Cheshire Local Medical Committee Ltd
A Practice Guide to the Future of General Practice

What Next following The Fuller Report and Parliamentary Committee looking at the Future of General Practice?

A resource for 2022/24
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This is a Practice Guide developed and issued by Cheshire LMC. No part of the document supersedes the actual guidance or notes issued by NHS England or the Cheshire and Merseyside Integrated Care System. It is our intention to update the guide on our web site as further details are published.

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Introduction

Following a lengthy discussion at the latest Cheshire LMC meeting on the recent Fuller Report into the future of general practice we have taken the opportunity to pull together a range of topical themes from current reports and papers. This Guide is intended to be a reference point for your internal practice or PCN discussion.

It also builds on recent debate former CCG PCN CD meetings, LMC events and Cheshire Confederation events. We would encourage you to make the time to read it through from beginning to end. Having identified any opportunities that might be right for your practice. You can then begin to plan your discussions within your practice, Primary Care Network cluster or Care Community. You can also use your discussion and preferred approaches to inform your local Integrated Care Board (ICB) 'Place' commissioning team. Remember Place teams are there to support/ influence the Integrated Care System (ICS) hierarchy in the latter's strategy formulation and funding decisions.

Set out in sections, this guide aims to summarise:

- Some of the different policy strands that will impact your practice business and clinical models of delivery over the next 5 years or so
- What the opportunities can mean for your practice
- Relevant issues you might need to debate at practice and PCN levels and what areas of significant influence you may wish to bring to Place level
- Where to find more information

This LMC document will be updated to reflect new information and add any new resources to help you prepare your practice for change. We hope that this guide will save you time and effort. If you have any feedback or suggestions for improvement, please email them to Cheshire LMC at WGreenwood@cheshirelmc.org.uk

The LMC is committed to ensuring that as much information is made available to our practices in Cheshire to help them engage in debate and plan for the future. To help us champion our practices we will be developing events to help practices prepare for new models of general practice for any that wish to develop them. You can read more about these planned changes by looking out for items in our e-newsletter and on the LMC website.

As more details are received and when appropriate the LMC will be hosting sessions on key elements. If your practice or PCN has some specific areas, they would like to have debated more widely do let us know.

William Greenwood
Chief Executive
Cheshire Local Medical Committee

The burning platform

2021 was quite a year for general practice and the NHS. What can we take away from everything that happened, and where are we now as we reach halfway through 2022?

The year started with the vaccination programme (in a way hugely reminiscent of everything that is happening right now). When things were critical, and a fast response was needed, it was general practice that the NHS (and the government) turned to. History has a way of repeating itself! General practice has a pattern of a 15–20-year crisis/ major new contract.

Since the inception of the NHS general practice has been the largest provider of health care services and is the usual point of access for patients for their general health care. ***In the last 40 years in particular general practice has also evolved to take on more preventive and complex care.*** Unfortunately, the resource allocation has not kept pace with this, nor has the Dept. of Health or NHSE support for ensuring there is an adequate workforce to deliver this expanded role.

We now find ourselves back where we were in the 1970s and mid 1980s with not enough doctors coming into GP roles. Many of the former 'Red Book' incentives to address this have been scrapped and not replaced.

GP workforce recruitment, contract workload, the partnership model, and general funding are key issues (all of which were excluded from the remit of Claire Fullers review).

Since the 2004 contract changes things have not generally favoured general practice and funding over that time span has often meant that GPs in the partnership model have faired worse than most as partnership 'profit' has declined in real terms and so partners have had to take smaller annual drawings as income.

During the same period the Dept. of Health and NHSE have tried to break the central negotiating machinery of the BMA by shifting more resources out of the core GMS contract by the introduction of Designated Enhanced Services and Local Enhanced Services. Whilst the latter can help deliver locally sensitive commissioning for the population, it does mean more of the funding is subject to the control of the local commissioners.

So, developments such as the way the PCN DES is funded plus the introduction of more LESs points to a shift of resources out of the national contract after the current 5-year deal expires (2024), with far more to be allocated via ICSs. The distribution of this additional resource will likely be made by ICSs dependent on population health needs, regardless of the specific local needs of primary care providers and this means there are a number of risks ahead for general practice.

As Mike Pyrah (GP Alliance GP Federation) pointed out in his recent excellent summary of the Fuller Report ICSs are governed by a requirement to break even across the system and cannot ringfence funds in the way areas could in the previous CCG regime, when commissioners held individual contracts with providers. ***Any potential practice funding from an ICS cannot be guaranteed in the same way as funding the national GMS contract.*** To some extent we saw this when NHSE decided to end the PMS contract premium and

NHSE also instructed CCGs to commission GP contracts using only APMS rather than GMS contracts.

As noted above, the allocation of locally distributed funds is likely to be based on population health need, meaning the distribution across practices will vary significantly within an ICS footprint (think areas of Liverpool and Knowsley verses parts of Cheshire). ***Plus, the ability of general practice to influence funds flowing from the ICS is far less than its collective ability negotiating at a national contract level.***

Mike also correctly pointed out that it was likely that in future some of the existing PCN resources could be shifted out of the national contract and into local ICS control. My feeling, looking at the Annex to the Fuller Report is that this is almost certain to happen unless the BMA (via the GPC) take a strong stance.

The LMC view is that as much of the national and local resource should be distributed via the practices, who in turn can aggregate monies up to third parties including PCNs and GP Federations (as providers). As a profession locally we should be very careful about agreeing to any significant shifts of funding from the national contract into local systems. However, we support and endorse work to form local Confederations in East and West Cheshire (to match the new ICB outposts at Place) to ensure we have a unified voice for general practice: and to benefit from the combined knowledge and experience of our LMC, GP Federations and PCN Clinical Directors.

In addition, because of its 'personalised delivery' nature, general practice is often less able to negotiate or be represented as a single provider with a common voice. Whilst the Local Medical Committee is recognised in statute (S97, NHS Act 2006) it can be by-passed in some circumstances, for example by an NHS Trust initiating new pathways or IT systems without consultation often with disastrous results for practices and patients. In some parts of the county past NHS commissioning bodies and Local Authorities have also done this with similar results. Whilst we have had issues in Cheshire these have been a lot less prevalent than elsewhere in England. From that starting point we have a solid foundation to work from.

Nationally and locally, there is a drive to develop new models of care, whether that is a move towards integration (with Care Communities) or a greater range of out of hospital services, but this is only achievable with a strong and resilient general practice foundation. That direction of travel has been further reinforced by the Fuller report.

The big concern is that there will be a loss of influence for general practice in the new NHS system. While CCGs were GP led, there is no such requirement of Integrated Care Systems. Indeed, the formal role of GPs in the new arrangements is very limited, and leadership of the new system by general practice feels unlikely. That is not however a reason not to engage and push for the voice of general practice to be heard and listened to and acted on.

It feels somewhat like a call to arms!

General practice at a crossroads: The Fuller Report

In November 2021 NHSE asked Dr Claire Fuller, (CEO designate at the time) Surrey Heartlands ICS and GP, to undertake a stocktake on integrated primary care, looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current general practice, community pharmacy, dentistry and optometry services) across systems. ***Her remit excluded the GP partnership model, the GP contract and the funding formula for GMS.***

As things go this is an important document, as it sets the direction for the potential future policy around primary care, including a significant focus on general practice, and a vision for integrated primary care. The document has been signed by the 42 Chief Executive designates of the Integrated Care Systems demonstrating their commitment to enabling change. We can therefore expect that ICS thinking and future funding streams will be geared to enabling change to happen.

The report in its introduction provides a good assessment of the current state of Primary Care: "Primary care teams are stretched beyond capacity, with staff morale at a record low. In short, left as it is, primary care as we know it will become unsustainable in a relatively short period of time.

What emerged following the review was a consensus.

- What is not working is access and continuity, with frustrations shared by both patients and staff alike. What also emerged was a consensus on what we can do differently.
- Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs) and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.
- Streamlined access to urgent, same-day care and advice from an expanded multi-disciplinary team, using data and digital technology to enable patients to quickly find the right support to meet their needs.
- Ensuring those who would most benefit from continuity of care in general practice (such as those with long term conditions) can access more proactive, personalised support from a named clinician working as part of a team of professionals.
- Taking a more active role in creating healthy communities and reducing incidence of ill health by working with communities, making more effective use of data and developing closer working relationships with local authorities and the voluntary sector.

General practice, likely via involvement of PCNs, therefore needs to set out its service offer in the world of integrated care at PCN and Care Community/Neighbourhood level.

What are the exam questions from the Report?

The Fuller Report puts forward a compelling set of principles and ideas. From a population, patient or care professional view point it is hard to do other than agree with them. The Annex

at the end of he Report contains a set of 15 'next step recommendations' which it is likely will translate into a sense of direction by the 42 ICS senior teams. General practice needs to fully understand these and practices and PCNs at Place level need an agreed view on how they would want to see them addressed locally. ***This can be debated with the local Place ICB lead Directors (Mark Wilkinson and Delyth Curtis in Cheshire).***

As an LMC we would however challenge the wording in many of the action areas. For example, at recommendation 6 "Embed primary care workforce as an integral part of system thinking, planning and delivery." If the system truly acknowledges that general practice should be the core building block for local health care why not ***"Embed health and social care workforce as an integral part of general practice thinking, planning and delivery"***.

Likewise, we will be asking the ICS and Place colleagues "What do you want general practice to deliver?" We would then be looking to ensure local resources provided to General practice are appropriate to deliver the ask.

Possibly the most important questions for general practice around recruitment, funding and core contracts are all excluded from the remit of the review. These cannot be ignored. One suspects they were excluded either for the benefit of NHSEs negotiation stance for 2024 or to allow a greater degree of flexibility for ICSs to become key players as they mature. From their establishment this year we might expect 2022 to be a year of consultation, scene setting and muscle flexing with significant focus on system change to align with 2024 national GP contract negotiation at the centre.

Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.
This is the first recommendation in the Annex to the Report. In many ways every other recommendation follows on from this. What does this really mean for practices? We believe that this is a re-framing of the debate around general practice at scale. All practices should already have considered their future business model. If not now may be a last chance to keep control of how you move forward.

Primary Care Networks are one current funded approach which in Cheshire has largely been successful despite of the level of funding and top-down target driven micro-management of NHSE.

Are there things we can take from the models developed in Middlewood and Knutsford where the practices have merged to equate to the PCN and Care Community footprints? This may (likely will) not be right approach for every area; or the timing may not be right for some due to current individual practice circumstances. ***But you should have at least held a local discussion about such models.***

Alternative models include those implemented by practices in Modality Healthcare Partnership; or Our Health Partnership - OHP - (33 practices in 42 surgeries) in the Midlands and Shropshire. In Walsall there is a 'vertical' integration model in which a local NHS Trust is running 18 practices. In the latter model the GPs have in effect given up their independent

contractor status to become 'sub-contracted' to the Trust with the GPs becoming salaried employees who must align their working standards with the Trust.

Clearly there is a lot of detail and many issues behind all these models. In the past we have held local sessions in which we invited the likes of OHP to present to our practices to explain their model of partnership and the issues they have worked through. We could hold further sessions to explore alternative models if required by our members.

At the sessions we explored improvements include centralised administration, recruitment and training, IT and digital support, preparation for CQC visits and common quality standards development. There was also an opportunity to learn about governance arrangements, decision making, risk and reward strategies, and subscription models.

The above models, including practice mergers, do show that there are several models which can not only support the sustainability of general practice, improve individual work/life balance but can also expand to delivering, or being an integrated part of, wider community services too.

The significant workforce challenges we face are acknowledged and locally we need to ensure that the shortage of GPs and the wider health professionals in primary care remains the top agenda item. Other workforce initiatives (including the ARRS scheme) will likely come and go but we must press locally and nationally for a focus on the core problem.

Whilst touching on the subject of alternative models for general practice we should restate the benefit of the independent contractor status that general practice enjoys. The reality is that the Secretary of State cannot directly tell GPs what to do, or instruct them how they should behave, in the same way that he can with NHS organisations and senior leaders in ICSs and NHS Trusts.

In summary the formal establishment of ICSs could not be timelier, and this report clearly signals the need for primary care voice and leadership to be at the heart of local and national priorities. Alongside a commitment to local action, this report sets out a requirement for additional support from Government and NHS England, targeted most of all at fixing workforce supply, estates and digital infrastructure. The successful implementation of the vision set out will also require a pivot to locally led action, as described in the King's Fund literature review 'Levers for change in primary care' published alongside the Fuller Report.

The GP partnership model

The current majority option for delivering the business of general practice since 1948. In that time this has been the single most important model of any group practice. In 2018 NHSE commissioned a review led by Dr Nigel Watson (Wessex LMC and GPC Member) which was publish in 2019. In the same year Dr Watson presented elements of the review at Cheshire LMC's Annual GP Conference.

The Report made key recommendations in the following areas:

- The challenges currently facing partnerships within the context of general practice and the wider NHS and social care, and how the current model of service delivery meets or exacerbates these.
- The benefits and shortcomings of the partnership model for patients, the population, partners, salaried GPs, locum GPs, broader practice staff (practice nurses etc.) and the wider NHS.
- Drawing on the above, consider how best to reinvigorate the partnership model to equip it to help the transformation of general practice, benefitting patients and staff including GPs.

In summary the recommendations were -

Recommendation 1: There are significant opportunities that should be taken forward to reduce the personal risk and unlimited liability currently associated with GP partnerships.

Recommendation 2: The number of General Practitioners who work in practices, and in roles that support the delivery of direct patient care, should be increased and funded.

Recommendation 3: The capacity and range of healthcare professionals available to support patients in the community should be increased, through services embedded in partnership with general practice.

Recommendation 4: Medical training should be refocused to increase the time spent in general practice, to develop a better understanding of the strengths and opportunities of primary care partnerships and how they fit into the wider health system.

Recommendation 5: Primary Care Networks should be established and operate in a way that makes constituent practices more sustainable and enables partners to address workload and safe working capacity, while continuing to support continuity of high quality, personalised, holistic care.

Recommendation 6: General practice must have a strong, consistent and fully representative voice at system level.

Recommendation 7: There are opportunities that should be taken to enable practices to use resources more efficiently.

Since the report was published there has been very little feedback or a structured formal response from NHSE. One can only draw from tis that they did not wish to really support the current majority model for managing general practice as a business. Nonetheless, if practices

support the model (the LMC has previously stated that it endorses the option for general practice locally) we would wish to see it supported by Place and ICS in developing their future strategies.

Hence, we also support the strategy that monies should flow via the national contract into practices who can then provide it to their PCN model and by doing so hold the PCN to account as part of a strong bottom-up governance arrangement.

Our members currently face a number of challenges within the GP partnership model, including in relation to financial risk, career progression and partner expectations, and sustainability. While addressing these issues, we must recognise and protect the strengths built into the current model; our members report support for the current model in terms of its basis in serving local populations of registered patients which facilitates the importance of continuity of care. Furthermore, a revised GP partnership model must enable and embrace the evolving primary care landscape, as well as support the ability for development across integrated care systems.

Tackling unsustainable increases in the volume and intensity of GPs' workloads will also be critical to ensuring the partnership model remains viable. A credible national workforce strategy which addresses gaps in the numbers and skills mix of health care staff needed to support general practice is also desperately needed.

Successive NHS long-term plans place general practice at the heart of improvements to the health service. If that ambition is to be met, then general practice should be provided with support and training in leadership, management and organisational development, and it will need to be central to integrated system plans.

As an LMC we also support the opportunity for practices to grow together and operate at scale using their preferred model of delivery by it PCN or another model. By funding flowing via the practice route, it allows practices to grow and develop their approach to general practice at scale that delivers the right care, at the right time and in the right place for their populations/ patients.

The GMS contract 2024/25

As always, the negotiations which are getting underway now and in the near future will be closely guarded as the GPC and NHSE take up their negotiating positions. Both sides will of course trail their key messages in advance as the first shots are fired.

The current five-year GP contract was negotiated between the BMA and NHSE in 2019-20, with provision for negotiated changes every year. But negotiations came to a standstill in February 2022 when the BMA said it was clear that NHS England would not be offering sufficient measures to

The GPC had 'sought improvements on the tabled NHSE proposals for 2022/23 and put forward suggestions outside the five-year framework for agreement. The key proposals rejected by NHSE included -

- resources to manage general practice pressures.
- a long-term-conditions recovery fund.
- reform of childhood immunisations IOS (Item of Service) and QOF (Quality and Outcomes Framework), with 'additional support for childhood immunisations' within QOF to enable practices to deliver more for their patients without being financially penalised.
- a tapered approach to QOF to support recovery.
- the provision of long Covid occupational health; and
- a new contract for general practice.

The BMA reported that NHS England had refused to discuss its proposals despite repeated requests from GPC England but instead remained aligned to the five-year plan agreed before the pandemic.

The 'default' position is for the existing contract to 'automatically roll forward unless it is changed' when the five-year framework concludes at the end of March 2024. The BMA view is that NHSE seem willing to understand the current day pressures being faced by GPs and their teams, but there is seemingly no willingness to act decisively to support the profession so that it can continue to deliver care to those who most need it.

In the interim the BMA launched its **'Build Back General Practice'** campaign in March 2022 which urges the Government to deliver on its commitment to deliver an additional 6,000 GPs in England by 2024. The campaign also demands that ministers and health leaders tackle the factors driving GPs out of the profession, such as burn out, and financial penalties in the NHS pension scheme, and to create a plan to reduce GP workload and improve patient safety. Cheshire LMC is promoting the campaign and would ask all practices to sign up to it and take local action.

The campaign aims to give GPs across Great Britain the time back to deliver the quality of care they want to be able to give patients while ensuring patients are cared for by the right team member. It also aims to resolve the difficulties many patients are facing in getting timely GP appointments and to benefit the NHS as a whole by alleviating pressure on

hospitals. It is hoped the campaign can also help to tackle the backlog which existed before, but has been exacerbated by, the pandemic.

Former health secretary and current chair of the Commons health and social care committee, Jeremy Hunt, described general practice as the 'beating heart of the NHS' and said he was 'worried' the Government was failing to learn the lessons of the past on NHS workforce planning and could 'repeat the mistakes of history'. The latest workforce report from the Commons Committee was issued on 25 July.

Apart from getting the level of funding/ historic underfunding addressed, a major battleground will be funding being within, not outside, the core national contract. There will undoubtedly be a variation across the ICS CEOs in how they view primary care and the role it can play. What they likely can agree on (unsurprisingly) is that they would like the funding for general practice to come via the ICSs rather than via a national contract. It is hard not to believe that this shift of funds was at least to some extent behind the total support ICS CEOs displayed for the report and the letter they all signed in the Fuller Report.

The Fuller Report will support the thinking those organisations and policy makers for primary care funding, including general practice funding, to shift from being nationally to locally driven. The extent of this shift is made clear in the annex at the very end of the report. They want the Additional Role Reimbursement Scheme for example to be delivered via ICSs not via a national contract.

The GPC has long argued against the PCN DES funding mechanism because of this sort of fragmentation risk and he potential for a post code lottery in terms of GMS development.

Interestingly whilst GP funding was outside the remit of the Fuller report it did reflect the context for Dr Nikki Kanani's (NHSE) comments at the recent NHS Confederation conference about reviewing the national funding allocation formula as part of the contract negotiations for the next contract from April 2024. ***The report says, "It is … generally accepted that the distribution of primary care funding to neighbourhoods is not always well aligned to system allocations and underlying population health needs – and we need a concerted local effort to try and fix this."*** (p28).

All of this, then, is pointing to a shift of resources out of the national contract after this five-year deal expires, with far more to be allocated via ICSs. The distribution of this additional resource (it seems) will be made by ICSs dependent on population health needs, regardless of the specific local needs of primary care providers.

PCN futures

The recently published Fuller Report was originally described as being a review of Primary Care Networks (PCNs), and while its remit evolved during the course of the report it is no surprise that it has resulted in some big implications for PCNs. So, what are the key ramifications?

The importance of PCNs is set to going to grow

It is clear the future of general practice and PCNs may be inextricably intertwined. At the outset of the document Dr Claire Fuller summarises, ***'This report offers a vision for transforming primary care led by integrated neighbourhood teams'*** (p4). She describes a future in which PCNs 'evolve' into integrated neighbourhood teams, and that these are to play a leading role in the delivery of the integrated care agenda. ***In Cheshire that would clearly mean PCNs would be maturing to perhaps 'merge' with a new form of Care Community entity***. Might that mean they need to become legal entities in order to hold contracts?

There will be a greater focus on joint working with other organisations

We know that to date PCNs have largely focussed on how the practices within the PCN work with each other. This is going to change. The Fuller Report describes how, in the new vision of the future, PCNs with, '*wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams dedicated to improving the health and wellbeing of a local community and tackling health inequalities*' (p6).

In the initial description of PCNs when the DES details were issued by NHSE it was said that other organisations would become part of the PCN board over time, and while that has not happened for a variety of reasons (time being the key one), this report is clear PCNs are no longer to remain within the sole domain of GP practices.

We have always known that (despite the rhetoric) the development of integrated teams was always the stated intention for PCNs. But is this what our local PCNs and practices are also thinking? This leads to several key questions that each PCN should consider discussing -

- Are our PCN footprints right for building new pathways such as new urgent care triage pathways?
- What is the right scale and how do we get there?
- How do you ensure consistency across 'place'?
- Do the PCN footprints meet the definition of neighbourhoods or communities for other Place partner organisations?

We must recognise that in some areas our local authorities and community services may not have had an input into the shaping our current PCN footprints. Other services may not view PCNs as natural neighbourhoods.

The leadership challenge will grow

Being a PCN Clinical Director is already difficult. Leadership of the scaled up integrated neighbourhood teams described in the Report will be even more challenging. It will require

bringing teams from multiple agencies together, with all of their associated cultures and ways of working, and creating a shared, cohesive way of working. ***Not all current GP leaders may be up for this challenge because of time and energy but others will be.***

The report does recognise this, '*More focus needs to be given to the development and support of clinical directors beyond the current basic arrangements provided through the national contract, including the provision of sufficient protected time to be able to meet the leadership challenge in integrated neighbourhood teams*' (p22).

The question is whether the current PCN Clinical Directors will want to take on this leadership responsibility and is there the spare capacity in their clinical role to do it. The risk is if they don't the leadership of these teams may come from one of the partnership organisations and from outside of general practice. The ICS and Place organisations need to recognise this and consider how they can support the lost clinical time and financial cost of the leadership time needed.

The source of funding will shift from national to local

One of the big messages, and potential threats, in the report is the request for the funding for PCNs to shift from national to local - '*National contractual arrangements, including for PCNs, have provided essential foundations including for chronic disease management and prevention. But they can only take you so far… getting to integrated primary care is all about local relationships, leadership, support and system-led investment in transformation*' (p28).

It very much looks like after the five years of the current deal expires in March 2024 funding for PCNs will not come via the national GP contract but via local Integrated Care Systems. ***This means that such monies will be lost from the future national contract negotiations and that the ask of PCNs will start to vary across the country, along with the level of investment in them.***

A scaling up of infrastructure support

PCNs have often struggled because so little has been invested in enabling them to have the systems, processes and functions necessary for success. The fact so many have succeeded is down to the personal sacrifices and commitment of Clinical Directors and the PCN teams. There was no way that funding two sessions a week of a Clinical Director and £1.50 a head running costs for what are now multi-million-pound businesses is ever going to be enough.

This is recognised in the report. It says it will make available, '*back-office and transformation functions for PCNs, including HR, quality improvement, organisational development, data and analytics and finance – for example, by leveraging this support from larger providers (e.g., GP federations, supra-PCNs, NHS trusts)*' (p7).

Implicit here is PCNs will no longer be able to support themselves. Clearly, the scale of what is needed is going to exceed the delivery ability of any individual PCN. The question is whether at scale general practice is in a position to provide this in each local area, or whether many ICSs will start to default to this being provided by the local NHS trust or even a local authority (think Welsh Health Boards structure and the like).

There are clearly big changes ahead. Worryingly the report states '*Systems should aim to have them* (integrated neighbourhood teams) *up and running in neighbourhoods that are in the…… most deprived areas by April 2023. This…… will create the necessary pace and ambition to move to universal coverage throughout 2023 and by April 2024 at the latest*' (p7).

Change is coming for PCNs, and it is coming quickly and some of it is likely unachievable with the current identified level of resourcing. On its own this issue is a significant threat to the future of general practice in terms of its development of at scale working.

The digital agenda

Digital is more than just computers, IT and smartphones. It encompasses the new ways of thinking and working which start with user needs. Digital solutions build on data, often start small and scale up, emphasise experimentation, more 'agile' approaches and less hierarchical organisational structures. In April 2019 a new government organisation, NHSX, was launched to oversee digital, data and technology across health and social care (now part of the Transformation Directorate at NHS England).

In the context of this guide, and the reviews of general practice and primary care, it is the growing demand for access to NHS primary care teams causing services to be under increasing pressure that is the focus. Many GP practices are using digital technologies (video/email/other online consultations) to try to improve access and efficiency. Alongside this is rapid growth in health technologies, which collect, measure, or interpret health data, and provide health information or advice.

Many technologies have positive potential; however, the speed with which they are becoming available, the increasingly blurred boundaries between health and lifestyle technologies and traditional healthcare provision, and the confidence and skills GPs have in using digital health technologies, bring new complexities and concerns.

The COVID-19 pandemic has resulted in a significant increase in remote consultations in general practice. The increased use of remote consultations has been necessitated by this international emergency, with vital safety considerations requiring substantial reductions in face-to-face contact between patients and healthcare professionals.

Previously it was estimated that up to 50% of UK consultations could be conducted remotely by 2030, but it is very likely these levels of remote consulting have been significantly exceeded in response to COVID-19 already. Some of the key areas being continuously debated and developed are -

Patient access v workload management
Safety/ effectiveness
Ethics

NHS England is supporting primary care to move towards a digital first approach, where patients can easily access the advice, support and treatment they need using digital and online tools. Unfortunately, NHSE has not communicated well enough with the population and so the approach has been tangled in the misinformation around overall GP access for face-to-face consultations.

Some strategic questions for the long-term

Integrated Care Boards (ICBs) were established on 1 July 2022 (one of two boards within the ICS) taking over the functions of former Clinical Commissioning Groups (CCGs). What happens next as we enter a transitional period offering an opportunity for the benefits of system working to be explored, and barriers worked through? What are some of the questions for ICBs to consider during this time?

How can we promote stronger integration at Place level?

CCGs and Places have worked hard to set up arrangements to ensure "continuity" from 1 July. But what next? How can an ICB drive more integrated decision-making at Place? This is key not only to improving health outcomes but also to the ICB's success as an organisation.

ICBs must continue in their efforts to think beyond continuity to what they would like their Places to achieve in the longer term. Initially, this will be a deepening of relationships between the Place partners and a trust building exercise which will be reflected in greater delegation and maybe even pooling of budgets and real joint decision-making. Part of this process will involve tackling the "wicked issues" in the post-Covid landscape which will not be comfortable territory for many system partners. ICBs will need to encourage and enable their Places to move beyond the here and now to evolve as genuine partnerships to address these difficult issues.

'Integration' will be a common thread in every discussion and forum. To get absolute integration they will need to establish an understanding of the total estate and its legal constraints and possibilities. Not an easy task given the historical divides. As is defining the sharing relationship between the parties so that there is clear understanding of responsibilities and potential liabilities as working relationships develop. Bearing this in mind, one of the first exercises will be a review of the estate portfolio that it has at system and Place levels so that it understands the terms on which it is held and how it can be used going forwards. The LMC understands this has largely already taken place.

This may lead to some difficult decisions on what to retain, develop, re-purpose, or dispose of. We need to understand this at Place level for Cheshire as it will be a major factor for our practices/ PCNs plans and potential delegated funding.

We also need Place to facilitate a better culture and respectful relationship between our various organisations – in particular hospital consultant and GP clinician. But also, between our GPs and pharmacists, dentists and optometrists.

How do we build a sustainable workforce?

The wider workforce challenge will need national and ICS funding and support

The national and local workforce shortages need to be addressed as a matter of urgency across the whole of the NHS and not just in general practice. Does the ICS have data on the whole workforce and are the numbers a result of workforce shortages or organisations past funding decisions**?**

The government's vision is to create a joined-up workforce in which health and social care professionals work together in a collaborative and co-ordinated way to deliver services jointly for their local communities. The long term sustainability of the healthcare workforce

is clear priority and the integration white paper – Health and social care integration: joining up care for people, places and populations - sets out the practical steps which will be taken to support the aim of "one workforce" delivering integrated care.

At a national level, the government has pledged that there will be a review of the regulatory and statutory requirements which currently hinder health and social care staff from working flexibly across the health and care system. We might expect to see the introduction of an "Integrated Skills Passport" which will enable staff to transfer their skills and knowledge between the NHS, public health and social care. It is expected that a range of test joint roles in health and social care will be created with these steps expected to ensure that suitably qualified staff are retained in the NHS and wider social care sector.

At a senior level a national leadership programme is proposed; this will address the skills required to deliver effective system transformation and local partnerships. It is possible each ICS will develop a local model supporting this.

There will be a focus on the health and wellbeing of all staff across the system, and ensuring that staff are provided with opportunities, training and skills required to undertake their roles effectively. Fostering a culture of inclusiveness and belonging to encourage the long-term

How do we improve same-day access for urgent care?
A key and possibly a radical recommendation in the Fuller Report. Likely to be a high priority for ICSs. It has a huge cultural change for practices (and patients). It raises many questions, and many will be difficult to answer. What is the planned funding model for such a 'at scale' urgent care triage model and will this be from new funding or recycled from the existing urgent care services? Is PCN or Place or County wide the footprint for this? Does the model rely on PCN wide services rather than using practice-based services?

We have practices with access reported as excellent, where patients receive personalised services who may be negatively impacted by a change in their pathway. Will the ICS and Place value and support different approaches for different communities or will they resort to a one size fits all which we would resist. We would need to see assurance that this subject area was not just focused on the 'access to your GP' element.

Getting the GP voice heard

In line with the changing architecture of the NHS, effective of 1st July 2022 NHS Cheshire CCG has been dissolved along with all other CCGs. Functions and resources that were managed within Cheshire will now be managed at a Cheshire and Merseyside level via the Integrated Care Board (ICB). This means that much of the statutory and contractual requirements and commissioning decisions that impact the delivery of general practice, and other primary care contractors will be at arm's length from Cheshire (until any delegation to Place).

There are a lot of layers in the new NHS structures. The distance between a practice and the ICS seems vast at this point in time.

The ICS recognises the importance of maintaining the smooth running of general practice especially during times of change and have acknowledged the need to keep resources, skills and expertise local. There is a commitment to aligning non contractual functions within the (ICB) to Place including relevant resources.

As a provider body, general practice has a significant role and influence in the commissioning and delivery of local health care services, however engaging and communicating effectively with 79 individual GP practices and/or 18 PCNs can be difficult. This is especially so for the ICS, local Placed based structures, Local Authorities and other providers such as NHS Trusts, the ambulance service, police, fire and rescue, etc.

Going back to the Fuller Report the introduction makes it clear that is remit didn't include contractual and funding arrangements but the need for significant work around these topics is essential. As part of this it is important that we return to the position where changes are negotiated and not simply included within the likes of PCN DES. It is essential that there is a clear primary care investment commitment to ensure that local ICS or Place investment and support is part of an overall longer-term national investment plan. We also need a commitment to ensuring general practice and wider primary care funding is protected. A strong local GP voice will support such local debate.

Why is this important as part of the local confederation discussions? Whilst local resources to support general practice are welcome, it is important to recognise that fair representation of general practice needs to play into any commissioning and provider discussions, including input into revised governance frameworks. The GP confederations will be essential in terms of representation of general practice and contributions to those discussions and decision-making processes.

Locally we have been developing proposals around a confederation approach bringing together the LMC, GP federations and PCN Clinical Directors to use our expertise and knowledge to support general practice engage and influence the local system (Cheshire East and Cheshire West Places – and also the ICS). In East Cheshire the confederation has a mandate (agreement in principle) from all GP practices to represent their interests in how services that impact on general practice can best be developed and delivered. The confederation also has been welcomed by the ICS as an enabling resource to support the development of general practice.

Equally the confederations will provide a communication and engagement function, be a voice to the system on behalf of general practice and express views on behalf of members practices to partners. The confederations are well placed to develop a Primary Care Development Plan that responds to the recommendations within the Fuller Stocktake Report and other current and the ICS priorities around health improvement and integration.

Similar arrangements are developing in Cheshire West albeit a few months behind the development in East. These important discussions cannot be rushed, and it is vitally important that all GPs and their practices are engaged in any agreements.

What are the challenges we are aiming to address? In partnership with system partners, the confederations will find innovation solutions that support general practice to strengthen each of these areas. It is recognised that the confederations will need time to grow and mature and in doing so build the confidence of general practice and the system, but we believe that the confederation approach can address the system objectives.

The confederations in Cheshire aligned to the two Places will –

- Representation: Ensure that general practice as a provider is represented at the right meetings and that this representation, is consistent, constructive, and representative of general practice.
- Clinical Leadership: Provide the effective and inspirational clinical leadership required to engage in system redesign, influencing and negotiation on behalf of general practice as well as leading effective “membership” discussions and debate.
- Delivery of the (so called) left shift: Supporting general practice to ensure that the right services are provided in the right place at the right time.
- Co-ordination: General practice is the largest provider in the system. The confederations will provide a co-ordination function across 79 practices, 18 PCNs, 3 GP federations and 1 LMC that supports effective communications between general practice and ICS and Place.
- Engagement: Primary care development and engagement will be a fundamental element of the confederations offer. they will be the primary point of contact for specified areas of primary care development and specifically benefit the ICS and Place colleagues in their mechanisms to effectively engage with General practice for a wide range of purposes. they will act as a single point of contact.
- Consistency of approach: The confederations will have the skills and aptitudes to support general practice in developing coherent and consistent service offers to support the system priorities, for example, working together around access requirements.
- Workforce: A key priority for the confederations will be stabilising general practice. We will work closely with the Place partners, Cheshire GP Training Hub and confederation partners to develop innovative ideas and solutions that will make general practice in Cheshire East and West attractive places to work. This includes opportunities for workforce recruitment, retention, and training of clinical, non-clinical and managerial staff.

- Quality: Working with wider partners we will support general practice and PCNs in adopting quality improvement methodologies to attain a consistent and high-quality service.

The confederation approach does not change the GP organisations concerned rather it enables them to work together for their member GPs and practices and share skills and knowledge. The LMC will still bring in their experience in national contract issues e.g., what is in/ not in the requirements of the GP contract); GP federations as coordinators of services 'at scale' and supporting recruitment and development of common standards; PCNs as the local planning unit for engagement re. integration and pathway design etc.

If we have an agreed commitment to a confederated approach in East and West Cheshire then we can forge an agreement to a sustainable overall vision, a process for the development of an implementation plan -recognising the need to link ICS and Place plans with the national agenda and actions. In particular the immediate needs to address the GP workforce crisis and the public perception of the service need system actions. It is important that we don't take up our time dreaming up new 'Primary Care Strategies' without focused action on these two key topics.

Help from the LMC

We will be working with the emerging local confederations to host sessions for practices and PCNs to come together to debate all of these issues in the coming months. Watch out for details (Heartbeat for LMC sponsored events)

Think Tank Sessions

Are the practices in your PCN thinking about new models of general practice? This session can be used early in your thinking process before you start writing a plan or if you are considering practice mergers. It's about open discussion, generating ideas, obtaining a different perspective and starting to pull out key themes to be developed. It's also an opportunity to spot weaknesses and areas for further development. Check out our merger briefing document on the LMC web site.

Sounding Board Sessions

Once you have something down in writing we can be your sounding board. Send it to us in confidence and we'll review it, sending you back any ideas, comments and questions. We'll look at it from the funder, commissioner or regulator perspective and try to be as ruthless as they will be.

GP Retirement Planning

The LMC is presently reviewing opportunities to run some retirement planning sessions for those GPs thinking of leaving general practice within the next 2 years. Pensions tends to be the most frequently requested session. Check out our Heartbeat newsletter in the coming months.

Availability of sessions will be limited in number and will be allocated on a first come first served basis. Your practice manager receives our Heartbeat e-newsletter which will include details of any of the above – or get in touch with us.

Reference List

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https://www.bma.org.uk/media/1610/bma-consultation-response-digital-first-primary-care-policy-aug-2019.pdf

Cheshire LMC is a member-based organisation, independently funded by its member practices. It is the only representative voice in the local NHS that is recognised by statute. We exist to represent and support you.

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