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Delivery plan for recovering access to primary care

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Our commitment is to tackle the 8am rush and make it easier and quicker for patients to get the help they need from primary care. We will:

Empower patients by rolling out tools they can use to manage their own health, and invest up to £645 million over two years to expand services offered by community pharmacy.

1. Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024.
2. Ensure integrated care boards (ICBs) expand self-referral pathways by September 2023, as set out in the [2023/24 Operational Planning Guidance \(https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/\)](https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/).
3. Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients, subject to consultation.
4. Launch Pharmacy First so that by end of 2023 community pharmacies can supply prescription-only medicines for seven common conditions. This, together with OC and BP expansion, could save 10 million appointments in general practice a year once scaled, subject to consultation.

Implement 'Modern General Practice Access' so patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message. We are re-targeting £240 million – for a practice still on analogue phones this could mean ~£60,000 of support over 2 years.

5. Support all practices on analogue lines to move to digital telephony, including call back functionality, if they sign up by July 2023.
6. Provide all practices with the digital tools and care navigation training for Modern General Practice Access and fund transition cover for those that commit to adopt this approach before March 2025.
7. Deliver training and transformation support to all practices from May 2023 through a new National General Practice Improvement Programme.

Build capacity so practices can offer more appointments from more staff than ever before.

8. Make available an extra £385 million in 2023/24 to employ 26,000 more direct patient care staff and deliver 50 million more appointments by March 2024 (compared to 2019).
9. Further expand GP specialty training – and make it easier for newly trained GPs who require a visa to remain in England.
10. Encourage experienced GPs to stay in practice through the pension reforms announced in the Budget and create simpler routes back to practice for the recently retired.
11. Change local authority planning guidance this year to raise the priority of primary care facilities when considering how funds from new housing developments are allocated.

Cut bureaucracy to give practice teams more time to focus on their patients' clinical needs.

[Privacy - Terms](#)

12. Reduce time spent liaising with hospitals – by requiring ICBs to report progress on improving the interface with primary care, especially the four areas we highlight from the Academy of Medical Royal Colleges report, in a public board update this autumn.
13. Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat.
14. Streamline the Investment and Impact Fund (IIF) from 36 to five indicators – retarget £246 million – and protect 25% of Quality and Outcomes Framework (QOF) clinical indicators.

Summary

Primary care is one of the most dynamic and innovative parts of the health service. We saw this in the rapid and comprehensive rollout of the NHS COVID-19 vaccination programme.

General practice is delivering more than a million appointments every day and half a million more every week than pre-pandemic.^[1] This has been possible because of the hard work of staff and through significant investment since 2019, which has grown the general practice workforce by 27% to meet rising demand and the needs of an ageing population. The number of people in England aged 70 or over is up around a third on 2010, from 6.1 million to 8.1 million, and this group has on average five times more GP appointments than young people.^[2]

However, the pandemic has changed the landscape, and the increase in practice capacity needs to keep pace with growing demand. Primary care, like many parts of the NHS and health systems globally,^[3] is under tremendous pressure – one in five people report they did not get through or get a reply when they last attempted to contact their practice.^[4] The Fuller Stocktake stated, “there are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it”.

The Fuller Stocktake (<https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/>) built a broad consensus on the vision for integrating primary care with three essential elements: streamlining access to care and advice; providing more proactive, personalised care from a multidisciplinary team of professionals; and helping people stay well for longer. This remains our intent.

But before we can fully implement the wider reforms necessary to achieve this vision, we need to take the pressure off general practice and tackle the 8am rush. Although this plan supports all three elements of the Fuller Stocktake vision, it makes no excuses for focusing on the first.

This plan has two central ambitions:

1. To tackle the 8am rush and reduce the number of people struggling to contact their practice. Patients should no longer be asked to call back another day to book an appointment, and we will invest in general practice to enable this.

2. For patients to know on the day they contact their practice how their request will be managed.

1. If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.
2. If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.
3. Where appropriate, patients will be signposted to self-care or other local services (eg community pharmacy or self-referral services).

The first part of this plan describes how we will empower people by investing in tools they can use to stay healthy and manage their care without needing to see their GP. This includes funding technology so practices can monitor long-term conditions from readings patients take in their own homes; enabling patients to self-refer to specialists for certain conditions; and rolling out existing NHS App functionality to 90% of practices by March 2024.

NHS England and the Department of Health and Social Care (DHSC) will expand the role of community pharmacy by supporting seven further common conditions through delivering Pharmacy First and expanding pharmacy oral contraception and blood pressure services. DHSC will consult the sector on this proposed expanded role, which we estimate could alleviate pressure by saving up to 10 million appointments a year, once scaled up, equivalent to around 3% of all appointments, and give the public more choice in where and how they access care.

NHS England will lead the implementation of a modern approach to general practice that makes it easier for patients to contact their practices by phone or online and supports practices to rapidly assess the nature and urgency of requests by involving the whole practice team. This dynamic approach builds on what hundreds of innovative practices are already doing to improve access and patient experience. We have spoken to and received feedback from these practices, and they say such changes have been a ‘game-changer.’ We call it ‘Modern General Practice Access’.

This approach is a major change to how many practices have traditionally worked. Patients may be asked to provide more information about their issue when they make a request, but in return the practice team can better assess their need and tell them on the day how their request will be handled, based on clinical need and respecting their preference for a call, face-to-face appointment or online message.

Patients will always be able to choose to contact their practice by telephone, in person, or online, and should be asked how they prefer to get a response.^[5] But practices that have implemented this new approach say most patients find it more convenient to go online to make a request and are often happy to get a response the same way. These practices find that far fewer patients request face-to-face appointments, and even though for clinical reasons more face-to-face appointments are delivered than requested, the number is well below the national average for all appointment types.^[6] It also means many requests can be dealt with without an appointment, which can be quicker for patients and practices, and means those patients who need an appointment get one sooner.

When more people go online, this frees up the phones for those who prefer to call and spreads work across the day. To further improve the experience for those who do prefer to call we will invest in high-quality digital phone systems so calls are not met by an engaged tone. Implementing this approach takes planning, resources, training and leadership, and this plan addresses each of these. We will invest in care navigation training to help teams direct patients to the right person. Effective care navigation could direct over 15% of patients to teams that could better help them: administrative teams, self-care, community pharmacy or another local service.^[7] Other patients can be directed to the most appropriate practice staff member for assessment and response, without first being seen by a GP. We will also fund the digital tools that make it easier for practices to receive, navigate, assess and respond to requests in this way.

We can also do more to build capacity, reduce workload and cut bureaucracy. We will deliver on the commitment of 26,000 more direct patient care staff and 50 million more appointments in general practice by March 2024. The NHS Long Term Workforce Plan, which will be published shortly, will set out our plans to expand GP training and ensure the NHS can recruit and retain the GP workforce it needs in the future, alongside an expanded and empowered wider primary care team. The Chancellor has also announced significant pension changes to encourage experienced GPs to remain in practice.^[8]

Published alongside this plan is a [report from the Academy of Medical Royal Colleges \(AoMRC\)](https://www.aomrc.org.uk/reports-guidance/general-practice-and-secondary-care-working-better-together/) (<https://www.aomrc.org.uk/reports-guidance/general-practice-and-secondary-care-working-better-together/>), on how bureaucracy and workload can be cut by improving the interface between primary and secondary care. NHS England will ask integrated care boards (ICBs) to report on their progress at their public boards in October or November 2023.

DHSC will also cut unnecessary burdens on GPs through the Bureaucracy Busting Concordat, which is increasing self-certification to cut requests to GPs to provide medical evidence. For 2023/24 we are streamlining the Investment and Impact Fund (IIF) from 36 to five indicators. We will also consult on the future of the Quality and Outcomes Framework (QOF) this summer.

This plan seeks to support recovery by focusing this year on four areas:

1. **Empower patients** to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice.
2. **Implement Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.
3. **Build capacity** to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.
4. **Cut bureaucracy** and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

To support this plan, NHS England and DHSC have retargeted over £1 billion and committed to:

1. Retarget over £240 million of funding in 2023/24 for new technologies and support offers for primary care networks (PCNs) and practices that help them plan and implement Modern General Practice Access, including online tools, digital telephony, care navigation training and transformation support.
2. Invest up to £645 million over the next two years to expand community pharmacy services, subject to consultation.
3. Redirect £246 million of the streamlined IIF towards improving access; 70% will be given to PCNs unconditionally to support driving change (~£11,500 per month for the average PCN), with the remaining 30% awarded by ICBs conditional on PCNs achieving agreed improvement in access and patient experience.
4. Delivering on our commitment to make a further £385 million available in 2023/24 to reach the existing target of 26,000 more direct patient care staff and 50 million more appointments in general practice by March 2024.^[9]
5. Continue to allocate System Development Funding (SDF) to ICBs, which for 2023/24 totals ~£170 million. NHS England expects systems to use a large part of this to support primary care transformation.
6. Given the scale of proposed change, NHS England will launch a major communications campaign to explain the evolving nature of primary care to the public and how they can best use the NHS.



For a practice on analogue telephony that implements Modern General Practice Access, this plan provides an average of ~£60,000 to support the move to digital telephony, digital tools, and transition support over the next two years. This is in addition to training and transformation offers from NHS England, and the IIF and Additional Roles Reimbursement Scheme (ARRS) funding outlined above.

Delivery will require national and regional teams to work flexibly with ICBs, while reinforcing their accountability as commissioners of primary care. NHS England wants ICBs to lead the change that is right for their system. We will measure progress from ICB public board reporting and offer support to any ICBs that are falling behind.

This plan represents the first steps towards the vision described in the Fuller Stocktake; it is not the whole implementation path. So, we will also engage widely in 2023/24 on the contract and programme changes needed to deliver the longer-term vision of more streamlined access, more proactive and personalised care, a more joined-up approach to prevention, and again making primary care an attractive place to work for all staff.

NHS England has engaged with a wide range of stakeholders to develop this plan – thank you to everyone who has contributed.

Why we need a plan to recover access to primary care

Pressures in primary care

The NHS is focused on recovering core services from the significant and ongoing impact of the pandemic, and this plan sits alongside our delivery plans for recovery of elective^[10] and urgent and emergency care services.^[11]

General practice is one part of primary care, the others being community pharmacy, optometry and dentistry,^[12] which together support more patients every working day than any other single part of the health system. General practice, comprised of 6,500 individual practices, delivers over 330 million appointments a year (excluding those for Covid vaccinations). It delivers, from cradle to grave, across the spectrum of prevention, urgent, and long-term condition care for millions of people. Our last annual survey showed the public's satisfaction with the care provided remains extremely high; for example, scores for 'were your needs met in your last appointment?' were over 90% nationally.

Like many parts of the NHS, general practice is under intense pressure. Where demand is greater than capacity it means general practice cannot always be effective, and patient experience and access are negatively impacted. It also means that stresses appear in other parts of the health system as patients seek alternative routes to get NHS care.

One key driver of growth in demand is the ageing population. Most of those over 70 live with one or more long-term condition and have five times more GP appointments on average than teenagers.^[13]

In 2019 the NHS Long Term Plan^[14] recognised this growing pressure, the benefits of moving more care closer to home and the value of more preventative and proactive care. It outlined three changes for general practice: increased funding; a major expansion of staff roles; and the development of primary care networks (PCNs) as a way practices can work together for their communities.

Government prioritised health and social care in the [Autumn Statement](https://www.gov.uk/government/publications/autumn-statement-2022-documents/autumn-statement-2022-html) (<https://www.gov.uk/government/publications/autumn-statement-2022-documents/autumn-statement-2022-html>) by announcing a funding increase of £14.1 billion over two years. Core entitlements for general practices and PCNs will be a record £11.5 billion in 2023/24, an increase of ~£700 million over 2022/23 and 38% (£3.2 billion) higher than in 2018/19.^[15] Additional funding in previous years amounted to more than £3 billion.^[16] Practice funding continues to be allocated according to need, with consideration of patient demographics, deprivation and rurality.

Overall general practice staffing is 27% higher and the number of staff delivering direct patient care is 44% higher than March 2019.

Separately, community pharmacies receive ~£2.6 billion per year^[17] through the [Community Pharmacy Contractual Framework: 2019 to 2024](https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacy-contractual-framework/) (<https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacy-contractual-framework/>), and we have expanded the services they offer as another step to strengthen the overall primary care offer.

The pandemic has changed the nature of demand. Patient contacts with general practices are estimated to have grown faster than demographic pressures, at between 20% and 40% since pre-pandemic,^[18] in part as COVID-19 backlogs have increased workload. Local practice surveys tell us administrative tasks outside a consultation, measured by entries to medical records, are up 50% since 2019.^[19] Practices tell us they have never been as busy.

Over the same period, growth in the number of GPs has lagged behind that of total practice staff employed. Although government has increased GP specialty training numbers from 2,671 in 2014 to over 4,000 today, and increased medical school places by 25% (from 2018), training fully qualified GPs takes time. Importantly, the pressure in general practice is felt strongly by these experienced GPs, who today are managing larger practices, with more patients, and supervising more doctors in GP training, more practice staff, and more clinical roles, yet remain critical to assessing the on-the-day urgent

clinical need. While there is significant variation, we estimate induction, training and clinical supervision of the expanding practice team can take 10% to 20% of GP time.^[20] In May 2023, NHS England will publish guidance for PCNs and practices on different models of supervision for roles new to general practice.

The problem for patients and practices

As demand rises, many practices are struggling to meet all the needs of their patients. Overall patient satisfaction with practices fell 10% in 2022, with falls in 99% of PCNs and over 85% of practices.^[21]

This appears to be related to a drop in scores for 'experience of making an appointment', which strongly correlates with the 'ease of getting through'. Variation between practices is a large part of the problem: only 1% of those who said it is 'very easy to get through to their practice' rate their practice overall as poor, whereas 43% give a poor rating when they say it is 'not at all easy to get through'. Difficulties with access were also highlighted in a recent survey where one in five of the public said they either did not get through or get a reply when they last tried to contact their practice.^[22] Good access is central to general practice being effective at meeting the reasonable needs of patients.

As demand rises, the number of calls is challenging for reception staff. For those practices still on analogue lines, patients find repeated engaged tones frustrating. Retaining staff in this environment can be difficult.

In the model described in this plan, the receptionist role expands. Receptionists become more skilled and empowered as care navigators who gather patient information to match patients to the right member of an increasingly multidisciplinary practice team.

While many practices have implemented this new model, others feel it is out of reach because they lack the time and bandwidth to change practice workflows. We recognise this and the need for PCNs and practices to carefully plan change and we are offering them a broad range of support.

What we will deliver for patients, the public and staff

We need a sustained focus on the four areas described in this plan to deliver our central ambitions:

- empowering patients
- implementing Modern General Practice Access
- building capacity
- cutting bureaucracy.

This plan also describes accountability for delivery, transformation support, and how we will ensure choice and equity of access. It outlines the actions for ICBs, PCNs and practices, and how to make the most of the funding and support offers to reduce unwarranted variation in patient experience.

This plan focuses on access to make it easier for the public to contact practices when they are open and get a timely response. The 2023/24 contract requires practices to assess patient requests on the day – they should not normally be asking patients to call NHS 111 when the practice is open.^[23] As this plan delivers, we expect it to relieve pressures on 111 during the day.

We have also invested in enhanced access through PCNs. Since 1 October 2022, a PCN must provide network appointments between the hours of 6.30pm and 8pm Mondays to Fridays, and between 9am and 5pm on Saturdays. In 2023/24, ~£470 million is available for PCNs to deliver this.

NHS England will continue to explore how to better integrate out-of-hours and urgent care services and, as set out in the delivery plan for recovering urgent and emergency care services, is undertaking an extensive review of 111 services. This will consider the impact of delivering this plan, as well as the actions needed to create the single integrated urgent care system described in the Fuller Stocktake. In the meantime, when practices are closed, the public should call 111.

Empowering patients

Increasingly sophisticated technology continues to change many aspects of our daily lives. Technology can empower us with information to make decisions, make processes more efficient, give staff more flexibility and reduce costs.

To help the public do more for themselves, we want to make information and easy-to-use tools available by:

1. improving information and NHS App functionality
2. increasing self-directed care where clinically appropriate
3. expanding community pharmacy services.



A. Improving information and NHS App functionality

Ambition

We want the public to have access to health information they can trust, find local services, and use the NHS App where this is their preference to see their medical records, order repeat prescriptions, manage routine appointments with their practice or local hospital and see messages from their practice.

The NHS App ambitions are already a reality for people registered with around 20% of practices, so this plan focuses on how to increase that to over 90% by March 2024.

How we will deliver

Information

The NHS.uk (<http://www.NHS.uk>) website receives around 75 million visits a month,^[24] the highest for any UK health website. It is continually updated and refreshed: in 2023/24 NHS England will expand information on local services and women's health and refresh content to support new parents. It will also improve the heart age and blood pressure monitoring tools.

NHS App

The NHS App has over 15 million log-ins a month, and over 31 million people have signed up. NHS England is working to give more of the public access to four existing functions: (i) to view their prospective clinical records (including test results); (ii) order repeat prescriptions; (iii) see messages from their practices as an alternative to text messaging; and (iv) manage routine appointments.

Over 20%^[25] of practices offer patients the ability to see their prospective clinical records online and over 99% of practices offer patients the ability to order repeat prescriptions online, with 22 million prescriptions ordered through the NHS App in 2022 (see Solihull case study).^[26] Over 3,800 (58%) practices have enabled secure messaging through the NHS App and nearly 2 million messages have now been sent. Over 90% of practices have enabled patients to book and manage appointments, such as vaccination clinics, online, with over 250,000 managed in the NHS App each month.^[27]

The 2023/24 contract asks all practices to enable prospective record access for patients by November 2023. This will allow patients to see prospective entries in their medical records such as immunisations, test results and consultations in their NHS App. NHS England published [directly bookable appointments guidance](https://www.england.nhs.uk/long-read/directly-bookable-appointments-guidance-for-practices/) (<https://www.england.nhs.uk/long-read/directly-bookable-appointments-guidance-for-practices/>) and practices should make online booking of routine appointments available, such as for smear tests, B12 injections or vaccination clinics.

Case study – promoting NHS App functionality

Solihull Healthcare Partnership PCN has promoted the use of the NHS App's repeat prescription functionality. Previously it regularly received phone calls from patients wanting to order their repeat medications, ask to change pharmacy nominations and/or check if the GP had signed their prescriptions and sent them to the pharmacy.

The app is helping to ease the pressure on primary care services in the area. Over 31,000 of 56,000 patients are registered to use it and 650 to 700 repeat prescriptions a week are made through the app.

Patients appreciate they can also change their nominated pharmacy using the app, ensuring they can pick up their prescription from a pharmacy of their choice.

B. Increasing self-directed care

Ambition

For some conditions general practice involvement is not necessary if it is clear to patients where to get care and it is clinically safe to do so directly. This is more convenient for patients and frees up valuable practice time. This is already a reality for some conditions, but we will increase the number of self-refer options, guided by clinical advice.



We also want to help patients care for themselves. We want to make it easier for them to monitor certain long-term conditions at home, such as high blood pressure, where it is clinically safe, and make it easier for practices to review their patients' self-monitoring. 20% of patients consult their GPs for problems that are non-clinical or social in nature.^{[28][29]} and NHS England will continue to support social prescribing link workers who improve patient outcomes and reduce pressure on primary care.

How we will deliver

Already more than 30,000 people self-refer each month, and in the 2023/24 operational planning guidance NHS England asks systems to expand this for certain carefully considered community-based services from September 2023.^[30] These include selected community musculoskeletal services,^[31] audiology for older people including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services. We estimate up to 50% more patients could be self-referring by March 2024. NHS England will monitor this to ensure opening these self-referral pathways does not lead to inappropriate demand.

Home monitoring can substantially improve health outcomes and reduce the need for regular and urgent appointments. A good example is blood pressure control through home monitoring, reducing heart attacks and strokes. To make home monitoring easier for patients and practices, we are funding the digital tools for patients to send their readings to their practice, where staff can review and add them to their clinical record with 'one click'.

As of December 2022, there were over 3,000 full-time equivalent (FTE) link workers in general practice managing over 1.6 million referrals.^[32] ICBs will support them as they continue to develop in their role connecting people to activities, groups and community-based services that can help meet practical, social and emotional needs and improve health outcomes and wellbeing. For example, around one in six practices have a link to their local Parkrun, which helps people to improve their own health.^[33]

C. Expanding community pharmacy services

Ambition

Community pharmacy is an essential part of primary care and offers people easy access to health services in the heart of their communities. 80% of people in England live within a 20-minute walk of a pharmacy and there are twice as many pharmacies in areas of deprivation. They give expert clinical advice and 90% of people feel comfortable consulting a community pharmacist for a minor illness. Over 90% who have done so say they received good advice.^[34]

Pharmacy's role has been increasing in recent years. In 2019 we set out how we would work to embed and integrate community pharmacy into the NHS, delivering more clinical services and making them the first port of call for many minor illnesses. We have made good progress:

- General practice and NHS 111 can refer patients to community pharmacies for advice and treatment,^[35] and 111 can also refer for urgent medicines supply. Over 2 million referrals have been made through these routes.^[36]
- Community pharmacies support over 200,000 people a month when they start new medicines and 8,000 patients a month who have had their medicines changed following a visit to hospital, which reduces readmissions.
- ~6,000 pharmacies have delivered over 930,000 blood pressure checks in just over a year, allowing those with high blood pressure to be identified and referred for onward management.
- Pharmacy is increasing its contribution to our vaccine programmes, including delivering almost 5 million flu vaccinations in 2021/22, and a third of the COVID-19 vaccines in the Omicron surge.^{[37][38]}

We want to build on this success and expand the services offered, increasing convenience for the public by introducing a Pharmacy First service for patients and expanding two existing services if agreed through consultation. We recognise this requires new funding, which would mark the next step in the journey we started in 2019 to make better use of the clinical skills in community pharmacy teams and better integrate community pharmacies into the NHS by making them the first port of call for minor common conditions.

How we will deliver

Pharmacy First

Pharmacy First will launch before the end of 2023, learning from areas that have implemented similar models, subject to a DHSC-led consultation with the Pharmaceutical Services Negotiating Committee.^[39] This service will enable pharmacists to supply prescription-only medicines,^[40] including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women) without the need to visit a GP. NHS England will also support research to ensure a consistent approach to antibiotic and antiviral use between general practice and community pharmacy.^[41]

Blood pressure check service and oral contraceptives

NHS England introduced a blood pressure check advanced service in October 2021, and over 6,000 community pharmacies are supporting the identification and prevention of cardiovascular disease. This service currently delivers up to 120,000 checks per month, which we will expand with new funding to a further 2.5 million blood pressure checks in community pharmacy to support ongoing monitoring in partnership with GP practices (subject to consultation). Good blood pressure control helps to reduce heart attacks and strokes. We estimate that the increase in capacity in community pharmacy in year 1 could prevent over 1,350 cardiovascular events such as heart attacks and strokes. Savings of around £13 million would be seen from the reductions in these events across primary, secondary and social care.

From April 2023, community pharmacy started to manage ongoing oral contraception for women. We will expand this service from late 2023, dependent on findings from initial pilots currently underway and consultation. We estimate a quarter of women taking oral contraceptives could be using this service by 2024.

The new funding will allow for the expansion of these services, so more patients can be supported outside a general practice setting, subject to consultation.

IT system connectivity

As part of the new funding and to ensure the highest standard of care for patients, we will invest to significantly improve the digital infrastructure between general practice and community pharmacy. NHS England will work with community pharmacy suppliers and general practice IT suppliers to develop and deliver interoperable digital solutions. These will streamline referrals, provide additional access to relevant clinical information from the GP record, and share structured updates quickly and efficiently following a pharmacy consultation back into the GP patient record.

These IT improvements will improve existing and future services; for example, by allowing GP patient records to be updated following supply of oral contraception or a blood pressure consultation in community pharmacy.

Greater flexibility

We also want to give community pharmacy contractors more choice about how they deploy staff and release pharmacists' time for more patient-facing services. Pharmacists and pharmacy technicians are experts in medicines, and from 2026 updated training standards will ensure all newly qualified pharmacists are independent prescribers.^[42] We want to better use these clinical skills to benefit patients. To support this:

- The Government is introducing VAT (value added tax) reliefs to support pharmacists and pharmacies in two ways. Medical services provided by pharmacists are already exempt from VAT. The Government has changed the law to extend this exemption to medical services carried out by staff supervised by registered pharmacists from 1 May 2023. Prescription medicines currently have a zero rate of VAT. This zero-rating will be extended to medicines supplied through PGDs by pharmacists, from autumn 2023.
- DHSC will clarify the roles of pharmacy professionals and enable a better use of skill mix, after consulting on the law on pharmacist supervision in the summer alongside the work the General Pharmaceutical Council is doing to revise the standards on responsible and superintendent pharmacists.
- DHSC will also enable pharmacy technicians to administer and supply medicines under PGDs subject to consultation.
- Government will give pharmacists the flexibility to dispense medicines in their original packs and to widen pharmacy hub-and-spoke arrangements, both of which aim to facilitate greater use of automation to increase efficiency, by progressing legislation following the consultations.
- The Medicines and Healthcare products Regulatory Agency, DHSC and NHS England will work together with suppliers to identify medicines which could be reclassified from 'available only on prescription (POM)' to 'available in a pharmacy (P)', based on international practice and real-world evidence of safety.^[43] This might include different strength medicines to those available today, combination formulations, or medicines manufacturers already offer without prescriptions in other countries.

Implementing Modern General Practice Access

Our central ambitions are to tackle the 8am rush by making it easier for the public to contact their practice by phone and online, and to know the same day how their request will be handled. It is time to consign to history patients being asked to call back on another day for an appointment. While this is the right thing to do for patients, we recognise it will be a major change for some practices.

Hundreds of innovative practices have shown the way forward.^[44] They use better digital online contact tools and telephony and have changed their workflow to assess requests better and navigate them to the right local service or member of the practice team. The approach, which we are calling Modern General Practice Access, has three components:

1. better digital telephony
2. simpler online requests

3. faster navigation, assessment and response.

Practices that have fully implemented this approach have overall patient experience scores on average 6 percentage points higher than the national average.^[45] As the Priory case study shows, in some cases these gains can be much larger (>50 percentage points). These practices also find most patients choose to contact them online, and those who phone find it much easier due to shorter queues and better digital telephony.

We estimate around 40% of practices use clinicians to triage requests and 10% receive most requests online. But while many practices have adopted all or parts of this approach, for practices still largely working in a traditional model, this is a major change and to many may not feel achievable. However, practices that have implemented it provide evidence that demand is predictable and finite:^[46] many older people prefer online; modern digital tools make it easier to manage patient requests and involve the wider practice team; and patient satisfaction rates are higher than with the traditional model.

Case study – Assessment and same-day response for all requests: StowHealth (rural Suffolk)

StowHealth was a rural practice struggling with high demand, stressed staff, three-week waits for routine appointments, challenges with patient continuity, and rising levels of complaints.

First, they moved to care navigation via telephone but noticed many cases could be answered more easily via email. So, in January 2020 they introduced an online tool (askmyGP), where patients fill in a simple online form describing their issue and capturing their preferences. Online requests go into a single workflow along with those requests that come in by phone, and care navigators sort and assign these requests across the full practice team, based on patient preference and clinical priority. The form can also be adapted quickly to direct messages to patients on emerging issues, such as Strep A infection, and automatically gathers GP Survey and Friends and Family Test feedback, saving practice staff time.

Implementation was preceded by an analysis of existing demand, which suggested a revised model for staffing across the week. Training was offered to staff in advance as part of the rollout, and the practice sent a letter to patients about the new system so they would understand the changes.

Although the phone line will always remain an option, the practice now has 80% of requests coming in online, including from patients in their 90s. If a patient does not want to use the online system, the reception team simply asks the patient the questions on the online form and fills it in for them, so the service is identical whether contact is online-only or on the phone. Since the phone lines are less busy, care navigators are able to spend longer on the phone to those who need more help.

Now, twice as many patients are seen face-to-face than request it, based on need following clinical assessment. And 45% of requests ask for email responses. This allows clinicians to respond to and resolve many requests very quickly.

The median closure time of patient requests over the last eight weeks was 120 minutes, and all patient contacts are concluded on the same day unless they choose to be seen on a later date. 80% of patients rate their experience as better than before. Instead of 21 days for routine requests, almost all patient contacts are now concluded on the same day, unless they choose to be seen on a later date.

A. Better digital telephony

Ambition

We want to see an end to people getting engaged tones when they call their practice, in part because the frustration of long waits on the phone without information can affect the caller's interaction with reception staff when they do get through. This occurs when practices have analogue phone systems with a fixed number of lines and no call management system. During the 8am rush an average-sized practice can receive over 100 calls in the first hour of opening on a Monday.^[47] To manage this we want all practices still on analogue lines^[48] to move to digital telephony that handles multiple calls and includes call-back functions so patients get a better experience, particularly for those calling on pay-as-you-go phone plans.

All analogue phone systems across the country are due to be switched off by December 2025,^[49] so this move is also a prerequisite ahead of this date.

How we will deliver



NHS England will support the transition to digital telephony for practices that commit by 1 July 2023 to the move, including procurement, contract negotiation and financial support for new equipment, transition costs and training. Our ambition is to transition at least 1,000 practices before the end of 2023, so around 65% of all practices will be using this technology, and we expect to transition all other practices who sign up by the end of March 2024.

In trials, moving to high-quality digital telephony raised 'ease of getting through' scores by 30 percentage points,^[50] driven by these features:

- **queuing:** enables practices to manage multiple calls, patients are notified of queue position and wait time, and never get an engaged tone
- **call-back:** patients have the option to be called back when they are higher in the queue
- **call-routing:** supports directing patients to the right person or team (eg a medicines team serving the whole PCN)
- **integration with clinical systems:** allows practice staff to quickly identify patients and find relevant information with less searching.

The [2023/24 GP Contract](https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2023-24/) (<https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2023-24/>)^[51] requires practices to use the nationally set Cloud (digital) Telephony Framework ^[52] for procuring digital telephony. This lists suppliers who can provide the functionality required to support high-quality patient access.

Digital telephony offers detailed management information to support further quality improvement, such as the call volume and length for each member of the practice staff. This is helpful in planning capacity quality improvement. It is also important for practices, PCNs, places and systems to have in mind the strategic direction described in the Fuller Stocktake, especially Shared Action #1 to develop a single system-wide approach to managing integrated urgent care. Some of the benefits are being able to direct calls easily to teams working on different sites. NHS England recommends PCNs use the same provider, and ICBs may want places or whole systems to do so (see Leeds case study).

Case study – Leeds Digital Telephony

54 practices across Leeds have moved to a single digital (cloud-based) telephony system to overcome access issues and complaints related to fixed analogue phone lines and patients getting engaged tones when lines were busy.

The 8am rush is now consigned to history, by rostering more staff onto answering the phone first thing and introducing automatic prompts to route callers to the most appropriate team member. The data provided means the team can learn from and respond to the real-time feedback about call length and waiting times. Both practices and the ICB can now better understand demand and match resources to improve response times to patient calls.

Other benefits include working remotely, and practices across Leeds can support each other if under pressure or short-notice changes mean a practice may not be able to meet its daily requests from patients.

The team plans to adopt queueing and call-back features, so patients can opt to hang up and be called back when they reach the front of the queue, freeing up patients' time. A further feature will be integration of the clinical patient record so that a clinician can open the patient's record when they call, or even click 'call' from within a patient's record, which will release practice team time.

B. Simpler online requests

Ambition

While people will always be able to ring their practice, we want to make online requests easy and dependable. Many practices that encourage patients to make online requests find it becomes the preferred route and overwhelmingly so for working age adults when using high quality tools. These requests are easier for practices to sort to different members of the practice team and respond to, especially where practices combine all patient requests (online, in person and by phone) into a single online tool. An additional benefit is improved management data.

How we will deliver

Practices are required contractually to provide online access. However, this was introduced during the pandemic, and we recognise that due to the inevitable pace the pandemic demanded, many practices neither had the time to fully assess the range of products on offer nor to fully implement systems and workflows supporting online access.

NHS England will make high-quality online consultation, messaging and booking tools available to general practice,^[53] alongside guidance on the relative strengths of the tools in different areas by July 2023.^[54] ICBs will work with PCNs and practices to decide which tools will best enable them to shift to the Modern General Practice Access model.^[55]

Practices need to offer accessible and easily usable websites, and NHS England will encourage the implementation of the 'what good looks like' guidance,^[56] by giving ICBs a simple tool to help them review sites, identify best practice examples in their systems, and target areas for improvements.

Case study – Modern General Practice Access: the Priory Medical Group (York)

The Priory Medical Group (60,000 patients) implemented a same-day response model in November 2020, after nine months of planning and seeing demand rise by a third compared to pre-pandemic.

The team uses an online consultation system (Klinik) where patients fill in a simple form and the practice responds the same day. From the outset patient uptake was high, and soon 80% of requests were logged online, with traditional phone and walk-in channels maintained to ensure no one was excluded.

The software collects high-quality information and allows phone and online contacts to be viewed on a single dashboard. The practice did extensive data analysis in the planning period to understand true clinical need, and reviewed and streamlined hundreds of common patient requests, so staff knew which practice team member should handle which. This process is helped by artificial intelligence, which proposes the initial patient navigation and flags potentially urgent requests, releasing time for clinicians and reception staff.

The system has meant that the practice can use nursing and pharmacist staff to deal with 7.3% and 10% more requests respectively, allowing the group to contact 8,000 more patients per quarter with no extra clinical resource since launch.

Patient satisfaction with access has increased from 27% to 83%, and 92% of staff think the new system is better than the old.

C. Faster navigation, assessment and response

Ambition

We want to make it easier for people to contact their practice and to make getting a response the same day the norm, so patients know how their request will be dealt with.

Care navigation becomes a critical role as ~15% of current GP appointments could be navigated to self-care, community pharmacy, admin teams or other more appropriate local services.^[57] With the right protocols it can also mean directing patients to secondary care (see Maidstone Care Navigation case study below), while others are directed to the most appropriate staff member in the wider practice team. It requires good understanding of local services and the expanded range of practice roles,^[58] as well as the customer service skills to effectively direct patients. Therefore, we will invest in a new National Care Navigation Training programme for up to 6,500 staff, rolling this out from May 2023. This will use the [care navigation competency framework](https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf) (https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf) developed by Health Education England and every practice will benefit. A key element of navigation is identifying those patients who would like or benefit from continuity, and this will be part of this training.

Evidence shows that relational continuity yields significant benefits for patients, systems and staff, and is especially important for patients with multiple or complex conditions.^[59] The care navigator role improves continuity; this may be as simple as asking if the patient would like to wait for a preferred staff member or using flags in a patient's notes to direct them to a certain staff member. We encourage practices to use the [Royal College of General Practitioners \(RCGP\) Continuity Toolkit](https://elearning.rcgp.org.uk/mod/book/view.php?id=12895) (<https://elearning.rcgp.org.uk/mod/book/view.php?id=12895>) as part of the QOF quality improvement module for 2023/24 on avoidable appointments.

Case study – Maidstone Care Navigation



In Maidstone a new system allows patients who contact their GP practice to be referred directly to specialist cancer services without the need for an appointment. If the patient has certain cancer symptoms, eg coughing up blood, then care navigators use a clinical algorithm at the first point of contact and automatically refer them to the right cancer service.

Previously, patients would need to see a GP before being referred, so navigating them directly to a specialist service gives patients faster access to cancer pathways. This approach also releases GP appointments and improves patient experience and access.

For those contacts directed to the wider practice team, our ambition is that clinically urgent requests should be assessed on the same day, and when the request is not urgent, an appointment, if needed, should be scheduled within two weeks. For some routine follow-up requests (eg a B12 injection or a cervical smear), a longer timeframe may be clinically appropriate or preferred by the patient. Importantly, by putting the assessment of the urgent clinical risk front and centre, patient safety is improved.

How we will deliver

NHS England will fund higher-quality digital tools that enable the shift to online and support the combined workflow for all requests, for the whole practice team to contribute to rapid assessment and response.

Practices also tell us that ahead of moving to Modern General Practice Access, the existing appointment book should be reduced ahead of time to provide good capacity at the launch of the new approach. NHS England will also support practices that commit to significant transformation with extra capacity over the next two years, ~£13,500 per practice.

We have streamlined the IIF to provide unconditional funding to PCNs (~£11,500/month for an average PCN) to support the transition. We have also strengthened the 2023/24 GP Contract to include the expectation that patients will be offered an assessment of need, an appointment, or signposted to an appropriate service when they contact their practice and should not be advised to 'call back another day'.

Building capacity

Our broader plans on workforce, including primary care, will be described in the NHS Long Term Workforce Plan that will be published shortly.

Shorter term, as practices improve access, they will have to manage more patient requests and optimise the use of the full practice team, but it also means we need to continue to build total general practice capacity. The immediate growth will be in the broader practice team, strengthening the foundation for more multidisciplinary working in the future.

GP numbers are not where we would like them to be, and it will take time for higher training numbers to work their way through. We will do more to bring new doctors into general practice, retain those working today and encourage recent leavers to return.

We know there is pressure on estates, particularly in areas of housing growth. Ahead of ICBs doing longer-term planning, government will consult on planning guidance to raise the priority of primary care. In addition, we will support the development of a new standardised design for primary care buildings, providing modern facilities that create a positive working environment for staff and patients and use modern construction methods.

We will build capacity through:

1. larger multidisciplinary teams
2. more new doctors
3. retention and return of experienced GPs
4. higher priority for primary care in housing developments.

A. Larger multidisciplinary teams

Ambition

We want to continue to grow the practice team, especially roles with responsibility for direct patient care which can be part of larger multidisciplinary teams. We will deliver our commitment of 26,000 more direct patient care professionals in general practice and 50 million more appointments by 31 March 2024.

How we will deliver



Since its introduction in 2019, the Additional Roles Reimbursement Scheme (ARRS) has supported salary costs for ARRS staff, including pharmacists, care co-ordinators and social prescribing link workers.^[60] This has helped grow the total number of clinical and direct patient care staff in general practice by over 25,000 FTE staff against our commitment of 26,000.^[61] Although the five-year framework contract ends this year, ARRS staff are a critical part of general practice and staff will continue to be funded after 2023/24.^[62] We want PCNs to make full use of their entitlement in the full knowledge that support for these staff will continue.

For 2023/34 we will make up to a further £385 million available in ARRS funding to continue to grow capacity. We have also expanded the roles in ARRS and, so PCNs have more choice over who they recruit and, by streamlining the IIF, how they deploy them. New roles include the recently announced digital and transformation lead, which will help practices move to the new digital tools and support the Modern General Practice Access approach.^[63]

Practice nurses pre-date ARRS, but for 2023/24 we have added advanced clinical practitioner nurses, and in the [October 2022 update \(https://www.england.nhs.uk/wp-content/uploads/2022/04/B1963-vii-Primary-Care-Network-Contract-Directed-Enhanced-Service-cover-note.pdf\)](https://www.england.nhs.uk/wp-content/uploads/2022/04/B1963-vii-Primary-Care-Network-Contract-Directed-Enhanced-Service-cover-note.pdf) we added reimbursement of training time for nursing associates to become registered nurses. We will continue to provide systems with £4 million of System Development Funding (SDF) which they can use to recruit and retain general practice nurses.

We will continue to ensure that all primary care staff have access to the ['Looking After You' suite of accessible health and wellbeing offers \(https://www.england.nhs.uk/supporting-our-nhs-people/support-now/looking-after-you-confidential-coaching-and-support-for-the-primary-care-workforce/looking-after-you-too/\)](https://www.england.nhs.uk/supporting-our-nhs-people/support-now/looking-after-you-confidential-coaching-and-support-for-the-primary-care-workforce/looking-after-you-too/), and we have recently extended the [Practitioner Health service \(https://www.practitionerhealth.nhs.uk/\)](https://www.practitionerhealth.nhs.uk/), a free, confidential mental health and addiction service, to all primary care staff to self-refer.

NHS England will publish further resources, developed with frontline staff, to make best use of these roles, as we know there is variation in how they are deployed. NHS England is also asking and incentivising practices to refine their General Practice Appointments Data (GPAD), to help us more accurately track appointments and who is delivering them. This will also enable practices to better track the commitment to action urgent clinical need on the same day and non-urgent needs within two weeks.

We are launching care navigator and digital and transformation staff training to help upskill these newer roles in general practice.

Case study – embedding ARRS staff

Kingswood Health Centre is a practice with 13,000 patients and a practice team with a wide range of ARRS roles. The lead GP partner developed a protocol for care navigators to match requests to who in the team could provide the most appropriate care. For example, a patient with knee pain would be booked directly with the practice first-contact physiotherapist, instead of seeing a GP first. The protocol means the reception team knows how to direct and book with the right clinician, and effective communication between the GPs and the reception team means that questions can be dealt with quickly if they are unsure where to book in. This model has freed up enough GP time to move from 10 to 15-minute GP appointments, giving patients more time where it is needed, and recruitment to and retention of the practice team have significantly improved. The reception team feels better able to help patients and patient feedback has been positive. Patients now phone to request to see the paramedic or the physiotherapist, as they know more about the breadth of the practice team.

B. More new doctors

Ambition

We want to continue to have more new doctors in general practice by training more GPs and supporting other doctors to transition to general practice.

How we will deliver

The NHS Long Term Workforce Plan, which will be published shortly, will set out our ambitious plans to significantly expand GP specialty training and ensure the NHS can recruit and retain the GP workforce it needs in the future, alongside an expanded and empowered wider primary care team. NHS England will continue to support newly qualified GPs into general practice. All doctors completing GP specialty training can access our two-year fellowship, including international medical graduates and nurses. Up to £35 million of SDF funding will be available for general practice fellowships in 2023/24.

Over half of doctors in GP training are international medical graduates, who are critical to general practice. Given the length of GP training, these doctors are typically not eligible for indefinite leave to remain when they qualify and must be employed by a practice with a visa sponsorship licence to continue working in the UK. Working with the Home Office, from autumn 2023 government will introduce an additional four months at the end of a visa for newly trained GPs to remain in the UK and NHS England will continue to increase the number of GP surgeries holding visa sponsorship licences.

In 2023/24, NHS England will work with partners to facilitate ways in which doctors other than GPs, such as SAS doctors, [64] can work in general practice as part of a multidisciplinary team to help increase practice capacity while providing a new and rewarding career option. DHSC will consult on reforms to the Medical Performers List to retain the flexibilities introduced during the pandemic so these doctors work in a safe and supported way.

C. Retention and return of experienced GPs

Ambition

We want experienced GPs to stay in general practice and encourage those who have recently left, or taken a short break or time overseas, to return.

How we will deliver

We want to address the pension challenges that contribute to the loss of experienced GPs. Following [consultation](https://www.gov.uk/government/consultations/nhs-pension-scheme-proposed-amendments-to-scheme-regulations/outcome/nhs-pension-scheme-proposed-amendments-to-scheme-regulations-consultation-response) (<https://www.gov.uk/government/consultations/nhs-pension-scheme-proposed-amendments-to-scheme-regulations/outcome/nhs-pension-scheme-proposed-amendments-to-scheme-regulations-consultation-response>) DHSC has decided to make it easier for staff to retire and return and to protect NHS staff from unintentionally higher tax charges driven by inflation. Implementation is planned for later in 2023.

Government also recognised that the annual and lifetime allowances incentivised GPs to work fewer hours or to retire. As announced in the 2023 spring Budget, the government is increasing the annual allowance from £40,000 to £60,000 to encourage GPs to continue to work their existing, or more, hours, and abolishing the lifetime allowance entirely so pension tax charges do not act as a driver for early retirements.

NHS England already welcomes over 100 qualified GPs every year through the [GP Return to Practice](https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/general-practice-gp/how-to-apply-for-gp-specialty-training/return-to-practice) (<https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/general-practice-gp/how-to-apply-for-gp-specialty-training/return-to-practice>) and [International Induction](https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/general-practice-gp/how-to-apply-for-gp-specialty-training/international-induction-programme) (<https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/general-practice-gp/how-to-apply-for-gp-specialty-training/international-induction-programme>) programmes. From May 2023, we are making it easier for doctors to return by replacing the fixed set of multiple assessments with an individual pathway based on a personal review. For those GPs who would benefit from a placement in general practice, we have from April increased the monthly bursary from £3,500 to £4,000.

NHS England will run a campaign to encourage GPs to return to general practice or to support NHS 111 in flexible roles where, for example, working from home is possible, as described in the delivery plan for recovering urgent and emergency care services. We will continue to invest in GP retention schemes with funding for this part of the SDF allocated to each ICB. We have already engaged with over 750 general practice staff to better understand the value of these various schemes and will use this and broader stakeholder feedback to shape a simplified set of offers that support GPs throughout their careers.

D. Higher priority for primary care in housing developments

Ambition

As practice teams grow, we need to invest in the general practice estate. ICBs should take this into account when considering their wider strategy and investment requirements.

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

How we will deliver

ICBs have delegated responsibility to ensure that the population has adequate primary medical services. As part of normal planning processes, ICBs should work with local stakeholders and take account of areas where housing developments are putting pressure on existing services.



As part of the government's wider review of the National Planning Policy Framework and planning guidance, we will consider how primary care infrastructure can better be supported. Before this, government will update planning obligations guidance to ensure that primary care infrastructure is addressed by local planning authorities as they do for other infrastructure demands, such as education. Government will also update guidance to encourage local planning authorities to engage with ICBs on large sites which may create need for extra primary care capacity.

The Levelling Up and Regeneration Bill introduces a new Infrastructure Levy^[65] to support local infrastructure such as roads, schools and GP surgeries, and a requirement for local authorities to prepare an infrastructure delivery strategy to consider how this levy will be spent. Government is consulting on how ICBs, along with other infrastructure bodies, should be part of this improved planning process. The Infrastructure Levy is designed to increase certainty about what forms of infrastructure will be delivered alongside new development, reducing the scope for negotiation and delay experienced in the current system.

Cutting bureaucracy

A major part of the access challenge is the rise in workload, particularly for experienced GPs, which risks them being overloaded and having less time available for patients.^[66] Pressure stems from the rising number of patient contacts, which practices report have grown by 20% to 40% since pre-pandemic.^[67]

We have heard from the profession that recording of targets can detract from time for clinical care and reduce flexibility. In the 2023/24 contract we significantly streamlined the IIF from 36 to five indicators to support practices to focus on improving patient experience and to create the capacity to deliver the changes in this plan. This higher-trust, lower bureaucracy approach is also in line with the recommendations of the recent Health and Social Care Select Committee report into the future of general practice. ^[68]

We will also consult on the future of the Quality Outcomes Framework (QOF) and IIF this summer. But another part of the workload challenge is administrative burden. We know over 30% of GP time is spent on indirect patient care (including paperwork such as referral letters, fit notes and medical certification, and analysing and responding to test results).^[69] There are opportunities to reduce this workload by:

1. improving the primary-secondary care interface
2. building on the [Bureaucracy Busting Concordat](https://www.gov.uk/government/publications/bureaucracy-busting-concordat-principles-to-reduce-unnecessary-bureaucracy-and-administrative-burdens-on-general-practice) (<https://www.gov.uk/government/publications/bureaucracy-busting-concordat-principles-to-reduce-unnecessary-bureaucracy-and-administrative-burdens-on-general-practice>).

A. Improving the primary-secondary care interface

Ambition

We want to reduce time spent by practice teams on lower-value administrative work and work generated by issues at the primary-secondary care interface. Practices estimate they spend 10% to 20% of their time on this.^[70]

How we will deliver

In September 2022, NHS England asked the AoMRC to review how to reduce unnecessary work on the interface between general practice and NHS trusts. Its report is published alongside this plan and includes many case studies of improvements which have already been made across the country.^[71]

NHS England is asking ICB chief medical officers to establish the local mechanism, which will allow both general practice and consultant-led teams to raise local issues, to jointly prioritise working with LMCs, and to tackle the high-priority issues including those in the AoMRC report. In addition, ICBs must address these four areas:

1. **Onward referrals:** if a patient has been referred into secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them, rather than sending them back to general practice which causes a further delay before being referred again.^[72] This improves patient care, saves time and was the most common request we heard from general practices about bureaucracy.
2. **Complete care (fit notes and discharge letters):** trusts should ensure that on discharge or after an outpatient appointment, patients receive everything they need, rather than – as too often happens now – leaving patients to return prematurely to their practice, which often does not know what they need. Therefore, where patients need them, fit notes should be issued which include any appropriate information on adjustments that could support and enable returns to employment following this period, avoiding unnecessary return appointments to general practice. Discharge letters should highlight clear actions for general practice (including prescribing medications required). Also, by 30 November 2023, providers of NHS-funded secondary care services should have implemented the capability to issue a fit note electronically. From December this means hospital staff will more easily be able to issue patients with a fit note by text or email alongside other discharge papers, further preventing unnecessary return appointments.

3. **Call and recall:** for patients under their care, NHS trusts should establish their own call/recall systems for patients for follow-up tests or appointments. This means that patients will have a clear route to contact secondary care and will no longer have to ask their practice to follow up on their behalf, which can often be frustrating when practices also do not know how to get the information.
4. **Clear points of contact:** ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly: eg single outpatient department email for GP practices or primary care liaison officers in secondary care. Currently practices cannot always get prompt answers to issues with requests, such as advice and guidance or referrals, which results in patients receiving delayed care.

NHS England will expect ICBs to provide an update to their public board in October or November 2023 on the four areas above. Their priorities, implementation plans and timelines are part of the annual assessment of performance that has been a requirement of the NHS Standard Contract since 2021/22.^[73]

B. Building on the Bureaucracy Busting Concordat

Ambition

We want to reduce the demands on practice time from unnecessary or low-value asks and improve processes for only the most important requests for medical evidence that remain.

How we will deliver

Since 2020, we have been reducing the burden on GPs of verifying health information and providing medical evidence, including by developing the COVID-19 isolation note, streamlining appraisals, digitising fit notes and expanding the range of health professionals who can sign fit notes or answer DVLA medical information requests.

DHSC also developed the [Bureaucracy Busting Concordat](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpublications%2Fbureaucracy-busting-concordat-principles-to-reduce-unnecessary-bureaucracy-and-administrative-burdens-on-general-practice%2Fbureaucracy-busting-concordat-principles-to-reduce-unnecessary-bureaucracy-and-administrative-burdens-on-general-practice&data=05%7C01%7Cjameskent99%40nhs.net%7C73160acd09454235da6208db05eb3f10%7C37c354b285b047f5b) (<https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpublications%2Fbureaucracy-busting-concordat-principles-to-reduce-unnecessary-bureaucracy-and-administrative-burdens-on-general-practice%2Fbureaucracy-busting-concordat-principles-to-reduce-unnecessary-bureaucracy-and-administrative-burdens-on-general-practice&data=05%7C01%7Cjameskent99%40nhs.net%7C73160acd09454235da6208db05eb3f10%7C37c354b285b047f5b>), setting out seven principles to reduce unnecessary bureaucracy in general practice in consultation with RCGP and the British Medical Association. We will continue to reduce medical evidence requests and increase self-certification; examples include:

- Working with the aviation industry to encourage clear, proportionate and pragmatic processes, so passengers with medical conditions who need to fly with medication or medical equipment can do so easily.
- Working with His Majesty's Courts and Tribunals Service to amend guidance to staff and correspondence with jurors, so people summoned for jury service do not seek a note from a GP as evidence of illness unless they are asked to by the court service. These changes will be made by September 2023.
- Exploring opportunities to improve efficiencies for both GPs and local authorities regarding the medical needs of people wishing to access social housing, such as updating guidance to local authorities and housing associations on when it is appropriate to seek medical advice.

If practices have examples of any burdensome bureaucracy in general practice they would like to reduce, please contact us using this [online form](https://forms.office.com/pages/responsepage.aspx?id=MIwnYaiRMUyMH-9N6Jc6HFmKHDdTZsJFmTazab7c22JUNVU4SINVWjcxVTRBVkMyVTkyNFMwVUxXOCQIQCN0PWcu) (<https://forms.office.com/pages/responsepage.aspx?id=MIwnYaiRMUyMH-9N6Jc6HFmKHDdTZsJFmTazab7c22JUNVU4SINVWjcxVTRBVkMyVTkyNFMwVUxXOCQIQCN0PWcu>).

Delivering this plan

Accountability

ICBs are accountable to NHS England for the commissioning of general practice services and delivery against the contract. From April 2023 all ICBs have accountability for commissioning community pharmacy, dental and optometry services. NHS England will ask ICBs to develop their own system-level access improvement plan, which includes a summation of the actions their PCNs and practices have committed to, including confirmation of the funding and offers each want to take up, and the outcomes expected. ICBs should take these plans to their public boards in October or November 2023 with a further update in February or March 2024.

ICBs will want to ensure the actions in their plans align with the vision described in the Fuller Stocktake. An immediate critical enabler is to ensure digital telephony systems can support the future direction of PCNs and places in offering a single system-wide approach to integrated urgent care and integrated neighbourhood teams.^[74]



To reinforce the ICB role as commissioner and in driving improvement, each element of the plan is supported by one or a combination of: (i) a new 2023/24 contract requirement; (ii) a new 2023/24 contractual incentive; (iii) reprioritised national funding; (iv) greater transparency of outcomes at system, PCN and practice level; or (v) the ability to leverage the existing standard trust contract.

A major change in 2023/24 is for 30% of the retargeted IIF incentive to be awarded by ICBs conditional on PCNs achieving agreed improvement in access and experience. This will require systems to understand the GP Patient Survey for their PCNs and practices and triangulate the data with local feedback and insights. NHS England regional teams will play a key role in supporting systems and providing assurance on the delivery of these plans. Local system-level access improvement plans should prioritise supporting those with the lowest patient satisfaction scores. Taking local plans and updates through the ICB public boards this autumn will raise transparency. The core data in these plans will be used in regional assurance and national-level public reporting.

Transformation support

From May 2023, NHS England will introduce a National General Practice Improvement Programme with three tiers of support to help general practice deliver change. These offers will be underpinned by a set of principles to ensure change is clinically led, data-driven, evidence-based and measurable.

The first tier will be open to everyone. NHS England will build communities of practice and run a series of webinars on each of the key areas of this plan, including learning from peers. We will look at how those who have implemented change can share their experiences, including planning around demand and capacity, and for companies providing digital telephony and tools to showcase their offers.

To address variation in patient experience, NHS England will adapt its existing 'Accelerate' programme into the second and third tiers to help practices in the most challenging circumstances or those that simply feel they do not have the capacity or bandwidth to plan a path towards a Modern General Practice Access approach. In 2022, the Accelerate programme reached 550 practices and 97% reported productivity gains which helped patients and staff.^[75]

Of these two offers over the next two years, up to six months of support will be provided for up to 1,500 practices, which will be selected based on need and ICB nomination. An intermediate option will provide up to three months of support to 800 practices and 160 PCNs. Both options will involve hands-on support, a data diagnostic and a tailored analysis of demand and capacity. NHS England will facilitate courses for systems to help build transformation capability so that they can support a further 850 practices. For practices looking to implement a Modern General Practice Access model over the next two years, and which need appointment books to be cleared in advance, we will also fund up to three weeks of transition cover (~£13,500/practice) – this could include sessions from current practice staff, by sessional GPs or support from experienced peers.

Choice and equity of access

Our ambition is to make it easier for **everyone** to contact their practice in the way they prefer. To reduce variation, ICBs will need to focus the most intense support on PCNs and practices in the most challenging circumstances.

That is why this plan largely does not call out specific cohorts of patients – we want to improve access, experience and outcomes for all – but we will ensure that primary care services reflect the needs of diverse groups of people, including all age groups, people with mental health issues or dementia, people with learning disabilities and autistic people. And patients will always have the option of visiting their practice in person. The move away from a 'first come, first served' approach towards a more equitable approach will benefit all patients, regardless of their chosen route of access.

Patients are entitled to choose which GP practice they register with, and to ask to see a particular member of the GP practice team. To make it easier to join a new practice, NHS England has simplified the forms and created an easy-to-use online registration service that is also available on the NHS App. This service is already in use across 750 practices and is available to all practices. We aim to have it rolled out to up to 2,000 practices by December 2023.

Patients also have the legal right to choose which hospital or secondary care service they go to – whether this is an NHS organisation or an independent sector provider. We want to make it easier for people to exercise this right, by giving patients more information to compare services and make the most of modern technology to make choices in a seamless way. GP practices play a critical role in supporting patients to make their choice and should therefore discuss patients' options with them and offer a full range of providers to choose from which are appropriate to clinical need. ^[76]

We are making more options available to the public by expanding services in community pharmacies, subject to consultation, and continuing to support rural locations through the [Pharmacy Access Scheme \(https://psnc.org.uk/quality-and-regulations/the-pharmacy-contract/pharmacy-access-scheme-phas/\)](https://psnc.org.uk/quality-and-regulations/the-pharmacy-contract/pharmacy-access-scheme-phas/). We will also work with distance selling pharmacies (DSPs) to help remove barriers to the provision of remote services where appropriate and make it easier for patients to choose these services if they wish.

Communicating with the public

We know navigating healthcare is not always easy and many of us have at some point wondered whether it is best to call our practice, go to a pharmacy, ring NHS 111 or go online, or whether we should attend an urgent treatment centre or accident and emergency department (A&E). We want to make navigation clearer for patients.

This plan commits to a national campaign with three components to increase public understanding of the changes to primary care services, the benefits they bring, and how and what services they can access.

1. **Digital access:** to build knowledge and confidence in use of the NHS App and the digital access routes to general practice.
2. **Wider practice team:** to explain to the public that there is now a much broader range of staff in the practice team (eg pharmacists). Greater knowledge will help practices increase use of these roles, protecting GP time for what only they can do.
3. **Wider care available:** to help the public better access the right care by explaining when, why and how to access self-care advice, community pharmacy, general practice, NHS 111, 111 online and A&E.

The campaign will also create a set of communications toolkits for ICBs to develop their own local messages.

Case study – Quality communications

During 2021, Humber and North Yorkshire Integrated Care System piloted a well targeted, consistent communications approach to assess its effectiveness in improving patients' awareness and understanding of the changes in access to general practice and building confidence in these changes.

In total 69 practices took part, with a toolkit of materials communicating that, "there are three ways patients can request care from their practice, by phone, in person or using a secure online form on their practice's website. Whichever route used, patients would receive the care they need with either a face to face, phone, text or online message or a referral to another service".

53% of patients interviewed were open to trying online requests, with only 14% aware this was an option offered by their practice. After the communications were shared, 64% felt more confident their practice would respond if they used the online form.^[77]

Engaging on the future of primary care

General practice

This plan is the first step to address the access challenge ahead of longer-term reforms. The other two elements of the [Fuller Stocktake](https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/) (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/) vision of more proactive, anticipatory and preventative care, delivered by multidisciplinary teams and integrated neighbourhood teams, remain important and can help mitigate demand. Some PCNs and practices that have already implemented Modern General Practice Access are successfully working on these, helping to build the learning on what it takes to implement.

Case study – Optimising workforce and continuity of care

Foundry PCN has a key goal to implement the Fuller Stocktake vision. Its first step was to better manage reactive care by putting all patient requests across three surgery sites into a single risk-stratified workflow. This approach has allowed more efficient use of staff across the PCN of four practices and reduced avoidable appointments to 6%. A PCN dashboard of waiting times for types of need indicates whether they are 'running hot', which helps manage capacity dynamically.

For anticipatory care, multidisciplinary teams were set up to include specialised staff to proactively deliver healthcare for a group of patients with specific needs, such as those with dementia. This approach has delivered team-based continuity of care and markedly reduced unscheduled demand in both primary and secondary care from patients under each multidisciplinary team, saving an estimated £2.3 million over three years. By integrating

its PCN team into their neighbourhood team – eg designating a dedicated nursing home team (GP, nurse and paramedic) – Foundry PCN has been able to offer seven-day cover with a weekly ‘ward round’ for scheduled reviews, and urgent on-the-day requests supported by a weekend check-in.

Integrating primary care requires general practice to operate at a larger scale either as part of PCNs or at place level, and other system partners, such as community, acute and mental health services, will need to organise care more locally to integrate with primary care. This may require changes to today’s arrangements, and indeed the Fuller Stocktake called on DHSC and NHS England to “rapidly undertake further work on the legislative, contractual, commissioning and funding framework to enable and support new models of integrated primary care”, to improve equity in resource distribution and improve health outcomes.

We will engage on a broad set of themes ahead of the 2024/25 contract discussions. The 2024/25 contract provides an opportunity, after the 2019 five-year framework ends and the PCN DES was introduced, to reflect on successes and lessons learned.

We will explore alternative approaches that can work alongside the partnership model and explore additional opportunities to better align clinical and financial responsibilities in primary care, enabling primary care teams to shape NHS services in their area and reinvest savings in frontline services. NHS England will review and evaluate the Additional Roles Reimbursement Scheme as part of this work and to inform future options that could apply from 2024/25 onwards. We want to work with the profession and consult on the future of QOF this summer. We will also explore how to link QOF to key strategies such as the upcoming Major Conditions Strategy.

Community pharmacy

Community pharmacy is core to delivering on the Fuller Stocktake vision of integrating primary care, and the proposed changes in this plan, the enabling IT infrastructure and the legislation changes move us a step closer.

We will continue to support the transformation of services offered by community pharmacy by removing barriers to innovation and improving the IT connectivity with other parts of the NHS, supporting both community pharmacies and DSPs to receive referrals more promptly, manage appointments remotely where appropriate, and more rapidly update patient records. But we know there is more to do, and alongside the service expansions outlined in this plan we are supporting a series of further pathfinder sites across England over the coming year to test independent prescribing models. We will continue to engage with the sector as these progress, including on the outcomes of the work The King’s Fund and the Nuffield Trust are doing over the summer on the future of community pharmacy.

Acknowledgements

This plan has been informed by and developed with a wide range of stakeholders, including:

- Academy of Medical Royal Colleges
- The Association of Pharmacy Technicians
- British Medical Association General Practice Committee
- Care Quality Commission
- The Health Foundation
- Healthwatch
- Integrated care boards – chief executives and some primary care leads
- Institute of General Practice Management
- The King’s Fund
- National Association of Primary Care
- National Association of Sessional GPs
- National Voices
- NHS Confederation
- Nuffield Trust
- Patients’ Association
- The Pharmaceutical Services Negotiating Committee
- Practice Managers Association
- Richmond Group of Charities
- Royal College of General Practitioners
- The Royal Pharmaceutical Society

Staff insights and ideas, and contributions from practice managers, clinicians, and primary care providers, have been invaluable.



We remain committed to working with partners as we deliver this plan, including through national engagement forums, communities of best practice and existing primary care advisory groups.

Thank you to everyone for sharing their time, energy, expertise and experience.

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