6th November 2014

Dear Colleague

Since I last wrote to you, NHS England has published its *Five Year Forward View* – its first major policy report since Simon Stevens became chief executive in April. The strategy is far-reaching and enters uncharted waters for the NHS, including proposals for radical new models of care, which would have significant implications for GPs and practices. The BMA GPs committee is giving this report full consideration. Meanwhile I'd like to outline some of its key components.

The report begins with a strong emphasis on prevention and public health, drawing on Sir Derek Wanless's report of 12 years ago. In an NHS where demand is relentlessly outstripping capacity, we clearly need to think of every imaginable way of improving health and preventing illness. Crucially, this must include considering the wider social determinants of health. There is a section on 'empowering patients', which should, I believe, place greater emphasis on patient self-care and management. This would in turn help manage demand on general practice.

The report also reiterates the projected funding shortfall in the NHS of £30bn by 2020/21. The solutions proposed rely on creating annual 'efficiency savings' of 2-3 per cent, but it is a punishing and unfair expectation on the NHS to deliver more year on year for the same resource. This concept has dogged annual GP contract negotiations, throughout which we have resolutely rejected the notion of such 'efficiencies', given that GPs are already manifestly working harder to deliver more care with shrinking resources.

The report also mentions increasing funding for the NHS 'as the economy allows'. However, regardless of the economy, there is no escaping the fact that the NHS needs a major increase in investment, or that the UK is trailing European averages in terms of the proportion of GDP spent on health.

What will this mean for you?

It is positive that NHS England has listened to proposals that the GPC has put forward over the past year, including our Your GP cares campaign.

There is finally recognition that we are underfunded and have an inadequate numbers of GPs:

'NHS England acknowledges the strain general practice is under, noting that recruitment is not keeping pace with demand and that this is the result of the relative under-resourcing of general practice.'

There is also a commitment to 'a shift in investment from acute to primary and community services' and to an expansion of the GP workforce: 'The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.'

The 'new deal' proposed for general practice is much needed, as is a pledge to invest more in primary care over the next five years. However 'stabilising core funding' for two years is not enough – we need resources immediately just to cope with the current workload. The GPC has already told the government and NHS England what urgent, short-term measures they need to put in place.

What ultimately counts is whether these aspirational words are translated into a reality of more GPs, an expanded infrastructure – including premises, staff and wider primary care teams – and a manageable workload that allows GPs to return to their core purpose and start enjoying their work again.

New models of care

Everything I've mentioned so far must be seen in the context of proposed radical options for 'new models of care', which could dramatically alter the way general practice will operate in the future. Importantly, NHS England has committed to list-based general practice as the bedrock of the NHS. It is vital that any new models preserve the values and ethos of general practice, and we will work to ensure that these principles are at the heart of any changes.

One new option is the MCP (multispecialty community provider), which 'will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care'. These providers would be able to employ hospital consultants, and have admitting rights to hospital beds, or run community hospitals. The potential scale of this is clear: the 'majority' of outpatient consultations and ambulatory care would shift out of hospitals.

A second option would be integrated PACS (primary and acute care systems), which are described as 'combining for the first time general practice and hospital services, similar to the accountable care organisations now developing in other countries too'.

Better integration is also proposed between emergency departments, GP out-of-hours services, urgent care centres, NHS 111 and ambulance services – something the GPC has been calling for since the botched introduction of NHS 111 last year.

We must protect a global success story

While major policy documents have come and gone over the years, these proposals go much further and must be taken very seriously since they totally redefine the provider landscape. In some cases this could end the historic divide between primary and secondary care. The models raise hugely important questions: how would the current GP contractor status operate? Would this lead to local contracts, or to GPs being salaried within larger providers? Would general practice be subsumed in a hospital-led service in some models?

The GPC will be carefully considering the implications of this report in our meeting this month, and we will produce our response soon after. We have also already invited Mr Stevens to speak at the LMC (local medical committee) secretaries' conference in December.

It is vital that we learn from the past and avoid hasty or imposed change, which is inevitably disruptive. Equally, we must protect and preserve a model of general practice that has stood the test of time with unparalleled success and is admired globally. As ever, the GPC is committed to influencing NHS England to ensure that any new proposals are in the best interests of GPs, practices and patients.

With best wishes,

Chaand Nagpaul
Chair, BMA GPs committee