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Internal Audit Report 2018/2019 - Draft

Corporate Governance - Primary Care Strategy

NHS Wolverhampton CCG

January 2019

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Contents

Distribution list

For action:	Steven Marshall (Director of Strategy and Transformation) Sarah Southall (Head of Primary Care)
For information:	Audit and Governance Committee Members

Executive summary

Headlines/summary of findings

This review focused on the CCG's Primary Health Care (PHC) Strategy and considered whether the strategy remains relevant and is fit-for-purpose or whether it requires an update. Our review also integrated questions linked to the GP Forward View (GPFV) initiatives focusing on how well progress being made is communicated to General Practitioners and whether there were further initiatives/schemes that could be introduced linked to skills mix and services provided in GP practices.

Our review has been performed through interviews with a range of employees involved with the CCG focusing on the questions contained on slide 14. We also undertook a broader survey of the GP membership of the CCG based on the questions outlined on slide 15.

Key outcomes from the interviews performed

- **GP Practice Groups** – the PHC Strategy should be updated to reflect the actual GP practice group structure to ensure that consideration is given to the additional challenges/risks that the structure may pose to the delivery of the PHC strategy;
- **Linkage with other guidance/strategies** – a number of key initiatives including GP Forward View, Sustainability and Transformation Partnerships, and the NHS Long Term Plan, have been issued since the PHC Strategy was first written. The PHC strategy should be updated to reflect the relationship and impact these have/will have on the intended outcomes of the strategy;
- **Impact assessments -** the CCG will ensure that appropriate mechanisms are in place to assess the potential impact of GPFV and PHC strategy initiatives that involve moving services from secondary into primary care and the ability of the GP practices to deliver the expected activity. These mechanisms should also verify that the GP practices are using any additional resource allocated to them for the additional service to increase their capacity within their practices rather than attempting to absorb change within existing resources; and
- **Stakeholder engagement** - the CCG will consider updating the PHC strategy to reflect on key areas of success achieved to-date against the strategy and GPFV initiatives to help communicate this to the GP membership. This will also help to ensure all stakeholders of the CCG can receive information on the changes being made in primary care regardless of whether they are actually using the service.

Key outcomes from the GP Membership Survey performed

- **Communication** - the CCG will ensure that the GP Group Leads are aware of their responsibility for disseminating the progress updates on both PHC strategy and GPFV initiatives to their practices. The CCG will also consider whether alternative communication mechanisms may be required to ensure messages are received and read by GPs such as using instant messaging facilities and other alternative technologies.

Each of the above outcomes and additional development areas are discussed in further detail on the following slides.

Please note that our report has not been risk rated as this is not a review of the adequacy and effectiveness of controls. Instead we have provided an output that summarises the results of our work and makes recommendations for the CCG to take forward.

Background

The CCG established a Primary Health Care (PHC) Strategy in 2016 in preparation for full delegated commissioning from NHS England. This included consideration of the alternative delivery models that were proposed through the NHS five year plan. The strategy was intended to cover five years to 2021. The CCG used external consultant support to work up the strategy which set out the objectives attached in **Appendix D.**

The day-to-day delivery of the PHC strategy is implemented through six Task and Finish Groups:

1) GP practices as providers
2) Primary Care contracting
3) Locality/practice groups as commissioners
4) Information Management and Technology
5) Workforce
6) Estates

Overarching the strategy was a focus on combining GPs into larger groups. The strategy initially outlined a vision of networks of practices covering 20-30,000 patients that would result in nine GP practice networks across the three CCG localities. In practice, four GP practice groups have organically developed. These are:

a) Primary Care Home 1 – a group of practices that are overseen by a limited company. Transformation funding is distributed to the limited company to implement the service rather than to individual practices.
b) Primary Care Home 2 - a group of practices that are overseen by a limited company. Transformation funding is distributed to the limited company to implement the service rather than to individual practices.
c) Medical Chambers (Unity) – a group of practices that work together but have not established a separate legal entity like the above. Please note that since the completion of our review Unity has now become a limited company.
d) VI practices – a group of practices that are now part of the Royal Wolverhampton NHS Trust.

Approximately six months after the CCG developed the PHC strategy, the General Practice Forward View (GPFV) was released. This outlined five initiatives attached in **Appendix E** to help prepare GP practices for the future. A number of these initiatives, such as workforce and extended access, overlap with the CCG's PHC strategy and the transformation funding linked to them has helped the CCG move towards the PHC strategy objectives.

Interviews with CCG employees

The first part of our review was performed through interviews focusing on the questions contained on slide 14. We conducted interviews with the GP Leads for each of the four GP Practice Groups and three Task and Finish Group leads.

The interviewees highlighted a number of positive changes that had materialised through the implementation of the PHC strategy and the GPFV initiatives which included:

- A Group Lead meeting has been established. This involves the lead from each of the four GP Practice Groups meeting with the Head of Primary Care for the CCG. The CCG utilise this meeting to disseminate key information on GPFV initiatives and the PHC strategy which the Group Leads can then take back to their practices. The GPs find this a helpful forum to share ideas and experiences of initiatives being undertaken within the hubs, such as trials of new service delivery.
- The practice group structure, supported by the Group Lead meeting, has improved the level and the quality of the interaction between practices. This was seen as a positive step forward from locality meetings which were deemed to be less effective.
- The majority of interviewees were supportive of the movement of additional activity from secondary care into a primary care setting. It was felt that the clustering of the GP practices combined with initiatives to improve the skill mix available within practices helped to facilitate this implementation.

Our interviews also highlighted a number of opportunities where PHC strategy should be updated:

GP Practice Groups

1

Finding

The PHC strategy outlined an expectation of up-to nine practice networks covering up to 20-30,000 patients. The actual structure of GP practice groups, as outlined on slide 4, is considerably different to this. The scale of the groups is much larger with the networks moving towards 40-50,000. The groups also have different operating models and legal status. The PHC strategy therefore remains partially relevant, as the expectation of GP practices working in larger networks is still being achieved. However, the actual structure that has materialised should be reflected as this in turn has additional challenges such as how the CCG will contract for services for each of the GP groups. It is also recognised that the reconfiguration of the practices remains on-going with some cross locality and geographical realignment of GP practices still to be undertaken. .

Recommendation

Recommendation 1– the CCG will update the PHC strategy to reflect the actual GP practice group structure that has materialised and ensure that that consideration is given to the additional challenges/risks that the structure may pose to the delivery of the PHC strategy

Linkage with other guidance/strategies

2

Finding

The PHC strategy was developed prior to the implementation of the GPFV and does not therefore make reference to this. As outlined on the previous slides, there is significant overlap in the initiatives under the GPFV and the CCG's PHC strategy.

In addition to the GPFV, the CCG has also subsequently developed more detailed strategies outlining its approach in areas such as workforce and estates. The PHC strategy includes these areas as key enablers to the delivery of the strategy objectives and makes reference to the need to develop a strategy in these areas but no further amendments have been subsequently made to reflect the actual strategies.

Sustainability and Transformation Partnerships (STP) - another key development since the CCG issued the PHC strategy has been the introduction of STPs. The Black County and West Birmingham STP Plan includes specific priorities linked to GP and community services which should be referenced to clarify the relationship between the two.

NHS Long Term Plan (LTP) – the most recent development has seen the introduction of the LTP which sets out a number of commitments which link directly to the delivery of primary care services including:

- GPs will be required to sign new network contracts that will sit alongside existing contracts. The network contracts will have a designated fund and will be part of the new multi-year GP contract agreement being negotiated between NHS England and the British Medical Association
- Patients will have a new right to switch from their existing GP to a digital first provider and all patients in England will have access to a digital first primary care offer, such as on-line video consultations, by 2022-23

The CCG should revisit the PHC strategy in-light of this new plan to ensure that the strategy objectives are aligned to the intentions of the LTP.

Recommendation

Recommendation 2– the CCG will update the PHC strategy to reflect the relationship between the GPFV and the strategy.

Recommendation 3– the CCG will update the PHC strategy to reflect the more detailed strategies that have been developed for key enablers such as workforce and estates.

Recommendation 4– the CCG will update the PHC strategy to reflect the relationship between the STP plan and the CCG's strategy.

Recommendation 5 - the CCG will update the PHC strategy to reflect on the commitments outlined within the LTP and demonstrate how the delivery of the PHC strategy will align with the expectations of the LTP moving forward.

Primary Care Impact Assessments

3

Finding

Slide 5 outlined how the majority of interviewees were supportive of the movement of activity from secondary care into primary care settings. However, one of the practice group leads did express strong concerns regarding the continuing movement of additional services into a primary care setting without there being an appropriate assessment on the resulting activity levels/available capacity of GP practices. The group lead also expressed resistance towards the movement into GP networks with their preference to remain as individual GP practices.

A separate interviewee also expressed a concern regarding the differing GP practice group models that had materialised and the extent to which this creates a risk of differing service provision depending on which group a practice falls under. This risk would be exacerbated by group leads who were against the additional provision of services within primary care which creates a risk to the CCG.

Recommendation

Recommendation 6 - the CCG will ensure that appropriate mechanisms are in place to assess the potential impact of service changes into primary care and the ability of the GP practices to deliver the expected activity. These mechanisms should also verify that the GP practices are using any additional resource allocated to increase capacity within their practices rather than attempting to absorb change within existing resources

Stakeholder engagement

4

Finding

Our interviews highlighted a number of success stories that CCG employees were proud of that have been achieved through the implementation of the PHC strategy and GPFV initiatives. Examples include the roll out of extended hours across all the GP practice groups and the use of clinical pharmacists, occupational therapists and care navigation within GP practices. The first practice group (Primary Care Home 1) was originally selected as one of fifteen Rapid Test Sites to develop and test new enhanced approaches to Primary Care in line with the ambitions of NHS England's 'Five Year Forward' View. The revision of the PHC strategy provides an opportunity for the CCG to step back and reflect on the progress that has been made and to capture examples of this, such as using case studies. Our interviews, and the survey below, highlighted that there is a lack of communication of success stories across the GP membership. These could be used to help engage further practices with service changes. Inclusion of these stories in an updated PHC strategy would also mean that any stakeholder who reads the publically available document would be informed of developments occurring in primary care regardless of whether they were actually using the service and experience the changes.

Recommendation

Recommendation 7– the CCG will consider updating the PHC strategy to reflect on key areas of success achieved to-date against the strategy and GPFV initiatives to help communicate this to the GP membership. This will also help to ensure all stakeholders of the CCG can receive information on the changes being made in primary care regardless of whether they are actually using the service.

GP membership survey

The second part of our review was performed through a survey of the GP membership focusing on the questions contained on slide 15. The full outcome of the survey is documented with Appendix C of this report.

The survey highlighted positives for the CCG in relation to the PHC Strategy and GPFV including:

- **How aware are you of Wolverhampton CCG's Primary Health Care Strategy?**– only 1/12 respondees responded negatively to this question with 5/12 strongly agreeing or agreeing. The remainder answered neither agree or disagree.
- **How well do you feel the CCG is progressing against the initiatives outlined within the General Practice Forward View?** - only 1/10 respondees responded negatively to this question with 4/12 strongly agreeing or agreeing and 6/12 neither agreeing or disagreeing. The remainder answered neither agree or disagree.

The following questions received a mixture of positive and negative responses:

- **Were you given the opportunity to be involved in the development of the strategy?** – 4/12 respondees strongly agreed or agreed with the question with 3/12 disagreeing. The remainder answered neither agree or disagree.
- **Do you believe the CCG is performing well against the strategy?** – 3/12 respondees strongly agreed or agreed with the question with 3/12 disagreeing or strongly disagreeing. The remainder answered neither agree or disagree.
- **Do you feel the strategy remains relevant and will deliver the transformation required within primary care?** - 3/12 respondees agreed with this question with 2/12 disagreeing or strongly disagreeing. The remainder answered neither agree or disagree.

The following slide outlines two questions that received a predominately negative response.

GP membership survey

The survey also highlighted a number of opportunities for improvement in relation to the PHC Strategy and GPFV including:

Communication

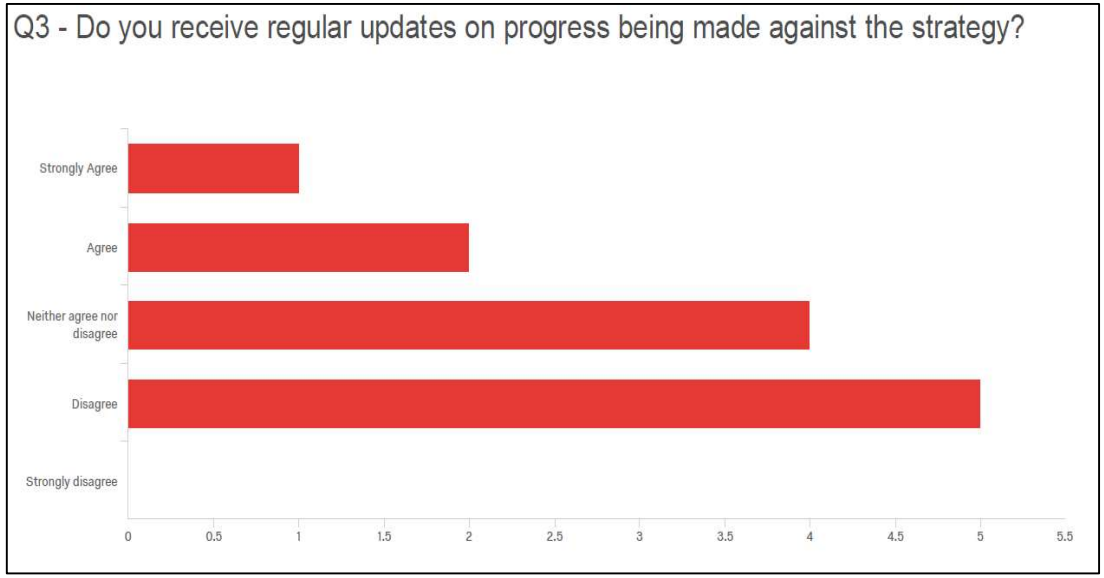
5

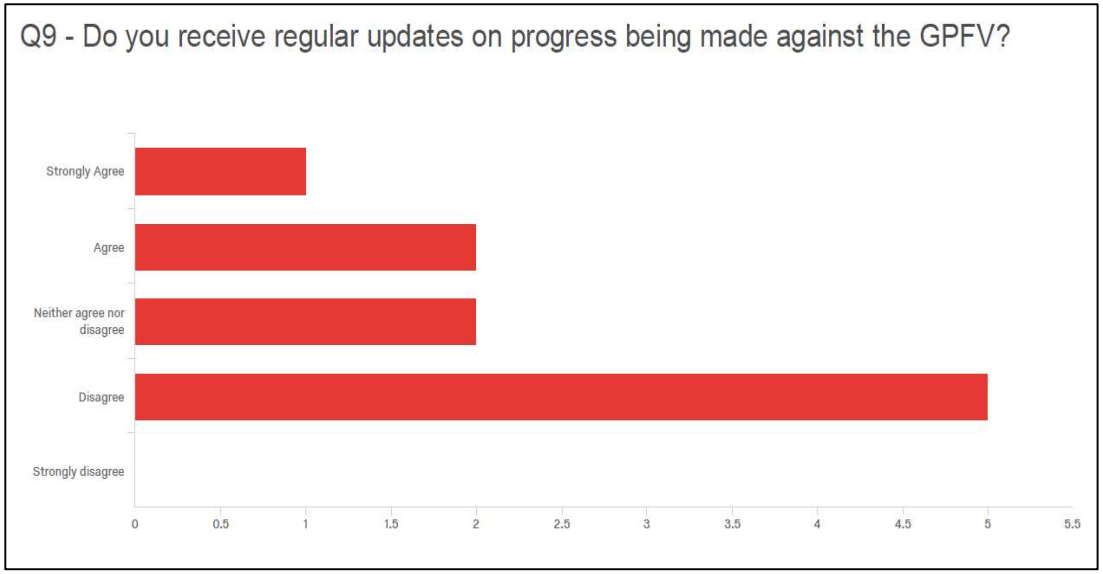
Finding

The survey included two questions linked to the receipt of updates against the PHC strategy and GPFV initiatives (see graphs below). 5/12 individuals who completed the question responded as 'disagree' in relation to the receipt of updates on the PHC strategy and 5/10 individuals who completed the question responded as 'disagree' in relation to the receipt of updates on the GPFV. The CCG therefore needs to consider what communication mechanisms are in place to ensure that progress updates in relation to both the PHC Strategy and GPFV are being received by the whole GP membership.

Recommendation

Recommendation 8 – the CCG will ensure that the GP Group Leads are aware of their responsibility for disseminating the progress updates on both PHC strategy and GPFV initiatives to their practices. The CCG will also consider whether alternative communication mechanisms may be required to ensure messages are received and read by GPs such as using instant messaging facilities and other alternative technologies.





Skill mix and hub services

6

Finding

The survey included two questions linked to whether the GP practices were seeing any changes in the skill mix within their practices and also whether services are becoming available at a hub level within each of the four groups. Our survey and interview questions also focused on whether there were opportunities for further developments in these areas. Both questions received a mixed response with 3/5 respondees indicating there had been a skill mix change and 3/6 respondees indicating services had been available through a group hub. The survey also highlighted two areas where further services could be delivered at scale – Out of Hours and Spirometry. The survey responses mirrored the outcomes from our interviews which recognised that progress was being made in this area. The hubs were delivering extended hours and new skills were being brought in, such as clinical pharmacists, and existing resources were being trained up, such as on care navigation. GP practice managers also have a new forum where they can interact and share knowledge and experiences. However, GP group leads felt that there were still areas where GP specialisms could be better utilised, skills such as social care and mental health that could be more prominent in GP practices, and other examples of services that could be delivered through a hub which included:

- Home visits
- Prescribing support
- Children Phlebotomy
- Dressing services
- End of life/frailty
- Spirometry service

Recommendation

Recommendation 9 – the CCG will review why 2/5 GPs do not appear to have seen any changes in skill mix within their practices and 3/6 GPs have not been able to access services through a group hub and whether this provides an opportunity to enhance the delivery of alternative services in primary care.

Recommendation 10 – the CCG will continue to explore the different GP specialisms available across Wolverhampton and whether there are further opportunities to move activity from secondary to primary care.

Recommendation 11 – the CCG will review the skill mixes within GP practices and whether additional social care and mental health provision could be made available within a primary care setting. This will also support initiatives outlined within the GPGV and LTP.

Recommendation 12 – the CCG will review the examples of services provided to PwC as part of our audit work and feed back to GPs on whether the services can be delivered on a hub basis or whether there are already trials/practice groups delivering these services from which others can learn from.

Appendices

Appendix A: Terms of reference

This review is being undertaken as part of the 2018/2019 internal audit plan approved by the Audit and Governance Committee.

Background

The CCG established a Primary Health Care (PHC) Strategy in 2016 in preparation for full delegated commissioning from NHS England. The strategy was intended to cover five years to 2021. The strategy is implemented through six Task and Finish Groups:

1) GP practices as providers
2) Primary Care contracting
3) Locality/practice groups as commissioners
4) Information Management and Technology
5) Workforce
6) Estates

The PHC Strategy is revisited on an annual basis via deep dives into the terms of reference for the Task and Finish Groups to assess their continuing relevance.

Our internal audit review in 2018/19 will focus on whether the strategy remains relevant and is fit-for-purpose or whether it requires an update. The audit work will be performed through:

- Interviews with key stakeholders including Task & Finish Group Leads and GP Practice Group leads; and
- A survey of the CCG membership to assess their awareness of the PHC Strategy, level of updates on the PHC Strategy progress they receive and the relevance of the PHC Strategy moving forward.

Our work will not focus on assessing the design or operating effectiveness of controls. Our report will therefore include suggestions on development areas but will not be risk rated.

Appendix A: Terms of reference

Limitations of scope

Our review will be performed through interviews and a survey only. Our work will not focus on assessing the design or operating effectiveness of controls. Our report will therefore include suggestions on development areas but will not be risk rated.

Audit approach

Our audit approach is as follows:

- Interviews with T&F Group Leads, GP Practice Group Leads and the Local Medical Council representative based on the questions listed within appendix 1;
- A survey of the CCG membership based on the questions listed within appendix 2; and
- A meeting with the Director of Strategy to discuss the outcomes of the above and agree the developments for the PHC Strategy.

Appendix A: Terms of reference

Interview questions

Primary Care Strategy

- What was your involvement in the establishment of the original Primary Health Care Strategy for Wolverhampton CCG?
- How has the strategy been integrated into the work performed by you?
- How well do you feel the CCG is progressing against the strategy, particularly in your Task and Finish Group area (where applicable)?
- Do you feel the strategy still remains relevant for implementation up to 2021?
- Are there any areas of the strategy you would change or refresh?

GP Forward View (questions for GPs)

- How well do you feel the CCG is progressing against the initiatives outlined within the General Practice Forward View?
- Have your practices seen any changes in the skill mix and roles performed by employees? If so, how do you feel these changes are working for your practices?
- Have your practices/patients been able to access any service(s) available through your respective practice group hub. Have you been involved in developing the service(s)? If so, how?
- Do you feel the change in service delivery is working? Are there any other services you would like to see delivered at scale that practices can refer to?

Appendix A: Terms of reference

Membership survey questions

Primary Care Strategy

- How aware are you of Wolverhampton CCG's Primary Health Care Strategy?
- Were you given the opportunity to be involved in the development of the strategy?
- Do you receive regular updates on progress being made against the strategy?
- Do you believe the CCG is performing well against the strategy?
- Do you feel the strategy remains relevant and will deliver the transformation required within primary care?
- Are there any areas of the strategy you would refine or update?

GP Forward View

- How well do you feel the CCG is progressing against the initiatives outlined within the General Practice Forward View?
- Do you receive regular updates on progress being made against the GPFV?
- Has your practice seen any changes in the skill mix and roles performed by employees? If so, how do you feel these changes are working for your practice?
- Has your practice(s)/patients been able to access any service(s) available through your respective practice group hub. Have you been involved in developing the service(s)? If so, how?
- Do you feel the change in service delivery is working? Are there any other services you would like to see delivered at scale that practices can refer to?

Appendix B: Limitations and responsibilities

Limitations inherent to the internal auditor's work

We have undertaken this review subject to the limitations outlined below:

Internal control

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness is not relevant to future periods due to the risk that:

- The design of controls may become inadequate because of changes in operating environment, law, regulation or other changes; or
- The degree of compliance with policies and procedures may deteriorate.

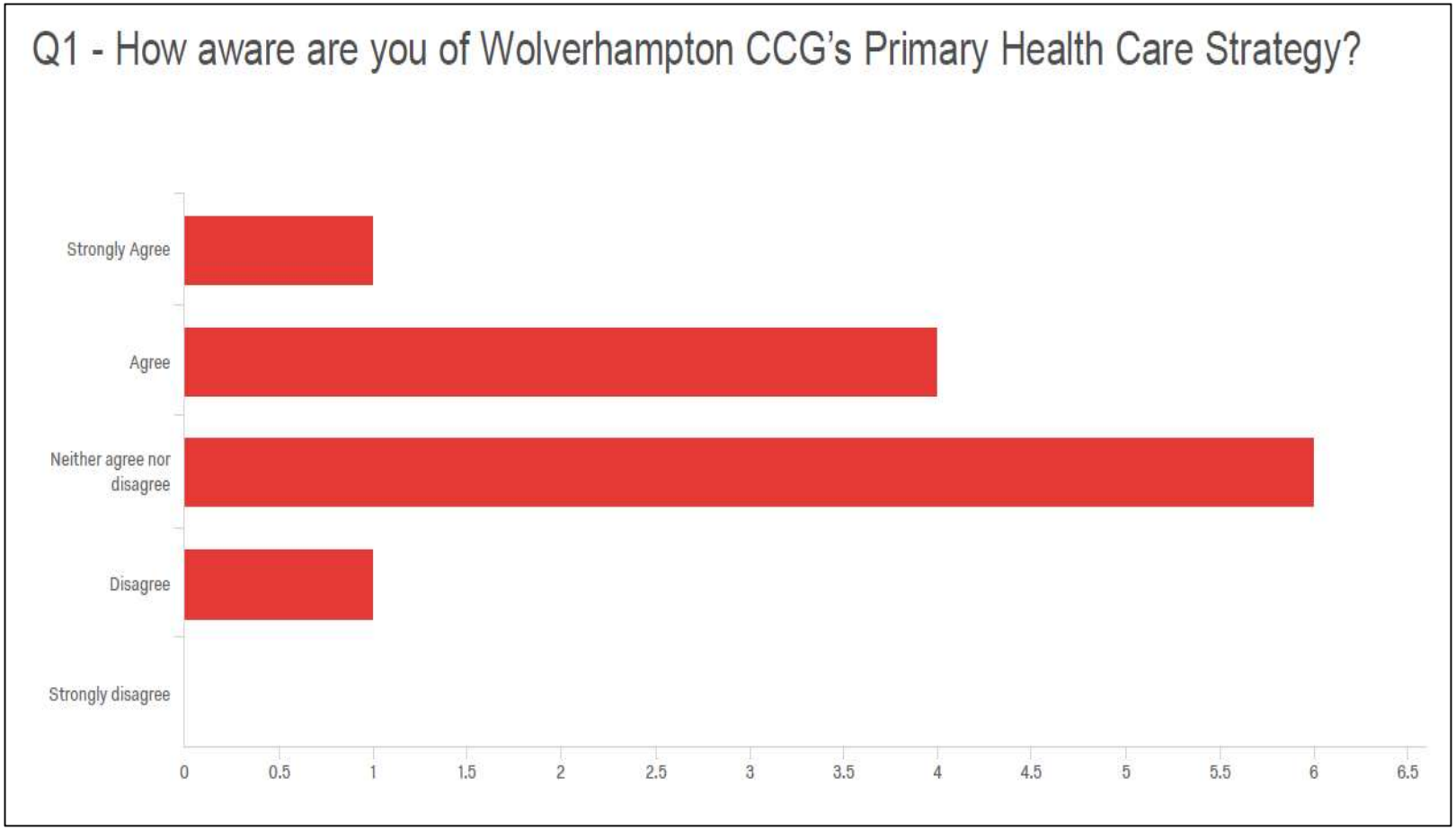
Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

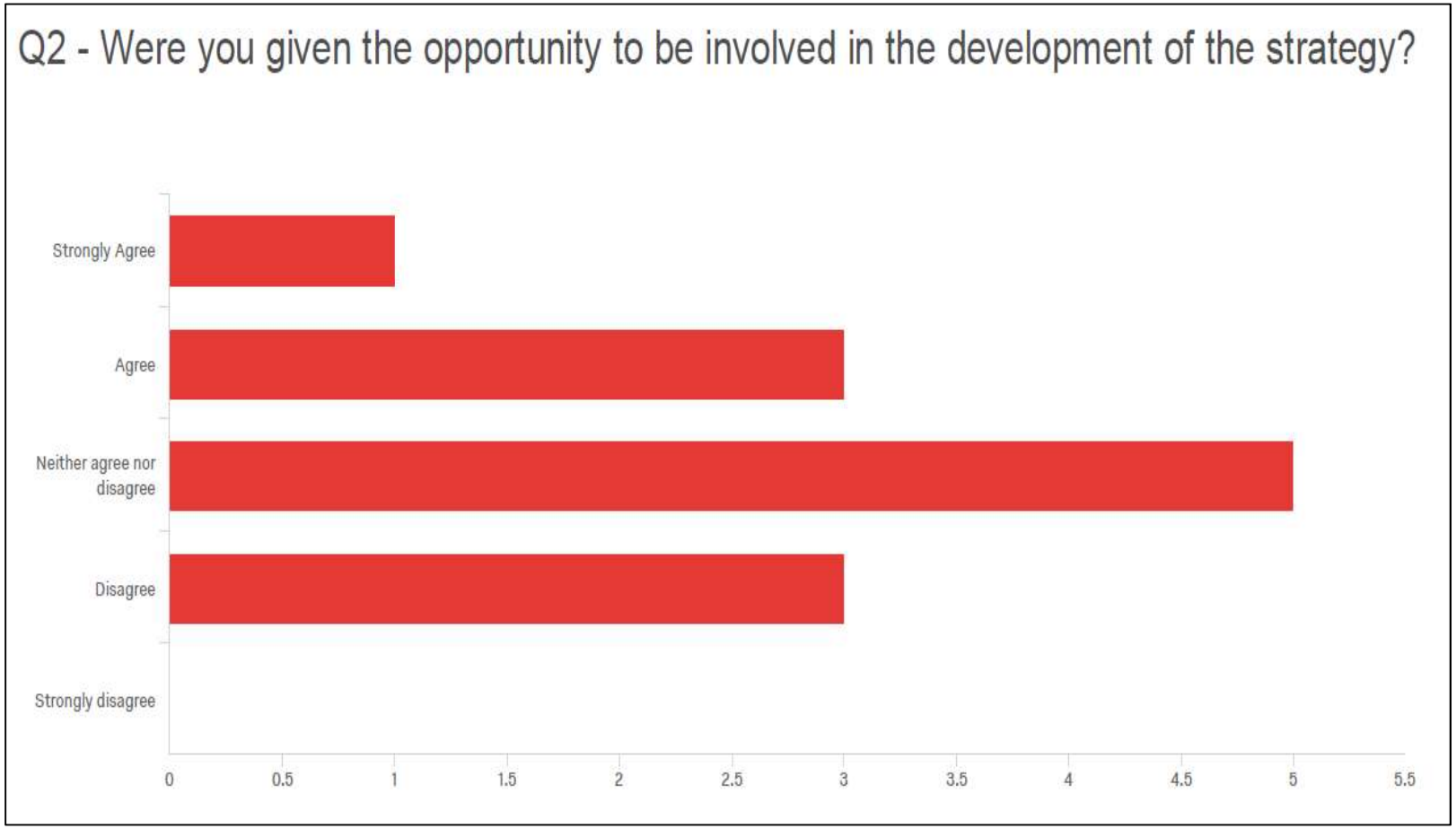
We endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected.

Accordingly, our examinations as internal auditors should not be relied upon solely to disclose fraud, defalcations or other irregularities which may exist.

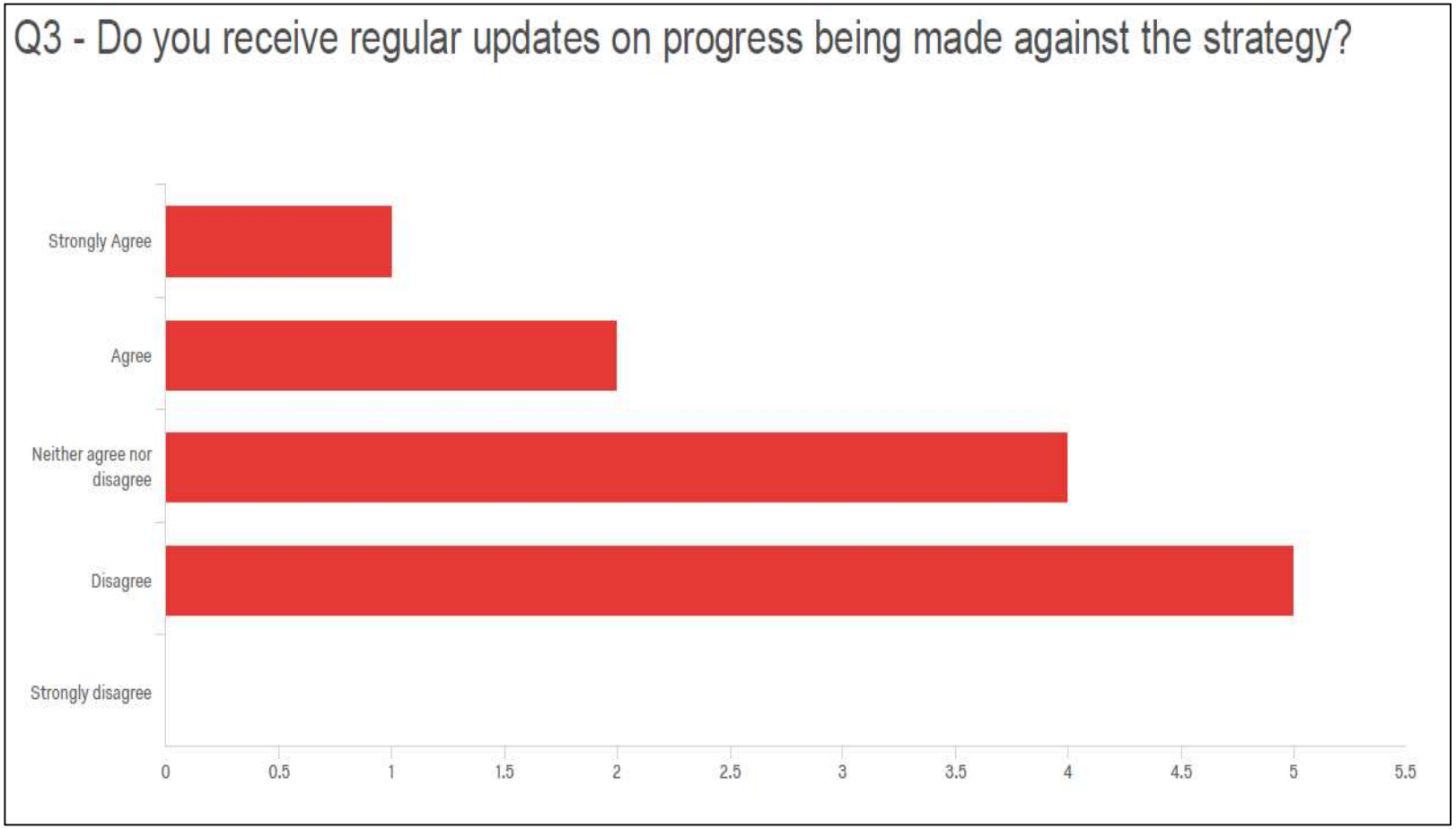
Appendix C: GP Membership Survey



Appendix C: GP Membership Survey



Appendix C: GP Membership Survey



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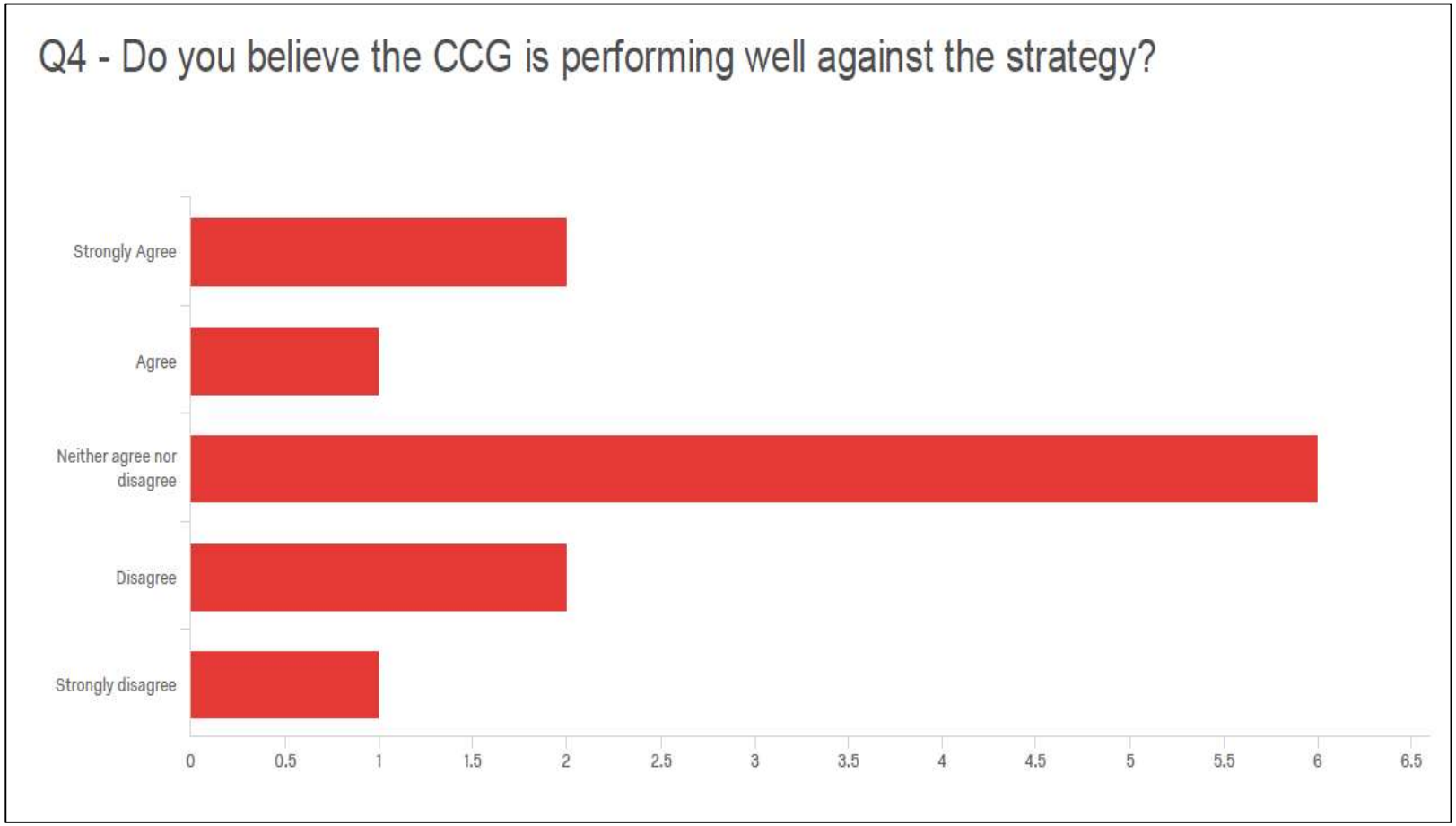
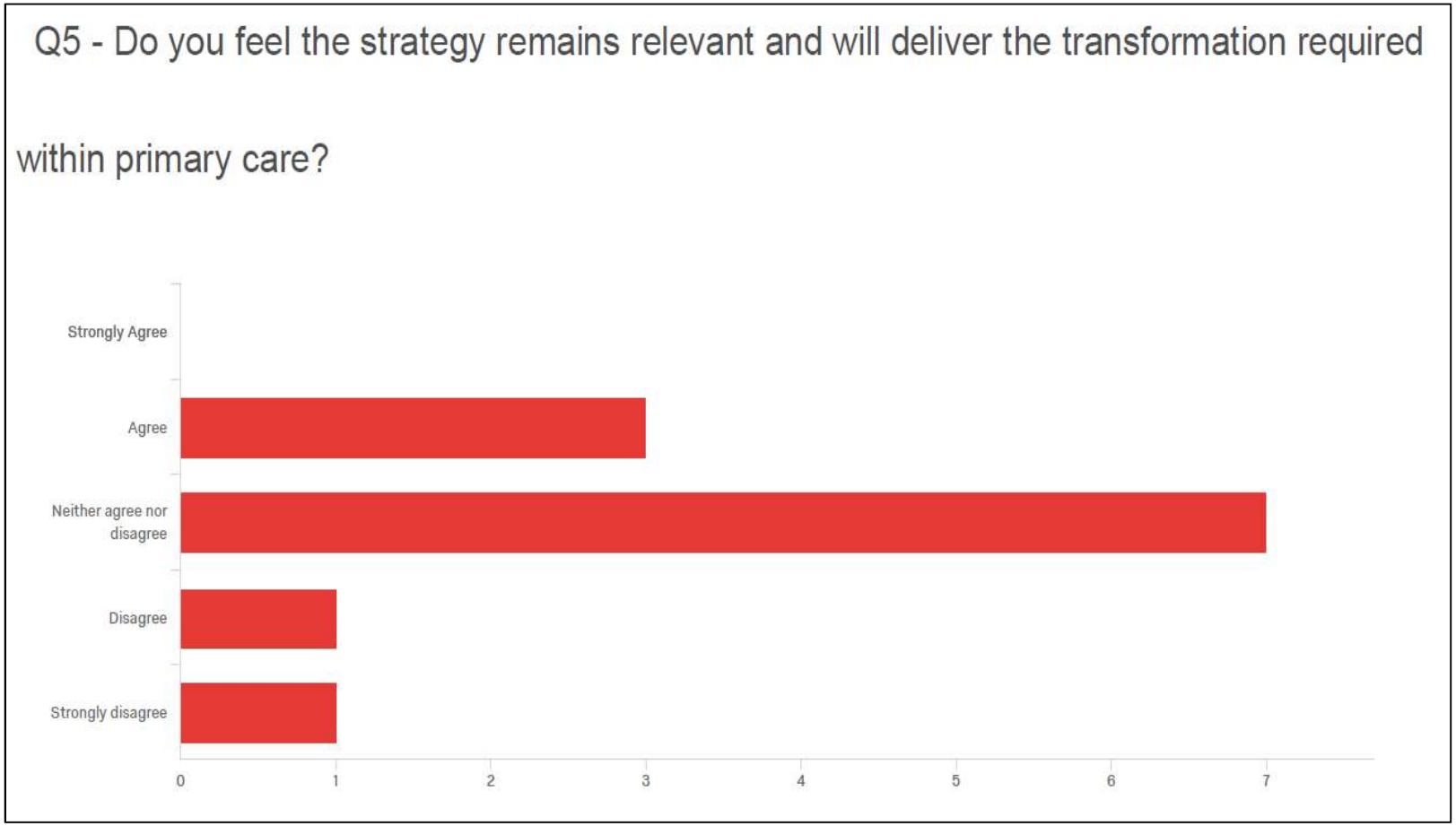


Appendix C: GP Membership Survey



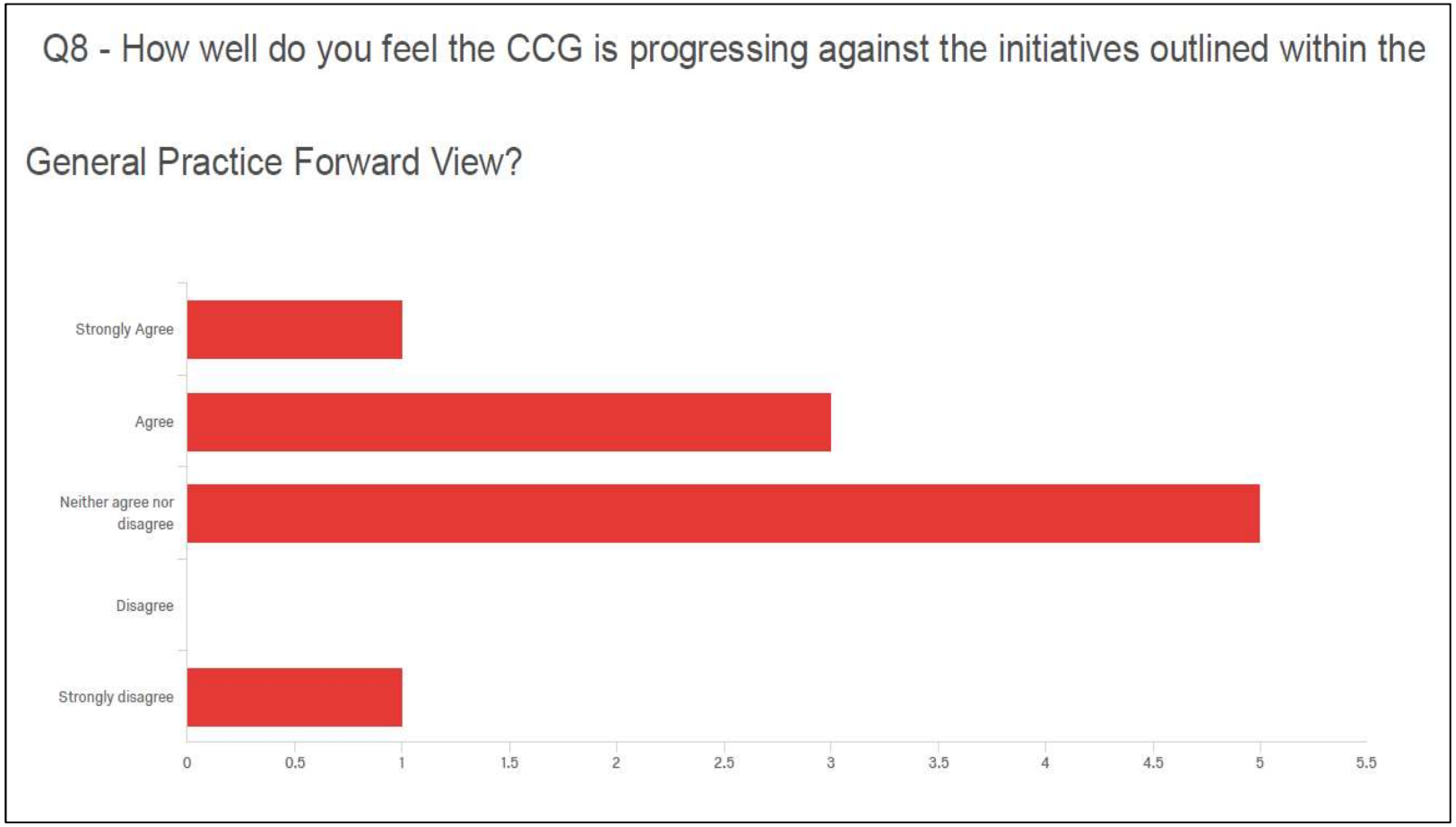
Appendix C: GP Membership Survey

Q6 – Are there any areas of the strategy you would refine or update?
I know attempts are made by Wednesday lectures, but poor attendance from GP,clinic,baby clinic, either visit surgeries , more emails will be beneficial, improve awareness and contributions
No
Not sure what the strategy exactly is
Nk
GP recruitment, Premises strategy

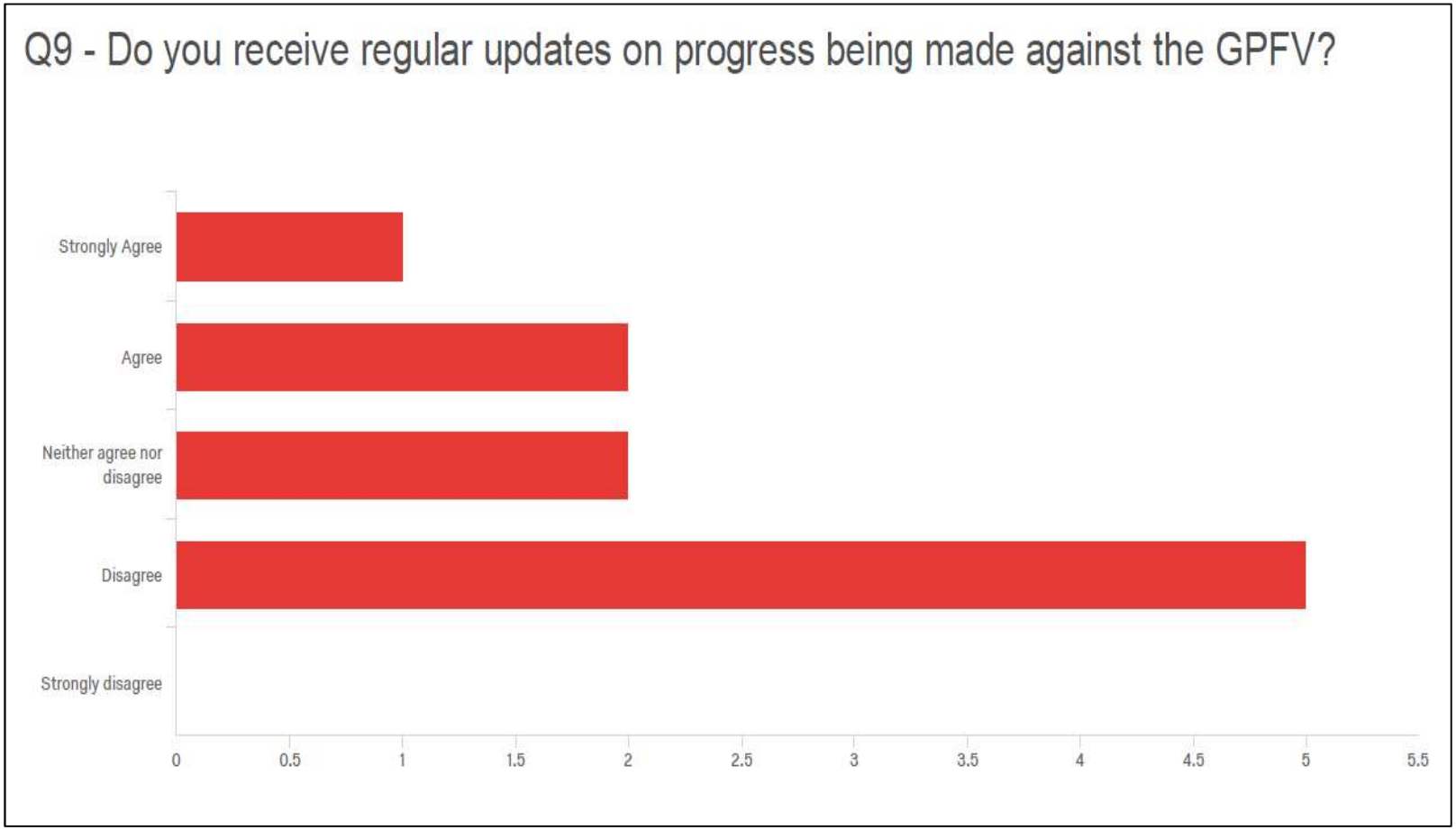
Appendix C: GP Membership Survey

Q7 – If you answered 'Disagree' or 'Strongly Disagree' to questions 1 to 5 please provide additional details of changes that would help to improve the performance?
it appears unstructured and not well thought through

Appendix C: GP Membership Survey



Appendix C: GP Membership Survey



Appendix C: GP Membership Survey

Q10 – Has your practice seen any changes in the skill mix and roles performed by employees? If so, how do you feel these changes are working for your practice?
Still budding through a new experience
No
have pharmacists that come in half day per week- taking some time to bed in currently, doing some useful tasks but also initially created more work for doctors
No
newly employed pharmacists, health physicians role increasing, navigation.

Appendix C: GP Membership Survey

Q11 - Has your practice(s)/patients been able to access any service(s) available through your respective practice group hub. Have you been involved in developing the service(s)? If so, how?
Nil
yes. Part of the vertical integration
No
Not aware of the group hub
Yes. 7 day opening and evening opening.
Extended hours. Our practice involved in setting up and delivering. Diabetic care monitoring and advice via diab,specialist nurse.

Appendix C: GP Membership Survey

Q12 - Do you feel the change in service delivery (referred to in the previous question) is working? Are there any other services you would like to see delivered at scale that practices can refer to?
Don't know
Yes. Out of hours service needs to be looked at.
No
yes need practice group hub spirometry service
Yes, but is it value for money?
Not as well I would like it to

Appendix C: GP Membership Survey

Q13 - If you answered 'Disagree' or 'Strongly Disagree' to questions 8 to 9 please provide additional details of changes that would help to improve the performance?
Need to involve more members .... gp
I have not been informed about GPFV progress- perhaps regular updates via email or roadshow may help?

Appendix D: Primary Health Care Strategy Objectives

Objective	Description
Treating patients in the Community	Between 2016-2021 the CCG will prioritise developing: • General practice Clinical Networks and Integrated Community Teams; • Self-care – with City of Wolverhampton Council to develop a balanced portfolio of self-care initiatives including managing short-term self-limiting ill-health and injury and self-care following discharge from hospital; and • Access to a range of standard primary medical services 8am to 8 pm 7 days a week through a combination of GP practice, extended hours and out of hours services provision with full access to a patient's notes irrespective of how or where access occurs. This will include use of technology to develop a number of non-face-to-face consultations including emails and telephone triage of the majority of appointment requests
A range of Extended Primary Care Services that will provide more services closer to home	• GPs able to consult consultants using emails/texts/phone/advice and guidance/Skype; • A range of health and social care services that will support an individual to be treated at home or in a nursing home when previously they would have been treated in a hospital; • A full range of support services to allow all those who wish to die at home to do so; • Refugees and Migrants – services specifically tailored to this population; • Looked After Children – to ensure this population receives all necessary support; • Children and Young People with Special Educational Needs and Disability Strategy – support implementation of the strategy particularly at transition to adult health services; and • Young People – primary care services tailored reduce unnecessary use of emergency and GP services.
A range of Secondary Care Services being provided in a primary care setting	• Outreach of elderly care specialist services in the primary care setting including a patient's home and local residential care homes (already in place in nursing homes); and • Outreach of cardiology and respiratory specialist services in the primary care setting including a patient's home and local residential and nursing care homes (this is already in place for diabetes).
General Practices as Providers - GP Clinical Networks covering 20-30,000 population with Community Teams wrapped around these networks	• The CCG will support the development of Federations/collaborations between practices that support practices with back office, CQC inspections, HR and other services they need to function to a high standard; and • General Practices and Networks of General Practices as Extended Primary Care Service Providers – the CCG will support the development of local General Practices and Networks of General Practices to provide a wide range of services as close as possible to the patient. We will support Networks of GP Practices to achieve activity and access targets for their populations. We will purchase Extended Primary Care Services from General Practices using the National Standard Contract which allows sub-contracting of service provision to other providers.

Appendix E: GP Forward View

Investment: by 2020/21 recurrent funding to increase by an estimated £2.4 billion a year, decisively growing the share of spend on general practice services, and coupled with a 'turnaround' package of a further £500 million. Investments in staff, technology and premises, and action on indemnity and redtape.	**Workforce:** pulling out all the stops to try to double the growth rate in GPs, through new incentives for training, recruitment, retention and return to practice. Having taken the past 10 years to achieve a net increase of around 5,000 full time equivalent GPs, aiming to add a further 5,000 net in just the next five years. Plus 3,000 new fully funded practice based mental health therapists, an extra 1,500 co-funded practice clinical pharmacists, and nationally funded support for practice nurses, physician associates, practice managers and receptionists.
Workload: a new practice resilience programme to support struggling practices, changes to streamline the Care Quality Commission inspection regime, support for GPs suffering from burnout and stress, cuts in redtape, legal limits on administrative burdens at the hospital/GP interface, and action to cut demand on general practice.	**Infrastructure**: new rules to allow up to 100% reimbursement of premises developments, direct practice investment tech to support better online tools and appointment, consultation and workload management systems, better record sharing to support team work across practices.
Care redesign: support for individual practices and for federations and superpartnerships; direct funding for improved in hours and out of hours access, including clinical hubs and reformed urgent care; and a new voluntary contract supporting integrated primary and community health services	

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