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General Practitioners Committee

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Dear Ros

Improving General Practice: A Call to Action

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK. With a membership of over 152,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

We welcome NHS England's attempt to comprehensively asses the opportunities and challenges facing general practice. The BMA's response to the review questions can be found below. UK general practice is recognised throughout the world as one of the most cost-effective, high quality primary care services. UK general practice provides excellent continuity, is responsive to local needs, and provides a focal point for a patient's pathway through the wider health service. General practice in England is, however, facing a number of significant challenges. Changing patient demographics and increasing demand are placing significant pressure on a service already reaching workload saturation. Year on year reductions in funding are exacerbating problems with recruitment and retention.

General practice has a proven track record in adapting and developing to meet new challenges, whilst providing the continuity of care so valued by patients. Many practices are already developing innovative new ways of working, including working together and with other health and care providers to deliver integrated services. However, in order to encourage this development, general practice needs essential resources and support. This includes placing trust in GPs to shape services to best meet the needs of their patients.

Yours sincerely

Vicki Chapman

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British Medical Association

Improving General Practice: A Call to Action
BMA response
November 2013

Information, choice and control

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

The BMA recognises the need for greater transparency in the NHS, with patients having access to accurate data about services. The publication of appropriate primary care data has the potential to drive up standards and achieve better outcomes for patients.

There are a number of practical issues to consider in publishing comparative information. We would recommend a focus on improving and safeguarding the accuracy and quality of data captured across the NHS so that patients are not misled, results cannot be manipulated and services do not suffer due to poor quality data.

Data need to be presented in a clear and unambiguous way to be of greatest use to patients. For example, when comparing performance between providers, efforts should be made to ensure data are truly comparable, acknowledging local context and challenge. Raw health data cannot always reflect the complexities and subtleties of providing care in a particular area and it is vital that healthcare professionals are involved in decisions about the publication of data, to point out caveats, potential misinterpretations and limits to the data which may not be apparent to others. Misinterpretation could impact unfairly on a clinician's reputation, which in turn can negatively affect patient choice.

We believe NHS England should avoid the use of league tables for primary care data, as these generally focus on overly simplistic figures and are not the best way to compare providers' performance. In any league table there will be a 'normal distribution' and so half of all providers will be below average by definition. In addition, random fluctuations in small numbers, outside the control of the provider or due to external factors, can have significant impact on a provider's ranking. The abandoned star rating system for hospitals demonstrated that such systems did not reliably reflect the quality of the clinical care provided. A similarly simplistic scoring system would equally fail to reflect the complexities of general practice. We have shared these concerns with the Care Quality Commission, as they develop their own ratings system.

Significant statistical experience is required to construct league tables and to make sense of the data in the context of the particular case mix for that provider. Any organisation that takes on the role of generating league tables or presenting comparative data must be properly monitored and regulated to ensure its statistical analyses are accurate, fair and meaningful.

On patient surveys and feedback, careful consideration must be given to which indicators are collected and why. Inherent data collection biases, such as less feedback coming from patients of lower socio-economic status, must be overcome. Ratings must differentiate between the quality of experience that the patient perceives and the quality of care that the expert observer might consider has been delivered. It is far more common for people to report bad experiences than good experiences, and so any form of patient rating system has to be interpreted with great care.

We believe that practices would be more willing to publish comparative public information if they are satisfied that the data will be useful to patients and fair to providers. Information should be presented with clear explanations and guidance on how it should be interpreted.

In addition, there must be adequate support and resources for practices if they are to consider becoming more involved in publishing comparative information. As recognised in the NHS England Call to Action documents, general practice is facing increasingly unsustainable pressures and practices are not able to take on further unresourced work.

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

The BMA agrees that partnership working between the CQC and new Chief Inspector is important in order to avoid duplication of work between the two bodies. There is otherwise a risk that Area Teams and the CQC could ask practices for the same or very similar practice monitoring information, increasing the bureaucratic burden on practices.

We are concerned that ratings for primary medical services providers could be arbitrary for patients. It risks reducing the highly complex activity of managing healthcare performance to an overly simplistic measure which could have unintended consequences for the services that providers are able to offer to patients.

While we have concerns about the implementation of these ratings, we can see there is potential benefit and would like to work with the CQC and NHS England to try and minimise the negative impact on patients and practices.

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

The involvement of patients in general practice helps practices and commissioners ensure services are responsive to local need. Existing methods of patient participation need to be well advertised to patients. For example, all practices should clearly signpost patients to ways in which they can feedback about service received.

Efforts to increase patient involvement should be tailored to include harder to reach groups, particularly those who may have difficulty accessing newer technology. Local Healthwatch may provide useful links with voluntary and community organisations to help facilitate the engagement of these groups.

With respect to the Friends and Family test, doctors generally welcome feedback from patients and their families. However, the friends and family test is based on a model developed to test satisfaction with consumer products and we believe there are better ways of getting useful information from patients in a form that enables the NHS to improve services. The recent publication of the first results from the test in secondary care highlighted that simplistic rating systems or questions often fail to provide the context in which care might be being delivered, and do not address systemic failures in the NHS. There were significant criticisms from a range of stakeholders, including patient organisations. The Patient's Association warned that asking patients whether they would recommend a hospital or ward is not straightforward, as patients fear retribution if they give an unfavourable answer. It also commented that while highlighting

areas of poor care is to be welcomed, the friends and family test does not clarify who will address any problems that are highlighted[1].

We are disappointed that the roll out of the friends and family test into general practice was announced prior to full discussion with the general practitioners. The national GP Patient Survey already asks whether the respondent would recommend a GP practice to someone who has just moved into the area, which is answered by around one million people each year. As such, it is difficult to see what the friends and family test will add, or how it will fit in with other feedback mechanisms.

Clinical events often have no clear boundaries in primary care. For example:

- An episode of depression or a symptom such as tiredness may last for many months without a clear end point; at what stage will patients be asked to feedback on the friends and family test?
- How will the data be analysed and presented to GP practices in a user friendly way so that it can be used to improve care?
- Will these data be presented alongside patient feedback data collected by other mechanisms so that organisations are presented with collated evidence rather than piecemeal feedback?
- This will inevitably create additional workload both in terms of collecting the data and considering the findings – how will this be resourced?

The GPC looks forward to working with NHS England to ensure the roll-out of the friends and family test in general practice is appropriate and takes into account the issues outlined above.

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

Patient choice is important. Within general practice itself, the vast majority of patients who do not live in very rural or remote areas have a good choice of general practitioner. Patient addresses are usually covered by several practice areas and the regulations on patient registration mean that practices need a reasonable, non-discriminatory reason for turning down registration applications. However, it is important that patients are able to exercise this choice by making the process of changing general practice as smooth as possible.

The development of new and integrated care pathways in the community offers potential to increase choice, giving patients the option to be treated closer to home. In order for this potential to be fully realised, it is important that efforts to shift care into community settings are properly resourced and clinicians in different providers are supported to work collaboratively.

It is important that new models of patient choice are responsive to local need. Local commissioners are best placed to take the lead in deciding where and how to extend patient choice. We highlighted in our response to the recent Monitor Review of Walk-in Centres[2], the commissioning of walk-in centres in 2007 is a revealing example of the importance of ensuring that efforts to increase patient choice are locally driven and not the result of central policy. Following Lord Darzi's Next Stage Review report of October 2007[3], Department of Health policy dictated that every PCT

[1] Boseley, S. 'Thirty-six NHS wards fail 'friends and family' test' *The Guardian* 30 July 2013 http://www.theguardian.com/society/2013/jul/30/nhs-choices-website-patients-hospital-ratings
[2] Monitor *Review of Walk-in Centres Consultation* May 2013
[3] Department of Health *Our NHS Our Future: NHS Next Stage Review interim report* October 2007

should commission at least one walk-in centre. The result of this blanket policy is that walk-in centres were created without regard to existing local services or gaps in provision. Many of these centres are now being decommissioned[4], judged to be under utilised by local populations and poor value for money.

News models of choice should be driven by clinical need. Easy access to services is a priority for some patients (for example, people who work and do not have a long term condition). For many patients, continuity in the provision of their general practice services is most important and, if personal circumstances allow, stay with their family practice all their lives. The 'cradle to grave' care offered by the local GP practice and the development of a strong relationship between GP and patient is invaluable to the delivery of high quality services, in particular for the rising number of patients with complex long term conditions.

Clinical leadership and innovation

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

The general practice workforce is under enormous and increasing pressure. The impact of year on year reduction in funding, increasing patient demand, and workload increases as a result of the 2013-14 contract imposition cannot be underestimated. In September, the GPC carried out a survey of GPs to which 3,629 GPs responded; more than one in 10 GPs in England[5]. The result clearly demonstrated that general practice is workload saturated:

- 97% of GPs said that bureaucracy and box ticking had increased in the past year while 94% said their workload has increased;
- 82% felt that some of the new targets were actually reducing the number of appointments available to the majority of patients;
- 90% of GPs said their practice's resources are likely to fall in the next year.

Good morale is essential if clinicians are to feel motivated to lead change. In the BMA Workload Survey, 86% of GPs reported a reduction in their morale in the past year[6] and repeated attacks on GP performance from politicians and in media reports are incredibly de-motivating for GPs who are already workload saturated.

GPs want to have the autonomy and time available to shape their services to improve care and meet patient need. Innovation occurs when clinicians are able to operate as trusted professionals, leading and shaping change, and not micromanaged or asked to implement externally imposed reform. However, GPs will need to be appropriately resourced and supported to do so. For example, responding to the survey above, 45% of GPs said they are less engaged with CCGs because of increased workload. Therefore, CCGs need to resource GPs for time away from their practice to undertake commissioning activity. GPs and other clinicians need to be given ample

[4] This trend is highlighted in Monitor's review of the provision of walk-in centres in England http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-40

[5] BMA *GPC Survey of GP Workload* September 2013, available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/general-practitioners-committee/gp-workload-survey

[6] BMA *GPC Survey of GP Workload* September 2013, available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/general-practitioners-committee/gp-workload-survey

opportunity to feed into decision-making processes. With current practice workload, this means giving sufficient time for practices to be able to respond to requests for input into commissioning decisions.

There are a number of positive steps that could be taken to adapt the GP contract to remove bureaucratic demands and refocus GP time on treating patients in a holistic and clinically-driven fashion. This, in turn, would give GPs the space and energy to get involved in wider decisions about patient services. These include ensuring QOF is fit for purpose by removing the components of QOF that lack a clinical evidence base, increasing timescales of some indicators, and not arbitrarily increasing thresholds as in the 2012 contract changes.

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

Primary care will be vitally important if the NHS is to meet the challenge of changing population demographics and associated rise in long term conditions, particularly given current funding pressures. Local commissioners and Health and Wellbeing Boards need to think innovatively and support primary care services to develop to meet this demand. In doing so, the close involvement of clinicians will be essential.

We would strongly encourage local commissioners and Health and Wellbeing Boards to liaise closely with Local Medical Committees (LMCs). LMCs are the statutory representatives of general practice and have enormous insight into local health economies, the challenges and opportunities therein and can provide a useful channel for communication with local general practitioners.

It is important that new ambitions for primary care ensure that any new demands on existing services are appropriately resourced, and that the clinicians are properly supported to deliver these changes. 'Stretching ambitions' must truly address increasing demand and lack of resource in the system and not simply require more of an already stretched service.

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

Commissioners have told us that there remains significant confusion over the relationship between integration and competition, and that they have concerns that attempts to commission integrated care pathways may leave them open to challenge under competition law. It is essential, therefore, that as much clarity as possible is provided about when commissioners can commission services from one or a selection of providers without competition, in the interests of developing integrated primary and community services. GPs have told us they are concerned about falling foul of competition rules and regulations when planning innovative integrative services, for example involving larger groupings of GP practices delivering new community services. It is vital that commissioners and providers are empowered to commission high quality, integrative services; this will require clear information about what is permissible under the current legislation. We would also stress the vital long-term importance of retaining medical research, medical education, and training capacity in any integrated services.

Freeing up time and resources

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

As reflected in the GPC workload survey published in September 2013, the government's imposition of the 2013/14 contract has increased practice workload and damaged the morale of the profession. This was further illustrated in a survey about the imposed QOF indicators published by Leeds LMC which showed that QOF had become increasingly bureaucratic[7] and was restricting practice ability to respond in a flexible manner to the needs of patients. In addition, annual renegotiation creates instability and bureaucracy. Any future changes should ensure that QOF indicators are more closely aligned to targets set for others in the NHS, to ensure a joined up approach and consistency across services.

There needs to be a re-evaluation of the timescales for which data is collected, in particular:

- Blood Pressure for hypertensives should be annual, as per NICE guidance.
- 12 month time slots should be changed back to 15 months (or longer) as recommended by NICE, to allow for patient variability in attendance.
- Avoiding repetitive questioning of lifestyle matters such as smoking, sexual performance and exercise.
- Avoiding repeated assessments that change little over time, such as FRAX scores or cardiovascular risk assessments where the previous values have been well away from intervention levels

It is important that QOF indicators are within the scope of GP practice influence. For example, diabetic targets such as retinal screening depend on local resources. Practices are unable to screen within 12 months without missing those who default because of illness, holidays or personal circumstances. GPs should not be penalised for missing these targets but should be incentivised to provide holistic care based on clinical need.

All domains should refer to items which occur normally in the vast majority of practice lists within the year. If the indicator occurs less often not only does it become impossible for some practices to gain the points, but the meeting or not of the target is so statistically variable that it cannot be a measure of quality.

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

Enhanced services are a valuable lever to drive up quality and develop locally responsive and innovative services. It is important that these are focussed on the delivery of high quality services and are not overly bureaucratic, for example, involving multiple audit requirements. The funding of enhanced services need to include not only the obvious costs, but also those of infrastructure, administrative staff and GP oversight. CCGs and GP practices report that the NHS Standard Contract is proving to be an unwieldy mechanism by which to commission enhanced services from practices. Further guidance and support is needed for CCGs and practices to ensure that the bureaucratic demands and complexity of the Standard Contract do not act as a barrier to the commissioning of enhanced services.

[7] Leeds LMC QOF survey, 2013. Available here: http://www.leedslmc.org/news/detail/?id=52

We would encourage caution when reducing process-oriented measures. Removal of measures relating to 'tick box' or audit requirements are desperately needed. However, investing in the good clinical processes will lead to good clinical outcomes. Conversely, a focus solely on outcome measures does not encourage best practice.

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

The BMA welcomes the commitment from NHS England to simplify the demands placed on practices and improve efficiency. Information technology is a vital part of general practice and will play a significant future role in improving processes and the quality of care provided to patients. IT systems and programmes need to be designed and implemented carefully. This will require effective leadership and extensive engagement of stakeholders in IT developments.

We believe that the key to achieving improvements to general practice IT will be a focus on interoperability between systems. This is particularly relevant to the electronic transfer of patient records between GP clinical systems. Electronic transfer is key to supporting and maintaining the rich clinical content of the patient electronic health record when a patient chooses to register with a new GP. GP2GP represents a huge achievement in interoperability, with entire lifelong records being exchanged screen to screen in general practice. NHS England should continue to work to resolve the outstanding issues with GP2GP so that the benefits to practices and patients are maximised, such as allowing fully paperless transfers and large message transfers.

The Electronic Prescription Service 2 (EPS2) will also increase efficiency and integrated working. The EPS2 enables GPs to send prescriptions electronically to a dispenser of the patient's choice. The BMA supports the deployment and utilisation of EPS2, recognising the benefits to patient safety and choice. NHS England should continue to encourage the implementation of EPS2 by practices. The key to managing change in practices will be engaging with GPs and demonstrating the benefits that can be achieved. Furthermore, developments in IT must have realistic timescales and go through a managed pace of change. Problems and disengagement will occur where projects are rushed or badly thought through. Steps must be taken to ensure clinicians are both involved in and signed up to IT projects at all stages, including development, procurement, roll-out and monitoring.

The BMA is concerned about top-down government mandates for general practice IT. For example, the government has committed to providing all NHS patients with online access to their record and other services (electronic booking and cancelling of appointments, ordering of repeat prescriptions and communication with the practice) by 2015. The BMA has serious concerns with the timescale set for implementation, the support that will be provided to practices and the extra work this will generate. Although some of the transactional elements of these proposals, (i.e. online appointment booking and ordering of repeat prescriptions) have the potential to deliver benefits to practices and patients, online access to records and electronic communication with the practice presents some ethical and implementation challenges. NHS England must engage with the profession to consider how to address these issues.

How can we help improve the productivity of practice systems and processes, for example through the Productive General Practice programme?

The BMA supports the aim of the Productive General Practice programme, which is to enable all staff in the GP practice to improve their working processes and make it possible to release time to invest in improving patient outcomes and staff wellbeing. We are pleased to see that the programme has been co-designed and tested by GPs and practice staff and that the focus is on practical solutions.

However, we believe that many practices will be dissuaded from using the programme given the cost, which starts at £2105 for the basic license. Many practices are experiencing financial strain caused by consecutive freezes to contract funding and unmet increases in practices expenses and are unlikely to be in a position to meet this cost. We believe that the programme should be made freely available to all practices.

Practices are also likely to struggle to find the time to work through the modules within the programme, given the existing workload pressures on GPs and staff. We recognise that the aims of the programme are to improve ways of working and to increase productivity and efficiency in the longer run, but many GPs and practice staff will not have the time to watch instructional videos and undertake e-learning courses etc. We believe that freeing up time in other areas will help allow practices to participate in this programme.

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

Many practices operate functional, multidisciplinary teams. Changing demographics and the rise of numbers of patients with complex long term conditions means that such teams are becoming ever more essential. Practices need sufficient resources to train practice staff and develop their teams.

As general practice develops, practice managers are playing an increasingly strategic role, particularly with the formation of larger groupings or federations of practices. Practice managers can be instrumental in helping practices develop to meet many of the challenges facing practices. For example, with increased use of procurement, general practices will rely on practice managers becoming skilled in tendering and associated processes. Practice managers may also begin to play an increasing role in the new commissioning structures as they have a good insight into the operation and functioning of general practice at a detailed level. Their expertise needs to be recognised, and where appropriate, resource provided to support their involvement in commissioning.

How do we engage practice managers more effectively?

Local Medical Committees (LMCs) work very closely with practice managers and are a valuable channel of communication with practice managers.

Defining practice accountabilities for high quality

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

The BMA agrees that this would be a sensible idea and it is essential that the BMA's GPC, as the representative body for GPs, be involved in any discussions on this concordat.

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

There is huge potential for GPs and practices to play an important role in delivering and coordinating integrated services in community settings. Close collaboration between all clinicians involved will be essential. For instance, practice-based community nursing teams allow for effective communication between GPs, district nurses and provide a focal point for collaboration between other health and social care professionals, such as social workers. GPs would welcome a return to practice-based community nursing teams and are ideally placed to coordinate this sort of collaborative working between professionals, ensuring holistic and joined-up services for patients.

Greater integration will also require the development of inter-operable IT systems to allow different providers to communicate and share information. General practice IT systems are generally more advanced than systems used in secondary care and so focus is needed to ensure clinicians are able to share information safely and securely. We would encourage NHS England to support CCGs to develop secondary care IT capability, encouraging sharing of learning between areas.

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

The GP contract is a framework for the services that GP practices are expected to deliver and the way in which they are provided. Defining high quality general practice is much broader endeavour, involving dialogue with health professionals, patients and the public. The focus should be on empowering practices to deliver high quality services through reduced bureaucracy and adequate funding for the provision of care and investment in premises.

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

The BMA is concerned that ratings for primary medical services providers could be arbitrary and overly simplistic and have unintended consequences that damage services to patients. We would, however, like to work with NHS England and the CQC to ensure that the rating system paints as accurate a picture as possible of the quality of services delivered by practices.

GP contract: incentives for outcomes

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

General practice provides a natural focal point for patients, acting as coordinators of care and managing transitions between services. Practices should be empowered and charged to be the central organisation within the community from which community care is organised and coordinated. GP leadership in CCGs provides an opportunity to develop services centred around general practice with GPs acting as the conductors of a co-ordinated, patient responsive health care system.

Many practices are exploring closer collaboration. The motivators behind the move towards larger groupings of practices include easing the administrative burden placed on practices, which is

placing particular pressures on smaller practices, as well as providing opportunities to develop innovative services across locality groupings. There is no 'one size fits all' approach to this. Collaboration between practices will look different in urban and rural areas, and may be more relevant for smaller practices than larger ones.

The risk of being seen as anti-competitive through greater collaboration needs to be urgently addressed. Practices are understandably cautious of falling foul of competition law and need encouragement and support, as well as clear information from Monitor and NHS England where necessary, about the different mechanisms through which they can collaborate within existing rules and regulations.

At the moment 'collaboration' between different sorts of providers consists of the development of pathways that move work from one part of the health service to another. Successful collaboration can only occur if the funding is appropriately distributed and if adequate premises are provided. Adequate IT systems to allow sharing of information between providers in a safe, secure and simple manner are also essential. NHS England should work with CCGs to support the development of such systems, focussing in particular on secondary care IT capability.

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

GPs need sufficient time with all patients to understand their problems, relate to their circumstances and plan care solutions. This is even more important for patients with co-morbidities and complex health and care problems.

The ten minute consultation is insufficient time to provide holistic care to patients with complex needs. Longer consultations are required, which in turn necessitates an expansion of the GP workforce in order to be able to meet patient demand and successfully manage the shift of care into community settings, as more patients with complex health and care problems are treated away from secondary care settings.

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

QOF has proven value in improving the management of long-term conditions in general practice, for example to the outcomes of CVD and Diabetes. Incentives for evidence based interventions are valuable lever to improve quality and outcomes.

However, QOF and other targets within general practice have become increasingly bureaucratic. Removing targets which lack a clear clinical evidence base would allow GPs more time to care for their patients in a holistic and clinically-driven manner.

There is huge potential to improve health outcomes if wider services (such as community matrons and social services) were better integrated with general practice. The disintegration of community teams in recent years has resulted in less frequent and more disjointed communication between professionals, and has fragmented the patient experience. Closer working, and increased recruitment of and investment in these health and social care professionals, would support

improved management plans and care for vulnerable patients. The BMA would strongly support a return to practice-based community nursing teams, lead by GPs with the practice providing a focal point for close working between professionals.

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

PMS and APMS contracts can have a valuable role in addressing the needs of particular populations, for example, student or homeless populations. However, a national contractual framework is vital to ensure consistency of services and quality, as well as to avoid exacerbating serious recruitment issues already experienced in some areas of the UK. Whilst local flexibilities, such as PMS and APMS, can allow for the tailoring of locally responsive services to meet particular needs, it should be noted that Local Enhanced Services have proven to be equally valuable in delivering flexibility alongside the GMS contract.

Safe, controlled investment

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

Health and Wellbeing Boards have a crucial role to play in coordinating commissioning of integrated pathways. Where Health and Wellbeing Boards are functioning successfully this is because of close involvement of provider and patient representatives on the Boards, as well as the representatives of the commissioning bodies (local authorities, CCGs and NHS England). We would encourage Health and Wellbeing Boards and the different commissioning bodies to gather the views of local GPs and LMCs, as the representatives of general practitioners. The BMA has strongly recommended that Health and Wellbeing Boards include in their membership LMC representation, as the statutory representatives of GPs at a local level.

The resource and workload pressures in general practice described previously are a significant barrier to the development of effective out-of-hospital services. A whole-systems approach to the commissioning of these services is required

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

Community services (previously local enhanced services) are an important lever to drive up quality of care and ensure local services are responsive to local needs. It is therefore vital that conflicts of interests are properly managed to ensure that CCGs are able to shape local services in partnership with their practices.

CCGs are required by law to have robust mechanisms for dealing with conflicts of interest, including the regular publication of a register of interests and processes for when the CCG board are making decisions about investment in general practice. The NHS England guidance states that an individual with a 'material interest' in an organisation which provides or 'is likely to provide substantial business' to a CCG (and this encompasses commissioning support services) should not be a member of the governing body.

In addition, we recommend that CCGs should consider mechanisms to provide reassurance that decisions about investment in member practices have been made in the best interests of patients. Such mechanisms could include:

- *Seeking advice from the Health and Wellbeing Board and/or other CCGs:* The Health and Wellbeing Board will also produce the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy for their area and so will have a good overview of the needs and priorities of local populations. As such, CCGs could ask the Health and Wellbeing Board for independent but informed oversight if they thought it would be constructive. Likewise, CCGs could work with other CCGs to seek external oversight of commissioning decisions if it was felt that additional input would be helpful in addition to the CCG's own processes for managing conflict of interest.

- *Seeking advice from the NHS England Area Team:* Technically, a CCG's ability to commission services from general practice is an authority delegated from NHS England. It may be appropriate in some instances for CCGs to ask the Area Team for external oversight of a commissioning decision.

BMA guidance for commissioners on handling conflicts of interest can be found on the BMA website.

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

Investment plans need to move away from short term timescales, with little opportunity for real impact on outcomes. Longer timescales will allow for proper planning, assessment and review of services, involving real collaboration between providers.

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

Well equipped general practice premises are essential for the long term sustainability of the NHS. If more services are to be relocated into community primary care settings, facilities need to be available to accommodate them. This will not only ensure patients receive good quality services in suitable surroundings, but will also aid efforts to ensure preventative treatments occur before conditions require more expensive urgent treatments (i.e. ambulance call-outs, visits to A&E or avoidable hospital admission).

The starting point for this should not just be how NHS England and CCGs can work together more effectively, but how they can work together with NHS Property Services (NHSPS), Community Health Partnerships, Local Authorities, GPs, the banking sector (as lenders), third party developers and Local Medical Committees.

Stage one of the process is already underway with NHSPS and Community Health Partnerships working to formalise lease arrangements with GP tenants occupying premises formerly owned by PCTs. This should enable Area Teams and CCGs to get a better understanding of space that is underutilised in existing premises.

GPs already operate a multitude of arrangements providing facilities for the extended primary care team, for example, district nurses, physiotherapists, counsellors. There have been problems in the

past in relation the charging of rent for the space used and the reimbursement that practices receive from the NHS. A simple solution for this would be for CCGs, as commissioners of the services, to deduct premises running costs from contract payments to providers and pay this directly to Area Teams. Area Teams would not then have to calculate a rent and running cost abatement for practices, and providers would be free from the bureaucratic burden of paying the premises running costs to the practice.

The above solution would provide practices with an assurance that, should arrangements change in relation to the use of space by the extended primary care team, they would not be left in a situation where they were not receiving reimbursement for a proportion of space within the premises. This would have the positive effect of either allowing the practice themselves to make use of the free space or make arrangements with other providers within the extended primary care team.

Enabling GPs to invest in their own premises has also served the NHS particularly well. The scheme for GPs to access funding for this, however, now requires urgent review. The borrowing costs scheme is woefully out of date as reimbursement from the NHS falls considerably short of modern costs of lending. This means that lenders are less willing to lend to GPs because there is little confidence that GPs will reliably have the means to make loan repayments.

NHSPS has a significant premises estate and thought should be given as to how the capital can be used to pump-prime premises investment. This is one possible option for ensuring lenders begin offering affordable, competitive loans to GPs and other providers again.

Section 106 of the Town and Country Planning Act 1990 should also be enforced strictly to ensure that developers are obligated to invest in healthcare facilities when building on large plots of land. The cost of such healthcare developments in relation to the impact this would have on the developer's final profits would be minimal.

Finally, NHS England must also overcome the problems relating to the premises reimbursement deficit. Due to poor accounting arrangements overseen by PCTs, GP practices will understandably find it difficult to absorb unexpected service charge increases relating to their premises. If Area Teams cannot find the additional resource to make these reimbursements, this will affect the future viability of a number of practices.

Market management

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

It is crucial that LMCs are involved in this process as the organisations with a clear mandate to represent GPs at a local level. GPs and practices are regulated by a number of different organisations so it is also important that NHS England and the CQC work together to avoid duplication of work in indentifying poor performance, as GP practices are increasingly faced with numerous layers of bureaucracy which hinders rather than helps practices in the delivery of good quality services.

NHS England should take a consistent but flexible approach in its application of the regulations governing GP practices, ensuring that practices are not treated differently according to the geographical area in which they operate.

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

It is important that efforts to increase plurality are driven by identified gaps or failings in existing services or providers. In the current financial climate, pursuing plurality of provision as an end in itself, with no regard to existing services, is a wasteful use of resources and has potential to fragment services. We would strongly recommend that investment in existing providers should be prioritised over facilitating new market entry, in order to stabilise services that are already pressurised by increasing workload and decreasing investment.

Where new market entry is to be facilitated, it is important that procurement processes are open and fair for all providers to ensure a level playing field. Smaller providers, such as GP practices, may not have the resources or expertise to enter into lengthy and complex procurement processes, competing against larger and more commercial organisations.

The Any Qualified Provider (AQP) qualification process is an example of how overly bureaucratic processes may restrict the range of providers competing to provide a particular service. GPs have reported that the process simply to qualify as an AQP provider has taken up to 50 hours of practice time and has required investment in new equipment, without any guarantee of income (as AQP providers are remunerated on a case by case basis).

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

There is a trend towards larger general practices[8]. This trend is accompanied by a general consensus that larger groupings of general practices, whether formed through federations, super-practices or other networks working together, will be best equipped to deal with rising demand and the shift of work into community and primary care settings, whilst retaining the continuity of care and important patient-GP relationship valued in the current model of general practice.

However, many general practices do not have the capacity or resources (including adequate investment in premises) to consider the development of these newer models. In addition, many GPs lack knowledge of and are wary of contravening competition law and regulations that may govern the formation of larger groupings described above. It is important that this lack of awareness does not hinder the development of innovative provider models. GPs need to be encouraged to collaborate and work together to develop innovative ways of meeting patient need.

In addition, any development of new models needs to be strongly clinician-led. Recent BMA research found that autonomy, the ability to shape the services provided to their patients and the development of long-term relationships with patients are significant motivators for those choosing general practice as a career[9]. General practice is already facing serious problems with recruitment and retention and GPs participating in this research were clear that the development of new

[8] This trend is highlighted and explained further in the Centre for Workforce Intelligence GP In-Depth Review Preliminary Findings

[9] The BMA held three focus groups with six to 11 GPs in August and September, to explore GP opinion on the 'Future of General Practice'. Findings unpublished.

provider models that do not have the support of general practitioners and are not clinically-led and driven by local need would exacerbate existing recruitment and retention problems.

The salaried workforce in general practice is increasing. For many, particularly younger GPs or GPs undertaking 'portfolio' careers, a salaried position is an attractive option. However, a major theme of the research above was that GPs, whether salaried or partner, value working in clinician-led organisations. The development of new provider models that would see an increase in the salaried workforce would need to ensure that the new models, likely to be larger organisations, retain the clinical leadership elements found in traditional models of general practice.

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

Community-based services (previously called Local Enhanced Services) offer extensive opportunity for commissioners to develop locally responsive, innovative services, essentially offering 'primary care plus', but without developing entirely new contracting mechanisms. It is important, therefore, that CCGs and local authorities are encouraged and supported to commission community-based services from general practice.

As of April 2013 all new community-based services were required by statute (Health and Social Care Act, 2012) to be commissioned using the NHS Standard Contract. We have received reports from commissioners, LMCs and general practice providers that the NHS Standard Contract is proving to be an unwieldy contracting mechanism for these services, which are often very low value. The Standard Contract is over 40 pages long and includes many clauses extraneous to the requirements of these sorts of services, which are effectively add-ons to the substantive general practice contract. We would encourage NHS England to produce clear guidance for CCGs and GPs relating to the Standard Contract and how it can be modified for use with general practice in particular.

Workforce development

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

There is wide consensus that increased numbers of GPs are required in order to meet increased demand for GP services. The government has proposed a target of increasing GP trainee numbers to 3250 per year by 2015 and Health Education England has included in its mandate a target of 50% of all medical students to become GPs. However, greater capacity and funding to train this increased number of GPs is needed, along with the extra resources to take them on once they qualify. There is also evidence that general practice is an unattractive specialty for future doctors - competition ratios for places in GP training are the third lowest of any specialty[10]. Urgent action to make general practice an attractive career will be essential if the government is to deliver its target of increased general practice workforce. In addition to greater numbers of trainees, practices need contractual stability in order to take on substantive GP posts, providing career opportunities and development for newly trained GPs. Many aspiring GPs express a wish to become partners at some point in their career, and so it is important that this is taken into account as a key motivator for young doctors to choose general practice as a career.

[10] Centre for Workforce Intelligence, 'GP in depth review', March 2013.

Addressing workload pressures will be a key factor in retaining and expanding the current GP workforce. Practices will require additional resources if they are to respond effectively to the various challenges identified in the Call to Action evidence pack. The increased administrative burdens placed on GPs, including those elements of QOF that do not positively contribute to patient care, must also be addressed to allow GPs more time for direct patient contact. There is significant potential to exacerbate recruitment and retention problems if efforts to increase patient access to general practice services are not properly managed and resourced.

Additional funding for practices will be needed to ensure that rising practice expenses are covered and ensure levels of pay are not a disincentive for junior doctors considering general practice as a specialty.

We would like to see a revitalised retainer scheme for GPs who need to reduce their commitment to general practice for a period of time whilst remaining up-to-date clinically. The scheme is a cost-effective way of maintaining the GP workforce, with the majority of participants increasing their commitment to general practice as salaried GPs or partners on completion of the scheme. We would recommend that ring-fenced funding be made available so that GPs in all areas of the country can access the scheme to ensure that experienced GPs are not lost to the workforce.

Similarly, the arrangements for GPs returning to practice and applying for re-admittance to the Performers List must be reviewed. There should be individual assessment to identify the learning needs of each GP returner and ring-fenced funding for Induction and Refresher (I&R) training where appropriate, including adequate remuneration. It is unacceptable that many GPs are currently forced to self-fund completion of an I&R scheme. This has potential to act as a major disincentive to them returning to the workforce.

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

The Royal College of General Practitioner's educational case for Extended and Enhanced GP training, if implemented effectively and with adequate resource, could play a significant role in ensuring that education and training evolves to meet the changing role of general practice. Among other things, the educational case suggests an increased focus on management side of the job. Ensuring the implementation of the programme reflects the intentions of the educational case is a priority.

Contract negotiations for new formalised GP trainees contract (as part of the Juniors negotiations) will need to ensure that the strengths of the existing contractual arrangement are retained, if general practice is to remain an attractive option. Given the Government's stated aim of increasing GP numbers as part of the shift towards more community based health services, this is a particular imperative.

Ensuring a suitable successor to this, the GP trainees supplement payment system (bringing their pay broadly in line with other junior doctors) will be crucial, as will maintaining the focus on educational development within the contractual arrangements. As the role of GPs expands, there is an even greater need for protected study time, and this must not be overlooked. In contrast to their hospital colleagues, GPs tend to become less specialised as they progress in their careers and their knowledge base expands. The emphasis on continuous learning should be strong throughout.

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

If practices are backed with the financial resources to accompany the increase in community based care, this would allow further time and opportunities for career development for GPs within practices. For example, increased protected learning time and opportunities to gain additional skills and experience through funded secondment.

The development of larger practices may provide increased opportunities to provide more structured careers for primary care practitioners. For example, larger practices will employ or take on more GPs, which provides a greater opportunity for work to be shared out between GPs in different ways, and for GPs to take on different roles. It should be practical for practices to remain smaller if they choose to do so, however, as this provides patients with a choice between different types of practices.

There are a number of advantages for practices themselves in providing structured careers for primary care practitioners and practices should be encouraged to recognise these. The BMA would be pleased to work with NHS England to develop guidance for practices in how to support and develop the primary care workforce. For example, by providing a welcoming and structured environment for new joining doctors, practices are more likely to retain talented GPs within their workforce.

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

Training and development needs arise as practices take on new staff and new work. If general practice is to meet the demands of changing population demographics and the shift in care from secondary to community settings, it is vital that the general practice team is able to adapt and develop.

As such, resources for staff training to need to be borne in mind in the costing and commissioning of general practice services. For directed and local enhanced services in particular, sufficient resource for staff training needs to be included in the costings for the service to ensure that practices are able to deliver these services.

With the above in mind, it is important to note that increasing the workload for practices whilst failing to increase investment or reimburse expenses is likely to result in practice staff reductions. Where staff reductions are made, there is a risk that services to patients are likely to suffer too.

Specific issues and questions

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

The BMA is working closely with NHS England with respect to the role for GPs in coordinating and leading the care of people with complex needs. GPs play a crucial role as a patient's 'first port of call' in the health system and coordinators of care. In order to perform this role effectively, close collaboration between professionals involved in a patient's care is necessary. This could be

facilitated by the reinstatement of practice-based community nursing teams, closer working with secondary care and improved and secure data sharing between providers.

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

Commissioners should liaise closely with GPs when considering processes for developing service specifications and procuring OOHs services. The development of good working relationships between practices and CCGs would facilitate this process and strengthen general practice involvement in ensuring high quality OOHs services. Good commissioning will also involve ensuring that OOHs services are adequately funded to provide high quality services with appropriately trained clinicians.

In terms of how OOHs services should be delivered, it is vital that a thorough analysis of the issues encountered in the roll out of NHS 111 is undertaken. Triage of patients presenting with urgent problems is best undertaken by the most skilled and experienced clinician available. GPs and other medics are highly trained to manage risk and make swift and accurate judgements of a patient's clinical need. There is general consensus that replacing clinical triage with non-medically trained call handling is likely to result in higher numbers of A&E attendances and unnecessary ambulance call-outs.

The BMA's GPC is working with NHS England to explore ways in which day time general practice is more integrated with OOHs and urgent care services. An important part of this will be to empower GPs to respond swiftly to patients presenting with urgent problems in-hours, for example by reducing the bureaucratic demands placed on GPs and so freeing up practice resources.

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

The results of the NHS England annual GP patient survey – a survey of patient satisfaction with GP services - are generally very favourable in relation to access to GP services, including patients' experience of making an appointment and surgery opening hours[11]. It is important that discussions about access take place in the context of these high levels of satisfaction. Often, public perceptions of general practices are based on negative media coverage and not on awareness of the access arrangements at their general practice. As a starting point therefore, general practices need to ensure that there is clear information about the access they provide for patients, including different ways patients can make an appointment or make contact with a GP or other clinician.

The current funding pressures in general practice are also central to discussions about improving access, to ensure scarce resources are used wisely and in response to patient need. Large numbers of existing providers in general practice would very much like to provide more extended services for their patients and take over some of the work carried out in secondary care. However, they are often unable to do this due to a lack of funding both for provision of care and investment in

[11] Details of the results are available here http://www.england.nhs.uk/statistics/category/statistics/gp-patient-survey/

premises. Increases in investment in general practice have also been low; for example, the increase from 2010/11 to 2011/12 was just 0.57%[12] and not all of this funding reaches GP practices. Relatively small increases in GP funding for both services and physical capacity would transform practices' ability to expand their services and improve patient access to services. This would be a very cost-effective way of expanding the general practice services available to patients and ultimately offering greater choice.

Some general practices are developing models of telephone triage, holding telephone appointments with general practitioners in the morning and offering afternoon appointments to patients who need face to face treatment that afternoon. Crucial to the success of such systems is the fact that triage is carried out by the most senior clinician available – the patient's GP – meaning that the majority of minor problems, particularly those requiring self-care can be successfully dealt with during the phone call. However, such systems will not be appropriate for all practices or patient populations and so decisions about implementation need to be taken at a local level and driven by the clinicians involved.

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

In general, general practitioners have excellent understanding of the access preferences of their populations. Indeed, as mentioned, the results of the NHS England annual GP patient survey – a survey of patient satisfaction with GP services - are generally very favourable in relation to access to GP services, including patients' experience of making an appointment and surgery opening hours[13].

There also needs to be an honest and open debate with the public and patients about the current resource pressures and the price of a fully accessible, 'convenient' service as opposed to a safe and comprehensive service that may not provide instant access for non-urgent problems. This debate would need to involve clinicians and patients, and the BMA would be pleased to work with NHS England to encourage such discussions.

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

There is general consensus that changing patient demographics and developments in health care delivery mean that delivering more services in community settings will result in improved patient experience, better outcomes and will also provide better value for money. It is vitally important that resources accompany this shift in service delivery. These resources should be focussed on developing strong integrated community care teams, focussed around general practices as the focal point. Such teams, led by GPs and with the practice as the focal point for service delivery would allow for greater communication between professionals and a more seamless patient experience. General practice and other primary care premises are suffering from significant lack of investment and so it is likely that an initial injection of resources focussed on premises development will be necessary in order to support these new services pathways.

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[12] *Investment in General Practice 2007-08 to 2011-12,* Health & Social Care Information Centre http://www.hscic.gov.uk/catalogue/PUB07472

[13] Details of the results are available here http://www.england.nhs.uk/statistics/category/statistics/gp-patient-survey/