CHARTERED ACCOUNTANTS, TAX CONSULTANTS & FINANCIAL PLANNERS

ALBERT GOODMAN

PRACTICE NEWS MAY 2016

Welcome to the latest issue of the Albert Goodman e-Update specifically for medical practices.

If you have any feedback on the contents of this newsletter, or would like to discuss how this may affect your practice please click on the feedback link. Likewise, if you are not a client of ours and would like to see if we are the right team for you please forward Keith Miller, our medical practice specialist, your details who will be delighted to get in touch for an informal chat.

Thank you for taking the time to read this newsletter.

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MATHS MISSING FROM 7 DAY NHS PLAN, WARNS PAC

Doctors have taken heart today from a Public Accounts Committee report which calls for an urgent review of NHS clinical staffing in England.

The Committee raises serious concerns about supply, budgeting, agency costs and leadership.

And it concludes: 'national bodies need to get a better grip on the supply of clinical staff in order to address current and future workforce pressures'.

It also warns there has been 'no coherent attempt' to assess the headcount implications of major policy initiatives such as the 7-day NHS.

Commenting on the Government's commitment to provide an extra £10 billion in funding for the NHS by 2020, the PAC concludes this funding is a pot the Department of Health 'seems to expect will cover everything—despite not having separately costed 7-day services and other initiatives'.

It adds: 'We are therefore far from convinced that the Department has any assurance that the increase in funding will be sufficient to meet all of its policy objectives.'

BMA leader Dr Mark Porter responded: 'At a time when there is growing evidence casting doubt on a 'weekend effect' – the basis for the Government's plans for expanding seven-day services – this report further underlines the Government's failure to consider how it will staff and fund additional services when the NHS is struggling to provide existing services.

'Despite what ministers claim, NHS funding has not kept up with rising patient demand and the increased cost of delivering care. Staff shortages are seen across the NHS, patients are waiting longer for appointments, and there is no real solution to the £22bn funding gap facing our health service.'

He warned the situation was set to get worse, blaming the Government's handling of the junior doctor contract 'which has alienated a generation of doctors.'

Dr Porter said if the Government wanted more seven-day services, then it must finally answer the question asked by doctors, senior NHS leaders, medical royal colleges, and now the PAC: how will it staff and fund them?

'UNREALISTIC EFFICIENCY TARGETS'

The PAC said NHS trusts and NHS foundation trusts had been set unrealistic efficiency targets, leading to 'overly optimistic and aggressive staffing profiles' which have in turn led to staffing shortfalls.

It warned that efforts to retain clinical staff were not well managed, which might cause more shortfalls, and inaccurate headcount planning was largely responsible for a significant increase in agency costs.

The Report states: 'NHS England told us that some agencies had taken advantage of trusts' need for staff to charge 'rip-off' fees. In fact, the rise in spending is mostly the result of trusts needing to use more agency staff, often to cover vacancies.'

The Committee urged the Department of Health, NHS Improvement and Health Education England to provide 'greater national leadership and co-ordinated support to help trusts reconcile financial, workforce and quality expectations'.

It recommends that 'all major health policy initiatives should explicitly consider the workforce implications'" and calls on the Department to report back by December 2016 with a summary of these implications in relation to the 7-day NHS.

By the same date, NHS Improvement should review trends in clinical staff leaving the NHS and provide the Committee with a plan 'on how it will support trusts to retain staff better'.

PAC chair Meg Hillier MP said: 'There are serious flaws in the Government's approach to staffing the NHS and without urgent action the public will pay for it on multiple fronts. Frontline staff such as doctors and nurses are the lifeblood of the service, yet the supply of these staff in England is not keeping pace with demand.

'This poor workforce planning means patients face the possibility of longer waiting times and a greater cost to the public purse. It is unacceptable for the Government to blame staffing agencies for the growth in spending in this area when its own mismanagement is a major contributor to the size of the bills.

‘At the same time, taxpayers are being asked to accept uncosted plans for a 7-day NHS—plans which therefore present a further serious risk to public money. It beggars belief that such a major policy should be advanced with so flimsy a notion of how it will be funded—namely from money earmarked to cover all additional spending in the NHS to the end of the decade.’

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HOT GP MONEY TOPICS DUE FOR DEBATE

Money and cost topics will be high up the agenda next week when GPs from all over the UK meet for the annual policy-making conference of Local Medical Committees (LMCs).

They will be debating a wide range of issues affecting GPs’ income and finances:

Doctors in Hull will call for GP IT needs to be fully funded. They want: improved support services, fast and reliable broadband connections,) scanning, digitising and shredding of paper records, interoperability and ‘a fit for purpose national primary care IT specification.’

Suffolk GPs will present a motion claiming that the current emphasis on 7-day working is ‘a political push for the unachievable particularly in the light of the continued under resourcing of primary care.’

They want ‘the 7 day mantra’ abandoned and any additional resource available used to enhance the weekend emergency cover services.

Dorset doctors will voice concern at the lack of integration between the out of hours GP care providers with each other and in hours GP services.

They will ask GPs nationwide to back: a radical redesign and integration of all current out of normal hours services, an integrated IT system across all out of hours providers and for) work that comes to a practice after 6pm to be directed to OOH services.

Their same motion also urges the setting up of an out of practice daytime visiting service plus community urgent care centres which patients can access when their practices have no more capacity for same day access.

Practice premises are always a hot topic and this year Kent LMC will propose that conference believes NHS Property Services is not fit for purpose and has failed in its mandate ‘to provide a quality service to its tenants’.

It is claimed the body has not been made accountable for ‘its mismanagement and lack of action’ and has demanded charges that are unrealistic, unaffordable and destabilising to practices.

Overseas visitors are also back on the agenda and there will be calls for them to be seen on a private fee paying basis only.

Fees would be retained in full by the general practice. Doctors will say that it remains open to the Government to offer NHS care free to overseas visitors at walk in centres, urgent care centres, and accident and emergency departments, and patients can be offered these alternatives.

Conference will also be asked to reject the principle that the Department of Health can unilaterally fix a market price for locum services.

Speakers will ask GPs to reject compulsory reporting by practices of locum payments, affirms that practices and locum GPs should be allowed to mutually agree terms and conditions, and reject any attempt to cap the fees charged by GP locums.

GPs in Derbyshire, however, will be aiming to ask doctors to come together to agree a ‘fair and reasonable’ cap on GP locum fees.

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RCGP HELP TO MAKE GP PRACTICES ‘ FRIENDLIER ’

GP practices in England are being sent resource packs by their royal college to support them and their teams to make their surgeries more visibly friendly for patients with an Autism Spectrum Disorder.

The packs aim to support GP practices to meet the commitments in the RCGP Autism Patient Charter, which provides a framework for making GP surgeries more visibly friendly for those on the autistic spectrum. Resources in the pack include a guide for patients on the autistic spectrum to help them get the most out of their GP visit, and a guide for GPs to support effectively consultations with patients on the autistic spectrum. RCGP chair Dr Maureen Baker said Autistic Spectrum Disorder was a clinical priority for the College.

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CQC WARNING TO ‘POOR’ GPS AS BMA EXPOSES FUNDING LINK

Failing or suspected failing GP practices face a new round of tough inspections following publication today of the Care Quality Commission’s (CQC’s) new strategy for 2016 to 2021 which sets out plans for ‘a more targeted, responsive and collaborative approach’ to regulation.

The watchdog aims to use better intelligence from the public and others to focus inspections more tightly to where it thinks GP patients may be at risk of poor care. A CQC spokesman said: ‘Against a context of increasing care needs, combined with financial pressure, services are changing the way they organise and deliver care – and CQC’s approach is evolving to reflect these changes.

‘The new strategy will help encourage services to innovate and collaborate in order to drive improvement, while ensuring that people continue to receive good, safe care – which, in a time of tighter public finances, will be more crucial than ever.’

CQC’s enhanced targeting, following a tighter budget itself, comes as new research from the BMA has shown a link between the CQC ratings allocated to GP practices and the level of funding they receive.

The BMA said the CQC failed to take resources into account when publishing its verdicts on the performance of GP practices.

The new report examined the amount of funding each GP practice in England received per patient and cross referenced this with the recent ratings given to the GP practice by the CQC. Overall, results from inspections carried out at 2,814 GP practices in 2015 were included in the research.

The research found that:

- GP practices receiving an ‘outstanding’ or ‘good’ rating from the CQC received £152 and £140 per patient in funding respectively;
- GP practices that scored the lowest rating – ‘inadequate’ – in contrast on average received £128 per patient, while those marked as “needs improvement” were allocated £111 per patient;
- The average level of funding for GP practices across England is £141 per patient, placing it below the level of resources received by most GP practices who were given an “outstanding” rating.

GPC chair Dr Chaand Nagpaul said the analysis showed a clear link between the amount of funding a GP practice receives and the rating they are allocated by the CQC.

He continued: ‘Despite this, the CQC takes no account of resources available to a GP practice when they grade their care, even if this leads to GPs and their staff being publically shamed with an ‘inadequate’ or ‘needs improvement’ rating.

‘This is wholly unfair given the obvious impact that funding has on the ability of GPs and staff to run their practices, and which will impact on the CQC’s own rating system. The research also demonstrates the wide disparity between funding for practices which is completely unacceptable.’

Dr Nagpaul, said NHS England needed to listen to the BMA's Urgent Prescription for General Practice campaign and ensure GP practices received an uplift in funding that resulted in every practice in England getting the same high level of support.

'We also need the current CQC assessment system to end and be replaced by a proportionate and fair alternative, especially as a recent BMA survey showed the vast majority of GP practices had lost faith in its flawed inspection regime. GP practices must not be unfairly judged when they are not being given the tools they need to effectively run their practices to provide care to the public.'

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NOW 'FAILING' PRACTICES FACE MORE UNANNOUNCED CQC VISITS

GP practices deemed to be poor or inadequate by the CQC inspection watchdog can expect more pressure in future – with unannounced visits from inspectors.

The CQC said today it will make improved use of information from the public, providers, other regulators and oversight bodies in order to target resources more effectively to where it believes risk to the quality of care provided is greatest, or to where quality is likely to have changed.

It added: 'In practice, this will mean more use of targeted unannounced inspections, based on information that is constantly updated – for example, if there is a sudden spike in people reporting poor care from a particular service. It would also mean longer intervals between inspections for services rated good or outstanding if they can continue to demonstrate that they are providing good care.'

CQC boss David Behan said: 'Inspection will always be crucial to our understanding of quality but we'll increasingly be getting more and better information from the public and providers and using it alongside inspections to provide a trusted, responsive, independent view of quality that is regularly updated and that will be invaluable to people who provide services as well as those who use them.

'And we'll make more use of focused unannounced inspections which target the areas where our insight suggests risk is greatest or quality is improving – with ratings updated where we find changes.'

He said the CQC would do more to help providers to monitor and report on their own quality.

CQC chair Peter Wyman said: 'Over the next five years the health and social care sector will need to adapt, and we do not underestimate the challenges that services face. Demand for care has increased as more people live for longer with complex care needs, and there is strong pressure on services to control costs. Success will mean delivering the right quality outcomes within the resources available.

'As an organisation, CQC will be costing less – reducing our budget by £32m over the next four years, while ensuring that our focus on the safety and welfare of people who use services is never compromised.

'We'll do this by working smarter and faster – for example by using new technology and data to make better use of what people tell us, so that we can use the most up-to-date information to help spot when people might be at risk of poor care. We will improve the processes that underpin our inspections so we can report what we find more quickly.'

Many GPs are up in arms over the recent increase in CQC fees they have to pay at a time when the body's budget is being cut back.

Major concerns surfaced again last week at the annual conference of Local Medical Committees. GPs argue that if the overall number and frequency of inspections is to be cut back then they should not have to pay such high fees.

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GPS FEEL THEY ARE BEING 'SET UP TO FAIL' CLAIMS GP LEADER

GP leaders are pushing for the urgent implementation of the promises made in the recently announced General Practice Forward View in England, together with recommendations in the BMA's urgent prescription rescue plan.

They believe these are key to helping save GP services from crisis, according to GPC chair Dr Chaand Nagpaul.

But he told the annual conference of Local Medical Committees, which brings together GPs from across the four countries, that at the moment 'GPs are facing an environment in which it feels we're being set up to fail'.

He hit out at a system where:

- A workforce that is thousands of GPs short is expected to treat an expanding older population with multiple complex needs.
- A shrinking share of resources is given to doctors facing a mountain of un-resourced work moving out of hospitals.
- Organisations that support GPs in the community have their budgets cut, 'while those that belittle us with petty regulations and threatening inspections are allowed to flourish.

He said: 'The Government finally responded with NHS England's General Practice Forward View last month. This represents a symbolic change in language by the centre. Simon Stevens could not have been clearer in the introduction. He quotes a recent headline 'if general practice fails, the NHS fails'. How long have we been telling the Government that?

Talking about the implementation of the General Practice Forward View to the policy-making conference in London, Dr Nagpaul said: After a decade of declining funding, general practice will finally see an upturn of investment significantly higher than other sectors, and with increased share in the overall NHS budget.

'This is positive, but is tempered by the fact that general practice endured gross disinvestment at a time of plenty, while the Government is belatedly trying to make up the deficit at a time when the NHS is virtually running on empty.

'Last summer I called on government to end its obsession with seven-day opening. It's notable that the Forward View was not launched with any publicity regarding routine seven-day GP services, and the words 'seven days' or '8-8' do not appear in the document. Furthermore, our lobbying has ensured there are no changes to the contractual hours of GPs.'

GENERAL PRACTICE'S FUTURE

Dr Nagpaul said general practice had been given a 'glimmer of hope but not yet a solution, recognition but not yet repair.'

He told his audience: 'We would be failing in our duty if we did not do our utmost to exploit the positives in the Forward View in the interests of GPs we represent. To make sure the funding announced actually reaches practices without needing to jump through hoops, that new schemes are used to relieve workload, not add to our burdens, and to hold NHS England to account to make sure these are not just platitudes.

'We would equally be failing in our duty if we considered the Forward View as the final word in rescuing general practice. We will fight for what the Forward View has not tackled, where it has not gone far enough, and to implement those proposals in our urgent prescription that are missing.

'Within this reality, the fightback continues. General practice matters far too much to me, you and our patients to pack our bags because the government hasn't gone far enough. We know the decade of neglect can't be turned around overnight, and our message to ministers as representatives of UK general practice is resolute and clear – we remain determined to rescue our proud profession and we will not give up until and when we achieve success.'

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THE FORWARD VIEW – GPC LEADER'S SPEECH IN FULL

With a number of accountants at the AISMA conference admitting they did not really know much about the NHS England's Forward View document, which has big implications for their clients, we provide here the full speech of GPC chair Dr Chaand Nagpaul to last week's LMCs' conference in London.

It gives a useful insight into the thinking of GP leaders as well as a briefing on many of the issues facing GP practices.

As such it is likely to be useful reading for experienced AISMA members and their new staff…..

Dr Nagpaul said:

'Four months ago, in this very hall the profession declared that general practice is in a state of emergency.

We made an unequivocal statement that day; that GPs are no longer prepared to work in an environment of unmanageable workload that prevents us providing safe, quality care to patients; one that undermines our professionalism; and which suffocates us with demeaning regulation. This has created a toxic mix from which existing GPs can't wait to escape, and which many young doctors will not join

We gave the Government six months to negotiate a plan to rescue general practice from the brink of irreversible collapse.

GPC has worked hard in these past four months. The special conference was a launch pad for our urgent prescription for general practice campaign. We produced national heat maps demonstrating the bleak reality of nine in ten practices seeing an increase in workload over the past year, half reporting further deterioration in quality of care, 1 in 10 state they're financially unsustainable, and almost half struggle to obtain locum cover for essential services.

The campaign penetrated the media far and wide. We made the front page of the Guardian, appeared numerous times on primetime national TV, the Today programme, and with a total of 663 mentions across broadsheets and national and regional media. Next week GPC is hosting a parliamentary event in Westminster so that MPs can confront the harsh realities of general practice with their LMC constituents.

Opinion is shifting, awareness is growing, that there is a crisis in general practice.

We heeded the call from special conference to cease bureaucratic annual contract changes. The 2016-17 contract agreement doesn't have a single new clinical requirement. We rejected all NICE recommended QOF changes. We reduced workload by negotiating an end to the dementia DES, a political sacred cow which distorted clinical behaviour, and we've transferred that money into core funding. We negotiated an uplift of £220m to the contract value – twice that of the previous year, and for the first time factored in rising expenses of indemnity and CQC fees.

But any such positive change to the contract is totally drowned by the growing tidal wave of relentless demand and unfunded workload outside the core contract.

Unlike the disputes that have faced our hospital colleagues, our problems and solutions are not confined to changing our contractual terms, but are as much about changing the wider environment in which general practice operates.

SET UP TO FAIL

An environment in which it feels we're being set up to fail. Where a workforce that's thousands of GPs short, is expected to treat an expanding older population with multiple complex needs. Where a shrinking share of resources is given to doctors facing a mountain of un-resourced work moving out of hospitals. Where the organisations that support us in the community have their budgets cut, while those that belittle us with petty regulations and threatening inspections are allowed to flourish.

There's no single magic bullet to address this. Moreover, unlike our hospital colleagues we're not bound by a common national contract. In parts of the country half of GPs work in a sessional capacity, and that means that our solutions have to reflect these diverse career aspirations, different contractual options, and we must be inclusive of all GPs that make up our broad profession.

With this in mind, GPC has laboured since January putting together our urgent prescription rescue plan "responsive, safe, sustainable". It's a package of tangible proposals we believe can first stabilise the current parlous state of the profession, and further create a platform for future sustainability.

Since January, I've been through the doors of number 10's policy unit, the offices of the Secretary of State and NHS England, putting forward our ideas about what we believe needs to happen to salvage general practice.

THE FORWARD VIEW

The Government finally responded with NHS England's GP Forward View last month. This represents a symbolic change in language by the centre, headlining pressures in general practice and the need for support and investment. Simon Stevens could not have been clearer in the introduction, citing that UK GPs suffer greater workload and stress than their international counterparts.

He explicitly damns a decade of disinvestment in general practice which saw GP numbers rise by only one third that of hospital consultants. He quotes a recent headline "if general practice fails, the NHS fails". How long have we been telling the Government that?

I've stood on this platform before and reflected that successive governments have recognised pressures and deficits in every part of the NHS except general practice. After all our collective lobbying, media publicity and the special conference it seems our message is finally getting through.

The Forward View is not a single proposal, and has no fewer than 108 commitments and various funding pots. It would be simplistic to either support or dismiss it in toto, and there are several positives that we as GPC have directly influenced, and which match those in our urgent prescription.

After a decade of declining funding, general practice will finally see an upturn of investment significantly higher than other sectors, and with increased share in the overall NHS budget. This is positive, but is tempered by the fact that general practice endured gross disinvestment at a time of plenty, while the government is belatedly trying to make up the deficit at a time when the NHS is virtually running on empty.

7 DAY OPENING

Last summer I called on Government to end its obsession with seven-day opening. It's notable that the Forward View was not launched with any publicity regarding routine 7 day GP services, and the words seven-days or 8-8 do not appear in the document. Furthermore, our lobbying has ensured there are no changes to the contractual hours of GPs.

The Forward View states that local commissioners can decide the level of routine capacity required on evenings or weekends, and further offers flexibility for this to be aligned to urgent care or GP out of hours services. It's not gone far enough, but in the context of a manifesto pledge that formed the basis of the government's intransigence with our junior colleagues, we may have partly won the argument.

Of course politicians will resurrect the seven day agenda but it's vital that we hold NHS England to account to their words to ensure that the priority for seven days is where it should always be – for properly funded urgent care and GP out of hours services, and we must reject the immorality of taking GPs away from caring for acutely ill patients to sit in empty surgeries superfluous to need.

Our urgent prescription is clear that the immediate priority must be to provide stability to vulnerable practices, or practices coping on the outside but with a fragile foundation that could suddenly collapse.

GPC proposed local taskforce teams to provide funding, management resources, or interim clinical cover which could be called upon at short notice. This would be in a supportive nonthreatening environment of amnesty, where practices can hold their hands up to seek support without fear of a breach notice or a CQC intervention.

It should be a significant untoward incident and a failing of the local NHS if any practice needlessly closes. This creates disruption and displacement of essential family doctor services to patients, and the domino effect of instability on neighbouring practices, not least wasted costs to the taxpayer of re-providing the service.

I therefore call upon NHS England to use the Forward View's practice resilience programme to make it an explicit KPI for all Area Teams to ensure there's not a single unnecessary or avoidable practice closure now or in the future.

Clearly any rescue plan must at its heart tackle inexorable, unmanageable workload – this is the root cause of the desperate plight of general practice today, and a direct result of demand running roughshod over our skeletal capacity. It's simple. We need to reduce demand, or increase capacity, or best do both.

On managing demand, the Forward View estimates that more than a quarter of GP appointments are potentially avoidable. That's patients who could more appropriately have seen another professional or service, patients who didn't need medical advice at all, or appointments taken up for completely bureaucratic purposes.

Just reflect on any of our surgeries – if not a quarter, we could probably agree that a conservative 10 per cent of GP appointments could be avoided. Free up those appointments and you increase GP capacity by 10 per cent. That's before any change in actual GP numbers, and therefore it's a no-brainer that the system must do everything possible to stop inappropriate or avoidable waste of precious GP appointments.

On that note, we're told the standard hospital contract has been amended to stop hospitals sending patients who've missed appointments back to their GP. That asking GPs to re-refer to a related specialty will cease. And that there'll be an end to asking GPs to chase up hospital results, with responsibility falling upon the requesting clinician.

This is most welcome, and must become a reality now – but our urgent prescription goes much further in proposing an end to a raft of other examples of secondary to primary shift, from inappropriate transfer of specialist prescriptions to ending GPs chasing up hospital follow up appointments, and it's positive that NHS England are setting up a primary/secondary care interface group to address this perennial problem

The Forward View heeds our call for a national patient self-care campaign scheduled for September. This must deliver an unequivocal public facing message of the pressures on general practice, that GP appointments need to be used wisely and to empower patients to self-care both for minor ailments and as experts in their chronic disease, or signpost them to other services.

THE GPs' 'URGENT PRESCRIPTION'

Our urgent prescription supports GPs working together in collaborative alliances. I grew up in the days of sharing out of hours work in a rota with three neighbouring practices. When the workload became intolerable, in 1995 GPC negotiated an out of hours development fund that transformed our ability to cope, with the birth of the GP out of hours cooperative movement. It demonstrated how GPs can be imaginative, effective and do great things together when given support and resources.

Now is the time to resurrect that spirit of collectivism and mutual support. We need development funding for an in hours cooperative movement, and pull together in local communities as one GP profession. We're seeing examples of this working already-in one instance a practice about to close after losing two partners was kept afloat by employed doctors in the local federation and is now back on its feet. In another example a federation's urgent care hub was able to support a practice unable to cope due to GP illness.

We must ensure the Forward View's funding for working at scale becomes a reality focussed on supporting practices and not for political expedience.

GP WORKLOAD

Fundamental to any rescue package is the ability to put limits on workload. We must end the current unsustainable reality of GPs working to unsafe open-ended demands and exhausting non-stop days without a break. In our urgent prescription we propose maximum workload limits, and the creation of overflow hubs to support practices when that point has been reached.

Neither is it humane nor defensible for GPs to be forced to manage patients with complex multiple problems in a pressure cooker intensity of 10- minute aliquots. GPs must be given longer consultation times in the interest of safe care, even if it means exposing a waiting list to see us.

Managing workload is also about taking control ourselves. GPC has launched a new quality and safety first webpage. This will give practices off the shelf ideas and tools on how to manage workload, drawing upon examples that have worked elsewhere. This is also about empowering and valuing ourselves and pushing back on unresourced non-core work, with the support of LMCs and local coordinated strategies. These initiatives need resources and headroom, and it's vital that the forward view's releasing capacity funds are used for this purpose.

Moving to workforce capacity this is much more than just a number. I'll spare ourselves the conjecture on the repeated political mantra of 5,000 more GPs by 2020. As we've said before, this puts the cart before the horse, since you first must create a job that doctors want to do.

Meanwhile we must surely first exploit the full working potential of the existing GP workforce. Our BMA survey shows that excessive workload is fuelling GPs turning to part-time work, with one in five GPs intending to reduce clinical sessions further. Making the job doable and rewarding will reverse this trend and itself expand workforce capacity. And with Government figures stating 38% of GPs intend to quit in the next five years, mass resignation is not a threat – it's an impending reality. The Government must ensure we retain the current workforce, in particular tackling the perverse factors driving older GPs to leave early.

'CRIPPLING' INDEMNITY COSTS

As part of this, NHS England must urgently address crippling indemnity costs. This is not just about punitive expenses on GPs compared to others doctors in the NHS. This is directly reducing workforce, with ample evidence of GPs reducing sessions while others are leaving due to prohibitive fees. The forward view's commitment to address this must grasp that reducing the indemnity burden is a cost-effective investment to instantly expand existing GP workforce today, while we await the promise of training more GPs tomorrow.

We must also embrace skill mix to support us while we're thousands of GPs short. When I started out as a GP, I routinely gave travel and childhood immunisations, syringed ears, and even dressed wounds. It was an inappropriate use of my time, and the expansion of practice nursing has fortunately put an end to this.

Today, there are multiple emerging ways in which skill mix can support GPs, from independent nurse practitioners, the expanding role of practice pharmacists, direct access extended scope practitioners, enhanced community nurses and paramedics doing GP home visits and so forth. We need recurrent funding for embedded skill-mix not time limited subsidised schemes, and with the flexibility to meet the needs of practices rather than be constrained by political initiatives such as physician associates.

'PERNICIOUS IMPACT OF CQC OVER-REGULATION

I mentioned in January the pernicious impact of CQC over-regulation. The Forward View's proposals to reduce inspections every five years totally misses ¬¬the point – we don't want to simply reduce the frequency of a process which is utterly flawed and damaging to GP practices.

We're calling for it to be decisively expunged and replaced with a system that's proportionate, targeted, understands context and supports practices rather than threatens them.

This is why the GPDF (General Practice Defence Fund) is funding a judicial review challenging CQC's heavy handed processes that are neither fair, equitable nor reasonable which we believe falls foul of the basic principles of natural justice. And a system in which we've this week exposed that their rating of a practice correlates with its level of funding, and which penalises and shames those that are the most disadvantaged already.

On inspection fees, of course we'll fight for these to be fully reimbursed, but the true cost of CQC goes far beyond its fees but in terms of the days and weeks of stress and preparation taking GPs and staff away from patient care, and with tens of thousands of GP appointments cancelled weekly to accommodate inspection teams. This is why the current process absolutely needs to be culled, and put millions of pounds squandered in nit-picking senseless processes back into patient care instead.

So where do we go from here?

General practice has been given a glimmer of hope but not yet a solution, recognition but not yet repair. We would be failing in our duty if we did not do our utmost to exploit the positives in the Forward View in the interests of GPs we represent. To make sure monies announced actually reach practices without needing to jump through hoops, that new schemes are used to relieve workload not add to our burdens, and to hold NHS England to account to make sure these are not just platitudes.

GPC is on the national oversight group of the Forward View and I've additionally proposed an LMC reference group to ensure high level ideas are translated into reality on the ground

We would equally be failing in our duty if we considered the Forward View as the final word in rescuing general practice. It's not. Four months into our six months timescale, our campaign for general practice continues. We will fight for what the forward view has not tackled, where it has not gone far enough, and to implement those proposals in our urgent prescription that are missing.

MONEY – THE ELEPHANT IN THE ROOM

Our campaign must also expose the elephant in the room which is money. While general practice will finally get a larger slice of the NHS cake, it remains a cake that's woefully too small to feed the needs of the population. A rationed cake in which we spend less of our national wealth on health than most of the western world, where we have a fraction of the hospital beds of France and Germany and lag behind most other OECD countries in our doctor and nurse numbers.

We need an honest wider debate about NHS funding, but also about what general practice can deliver within its current meagre resource, how we can responsibly cut our cloth according to the money we spend on healthcare, and put an end to the irresponsible political pretence of offering a consumerist service on a shoestring.

Within this reality, the fightback continues. General practice matters far too much to me, you and our patients to pack our bags because the Government hasn't gone far enough. We know the decade of neglect can't be turned around overnight, and our message to ministers as representatives of UK general practice is resolute and clear – we remain determined to rescue our proud profession and we will not give up until and when we achieve success.'

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NEW TEMPLATE PREMISES LEASE AGREEMENT FOR GPS

A new template lease agreement in England is said to deliver benefits to GP practices located within NHS Property Services premises.

Practices who sign up to the lease between now and November 2017 will see relevant costs incurred during the sign up process, such as stamp duty, paid for by NHS England.

The BMA said other benefits included:

- A clause allowing practices who lose their core contract to break their lease.
- A requirement entitling practices that see their rents revised to equivalent reimbursement.
- The removal of a previous clause that allowed NHS Property Services to relocate a practice.
- Increased transparency for service charges in newly revised guidance.
- Agreed dispute resolution procedures for all GP practices signing up to the new template.

The new template lease has been designed with the input of the BMA's GP committee, NHS England and NHS Property Services.

Dr Brian Balmer, BMA GP executive member, said: 'This is the first agreed template lease between NHS Property Services and the BMA. It has been produced after considerable negotiation and we believe it allows practices to sign up to individual leases with the confidence that they are entering into a fair and modern relationship with the landlord.

'There will of course always be local issues which need to be resolved and this agreement is not a magic bullet to every problem that arises with GP premises.

'The Government still, for example, needs to deliver on their planned investment in GP infrastructure. However, this new agreement is a significant step forward and presents an opportunity that I would urge GP practices to seriously consider, especially as some of the benefits of this agreement are only available for a specific period of time.'

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NEW FEARS OVER COST OF NHS CLAIMS

A YouGov online survey of 2,000 British adults reveals the mismatch between public perceptions about how much the NHS pays out for clinical negligence claims, and the reality.

Last year the NHS Litigation Authority (NHSLA) paid out £1.1bn to claimants for clinical negligence – which includes damages and legal costs ¬– but 43% of the public thought it was closer to £1m.

46% thought it was £1m – £50m and 6% thought it was £100m – £2bn.

When told about the reality of the cost to the NHS, 82% of respondents stated they were concerned at the increase in the cost of clinical negligence from £863m in 2011-12 to £1.1billion in 2014-15. The NHSLA manages claims arising in the NHS hospital sector.

The Medical Protection Society (MPS), which commissioned the survey, believes urgent action needs to be taken to drive down the cost of negligence and make it more affordable.

Claims boss Emma Hallinan said: 'This is a strong indicator of the lack of public awareness around the cost of clinical negligence to the NHS. The NHS is now seeing damages reaching well over £10m in some cases.

'It is crucial that we ask ourselves whether it is appropriate and affordable to continue to pay such high costs in damages. We recognise that this is a difficult message but difficult decisions about spending in the NHS are made every day, and the cost of claims should not be considered as separate to this.

'The NHS LA received around 11,500 new clinical negligence claims last year, an increase of 73% from just five years ago. Furthermore, at last count the NHS's ever-expanding liabilities reached £28.3bn.'

She said the MPS did not believe the figures indicated as deterioration in professional standards but were likely due to the increasing complexity of care, enhanced patient expectations and the challenging and expensive legal environment.

Last year the NHS successfully defended claims initially estimated at £1.2bn, highlighting the scale of unmeritorious claims.

The defence body is worried that diverting vital funds from frontline services to meet the increasing costs of clinical negligence claims may have an impact on patient care in the long term.

It urged the Government to prioritise reform of the legal system to drive down the cost of clinical negligence. It believes introducing fixed costs for small value claims and a limit on damages for future costs of care and earnings will help make clinical negligence more affordable.

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Keith Miller

Keith joined Albert Goodman in 2006 from a local Somerset firm of Accountants where, having qualified as a Chartered Accountant in 1988, he had been a Partner since 1990. He recently went on to achieve further success becoming a Certified Financial Planner in 2006.

Although best described as a General Practitioner, providing financial and taxation advice to an expanding portfolio of high net worth individuals, limited companies, sole traders and partnerships, Keith specialises in assisting medical practices and solicitors on all aspects of financial and taxation advice. He leads our GP medical team and is a member of AISMA, the Association of Independent Specialist Medical Accountants.

As a qualified Certified Financial Planner, he is ideally suited to obtaining a detailed understanding of the issues facing proprietors and their personal objectives in order to make a key contribution on strategic and tax issues, as well as dealing with the very complex areas of Capital Gains Tax and Inheritance Tax planning

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