House of Commons

Health and Social Care Committee

The future of general practice: Government Response to the Committee's Fourth Report

Ninth Special Report of Session 2022–23

Ordered by the House of Commons
to be printed 19 July 2023

HC 1751
Published on 24 July 2023
by authority of the House of Commons

Health and Social Care Committee

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Ninth Special Report

The Health and Social Care Committee published its Fourth Report of Session 2022–23, The future of general practice (HC 113), on 20 October 2022. The Government response was received on 10 July 2023 and is appended below.

Appendix: Government Response

Introduction

The Department of Health and Social Care welcomes the Health and Social Care Committee's report, and we are grateful to everyone who contributed their time and expertise to the inquiry.

The Committee's report highlights the challenges being faced by general practice and provides clear recommendations to respond to them. This document sets out the Government's reply to each of these recommendations.

This response is not the only publication considering the longer-term sustainability of general practice. The Fuller Stocktake was published on 26 May 2022, with support from all 42 Integrated Care System (ICS) chief executives. This culminated from a stocktake by Dr Claire Fuller, Chief Executive-designate Surrey Heartlands ICS and GP, into the integration of primary care, at the request of Amanda Pritchard, Chief Executive Officer of NHS England. It sought to understand what is working well, why it is working well, and how we can accelerate the implementation of truly integrated care across systems.

As part of the review, the team working on the stocktake engaged with almost 1,000 people, including ICS CEOs, through workstreams, roundtables and one-to-one meetings, alongside over 12,000 individual visits to a dedicated engagement platform and over 1.5 million Twitter impressions of #FullerStocktake.

The stocktake describes integrated neighbourhood 'teams of teams', which should form from Primary Care Networks (PCNs), with a shared aim of improving health and wellbeing for their local populations, with teams co-located and built around the needs of the local population, where appropriate with a blended mixture of primary and secondary care expertise.

The stocktake sets out a vision for integrated primary care, utilising these teams, that recognises how people's needs, preferences, expectations, and risk factors inform how and when they draw on care. It advocates for a parallel focus on access and continuity of care, to streamline access to urgent and same-day care and advice. This will ensure that those who would most benefit from continuity of care get more proactive and personalised support. Additionally, the stocktake calls for more prevention activities and health promotion in communities. Integrated neighbourhood teams should work across communities, primary care, community services, local authorities, and the voluntary sector to help people stay well for longer, reduce the incidence of ill-health and make effective use of data for population health management.

The Secretary of State for Health and Social Care appointed the Rt Hon Patricia Hewitt to consider the oversight and governance of integrated care systems (ICSs). The Hewitt Review considered how the oversight and governance of ICSs can best enable them to succeed, balancing greater autonomy and robust accountability. The final report was published on 4 April 2023, and the government responded on 14th June 2023, setting out its response both the Hewitt Review and the Seventh Report of the Health and Social Care Committee.

We share the Committee's view of the importance of ensuring that people can access GP appointments when they need them. In the Autumn Statement we committed to creating a Delivery Plan for Recovering Access to Primary Care, that addressed the challenges facing general practice. Supported by the updates to the GP contract for 2023/24 that was published on 6 March 2023, the Recovery Plan published on 9 May 2023, sets out two central ambitions: to tackle the 8am rush and reduce the number of people struggling to contact their practice; and for patients to know on the day they contact their practice how their request will be managed. It will achieve this by empowering patients, implementing Modern General Practice Access, building capacity and cutting bureaucracy.

This builds on the Plan for Patients (published on 22 September 2022), which underlined our expectations that patients who need an appointment with their GP practice within 2 weeks should get one; and those with urgent needs should be seen on the same day. This will be achieved by increasing both the number of appointments available and improving telephony functionality. Alongside this, digital tools will be used to improve IT systems and ease administrative burdens, and experienced GPs will be incentivised to stay in-post.

The Recovery Plan focuses on taking the pressure off practices and improving access, which will open the door to longer term reforms in primary care. Some practices have already implemented many of the elements of this plan, underpinned by the vision outlined in the Fuller Stocktake, generating the evidence of the benefits and best practice. For other practices, the focus of the next two years is to create the strong foundation upon which to build.

Realising this broader vision may require significant changes to the way general practice operates and is contracted today. Over the course of the year, we aim to engage with the professions, patients, ICSs, and key stakeholders, on a broad range of themes including contracts, operating models, funding of GP IT and estates, to help inform how to shape general practice for the future.

Indeed, looking ahead, the current 5-year GP contract framework—the most ambitious GP contract in recent years, which was agreed with the British Medical Association in 2019—is due to be fully implemented by March 2024. As we consider what will succeed the Five Year Framework, updates have been made to the GP contract for 2023/24 to enhance access, including by freeing up workforce capacity through changes to the Investment and Impact Fund (IIF) and the Quality and Outcomes Framework (QOF), and by targeting £246m towards driving improvement in access through the Capacity and Access Fund (CAF). We are keen to engage a broad range of stakeholders on this further and this will form part of the upcoming engagement work, considering how we incentivise quality and outcomes.

On 30 June 2023, NHS England published the Long Term Workforce Plan, which puts the workforce on a sustainable footing for the long term. The Plan includes projections for the number of doctors, nurses and other professionals that will be needed in 5, 10 and 15 years' time across acute, mental health, primary care and community services. The Plan also sets out the reform, improvements and growth that are required to close the gap between demand and supply of staff. We agree with the Committee that we must ensure that general practice has the tools to operate effectively and sustainably, enabling timely access to patients and continuity of care where it is needed. We, once again, thank the Health and Social Care Committee for their report and recommendations to help us in achieving this.

Access to General Practice

Recommendation 1

In response to this Report the Government and NHS England should be clear in acknowledging that there is a crisis in general practice and set out in more detail the steps they are taking in response to this crisis in the short term, to protect patient safety, strengthen continuity, improve access and reduce GP workloads.

Response

Partially accept.

The Department partially accepts this recommendation. We recognise that some people are facing challenges trying to access general practice services in a timely way, and general practice teams have been working immensely hard to meet increased demand for care. The Delivery Plan for Recovering Access to Primary Care, published on 9 May 2023, acknowledges the pressure that general practice is under and commits to making it easier and quicker for the public to get the help they need from primary care. The Plan includes measures to empower patients by investing in tools people can use to manage their own health better and expanding services offered in community pharmacy by:

- Retargeting over £1bn including investing up to £645m, over 2 years into community pharmacy; implement a new 'Modern General Practice Access' approach to tackle the 8am rush, backed by retargeted funding of £240m, so patients will no longer be asked to ring back another day for a response.
- Building capacity so practices can offer more appointments, from more staff, than ever before; and cut bureaucracy to give practice teams more time to focus on the clinical needs of their patients, including freeing up £246m in funding for networks and reducing workload by streamlining the Impact and Investment Fund and Quality and Outcomes Framework.

We have also committed to expand the use of self-referral and direct access into a range of community and secondary services for patients where GP involvement is not clinically necessary to free up GP and other general practice time and appointments.

Alongside these measures, NHS England will introduce a National General Practice Improvement Programme with three tiers of support to help general practice deliver change that is clinically led, data-driven, evidence-based and measurable.

We have committed to provide an additional 50 million appointments which will depend on growing and diversifying the workforce in general practice. We are working with NHS England and Health Education England[1] to explore what more can be done to grow the GP workforce. In particular, we have record numbers of doctors in GP training. The NHS Long Term Workforce Plan sets out how many doctors—including GPs—the NHS will need in future, and the actions that are required to increase workforce capacity in primary care. This includes increasing the number of GP training places from 4,000 to 6,000 by 2031/32 with the first 500 new places available from September 2025. The Plan builds on the actions already in train. General practice teams include a range of other health professionals who are able to respond to the needs of their patients, which is vital for improving access to General Practice services. As of 31 March 2023, over 29,000 additional primary care professionals have been recruited compared with a baseline of March 2019. We are supportive of enabling appropriately qualified doctors other than GPs to work in general practice as part of a multidisciplinary team to help increase practice capacity and improve care for patients. Local systems can use available flexibilities within the regulations to deliver care in a different way in line with local need and where general practice wants to take advantage of this.

We have also made further changes to reduce unnecessary bureaucracy for GPs to free up time for appointments, including expanding the range of healthcare professionals who can sign fit notes, and publishing the Bureaucracy Busting Concordat, which consists of seven principles to reduce unnecessary burdens. We continue to work across Whitehall on this important agenda, seeking opportunities wherever possible to remove, reduce or streamline the requests on general practice.

Recommendation 2

The Government should commission a review into short-term problems that constrain primary care including, but not limited to: the interface between primary and secondary care, prescribing from signing to dispensing, administrative tasks e.g. reports and sick notes, day-to-day usability of IT hardware and software, and reviewing of bloods, pathology and imaging reports.

Response

Partially accept.

The Department partially accepts this recommendation. We agree with the need to explore solutions to problems which constrain primary care, particularly given the high levels of demand and workforce pressures. However, we do not wish to duplicate work already underway. The Academy of Medical Royal Colleges was commissioned by NHS England to undertake a review of the interface between general practice and hospitals. Its report was published on 9 May 2023, and key actionable insights are reflected in the Delivery Plan for Recovering Access to Primary Care.

1 Health Education England merged with NHS England into a single organisation in March 2023, with NHSE assuming responsibility for all activities previously undertaken by HEE.

We have also completed a thorough review of unnecessary bureaucracy in general practice to determine what actions the Government could take to reduce this burden on GP time, and as a result have implemented improvements such as expanding the range of healthcare professionals who can sign fit notes. In parallel, NHS England reviewed processes and non-governmental bureaucracy which impacts upon general practice. DHSC is continuing to work across government and with the NHS to implement the solutions that emerge and has published a 'Bureaucracy busting concordat; seven principles to reduce unnecessary burdens.'

In addition, NHS England is supporting pilots testing automation of clinical administrative processes. Further detail on this work is provided in the response to recommendation 9. This recommendation also links to recommendation 10 which has been addressed separately.

Recommendation 3

The Government should provide the funding necessary to create 1,000 additional GP training places per year and consider extending the GP training scheme to four years, to allow GP trainees more time to develop their skills in practice as well as learn the skills required to enter a GP partnership.

Response

Partially accept.

The Department partially accepts this recommendation. The Department recognises the importance of the future pipeline of GPs, which is critical for growing the number of doctors in general practice. This is why we have taken steps to expand the number of GP speciality training places to 4,000 per year from 2021 (increased from under 2,700 in 2014), with a record-breaking 4,032 doctors accepting a place on GP speciality training this year. The NHS Long Term Workforce Plan has set an ambition to increase the number of GP training places by 50% from 4,000 to 6,000 by 2031/32, with the first 500 new places available from September 2025.

To give doctors in GP training more time to develop their skills in general practice, we are increasing the proportion of the training programme spent in general practice, from 18 to 24 months (reducing the time that trainees spend outside general practice to 12 months). This will grow the number of doctors in general practice providing direct patient care, and better prepare doctors for their career in general practice. The General Practice Fellowship scheme also provides a two-year programme of support for all newly qualified GPs working in general practice. Participants receive an experienced GP mentor and funded continuous professional development opportunities to develop experience and support their transition into the general practice workforce. There is no plan to extend GP training beyond three years.

We recognise that skills required to enter partnership are important for recruiting more GP partners. However, GP specialty training is not the appropriate setting for aspiring partners to develop the skills required to enter GP partnerships, as this could delay doctors completing training and taking a substantive role in general practice. In addition, it may

not be suitable for all doctors in training, particularly as it could dissuade some doctors from undertaking GP training. Primary care training hubs can direct qualified GPs to local training opportunities, as they do more broadly for all practice and PCN staff.

Recommendation 4

The Government and NHS England should identify mechanisms to distribute GP trainees more equitably across the country so that under-doctored areas receive a balanced proportion of domestic and international GP trainees. The Government should explore schemes that incentivise GP trainees to settle in the areas they train; this could come in the form of improving opportunities to become GPs with Special Interests, incentivising GPs to join partnerships in understaffed areas, and look to create easier ways for GPs to set up their own practices in primary care "black spots".

Response

Accept.

The Department accepts this recommendation – GP specialty training is currently regionally distributed on a weighted capitation basis. However, this is being adapted to better reflect current and future population weighted need, as part of the wider NHS England's trainee redistribution programme. In addition, and in part to help distribute GPs more equitably across the country, new medical schools were created in 2018, in areas of the country without existing medical schools. These schools were primary care and psychiatry focussed, which should increase the domestic pipeline into GP training. This is in addition to the continued and valued recruitment of international medical graduates into GP training, for whom Health Education England (HEE) have put in place additional support where needed. The NHS Long Term Workforce Plan sets out how we could build on these actions, to ensure that there is an equitable distribution of GP training places aligned to population need.

NHS England and HEE launched the Targeted Enhanced Recruitment Scheme (TERS) in 2016, which was subsequently run by HEE. This has attracted hundreds of doctors to train in hard to recruit areas by providing a one-off financial incentive of £20,000. The scheme has since widened its criteria to include under-doctored and deprived areas. 550 places were available in 2021 and through additional government investment, there were 800 places available in 2022.

Recommendation 5

NHS England should set out how it plans to increase the flexibility of the Additional Roles Reimbursement Scheme to allow Primary Care Networks to hire both clinical and non-clinical professionals other than those set out in the current guidance, according to local need. (Paragraph 47)

Response

Partially accept.

The Department partially accepts this recommendation. We will continue to consider greater flexibility in the Additional Roles Reimbursement Scheme (ARRS). That is why in the changes to the GP contract published on 6 March 2023, we have increased the flexibility of the ARRS by adding Advanced Clinical Practitioner Nurses and apprentice Physician Associates to the reimbursable roles, increasing the cap on Advanced Practitioners, and removing the caps on Mental Health Practitioners. These roles sit alongside Care Coordinators, Clinical Pharmacists, Pharmacy Technicians, First Contact Physiotherapists, General Practice Assistants, Health and Wellbeing Coaches, Occupational Therapists, Paramedics, Podiatrists, Dietitians, Nursing Associates and Social Prescribing Link Workers. ARRS staff are a critical part of general practice and funding will continue to be available to continue their employment after 2023/24. However, we will not commit to allowing recruitment of all clinical and non-clinical roles according to local need as the scheme is used to encourage growth of an under-represented element of the workforce and a review of the scheme is being worked through to determine how it might operate from April 2024. We do not want to pre-empt the outcomes of that review in our response. Practices and Primary Care Networks (PCNs) are free to employ any non-clinical or clinical staff directly without using the ARRS.

We recognise the need for practices and the PCNs they form to make decisions about the make-up of their workforce as independent contractors and that they are best placed to understand what workforce will provide the best service to their patients. NHS England keeps the additional roles scheme under review to ensure that it remains fit for purpose. Since 2019, we have more than tripled the number of roles available for reimbursement and continue to introduce greater flexibility where possible.

As of 31 March 2023, over 29,000 additional primary care professionals have been recruited compared with a baseline of March 2019. Over the lifetime of the scheme to date NHS England has also responded to stakeholder feedback to increase the flexibility of the scheme by adding new roles, providing high-cost area support where appropriate, and widening reimbursement to include training time and apprenticeships for certain roles.

- In October 2022 as part of the 'Plan for Patients', two non-clinical roles (General Practice Assistants and Digital and Transformation Leads) were made available through the scheme. Digital and Transformation Leads are well placed to support the embedding of other ARRS roles within PCNs as well as improving digital access.

- As of October 2022, PCNs were able to be reimbursed through the scheme for the time Nursing Associates spend training to become a registered nurse, building a pipeline into GP nursing and providing career opportunities for more junior roles through the ARRS.

- High-Cost Area Supplements were added to the scheme, this increased the maximum reimbursable amounts for PCNs located in areas with higher associated costs such as London.

Where required, specific hiring controls are placed on roles such as paramedics being employed in rotational models. Employment models such as these ensure that the skills of specific roles can be employed across settings without leading to workforce shortages in any particular setting, whilst simultaneously providing career opportunities to professionals.

Recommendation 6

Receptionists play an incredibly important role in primary care that often goes unrecognised. Given they are often the first point of contact with primary care for most patients, NHS England should review and consider providing standardised national training to drive up standards and equip receptionists with the skills required to navigate and signpost in a 21st century NHS. (Paragraph 48)

Response

Accept.

We support this recommendation, and we recognise the important role that receptionists, who will often be the first point of contact for patients at their practice, play in general practice teams. Following the pandemic, practices are making greater use of triage, to direct patients to the most appropriate services and professionals first time, and this means that practice receptionists have a crucial role in signposting patients and helping them to navigate new ways of accessing general practice services.

As announced in the Delivery Plan for Recovering Access to Primary Care, we are investing in a new National Care Navigation Training programme for up to 6,500 staff rolling out from summer 2023. The training will use the Care Navigation Competency Framework developed by Health Education England and every practice will benefit. Care navigation will be a critical function to help navigate patients to the most appropriate member of the practice team, or to self-care, community pharmacy, administrative teams or other, more appropriate, local services.

In the 2023/24 GP contract changes, one of the Quality and Outcomes Framework (QOF) Quality Improvement modules will focus on optimising demand and capacity in general practice with an emphasis on using data to analyse potentially avoidable appointments and build on care navigation and use of wider workforce or local services to reduce pressure on general practice.

It is the responsibility of practices themselves to ensure that their receptionists are adequately trained, and NHS England made £35m available between 2016/17 – 2020/21 to Clinical Commissioning Groups (as they then were) to fund training and backfill for GP receptionists and clerical staff. NHS England has developed a programme of e-learning tailored to support both administrative staff and clinical roles in general practices to effectively carry out information gathering, signposting and triage and to support decision making about the appropriateness of different types of consultations and care.

Recommendation 7

The Government and NHS England should explore the possibility of providing an uplift to the Additional Roles Reimbursement Scheme to support non-staff costs such as

supervision and training or to provide weighted salaries in areas where the cost of living is high or it is hard to recruit. Consideration should also be given to allowing staff to be employed on Agenda for Change terms and conditions as soon as resourcing allows. (Paragraph 49)

Response

Partially Accept.

The Department partially accepts this recommendation. While supervision and training are not explicitly covered through the Additional Roles Reimbursement Scheme (ARRS) for all roles, the support for the growing multidisciplinary team does create supervisory capacity, particularly in the Advanced Practitioner roles. We have recently increased the cap on recruitment of Advanced Practitioners, and are reimbursing Primary Care Networks (PCNs) for the time that First Contact Practitioners spend out of practice undertaking education and training to become Advanced Practitioners. We are exploring measures to improve supply into these roles in 2023/24.

The ARRS reimburses time spent in training for some roles, balancing the overarching aim of the scheme to increase direct patient care with support for staff development, and PCNs are able to access other pots of funding through the contract to cover the costs of either staff backfill or training itself (e.g., PCN funding based on the population size, leadership, and management funding).

System Development Funding for primary care provides systems with investment to commission programmes from training hubs which focus on the training and development of primary care staff. It also includes a broad 'GP Transformational Support Fund', worth £78m in 2022/23, which can be used to build staff skills and capabilities.

Within the ARRS itself, we have allowed the use of apprenticeships for some roles, such as those providing a supply of practice nurses, and NHS England will continue to explore the expansion of these schemes through the ARRS review.

We are supportive of practices and PCNs employing their staff on Agenda for Change terms and conditions. Inner and outer London weightings are reflected within the current ARRS allocations to PCNs.

Recommendation 8

NHS England should take further steps to address the administrative workload in general practice, including by introducing e-prescribing in hospitals and focusing on the primary-secondary care interface by encouraging ICSs to provide a reporting tool for GPs to report inappropriate workload transfer.

Response

Partially accept.

The Department partially accepts this recommendation. We agree that e-prescribing should be introduced in hospitals. Work is already underway, with NHS England working on a 3-year programme for hospitals. The Academy of Medical Royal Colleges review of

the interface between general practice and hospital service identified a range of insights and practical improvements and this has been shared with systems to action within their local contexts.

NHS England will continue to emphasise the importance of improving interface working and gathering systematic GP feedback to inform this. However, we do not agree that mandating a single approach at national level, such as a standardised reporting tool, would be appropriate. Rather, each Integrated Care Board should decide on its own approach, proportionate to local circumstances, to identifying issues, improving communication and agreeing changes to local pathways.

Recommendation 9

The Government should also fund research into the specific role that machine learning can play in the automation of reporting and coding test results to reduce clinical admin in general practice.

Response

Partially accept.

The Department partially accepts this recommendation. We are keen to explore the potential opportunities of automating processes in general practice to free up clinical capacity, and will explore opportunities to commission research via existing formal routes.

NHS England is already supporting two pilots being led by the Health Innovation Network in London testing the automated coding of bowel screening results and other clinical administrative processes to explore the potential of this technology. Likewise, some Integrated Care Boards are using Transformation Support Funding to pilot other automation tools and improvements to workflows within general practice.

Recommendation 10

The Government should undertake a full review of primary care IT systems from the perspective of the clinicians with an emphasis on improving the end user interface. Making the working life of each clinician that bit easier will drastically improve morale and efficiency.

Response

Partially accept.

The Department partially accepts this recommendation. We appreciate the impact on clinicians and patients that effective primary care IT systems can have.

As set out in the Delivery Plan for Recovering Access to Primary Care, NHS England will fund high-quality digital consultation, booking and appointment management tools whilst providing support to practices to adopt high-quality cloud-based telephony systems. This will simplify the routes for online access and support combined workflow for all patient requests, so the whole practice team can contribute to rapid assessment and response.

NHS England's Transformation Directorate operates an established digital primary care service which continues to deliver on the commitments set out in the NHS Long Term Plan and Delivery Plan for Recovering Access to Primary Care, to drive digital and technology transformation in general practice. The digital primary care model continues to create new frameworks for digital suppliers so they can offer their platforms to Primary Care Networks on standard NHS terms, mandate and enforce technology standards to ensure interoperability of data and digital systems, and grow a supportive health IT industry environment for digital developers. NHS England has development work ongoing, looking to improve the quality of general practice IT systems, and recently launched their new Tech Innovation Framework that will support systems suppliers to deliver innovative cloud based technological solutions to the general practice market place. The NHS Primary Care Test Lab also provides a new way for the design and functionality of GP IT solutions to be tested by clinicians and practice teams.

Recommendation 11

As part of ongoing efforts to improve the retention of GPs, NHS England should include a specific focus on encouraging locum GPs back into regular employment by supporting GP practices to offer more flexible working patterns.

Response

Partially accept.

We recognise the importance of retention in growing the GP workforce, and partially accept this recommendation. To support retention, NHS England have in place the National GP Retention Scheme. This scheme is a package of financial and educational support to help doctors remain in clinical general practice. As GPs are independent contractors it is the responsibility of GP partnerships, supported by the Royal College of GPs and the British Medical Association, to review their working conditions and consider what would attract salaried GPs or new partners.

NHS England has provided funding to support newly qualified GPs into regular employment. This includes career coaching through the Looking After Your Career scheme, and the General Practice Fellowship Programme. The Fellowship Programme guarantees the opportunity for every newly qualified GP entering general practice to receive funded mentorship, funded continuing professional development (CPD) opportunities of one session per week, and rotational placements within or across Primary Care Networks to develop their experience and support their transition into the workforce in a local area.

We recognise that flexible working can often be a reason for GPs choosing to become locums. NHS England is exploring how primary care organisations can practically embed the principles of flexible working. The Institute of Employment Studies—commissioned by NHS England—have recently completed research on job crafting in general practice and published a report with six case studies illustrating examples of where practices are working innovatively to support improved flexible working opportunities for staff.

Recommendation 12

Urgent work needs to be done to stop a bidding war for the services of locums and establish requirements for a minimum fair share of administrative duties.

Response

Do not accept.

The Department does not accept this recommendation as we are not able to establish requirements for a minimum fair share of administrative duties, as locums and practices enter into individual contractual arrangements. Neither DHSC nor NHS England are able to stipulate what these arrangements must look like – this is instead down to individual agreement between the locum and the practice.

NHS England has established flexible locum staffing platforms in each Integrated Care System (ICS) over the last two years, supported by the recently re-procured digital suppliers framework. These virtual pools will allow for better visibility of locally available resource to optimise deployment and create a new offer and greater structure and consistency for local GPs wanting to work flexibly. Where ICSs use the supporting digital suppliers framework, they also provide greater transparency on spend for their respective platforms.

Recommendation 13

The Government and NHS England should adopt the recommendations related to NHS pensions in our recent Report on Workforce: recruitment, training and retention in health and social care. In developing short and long-term solutions to the NHS pensions issue the Government and NHS England must specifically account for the status of GP partners as employers, for example by providing specific guidance and support for GP practices to help them adopt pension recycling and retire and return approaches. We welcome the focus on this issue in the Government's Plan for Patients but the Government must provide further detail on what changes it will introduce.

Response

Partially accept.

The Department partially accepts this recommendation. We recognise that pension arrangements can sometimes drive GPs to reduce their hours or leave the profession altogether.

In the 2023 Spring Budget, we announced a 50% increase in the annual allowance from £40,000 to £60,000 and abolished the lifetime allowance entirely so pension tax charges do not act as a driver for early retirements, which expect will encourage GPs to continue to work. In addition, the Department has changed NHS pension scheme rules to prevent staff receiving unintentionally higher annual allowance tax charges driven by the current high inflation environment. Taken as a whole, these tax measures will encourage experienced GPs to remain in practice.

As promised in Our Plan for Patients, we are implementing new retirement flexibilities to help retain experienced staff, including GPs, whilst making it easier and attractive for

retired staff to return. We abolished from 1 April 2023 the pension rule that staff could only work up to 16 hours a week in the first month after returning from retirement without affecting their pension. We removed from 1 April 2023 the rule that prevented retired staff who return to NHS work from re-joining the scheme and building up more pension. We intend making a new 'partial retirement' option available to staff from October 2023 as an alternative to full retirement. Staff will be able to draw down some or all their pension whilst continuing to work and build up further pension.

Our Plan for Patients set out that we will work with NHS England to ensure that NHS employers are able to offer local solutions to pension tax issues such as employer pension contribution recycling. This is already within the gift of employers in general practice. However, the changes announced at Budget mean far fewer staff will now experience pension tax issues and so the need for local solutions reduces.

Continuity of Care

Recommendation 14

The Government and NHS England must acknowledge the decline in continuity of care in recent years and make it an explicit national priority to reverse this decline.

Response

Partially accept.

The Department partially accepts this recommendation. As mandated in the GP contract, all patients must be assigned a named GP, who must lead in overseeing the care provided to a patient. Practices must endeavour to comply with all reasonable requests from a patient to see a particular GP.

We agree that evidence on the benefits of continuity of care affirms its relevance for patient care and recognise the importance of continuity of care for many patients. The Fuller Stocktake sets out that identifying the patients who will benefit most from continuity of care should be determined through conversations with patients and clinical judgment. It also states that continuity of care has been directly linked to improved patient experiences and lower mortality for more complex patients. However, the stocktake highlights that some patients may, at different points in their lives, prioritise speed and convenience of access over seeing the same, named clinician. As such, we note that continuity of care needs to be pursued alongside a parallel focus on access, streamlining access to urgent and same-day care and advice.

A toolkit by the Royal College of General Practitioners (RCGP) notes that while certain groups, such as those experiencing acute episodes of care, place a high value on continuity of care, there are others for whom this is not a priority. For the latter group, accessing primary care services quickly and conveniently is paramount, although, they note that this will change over time and at different points of life. The 2023/24 GP Contract promotes the use of the RCGP's Continuity of Care toolkit via the Quality and Outcomes Framework Quality Improvement module on Managing Clinical Capacity, and within the Tackling

Neighbourhood Health Inequalities Primary Care Network service specification. This is designed to further encourage continuity of care in general practice to help ensure more patients can benefit from it when appropriate.

The RCGP has also published guidelines about how practices can achieve team-based continuity. For a patient with a range of needs it is sometimes more clinically appropriate for different groups of clinicians to combine their skills to offer continuity of care via multi-disciplinary teams, rather than a single named GP, this can also free up GPs' time to see patients presenting with more complex issues. The RCGP has published guidelines about how practices can achieve team-based continuity. It is therefore important that we consider continuity of care in the context of multi-disciplinary team working, in which there is continuity and consistency in clinical management across the professionals involved in someone's care. For instance, coordination, teamwork, good record systems and timely communication.

Recommendation 15

NHS England should introduce a national measure of continuity of care to be reported by all GP practices by 2024. The new measure should be based on existing models such as the Usual Provider Continuity Index and the St Leonard's Index of Continuity of Care and in the short term should be based on measuring either continuity delivered by a named GP (in pooled list practices) or by a personal GP (in personal list practices). The measure should be reported quarterly at practice, Primary Care Network and Integrated Care System level as well as nationally.

Response

Partially accept.

The Department partially accepts this recommendation. We agree that continuity of care is important in general practice, and we are introducing methods to further promote continuity of care in general practice to help ensure more patients can benefit from it when appropriate.

We will consider how best to measure continuity of care, but we do not agree with the specific approach described. Firstly, continuity of care would need to be accurately defined for a national measure to be practicable. Alongside an individual GP or doctor, a multi-disciplinary team can provide continuity of care to a patient, leveraging their combined skills and offering continuity as a team, and we would want a measure to reflect this. The two measures proposed above do not do this.

In addition, any national measure of continuity of care in general practice would need to be designed carefully to ensure that increased continuity of care is provided to those patients who most need it, while ensuring practices are not constrained from making best use of the skills and time of their general practitioners and multidisciplinary teams to meet their patients' needs. While we will consider whether it is practicable to introduce a measure which achieves these aims, it would not therefore be appropriate to commit to introducing a measure by 2024.

Recommendation 16

NHS England should provide Primary Care Networks with additional funding to appoint a 'continuity lead' for at least one session per week, and additional admin staff funding to support the lead in the role. The role of the continuity lead GP would be to support practices within their network to increase the proportion of patients consulting with their named or regular GP, learning from best practice around the country. There should be a specific uplift for areas of high deprivation. (Paragraph 96)

Response

Do not accept.

The Department does not accept this recommendation. Whilst we believe continuity is an important element of care, we believe that it should be considered alongside other expectations of Primary Care Networks (PCNs) such as improving access, addressing inequalities, and delivery of new services like structured medication reviews. Furthermore, we think the right approach is empowering PCNs to make decisions about their workforce, instead of adding more top-down bureaucratic requirements.

Funding is provided for leadership and management in the current PCN package, and PCNs can appoint their own continuity leads and allocate this responsibility to a specific staff member if they think this will provide a better service for their patients. Supporting the diversification of the general practice workforce and establishing multi-disciplinary teams through the ARRS will support continuity for patients, as effective multi-disciplinary teams can provide team-based continuity of care.

NHS England will continue to work with Royal College of General Practitioners (RCGP) and the Health Foundation on the continuity toolkit (which provides a more holistic approach to make continuity a practice team effort), how to promote and share best practice, and consider how receptionist training (paragraph 48) could support of continuity of care. As stated in recommendations 14 and 15, the 2023/24 Contract promotes the use of the RCGP's Continuity of Care toolkit via the Quality and Outcomes Framework Quality Improvement module on *Optimising Demand and Capacity management in general practice*.

Recommendation 17

As part of wider efforts to improve continuity of care NHS England should champion the personal list model rather than dismissing it as unachievable. NHS England should set a stretching ambition that by 2027 80% of practices have returned to personal list continuity and provide support for practices to do so.

Response

Do not accept.

The Department does not accept this recommendation. We agree that continuity of care is important within general practice but do not agree that requiring a return to the personal list model is the correct approach. Prior to 2004, patients were registered with

individual general practitioners who each held a contract to provide services to their registered patients. In 2004, the practice-based contractual model was introduced, which has enabled practices (for example partnerships) to hold GP contracts.

The practice-based contractual model was introduced in 2004 to give practices more flexibility to deploy their workforce to meet their patients' needs, to allow practices to leverage the benefits of working at scale (including increased resilience – for example, should a GP take long-term leave), and to enable more non-GP professionals to be partners. In addition, through the introduction of Primary Care Networks and the Additional Roles Reimbursement Scheme, we are supporting general practice teams to deliver a wider range of services to patients, by providing them with resources to expand and diversify their workforce and build multidisciplinary teams. It is vital that we protect those benefits and make best use of the growing range of skills in our general practice teams, alongside delivering continuity of care to those patients who need it.

Since 2015/16 (and since 2014/15 for patients aged 75 and over) practices have been required to assign all patients a 'named GP' who is accountable for the care of each patient they are assigned to. Practices must take reasonable efforts to accommodate patients' requests to be assigned a particular accountable GP and must endeavour to grant all reasonable requests of patients to see a particular practitioner for their appointment, including their 'named' GP. Patients may however need to wait longer to see a particular GP (for example, if that GP is on leave).

Within this context, it is for practices to determine the best way to meet the needs of their patients. There are no contractual barriers to practices operating a system where the contract remains practice-based, but within a practice, each GP is assigned a list of patients who they are responsible for and conduct appointments with.

However, to ensure the 'named GP' policy is delivering on improving continuity of care we are further embedding continuity via the 2023/24 GP contract by promoting the use of the Royal College of GP's Continuity of Care toolkit via the Quality and Outcomes Framework Quality Improvement module on *Optimising Demand and Capacity management in general practice*.

Recommendation 18

The Government should examine the possibility of limiting the list size of patients to, for example, 2500 on a list, which would slowly reduce to a figure of around 1850 over five years as more GPs are recruited as planned. These numbers should reflect varying levels of need in local populations. This would draw us closer in line with our European counterparts, and help improve access and continuity. It should only be implemented in a way that does not undermine the fundamental rights of patients to access a GP.

Response

Do not accept.

We recognise that GP to patient ratios and the size of patient lists can vary across England. However, as independent contractors, it is for each general practice to determine the size and skills mix of their workforce to meet the reasonable needs of their patients, and we therefore do not accept this recommendation.

There is no Government recommendation for how many patients a GP should have assigned, or the ratio of GPs or other practice staff to patients. The demands each patient places on their GP are different and can be affected by many different factors, including rurality and patient demographics.

Patient care is not only delivered by GPs but also by the range of health professionals available within a practice or Primary Care Network who are able to respond to the needs of their patients. Ensuring the correct mix of skills available in general practice is critical to delivering appropriate patient care across England, and we are taking steps to diversify the general practice workforce. As of 31 March 2023, over 29,000 additional primary care professionals have been recruited compared with a baseline of March 2019.

Recommendation 19

NHS England should re-implement personal lists in the GP contract from 2030 onwards.

Response

Do not accept.

For the reasons stated in our response to recommendation 17, we do not accept this recommendation.

However, as previously mentioned in that response, and as per our response to recommendation 15, we are introducing methods to further promote continuity of care in general practice to help ensure more patients can benefit from it when appropriate.

We are further embedding continuity of care through the 2023/24 GP contract. It will promote the use of the Royal College of GP's Continuity of Care toolkit via the Quality and Outcomes Framework Quality Improvement module on *Optimising Demand and Capacity management in general practice*.

General Practice and NHS Organisations

Recommendation 20

Integrated Care Systems should prioritise simplifying the patient interface with the NHS by improving access, triage and referral across first-contact NHS organisations including general practice.

Response

Accept.

The Department accepts this recommendation and agrees that this should be a priority for Integrated Care Systems. NHS England have already issued a framework to support conversations between Integrated Care System teams and GP practices or Primary Care Networks, to assess where additional support may be required to improve patient access.

The ways patients can access general practice has changed, with increased use of triage to prioritise care appropriately, and remote consultations. It is important that patients are supported to access and navigate general practice services, and are not dissuaded from seeking care.

The Modern General Practice Access approach from the Delivery Plan for Recovering Access to Primary Care puts an emphasis on better navigating patients and assessing the clinical need of all patients. Clinically urgent requests should be assessed on the same day, and when the request is not urgent, an appointment, if needed, should be scheduled within two weeks.

NHS England has begun commercial work to support the rationalisation of patient-facing digital services for general practice, as well as on user research and guidance to support improvements to general practice websites and online consultation systems.

NHS England also has started work to increase standardisation of language and communications to use with patients to help simplify their experience when making contact with general practice services.

Recommendation 21

NHS England should abolish the Quality and Outcomes Framework (QOF) and Impact and Investment Fund (IIF) and re-invest the funding in the core contract, weighted to account for patient demographics including deprivation, to incentivise continuity of care.

Response

Partially accept.

The Department recognises the Committee's concern that there are too many micro-incentives in general practice. Reflecting this in the short-term, for 2023/24 there will be a 25% reduction in QOF indicators (from 74 to 55) as QOF disease register indicator points are awarded to practices based on 2022/23 outturn and releasing £97m of funding. The Investment and Impact Fund (IIF) has also been reduced from 36 to 5 indicators. Both the Department and NHS England have acknowledged that there are opportunities to improve the use of incentives, including a need to focus more on outcomes and transparency. The Delivery Plan for Recovering Access to Primary Care, published on 9 May 2023, reflects this and agrees with the Committee that there is a need for greater emphasis on outcomes and transparency.

The Department and NHS England will formally consult on the future of QOF during 2023/24 and engage with stakeholders on IIF reform more generally. The Department is committed to constructive engagement with stakeholders and the profession during the reform process.

Recommendation 22

In particular, NHS England should focus on significantly improving the outcomes data provided to GPs by focusing data collection and analytical resource on outcomes measures rather than the process data and reporting required by these micro-incentives.

Response

Partially accept.

We accept this recommendation in part and agree with the Committee about the importance of collecting and understanding outcomes data. We will look at ways to strengthen data collection and monitoring of outcomes as part of our commitment to consult on the future of Quality and Outcomes Framework during 2023/24. Further work would also need to be done to understand the feasibility of implementing new measures, particularly if they are outside of existing structures.

Our view is that collection of data on delivery of care processes and final health outcomes is not in opposition and helps to reduce unwarranted variations in care. There is an important role for monitoring the delivery of care activities which are known to lead to improvements in patient health outcomes and can be measured within shorter periods of time (for example, annually). Without data in this area, clinicians would find it more difficult to understand actions that can be taken to improve patient outcomes.

Recommendation 23

NHS England should support Integrated Care Systems to implement gain sharing so that Primary Care Networks and individual practices that support the reduction of secondary care expenditure, such as through reducing unplanned admissions, are able to share in the financial gains.

Response

Partially accept.

The Department partially accepts this recommendation. We appreciate the sentiment of sharing the rewards of cost reductions where primary care has had a part to play. NHS England can provide light touch support for Integrated Care Systems (ICSs) to implement gain sharing, for example by way of sharing appropriate case studies.

The difficulties in proving causality of reduction in expenditure mean that a gain sharing agreement where funds are taken from secondary care and given to primary care would not always be suitable. In addition, whether savings can be extracted and redistributed depends on the nature of provider contracts locally as well as the underlying fixed and variable costs.

However, there are already mechanisms in place which reward primary care where it supports the reduction of secondary care expenditure. ICSs have been designed to have an overview of the whole system so that resources are used most effectively across primary, secondary, community and social care. Within an ICS, savings made in one area typically contribute towards overall system control totals.

Work is ongoing to consider additional opportunities to reward primary care for actions taken to relieve pressure on secondary care. The recovery plans sets out that NHS England will explore alternative approaches that can work alongside the partnership model and explore additional opportunities to better align clinical and financial responsibilities in primary care, enabling primary care teams to shape NHS services in their area and reinvest savings in frontline services.

Recommendation 24

NHS England should revise the Carr-Hill formula to ensure that core funding given to GP practices is better weighted for deprivation. NHS England must also review new PCN funding mechanisms to ensure that they do not inadvertently restrict funding for areas which already have high levels of need.

Response

Partially Accept.

The Department partially accepts this recommendation. GP practices receive funding from a range of sources, including those distributed according to the Carr-Hill Formula and funding delivered to Primary Care Networks. NHS England keeps funding mechanisms such as the Carr-Hill formula under review to ensure they remain appropriately weighted for different components, including deprivation.

As agreed with the British Medical Association in 2019, the Carr-Hill formula will not be changed for the duration of the five-year contract framework. The agreed investment envelope is fixed, providing funding clarity and certainty to practices until the end of 2023/24.

Recommendation 25

The Government and NHS England should increase the level of organisational support provided to GPs with a particular focus on important back-office functions such as HR, data and estates management.

Response

Accept.

The Department accepts this recommendation. The Fuller stocktake also noted the importance of organisational support, and made a recommendation to Integrated Care Systems (ICSs) to co-design and put in place appropriate infrastructure and support for all neighbourhood teams, including HR, data, and estates management. All 42 ICSs have signed up to implement the recommendations made by the stocktake.

The Delivery Plan for Recovering Access to Primary Care includes organisational support offers for Primary Care Networks (PCNs) and practices. NHS England will provide all practices with the digital tools and care navigation training for Modern General Practice

Access, and fund transition cover for those that commit to adopt this approach before March 2025. This will be complemented by the training and transformation offer in the new National General Practice Improvement Programme, available to all practices.

There is also existing and upcoming organisational support via PCNs—for example the funded Clinical Director role, and additional funding for Leadership and Management —and upcoming work via implementation of the Fuller Stocktake, to offer support and expertise to Integrated Care Systems.

Current examples of at-scale working, such as integration with community or acute trusts, or the establishment of federations, involve the support of practices through shared back-office functions. This has been shown to bring additional benefits such as using data for population health management and preventative care. Some areas may wish to go further and consider whether working at scale could be beneficial in their local circumstances.

GP Partnership

Recommendation 26

In response to this Report the Government should reaffirm its commitment to maintaining the GP partnership model and explain how it will take forward our recommendations to better support the partnership model, alongside ongoing work to enable other models of primary care provision.

Response

Partially accept.

The Department partially accepts this recommendation. The Government confirms there is currently no policy to abolish the partnership model, which is the majority model for general practice delivery and works well in many places. We have already invested in growing general practice through the 2019 Five Year Framework contract, the Additional Role Reimbursement Scheme, New to Partnership Payments, and an associated rise in funding. We have responded to the committee's specific recommendations on GP premises and ability to form limited liability partnerships below.

We note the reference to other models of primary care provision, and agree that different localities have varying needs and challenges to address. In response to these, practices can and do choose to organise themselves in different ways to deliver services and we wish to support a range of models of primary care provision, including the partnership model. Commissioners can also choose to commission these providers in different ways to meet the specific needs of their populations.

Recommendation 27

The Government should consider adopting the approach to GP premises taken in Scotland and conduct its own analysis of whether this would be viable for general practice in England. More widely the Government must make additional investment available for the general practice estate to enable integrated care to be effectively delivered.

Response

Partially accept.

The Department partially accepts this recommendation. In 2019, the General Practice Premises Policy Review[2] highlighted the challenges faced by GPs and the wider NHS in terms of property ownership and liabilities. Stakeholders including the Royal College of General Practitioners, the Care Quality Commission, and General Practitioners Committee of the British Medical Association, were clear that they did not support a similar approach to Scotland in England. We agree Government should undertake analysis of the GP estate, but should consider all alternative viable models.

Government ordinarily makes decisions about capital investment at fiscal events. Currently, capital is allocated to Integrated Care Systems (ICS) on a regional basis using a weighted population approach that considers local populations growing annually, and the responsibility for shaping the right size and fit for purpose NHS estate remains at a local level.

Government will continue to consider the need for capital investment across public services. To inform future decisions, a Primary Care Data Gathering programme was completed at the end of 2022–23, which provides relevant data on the age, profile, utilisation, and condition of the primary care estate. This will allow commissioners and general practice providers to better understand their estates needs at neighbourhood level. ICS Estates Infrastructure Strategies are being developed to plan for future estate investment, necessary to ensure value for money for the taxpayer when developing the general practice estate. Integrated Care Boards (ICBs) should take the general practice and primary care estate into account when considering their wider strategy and investment requirements.

NHS England and the Department will continue to explore potential solutions to the challenges faced in GP premises through Fuller implementation boards and other ongoing work.

As pressure on primary care estate is particularly intense in areas of rapid housing growth, it is important that new development is accompanied by primary care infrastructure, and that this is supported by the planning system.

As part of Government's wider review of the National Planning Policy Framework and planning guidance, we will consider how primary care infrastructure can best be supported through the planning system where new development creates a need for it. Prior to this, we will update planning obligations guidance to ensure that primary care infrastructure is referenced and considered by local planning authorities alongside other infrastructure demands, such as education. We will also update guidance to encourage local planning authorities to engage with ICBs on large sites which may create need for additional primary care capacity.

Recommendation 28

The Government should accelerate plans to allow GP partners to operate as Limited Liability Partnerships or other similar models which limit the amount of risk to which GP partners are exposed.

Response

Partially accept.

The Department partially accepts this recommendation. We will continue to consider this option, but further exploration is needed before the government can commit to accelerate plans to allow GP partners to operate as Limited Liability Partnerships (LLPs). In particular, the impact on NHS England or Government regarding responsibility for the legal and financial risks of GP partnerships need to be considered.

Many general practices in England operate as unlimited liability partnerships, with regulations to restrict which types of organisations can hold GMS contracts to deliver NHS primary medical services. There are existing flexibilities for general practices to operate in different ways, for example, companies limited by shares, cooperative corporate structures, or LLPs that hold specific assets of the practice. In Scotland general practice LLPs are permitted, though this has seen relatively low take-up.