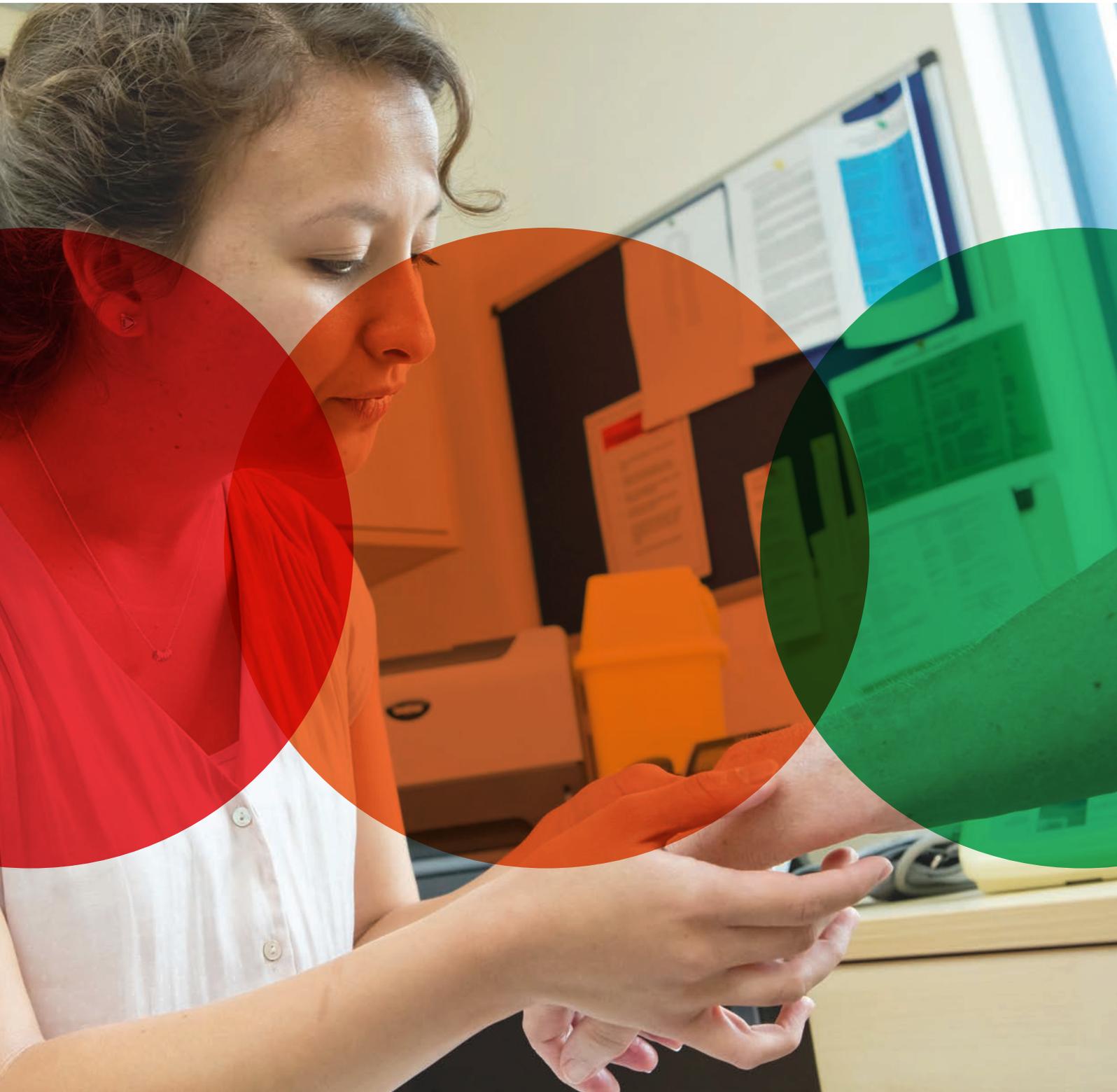




Royal College of
General Practitioners

GP Forward View Interim Assessment



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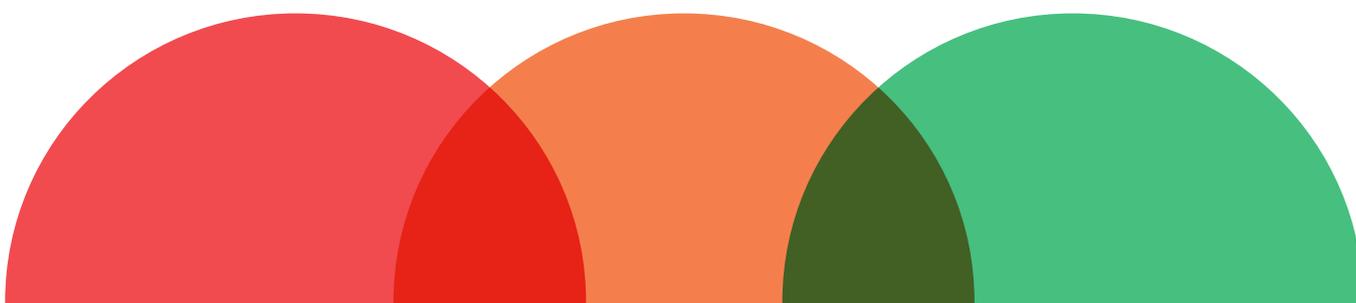
Overview

The success of the *GP Forward View* rests on its pledges being implemented on time and in full. The College welcomed the *GP Forward View* when it was published in April 2016 but we also pledged to members that we would hold the Government, NHS England, Health Education England (HEE) and others to account for the successful delivery of the plan. While the pledges made in the *GP Forward View* are an important step to relieving the pressure on general practice, they will only be meaningful for frontline GPs, who are facing a severe crisis, if the situation improves on the ground to the benefit of GPs, practice teams and their patients.

This interim assessment of the *GP Forward View* consists of two major elements. Firstly, because the *GP Forward View* promised to bring immediate benefits to practices, we have analysed the delivery of commitments scheduled for delivery in 2016/17, as well as the delivery of commitments expected to make visible progress in 2016/17.

Secondly, the assessment analyses the development of Sustainability and Transformation Plans (STPs) and the extent to which they reflect the need to invest in general practice. STPs are the local delivery bodies for the *Five Year Forward View* and are crucial to the future shape of the NHS in England – it is essential that they plan to invest in general practice and to deliver the *GP Forward View*. If general practice is to receive the 11% share of the NHS budget for which the RCGP has been campaigning, STPs will have to significantly increase investment in general practice, as well as NHS England nationally.

A number of findings have emerged from our analysis of both the delivery of the early pledges from the *GP Forward View* and the STPs. As well as successes, there are some key areas in which pledges have been delayed, and significant risks to future delivery. It is imperative that urgent action is taken by Government, NHS England, Health Education England and others to tackle these. The College will continue to monitor the *GP Forward View's* progress carefully to ensure that the pledges it contains are translated into meaningful change for our members and practice teams on the frontline with the aim of improving patient care.



Overall assessment of progress

Significant progress has been made at national level in delivering many of the short-term commitments in the *GP Forward View*. For example, changes have been made to the Induction & Refresher scheme for GPs returning to English general practice and a new scheme has been launched to provide immediate protection against the rising costs of medical indemnity. On the crucial issue of investment, NHS England reports that the 4.4%, £322m uplift in primary medical care allocations in 2016/17 is on course to be invested in full, although some of this will depend on spending by Clinical Commissioning Groups (CCGs).

However, national progress and ambition has not been matched by local implementation in some crucial areas. Many GPs will be frustrated that they have yet to see significant change. Failure to spend the full £16m allocated to practice resilience programme means that many struggling practices have not yet received the lifeline they desperately need. In addition, some national level policy changes have been delayed, for example the commitment to bring in new rules to allow NHS England to fund up to 100% of the cost of premises developments.

The gap between national and local delivery is also evident in the development of STPs, which are crucial to the delivery of the *GP Forward View* but in many cases fail to adequately engage with its contents, to acknowledge the need to significantly increase investment in general practice or to demonstrate consultation with local GPs.

Finally, it is as yet unclear whether some of the initiatives committed to in the *GP Forward View* will deliver the positive impact it was hoped they would. For example, while good progress has been made in delivering some aspects of the general practice development programme, it is yet to be established whether the programme will bring significant benefits to practices and patients.

Key successes

- **Short-term action on indemnity.** £30m will be distributed to practices by April 2017 to counteract rises in the cost of indemnity in 2016/17, and similar action will be taken to address rises in 2017/18. NHS England has also extended the winter indemnity scheme for out-of-hours GPs, which is worth £5m.
- **Changes to the Induction & Refresher scheme.** As part of a pledge to attract 500 GPs to return to general practice in England, NHS England made a number of changes to simplify the process and increase the financial assistance available to doctors on the scheme. There are currently over 200 doctors on the scheme, the majority of whom have joined since the changes were implemented in November 2016.

- **Launch of the GP health service.** This programme, worth £19.5m in total, will offer GPs in England access to a health service via a self-referral phone line. It is a vital programme that could potentially bring significant benefits to a workforce under considerable strain.

Areas of concern

- **Practice resilience.** Progress on the delivery of the practice resilience programme has been too slow. GP practices are facing significant pressures and many are at risk of closure. It is therefore extremely disappointing that, although the vast majority of the £16m identified for practice resilience has now been committed, as of 31 December 2016, only £2.5m had been spent. NHS England must ensure that any money not invested this financial year is rolled over and utilised in supporting struggling practices as soon as possible.
- **Sustainability and Transformation Plans.** These 44 plans are key to the future shape of the NHS, and in particular are intended to plan for the movement of care out of hospitals and into communities. This shift cannot succeed without strong general practice, yet many of the STPs fail to cover the *GP Forward View* in any detail. While a small number of STPs have done a significant amount to reflect the *GP Forward View*, others fail to mention it at all. Many STPs are driven by the need to tackle large acute sector deficits and a number treat general practice as a solution to the problems in secondary care without planning to adequately stabilise and support it. Most alarmingly, a number of STPs appear to plan for a reduction in the number of GPs, contrary to the vision of the *GP Forward View* and despite the planned movement of care into the community. NHS England must ensure that increasing investment in general practice is at the core of all STPs and that all STPs have clear plans to deliver the *GP Forward View*, including clear plans to grow their GP workforce.

Key risks to delivery

- **Investment by CCGs.** The delivery of the *GP Forward View* depends on national and local level investment. As well as weaknesses in STPs, the risks of which are detailed above, CCGs also pose a risk to the delivery of the *GP Forward View* in that they may fail to sufficiently invest in general practice. Much of the funding provided by the *GP Forward View* is to be invested by CCGs. This includes elements of the central £322m uplift for this year, as well as £45m each for the delivery of active signposting training for receptionists and increasing the uptake of online consultation systems. For some of the funding identified in the *GP Forward View*, such as the £171m identified for practice transformational support, it is the responsibility of CCGs themselves to identify these funds from within their own budgets.

- **Procurement requirements.** A key reason for the delay to the delivery of a number of the short-term commitments of the *GP Forward View* has been the central government procurement rules by which NHS England and CCGs are bound. Due to the strict requirements placed on NHS England and CCGs when procuring services, they have been inhibited in commissioning programmes such as the practice resilience programme and the training of reception and clerical staff in active signposting. The Government must work with NHS England to break down these procurement barriers and enable NHS England to deliver support quickly at the local level.
 - **Communication with practices.** Ultimately, the success of many of the pledges made in the *GP Forward View* will depend on frontline GPs being aware of how to access certain programmes. This is a particular barrier to pledges related to new practice staff, for example the roll-out of practice-based pharmacists, as well as those pledges for which practices were invited to apply such as the Estates and Technology Transformation Fund. Engaging practices will also be key to the successful roll out of new models of care, especially for smaller and medium sized practices for whom the barriers to involvement may be greater. All new initiatives should be well publicised and be offered with clear guidance to ensure that busy GPs and practice staff are enabled to take full advantage of the programmes.
4. **NHS England and HEE** must ensure there are clear timeframes and organisational accountability for every pledge in the *GP Forward View*.
 5. **NHS England** should continue to engage with STPs to reinforce the need for local investment in general practice and the STPs' role in delivering the *GP Forward View*. **NHS England** must reject STPs which do not sufficiently cover the 'must do' to "Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues"^{cxii}. Our analysis for this interim assessment suggests that a significant proportion of STPs should be rejected in their current form on this basis.
 6. **STP footprint leaders** should ensure that their STPs include a plan for implementing the *GP Forward View* locally, including plans to expand the GP workforce, and an outline of how the STP has engaged with local GPs.
 7. **STP footprint leaders** should publish detailed financial plans setting out their proposed spend on general practice, which should include a commitment to invest 15-20% of Sustainability and Transformation Fund allocations in general practice. **NHS England and STP footprint leaders** must engage in an honest conversation about how to address acute trust deficits so that these do not hinder investment in general practice. Where money is not currently secured, for example for capital spend, this should be clearly indicated and alternative plans for securing funding outlined.

Recommendations

1. **The Government** must continue to prioritise the sustainability and transformation of general practice through the full delivery of the *GP Forward View*. To achieve this the *GP Forward View* must be included as a key objective in the mandates for NHS England and HEE for 2017/18 and every year to 2020/21.
2. **NHS England and HEE** must take concerted action to ensure that any immediate *GP Forward View* pledges that are not currently on track are delivered by the end of the first year of the *GP Forward View* and that monies not spent are rolled over to the 2017/18 financial year. This is particularly true for those pledges that we have rated as red in this interim assessment, such as the practice resilience programme. Any short-term pledges not delivered by the end of 2016/17 should be delivered as soon as possible in 2017/18.
3. **The Government and NHS England** must work together to tackle delays in delivery as a result of central government procurement rules, by reviewing the way in which these rules are applied and reducing turnaround times.
4. **NHS England and HEE** must hold CCGs to account for delivery of the *GP Forward View* locally and should carefully evaluate the upcoming plans being prepared by CCGs to ensure that they will support delivery of the *GP Forward View* and have buy-in from local GPs.
5. **CCGs** should set out clear plans to increase investment in general practice, both in general and through the specific funding programmes identified in the *GP Forward View*. This must include setting aside funding for the £171m transformational support pledged in the *GP Forward View*, and ensuring that all funds channeled through CCGs for expenditure on the *GP Forward View* are spent on time and for their intended purpose.
6. **NHS England and HEE** must further develop their communications to ensure that key messages on the *GP Forward View* reach frontline GPs and that all practices are engaged in decisions about new models of care.

Introduction

When the *General Practice Forward View* was published in April 2016, the College welcomed it as a hugely significant step to bringing an end to the crisis in general practice in England. The unprecedented pledges it contained, including to invest an additional £2.4bn per year in general practice and to increase the general practice workforce by 5,000 GPs and 5,000 other members of the staff by 2020, represented a turning point for general practice.

However, the College was always clear that the key test would lie in the *GP Forward View*'s implementation. When the *GP Forward View* was published, we pledged to our members that we would work to hold the Government, NHS England, HEE and others to account for their delivery of the plan. This interim assessment is a key part of that effort.

This document focusses on two main areas. The first section assesses the pledges made in the *GP Forward View* which were scheduled to be delivered in full in 2016/17, which we have termed short-term commitments. It also includes an assessment of medium-term commitments on which we expected to see significant progress in 2016/17. These short and medium-term pledges are of particular importance to bringing immediate benefit to struggling practices. This section of the analysis sets out where progress has been made or where it is lacking and needs greater focus.

The second section consists of an analysis of the 44 STPs in England. STPs bring together NHS providers, CCGs, local authorities and other health and social care providers, including GPs, within 44 'footprint' areas in order to develop plans for the future of the health service in their geographical area. These plans, which are currently being developed and are intended to move to implementation soon, are crucial to the delivery of the *GP Forward View*. While the College supports the principle underpinning STPs, we are equally clear that they must both involve GPs and commit to increase investment in general practice.

Finally, we set out the actions that NHS England, HEE and other delivery bodies such as STPs and CCGs must take to ensure the full implementation of the *GP Forward View*.

At this point in the delivery of the *GP Forward View* it is still too early to make definitive judgments in a number of areas, particularly in the delivery of key long-term pledges mentioned above such as the additional £2.4bn annual recurrent investment in general practice and the 5,000 GPs and 5,000 other members of staff working in general practice. The College pledged to produce an annual assessment of the *GP Forward View* in each year of the life of the plan. Our first such assessment will be published later in the year and will offer a more complete analysis of progress, including in the delivery of long-term pledges, than this interim assessment, which focuses on the short and medium-term.

Methodology

Following the announcement of the *GP Forward View* the College appointed 33 Regional Ambassadors working across England to make the case for general practice at STP level. We have used their input to help inform this assessment, together with our analysis of public information sources and evidence provided to us by NHS England and Health Education England.

All the pledges chosen for analysis in this assessment were either for delivery in 2016/17 or were expected to have made significant progress this year. Not all of them are of equal importance.

The assessment of short-term pledges rates each commitment as red, amber or green (RAG rating) according to how successfully they are being delivered, with a short explanation of how we have come to this judgement. Given the difficulty of reliably measuring the progress of pledges due to be delivered after 2016/17, RAG ratings are not applied to medium-term pledges.

All 44 STPs have been systematically reviewed and analysed, based on the information publicly available on 23 December 2016. The analysis is thematic in nature and is not intended to be a full analysis of every STP. It considers factors such as the level of investment identified for general practice, the extent of STPs' engagement with the provisions of the *GP Forward View*, and their acknowledgement of the problems facing the GP workforce, as well as highlighting specific examples of both good and poor practice from among the STPs.

Assessment of short-term commitments

The *GP Forward View* made a number of pledges that were intended to bring swift impact to frontline GPs, by making changes and releasing funding before the end of the 2016/17 financial year.

Supporting struggling GP practices now is essential given the current crisis facing general practice. If the sustainability of general practice is not ensured in the short term then the transformation planned in the *GP Forward View* will be impossible. It is therefore important to ensure that key pledges made for 2016/17 in the *GP Forward View* are on track to be delivered.

This section assesses those pledges made in the *GP Forward View* which have a clear commitment to delivery in 2016/17. It highlights areas where progress has been strong as well as areas of concern, rating each pledge red, amber or green.

The College will continue to push the Government, NHS England and HEE to ensure that all of the pledges made for 2016/17 are delivered in full and on time.

Investment

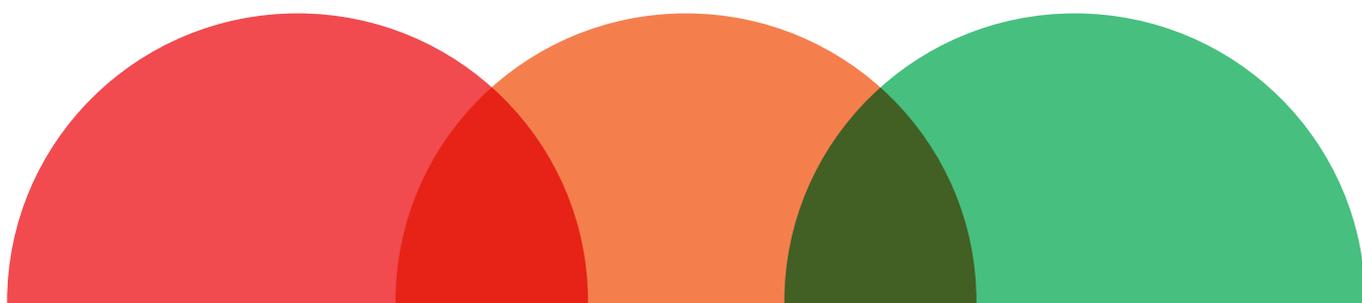
For 2016/17, NHS England will allocate an additional £322m in primary medical care allocations, providing for an immediate increase in funding of 4.4%.

Rating



NHS England pledged a 4.4% increase in the money delivered to general practice through primary medical care allocations in 2016/17. This is equivalent to an extra £322m and comprises a core contractual uplift of 3.9%, plus additional investment relating to population growth and other elements that are not part of the contract negotiations, such as support for improving access. NHS England advise that the £322m is on track to be spent.

Analysis published last year by the College revealed that, as of July 2016, CCGs involved in delegated or co-commissioning were on track to underspend their GP commissioning budgets by £33m by the end of 2016/17 if their spending patterns remained the same. This would lead to an underspend on this commitment. We have been informed by NHS England that they have issued strong guidance to CCGs to ensure that they spend allocated funding for general practice in full in 2016/17. Until NHS Digital's investment in general practice report is released in the autumn, we will not be able to confirm whether CCGs have adhered to this guidance.



Investment

NHS England will introduce a practice resilience programme worth £40m over five years, with £16m available in 2016/17.

Rating



In July 2016, NHS England announced the release of the first tranche of practice resilience funding, worth £16m. Local NHS England area teams were asked to confirm practices to receive support in October. 1,453 practices have been identified to receive support, which is intended to take a variety of forms based on individual circumstances, such as management support to improve operational efficiency, or mentoring from neighbouring GPs or practice managers.

All local teams are expected to have fully committed their allocated funding by the end of January, which would mean that £16.5m has been committed to delivering support to general practice to become more sustainable and resilient.

Despite this, only 219 practices (15%) have so far actually received support, and while £15.9m of funding had been committed, only £2.5m had been spent as at 31 December 2016.

Given the serious pressures that GPs and their teams are currently facing, it is of grave concern that the delayed progress of this vital programme has resulted in it having such a limited impact so far on the ground. In particular it is unacceptable that the central government procurement rules by which NHS England is bound have been allowed to act as a barrier to NHS England local area teams quickly commissioning the support practices need. As it now appears very unlikely that the full £16m will be spent before the financial year end, NHS England must ensure that the remainder is retained for investment as soon as possible in 2017/18.

It is also disappointing that the full £10m investment for vulnerable practices identified in December 2015 has not yet been invested, with only £6m having been spent as at 13 January 2017. As with the practice resilience programme, NHS England must take concrete steps to ensure that the remaining £4m is spent by the end of the year, and put in place contingency plans to ensure that any money unspent is rolled over and spent in 2017/18.

NHS England and the Department of Health will bring forward proposals, in July 2016, 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.

Rating



In July 2016, NHS England announced that it would offset the rising cost of GP indemnity, with £30m to be distributed to practices by April 2017 relating to rises in 2016/17, and a similar process to 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. In October NHS England announced the extension of the winter indemnity scheme, which in 2016/17 is open from October to March and is worth £5m.

The cost of indemnity is a major concern for GPs and it is essential that these short-term measures remain in place while a long-term solution is developed.

Less progress has been made on the wider reform of indemnity arrangements. Though conversations have started, no formal consultation has begun. Similarly, the Department of Health's consultation on introducing a Fixed Recoverable Cost scheme in clinical negligence claims, which would potentially have an impact on the cost of medical indemnity, has been both delayed and downgraded. The consultation, described in the *GP Forward View* as opening "shortly," has only just been launched, and the size of the lawsuits potentially covered by the scheme has been reduced from £250,000 to £25,000.

Workforce

HEE will increase GP training recruitment to 3,250 per year.

Rating



HEE and its equivalents in Scotland, Wales and Northern Ireland have taken a number of steps in 2016/17 to streamline the recruitment process and increase its flexibility. Changes include moving to twice yearly recruitment, in August and February; allowing applicants to indicate their geographical preferences in greater detail; and awarding applicants a single transferable UK score for their application rather than awarding a score specific to their assessment location. In 2016, 2,927 places were filled across Round 1 and 2 of GP recruitment, at a fill rate of 90%. The target to increase GP recruitment to 3,250 was therefore not met in 2016 – however, the recruitment rate for 2016 represents a marked improvement from the 2,513 recruited in 2015. Figures are not yet available for recruitment Round 1a for 2017.

Changes will be made to improve NHS England's Induction & Refresher scheme for doctors returning to work in English general practice.

Rating



NHS England have made the following changes to the Induction & Refresher scheme, as part of efforts to attract an additional 500 GPs back into general practice in England:

- A new portfolio route was launched in April 2016 for GPs with previous UK experience.
- Doctors wishing to return to general practice in England are now assigned a caseworker to guide them through the process.
- The monthly bursary for doctors on the scheme has increased from £2,300 to £3,500.
- A £1,250 top up to the bursary has been introduced to help with the costs of indemnity, until October 2018.
- Assessment fees for first time applicants will be removed, worth up to £1,000.
- Doctors on the scheme will be reimbursed up to £464 to cover the costs of GMC annual fees and Disclosure and Barring Service fees until 31 October 2018.
- In May 2016 NHS England launched a pilot scheme for targeted investment in recruiting returning doctors, allowing designated practices to access up to £10,000 in relocation allowances and an educational bursary for GPs they are able to recruit.

These changes meet the commitments made in the *GP Forward View*. Since the scheme was launched on 1 April 2016 88 doctors have completed the scheme, though it is not clear how many of these are now working in English general practice. There are now currently over 200 doctors on the scheme, the majority of whom have joined since the monthly bursary was increased in November 2016.

NHS England and HEE will evaluate the Targeted Enhanced Recruitment Scheme, which offers £20,000 salary supplements to GP trainees committing to working in hard to recruit areas.

Rating



In 2016 the scheme, which launched in February, saw 105 GP trainees accepting posts in seven hard to recruit areas, with an overall fill rate of 86.07% (122 posts advertised). The fill rates for these posts by locality were as follows:

- Isle of Wight: 100%
- Blackpool: 100%
- East Cumbria: 100%
- Lincolnshire: 97.3%
- South Cumbria: 83.33%
- West Lakes: 66.67%
- Northern Lincolnshire: 52.38%

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. Over the coming year HEE should consider measures to further expand and improve the scheme.

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

Rating



NHS England delivered increased financial compensation from 1 July 2016 for doctors on the scheme as well as those joining between 1 July 2016 and 31 March 2017. However, it is unclear whether the changes are having any impact on the number of GPs on the scheme.

NHS England is working with the RCGP, HEE and the BMA to design the new GP retainer scheme. This is on track to be delivered by April 2017 and will form part of the new GMS contract for 2017/18.

In November, the Secretary of State for Health announced the GP Career Plus pilot scheme, worth £1m, to test out measures to retain older GPs. In January NHS England selected 11 pilot areas to begin developing the scheme, in locations where retention pressures are particularly severe. The College played a key role in pushing for the introduction of the scheme and we are keen to see it taken forward as soon as possible.

Workload and fatigue

NHS England will invest a further £16m in a new national service, beginning in December 2016, to improve GPs' access to mental health support.

Rating



This service, which is worth £19.5m in total, has just launched, offering GPs in England access to a support service for mental health needs via a confidential self-referral phone line, website, and app. Face-to-face services will include:

- General psychiatric assessment and treatment.
- Support for addiction related health problems.
- One-to-one and group sessions.

The scheme 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.

NHS England will introduce new standards for hospitals to improve the interface between hospitals and general practice.

Rating



Changes to the hospital-general practice interface introduced as part of the new National Standard Contract for hospitals include:

- Ending the practice of automatic discharge back to general practice for patients failing to attend an outpatient clinic.
- Requiring direct electronic or email transmission of discharge summaries for inpatient, day case or A&E care within 24 hours.
- Requiring communication with GPs within 14 days following outpatient clinic attendance.
- Clarifying that for a non-urgent condition directly related to the original complaint or condition, onward referral to and treatment by another professional within the same provider is permitted without reference to the GP.
- Requiring providers to take account of GP feedback and to involve GPs when considering service development and redesign.
- Requiring providers to supply patients with a minimum of seven days' worth of medication following discharge from inpatient or day case care.
- Requiring providers to organise the different steps in a care pathway promptly and to communicate clearly with patients and GPs.

These changes have the potential to significantly reduce GP workload. The College is contributing to the working group that is overseeing them and further changes are being sought for 2017/18. However, 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, but should continue its efforts to ensure that frontline practitioners are aware of these changes and that commissioners introduce and enforce the new contract terms.

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 rolled out from late summer 2016 onwards.

Rating



The Elective Care Rapid Testing Programme involved staff, including GPs, from across health systems working to co-design new models for the delivery of care across specialty pathways.

NHS England is currently evaluating the learning from the programme, with findings expected in February 2017. A further four to five vanguard sites will be identified to further test the interventions ahead of a planned national roll-out in 2017/18 and 2018/19. Although a start has been made, this represents relatively slow progress. NHS England should establish clear milestones for the national roll-out of this programme to ensure that it takes place as quickly as possible.

The maximum interval between CQC 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.

Rating



The CQC's strategy for 2016-2021 commits to a maximum inspection interval of five years for practices rated good and outstanding. 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.

However, we are disappointed that the establishment of the new CQC inspection framework has not been used as an opportunity to curtail the costs of inspection for practices, with the introduction of further proposed fee increases for 2017/18. Instead of increasing fees, CQC should focus on reducing the cost of its inspection regime. CQC should also work with the Government and NHS England to consider alternative mechanisms through which the costs of inspection could be met by the Government, so that money is not diverted away from funding for frontline general practice care.

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, in order to improve and simplify transparency of information about general practice.

Rating



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.

NHS England will undertake a review of the Quality and Outcomes Framework (QOF) in 2016/17.

Rating



In October 2016 Simon Stevens stated that QOF is “nearing the end of its useful life” and that, while QOF will not end immediately in 2017/18, NHS England will begin to consider how to replace it. However a review will not be concluded this year. In addition, for those practices opting in, the Multispecialty Community Provider voluntary contract provides for the replacement of QOF with holistic team-based funding.

Care re-design

NHS England will bring forward £30m ‘Releasing Time for Patients’ development programme to release capacity within general practice.

Rating



This programme launched in July 2016 as ‘Releasing time for care’, part of the wider General Practice Development Programme. It is intended to help practices deliver the 10 High Impact actions to release capacity in general practice, such as active signposting, developing quality improvement expertise, partnership working, and the development of the general practice team.

The programme is open to all practices in England and has to date engaged 67 cohorts of practices, covering 31% of the practice population. However, we will not know how much has been invested in the programme in 2016/17 until the end of the financial year.

NHS England estimate that most practices can expect to release 10% of GP time through the programme, based on practices which have already implemented the programme. They report that feedback has been positive, in part due to the practical focus on the programme which is designed to help all practices, not merely those who are already innovating. In further developing the programme, NHS England should ensure that it makes a meaningful difference to practices by genuinely releasing capacity and that it proactively targets those practices most in need of support.

As part of the General Practice Development Programme NHS England has also released £5m in 2016/17 to CCGs to deliver training for receptionists and clerical staff to play a greater role in signposting, and has set out requirements for how this funding should be used. However, we are concerned that procurement issues have led to delays in this money being spent. NHS England must ensure that the training for which the £5m is intended is delivered as quickly as possible, and that any money not spent by the end of the financial year is rolled over into 17/18.

NHS England will launch a national programme by September 2016 to help practices support people living with long-term conditions to self-care.

Rating



NHS England has made progress in delivering this pledge through a number of different initiatives, such as a pilot scheme across 50 sites to deliver patient activation. Patient activation is a process by which patients are targeted for self-management educational programmes based on an assessment of their skills and confidence.

NHS England has 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 began this month and will be evaluated after March.

NHS England is also working with the College to develop collaborative care and support planning for people living with multiple long-term conditions, with the goal of easing the burden on GPs and empowering patients to play a collaborative role in their care.



Technology and infrastructure

NHS England will invite CCGs to put forward recommendations for investment in primary care infrastructure and technology by the end of June 2016.

Rating



CCGs submitted recommendations for investment to NHS England in June 2016 through the Estates and Technology Transformation Fund following bids from GP practices. Nearly 300 schemes in general practice have been identified for funding in 2016/17, subject to due diligence, with further schemes to be funded in 2017/18 and 2018/19. This follows the funding of nearly 900 schemes in 2015/16 and 2016/17.

Not all practices who applied for funding through the Estates and Technology Transformation Fund are expected to receive funding. Practices who submitted fundable bids to their CCGs must not lose out on vital capital funding, and it is 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 year of the programme is carried over to next year.

NHS England will introduce new rules from September 2016 which will enable NHS England to fund up to 100% of the costs of premises developments, rather than the previous cap of 66%.

Rating



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.

NHS England will agree arrangements for May 2016 to October 2017 to provide additional support to practices in three areas:

- Stamp Duty Land Tax for practices
- VAT on premises where the landlord has elected to charge VAT
- Transitional support where practices have seen a significant increase in the costs of facilities management on leases held with NHS Property Services and Community Health Partnerships

Rating



Measures to support practices with undocumented tenancies have been agreed with NHS Property Services (NHSPS) and Community Health Partnerships (CHP). These include making Stamp Duty Land Tax reimbursable for the initial term (up to 15 years), reimbursement of VAT on the rent for the duration of the lease when charged by NHSPS or CHP and a subsidy on NHSPS and CHP service charge costs increases.

NHS Property Services has identified that nearly 1,200 practices could benefit from these initiatives. It is essential that clear guidance is developed and issued to these practices to ensure practices are able to take full advantage of them before October 2017.

NHS England will introduce an expanded range of core requirements for technology services to be provided to general practice.

Rating



These were introduced in the 2016-18 GP IT services operating model, which contained a number of changes to core IT requirements. Practices should have begun to see these changes which include:

- Access to SMS or an equivalent electronic messaging system for direct patient communications.
- Remote access to the clinical system outside the practice at the point of care.
- Specialist IT security support services for practices including cyber security.
- A GP Data Quality advice and guidance service including training in data quality, clinical coding and information management.
- The development of a local digital roadmap.

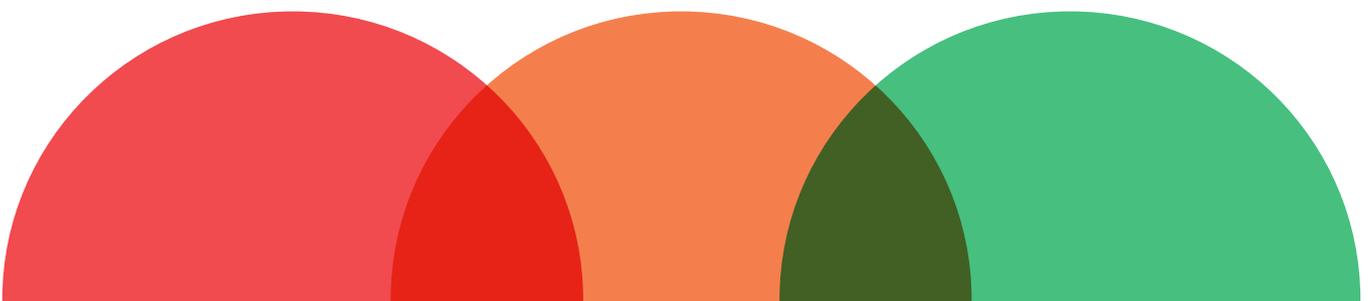
Responsibility for commissioning these new services rests with CCGs, and it is important that NHS England takes steps to monitor compliance and ensure that additional support set out in the new operating model is delivered. CCGs received an 18.5% real terms uplift in GP IT revenue allocations in 2016/17, and it is essential that this is invested in enhancing the IT capabilities of general practice.

The roll-out of access to the summary care record to community pharmacy will be completed by March 2017.

Rating



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. The roll-out of access to the summary care record means that pharmacists will be better able to give advice to patients and potentially reduce unnecessary GP appointments.



Assessment of medium-term commitments

The *GP Forward View* includes a number of commitments which are not necessarily for delivery in 2016/17, but which were expected to be launched in 2016/17, or against which progress should have been achieved by the end of this year. The following section assesses the progress of these commitments, which we have described as medium-term. Given that the interim progress of measures deliverable beyond 2016/17 is difficult to reliably measure, no RAG ratings have been assigned.

Clinical pharmacists

NHS England pledged to invest an additional £122m in the current pilot scheme for practice-based pharmacists, in order to deliver a further 1,500 pharmacists by 2020. This is on top of the 470 pharmacists funded through the original scheme. The progress made in extending this programme has been strong. The expanded scheme recently launched, with practices able to apply to access a practice-based pharmacist from 9 January.

Return to general practice nursing

The general practice nursing development strategy does not include a set delivery timeframe, but the College has consistently called for the quick delivery of return to general practice nursing schemes, which the *GP Forward View* pledges as part of the strategy. These schemes would encourage nurses who have left the workforce to return to general practice. We have estimated that a national scheme could be achieved for £2m, based on 500 nurses.

However, despite the existence of a bespoke return to nursing programme in one locality, little progress has been made in rolling this approach out at a national level. HEE must prioritise the wider roll-out of return to general practice nursing programmes to deliver a rapid increase in the numbers of nurses returning to work in general practice.

Mental health therapists working in general practice

NHS England pledged to deliver 3,000 mental health therapists working in primary care by 2020, which was scheduled to begin in 2016/17. This is part of an expansion of the wider Improving Access to Psychological Therapies (IAPT) workforce by 4,500 practitioners by 2020, of which 3,000 will be part of integrated services in primary care.

NHS England recently identified funding for 22 early implementer sites to develop their offer of integrated psychological therapies and expand access for patients with common mental health problems. New therapists began to come into post in January and services will be in place from the beginning of 2017/18. However, there is currently no plan for how many IAPT practitioners will begin working in general practice each year until 2020.

Given that the new mental health therapists will be largely employed by existing IAPT services rather than directly by GP practices, it is absolutely essential that the therapists are genuinely integrated with general practice rather than simply absorbed into IAPT teams. To provide genuine benefit to general practice and ease the pressure caused by common mental health problems, the new therapists must be fully integrated with general practice and accessible to GPs. The College will be working with NHS England and others to ensure that this happens.

250 post-CCT fellowships

HEE pledged to roll out 250 post-CCT fellowships to offer wider and more varied training opportunities to attract GP trainees to areas of poorest GP recruitment. 100 fellowships have been delivered to date with a further 150 anticipated to be delivered by September 2017, broadly in line with the summer 2017 timeline set out in the *GP Forward View*.

Introduction of pilots of new GP assistant roles

The College has also consistently called for the introduction of new GP assistant roles as a means of reducing the GP workload. GP assistants could take on a number of functions to help make GPs' time more productive, for example by handling administrative tasks and carrying out basic clinical tasks.

HEE has begun work to pilot the role in a number of localities including the North West, Yorkshire and the Humber, and in London, with a view to understanding how effective GP assistants can be in reducing the administrative burden for GPs. HEE plans to recruit into these pilots in early 2017, in waves of around 50, and to progress work in developing an apprenticeship scheme. However, there is still considerable uncertainty about the scope of the role of GP assistants. It is important that HEE works with the College to resolve this uncertainty as quickly as possible so that clear success criteria for the pilots can be agreed. If the potential for GP assistants to relieve the administrative burden on GPs is to be realised it is essential that this programme moves from pilot stage to national roll-out as quickly as possible.

£45m programme to support the training of reception and clerical staff

Along with the £5m of funding for this five year programme released to CCGs in 2016/17, a further £10m has been allocated for each year to 2020/21. CCGs have been asked to describe how this funding will be invested in training as part of their *GP Forward View* delivery plans. CCGs will also be required to report on their delivery of this funding on a regular basis.

It is important that NHS England ensures that the money distributed to CCGs is ringfenced to this programme and that the procurement issues that have affected the delivery of the first tranche of training in 2016/17 are not allowed to reoccur.

Extended access

During the development of the *GP Forward View* the College made it clear that increased investment for general practice could not be predicated on requiring GPs to work extended hours and GP practices to open seven days a week. This was recognised in the *GP Forward View* with the commitment that no GP practice will be forced to open seven days. The *GP Forward View* also stated that it will be up to local commissioners to decide levels of extend access provision, based on patient demand in their area and to ensure best value for money.

These principles were recognised in the Operational Planning and Contracting Guidance for 2017-19, which identified funding for CCGs to commission extended access based on an additional 1.5 hours after 6.30pm on weekdays, and based on local population needs on Saturdays and Sundays. Recurrent funding of £6 per head of the population will be available to all CCGs to provide these services from 2019/20, with some early adopters including those with existing GP Access Fund Schemes receiving investment from 2017/18.

It is important that these commitments continue to be recognised in the roll-out of extended access going forward.



Sustainability and Transformation Plans

The *GP Forward View* is a set of commitments made nationally but most of which will need to be delivered at a local level. The central funding commitments made in the *GP Forward View* are significant but in order to see 11% of the health budget in England spent on general practice, the amount the RCGP has been campaigning for, there will need to be substantial additional investment made locally.

STPs have been developed in 44 footprints to plan for future healthcare delivery until 2020/21, and therefore are critical vehicles for positive local progress on general practice. One of the key items NHS England set out as a 'must-do' for STP footprints was to "develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues"ⁱⁱⁱ.

This section of the report brings together analysis of all 44 STPs, including feedback from RCGP Regional Ambassadors, to identify themes and key examples that indicate the level of support for the *GP Forward View* in the plans as they currently stand.

Key insights

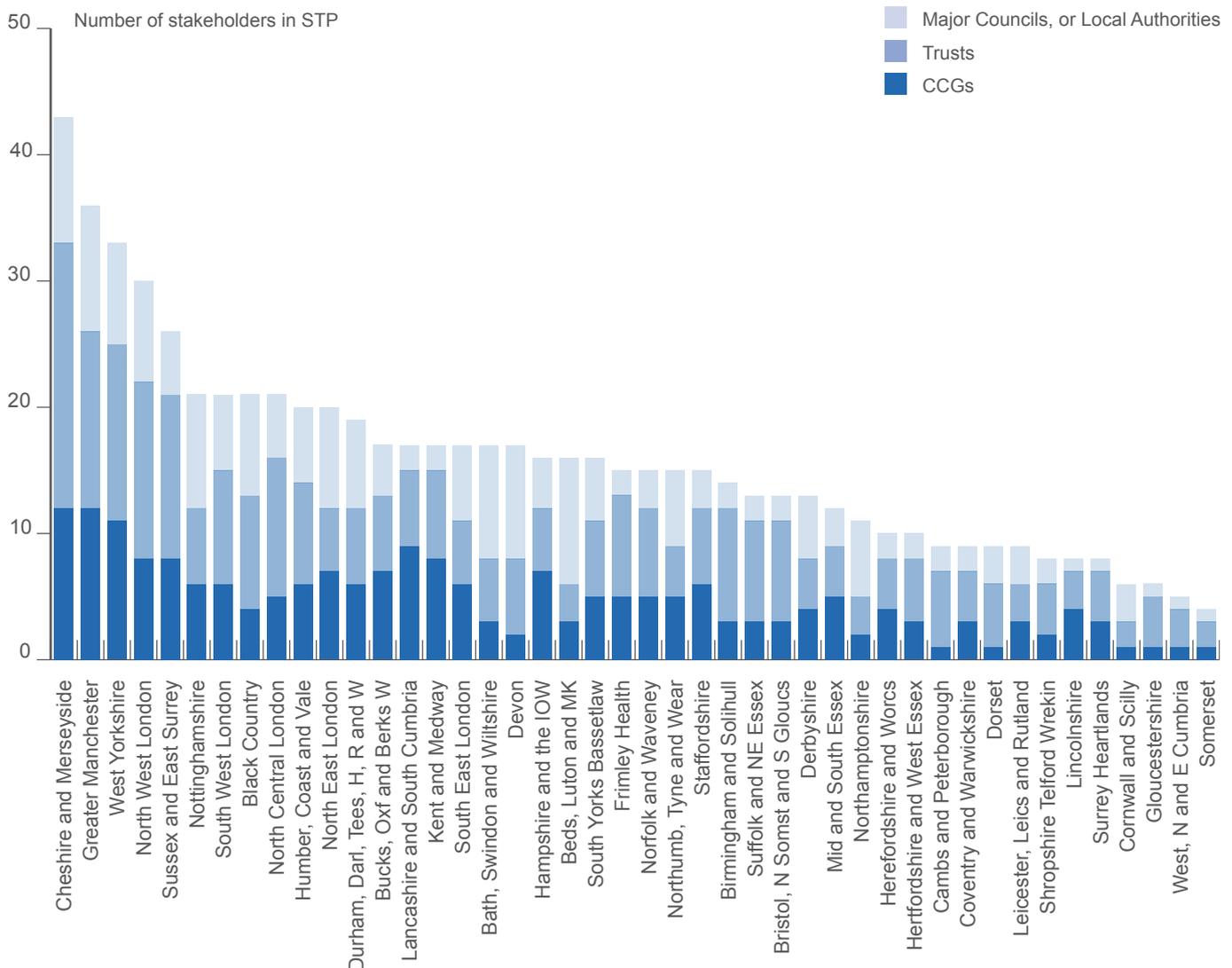
- The *GP Forward View* is not mentioned at all in a number of STPs.** While a small number of STPs demonstrate significant engagement with the *GP Forward View*, it goes without mention in five STPs, with several others referring to it only in passing.
- STPs are often driven by the need to tackle large deficits in the hospital sector, with very optimistic financial forecasts.** This is likely to affect the level of investment available for general practice. If forecasts are not met, funding for general practice may well be at risk.
- General practice is frequently seen as a solution to problems in secondary care, without sufficient efforts made to stabilize and support it.** There is much that robust and effective general practice can offer to provide the best and most appropriate care for patients and it should be at the heart of the future health service. However, given the recognition by many STPs that general practice is in crisis itself, insufficient regard is being paid to the need to put it on a stable footing. This has to be a precondition to creating a coherent platform for subsequent investment in the delivery of enhanced services in the community. General practice cannot have more pressure applied without significant financial support and an expanded workforce.
- Workforce plans for general practice are not sufficiently robust.** There is often acknowledgement of a workforce shortfall or high anticipated retirement numbers, but steps to contend with these are largely absent.
- Some STPs foresee a decrease or stagnation in GP numbers.** This is entirely contrary to the vision of the *GP Forward View* and is especially alarming considering the high expectations for general practice to deliver more of the care in the community.
- An increase in hubs and general practice working at scale is based on an assumption that the number of practices will reduce in some STP footprints.** Where this is the case it is often unclear how this will be approached, how GPs will be consulted and what the impact will be on patients, particularly in more rural areas.
- STPs identify very limited ring fenced funds for general practice infrastructure.** Often these are dependent on bids or delivery of other aspects of the STPs, with a failure to recognise the importance of vastly improved estate and digital capabilities in general practice in order to deliver new models of care.
- Local demand for extended access is seldom being assessed.** Most STPs have not demonstrated an understanding of local demand or indicated whether GPs have been consulted or how they will be required to deliver plans.
- STPs are top down strategic outlines, which have seldom been developed in a transparent way, and in many cases GPs have not been consulted.** Broad consultation could not always be achieved with tight reporting deadlines. While Trusts and larger GP federations may have been represented via CCGs the section of the GP community that appears to have been least engaged are mid to smaller sized GP practices. Their buy-in is vital to the success of the *GP Forward View*.
- Many STPs lack detail, with further information either not publicly available or missing entirely.** There is much that will not have been visible as the STPs have been analysed. The RCGP's expectation is that several more months will pass until all plans are finalised. It is critical that GP voices are heard during this time and the numerous STP footprints that are lacking these should make substantial efforts to consult with their GPs and the RCGP.

Starting points

The STPs vary hugely. This is unsurprising considering the broadly free rein that was given in terms of structure and content and the rapid process of their formation but also the very different contexts they are working in. The largest STP footprint, Greater Manchester, contains 12 CCGs and 487 GP surgeries for 2.9 million patients, while the smallest, Shropshire and Telford and Wrekin, has under half a million patients, with two CCGs and 64 GP surgeriesⁱⁱⁱ. Six STPs contain only one CCG.

The key stakeholders named in STPs vary in scale and make-up as well, with larger STP footprints such as Cheshire and Merseyside indicating what seems to be an unwieldy number and some STPs demonstrating a failure to consult relevant stakeholders. Fig 1 shows the key stakeholders by STPs. Those that do not fall under the indicated categories have been excluded to avoid double counting or unfair comparisons.

Fig 1. Key stakeholders in STPs.



The make-up of STPs could impact on their effectiveness. For example very small STPs may struggle to achieve the scale needed to deliver the vision of the *Five Year Forward View* and *GP Forward View*. Alternatively, very large STPs may lack a natural community or be too bureaucratic in nature to enable innovation.

Variety extends to local general practice landscapes. While on average 39% of GPs are aged over 50, a large number of whom will become eligible for retirement between now and 2020/21, this issue is hugely exaggerated in particular STPs such as Lincolnshire, Mid and South Essex and Somerset where 45-50% fit this demography. Separate analysis shows a significant concentration of single practices in STPs such as Mid and South Essex, the Black Country and Lincolnshire. Practices with high concentrations of GPs nearing retirement or single-handed practices are more vulnerable, with a risk that practices could close, leaving patients without access to a GP.

Some STPs have dealt with the challenges of covering sometimes large and diverse footprints by having separate plans for different areas, which poses a risk of siloed working and as such may negate the purpose of the STPs. The RCGP Ambassador for Nottinghamshire notes:

“Nottinghamshire STP are planning to have ‘2 provider boards’ - one in Mid Nottinghamshire and one in Greater Nottinghamshire, who will be the decision making units. This seems a bit odd to me given the STP is supposed to bring together all provider organisations and try to break down barriers/bring about system wide change.”

Similarly, the Northumberland, Tyne and Wear STP has separate plans for areas^{iv} and Shropshire is considered separately to Telford and Wrekin throughout their shared STP^v.

Transparency and consultation

Within this varied context, the ambition and quality of STPs differ dramatically. In the most concerning cases, such as Cornwall and the Isles of Scilly^{vi}, Hertfordshire and West Essex^{vii} and South West London^{viii}, detail is seriously lacking, which may relate to differing stages of strategy development at the start of the STP planning process. Feedback from the RCGP Ambassador for Cornwall and the Isles of Scilly suggests there are elements of activity, such as the implementation of their Physician Associate programme, that are not reflected in the STP document. This sort of omission may mean some STPs are incomplete pictures. In some instances significant additional detail is offered in supplementary documents, such as Derbyshire’s 284 page Outline Business Cases document. The published STPs are often the tip of the iceberg and there may be much more detail to emerge.

Other STPs assert they have made good progress but lack transparency, referring to more detailed documents that are not in the public domain. The Dorset STP refers heavily to the primary care commissioning strategy^x, which is still in development and therefore not published. Similarly, the Sussex and East Surrey STP references three place-based plans, where the majority of detail relating to primary care would sit, but only one of these is public^{xi}.

The level of GP involvement and consultation during the construction of these plans has been varied. This is particularly evident in the mixed reception of our RCGP Ambassadors, many of whom have struggled to secure involvement in the STP process. One RCGP Ambassador, whose work relates to two STPs, noted the difference between their approaches in his comments on the Coventry and Warwickshire STP:

“I cannot believe how little engagement there has been with me, not for want of trying, and it is a stark contrast to the Birmingham and Solihull STP with whom we got loads of representation.”

Nonetheless, there are other positive areas, such as Cambridgeshire and Peterborough, an STP footprint with significant acute care deficit challenges but where a unified primary and acute STP plan was arrived at thanks in part to the contributions of the RCGP Ambassador. There has also been good engagement in Staffordshire and Stoke on Trent, where the RCGP Ambassador sits on the Health and Care Transformation Board^{vii}, and Dorset, where the RCGP Ambassador has endorsed the primary care approach^{viii}. The RCGP Ambassador for Northumberland,

Tyne and Wear reports although the STP submission produced in June contained no reference to the *GP Forward View* and little to GPs, he was able to meet with the STP lead and lead GP to discuss this further, leading to the next submission referring much more substantially to the *GP Forward View* and GPs.

However, engagement with the RCGP Ambassador alone is not sufficient to ensure effective consultation with local GPs. The RCGP Ambassador for Humber, Coast and Vale reports he is “closely involved in debating, shaping and writing the STP” but has concerns:

“[There has been] no consultation with broader collections of GPs at any stage so most GPs and practices do feel isolated, excluded and distant from the *GPFV* and STP Plans”.

Some STPs make no mention of GP involvement at all, including North Central London^{xiv}, Lancashire and South Cumbria^{xv} and Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby^{xvi}.

Areas with better levels of GP involvement include Birmingham and Solihull, which plans to hold regular meetings with GP providers and the GP Alliance, as well as working with GPs on ideas for the “practice of the future”^{xvii}. The Greater Manchester STP also indicates in their primary care strategy that they have worked with GP practice staff and plan for “continuous engagement” and “regular stakeholder engagement events such as the Primary Care Summits”^{xviii}.

As the timelines for compiling STPs have been very tight, it is perhaps unsurprising that some lack detail or appear to be works in progress. It seems likely that the December submissions will continue to be refined and it may be some time before complete, final documents are publicly available, which clearly will have an effect on timescales and delivery plans.

Engagement with general practice and the *GP Forward View*

Many STPs acknowledge a crisis in general practice and recognise how integral it is to the functioning of the healthcare system. In most STPs, the *GP Forward View* was at least mentioned, though even a cursory reference was absent from five. This is despite guidance from NHS England that STPs were required to address the *GP Forward View* in their plans.

STPs with no reference to the *GP Forward View*

- Bedfordshire, Luton and Milton Keynes
- Cornwall and Scilly
- North Central London
- Shropshire and Telford and Wrekin
- West, North and East Cumbria

Where the *GP Forward View* is included in STPs, detail is often lacking. Some documents state support for the *GP Forward View* or say briefly that they will enact it as required, without indicating how that would be achieved. While even an undetailed commitment is still a statement of intent, the lack of information could be indicative of minimal strategy or prioritisation. Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP is representative of this, placing a large green tick next to the NHS England ‘must do’ relating to primary care, which includes implementation of the *GP Forward View*, but for which the only further comment is that they will “ensure the sustainability of general practice by implementing the GP Five Year Forward View”^{xix}.

It is more encouraging to see the few STPs that dedicated significant space to the *GP Forward View*. Particularly impressive is the Surrey Heartlands STP, which reproduces the ten actions the College called for STPs to take relating to the *GP Forward View*^{xx} and indicates what they are doing to achieve them^{xxi}.

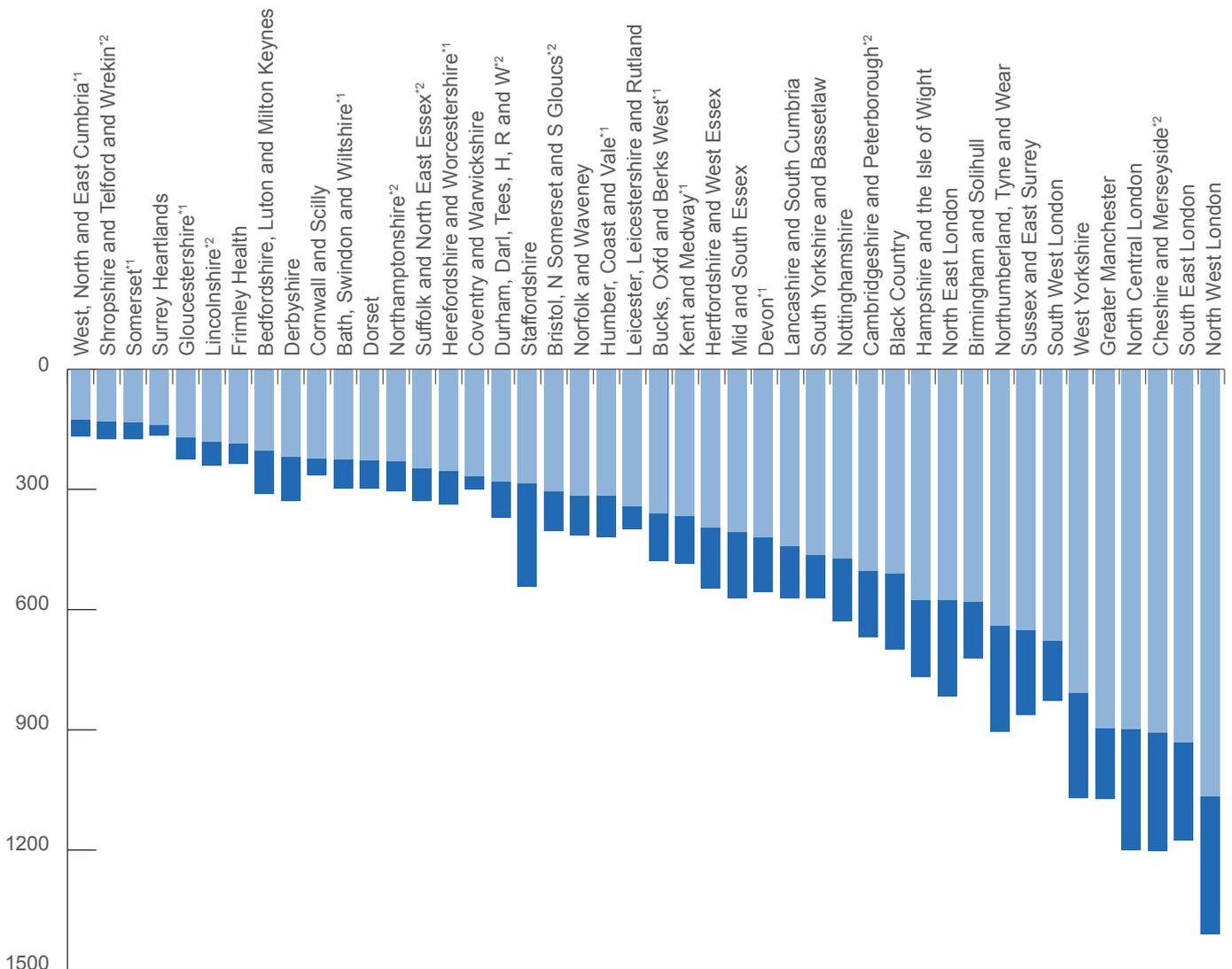
Following the previous submission of draft STPs in June, NHS England issued further instructions that the final documents should engage more fully with the *GP Forward View*, with mixed results. The Staffordshire and Stoke on Trent STP had feedback to “include stronger plans for primary care and wider community services that reflect the General Practice Forward View, drawing on the advice of the RCGP Ambassadors and engaging with Local Medical Committees”, and they subsequently

have included more information than many other STPs^{xxii}. However, the Bristol, North Somerset and South Gloucestershire STP received identical feedback^{xxiii}, but while they point to an Integrated Primary and Community Care programme, the STP does not show substantial engagement with the *GP Forward View*.

The wider financial context

It is undeniable that ‘do nothing’ deficits arising from the hospital sector are the key drivers of the action plans in most, if not all, STPs. (Fig 2)

Fig 2. STP ‘Do nothing’ deficits in health and social care budgets as of 2020/21 (£m)^{xxiv}



■ Health
■ Social

*1 Estimated health deficit based on average of 75% of system deficit for 2020/21. This is the average for 29 STPs where both the health and full system deficits are disclosed

*2 Estimated system deficit based on average of 133% of health deficit for 2020/21. This is the average for the 29 STPs where both health and full system deficits are disclosed

RCGP Ambassadors who have been party to STP development discussions indicate that it is normal for the emphasis of planning to be on eliminating these potential deficits. The Somerset STP is not unusual in wanting to “drive improvement in the system-wide financial and performance position” as its number one priority^{xxv}. However, general practice may be put under even more pressure as both an intended and an unintended consequence.

The majority of STPs indicate that they will achieve balance or even a small surplus in 2020/21 by enacting their plans. Given the scale of the deficits, this seems optimistic. Some STPs recognise this; for example, the Cheshire and Merseyside STP notes:

“Whilst the plans at this stage show a balanced position there is still a significant amount of further planning required on many of the solutions before we could present them as robust and with confidence of delivery.”^{xxvi}

The RCGP Ambassador for Hampshire and the Isle of Wight explained his concerns, which could easily be applied to many other STPs:

“The STP is full of bold statements that savings will be made and various idealistic goals will be achieved, painting an idealistic picture without really explaining the details of how any of this will be achieved... The financial restrictions are colossal, and could only be achieved by a massive reduction (not extension) of services.”

From a general practice perspective, a real concern is that if the proposed savings are not made each year as projected, any money committed to supporting general practice (as outlined in the next section) will be at risk.

STPs that are indicating deficits are perhaps instructive as they are more frank about the challenges. The Sussex and East Surrey STP, which forecasts a deficit of £60m in 2020/21, states:

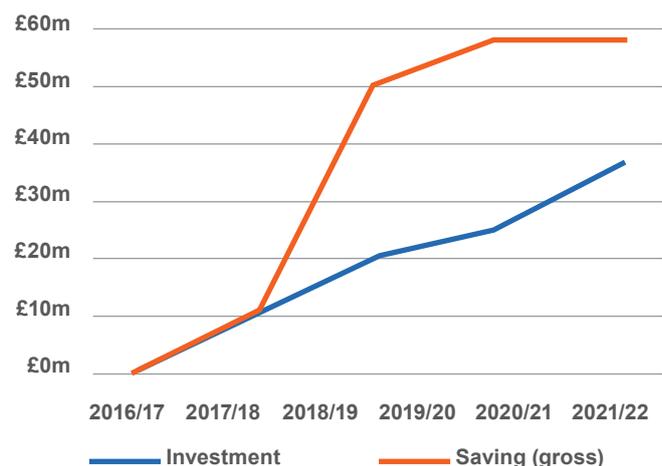
“Despite our plans achieving significant progress by 20/21, there exists a stark financial challenge across years 2-4 of the STP, driven by a starting deficit, increasing demand pressures and a time requirements associated with mobilising new place-based models of care.”^{xxvii}

These risks and challenges are shared by many STPs, which may struggle to meet their targets if solutions are not found. The STP for Sussex and East Surrey sets out several areas where additional funding would be needed^{xxviii} and other areas are also seeking more funding from NHS England. For example, the STP for West, North and East Cumbria indicates that £167m to £247m transitional funding is required, on top of transitional implementation funding of £22m^{xxix}.

Investment in general practice

Numerous STPs outline some intended spending in general practice. However, concerning, where the purpose of the funding is explicit, these are almost exclusively intended to deliver new, discrete initiatives (often in support of the other elements of the healthcare system) rather than recognising that general practice is in crisis and needs funding to stabilise it before it can be required to deliver more. Investment is normally intended to result in substantial savings, exemplified by the Norfolk and Waveney STP (Fig 3). Similarly, in Nottinghamshire, there are £50m worth of savings identified for delivery through the strengthening of primary, community, social care and carer services^{xxx}.

Fig 3. Financial impact of primary, community and social care programmes in Norfolk and Waveney^{xxxi}



Beyond these, there are some promising general commitments to invest in general practice, including Frimley STP, which states that “total primary care expenditure (excluding prescribing) is forecast to rise from £111m in 2016/17 to £136m [in 2020/21], over 21%, a larger increase than either the acute or mental health sectors”^{xxxii}. Similarly, the North West London STP shows annual increases in Primary Care medical allocations, which represent a cumulative increase of £58.2m, not including funding from national programmes^{xxxiii}. The Surrey Heartlands STP states there will be “above-allocation growth in primary care expenditure”^{xxxv}; and the Derbyshire STP indicates an 18% real terms increase in funding for general practice^{xxxv}. There are also a few rare instances of financial support that is primarily to shore up general practice. The Bath, Swindon and Wiltshire STP says it will “ensure local investment meets or exceeds minimum required levels” for primary care, as well as provide “sustainable support for vulnerable GP Practices”^{xxxvi}.

However, given the detail lacking in many of the STPs’ financial plans, commitments can be hard to interpret. The Black Country STP acknowledges that there are challenges with “current levels of manpower and capacity in General Practice”^{xxxvii}, but reassures the reader that £25m is being invested to mitigate this. However, elsewhere, the STP claims:

“With an extra £25m invested in GP services by 2021, an extra 25,000 GP appointments a year will be made available. All children under 5 and adults over 75 will be guaranteed same day access to GP appointments, meaning 200,000 people will be able to see a family doctor when they need to, starting in Dudley but rolled out across the Black Country and West Birmingham.”^{xxxviii}

It is unclear whether the £25m that is facilitating thousands of extra appointments is the same sum of money which is supposed to deal with the existing challenges in general practice.

In terms of the identification of investment specifically for the delivery of the *GP Forward View*, if figures are given these are generally headline, and in the vast majority of cases are linked to extended access:

- Suffolk and North East Essex: **£72.6m** for the *GP Forward View* and extended GP access, with money released each year^{xxxix}.

- Sussex and East Surrey: **£51m** to deliver the *GP Forward View*^{xl}.
- Cambridgeshire and Peterborough: **£37.9m** for the *GP Forward View* and extended GP access, with money released each year^{xli}.
- Surrey Heartlands: **£34m** non-recurrent investment in responding to the *GP Forward View* and delivering the Out of Hospital Strategy^{xlii}.
- North West London: **£30m** for the *GP Forward View* and extended GP access, with money released each year^{xliii}.
- Buckinghamshire, Oxfordshire and Berkshire West: **£28.9m** for the *GP Forward View* and extended GP access, with money released each year^{xliiv}.
- Leicester, Leicestershire and Rutland: **£18.5m** for the *GP Forward View* and extended GP access, with money released each year^{xliv}.
- Herefordshire and Worcestershire: **£7.5m** in 2020/21 from Sustainability and Transformation Funding, and additional figures in three preceding years^{xlvi}.

A few STPs also commit to spending related to the *GP Forward View*, without giving specific numbers. The Staffordshire and Stoke on Trent STP indicates that it will “monitor the investment profile into primary care through its assurance processes to ensure it adequately meets the national commitment of the GPFV”^{xlvii}, while Somerset STP confirms it will be “delivering the funding commitments set out in the *GP Forward View*”^{xlviii}, for example.

Many STPs do not isolate investment relating to the *GP Forward View* commitments. The RCGP Ambassador for Humber, Coast and Vale expressed why this might be worrying:

“[The] STP Finance Plan previously submitted did have specific GPFV funding highlighted - £14.7 million. I pushed for that figure to be highlighted in the STP but it wasn’t. That worries me, especially as it is now referred to as “primary care” funding not general practice. My concern, and our biggest fear as local GPs, is that the funding will go to NHS Trusts, large providers and only in a fragmented way to GP practices. If so the low morale, poor recruitment and fragile retention will not be addressed.”

It is worth noting that according to planning guidance, “CCGs should also plan to spend approximately £3 per head (totalling £171m non-recurrently) in 2017/18 and 2018/19, from their existing allocations, for practice transformational support, as set out in the General Practice Forward View”^{lxix}. In some instances, this is clearly included in investment plans, such as within the Hampshire and Isle of Wight^l and Lancashire and South Cumbria^{li} STPs. However, it is not always obviously forthcoming. The Northumberland, Tyne and Wear STP says this funding is “yet to be secured”^{lii} and many STPs make no specific mention of the planning guidance. The Devon STP is one such document, but it does state, “We are working across the STP footprint to ensure that we make best use of the additional funding available to support the *GP Forward View*”. It is therefore unclear whether they are incorrectly anticipating the £3 per head will be provided as additional budget^{liii}.

NHS England has also recommended that 15-20% of the Sustainability and Transformation Fund, which will be assigned by STPs, should go into general practice. In the Northumberland STP, 16.8% of their allocations from the STF will go into GP access and other commitments to GP transformation^{liv}, which indicates compliance with this. However, very few other STPs give explicit accounts of their use of the Sustainability and Transformation Fund in relation to general practice. It is therefore unclear whether or not this investment will be made as recommended.

A final area for concern relates to the timing of investment. For the *GP Forward View* to achieve its aims, investment in general practice should be undertaken as early as possible. This is particularly critical where acute care is being restructured and there will inevitably be increased pressure on general practice in the short term. However, where investment timelines are available, money going into general practice is almost always backloaded. In the Suffolk and North East Essex STP, the £72.6m identified for the *GP Forward View* and extended GP access will only be 27% (£19.6m) spent by the halfway point^{lv}. Only 27% of the £41m total outlined for enhanced primary care in the Bedfordshire, Luton and Milton Keynes STP will have been spent in the first two years^{lvi}. Meanwhile, in the Buckinghamshire, Oxfordshire and Berkshire West STP, £5.8m will be spent on the *GP Forward View* and extended GP access in 2017/18, compared with £10m in 2020/21^{lvii}.

Workforce

Many STPs recognise that there are current and future problems with workforce numbers, often showing awareness of the level of forthcoming retirements. Despite this, there is a paucity of solutions or strategy to address these concerns. In numerous instances, STPs indicate that they are intending to make a workforce plan, suggesting that work in this area is still at a very early stage. For example, the Staffordshire and Stoke on Trent STP states that capacity and demand modelling will be completed by March 2017^{lviii}, while the South Yorkshire and Bassetlaw STP has each area within the footprint developing a workforce strategy^{lix}.

Given the lack of strategy in many areas, there are concerns that lip service is being paid to problems. The RCGP Ambassador for Mid and South Essex identifies that there may be a more significant workforce problem than the document suggests:

“It identifies a problem with GPs being close to retirement but suggests problems with retention during restructuring are not very likely with a rating of 2. It also identifies difficulty recruiting but again rates issues with recruitment as only ‘might happen to some degree’. I think both these areas are very likely to be a significant problem for the area.”

Nonetheless, there are some promising signs. A number of STPs have targets for GP numbers, albeit normally only a limited plan for achieving them:

- Birmingham and Solihull: +114 WTE GPs^{lx}
- Gloucestershire: +65 GPs^{lxi}
- Leicester, Leicestershire and Rutland: +24 WTE GPs^{lxii}
- Lincolnshire: +24 WTE GPs^{lxiii}

Others commit more vaguely to increasing the number of GPs, including Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby^{lxiv}, Hampshire and the Isle of Wight^{lxv} and Northumberland, Tyne and Wear^{lxvi}, Lancashire and South Cumbria STP commits to doubling the growth rate for GPs and the Norfolk and Waveney STP aims to have a GP attrition rate of less than 5%^{lxviii}. The Northampton STP recognises that under a ‘do nothing’ scenario, 150 extra GPs would be needed, but does not explicitly set this as a target^{lxix}.

A few STPs stand out in appearing to have taken a more strategic approach. In terms of demand, the Bath, Swindon and Wiltshire STP notes that Office of National Statistics modelling has not fully factored in growth of population as a result of new housing developments, which means more GPs will be needed than would otherwise be indicated; as a result they identify a need for an additional ten GPs^{lxx}. Furthermore, while most STPs do not outline any plans for how to recruit and retain GPs in their area, a couple have clearly given this some consideration. The Cambridgeshire and Peterborough STP plans to try to address issues around housing that might affect retention of primary care staff trained in the area:

“Staff often train in our organisations but do not choose to stay because housing is too expensive, particularly in Cambridge. We are keen to address this and will seek to influence the planned new housing developments so that they include sufficient affordable homes. It is imperative that the HHCT campus and other developments have more key worker housing to attract staff to this area and ensure we retain them.”^{lxxi}

The Mid and South Essex STP also shows awareness of how wider factors affect the ability of general practice to attract the level of workforce it needs, and states progress will be enabled by seeing “Essex branded as a place to work and stay” “through various means including enhanced training through collaboration with universities and increased breadth and flexibility”^{lxxii}. Meanwhile, although not specific to the general practice workforce, the Kent and Medway STP highlights the intention to partner with local universities to develop a medical school^{lxxiii}.

However, it is very concerning to see that some STPs plan for a decreased GP workforce, despite the commitment in the *GP Forward View* to increase the number of doctors in general practice by 5,000. The Somerset STP in particular is embracing this strategy, planning for a decrease of 60 GPs (or 56 WTE GPs) by 2020/21.

As 25% of the GPs in the Somerset STP footprint are over 55, and 44% are over 50, retirement alone is likely to drive most of the projected 14% decline in GP headcount over the five year period. Other factors may well contribute to an ever greater decline unless significant work is done to recruit and retain GPs.



Fig 4. Somerset STP primary care workforce plan.

Primary Care Skill Mix (Optimal if Filled)		2016-17	2017-18	2018-19	2019-20	2010-21
Number of GPs		414	399	384	379	354
GP number (wte)	Decreasing	310	296	282	267	254
GP Return to Work/Retention/Portfolio Working	Increasing	0	5	10	15	20
Physician assistants	Increasing					
Health Coaches/navigators (Numbers of wte)	Increasing	60	65	112	168	224
Paramedics (Numbers of wte)	Increasing	0	28	56	84	112
Pharmacists (Numbers of wte)	Increasing	0	28	56	84	112
Counselling/CBT, psychological support	Increasing	11	36	61	87	112
Advanced Nurse practitioner (Numbers of wte)		109	116	123	130	137
Nurse (Numbers of wte)		109	116	123	130	137
Health Care Assistants (Numbers of wte)		109	116	123	130	137
Physiotherapy (Numbers of wte)		0	14	28	42	56
Mental health practitioner (Numbers of wte)		0	14	28	42	56
Administration/clerical (Numbers of wte)		547	547	547	547	547
Total WTE		1,256	1,382	1,551	1,727	1,905

Estimate of patient contact time per week (Hours)		2016-17	2017-18	2018-19	2019-20	2010-21
GP face to face		5,913	5,741	5,569	5,378	5,226
Health Coach/navigator face to face		1,526	1,653	2,848	4,272	5,696
Emergency care practitioners/Paramedics face to face		0	712	1,424	2,136	2,848
Pharmacists		0	712	1,424	2,136	2,848
Advanced Nurse practitioner		2,782	2,960	3,138	3,316	3,494
Nurse		2,782	2,960	3,138	3,316	3,494
Health Care Assistants		2,782	2,960	3,138	3,316	3,494
Total		15,785	17,698	20,680	23,871	27,101
% Increase Year on Year			12.1%	16.8%	15.4%	13.5%

As Fig 4 indicates, Somerset plan to compensate for the decline in the number of GPs by placing an increased reliance on other roles within the primary care workforce. Other STPs are also examining this approach, such as the Herefordshire and Worcestershire STP, which states there will be “consideration of new roles and extended roles to support a potentially smaller GP workforce in the future”^{lxxv}. Meanwhile, Bedfordshire, Luton and Milton Keynes are planning for zero growth in GP numbers, while increasing the numbers of nurses, care coordinators, community psychiatric nurses and physiotherapists in primary care^{lxxvi}.

Increasing skill mix is an important component of primary care transformation and it is positive to see Somerset’s commitment to increasing workforce levels in the general practice team, something which they have clearly given more thought to than most STPs and for which they should be commended. However, although optimal skill mix should take some pressure off GPs by allowing them to focus on what they do best, an increased GP workforce is required alongside increases in other members of the general practice team. With an ageing and growing population with increasingly complex health issues, as well as the expectation that general practice will be contending with a transfer of care from hospitals into the community, it is vital to see more GPs recruited and retained in all STP footprints.

Where a wider skill mix is referenced, some STPs, such as Buckinghamshire, Oxfordshire and Berkshire West^{lxxvii}, refer positively to its advantages but don’t outline how they foresee it working, or what the roles or numbers will be. However, some STPs include specific targets, such as Birmingham and Solihull, who calculate their share of the *GP Forward View*’s commitment to practice-based mental health therapists and clinical pharmacists^{lxxviii}, and Gloucestershire, who have targets for additional pharmacists and advanced/specialist nurses by 2021^{lxxix}. In West Yorkshire and Harrogate, although no specific targets are cited, the STP signals an intention to invest in nurses, pharmacists, advanced practitioners, physicians associates, clinical support workers and care navigators in primary care^{lxxx}.

New models of care

The transformation of primary care is seemingly often driven by a need to relieve pressure on hospitals. It is critical that general practice has the support required to suitably care for patients, particularly in the context of increased demand. It is equally important that GPs are central to the planning of new models of care that rely on them so fundamentally.

The transfer of more care into the community should be focused on delivering a better service to patients closer to home. However, it is not always clear that STPs are suitably supportive or conscious of the potential barriers. Too often, moving patients into the community or directing them to primary care is portrayed as a solution, without significant engagement with the effect this will have on workloads (as well as often being portrayed as cost-saving first, with patient care as a secondary consideration). In addition, the incredibly limited information contained in most STPs about the transformation process means it is uncertain what financial resources, time and human capital will be needed, particularly to rapidly support relocation and federation if necessary. Even where smaller practices are in principle sympathetic to transformation, they will need reassurance and appropriate resources to be fully engaged.

Where plans are outlined, they are often ambitious. The Hampshire and Isle of Wight STP’s various plans indicate almost 20,000 additional patients will be treated by primary care by 2020/21 as a result of their changes^{lxxxi}. In Hertfordshire and West Essex, there is a planned reduction of 51,874 bed days in hospitals over five years^{lxxxii} and South West London is aiming for a reduction in acute bed days of 44%^{lxxxiii}. Meanwhile, the Lincolnshire STP details plans to decrease activity in every area other than primary care, where it will increase by 10% over five years.

Fig 5. Planned shift in activity in Lincolnshire^{lxxxiv}.

Point of Delivery	% Activity shift over 5 years
A&E	-27.5%
Non Elective Admissions	-10%
Elective In-patients	-12%
Acute OPA	-21%
Mental Health Inpatient	-10%
Community Services	-21%
Primary Care	+10%

There is also a sense that some STPs are not very joined up. The Staffordshire STP has one measure of success that is “number of patients requiring access to GPs decreases”, based on their hopes for new roles and skill mix, but this seems like an incredibly ambitious ask given their plans to increase primary care interventions in favour of hospital care^{lxxxv}.

There are not many STPs that evidence strong involvement of GPs in these decisions, and even fewer that seem to be consulting with all GPs or practices. Those that are doing better include the Gloucestershire STP, which is planning to agree its model with 16 GP cluster groups, which GP surgeries have formed themselves^{lxxxvi}. However, where there are plans to establish hubs or similar large groupings of practices in order to deliver general practice at scale, it is often unclear what will happen to practices that are not willing or able to participate in the new arrangements.

Meanwhile, although most STPs are working to serve areas with populations of 30,000 to 50,000, this can vary, such as in the North East London STP, which envisages up to 70,000 patients per hub^{lxxxvii}. In the Kent and Medway STP, although the plans are predicted on extended practices treating 20,000 to 60,000 patients, it is intended that some of the hubs themselves will service over 200,000 patients^{lxxxviii}.

Some STPs are at an advantage as they have already started implementing new models of care. Others are hosting vanguards, which are producing useful lessons and data. For example, the Black Country STP is planning on making evidence-based decisions to move their care forward using their existing vanguards^{lxxxix}, while the Dorset STP will be able to use an existing hub as a model:

“Our existing Weymouth and Portland Integrated Care Hub has the potential to act as a blueprint for the rest of Dorset. The hub covers a network of nine local GP practices whom together service 74,000 people. It operates 8am to 6pm seven days a week, and brings together a wide range of health and social care coordinators working as one integrated team. It includes GPs with enhanced skills to manage chronic and acute illnesses, community nurses, social workers, an old people’s mental health worker, a community rehabilitation team nurse, a community matron, a paramedic and an in-reach nurse. Working collaboratively enables the team to identify and respond to people at the highest risk of needing more health and care with the aim of providing support in the community and reducing the need for an admission to an acute hospital. The staff use anticipatory care plans and frailty registers, and have close links to local practices to strengthen care planning. The hub also has access to local ‘step-up’ community beds. In its first four months the hub has had 500 referrals and the improved care pathways means only 32 people have needed to be admitted to Dorset County Hospital. Staff also report feeling more satisfied and motivated.”^{xc}

Extended access

The STPs uniformly commit to providing extended access to general practice. However, although planning guidance says that there needs to be “sufficient routine and same day appointments at evenings and weekends to meet locally determined demand”^{xc}, very few STPs demonstrate any attempt to analyse local demand. Where there has been an attempt to measure demand, it is not always clear how it has been done. For example, the Somerset STP is planning “focused weekend working tailored to those patients who would benefit most (end of life, complex patients, frail elderly)”^{xcii}, rather than having these as routine appointments for all. Yet non-working elderly patients may be more likely to be able to attend weekday appointments than some other demographics.

In addition, many STPs are vague about how extended access will be provided. Some GPs and other practice staff will be able and willing to work on evenings and weekends, but as the workforce is already overstretched, it seems unlikely that coverage of these times would be possible in all areas without some sacrifice of weekday appointments. It is also unclear whether GPs and other practice staff will be forced to work different or additional hours. Often extended access is said to be delivered through hubs (for example, in Lincolnshire^{xciii}, North East London^{xciv} and Hampshire and the Isle of Wight^{xcv}) but it is not clear how hubs will be formed and therefore if participation will be obligatory.

The RCGP Ambassador for Gloucestershire raises the potential for unintended consequences:

“There is currently a system throughout Gloucestershire delivering 'urgent' appointments available for all GP practices with appointments available seven days a week until 8pm. This is staffed by locum GPs and was established with money from the GP access fund. These [appointments] are allocated to practices, depending on list size. The urban and rural systems differ countywide. This system was adopted to remove urgent demand from practices originally. Unfortunately the shifts are popular and as a result locums are now very, very difficult for practices to find, and lots of GPs are working these shifts instead of OOH [out of hours] or salaried jobs etc.”

The lack of detail in most STPs' extended access plans means negative effects like these are less likely to be recognised and managed.

Infrastructure

In terms of premises and the primary care estate, there is some recognition that existing premises are not always fit for purpose. The situation in North West London is bad but not unusual^{xcvi}:

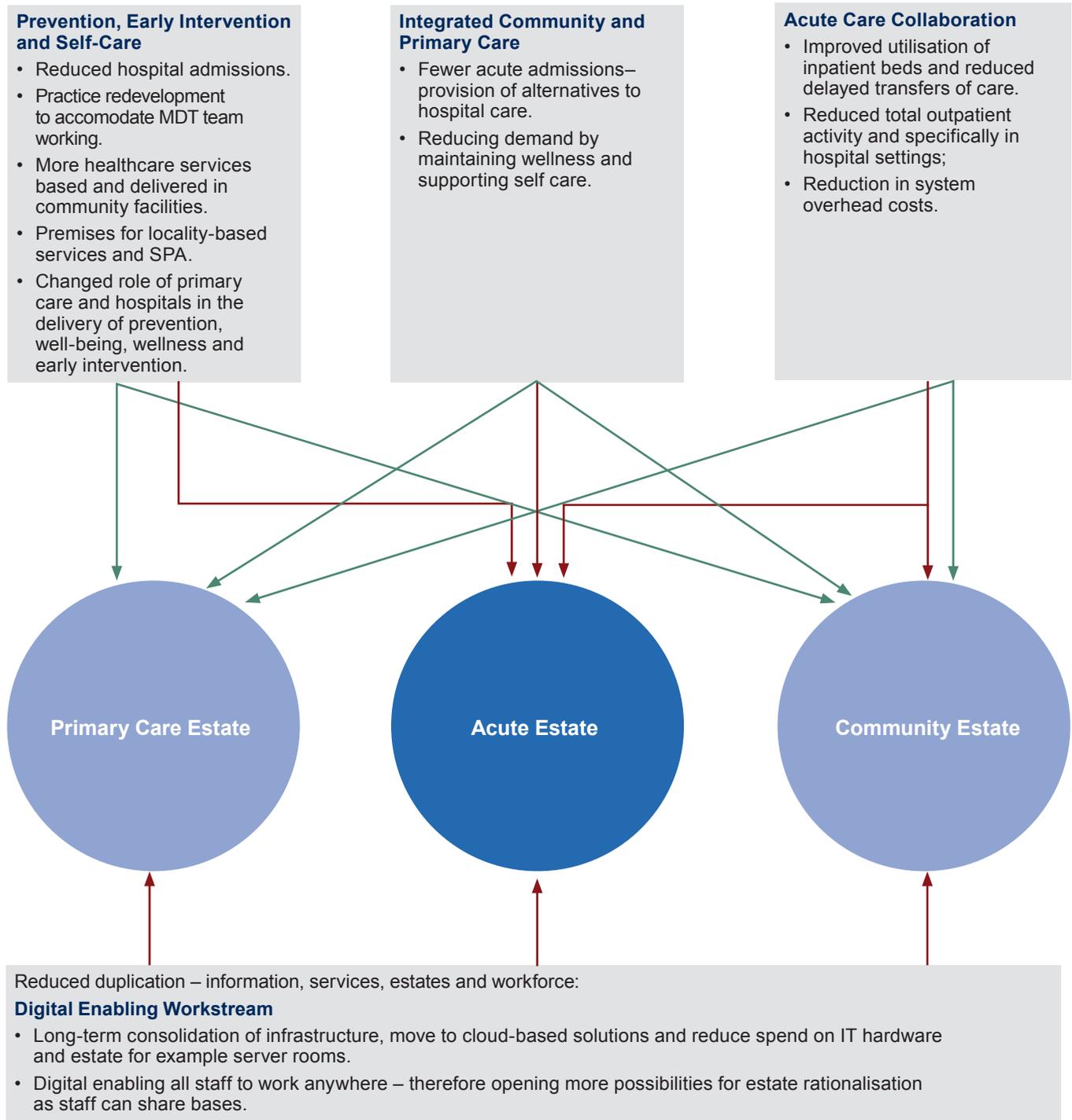
“Primary care estate is also poor, with an estimated 240 (66%) of 370 GP practices operating out of category C or below. Demand for services in primary care has grown by 16% over the 7 years 2007 to 2014, but there has been limited investment in estate, meaning that in addition to the quality issues there is insufficient capacity to meet demand.”

As well as the need to address existing premises problems, the creation of hubs emerges as a major stimulus for change. Many STPs foresee that GP surgeries will be brought together in some way or combined with other health and social care services. This means that different, larger premises are required, as the Coventry and Warwickshire STP recognises when stating, “aligning primary, community and acute services will require a very different primary care estate.”^{xcvii} Investment is sometimes driven by this; for example, the Lincolnshire STP allocates between £7m to £30m for each of six primary care hubs^{xcviii}. However, given the scale of property challenges in some areas, insufficient thought has been dedicated to this. For example, there is a higher concentration of small practices in large cities (particularly London), where it is likely to be particularly challenging and costly to find suitable premises for hubs that merge these smaller entities.

More nuanced STPs recognise that changes across the system have an impact on primary care estate, which is highlighted most clearly in Bristol, North Somerset and South Gloucestershire STP (Fig 6). The green arrows coming from three workstreams into the primary care estate show that the key programmes being implemented in the STP footprint will all put more pressure on primary care estate.

Fig 6. Bristol, North Somerset and South Gloucestershire STP map of workstream impact on estate^{xcix}.

An overview of the impact on estate arising from the 3 work-streams is given below:



↑ Increasing Need
 ↓ Declining Need

Meanwhile, some STPs plan for rationalisation of primary care estate. For example, the Dorset STP states there will be “a reduction in the number of GP sites”^c. This may well be an appropriate solution, alongside the formation of hubs. However, it is unclear how this will be achieved, whether GPs have been consulted and whether there will be attempts to impose these changes on GPs, which would clearly be a cause for concern. Similarly, the Devon STP states there will be “fewer individual GP practices” and there will be “conversion of existing estate”^{ci}, which concerns the RCGP Ambassador for the area:

“Closure of some GP premises, in combination with closure of community hospitals in what is a relatively geographically dispersed population will provide real challenges for community provision in the future.”

The *GP Forward View* promises an increase of over 18% in allocations to CCGs for provision of IT services and technology for general practice^{cii}, but many STPs don't explicitly reference general practice in their digital plans. Of those that do, many do not address all of the digital commitments in the *GP Forward View*, remaining much more focused on paperless and electronic data transfer, rather than more advanced steps. Where there is more exploration, this often builds on pilots or existing models. For example, South Yorkshire and Bassetlaw STP cites an award-winning telephone based care coordination centre for healthcare professionals seeking a care solution for their patients, to be used in Barnsley^{ciii}. Meanwhile, the Greater Manchester STP footprint has been piloting an app in Oldham that gives patients greater access to GPs^{civ}.

However, investment in primary care infrastructure is often not ringfenced or able to be funded entirely out of the STPs' budgets. This is demonstrated in the Frimley STP, which identifies £38m for primary care digital needs, but claims an additional £33m needs to be invested to achieve its ambitions^{cv}. The North West London STP will spend “up to” £100m on their primary care estate, presumably dependent on other factors^{cvi}. Therefore, several STPs are exploring alternative sources of funding. The RCGP Ambassador for Birmingham and Solihull writes:

“[There are] decent plans for technology (VDI, digital reception, digital signage interoperability of clinical system, patient app and portal) but dependent on a CCG driven ETTF [Estates and Technology Transformation Funding] bid for next year.”

The South West London^{cvii} and the Northumberland, Tyne and Wear^{cviii} STPs are also depending on Estates and Technology Transformation Funding to deliver their estate plans, among others. This reliance could be cause for concern as the Estates and Technology Transformation Fund (ETTF) received many more applications for funding than it was able to support in the most recent round, suggesting that numerous capital plans set out by STPs will lack funding. Meanwhile, the Humber, Coast and Vale STP will be exploring public private partnership arrangements as an alternative source of funding (for their more general estate plans)^{cix}. Finally, some investment plans are reliant on estate disposals, such as in South East London^{cx}.

While it is promising to see thought given to potential avenues for funding infrastructure initiatives, the fact that this is sometimes not covered by existing planned expenditure could be problematic if additional funding does not come through as planned. It is recognised that the general practice estate will be put under extra pressure through new models of care and that it is often not fit for purpose even at current capacity. It is therefore critical that investment is planned for in STPs.

Conclusion

The STPs are varied in their commitments to general practice. Some demonstrate an understanding of the pressures general practice is under and give clear indications of how they will address these. Most concerning are those exhibiting evidence of a total lack of engagement with the *GP Forward View*, plans to decrease the GP workforce and reduce the number of surgeries, a lack of consultation with local GPs and minimal transparency of financial and strategic plans.

Recommendations

This interim assessment of the *GP Forward View* illustrates that, while good progress is being made on a number of pledges, some urgent changes are needed to ensure that the *GP Forward View* delivers meaningful changes for GPs that they are able to identify as helping in their day to day work. This interim assessment is an opportunity

for national and local bodies to take stock of progress, acknowledge successes and to take concerted action where pledges are not currently on track. For STP footprint leaders this interim assessment is an opportunity to reflect on whether their STP does enough to support delivery of the *GP Forward View*.

We are calling for the following steps to be taken:

- The Government** must continue to prioritise the sustainability and transformation of general practice through the full delivery of the *GP Forward View*. To achieve this the *GP Forward View* must be included as a key objective in the mandates for NHS England and HEE for 2017/18 and every year to 2020/21.
- NHS England and HEE** must take concerted action to ensure that any immediate *GP Forward View* pledges that are not currently on track are delivered by the end of the first year of the *GP Forward View* and that monies not spent are rolled over to the 2017/18 financial year. This is particularly true for those pledges that we have rated as red in this interim assessment, such as the practice resilience programme. Any short-term pledges not delivered by the end of 2016/17 should be delivered as soon as possible in 2017/18.
- Government and NHS England** must work together to tackle delays in delivery as a result of central government procurement rules, by reviewing the way in which these rules are applied and reducing turnaround times.
- NHS England** must ensure there are clear timeframes and organisational accountability for every pledge in the *GP Forward View*.
- NHS England and HEE** should continue to engage with STPs to reinforce the need for local investment in general practice and the STPs' role in delivering the *GP Forward View*. **NHS England** must reject STPs which do not sufficiently cover the 'must do' to "Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues"^{txi}. Our analysis for this interim assessment suggests that a significant proportion of STPs should be rejected in their current form on this basis.
- STP footprint leaders** should ensure that their STPs include a plan for implementing the *GP Forward View* locally, including plans to expand the GP workforce, and an outline of how the STP has engaged with local GPs.
- STP footprint leaders** should publish detailed financial plans setting out their proposed spend on general practice, which should include a commitment to invest 15-20% of Sustainability and Transformation Fund allocations in general practice. **NHS England and STP footprint leaders** must engage in an honest conversation about how to address acute trust deficits so that these do not hinder investment in general practice. Where money is not currently secured, for example for capital spend, this should be clearly indicated and alternative plans for securing funding outlined.
- NHS England** must hold CCGs to account for delivery of the *GP Forward View* locally and should carefully evaluate the upcoming plans being prepared by CCGs to ensure that they will support delivery of the *GP Forward View* and have buy-in from local GPs.
- CCGs** should set out clear plans to increase investment in general practice, both in general and through the specific funding programmes identified in the *GP Forward View*. This must include setting aside funding for the £171m transformational support pledged in the *GP Forward View*, and ensuring that all funds channeled through CCGs for expenditure on the *GP Forward View* are spent on time and for their intended purpose.
- NHS England and HEE** must further develop their communications to ensure that key messages on the *GP Forward View* reach frontline GPs and that all practices are engaged in decisions about new models of care.

Next steps

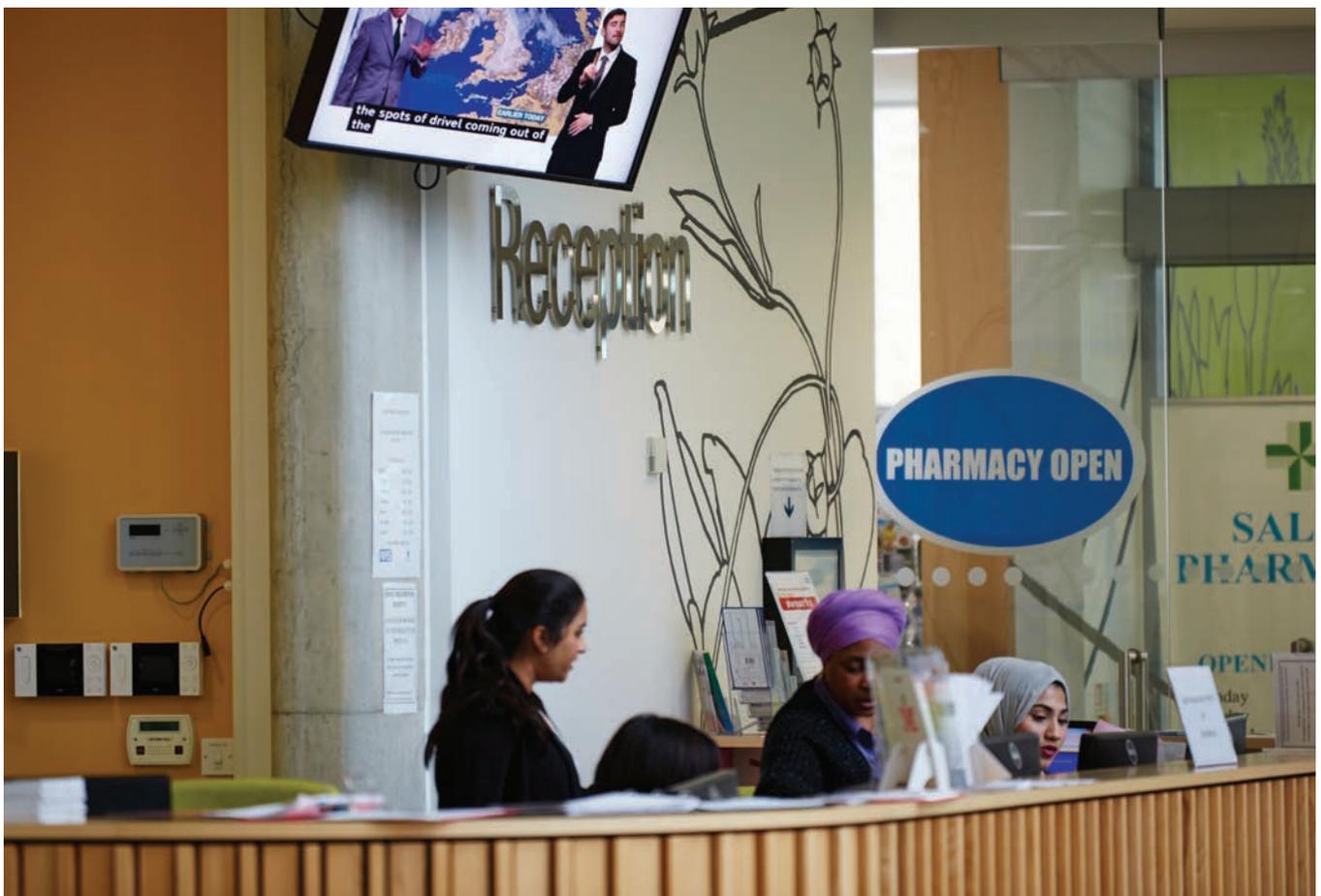
The College pledged to hold the Government, NHS England, HEE, and others to account for the successful delivery of the *GP Forward View*. This interim review is part of a planned programme and we have already committed to publishing assessments of the delivery of the *GP Forward View* every year to 2020/21. The review of the first year of the *GP Forward View* (covering the period from April 2016-March 2017) will update the status of the commitments assessed in this document, as well as considering the longer term commitments and reviewing the impact the *GP Forward View* has had for College members over the year.

In addition to this interim assessment, the College has appointed a network of RCGP Regional Ambassadors across England to engage with and monitor the development of STPs and the implementation of the *GP Forward View* locally and to advise the College on progress. The Regional Ambassadors' input has been critical to this interim assessment.

The College also published an independent financial analysis of the *GP Forward View*^{xiii} and is a member of a number of *GP Forward View* advisory groups in which key stakeholders including NHS England, HEE and the BMA meet regularly to discuss its implementation.

The College will continue to engage with our members about the *GP Forward View* to ensure that members are well informed about *GP Forward View* initiatives and are supported to access *GP Forward View* schemes and funding and to engage with their local STPs.

We would welcome any feedback on this interim assessment or the *GP Forward View* more broadly which can be provided to policy@rcgp.org.uk



Index of short-term commitments

Investment	Rating	Page
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%.		7
NHS England will introduce a practice resilience programme worth £40m over five years, with £16m available in 2016/17.		8
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.		8
Workforce		
Health Education England will increase GP training recruitment to 3,250 per year.		9
Changes will be made to NHS England's Induction & Refresher scheme for doctors returning to work in English general practice.		9
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		10
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.		10
Workload and Fatigue		
NHS England will invest a further £16m in a new national service, beginning in December 2016, to improve GPs' access to mental health support.		11
NHS England will introduce new standards for hospitals to improve the interface between hospitals and general practice.		11
NHS England established a Rapid Testing Programme in three sites to review ways of better managing outpatient demand. The <i>GP Forward View</i> will see the most effective measures emerging from this programme rolled out from late summer 2016 onwards.		12
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.		12
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.		12
NHS England will undertake a review of the Quality and Outcomes Framework (QOF) in 2016/17.		13
Care re-design		
NHS England will bring forward £30m 'Releasing Time for Patients' development programme to release capacity within general practice.		13
NHS England will launch a national programme by September 2016 to help practices support people living with long-term conditions to self-care.		14
Technology and infrastructure		
NHS England will invite CCGs to put forward recommendations for investment in primary care infrastructure and technology by the end of June 2016.		15
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.		15
NHS England will agree arrangements for May 2016 to October 2017 to provide additional support to practices in three areas.		15
NHS England will introduce a range of core requirements for technology services to be provided to general practice.		16
The roll-out of access to the summary care record to community pharmacy will be completed by March 2017.		16

- ⁱ NHS England, NHS Operational Planning and Contracting Guidance for 2017-19 (2016), p.8. Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf>
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- ⁱⁱⁱ Analysis by RCGP, based on figures sourced from: HSCIC, General and Personal Medical Services, England 2005-2015, as at 30 September 2015, Provisional Experimental statistics (2016). Available at: <http://www.hscic.gov.uk/catalogue/PUB20503>
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- ^{ix} Derbyshire STP Outline Business Cases. Available at: <http://www.southernderbyshireccg.nhs.uk/publications/joinedupcarederbyshire/>
- ^x Our Dorset: Our Sustainability and Transformation Plan for transforming local health and care, p.18. Available at: <http://www.dorsetccg.nhs.uk/Downloads/aboutus/Our%20Strategy/Our%20Dorset%20STP%20FINAL.pdf>
- ^{xi} Central Sussex and East Surrey Alliance Place-Based Delivery Plan. Available at: <http://www.brightonandhoveccg.nhs.uk/your-services/sustainability-and-transformation-plan>
- ^{xii} STP – October 21st submission, p.59. Available at: <http://www.healthcampaignstogether.com/pdf/Final-STP-October-Submission-Staffordshire-Stoke-on-Trent-Footprint-10-v9.pdf>
- ^{xiii} Our Dorset: Our Sustainability and Transformation Plan for transforming local health and care, p.24.
- ^{xiv} North Central London: Sustainability and Transformation Plan. Available at: http://www.camden.gov.uk/ccm/cms-service/stream/asset/?asset_id=3518090&
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