The financial challenges facing general practice

July 2017

in association with

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The author of this briefing was Mark Justesen (independent consultant). The survey was conducted by Natalie Fletcher (head of finance at Vale of York Clinical Commissioning Group), with support from the National Association of Primary Care. Natalie also provided valuable support and guidance during the drafting of the briefing.

The work was directed and supported by Sanjay Agrawal (consultant respiratory intensivist at University Hospitals of Leicester NHS Trust, HFMA trustee and senior responsible officer for the FFF close partnering workstream), Rebecca Edwards (FFF deputy programme manager) and Emma Knowles (HFMA head of policy and research).

Summary

We asked general practitioners (GPs) and practice managers about the current financial challenges facing general practice. Their responses highlight a number of serious concerns about the issues facing general practice and in this briefing we make a number of recommendations to address some of the most pressing issues.

General practice is facing unprecedented pressures and, with GPs managing heavier and more complex workloads, uncertainty about a sustainable future in a rapidly changing landscape is understandable. In such a stretched environment general practice needs guidance and support to manage the status quo, let alone deliver the increasing expectations set out in Next steps on the *NHS five year forward view*[1].

Key findings

- The majority of respondents were either 'not at all confident' (42%) or had 'some concern' (45%) about the financial outlook for their practice in two to three years' time. Fewer than 2% were highly confident. The most significant financial pressures were considered to be due to their ability to meet existing/growing demand within current core funding (94%), growth in obligatory costs (92%) and capacity required to provide additional activity (90%).

- Notwithstanding these views about the financial outlook, just under two thirds of respondents believe that their practice will still exist in five years' time as an independent organisation or as part of a larger primary care organisation, for example a federation, alliance or expanded partnership. The remainder thought that their services would be provided by either acute or community services.

- Overall respondents assessed themselves as having a good understanding of most areas of general practice finance. The exception to this was around the financial implications of federation or alliance working and there was an appetite for training and further support in this area.

- While knowledge of general practice finance was good, respondents had a lower knowledge base when it came to the financial workings of the NHS. The role of CCG finance, NHS contracts, the *NHS five year forward view*[2] and the scale of the national and local challenge were highlighted as areas where training would be most useful.

- When asked about the quality of the relationship between their practice and their CCG, respondents reported significant room for improvement. Areas highlighted were general practice engagement in decision making, CCG understanding of general practice and ad hoc communication, such as payment or contract queries.

- Respondents identified improved informal communication, better CCG understanding of primary care and having joint financial incentives as the best ways to improve relationships between general practice and CCGs.

- The information provided by CCGs to general practice varies significantly. For example, while the vast majority receive information about spend on medication, only 27% of respondents receive information on direct access diagnostics.

- When asked what information they would like to receive from CCGs, GPs preferences were for spend on medication and both local and national benchmarking data. Practice managers were also interested in data on referrals to acute services.

NHS England, clinical commissioning groups (CCGs) and local medical committees (LMCs) have a vital role in facilitating change and ensuring that general practice has the capacity, knowledge and tools to ensure decisions about service change and expansion are soundly based.

The priority given to transferring work from secondary to primary care settings and introducing new models of care, is adding additional risk to an already stretched general practice. There are urgent issues that need to be addressed and these will only be exacerbated should the pace of change continue to outstrip the sector's preparedness.

Reducing the administrative burden, improving relationships and partnership working (with commissioners and providers), and providing the right professional support and guidance to inform decision-making are key factors to be addressed as the NHS moves ahead with the *NHS five year forward view* the *General practice forward view*[3].

1 NHS England, *Next steps on the NHS five year forward view*, March 2017
2 NHS England, *NHS five year forward view*, October 2014
3 NHS England, *General practice forward view*, April 2016

Background

General practice provides the majority of health care for the NHS and GPs are the principal gateway for patients to access other NHS services. As such, general practice bears the primary impact of the increasing demand for healthcare.

However, for many years it has received less attention, less additional funding, and lower increases in GP numbers compared with the medical workforce in community or hospital-based care. Practice closures are at the highest for years, and GPs increasingly concerned about financial sustainability. This briefing summarises a Future-Focused Finance (FFF) survey of GPs and practice managers and discussions with other interested parties.

The pressures within general practice

GPs are not generally employed by the NHS and general practice comprises a diverse body of small independent businesses, increasingly working in collaboration with each other in alliances or federations. Recent policy changes have resulted in responsibility for public health being transferred from health to local government and primary care commissioning split between NHS England and CCGs. At the same time there has been a move to a more preventative model of care, delivered closer to home, with GPs better integrated within the wider NHS.

The King's Fund published a paper in May 2016, *Understanding pressures in general practice*[4], that highlighted increased pressure on general practice and its causes. Its key message is: 'General practice is in crisis. Workload has increased substantially in recent years and has not been matched by growth in either funding or in workforce.' The report noted that consultations, both face-to-face and by phone, have increased significantly; GPs' work is becoming more challenging because of the ageing demographic, the rising complexity of medical conditions, initiatives to move care out of hospitals, and increasing public expectations; and that practices have difficulties in recruiting and retaining GPs and medical staff.

The financial pressures were considered by Grant Thornton in its July 2016 report *Primary concern: shaping the future direction of primary care*[5]: 'The current arrangements for delivering primary care are unsustainable in the medium-term'. It goes on to state: 'Significant numbers of GPs face the prospect of going out of business unless they adapt their business models.'

This all means the primary care business model has become more complicated, and less profitable, in recent years and NHS England data shows the number of practices closing is at record levels, with trade surveys by BMA, *GPonline*, and *Pulse* indicating that many others are considering following suit. The most common reasons given are underfunding and staffing problems, but there is also frustration at the administrative burden associated with the diverse funding streams they do receive.

The issues have been recognised in *Next steps on the five year forward view* and in the *General practice forward view* but proposed solutions will take time to implement and many GPs are not yet feeling any impact. There are widely recognised pressures in the short to medium term, until the workforce can be expanded to manage the record demand and proportionate funding raised.

At the same time, *Next steps on the five year forward view* sets increasing expectations of general practice in terms of accessibility for patients and in working differently with community and preventative services to provide more care outside of the hospital setting. It also proposes further changes in the GP contract.

The 2017 *GMS contract letter*[6] introduced several changes but also flagged areas of future change that may have significant impact on the finances of individual practices. The current performance-related funding system (the Quality and Outcomes Framework) will be replaced and the model used to allocate money nationally to individual practices (the Carr-Hill formula) will be changed.

These uncertainties and changes are impacting on the sustainability of individual practices. Therefore any changes that can release clinical capacity from administrative exercises, or provide additional effective assistance to secure financial sustainability, are important to the future of general practice.

The research

Recognising that GP practices are under real financial pressure, Future-Focused Finance commissioned a survey of GPs, and staff in business or practice management roles, to identify the finance support needed to help them manage the financial challenges.

The survey, completed during November 2016 and February 2017, asked questions about the financial sustainability of GP practices and the preferred future primary care model; their financial understanding of practice finance and NHS finance, and related training or support; how to improve co-working with CCGs; and information received from CCGs. Some 356 responses were received and are summarised in this briefing.

Some of the respondents were spoken to in order to provide more in-depth material which have been included in this briefing as case studies or to provide additional context around survey responses.

A virtual roundtable for interested parties was held in June 2017 to validate the messages and agree the recommendations.

4 King's Fund, *Understanding pressures in general practice*, May 2016
5 Grant Thornton, *Primary concern: shaping the future direction of primary care*, July 2016
6 NHS England, *GP contract 2017/18 letter to service*, February 2017

The future of general practice

Given the prominent position of primary care in the *Next steps on the five year forward view*, this section explores what respondents felt about their practice's current financial sustainability and what new delivery model would best improve it.

Confidence in the financial outlook

The survey asked about how confident respondents were in the financial outlook for their practice in two to three years time. Some 87% reported that they were either 'not at all confident' (42%), or had 'some concern' (45%) about the financial outlook for their practice in two to three years time. Under 2% were 'highly confident'.

These results were even more stark when looking at the responses from GPs themselves, with 56% 'not at all confident' and 37% with 'some concern' – 93% being concerned about financial sustainability. While practice managers may be slightly less pessimistic, there are clear and strong concerns that the status quo is not sustainable.

The survey considered the drivers behind these concerns, asking respondents to assess the significance of the following:

- Cost of locums
- Cost of other workforce e.g. nursing and administration
- Growth in other obligatory costs e.g. medical indemnity, fees, service charges
- Ability to meet existing/ growing demand within current core funding
- Capacity to provide additional activity
- Maintenance/provision of suitable premises
- Reporting requirements.

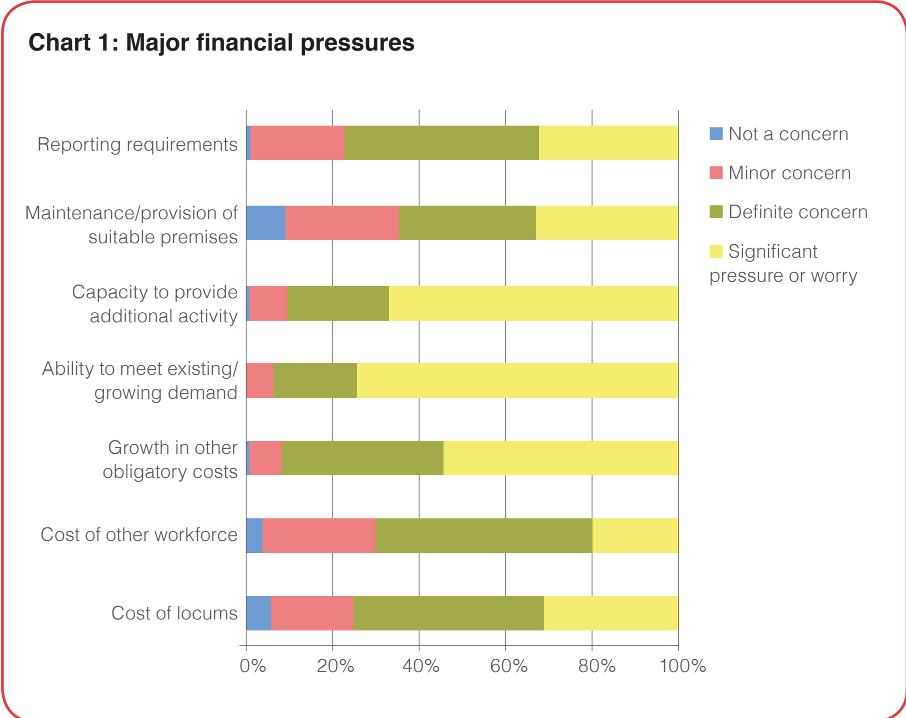
In all the categories above, the overwhelming majority saw these as either 'significant pressures or worries' or a 'definite concern'.

The principal concerns, all at over 90%, were:

- Ability to meet existing/growing demand within current core funding: 94% (but 98% of GPs)
- Growth in other obligatory costs (for example, medical indemnity, fees, service charges): 92%
- Capacity to provide additional activity: 90%.

The responses are shown in **Chart 1**.

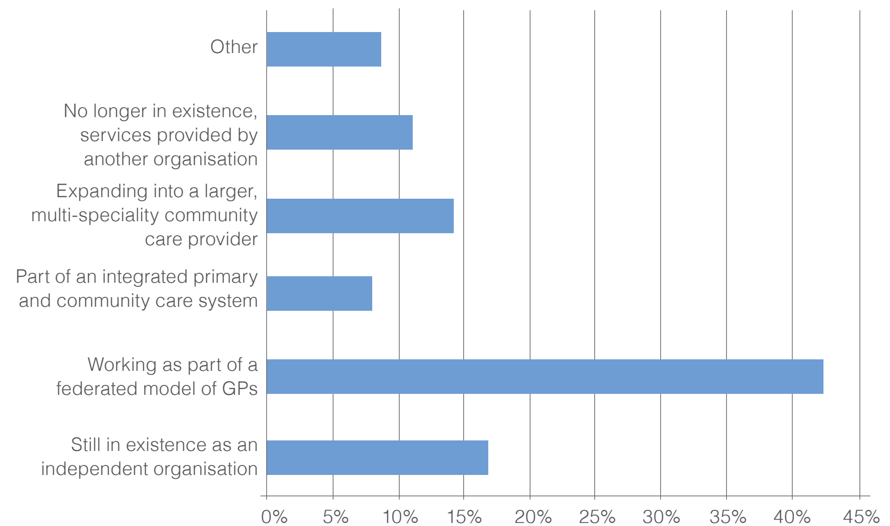
Freetext responses consistently referred to reduced funding, concerns about recruitment and retention, and increased bureaucracy. Collectively, it is clear from our survey that general practice feels under pressure from many quarters and is struggling to manage the status quo; let alone having the time needed to invest in remodelling the NHS and delivering an expanded service offering. Additionally many small practices find it difficult to meet Care Quality Commission requirements.



The future of their practice

Respondents were asked where they saw their practice in five years' time. Assuming they were still in general practice, under two thirds of respondents believed they would either still be in existence as an independent organisation or working as part of a larger primary care organisation, whether that be a federation, an alliance or expanded partnerships (**Chart 2**). The percentage was higher amongst practice managers (63%) than GPs (53%). The remainder believed their services would be merged with, or provided by, either acute or community services.

Chart 2: Where do you see your practice in five years?



It is clear, therefore, that there will be a significant number of new federations, alliances and partnerships established over the next few years, and CCGs have an important role to play in encouraging and supporting this change.

There are a range of cultural and practical barriers to overcome and no one-size-fits-all solution. As such CCG leadership needs to be based on face-to-face discussion and board to board support with strategic planning. Respondents also identified that non-recurrent funding, to cover set-up costs and locum cover, and professional HR, finance and legal advice were key success factors. Other suggestions included short and practical 'myth-busting' articles, in plain English, on why practices might wish to join an alliance or federation and the benefits that can accrue.

Models that support sustainability

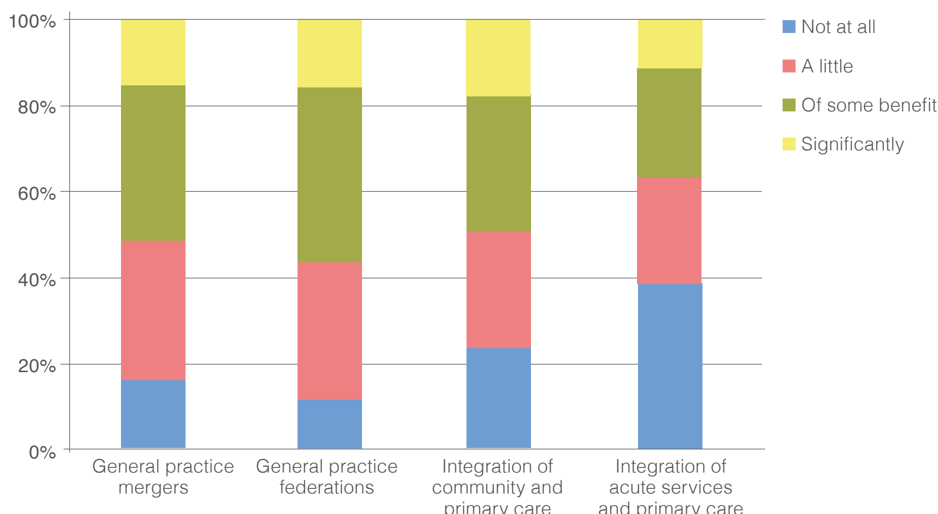
Respondents to the survey were asked to say what extent they thought that the following models of primary care support general practice sustainability:

- General practice mergers
- General practice federations
- Integration of community and primary care into multi-specialty community care providers
- Integration of acute services and primary care into a primary and acute care system.

Participants felt that all four of the options would support sustainability, but there was a preference for the first two, with over 80% believing they would offer some degree of benefit (**Chart 3**).

There was less support for integration, particularly among GPs; one third of which saw no benefit in integrating with community services and half saw no benefit in integration with acute services.

Chart 3: Which primary care models support sustainability?



Given the growing expectation that practices will need to merge, ally or federate with peers to work at a larger scale and deliver the ambitions of the *Five year forward view*, the survey also asked respondents whether they currently were part of a federation and, if so, whether they held any contract(s) to provide services at federation level.

While most practices were working in some form of federation (69%), most of these still only held contracts at practice level. Only 27% of respondents were in a federation that held a contract at federation level. This shows a positive alignment between the views of the general practice and NHS policy and direction but suggests there is a long way to go before federations have reached the level of maturity needed to enter into contracts that underpin the vision of the *Five year forward view*. Again CCGs have an important role in helping federations develop.

An important factor in this is building on the local sustainability and transformation partnership plans to link strategic commissioning intentions to capacity planning and workforce planning. While some staff may transfer from secondary care, along with the work, there is likely to be a need to identify new GPs with a special interest (GPSIs), and ensure they receive the necessary training and support in a coordinated and timely manner. At a local operational level, developing federations and alliances may need support with the contracting process, both in assessing the feasibility of delivery and through the tendering process.

Similarly CCGs will need to support the realisation of back office economies of scale in general practice. There are routine tasks that some CCGs have taken on to relieve the burden on general practice, such as central note summarising, but there are other opportunities for federations and alliances that they can facilitate. Repeat prescribing call centres, paramedic provision, information and telephony are some of the areas with scope for aggregation.

There is also an important interaction here with the accountable care systems model, which practically drives 'super-federations' of general practice in discrete areas of care. There is a risk this spawns an industry in sub-contracting back to practices unless contracts are at federation level. There is a related risk of effectively pushing CCG performance management responsibilities down to primary care, which will increase its administrative burden.

GPs have real concerns about the sustainability of general practice: income has not risen to match increasing demand pressures, costs and bureaucracy and they face difficulties in recruiting the staff they need to meet patient and modernisation expectations. As opposed to more structural reorganisation they prefer the idea of greater collaboration and partnership between practices, but need support to implement this in a properly managed manner.

The next section considers respondents' level of financial knowledge and whether training or extra support would be useful.

Financial knowledge and support needs

Respondents were asked about their understanding of general practice finance, and NHS finance more generally; whether they felt training would be helpful and, if so, how it could best be delivered.

Knowledge of practice finance

Respondents were asked how they rated their understanding of the following aspects of practice finance:

- GMS/PMS/APMS contracts as applicable to your practice
- Locally commissioned and/or enhanced services
- QOF (and any other quality/outcome related income)
- Cost of clinical staffing
- Premises costs
- Reception and back office costs
- Financial implications of federation or alliance working.

As one might have expected, there was good understanding of all but one of these areas, with over 80% assessing themselves as having 'good' or 'high' knowledge.

The exception was the financial implications of federation or alliance working, where only one third had 'good' or 'high' knowledge. Understandably there was only an appetite for training or further support in this one area.

Case study 1 overleaf was provided by one of the survey respondents and gives an example of how federation can work simply and effectively in practice.

Case study 1: Trust Primary Care and Ridge Medical Practice

The Ridge Medical Practice (RMP) has 16 GPs, with 11 GP partners and a business manager. It operates across three sites in Bradford, and is currently merging with another sole partner practice in Leeds. They historically delivered a range of enhanced services (vasectomies, minor surgery and diabetes) and some of their GPs did GPSI work for the local primary care trust. Under the Transforming Community Service programme, they expanded their enhanced services work and took on the management of the GPSI services. This work now accounts for around 20% of the partnership turnover. While there were opportunities to win more contracts, they were restricted by the implications on cover arrangements.

They federated with another 18 practices across Bradford, as Trust Primary Care (TPC). This gave access to an expanded clinical pool, with a wider range of specialism, and the critical mass to tender for more work. The federation has won a number of contracts under the Any Qualified Provider framework, one of which was to run a community dermatology service, across the Bradford and Airedale district. The service involves providing routine diagnosis and treatment of a wide variety of dermatological conditions.

TPC is a joint venture company, limited by shares, with a board of seven made up from the practices in the federation. It prepares an annual plan that sets out the planned income and expenditure, the director's remuneration, an outline of business objectives and planned service developments, and any impact on member loans. It is effectively a shared service centre for the coordination and delivery of enhanced services.

> The principle is for money to follow the activity. So 10% of any profit or loss is taken by the federation and the remainder is shared between those who delivered the work, in proportion to their consultations

The contracts are managed at federation level using a hub model (whereby one practice handles referrals and administration, four practices run the clinics, and any practice may provide a suitable clinician to deliver the service). Work is paid at tariff to the federation for the first appointment and follow-up consultations given, and they manage the resultant funds flows. An administration charge is paid to one practice for managing referrals and administering the process (equivalent to two hours per patient), others are reimbursed for the use of their premises, and the consultant doing the work receives a fee per consultation.

The principle is for money to follow the activity. So 10% of any profit or loss is taken by the federation and the remainder is shared between those who delivered the work, in proportion to their consultations.

They have found that the clinicians' ownership of the service, and confidence in its quality, has helped reduce referrals to secondary care.

The Ridge Medical Practice, with all of its TPC peers, is also involved in the Bradford Care Alliance (BCA); which is a community interest company – a social enterprise involving 64 of the district's 67 general practices. BCA already had a contract to provide a community-based GPSI service so now represents primary care, in an alliance of local providers, that will deliver diabetes care within an accountable care system. Were it to win the contract, will it sub-contract with the individual practices, or federations of practices, who might then contract with practices?

The practical reality is that emerging care models will often prefer to contract for larger blocks of work, often covering larger geographic areas. The health system needs to think carefully how it can best operate a clear and accountable model for its local provision, and avoid building a tangled map of contracts and subcontracts between alliances, federations and practices.

As general practice is stretched already, it is important that as much as possible of its spare clinical capacity goes into service delivery, rather than managing a larger administrative workload and meeting the strictures of contract performance management arrangements. This is ultimately just about paying a GP for doing the work needed to appropriate standards.

Knowledge of NHS finance

Respondents were asked to assess their understanding of the following:

- Structure of the NHS commissioning sector (for example, who commissions what services)
- The role of CCG finance
- Payment for acute services (for example, the national tariff)
- NHS contracts
- The *Five year forward views* for the NHS and general practice
- The scale of the local and national financial challenge.

Understandably there was a much lower knowledge base in these areas. The areas where most respondents felt training would be useful were: the role of CCG finance, NHS contracts, the *Five year forward view*, and the scale of the national and local challenge.

We asked respondents to highlight any other areas where they thought that NHS finance professionals could support general practice. These freetext comments echo many of the points highlighted elsewhere in this briefing, but also highlight some interesting areas to consider further:

- Tax and VAT updates
- Administration training
- The development of a single, reliable and prompt payment system
- All enhanced services under one umbrella, with a single return required
- Mandatory mergers
- The simplification of contracts
- Easier reimbursement process
- Finance e-learning.

The key theme that can be taken from the comments is simplifying and reducing administration – in contracting for enhanced services, in meeting related reporting requirements, and in how practices are paid. Clinical capacity spent on contract queries, data collection and chasing payments is time not available to patients.

Cashflow is also a concern for many, as some contracts are only paid after the work has been shown to have been delivered, either annually or quarterly, while the associated costs of delivery hit practices monthly. The risk associated with this is a deterrent to some, generally smaller, practices.

Some CCGs have recognised these issues and taken innovative measures such as:

- retrieving performance data directly via NHS Digital to avoid practices needing to complete returns
- consolidating funding for directed and local enhanced services to stabilise payment mechanisms
- paying 1/12 of 75% of the contract value on a monthly basis with a quarter or year-end adjustment to reflect performance against the relevant indicator when measured.

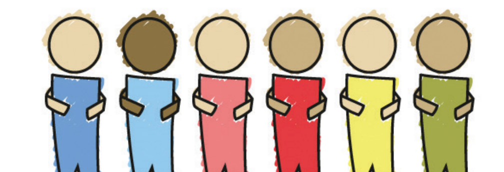
There was a clear general feeling that more knowledge, training or support might be useful but was not the real issue, as it would not address the core concerns around demand increasing faster than income. However, in specific cases, there was a recognition that more financial training was important.

Where GPs and practice managers are involved in the development of new pathways and potential innovations, they need the financial skills and robust cost information to complement the clinical appraisal, in reaching decisions. Including financial training for commonly raised queries and concerns in protected learning time was also suggested.

However, if were there to be more training or support, it would best be delivered face–to-face through either the LMC or relevant CCG. This would also seem to be the best way to take account of the diverse local contracting arrangements across the country.

GPs want a better understanding of the practicalities of increased collaboration but also see the need for changes in the how services are contracted. Incremental commissioning changes have increased the back-office burden on general practice and are a source of unnecessary frustration. They do not necessarily need more training but more targeted financial support in pathway redesign would be welcome.

So if financial training is not considered the most beneficial route, what other support would general practice value from the NHS finance community?



Relationships with CCGs

While general practice receives funding from various sources, an increasing proportion now comes directly from the local CCG, under delegated commissioning arrangements. This is expected to grow further to support delivery of the *Five year forward view*. While this allows greater flexibility in what services are provided locally by general practice, CCGs also have a performance management responsibility that can have a big impact on practices' need to collect and report performance information in accordance with contract stipulations. Finding the right balance, and incentivising the necessary changes in what care is delivered locally and how, is critical. Our research explored the strength of working arrangements with CCGs, and looked at what might improve relationships.

Current relationships

We asked respondents to rate the following aspects of the relationships between their practice and the CCG:

- Organised forums between CCG and general practice (council of representatives, practice manager meetings)
- General practice engagement in CCG decision-making
- Communications on changes to commissioned patient pathways and services
- Provision of activity and benchmarking information by practice
- CCG understanding of general practice and the associated financial challenges
- General practice understanding of CCG finances
- Ad hoc communication, for example, payment or contract queries.

Generally for all these areas, over 50% believed the relationship was 'poor' or 'could be improved'; but there were variations when the responses of GPs were compared with those in business/ practice management. The responses are shown in **Chart 4**.

The top three concerns for GPs, with over 60% believing the relationship needed improvement, were general practice engagement in CCG decision-making, CCG understanding of general practice and the associated financial challenges, and ad hoc communication, such as payment or contract queries.

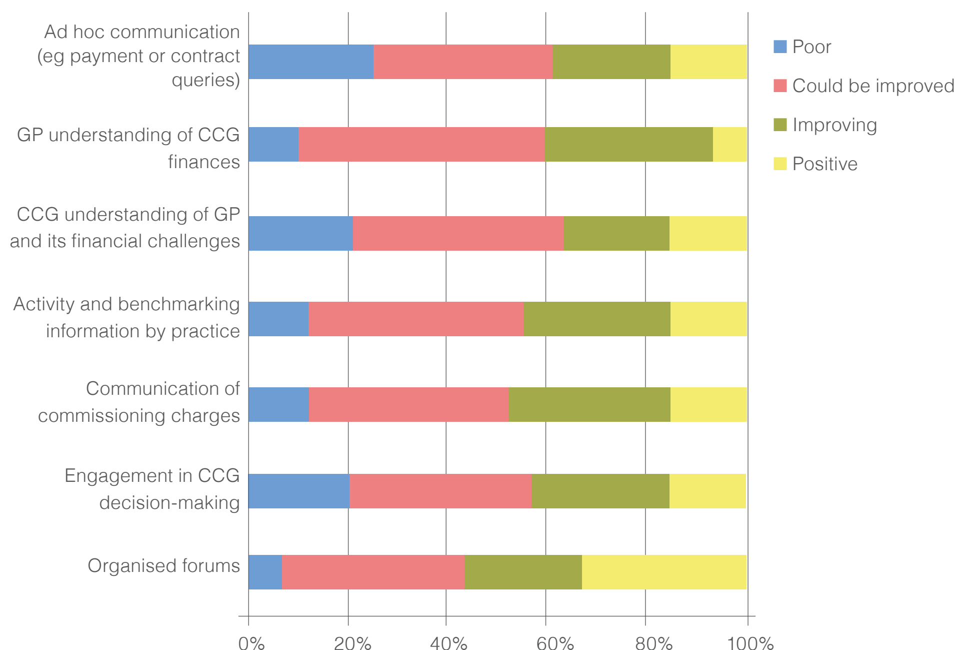
Improving relationships

The survey asked respondents whether, and by how much, they felt the following would improve their relationship with the CCG:

- Improved CCG understanding of primary care
- Improved general practice understanding of a CCG's role
- Improved formal communication (newsletters, organised forums)
- Improved informal communication (named contact for queries, informal discussion between CCG representatives and practices)
- Joint financial incentives (for example, gain share schemes)
- Co-production and/or review of practice activity and benchmarking information.

Improved formal communication was identified by respondents as the factor least likely to improve relationships with their CCG. However, it was a different story with informal communications, with over two thirds of respondents thinking that it was one of the three most profitable avenues to pursue.

Chart 4: Perceptions of relationship with CCG



Narrative comments suggest a lack of trust in CCGs' motivations because of their need to deliver efficiency savings each and every year. As such, formal communications can be seen more as political broadcasts from on high rather than evidence of local engagement and information sharing. Linked to this is a belief that the CCG model has not delivered the degree of bottom-up clinical leadership in planning and commissioning of local health services hoped for, and that general practice was still 'done unto'.

Informal communication was seen to be a good way of improving relationships as it allows a more flexible, open and honest two-way conversation. One popular option was having a named point of contact to resolve ad hoc queries by phone – but comments reflected that this only works where that person is able to offer practical and timely help. There was a recognition that CCGs may not have enough staff who are knowledgeable about the assorted regulations or have access to the necessary background information, which can lead to long delays as issues – sometimes unnecessarily – are referred on to NHS England. The most practical route to improving informal communications was considered to be via the locality commissioning managers, who have a more detailed understanding of the differences between local practices.

The top area identified was improved CCG understanding of primary care, with 80% believing it would lead to 'some' or 'significant' improvement in relationships. Respondents said CCG staff may benefit from shadowing practice managers to appreciate the broad spectrum of responsibilities they typically have.

About two thirds of respondents believed that having joint financial incentives was a good way to improve relationships. While there are legal and governance issues with such schemes that need careful consideration, aligning financial incentives helps build trust and ensures the impact of decisions on practice finances is fully understood. Gain share arrangements were also seen as a critical driver for innovation. However, respondents believed that CCGs, individually and collectively, could do more to share innovation.

Case study 2 is a good example of how an incentive scheme can work for both commissioners and providers.

As respondents work in very different practices, with different CCGs, views on how to improve relationships may not reflect local circumstances everywhere but do serve as useful areas for honest reflection and discussion.

Relationships between general practice and CCGs vary, nationally and locally, and need to improve given the challenges of delivering the *Forward view*. Many GPs do not feel more empowered as a result of the CCG model and are sceptical that commissioning changes are being driven by financial rather than service improvement objectives. They would value a better quality of contact and communication from CCGs, and more support and collaboration than performance management.

As CCGs have an increasing role in commissioning services from general practice, what other support might practices like by way of information?

Case study 2: Incentive scheme used by NHS Vale of York CCG

The CCG wanted to work with its local GPs to reduce acute referrals and develop a gain/share scheme with clinicians that would align incentives. Dermatology was selected as it is a specialty where most activity was generated by GP referral to outpatient services. They recognised that a key to the scheme's success would be how they managed the variability across different practices and that a reduction at one practice was not offset by increases at another. This was additionally complicated because some practices had already made significant progress in reducing referrals, while others still had easy wins to make.

The solution they identified was to set indicative budgets at alliance level, rather than for individual practices, by undertaking a bespoke modelling exercise that identified weighted populations based on dermatology spend across the CCG area and demographic. To address historic dermatology service development work and ensure the incentive worked for all, two trigger points were identified: the average spend per weighted head across the CCG and the benchmark, which was based on the lowest alliance's average spend. Alliances would retain 25% of savings above the CCG average, 50% between the average and the benchmark, and 75% below the benchmark.

Most alliances have elected to commit all dermatology referrals to the Referral Support Service (RSS) with a photograph, to allow a second opinion and help identify cases that could be successfully managed in primary care. This was supported by a local charity, York Against Cancer, who funded the purchase of dermatoscopes across Vale of York practices. GP engagement has improved due to the design of the incentive scheme, and as the RSS protocols and guidelines were co-produced by acute and primary care clinicians, there is confidence about quality. The scheme has resulted in a £121,000 saving in 2016/17, with £38,000 of this paid to practices through the gain share arrangement for reinvestment in primary care dermatology services.

The CCG have approached the dermatology scheme as a 'proof of concept' and are now working on rolling out the indicative budget and gain share scheme to prescribing. The savings are potentially much larger in this area with a CCG prescribing budget of around £50m, compared to the dermatology outpatient budget of around £2m.

Using information

General practice, especially in a primary care led NHS, needs relevant and timely data to manage its business effectively. Similar information is needed by commissioners to performance manage quality, and by regulators to inform inspection. This needs to be more sophisticated consideration than merely focusing on outliers. We set out to understand what types of information practices currently receive and what they would find useful.

Information currently received

Respondents were asked to confirm whether they received any or all of the following key data sets for their practice:

- Unplanned care activity and spend
- Planned care activity and spend
- Direct Access diagnostics activity and spend
- Referrals to acute care
- Spend on medications
- Benchmarking against other local practices
- Benchmarking against national data.

The results were varied, and surprising (**Chart 5**). While the vast majority receive information about spend on medication, only 27% of practices receive information on direct access diagnostics. Over one third of practices say they receive no information on unplanned care, and almost half receive no information on planned care; as the principal gateway to secondary care, this is worrying.

The freetext responses to this question however perhaps flagged the fundamental issues that undermine the value and importance given to data in many practices. A general message was that information was not generally available in a clear and readily usable format, but there were also concerns about the accuracy and timeliness of data. Several respondents referred to software tools either being too complex or time-consuming to use.

Another point raised by respondents was that the functionality of information depends on it having patient and diagnosis detail. Data received from CCGs is much harder to use as it is not patient-identifiable, and assorted data sets cannot be readily linked.

What information would be useful?

Respondents were asked whether they would, or do, find the above datasets useful. There was a marked difference between the replies of GPs and practice/ business managers, with more of the latter believing the data would be either 'largely' or 'extremely' useful.

Chart 6 shows GP responses. Two thirds felt data on medication spend and benchmarking against other local practices and against national data would be either 'largely' or 'extremely' useful. **Chart 7** shows the responses of practice/ business managers, who on average were 10% more positive about the usefulness of data.

Chart 5: Information received by practices from CCGs

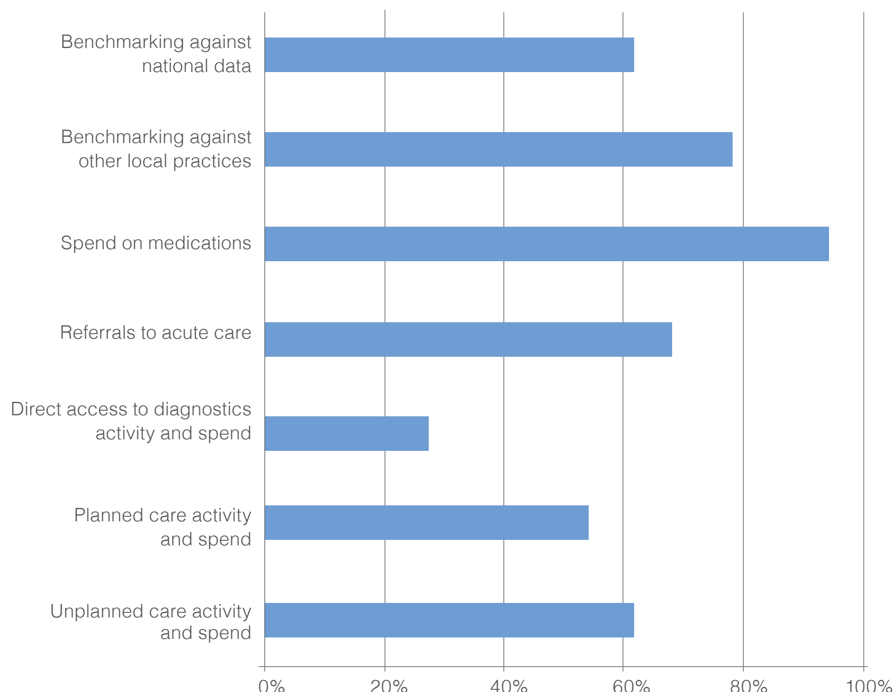


Chart 6: GP data preferences

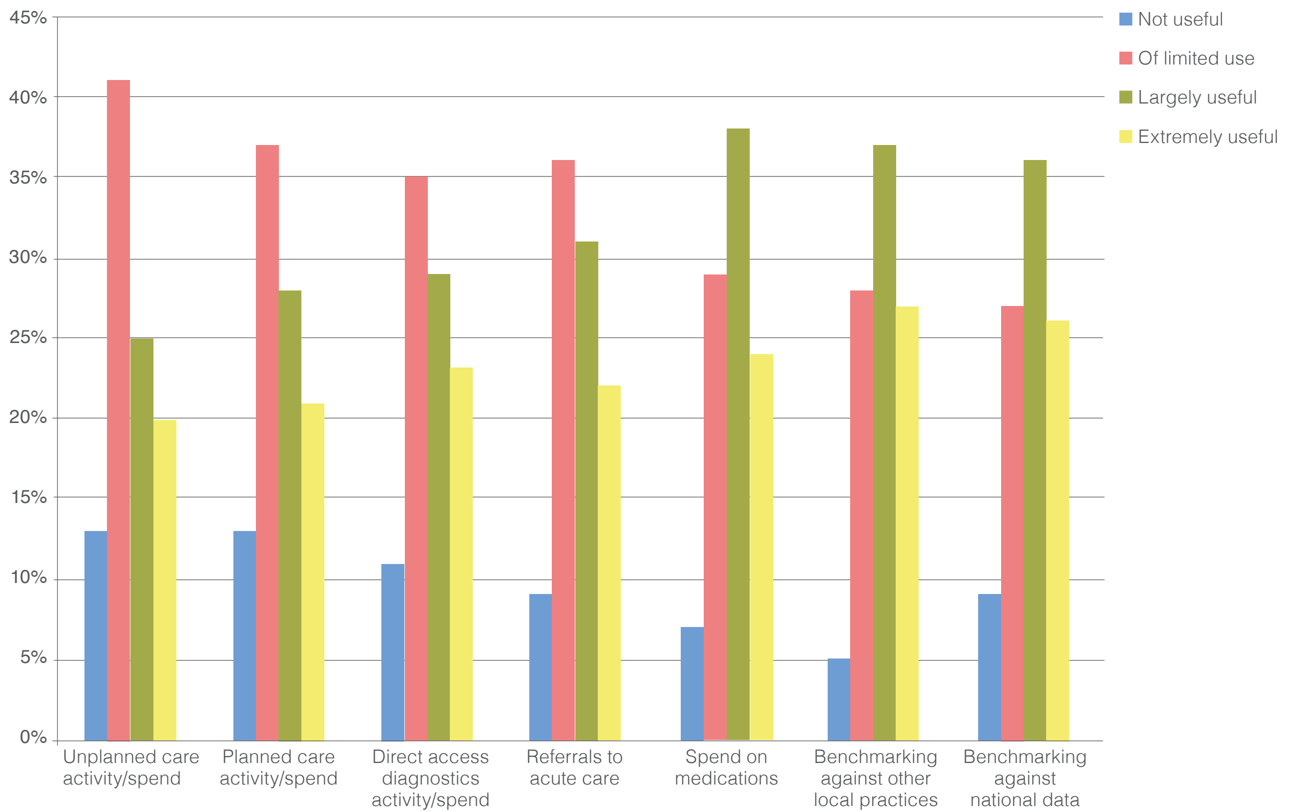
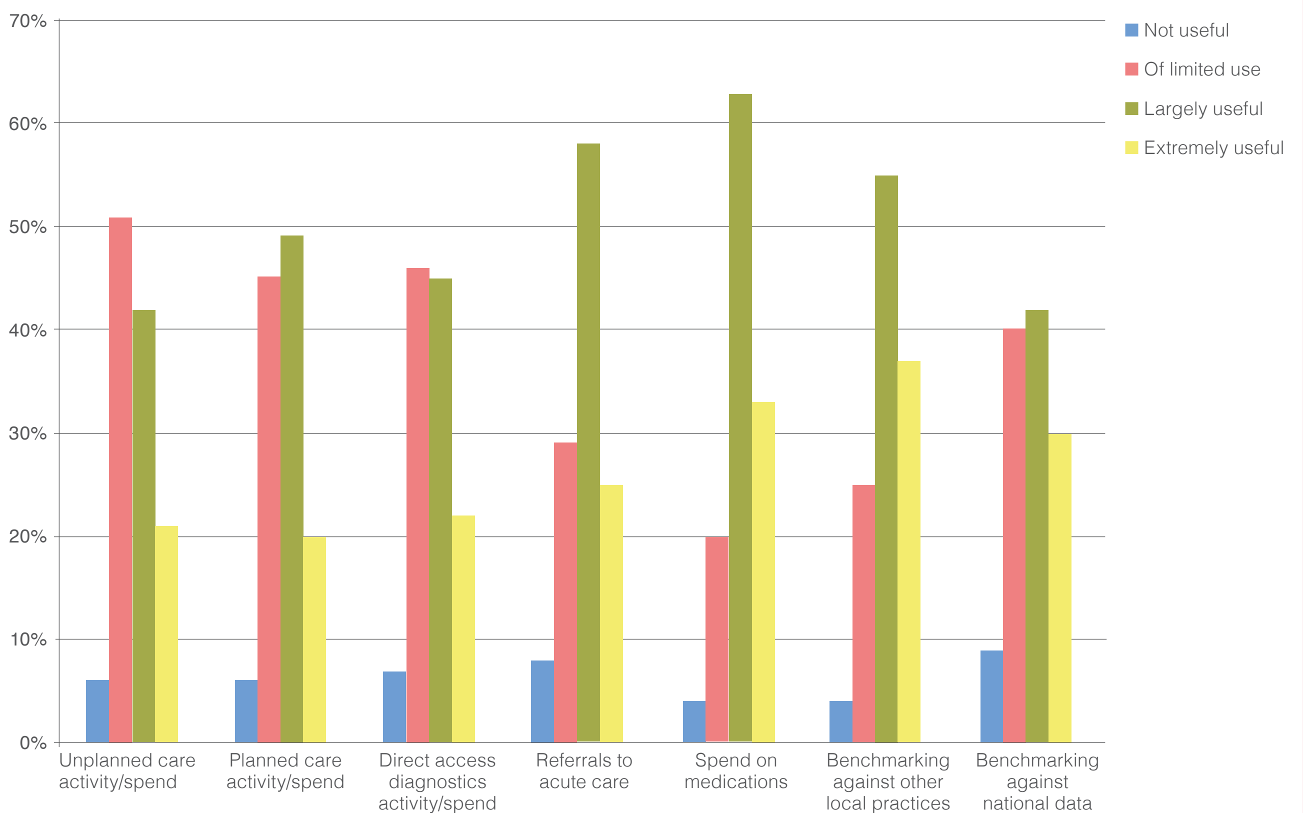


Chart 7: Business practice manager preferences



> Two particular matters were consistently raised as issues: the performance of the Calculating Quality Reporting Service and the performance of the Primary Care Support England. It was also suggested that it would be helpful for CCGs to explain why information is being requested and what will be done with it

However, they were less interested in national benchmarking and more so in acute referrals.

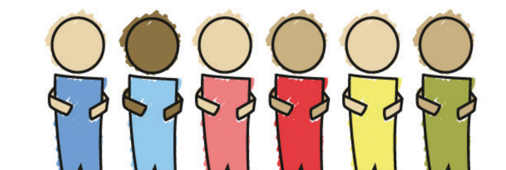
As for previous questions, the freetext comments provide useful and important context to these replies. Analysing and interpreting data, then translating it into actionable intelligence takes time. Many practices do not feel they have the capacity or see the benefit from the associated investment of time, but others believe there is a need to reduce variability between practices and can see there are wider system benefits from a joined up longer-term strategic approach to service improvement.

Suggestions for improvement were diverse. Some remarked on the potential of the locality commissioning manager to work with practice managers to explore variations in performance and to demonstrate how others are using information effectively. Some felt that CCGs should decide what was important and provide specific data to help tackle particular issues rather than sending out general summaries. Others felt that the development of a primary care dashboard was the solution.

Two particular matters were consistently raised as issues: the performance of the Calculating Quality Reporting Service (CQRS) and the performance of the Primary Care Support England (PCSE).

It was also suggested that it would be helpful for CCGs to explain why information is being requested and what will be done with it.

GPs often do not have the time, and in many cases the tools, to interpret data and to use it to drive business planning and performance improvement. They need timely and accurate patient identifiable data and support in its interpretation, perhaps via a meaningful practice referral dashboard with drill-down functionality.



Conclusion and recommendations

General practice is facing unprecedented pressures and, with GPs managing heavier and more complex workloads, uncertainty about a sustainable future in a rapidly changing landscape is understandable. Demand and costs are outstripping income and the ability to recruit the additional staff needed, and the increasing back-office demands are considered onerous and unhelpful. In such a stretched environment general practice needs guidance and support to manage the status quo, let alone deliver the increasing expectations set out in *Next steps on the NHS five year forward view*. Our research shows that organisational development, the design of new pathways, and expanding GPSI services are areas that many GPs have little experience of, or appetite for in the current climate.

NHS England, CCGs and LMCs have a vital role in facilitating change and ensuring that general practice has the capacity, knowledge and tools to ensure decisions about service change and expansion are soundly based. The priority given to transferring work from secondary to primary care settings and introducing new models of care, is adding additional risk to an already stretched general practice. There are urgent issues that need to be addressed and these will only be exacerbated should the pace of change continue to outstrip the sector's preparedness. Reducing the administrative burden, improving relationships and partnership working (with commissioners and providers), and providing the right professional support and guidance to inform decision-making are key factors to be addressed as the NHS moves ahead with the *General practice forward view*.

The following recommendations pick up key issues identified by survey respondents and should be considered by commissioners and support organisations.

Helping general practice move into the future

With many practices expected to ally or federate with others over the next few years, CCGs have an important role in facilitating this journey. While many already do excellent work in this area, we recommend:

- CCGs undertake detailed capacity planning for work transferring to primary care and implement governance processes to ensure training and recruitment needs are properly addressed in advance
- CCGs and/or LMCs proactively engage in discussions with single practices to address their concerns and support them with the strategic planning needed to join with others
- CCGs consider providing non-recurrent funding, and professional advice, to support the development of federations and alliances
- CCGs work with federations and alliances to find the most efficient ways of releasing back-office savings
- Before tendering contracts, commissioners work with federations and alliances to help them make informed decisions about bidding for additional work and to minimise the need for subcontracting to individual practices.

Financial knowledge and support needs

We recommend:

- Organisations contracting with general practice recognise the commercial realities of general practice and ensure payment for additional services is simplified and aligned to the underlying cost profile of their delivery
- Commissioners consider how performance information can be collected centrally from existing data sources to minimise the burden on general practice
- CCGs provide support and appropriate costing information to ensure decisions on new pathways are financially robust.

Strengthening CCG relationships

We recommend:

- CCG primary care teams review staff knowledge of primary care contracts and finances and, where necessary, arrange additional training
- CCGs identify a named point of contact for each practice to resolve ad hoc queries and concerns, referring matters on to NHS England only when absolutely necessary
- Locality meetings have jointly pre-agreed agendas, covering strategic and operational matters, to ensure the right attendees
- CCGs work with general practice to develop mutually beneficial gain share arrangements where possible
- CCG primary care teams spend time with practices to understand their specific concerns better.

Using information better

We recommend:

- CCGs work with practices to interpret data and provide a summary dashboard of information relevant to the management of a practice
- NHS England to urgently look to resolve the performance issues with CQRS and PCSE.

Finally, survey respondents noted that the survey is a situational analysis and it was suggested that a similar exercise be conducted at a later date, with a roundtable event to assess the results, gauge progress and identify changing support needs.

About Future-Focused Finance

In February 2014, the six heads of the finance profession in the NHS came together to form the Finance Leadership Council and to initiate Future-Focused Finance. Future-Focused Finance is about 'Making People Count' by ensuring that everyone connected with NHS finance has access to the relevant skills, methods and opportunities to influence decision making in support of the provision of high-quality patient services. It offers a vision for NHS finance to aspire to. That includes everyone who works in finance, in every role at every level, those we work with to deliver services and the patients and communities that use and support those services.

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The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For more than 60 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has a particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

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About the NAPC

The National Association of Primary Care (NAPC) is a leading membership organisation representing the interests of primary care professionals, including general practitioners, nurses, practice staff, pharmacists, opticians and dentists. It is at the centre of shaping the future of healthcare, spreading innovation, influencing policy, supporting and connecting professionals across primary care – enabling them to provide world-class sustainable patient-centred healthcare.

HFMA

1 Temple Way, Bristol BS2 0BU

T 0117 929 4789
F 0117 929 4844
E info@hfma.org.uk

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