Written evidence submitted by Dr Phil Whitaker (FGP0119)

I make this submission to the Health and Social Care Select Committee enquiry into the future of general practice in my twin capacities as an experienced GP and as an established, published medical commentator. I am senior partner at Westfield Surgery, Radstock, a small, largely urban practice near Bath with a list size of 5,100 patients and a medical team comprising three partners and several retained or salaried GP colleagues. All our doctors work less-than-full-time in general practice; most have other portfolio roles or family responsibilities. I am also an experienced educational supervisor and have been training GP registrars for over ten years; I have good insights into the aspirations and opinions of younger colleagues entering general practice. In addition to my NHS work, I have been medical editor of the New Statesman for the past eight years, where I write regularly on health matters. I am currently working on a book about the changes that the medical profession and the NHS have undergone over the course of my career, provisionally entitled 'What is a Doctor?', which will be published by Canongate in 2023.

Dr Phil Whitaker

8 December 2021

*

Twenty years ago, I was the junior partner in a central Oxford practice. We leased a handsome Georgian building - a pleasant working environment with no property ownership risk. We acted as doctors to five of the university's most prestigious colleges, and we enjoyed a comfortable standard of living in one of England's most beautiful cities. In 2002 we advertised nationally to replace our retiring senior partner. We had two applicants. Only one was suitable and, spoilt for choice, he eventually accepted an offer from another practice. Virtually no one wanted to be a GP back then. Morale was at rock bottom. Younger doctors were looking anywhere else for their careers.

Recruitment and retention crises in general practice are not new and nor are they mysterious. When a job is attractive, people will want to do it; when it isn't, they won't. In 2002, the burning issue was 24 hour responsibility, which was exhausting and blighting most GPs' home lives even with the advent of out-of-hours co-operatives. And back then, joining a practice was still, by and large, considered to be a commitment for the rest of one's working life (it remained a matter of great suspicion if a doctor resigned from a partnership for anything other than compelling relocation reasons). Remuneration wasn't a huge issue at the time, though it was a factor; earnings had been slipping relative to the two main competitors for GP recruitment: careers in secondary care, and emigration to practice in Australia, New Zealand or Canada.

The 2004 contract resolved those issues and made NHS general practice a job people wanted to do again. Twenty-four hour responsibility was removed in exchange for GPs forgoing £6,000 per annum - the amount we were paid for providing out-of-hours care. Contractor status was no longer to be held by individual doctors but was instead passed to practices, paving the way for the rapid expansion of the new role of salaried GP. And partner earnings jumped significantly with the introduction of QOF. An influx of enthusiastic doctors swept into primary care, practices were fully staffed, and patient access was good. It was, without doubt, the best period I've experienced in my thirty year career to date - enhanced, additionally, by the ready accessibility of investigations and outpatient appointments resulting from New Labour's programme of above-inflation investment and capacity-increasing reforms.

Interestingly enough, by 2006-8, on the rare occasions that GP partnership vacancies (as opposed to salaried posts) were advertised they would attract many dozens of applicants. The medical press was full of letters from, and articles written by, salaried GPs bitterly criticising existing partners for having created a two-tier profession - jealously guarding their partnership perquisites and denying their salaried colleagues the chance of progressing to this coveted career level. Received wisdom had been that younger GPs no longer wanted the long-term commitment and investment implied by partnership. But that era showed that, if you make a job attractive enough, people previously repelled by the prospect may very well change their minds.

*

What are the drivers of the current recruitment and retention crisis? What are the problems that need to be solved?

Our present day crisis is about retention rather than recruitment. Numbers embarking on GP training have recently surpassed 4,000, but as fast as new blood is poured in at one end, it is running out at the other. Experienced doctors in their fifties are taking early retirement. Others, not yet ready or able to hang up their stethoscopes for good, are reducing their hours. And younger GPs typically four or five years post-certification are deciding that NHS general practice really isn't for them and are leaving to follow alternative paths.

The common thread is the job of a GP - certainly that of an 8 or more sessions per week GP. It has once again become something that fewer and fewer people are willing to do. Those who continue in practice - either because they still relish the role, or else their personal circumstances preclude them from resigning - are undertaking fewer weekly sessions in order to survive. Some will have family responsibilities to meet when they're not being doctors, but many will undertake 'portfolio' work outside coal-face general practice. Just like in the early 2000s, remuneration is not the central issue, although the steady erosion of real-terms partner earnings since 2008 has undoubtedly played its part (salaried GPs are rarely to be found champing at the bit to enter partnership these days). Rather, the job of being a GP - whether partner or salaried - has become, in many places, something that most people simply cannot sustain.

What has gone wrong? The obvious but incomplete answer is workload. Eleven or twelve hour days - sometimes even longer - are the norm in many practices. And these are days spent working at a frenetic intensity, with high stakes for any error. The burgeoning workload is in part due to rising complexity - we are looking after ever more patients who are multimorbid, sicker, and more frail - and in part due to rising activity. But it is principally due to inadequate GP numbers. For the past six years, Government has acknowledged that we need 5-6,000 more GPs in England, yet none have materialised. And it is a self-fuelling cycle - unsustainable workloads drive more doctors to leave or reduce sessions, intensifying workload pressures for those who remain.

The plethora of initiatives - PCN-supplied clinical pharmacists, social prescribers and other professionals employed under ARRS - supposed to compensate for diminishing GP capacity and to alleviate

workload have yet to make more than a marginal impact, despite the huge sums invested by Government. In my own practice, at time of writing, we are just beginning to experience a reduction in prescription work but it is still inconsistent. PCNs and ARRS are the Government's chosen vehicle for channelling additional resources into general practice at present, but I seriously question whether whatever benefits are being delivered justify the costs. I am not aware of any objective evaluation of this, either, though if that is being undertaken then I hope its findings are presented to the enquiry.

Equally, technology based 'solutions' supposed to squeeze more from the remaining GP workforce - symptom sorter apps, triaging tools, online access, remote consultations - have engendered a blisteringly hostile reaction from some sections of the media (and, regrettably, government ministers and NHSE leaders) as the Covid pandemic has ground on.

While workload is the obvious issue, equally important - and helping to fuel the workload problems - is the 'depersonalisation' of general practice over the past 15 years, which is rendering the job of a GP ever less satisfying and less productive. There are two interwoven strands to this. One is the loss of continuity of care, where patients know and are known by 'their' doctor. The other is the prevailing culture of standardisation being driven by QOF - where GPs are incentivised to make patients 'fit' within an idealised management plan rather than treatment truly being tailored to each individual.

The unique relationship between an individual patient and 'their' doctor, characterised by patient-centred consulting and shared decision-making - which is exactly what contemporary GPs have trained for and want passionately to deliver - is fast becoming extinct. The Ipsos Mori annual GP Patient Survey, inaugurated in 2006, shows the number of patients who feel they have a relationship with a preferred GP has been declining year-on-year. In 2021, it dipped below 50% for the first time. Continuity of care is incredibly important to many patients. In fact, it ranks top alongside ease of access when people are surveyed about what matters most to them in primary care. With a doctor we know - particularly when we have chosen to stay with that GP - we experience a high degree of trust. We have confidence in their judgements, give due weight to their advice, and experience them understanding us and tailoring their care for us as individuals. The recent and vehement media campaign demanding a return to face-to-face

appointments is, I believe, less about mode of consultation and more a proxy for the visceral desire to have restored to us that relationship with a doctor we trust and can rely on.

Why is continuity being lost? Both Government and the medical profession have a share of the responsibility. The 2004 contract created the conditions for it by decoupling an individual GP from their specific list of patients. The profession colluded by increasing numbers of practices adopting a 'taxi rank' approach to medicine - each patient contact representing a new episode to be picked up by the next available clinician. Government targets for same-day and 48 hour access (but none for continuity) skewed the picture further. Stir into the mix the Government push for general practice to work 'at scale' - surgeries merging, taking over, federating - and increasingly we are seeing daytime general practice as 'industrial medicine'. Huge supersurgeries with 30,000 patients or more are increasingly common. Individual clinicians become cogs in the machine. Patients become things to be processed. When, as a harried GP, you know that the patient you have for the following ten minutes is unlikely to see you next time they manage to make an appointment, there is no incentive properly to engage with their problems. Patients experience being 'fobbed off', the bare minimum being done, with no one taking ongoing responsibility for their care. The contract requirement to allocate each patient a named GP is, in most practices, simply a paper exercise devoid of meaning. What matters is if patients are able to connect with their preferred doctor on the majority of occasions that they seek care. In many 'industrial scale' practices there are no systems in place to even begin to allow this to happen.

Continuity contributes significantly to doctors' job satisfaction: we greatly value getting to know and care for our patients over the long term. This is more than just the human instinct to form relationships. When we know our patients we arrive at better, more holistic diagnoses more rapidly and more efficiently. We have a greater chance of patients following our advice and treatments, and we are less likely to be subject to complaint. The NHS benefits hugely, too. High levels of continuity of care translate to substantially lower use of out of hour services and emergency hospital admissions, reduced prescribing costs and outpatient referrals, and up to a 25% reduction in mortality. The converse is also true. Lose continuity and costs and pressures elsewhere in the system rise, with clinical outcomes becoming poorer -

exactly the trends the NHS has been seeing over the past fifteen years, including a stalling, pre-Covid, in life expectancy for the first time since records began.

GPs' increasingly jaundiced view of QOF indicates a mounting dissatisfaction with the 'tick box' culture and the idea of one-size-fits-all medicine. Guidelines that set out the evidence for best practice in managing a certain condition are valuable tools, certainly, but the real world is usually messier and much more complex. There is a strong desire to see targets and standards removed, and for GPs to be free to tailor care in collaboration with each individual patient according to their goals and values - the re-professionalisation of general practice.

*

If those are the core problems, what are the solutions?

A key step that Government has to take is to make a firm and unequivocal commitment to the general medical practitioner as a cornerstone of the NHS. It has presided over numerous practice failures since the 2015 election, which hugely undermined confidence for prospective GP partners and led to Nigel Watson's 2019 Partnership Review, the recommendations of which are still on the table. Part of this unequivocal commitment to general practice must be the urgent replacement of the Carr-Hill formula. This perpetuates the inverse care law, rendering many practices in deprived communities - which are also less popular career locations - financially unattractive, compounding their recruitment problems and threatening their viability. Many have folded, leaving a void behind them.

The advent of PCNs did seem to signal that the Government believed general practice would continue to have a future, albeit that the emphasis on ARRS roles suggested a vision of primary care with a significantly scaled-down GP workforce. The firm and unequivocal commitment to general practice should include a published plan as to how the Government is going to recruit and retain the additional 6,000 whole-time equivalent GPs it has acknowledged are necessary in England, and which it is currently failing to attract.

Crucial to any such plan will be a strategy to re-professionalise general practice and to revitalise continuity of care - for the good of patients, the wider NHS, as well as for GPs. QOF in its present form should be axed - which would address the immense dissatisfaction with tick box and one-size-fits-all

medicine - and the funding should be recycled into incentivising continuity of care, whether offered by partners or salaried GPs. This might involve systems for measuring continuity as being developed following the recent Health Foundation/RCGP pilot study, rewarding practices according to their achievements. This study, and the research by Professor Sir Denis Pereira Gray's group and others, show that high levels of continuity of care are eminently achievable with less-than-full-time working and even in large scale modern general practices.

Alongside this, there needs to be new a contractual arrangement that supports safe consulting limits. This could take the form of an agreed maximum number of patient contacts per GP per working day, which would have the effect of defining the current capacity of primary care in England and would therefore enable the Government to understand and act on the glaring shortfall. An alternative approach would be an activity-based contract rather than the current block contract. The busier a practice is, the more resources it would attract, and the more able it would then be to design and recruit to the appropriate skill mix to address the demand.

Prioritising continuity of care, re-professionalising general practice, and supporting safe consulting limits will make the job of a GP attractive once again. Of course it takes many years to train new entrants, but there is currently untapped capacity from qualified GPs who have left or scaled back their time commitment. Were the role to be revitalised and rendered sustainable again, whole-time equivalent numbers would, I suspect, quickly start to recover (as happened following the 2004 contract).

In the meantime, other measures to reduce workload should be pursued. The PCN project should be evaluated for its cost-effectiveness but in the meantime should focus on relieving GP workload rather than generating new work and activity. While general practice should support the prevention agenda, all 'case finding' initiatives (NHS Health Checks, pharmacy blood pressure and pulse checks etc) should be suspended pending pilot study evaluation of clinical effectiveness (there is currently no evidence that these kinds of schemes actually result in clinically meaningful outcomes i.e. reduced morbidity or mortality). The same should apply to the whole of primary prevention in general practice, which reflects a misguided belief that medicine can currently predict which healthy people are going to develop disease in the future and prevent that from occurring. It cannot, and an enormous amount of appointments and investigations are

churned through in general practice each year in pursuit of this chimera. This capacity could then be liberated to deliver additional medical care for the unwell. In place of primary prevention work, as a society we should reinvigorate public health policy, which has a proven role in effecting disease prevention through population-level changes brought about by eduction, regulation, taxation and so forth.

*

I would like to thank the Health and Social Care Committee for embarking on this timely enquiry into the future of my profession. I hope that the evidence I have submitted will assist its deliberations. I would be pleased to offer clarifications or to provide additional information at any stage should these be necessary or helpful.

Dec 2021