
<tr>
<td>Working in partnership with other practices or pharmacies, etc.</td>
<td>34%</td>
</tr>
<tr>
<td>Social prescribing (linking patients with sources of support within the community)</td>
<td>32%</td>
</tr>
<tr>
<td>Increasing personal productivity through enhanced computer skills, etc.</td>
<td>21%</td>
</tr>
<tr>
<td>My practice is not doing anything to reduce workload</td>
<td>5%</td>
</tr>
<tr>
<td>My practice does not need to reduce workload</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7%</td>
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</table>
We highlighted in our interim assessment some concerns over delays in investing the initial £5m. At this point it is not clear that this has been resolved, though NHS England say that further information and funding allocations will be imminently going out to CCGs.

### NHS Standard Contract

The *GP Forward View* called for amendments to the NHS Standard Contract for hospitals to help relieve some of the administrative burden on GP practices. The updated contract was implemented in April 2016 with further changes introduced from April 2017 including new legal requirements to improve the hospital-general practice interface.

“*The primary: secondary care interface is a problem – a “fault line” – that runs through much of my observation and analysis.*”

*RCGP regional ambassador for South East*

These changes have the potential to significantly reduce workload for GP practices and so it is disappointing that the College’s survey in February indicated that only 3% of GPs have seen a reduction in the administrative workload of practices that they would attribute to changes in the NHS Standard Contract.

“*Yet more work is coming out from secondary care without the resources to fund and support it. The current level of workload is almost unsustainable and it’s getting worse by the month.*”

*GP, Yorkshire and the Humber*

A GP located in Yorkshire and the Humber said that “[w]ork dumping from secondary care continues despite changes to the contract.” Meanwhile, another GP from the North West said that they are seeing “[i]ncreasing admin tasks from secondary care.” However, the RCGP ambassador for Gloucestershire commented, “We are starting to see steps put into place to try and reduce unnecessary workload and the LMC has helped with contacting secondary care for unnecessary work in the form of Med3s [fit notes], requests for tests & results.”

NHS England and NHS Improvement contacted all CCG Accountable Officers and NHS Trust and Foundation Trust Chief Executives to underline the new requirements. However, more work is needed to ensure that frontline practitioners are aware of the changes and that commissioners introduce and enforce the new contract terms.

The *GP Forward View* committed to establishing a national stakeholder working group to drive action to improve the interface between primary and secondary care. This working group, of which the College is a member, was established in September 2016 and is leading a number of initiatives aimed at improved processes across the interface. An NHS England guidance document supported by the College and other organisations has been published and outlines key messages around the new measures contained in the NHS Standard Contract.

### Rapid testing programme

NHS England established a Rapid Testing Programme in three sites to review better ways of managing outpatient demand. In light of this programme, the *GP Forward View* brought about the roll-out of the most effective measures to a wider group from late summer 2016.

The Elective Care Rapid Testing Programme involves frontline staff, including GPs, from across health systems working to co-design new models for the delivery of elective care across specialty pathways. Innovative ideas are generated and tested over a 100-day period. The programme will test interventions across a number of high volume specialties in a series of waves over two years. Initial feedback from patients at the testing sites has been positive and the work will be written up as a series of specialty handbooks supporting best practice and case studies. The RCGP is keen to see a comprehensive evaluation. In the interim assessment, we called for clear milestones to be established for the national roll-out of the programme but this has not yet happened.

### Patient self-care

Under the *GP Forward View*, NHS England pledged to launch a national programme to help practices support patients living with long-term conditions to manage their own health and wellbeing.

There has been progress in delivering this pledge through a few different initiatives, including a pilot scheme that has been launched across 50 sites to deliver patient activation. Patient activation is a process by which patients are targeted for self-management interventions based on an
assessment of their skills and confidence. The RCGP is keen to understand the outcome of this pilot and plans for its subsequent rollout should it prove to be effective.

NHS England has also funded two Health Literacy Demonstrator Sites which will deliver an educational programme called Skilled for Health to people with long-term conditions and low levels of health literacy. This programme was delivered to 56 people living with diabetes in the East Midlands and 38 people living with long-term conditions in the West Midlands. NHS England report that initial results seem to suggest that it had an impact on people’s confidence to manage their conditions. The evaluation report on this work will be considered at the next meeting of the Health Literacy Collaborative (which includes an RCGP representative) in August 2017 when next steps will be considered. Meanwhile, there is continued follow-up with some participants to see if behaviour has changed or been sustained. This seems positive but we will engage with this further at the upcoming meeting.

Cross sector care

David Mowat MP (previous Parliamentary Under Secretary of State for Community Health and Care) wrote to Health and Wellbeing Chairs in November 2016 to ask all Health and Wellbeing Boards to review the GP Forward View and consider what more Boards could do to build effective relationships between primary care and wider local services. To date, there is no evidence available concerning the impact that this has had, although it is positive that action has been taken to communicate these messages.

In addition, the GP Forward View includes commitments to reform NHS 111 and work with CCGs to ensure they institute plans to address patient flows in their area. Some GP Access Fund schemes have developed, tested and embedded pathways with 111 services which include referral pathways and diversion schemes to ensure patients are offered care in an appropriate setting. These include front end booking arrangements to directly book patients into improved access service appointments and telephone triage by GPs with onward care managed based on assessment. Some have undertaken work in partnership with 111 to ensure accessibility and that capacity is effectively utilised, particularly at weekends. The RCGP has received positive feedback about the potential for these schemes to help alleviate burden on practices by reducing patient demand at the traditionally busiest times so we are keen to see them developed further.

Regulation and oversight

Care Quality Commission (CQC)

The College recognises that regulation can serve an important function in promoting accountability, address long-standing unacceptable performance and protect patients. It is extremely positive that further to the completion of all GP practice inspections in February 2017, 91% of GP practices inspected since October 2014 have been rated good or outstanding. However, many GPs and their teams are critical about the amount of time taken up in preparing for a CQC inspection, as well as associated costs.

In the GP Forward View, the CQC committed to consult on changes to its regulatory model with the aim of reducing the regulatory burden on GP practices that deliver good or outstanding care. The CQC recently published its consultation outlining proposed changes to the regulatory regime informed by learnings from the previous inspections. The proposals appear to address several distinct aspects of the regulatory regime; however, it is unclear how far the proposals will go in reducing the overall burden for frontline GPs.

The CQC’s strategy for 2016—2021 committed to a maximum inspection interval of five years for practices rated good or outstanding subject to the provision of transparent data, which is one of the commitments in the GP Forward View. This is a positive step. However, there may be unforeseen negative impacts of the proposed ongoing monitoring. The introduction of the GP Insight tool earlier this year aims to identify and monitor changes in the quality of care outside of the inspection cycle. It should reduce the need for inspections where they are not required; however, as practices will be required to keep their information updated it adds a potential administrative burden. As the tool was only recently implemented there is currently little indication as to how effective the tool will be and how much work is required to update the data.

A further CQC commitment contained in the GP Forward View was to implement a streamlined approach to inspections for new care models and federated or super-partnerships practices. The CQC is already regulating some new models of care, including some super-practices. It is encouraging that it recognises the need to be able to collect information without burdening providers with multiple requests, but it is still unclear how this will work. There is concern that it may introduce additional layers of bureaucracy and create confusion within complex providers.

The CQC has confirmed that the overall cost of regulation will not increase as a result of the changes and that the fees will “remain proportionate”. However, there is a lack
of evidence that the current model of regulation represents value for money. It is disappointing that the CQC has not committed to review the cost of inspections. On the positive side, NHS England has confirmed that it will cover the full cost of the CQC fee increase in 2017/18. The cost will be reimbursed directly to practices who submit their paid invoices to NHS England or their CCG. This is a good step but the changes to the regulatory inspection regime should provide an opportunity for fees to be further reviewed to prevent money from being diverted away from frontline patient care.

Overall, despite some good initiatives and proposals, the CQC must be careful about unintentionally increasing the regulatory burden instead of decreasing it. Furthermore, it has yet to be seen whether the sum of the changes will make a significant difference to the average practice.

Quality and Outcomes Framework (QOF)

In October 2016, Simon Stevens stated that the Quality and Outcomes Framework (QOF) is “nearing the end of its useful life… and for the most part it has descended into too much of a box-ticking exercise.” While QOF created a focussed structure for engaging in health care management, some GPs feel that it has become burdensome and that a revised framework is needed to allow a more holistic approach to managing health conditions. Too much time is being taken away from patient interaction by the need to complete the paperwork required by QOF.

“QOF/KPI etc has some value but continues to detract from effective clinical work.”

GP, London

Under the GP Forward View, NHS England committed to developing a new successor to QOF. A working group has been set up with stakeholders to discuss the future of QOF. The RCGP hopes that the review of QOF will lead to financial arrangements that incentivise effective and high-quality team based care in all practices, including those that are part of an Accountable Care Organisation (ACO) or other at scale arrangement, as well as a holistic approach to patient-based care. Additionally, it should incentivise quality improvement.

There are areas of the country exploring alternatives to QOF.

Cutting the bureaucratic burden through better co-ordination between regulators

The GP Forward View set out a programme of work to reduce the bureaucratic burden on practices through a Statement of Intent between NHS England, the CQC and the GMC.

“Every person with a corner to work in expects a different form to be filled in and won’t accept letters with more relevant information. Demand gets greater and greater and the amount of results, visits, paperwork and general rubbish increases exponentially.”

GP, North East

The Regulation of General Practice Programme Board was formed with the purpose of coordinating and improving the overall approach to the regulation of general practice in England. It is important that this avoids being too high level (and therefore irrelevant to GPs on the ground) or too prescriptive (and turning into a box-ticking exercise).

The National Quality Board (NQB) is aiming to reduce unnecessary workload on practices and GPs through greater alignment of data collection systems. As part of this workstream, NHS England, CQC and GMC are looking at approaches of ‘collect once and use many times’ to ensure practices are not asked the same question twice by different organisations. This seems positive, although it is important due care is taken with patient data.

These workstreams are in the early stages but appear to be addressing some of the key issues that add to the bureaucratic burden for practices and GPs.

Other workload issues

Training

The GP Forward View required a review of all mandatory training requirements for general practice and to reduce these requirements to ensure a more proportionate approach is taken. NHS England has clarified that there is no statutory or mandatory training for GPs. However, there is widespread belief among GPs that there are mandatory training requirements. A working group should be formed to investigate and clarify the situation.
Automation

The GP Forward View committed to develop, test and implement the technical requirements for a new task automation solution to reduce workload. NHS England has commissioned NHS Digital to provide an automated appointment measurement interface to help practices understand the demand for and capacity of their services. NHS Digital are working directly with GP system suppliers on the solution, with GP system suppliers integrating this information and solution into their clinical systems. This means general practice will be able to access their own information on capacity and demand from their own GP system easily. Practices should have access to this function this year, which is welcome.

Conclusion and recommendations

Measuring workload in general practice is complicated by the many different types of consultation and the range in the value that is added in each. Consultations vary in the number of different problems addressed, the progress made towards resolution, the quality of patient education and handover, and the inclusion of health promotion. It is therefore difficult to obtain data to demonstrate the overall increase in GP workload; however, we know that workload is a real and serious problem for GPs’ work and home life as well as their general health and wellbeing.

This is an area that is particularly linked to other parts of the GP Forward View. An increase in workforce is key to reducing workload, while plans for care redesign could see a reduction in administrative burdens on GPs. Even the GP Forward View itself is a contributing factor, with application processes for the various schemes needing to be considered in workload planning. Therefore, the other sections in this report also hold relevant recommendations.

Many of the schemes contained in the GP Forward View aimed at addressing the issue of workload are being implemented. However, it is disappointing that GPs are reporting little impact on their day-to-day workload. Overall, the College is concerned that the strategies to address workload in the GP Forward View will not be sufficient for the scale of the task. Our recommendations are:

- NHS England to review with stakeholders what more can be done to reduce GP workload to a manageable level.
- The CQC should conduct and publish an impact assessment of their proposed changes to CQC inspections in general practice. In particular they should indicate the change in regulatory burden expected as a result of each proposal.
- The CQC should use the opportunity of changes to the regulatory inspection regime to consider the reduction of fees to prevent money being diverted away from frontline patient care.
- NHS England and NHS Improvement should raise awareness of the changes to the NHS Standard Contract amongst trusts and hold commissioners to account to ensure the new contract terms are introduced and enforced.
- NHS England should continue to develop collaborative care and support planning for people living with multiple long-term conditions, with protected time for practices to receive training.
- NHS England should continue work with other organisations and the profession to develop a successor to QOF, with reduction in administrative burden made a key test for the development of the replacement.
- NHS England should form a working group to investigate and clarify mandatory training requirements.
- Work should begin with payment providers to streamline payment processes for practices to focus on improvements to consistency and accuracy of payments.
When the RCGP surveyed members in August 2016, three in ten (28%) said their practice building was not big enough to accommodate patient demand, while a similar proportion (29%) said theirs would need expanding in the future. Additionally, 21% said their practice building was not suited to providing high quality patient care.

With a growing and ageing population, issues of space and modernization will only become keener. Meanwhile, there are clearly opportunities offered by an increasingly digital world, and it is important that general practice is able to take advantage of these.

The GP Forward View makes a number of key pledges to improve practice infrastructure including developing the general practice estate and improving technology and digital infrastructure in general practice. At this point, results are mixed. There has clearly been difficulty in disseminating capital investment, with RCGP members reporting frustrating and unpredictable processes. Although investment has been substantial, not enough funding has got to where it is needed. There is progress on some aspect of digital transformation, with significant roll-out of Wi-Fi in practices.

### Key infrastructure commitments in the GP Forward View

- £900m of capital investment in general practice by 2020/21.
- New rules on premises costs to enable NHS England to fund up to 100% of the costs for premises developments.
- Support for other costs such as Stamp Duty Land Tax and VAT for practices who are tenants of NHS Property Services.
- An 18% increase in allocations to CCGs for the provision of IT services in 2016/17.
- Wi-Fi services in GP practices for staff and patients from April 2017.
- A £45m national programme to stimulate uptake of online consultation systems for every practice.

### Capital investment

#### Estates and Technology Transformation Fund

The GP Forward View identifies many pressing needs for investment in the general practice estate. Not only do many practices require investment to maintain their existing facilities, but significant investment is also required to allow general practice to deliver more care in the community as set out in NHS England’s Five Year Forward View.22

The GP Forward View therefore pledges to deliver £900m of capital investment by 2020/21, supported by measures to speed up the delivery of capital projects which can be frustratingly slow. This £900m is estimated to breakdown as follows:

- £225m from the Primary Care Transformation Fund (PCTF) (£75m/year until 2018/19)
- £150m from the extension of the PCTF, now the Estates and Technology Transformation Fund (ETTF) (£75m/year in 2019/20 and 2020/21)
- £525m other capital investment

Premises costs are a key concern for our members. Three in five members (57%) told us in our February survey that they do not think it is currently financially sustainable to run a general practice – of these, 44% name premises costs as a reason. This is up from 37% who said the same in August last year. It is therefore more essential than ever that NHS England delivers its pledges to improve the general practice estate.

The GP Forward View invited practices to apply through their CCGs for ETTF funding for 2016/17. In our interim assessment of the GP Forward View the College reported that nearly 300 schemes had been identified for funding, subject to due diligence. NHS England now reports that 198 schemes were completed in 2016/17 (69 of which related to technology), with 169 in delivery and a further 656 identified subject to due diligence, which demonstrates progress.23 NHS England have also publicised examples of how ETTF funding has been used to the benefit of practices.

However, some of our members have had difficulties applying for the scheme and its predecessors, reporting complicated application procedures, poor communication from CCGs and NHS England, shifting deadlines, “moving goalposts” and a high level of financial risk due to these factors.
Case study

Estates and Technology Transformation Fund

The RCGP talked to a GP partner and practice manager from the South West whose practice has been left in a financially perilous situation due to missing out on ETTF funding.

The practice had identified a potential site and made an application to the former PCIF for a c.1000m² new build premises to allow them to scale up, become sustainable in the long-term, and deliver the kind of transformation called for in the GP Forward View.

The practice manager described feeling optimistic about the business case, which had taken a week to produce, and was positively received by the CCG: “It seemed to tick all the boxes. It gave us resilience long-term, the ability to grow long-term, it serviced the community, it provided an appropriately located site for residential development and growth, in line with the STP, and right up until the last moment we were pretty confident it was going through.”

However, despite being due to find out the result of their application after three or four months, it was more than a year and a half before the practice heard anything, having had to update the business case for the ETTF in the meantime.

Subsequently the practice was informed that their bid had been unsuccessful – but they received no feedback about the reasons why this was, nor were they signposted to any alternative sources of funding.

Due to the delay and the subsequent decision not to award funding, the practice has been left in a very precarious position: “Unfortunately because this has all taken two or three years, in the meantime the ex-partners have given us notice on the two buildings we had occupied beforehand. We’ve therefore incurred huge legal and removal costs to figure out a medium-term solution so we still have somewhere to operate from, which has involved bringing porta-cabins in, which is a huge additional cost, and has increased the notional rents that NHS England have to pay.”

Ultimately, it the GP felt that short-term financial savings have been prioritised over long-term strategy: “One of the bits of feedback we got right at the very end was that the Estates team wanted to do a further review of the long-term running costs — they mean notional rent effectively — between what would be the new build option and the converted listed building option. The converted listed building option would almost certainly come in cheaper, however, it wouldn’t give us anywhere near the facilities that the new build option would. We would run out of space fairly quickly. The world has moved on significantly since the original scope of that development.”

“The key thing for me is that they haven’t looked at it strategically. My feeling is that they’ve looked at it from this week’s bottom line.”
“Deadlines for us were fixed but timescales for communication appeared fluid on their part. We needed to complete the work in a short timescale due to this — it was very stressful and we had the plans and permissions ‘on the shelf’ ready to go. Even to the last minute we feared we would lose the funding and become liable for the full costs.”

GP, East of England

Members also reported severe delays in the process both this year and last year with many waiting months to hear the outcome of their applications:

“In the first year everyone got late notice. I think it was formally announced in January sometime and I think the deadline was the end of February to apply. There’s always late notice. Our experience of the bid process in the first year was that there was this £250m they had which had to be spent by the end of the year. So everyone rushed to put out plans showing how they could spend the money in a year, and submitted those in February, and it was practically November before they announced whether your bids had been approved in principle. And of course then they said no to all of them because nobody could spend the money in three months. Well it doesn’t take a genius to work out that if you take eight months to reach a decision you’re not going to be able to spend the money in that financial year. The same thing’s happened this year. The decision process took slightly less long but it has still gobbled up huge chunks of the year and they still haven’t released any money for it.”

GP, London

Finally, the experiences of RCGP members highlight regional disparities in the delivery of the ETTF. Some report that NHS England local area teams have frustrated the process. For example, one GP in the South West reported that “the actual reality of dispersing the money didn’t happen until the CCG got involved.” Many reported mixed experiences with their local NHS England area teams, and a significant number reported poor communication and shifting deadlines and processes from NHS England.

However, others reported more positive engagement with NHS England area teams, and less positive experiences with CCGs:

“We put in a bid around August, September 2015 and actually got the backing of the NHS England estates chap who was incredibly supportive, he knows the practice really well, he knows we’re different from other practices… and said ‘I don’t see this being a problem, however it does need to go through your CCG…’ I thought, that’s great, as the CCG has always been right behind us so I don’t see that being a problem. And it completely stalled at the CCG and they started making all sorts of odd statements. And then they started making some additional clauses to the funding.”

GP, South West

Despite the positive news that 198 ETTF schemes have been completed, with more in progress, the RCGP’s research demonstrates some clear issues with the delivery of the programme which NHS England, working with CCGs, must take immediate steps to address.

Premises costs

Alongside capital investment, the GP Forward View also pledged several measures to assist practices with other premises costs, such as Stamp Duty Land Tax, VAT, and service charges.

NHS England has now brought forward support for practices to reimburse the costs of Stamp Duty Land Tax and legal fees when completing leases as tenants of NHS Property Services and Community Health Partnership properties, plus reimbursement of VAT on rent, where
appropriate; and to provide transitional support for the management fees on service charges for a period of up to two years. NHS Property Services has advised that 1,200 practices could benefit from the changes. However, according to NHS England and NHS Property Services, take up has been low so far. Current efforts must be redoubled to ensure that all practices who can benefit do so by the autumn. It is also right that further work is being undertaken to understand the barriers to take-up.

Concerningly, one of the themes to have emerged from the RCGP regional ambassadors is that NHS Property Services are acting as a barrier to the development of the general practice estate in line with the GP Forward View. For example, the ambassador for Birmingham and Solihull describes how lease issues with NHS Property Services “remain at the forefront of many practices’ minds” while two other ambassadors in Hereford and Worcester and South West London describe them as “actively hindering GP Forward View and GP morale” and “[putting] up barriers and [not] supporting GPs.” The Department of Health must act to ensure that the charges being levied by NHS Property Services are sufficiently ameliorated as promised, and that NHS Property Services are not acting to undermine the delivery of the GP Forward View’s estates strategy.

Premises Costs Directions

Another key pledge in the GP Forward View related to capital investment was the pledge to bring forward changes to the Premises Costs Directions to allow NHS England to fund up to 100% of the cost of premises developments. This was due to be concluded by September 2016, yet at the time of the publication of the College’s interim assessment of the GP Forward View in January 2017, these had not yet been issued.

The College is extremely disappointed that, seven months on, the situation remains the same. This has caused problems for our members, such as for one practice, which has been forced to borrow the remaining 33% of the cost of their new building, which has made their finances “ever more uncertain.”

NHS England report that the most recent delay in making the promised changes was due to purdah rules ahead of the general election and that the new directions will be published shortly. Given the long delay compared to the original deadline of September 2016, it is vital that all parties work together to ensure these new rules are brought forward as soon as possible.

Technology

The College’s interim assessment of the GP Forward View reported that new core requirements for GP IT services had been set in the 2016-18 GP IT services operating model, such as access as standard to SMS or an equivalent electronic messaging system, remote access to the clinical system outside the practice, and specialist IT security support services.

It is still unclear how effective the roll-out of these requirements has been; however, it is welcome that NHS England has brought forward a tool, the Digital Primary Care Maturity Assurance Model, to assist CCGs in ensuring that locally commissioned GP IT services are compliant with core requirements. However, this cannot be a replacement for NHS England carrying out its own monitoring of compliance.

The importance of delivering IT security support services for practices was outlined by the recent ransomware attack on the NHS so it is particularly critical that these services are commissioned and brought online quickly.

The GP Forward View also pledged at least an 18% real terms uplift in CCG GP IT revenue allocations in 2016/17, which has been delivered. NHS England have issued guidance on how this additional money should be spent, but it is too early to tell whether CCGs have fully invested their GP IT uplifts as the data is not yet available.

RCGP members suggest that changes to IT infrastructure could be among the most important changes to be made in general practice:

“I think if you get IT sorted then all those other things like promoting self-care, access, giving patients online access, collaborative working – it works if you have a single slick website — but in order to do that well it does require some upfront funding... having a patient portal, especially if you’re doing collaborative working... things like self-care, booking their own appointments and doing their own prescriptions becomes easier.”

GP, South West

It is therefore welcome that some RCGP regional ambassadors report positive changes to IT provision in general practice over the past year. For example, in Bristol, North
Somerset and South Gloucestershire, the RCGP ambassador reports that a GP federation has been successful in securing funds to develop IT systems across the group including shared telephony and a universal IT system. Similarly, the RCGP ambassador for Northamptonshire reports that more inter-practice working is being made possible. These are positive developments, but the picture is not consistent nationwide, or even within regions.

“In terms of IT, I’m really confused because one minute there might be money, the next minute it doesn’t seem like it, so I don’t know where we’re at with that.”

GP, South West

Similarly, NHS England pledged to fund the development of Wi-Fi in practices in 2017/18. Ten per cent of practices were covered by phase one funding in January and coverage is expected to be rolled out across all practices by the end of 2017, which would represent excellent progress. The funding is based on registered list size and is intended to cover implementation costs in 2016/17 and 2017/18 and some service charges. It is essential that NHS England delivers this funding and monitors it to ensure that it is sufficient. NHS England should also ensure that CCGs and practices have sufficient guidance to roll-out Wi-Fi effectively.

There is some positive feedback on the ground relating to Wi-Fi in practices. RCGP regional ambassadors for Hereford and Worcester and Northamptonshire report that some practices are now able to deliver Wi-Fi. One ambassador has noted the benefit this should provide to members of the wider community team such as community nurses, who will be able to access their iPads within GP surgeries despite not being based there. The progress is reflected in our own research. There has been an increase in the percentage of members offering Wi-Fi in practices according to the RCGP’s surveys, with the February survey showing 19% offering Wi-Fi in practices compared to 13% in the August survey.

NHS England has also launched a test version of its apps library to support clinicians and patients, which is being populated by approved apps which have undergone a digital assessment. It remains to be seen what benefit this library will bring to patients and doctors but it is a welcome attempt to make digital self-care tools more accessible for patients. This will be supported by the development of the Widening Digital Participation programme launched by NHS England to reduce digital exclusion in health.

There is a long way to go to improve interoperability between clinical IT systems so it is welcome that NHS England has begun work in this area, including investment through the ETTF. For example, it is a requirement in the new national standard contract for hospitals that discharge letters be shared electronically by October 2018. Similarly, the uptake of access to the summary care record in community pharmacy continues to improve,

The GP Forward View pledged to launch a new programme to offer every practice in the country support to adopt online consultation systems. This will begin with £15m of investment in 2017/18. However, at the moment it appears that in some areas funding has not been released and the responsibility for developing these services is uncertain:

“The money allocated for e-consultation has not yet been shared with practices and so far we have not been encouraged to go down this route, although some practices are looking at e-consult or similar. [There] is no central initiative for this coming from the CCG.”

RCGP Ambassador for Northamptonshire

NHS England must ensure that the full £15m available for these services is released in 2017/18 along with clear guidance detailing how and by whom the services are intended to be delivered. NHS England reports that it has begun work to establish a framework for the cost-effective purchasing of e-consultation tools – it is essential that this is delivered by December 2017 as pledged in the GP Forward View.
with take-up now at 77%, up from 55% at the time of the publication of the RCGP’s interim assessment.

Efforts to improve interoperability will be supported by the planned implementation of SNOMED CT, an electronic coding system, in secondary acute, mental health and community care settings by 31 March 2020. However, more must be done at a faster pace to promote interoperability not only across different care settings but also within general practice.

It is therefore welcome that the GP Forward View also pledges some changes to the systems underpinning the provision of technology in general practice. In some cases, these are being developed. For example, NHS England has begun work to develop national standards, procurement models and a digital buying catalogue to make the commissioning of digital services easier. This is a welcome step and we would urge NHS England to ensure that GPs are involved as early as possible in the development of these tools as well as to provide greater clarity about what tools are being delivered and when.

**Conclusion and recommendations**

NHS England has made reasonable progress in delivering its pledges on practice infrastructure. In the area of technology in particular, NHS England has amended the core requirements for IT services and begun to release funding for the roll-out of online consultation systems and Wi-Fi in practices. There is evidence that this funding is already having some impact on the ground, with some areas reporting improved IT interfaces between practices and positive benefits of Wi-Fi in practices.

Estates issues remain very challenging. NHS Property Services charges are a struggle for many practices holding leases with them, and appear in some areas to be undermining progress towards the estates vision outlined in the GP Forward View.

Moreover, some practices have struggled to access much-needed capital investment despite the pledges made in the GP Forward View. The Estates and Technology Transformation Fund was very complicated to apply for and communication throughout is reported to have been poor. Funding, where it has been released, has taken a long time to get through, and where practices have failed to secure funding many have been left unsure as to why and without any source of alternative funds.

To address these issues, NHS England and others must take the following steps:

- NHS England and the Department of Health must, as a matter of urgency, work with all parties to conclude the changes to the Premises Costs Directions allowing them to fund up to 100% of the cost of developments.
- NHS England and NHS Property Services must redouble their efforts to ensure that all eligible practices can take advantage of transitional support for premises costs.
- The Department of Health and NHS England must ensure that NHS Property Services proactively support the estates strategy outlined in the GP Forward View.
- NHS England must ensure that, as the ETTF is now fully allocated, practices that did not receive funding and need help have options open to them.
- NHS England must produce clear guidance and ensure firm oversight of the delivery of online consultation systems to ensure they bring maximum benefit to practices.
- NHS England and NHS Digital must monitor the funding formula for practice Wi-Fi to ensure that it is sufficient for practices.
Care redesign

The NHS was designed around patients with very different needs to those we see today. There is now growing consensus that new ways of working are required to enable the health service to continue to provide high-quality, safe care in a manner that is sustainable.

Given the complexity of the current system it will inevitably take time to bring about transformation on a wide scale. However, the GP Forward View outlines a number of steps to support this process.

While there has been some good progress on practice development, for the most part the commitments on care redesign were not due to be delivered in 2016/17. Nevertheless, over the past year there have been concerning signs that commissioners in some local areas may take a top-down approach to their eventual implementation.

Extended access

The College has always been clear that GP practices must not be forced to open when there is no local need. The GP Forward View recognised this, stating that it will be for commissioners to determine what extended access provision looks like in their local area based on the needs of patients and best value for money. The Next Steps on the NHS Five Year Forward View reconfirmed that the extended access plans do not require every practice to be open evenings and weekends.

The GP Forward View pledges funding for this extra capacity with £500m recurrent funding by 2020/21. The Operational Planning and Contracting Guidance 2017-19, which sets out NHS England's intentions for this funding, is aligned with the commitments in the GP Forward View on seven-day working. It requires CCGs to commission

Key care redesign commitments

- Additional funding provided to enable CCGs to commission and fund extra capacity across England to improve access to general practice.
- CCGs to provide £171m of practice transformational support.
- Go live with a Multispecialty Community Provider (MCP) contract in April 2017.

% patients who don’t find their GP surgery’s opening hours convenient and believe the following opening hours would increase convenience

After 6.30pm
extended access based on an additional 1.5 hours after 6.30pm on weekdays and based on local demand on Saturdays and Sundays. £6 per head of population recurrent funding will be available to CCGs to invest in existing GP Access Fund Schemes and transformation areas from 2017/18. Equivalent funding will become available to all CCGs from April 2019.27

NHS England have said they do not expect CCGs to invest this funding in its entirety in additional evening and weekend appointments but to support wider transformation.

However, better guidance for commissioners and local leaders is clearly needed to ensure that the principles in the GP Forward View are upheld as this funding becomes available. Our analysis of the 44 STP plans found that while the majority predicate investment in general practice on delivering extended access, very few show any attempt to analyse local demand.28 As the maps on this page show, there is significant regional variation in demand for different types of extended opening hours.29

Members have also reported that local decision-makers are defining extended access as 8am-8pm seven days a week. One GP in the South West said:

“The CCG are very, very keen to push us towards 8am—8pm seven days a week – that seems [to be] their priority...whenever you say we need a bit of funding to do what we need to do, we’re now at that stage where we’re ready to work together to do the GP Forward View, [the CCG says] well, you can get money if you do 8am—8pm seven days a week – that seems to be a bit of a retort.”
This signals a failure not only to understand the national requirements but also to recognise that the vast majority of practices already offer extended services. According to NHS England figures from March 2017, 83.4% of all practices, covering 86.4% of registered patients in England, provide at least partial extended access (defined as one day per week of access to pre-bookable appointments during extended hours, either on weekdays or at weekends) either on their own or in collaboration with other practices. In addition, in the most recent GP Patient Survey, 81% of patients who had tried to get an appointment said they were offered one that was convenient, while 76% of all patients were satisfied with their GP surgery’s opening times, indicating existing services are meeting the needs of most patients.31

NHS England also reports that the numbers of practices offering full provision of extended access are on the rise, up to 22.5%, an increase of 4.9 percentage points from October 2016.32 It is therefore vital that investment decisions are based on robust analysis not only of local need but also of existing service provision.

**Practice development**

Over the next few years there will be increasing opportunities for GPs to lead service redesign. Therefore, in addition to support for regular clinical and administrative workloads, GPs will also need support to prepare them for these new roles. The General Practice Improvement Leaders programme is a free nine month personal development programme which contributes to the **GP Forward View** commitment to invest further in leadership development, coaching and mentoring skills for experienced doctors.

As of 25 May 2017, 45 delegates had completed the programme with a further 51 taking part. The next two cohorts had 61 delegates booked to attend, with 24 on the waiting list. Furthermore, NHS England reports that 632 coaching sessions have been delivered for 318 experienced GPs. However, the numbers seem small at this point; given the scale of change required, this kind of training needs to be made available much more widely.

The **GP Forward View** also indicated that CCGs would need to strengthen arrangements for protected learning time and backfill to enable GPs to have time and space for development. Currently we are unaware of progress in this area. It is important CCGs take this on.

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**Practice transformation**

CCGs are responsible for identifying the £171m for practice transformational support from their own budgets. Most CCG plans do make provision for this. However, there are concerning signs of a disconnect between frontline GPs and commissioners in some areas. We recognise that some CCGs are in special measures but remedial plans being imposed on them should not inhibit them from meeting the **GP Forward View** pledges.

According to our latest survey, more than two thirds of GPs (68%) do not trust their local NHS and commissioners to implement the changes in the **GP Forward View** and around half (48%) think there is less local funding available than a year ago.

One GP in the Midlands told us there was “no money for ordinary practices despite savings held at the CCG”.

Another said:

> “Local area team have an opposing agenda to local practices and as such are withholding funds from the **GP Forward View** until practices align with their view rather than the needs of the practice. Local CCG has failed to hold trusts to account on overspends and seeks to recoup costs from GPs as the easy target.”

**GP, South West**

Another common theme is the emphasis from CCGs on investment in pilot initiatives intended to deliver quick wins, which is acting as a barrier to meaningful and long-lasting transformation. One member in the South East expressed their concern that the CCG seemed “determined to invest in untried schemes and gimmicks rather than practices”. Another GP in the South West told us they had been unable to make any long-term workforce planning decisions as a result.

This suggests that even if the funding commitment is delivered on paper, little impact may be felt at grassroots level. In addition to ensuring all CCG plans cover this investment, NHS England must therefore also hold CCGs to account on engagement with local GPs. Plans should not be implemented without their support.
New care models

The GP Forward View confirmed NHS England’s intention to go live with a new voluntary Multispecialty Community Provider (MCP) contract in April 2017. A draft contract, developed in conjunction with the vanguards, was published in December 2016. Publication of the version for use in 2017/18, now called the Accountable Care Organisation (ACO) contract, by the early adopters was delayed due to the General Election, but is expected to be available soon. This revised version is usable for accountable care models generally.

The College has had input into the development of the contract through representation on NHS England’s MCP Voluntary Contract Advisory Group. In response to our feedback about the importance of retaining flexibility of contractual options for GPs, NHS England has created three versions, giving GPs choice over the extent to which they integrate with an MCP or other types of ACO.

The College has always acknowledged the need for and been supportive of the development of new models of care, with the proviso that there is no single answer to the difficult questions currently facing the health service. We have, however, repeatedly raised concerns about the lack of engagement with frontline, specifically non-vanguard, GPs throughout the process. If the MCP contract is to be an attractive option for GPs that is fit for use on a wide scale, NHS England must ensure that it truly is voluntary and that GPs have all the necessary information to enable them to make an informed decision about their future.

Meanwhile, the national new care models agenda has moved forward significantly since the publication of the GP Forward View. The Next Steps on the Five Year Forward View sets out plans to encourage practices to collaborate at the 30-50,000 population level through ‘hubs’ or networks. It also identifies a small number of areas where STPs or new care models are further evolved where Accountable Care Systems will be introduced.

Pace of progress will inevitably vary; however, we are frequently hearing that positive rhetoric is failing to translate into action in some areas, while in others local leaders are pressing ahead without the full support of grassroots GPs. The RCGP regional ambassador for Cumbria reports:

“The only model being talked about in Cumbria is the Integrated Care Community (ICC). This is based on the formation of eight ICCs across Cumbria with population bases of 20—60,000. GP leads are being appointed and managers have already been appointed in three ‘early adopter’ sites.

The intention is to save £12m with investment of £4m in primary care. Already £1m has been allocated to managers alone, with the formation of ‘hubs’ likely to consume the rest. There is little sign that this ‘top-down’ approach to forming federations will lead to GPs integrating in any meaningful way and therefore little likelihood of this resulting in savings.

The Community Trust, Foundation Trust and local authority seem keen to start the merging of their organisations into an Accountable Care Organisation, but there are huge organisational challenges with lots of rhetoric and little change on the ground.”

Engagement from the earliest stages with all local clinicians to ensure there is support for the direction of travel will be critical to the success of service redesign across the country. It is also essential that NHS England ensures there is a system in place for enabling the spread of the new care models so that GPs are supported to take on leadership roles and genuine change is felt on the ground beyond the vanguard sites.
Conclusion and recommendations

Overall, progress on care redesign over the first year of the GP Forward View has been mixed. National schemes have taken positive steps: the General Practice Development Programme is providing support in a variety of ways, while the MCP contract was also on track, although the general election has slowed this down. It remains to be seen if NHS England will meet their original timetable.

However, for the time being at least, these initiatives will only have an impact in small pockets. It is the two key local pledges – the £500m recurrent funding for extra capacity by 2020/21 and the £171m of practice transformational support – that have the potential to act as an enabler for widespread transformation. These must therefore serve as the main benchmark of success.

Nevertheless, it is hard to define what these topline commitments mean for GPs and therefore what constitutes success. In one sense this is a positive, as transformation must be system-wide and locally driven if it is to make a genuine difference.

On the other hand, it is also a risk to their delivery. The pace and shape of change will rightly vary across the country. The benefits to patients, healthcare professionals and the NHS may also be ‘softer’, particularly in the short-term. This does not mean they should be ignored.

CCGs must resist the temptation to predicate this investment on sticking plaster solutions and measures that are more easily quantifiable. Delivery may not have been due to start until 2017/18, but the current prospects of this happening do not look positive in all areas. If commissioners do not work with frontline clinicians to deploy these funds flexibly according to local need, it will be a wasted opportunity the NHS can ill afford.

The College is therefore making the following recommendations:

- NHS England must hold CCGs to account on extended access requirements to ensure that no practice is forced to open 8am—8pm seven days a week.
- CCGs must not predicate investment in general practice solely on extended access and their plans for extended access must be based on analysis of both local need and existing service provision.
- NHS England must ensure that funding as part of the General Practice Development Programme continues to be delivered on time and in full, and that the programme makes a meaningful difference to practices.
- General practice must be at the heart of service redesign. The General Practice Improvement Leaders programme should be extended to support more GPs to take on leadership roles.
- All CCG plans must make provision for the funding commitment for practice transformation. Plans must only be implemented where they have the support of GPs in the locality.
- New care models must be developed through engagement with local GPs from the earliest stages, and GPs must not be forced to move onto new contracts.
- CCGs must strengthen arrangements for protected learning time and backfill to enable GPs to undertake development activities.
Among around 100 commitments, there are a couple that stand out as those on which the success of the GP Forward View will ultimately be judged. One of these fundamental commitments is to increase the FTE GP workforce by 5,000 over five years. A year in, this commitment looks to be on shaky ground. It will take time for some of the recruitment initiatives proposed in the GP Forward View to take effect, not least the increase in the number of GP trainees. Nonetheless, it is disheartening to see a decrease in the number of GPs and concerning to hear from our members how recruitment difficulties are translating into workload pressures that many do not feel they can cope with much longer. As doctors leave general practice, unable to cope with the intense demands, these issues are only exacerbated. The cycle of workforce issues is inevitable unless serious progress is made in increasing GP numbers. New and potentially radical solutions are needed to reverse the trends.

Investment being made in general practice should help turn the tide. Generally, investment that was promised in 2016/17 has been made, and while this may not yet be felt by all GPs, if funding continues to increase as assured then general practice will be receiving far better support than it has been used to in recent years. The key will be to make sure money is being distributed fairly, in ways that will have impact, with minimal bureaucracy.

This support will be needed given not only the ongoing pressures of general practice, but also the transformation of the health service. With care redesign accelerating, there are opportunities for general practice, but ultimately the priority must be to protect that which makes general practice such an integral service. The voices of GPs must be heard in transformation processes and general practice itself must have sufficient support and investment to broker any changes. The GP Forward View promises new and expanded buildings, advanced digital landscapes, multidisciplinary teams and innovative approaches to workload management. In some areas, these changes are starting to be seen, but there is a long way to go. The ambition of the GP Forward View must be seen through.

Recommendations

Our recommendations for NHS England fall into six categories:

- **Rethink**
  - In some areas NHS England must review their current strategy to ensure that pledges are delivered. This is particularly important for the delivery of 5,000 additional FTE GPs.

- **Improve**
  - In many areas NHS England is making progress but must take steps to ensure that the delivery of pledges is bringing meaningful benefit to practices, GPs, and patients.

- **Deliver**
  - It is not clear in some cases that funding is being delivered locally, with CCGs and NHS England local teams sometimes acting as a barrier to delivery.

- **Communicate**
  - Where pledges are being delivered NHS England must ensure that opportunities are effectively communicated to practices to make sure all GPs and practices who can do benefit.

- **Expand**
  - Some programmes which are already being delivered should be expanded.

- **Continue**
  - In some areas, we are calling for current work to continue.
**Rethink**

1. NHS England and HEE to work with partners to refresh their strategy to increase the number of FTE doctors working in general practice, to ensure much more progress is made. This should include a focus on retention and international recruitment.

2. The Government must consult on and implement long-term solutions to the indemnity crisis as a matter of urgency.

3. NHS England to review with stakeholders what more can be done to reduce GP workload to a manageable level.

4. The CQC should use the opportunity of changes to the regulatory inspection regime to consider the reduction of fees to prevent money being diverted away from frontline patient care.

**Improve**

1. Support given to practices (such as resilience funding) should reflect a shared understanding of GP practices’ needs and the kind of support that will be most effective in meeting these.

2. Management consultancies should not be contracted to deliver resilience support unless this is the explicit wish of the relevant practice.

3. Create a single website to administer applications for returning to general practice.

4. HEE should report on the number of doctors who complete GP training and work with NHS England to identify the number who take up jobs in general practice following GP training. This should inform workforce calculations and planning. If pressure points are identified, solutions should be put in place.

5. HEE to review the reasons for lower than anticipated post-CCT fellowship numbers and take action to increase these.

6. HEE to address barriers stopping nurses from becoming mentors.

7. Work should begin with payment providers to streamline payment processes for practices to focus on improvements to consistency and accuracy of payments.

8. NHS England and NHS Property Services must redouble their efforts to ensure that all eligible practices can take advantage of transitional support for premises costs.

9. The Department of Health and NHS England must ensure that NHS Property Services proactively support the estates strategy outlined in the GP Forward View.

10. CCGs must strengthen arrangements for protected learning time and backfill to enable GPs to undertake development activities.

11. The CQC should conduct and publish an impact assessment of their proposed changes to CQC inspections in general practice. In particular, they should indicate the change in regulatory burden expected as a result of each proposal.

12. NHS England and HEE’s plan for practice nursing must include a commitment to bringing forward targets for increasing nurses in general practice.

**Deliver**

1. CCGs must ensure they are fully spending their budgets relating to general practice.

2. CCGs must identify appropriate funding for practice transformational support, to ensure the commitment of £171m is met.

3. NHS England and the Department of Health must, as a matter of urgency, work with all parties to conclude the changes to the Premises Costs Directions allowing them to fund up to 100% of the cost of developments.

4. NHS England must hold CCGs to account on extended access requirements to ensure that no practice is forced to open 8am-8pm seven days a week.

5. CCGs must not predicate investment in general practice solely on extended access and their plans for extended access must be based on analysis of both local need and existing service provision.

6. All CCG plans must make provision for the funding commitment for practice transformation. Plans must only be implemented where they have the support of GPs in the locality.
Communicate

1. NHS England and CCGs should ensure that funding opportunities are widely publicised, with accessible application processes that do not take an unreasonable amount of time. This might involve processes that cover several schemes so key information does not require duplication, while ensuring that any practice aware of one scheme will also have the other schemes clearly flagged.

2. Communicate workforce schemes widely, including the returners scheme, retainers scheme, GP health service and clinical pharmacists scheme, through a national NHS England information programme advertising the opportunities and schemes to all doctors, nurses and Allied Health Professionals.

3. Ensure the ‘Nothing general about general practice’ campaign has wide reach among medical students and foundation stage trainees.

4. NHS England and NHS Improvement should raise awareness of the changes to the NHS Standard Contract amongst trusts and hold commissioners to account to ensure the new contract terms are introduced and enforced.

5. NHS England must produce clear guidance and ensure firm oversight of the delivery of online consultation systems to ensure they bring maximum benefit to practices.

6. New care models must be developed through engagement with local GPs from the earliest stages, and GPs must not be forced to move onto new contracts.

Expand

1. The practice resilience programme should be expanded to recognise the demand.

2. Review the returners scheme to make further improvements and ensure it is inclusive of those who have not practised for a while despite being on the performers list.

3. General practice must be at the heart of service redesign. The General Practice Improvement Leaders programme should be extended to support more GPs to take on leadership roles.

4. NHS England must ensure that, as the ETTF is now fully allocated, practices that did not receive funding and need help have options open to them.

Continue

1. The Department of Health and NHS England must continue to support GPs with rising indemnity costs while a long-term solution is being found, including urgent action to absorb the impact of the discount rate change.

2. NHS England should continue to develop collaborative care and support planning for people living with multiple long-term conditions, with protected time for practices to receive training.

3. NHS England should continue work with other organisations and the profession to develop a successor to QOF, with reduction in administrative burden made a key test for the development of the replacement.

4. NHS England and NHS Digital must monitor the funding formula for practice Wi-Fi to ensure that it is sufficient for practices.

5. NHS England must ensure that funding as part of the General Practice Development Programme continues to be delivered on time and in full, and that the programme makes a meaningful difference to practices.
## Appendix A: Short-term commitments

### Investment

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<td>For 2016/17, NHS England will allocate an additional £322m in primary medical care allocations, providing for an immediate increase in funding of 4.4%.</td>
<td>NHS England advise that the £322m is on track to be spent. But until NHS Digital’s investment in general practice report is released in the autumn, this will not be confirmed.</td>
<td>Amber</td>
<td>Although total spend on general practice in 2016/17 will only be confirmed by audited figures released by NHS Digital later this year, NHS England are confident that these allocations were made.</td>
<td>Amber</td>
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<td>NHS England will introduce a practice resilience programme worth £56m over five years, with £16m available in 2016/17.</td>
<td>Only 219 practices (15%) had received support, and while £15.9m of funding had been committed, only £2.5m had been spent as at 31 December 2016.</td>
<td>Red</td>
<td>At the end of March 2017, £17.2m has been spent in resilience funding and £10.2m of the vulnerable practices funding has been spent. However, some members have raised concerns about the efficacy of the support.</td>
<td>Amber</td>
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<td>NHS England and the Department of Health will bring forward proposals to tackle rising indemnity costs in general practice. In a related commitment, the Department of Health will consult on options for introducing a Fixed Recoverable Cost scheme in clinical negligence claims.</td>
<td>£33m was distributed through the contract in 2016/17 to offset indemnity increases in 2015/16. The winter indemnity scheme was extended for October to March 2016/17 and is worth £5m. Less progress has been made on the wider reform of indemnity arrangements. Though conversations have started, no formal consultation has begun.</td>
<td>Amber</td>
<td>In March and April 2017, £30m was distributed to practices relating to rises in 2016/17, and the winter indemnity scheme was extended to April 2017. The Department of Health and NHS England have expressly reassured general practice that any rises in indemnity costs associated with the change in discount rate will not be passed to them. However, several months have passed and there is still no clarity on how this will be prevented. There has also been no further progress related to long-term solutions to indemnity costs. The Department of Health has run a consultation on capping the level of recoverable costs on clinical negligence claims, though the results are not yet public.</td>
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### Workforce

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<td>Health Education England will increase GP training recruitment to 3,250 per year.</td>
<td>In 2016, 2,927 places were filled across Round 1 and 2 of GP recruitment, at a fill rate of 90%. Although not met in 2016 – it was a marked improvement from the 2,513 recruited in 2015.</td>
<td>Amber</td>
<td>HEE has indicated that things are on track for delivery of 3,250 GP recruits in 2017.</td>
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<td>Changes will be made to NHS England’s Induction &amp; Refresher scheme for doctors returning to work in English general practice.</td>
<td>Since the scheme was launched on 1 April 2016, 88 doctors have completed the scheme. There are currently over 200 doctors on the scheme, the majority of whom have joined since the monthly bursary was increased in November 2016.</td>
<td>Green</td>
<td>The numbers continue to rise: 106 have now completed, with 260 currently on the scheme.</td>
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NHS England and Health Education England will evaluate the Targeted Enhanced Recruitment Scheme, which offers £20,000 salary supplements to GP trainees committing to working in hard to recruit areas.

Local HEE offices have reported that the scheme has been successful in filling the hardest to recruit places. In 2017 the scheme will be repeated, with an increase in the number of training places to 144.

NHS England will increase the financial compensation available through the current GP retainer scheme from 1 May 2016, and to introduce a new GP retainer scheme more fit for purpose from 1 April 2017.

NHS England increased financial compensation for doctors on the scheme and for those joining up to 31 March 2017. The new GP retainer scheme is on track to be delivered by April 2017 and will form part of the new GMS contract for 2017/18.

NHS England will increase the financial compensation available through the current GP retainer scheme from 1 May 2016, and to introduce a new GP retainer scheme more fit for purpose from 1 April 2017.

Green

No changes since the interim assessment – the scheme continues.

Green

NHS England will increase the financial compensation available through the current GP retainer scheme from 1 May 2016, and to introduce a new GP retainer scheme more fit for purpose from 1 April 2017.

NHS England increased financial compensation for doctors on the scheme and for those joining up to 31 March 2017. The new GP retainer scheme is on track to be delivered by April 2017 and will form part of the new GMS contract for 2017/18.

The new GP retainer scheme was introduced in April 2017. It is too early to assess the impact of this.

Amber

Workload

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<td>NHS England will invest a further £16m in a new national service, beginning in December 2016, to improve GPs’ access to mental health support.</td>
<td>This service, which is worth £16m, launched at the end of January 2017. It is the first nationwide scheme of its kind in England and is welcome recognition of the need to safeguard the wellbeing of the GP workforce.</td>
<td>Green</td>
<td>There has been high take up of the scheme and feedback has been positive.</td>
<td>Green</td>
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<td>NHS England will introduce new standards for hospitals to improve the interface between hospitals and general practice.</td>
<td>These changes have the potential to significantly reduce GP workload. It is not clear if the new standards are being implemented by all hospitals. NHS England has written to all CCG Accountable Officers and all NHS Trust and Foundation Trust Chief Executives to reinforce the new requirements.</td>
<td>Amber</td>
<td>The College’s most recent survey indicated that only 3% of GPs have seen a reduction in the administrative workload of practices that they think are a result of the changes to the NHS Standard Contract since April 2016. There should be continued efforts to ensure that frontline practitioners are aware of the changes and that commissioners introduce and enforce the new contract terms.</td>
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<td>NHS England established a Rapid Testing Programme in three sites to review ways of better managing outpatient demand. The GP Forward View will see the most effective measures emerging from this programme would be rolled out from late summer 2016 onwards.</td>
<td>NHS England is evaluating the learning from the programme, with findings expected in February 2017. More testing will occur prior to a planned national roll-out in 2017/18 and 2018/19. This represents relatively slow progress.</td>
<td>Amber</td>
<td>A small 100-day programme ran with 2 sites in 2016, which was then expanded to a development collaborative with 4 sites working collected on the elective care demand management challenges. This has helped to build a stronger evidence base for sharing the learning and interventions more widely across the country. There are limited outcomes at this point.</td>
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## Workload cont.

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<td>The maximum interval between inspections for practices rated good or outstanding will move to five years, and a new streamlined approach to inspection will be introduced for new care models and federated practices.</td>
<td>This is a positive step towards ensuring that practices rated good and outstanding do not face excessive levels of inspection. It remains to be seen how it will be interpreted in practice. For new models of care including federations, the CQC intends to focus on how well-led these organisations are at a corporate level, and has committed to considering inspecting a sample of locations rather than every practice within a group. The CQC is currently consulting on these proposals. We are disappointed that this new inspection framework has not been used as an opportunity to curtail the costs of inspection. CQC should focus on reducing the cost of its inspection regime and work with the Government and NHS England to consider alternative mechanisms through which the costs of inspection could be met by the Government.</td>
<td>Amber</td>
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<td>NHS England will ensure practices are appropriately compensated for future CQC fee increases. They will publish a set of key ‘sentinel’ indicators for quality in general practice on My NHS in July 2016. We anticipate that NHS England will cover the cost of proposed CQC fee increases in the contract negotiation for 2017/18. The sentinel indicators were published on the MyNHS website in September 2016.</td>
<td>We anticipate that NHS England will cover the cost of proposed CQC fee increases in the contract negotiation for 2017/18. The sentinel indicators were published on the MyNHS website in September 2016.</td>
<td>Green</td>
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<td>NHS England will undertake a review of QOF in 2016/17.</td>
<td>QOF will not end immediately in 2017/18 but NHS England will begin to consider how to replace it. A review will not be concluded this year (2016). For practices opting in, the Multispecialty Community Provider voluntary contract provides for the replacement of QOF with holistic team-based funding.</td>
<td>Red</td>
<td>Discussions are taking place to consider what a replacement scheme may look like. There are already areas of the country exploring alternatives to QOF.</td>
<td>Amber</td>
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<td>NHS England will bring forward £30m ‘Releasing Time for Patients’ development programme to release capacity within general practice.</td>
<td>The programme has engaged 67 cohorts of practices, covering 31% of the practice population. NHS England reports that feedback has been positive, in part due to the practical focus on the programme. We are concerned that procurement issues have led to delays in the spending of the £5m for receptionists and clerical staff.</td>
<td>Amber</td>
<td>To date, there have been 90 schemes covering 115 CCGs. NHS England estimate that most participating practices can expect to release 10% of GP time based on feedback from those who have already taken part. There is no further clarity on spending.</td>
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### Infrastructure

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<td>NHS England will invite CCGs to put forward recommendations for investment in primary care infrastructure and technology by the end of June 2016.</td>
<td>Not all practices who applied for funding through the ETTF are expected to receive funding. Practices who submitted fundable bids to their CCGs must not lose out on vital capital funding, and it important that NHS England works with practices to identify alternative sources of funding in such cases. NHS England should also ensure that any money not allocated in this of the programme is carried over to next year.</td>
<td>Amber</td>
<td>There has been an increase in the number of practices benefiting from ETTF awards, with almost 200 projects completed in 2016/17. However, some members have reported severe delays in the process this year with many waiting months to hear the outcome of their applications.</td>
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<td>NHS England will introduce new rules from September 2016 which will enable NHS England to fund up to 100 percent of the costs of premises developments, rather than the previous cap of 66 percent.</td>
<td>Changes to the Premises Cost Directions are needed to bring in the new rules; these have not yet been issued and are now expected in February 2017.</td>
<td>Red</td>
<td>Changes to the Premises Costs Directions have not yet been issued.</td>
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<td>NHS England will agree arrangements for May 2016 to October 2017 to provide additional support to practices in three areas – 1) Stamp duty 2) VAT 3) service charges</td>
<td>Measures to support practices with undocumented tenancies have been agreed with NHS Property Services (NHSPS) and Community Health Partnerships (CHP). NHS Property Services has identified that nearly 1,200 practices could benefit from these initiatives.</td>
<td>Green</td>
<td>NHS England has now brought forward support for practices to reimburse the costs of Stamp Duty Land Tax and VAT where appropriate.</td>
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<td>NHS England will introduce a range of core requirements for technology services to be provided to general practice.</td>
<td>CCGs received an 18.5% real terms uplift in GP IT revenue allocations in 2016/17, and it is essential that this is invested in enhancing the IT capabilities of general practice.</td>
<td>Green</td>
<td>No change from interim assessment.</td>
<td>Green</td>
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<td>The roll-out of access to the summary care record to community pharmacy will be completed by March 2017.</td>
<td>NHS England reports that over 85% of pharmacy professionals have received training in the use of the Summary Care Record, and that all pharmacists will have received training by March 2017. 55% have accessed the summary care record and the rate of uptake is increasing.</td>
<td>Green</td>
<td>Approximately 32,000 pharmacy professionals have received training and 77% have accessed the summary care record.</td>
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### Care redesign

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<td>NHS England will launch a national programme by September 2016 to help practices support people living with long-term conditions to self-care.</td>
<td>NHS England has made progress in delivering this pledge through a number of different initiatives.</td>
<td>Green</td>
<td>NHS England continues to deliver initiatives aligned with this pledge. Pilots relating patient activation and health literacy are ongoing.</td>
<td>Green</td>
</tr>
</tbody>
</table>
Appendix B: Commitments for 2017/18

With the first year over, the College will be continuing to monitor the implementation of the GP Forward View. There are some commitments that are specifically related to 2017/18, either named in the document itself, NHS England’s board paper in March or their review of the Five Year Forward View. They are:

- £301m extra investment into primary medical care allocations in 2017/18 (increase of 3.9%).
- CCGs to start providing £171m in transformational support over two years.
- CQC fees will be reimbursed directly.
- Carr-Hill formula changes will be negotiated.
- Discussions to begin about the replacement to QOF.
- Aim for 50% of the population to have access to GP services at evenings and weekends.
- New GP retention scheme to be launched.
- Twelve month pilot of GP Career Plus, recruiting pools of GPs to work flexibly across the system.
- GP Improvement Leaders programme.
- Expansion of £20k salary supplement areas to 144 places.
- Second wave of practices receiving co-funding for clinical pharmacists.
- More extensive recruitment of overseas doctors.
- Additional support for practice nurses and non-clinical staff.
- Practice resilience programme (£8m) and GP development programme continuing.
- Increase in GP training recruitment to 3,250.
- Complete roll-out of 250 post-CCT fellowships in areas with the poorest GP recruitment.
- Develop, test and implement the technical requirements for a new task automation solution to reduce workload, with practices able to access the new automation function in 2017/18.
- Implementation of the programme of work to cut the bureaucratic burden of oversight.
- Start of the £45m national programme to stimulate uptake of online consultations systems for every practice.
- Free Wi-Fi in all surgeries.
- Ability for GPs to electronically to seek advice and guidance from a hospital specialist without the patient needing an outpatient appointment.
- At least £138m from CCGs to improve access to general practice services.
- £15m devolved to CCGs for technology.
- £10m devolved to CCGs for training reception and clerical staff to undertake document management and active signposting, to free up GP time.
References
