Editorials

General Practice Forward View:

a new charter for general practice?

The publication of NHS England's *General Practice Forward View* (GPFV)[1] is one of the most important events for general practice since the GP Charter of 1966. By 2020–2021, recurrent funding for general practice is set to increase by an estimated £2.4 billion per year. This increase in funding is coupled with an investment of £500 million in a sustainability and transformation fund. This is 'real' money. It is also 'new' money and a belated recognition not only of the 'unprecedented strain' on general practice and the struggle to keep pace with relentlessly rising demand but also of the value of general practice to both patients and the NHS.[2]

As Roland and Everington write, *'If general practice fails, the whole NHS fails'*.[3] This initiative is, in large part, the result of the high-profile Put Patients First: Back General Practice[4] lobbying campaign by the Royal College of General Practitioners (RCGP) and a general consensus that general practice is in crisis.

In 2014 Deloitte estimated that, taking into account inflation and increasing demand, the shortfall in GP funding would be approximately £3.36 billion by 2017–2018 if the problems of general practice were not addressed; and this was before the new models of care were introduced to shift work from the hospitals to general practice.[5] The proportion of NHS funding for general practice was approximately 11% in 2006, a figure that had fallen to 7.9% by 2015. This increase in funding goes some way towards restoring that proportion of total NHS funding allocated to general practice, with 'over 10%' promised by 2020. It is a remarkable achievement that, at a time when NHS funding is severely constrained and required to find £22 billion in efficiency savings, general practice will receive a 14% real-terms increase. GPFV should make a real difference to GPs and their patients, but will it? The impact of Brexit on the economy and the NHS [and the GPFV in particular] is unknown at present but it is unlikely to be favourable. A great deal now also depends on the commitment of our 'new' government to delivering GPFV.

WILL THE INCREASED FUNDING MAKE A DIFFERENCE?

The NHS and general practice in particular face major challenges: not only an increasing workload coupled with the current workforce shortages, but also an ageing population with increasingly complex medical problems being diagnosed and managed in the community. The relationship between patients and their clinicians is also changing, with higher expectations of the service by patients and more involvement in management and treatment decisions.[6] The traditional model of 10-minute appointments no longer allows the provision of the best possible care for patients living with increasingly complex long-term conditions.[2]

Hobbs and colleagues have recently shown that there has been a substantial increase in practice consultation rates, average consultation duration, and total patient-facing clinical workload in English general practice; English primary care (as currently delivered), is reaching 'saturation point'.[7] They also report an increase in the annual consultation rate per person of 10.5% (from 4.7 in 2007–2008 to 5.2 in 2013–2014). The mean duration of consultations has, in addition, increased by 6.7% (from 8.7 to 9.2 minutes) with an overall workload increase of 16%; and this is without taking into account additional indirect activities and professional duties.

One of the ways that GPFV proposes to deal with this workload crisis is by investing in and developing the practice-based primary healthcare team as recommended by the Primary Care Workforce Commission.[8] Good empirical evidence exists that the use of teams can improve both the quantity and quality of healthcare services, although there remains a strong need to measure a variety of organisational, team, and individual factors as contributors to, and predictors of, effective teamwork.[9] The NHS already has well-developed, effective multidisciplinary teams and well-developed IT systems.

The initiative contains, for example, a £112 million offer to enable every practice to access a clinical pharmacist, leading to an estimated 640 additional practice-based pharmacists by April 2017 and 1500 by 2020. The increased support for access to a clinical pharmacist for every practice seems a particularly good idea; there is good evidence that the input of a pharmacist to the practice-based team can not only reduce GP workload but also increase patient safety and promote rational prescribing (for example, the PINCER trial).[10]

There will also be a new programme to base an additional 3000 mental health workers in practice by 2020 (starting from 2016–2017) as well as the launch of a return to nursing programme to provide new general practice nurses. A further innovation is the proposed pilot of a new medical assistant role to help with the clinical paperwork and play a greater role in the navigation of patients through care services. This is all in addition to the recruitment of an additional 5000 full-time equivalent GPs in the next 5 years.

Primary healthcare teams should get a large boost to increase capacity and improve the care of patients.

However, it's unclear at present where the extra 5000 GPs are to come from. NHS England (NHSE), Health Education England (HEE), the RCGP, and the General Practitioners Committee of the British Medical Association are already working closely together to ensure a skilled, trained, and motivated workforce in general practice, and have produced a 10-point plan for improving recruitment into general practice, the retention of doctors, and support for those who wish to return to general practice.[11]

To encourage more medical students to choose general practice, it is important to ensure that the culture of medical schools does not mitigate against recruitment. A recent survey of almost 1000 medical students from 13 medical schools reports perceptions of the specialist hierarchy, witness of any disparaging comments against other specialists, and whether this had had an effect on their career choice.[12] Medical specialties were ranked according to the level of 'bad-mouthing'. Psychiatry and general practice attracted the greatest number of negative comments made by academic staff, doctors, and students. It is necessary for such stigmatisation to be challenged in medical schools if GP recruitment is to be increased.

CARE REDESIGN

Interestingly, there is no mention of 7-day working within the initiative but there will be support for individual practices, federations, and super-partnerships for direct funding to improve 'in-hours' and 'out-of-hours' access including clinical hubs and reformed urgent care. This is an implicit recognition that opening practices for 7 days per week

is neither desirable nor practical; the best way forward is by strengthening existing provision and avoiding spreading clinical and staff resources too thinly. There will also be a new voluntary multispecialty community providers contract for larger GP groups and community health services to support their integration. However, there is little detail provided by the GPFV about how GP federations, networks, and practices could operate, and few links to new models of care.

In addition, there will be a new £246 million to support practices in redesigning their services and this will include a requirement on clinical commissioning groups to provide around £171 million of practice transformational support. A new national £30 million called 'releasing time for patients' development programme for general practice will be created. The increased use of technology to support the take-up of online consultation systems in every practice will be backed by increases in the recurrent funding for GP information technology systems.

Finally, but by no means least, there will be new rules to allow up to 100% reimbursement of premises developments.

MORALE AND RESILIENCE

The recognition by NHSE/HEE of the increasing strain that GPs have experienced in recent years is most welcome. The need to minimise GP 'burnout' is directly addressed by the introduction of a new 4-year Practice Resilience Programme from 2016 and a £10 million investment to support the most 'vulnerable' GP practices. In addition, the £16 million extra investment in specialist mental health services to support GPs suffering with burnout and stress is long overdue and should help in the retention of some of the most capable and experienced GPs in the workforce. The extra commitment to develop proposals and tackle the issue of rising indemnity costs in the next few months should also allay one of the major concerns of GPs.

In his foreword to the report, Simon Stevens says, *'There is arguably no more important job in modern Britain than that of the family doctor.'*[1] Such public expressions of support for the overworked, overloaded, and exhausted GP with the promise of billions of pounds recurrent funding both now and in the years to come should help in boosting morale, although it will take a number of years for it to recover. In 1965, GPs threatened 'mass resignation' from the NHS and the resultant 1966 GP Charter addressed their major grievances, providing better equipped and staffed premises as well as greater practitioner autonomy, and it set the scene for a renaissance of general practice.

Over the past 60 years, GPs have had a whole series of new contracts. The 1990 one increased the role of the private sector and limited health spending, linking GP pay more strongly to performance, as did the 2004 contract, which introduced the Quality and Outcomes Framework designed to give GPs the incentive to meet clinical indicators. In both 1990 and 2004, there was an initial reluctance to accept the new contract provisions but a recognition that they had to be made to work. Both times GPs rose to the occasion and hopefully they will also do so in 2016. The reduction in frequency of Care Quality Commission (CQC) inspections to 5-yearly for those practices rated as 'good to outstanding' should improve morale and help with the implementation of these proposals. However, with the scaling back of CQC inspections, the GPFV does not include proposals about how the quality of care in general practice will be monitored and assessed. There should be no shortage of GPs volunteering to sit on the GPFV advisory oversight group, whose remit is to monitor progress and ensure that there is no reneging on these new proposals!

As the main group of expert medical generalists within the NHS, it will be incumbent on all GPs to hold the NHSE/HEE to account, just as the 1960s generation of GPs did, to ensure that the opportunities that this initiative provides enable general practice to 'get back on its feet' and provide the medical care that our patients deserve. There is little doubt that *'When general practice thrives, the NHS survives.'*[3]

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