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We are a group of clinicians, academics and public health specialists who believe that Primary care should be at the heart of Public Health and that its enormous capacity to deliver prevention is currently underused.

We would like to propose a radical large-scale solution that provides proactive, reliable and consistent access to primary care through a named, local Community Health Worker. This ambitious solution, which is based in international evidence, takes a broader view of access than the narrowly-framed one of access to a named GP, focussing as well on the continuity of care and building community cohesion.

A national Family Health and Wellbeing Strategy as laid out below in response to the enquiry will focus on strengthening this relational aspect of Primary Care.

What are the main barriers to accessing general practice and how can these be tackled?

The main issues are:

(1) Increasing workload for GPs

The consultation rate in the UK is 2-3 times that of comparable EU populations. Between 2007 and 2014 overall consultation rates for GPs in England rose by 13.6% (Oxford University, 2016). Consultations grew by more than 15% between 2010/11 and 2014/15 (King's Fund, 2016).[1]

We know that about a third of consultations are for non-medical issues and GPs are ill equipped to deal with these wider determinants of public health effectively. We also know that 80% of a person's health is determined by how and where they live, with only 20% of their health and wellbeing dependent on access to good health care provisions.

(2) Complex, aging population and increasing health inequalities

This makes 10 min consultation ineffective and insufficient. Rising inequalities, increase in absolute poverty and health disparities (Marmot 10 year review, 2020) mean some areas with complex patients have difficulties getting enough GP coverage.[2]

There is pent up need from the pandemic and the impact of secondary care work that has been shifted into primary care during the pandemic have further increased the burden on primary care staff. A workload analysis by Bedfordshire and Hertfordshire LMC, alongside Cambridgeshire LMC, found additional work transferred from secondary care during the pandemic would require an extra 1,150 full-time GPs across England[3] which is not reflected in payment.[1]

(3) Long term lack of investment

The current investment falls £3.7 billion short of BMA target of general practice receiving 11% of the NHS budget (excluding drug reimbursement), instead the investment has fallen from nearly 10% in 2005/06 to just under 8% in 2016/17. Primary Care and Public Health have seen an overall contraction of investment with the Public Health budget reduced by nearly a quarter since 2016 and both Primary Care and Public Health together consuming less than 12% of the entire health budget (King's fund, 2021) This led to reductions in vital services such as health visiting, smoking cessation support, sexual health services, resulting in a significant increase in STIs and drug related deaths. The Build Back Better plan promises shifting the NHS towards prevention, but any effort towards this shift has over the years fallen short of the scale and ambition needed, as pointed out by the Kings Fund. They highlight that integrated care systems present an opportunity to focus on improving population health through partnership working between NHS, local authority and the voluntary and community sector. Yet no clear plan exists about how to integrate these better.

(4) **Lack of skilled workforce** (ranging from GPs to all aspects of practice and community staff)

From September 2016 to September 2017, the total number of full-time equivalent GPs fell

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[1] workload-control-general-practice-mar2018-1.pdf (bma.org.uk)

[2] Tackling the elective backlog – exploring the relationship between deprivation and waiting times | The King's Fund (kingsfund.org.uk)

[3] The new workload crisis - Pulse Today

by 3%. (NHS digital) Additional GP trainees present a long lead in time of at least 10 years and are outweighed by the number of skilled and experienced GPs leaving. The overall number of medical doctors at 3 doctors per 1000 people is the lowest in the EU with only Poland having less doctors.(OECD 2017-19)[4]

Too few doctors are choosing general practice as a career and many GPs are reducing their time commitment. 34% of partners are exploring alternative working options and 75% of sessional doctors are put off partnerships due to excessive workload (BMA 2016 survey).

An underspend of 3bn this year is likely due to inability to recruit skilled people into the ARRS roles, lack of funding for training and management of these roles and no thought given to integration. There is a long lead time for training of physician assistants, nurse practitioners, community pharmacists and there is a lack of skilled workforce that can be recruited to these roles at present.

(5) Lack of continuity of care

Fragmented services, co-existence of underuse as well as overuse of services and a lack of overview, combined with a work force crisis and GPs increasingly choosing portfolio part time clinical work as full time GP work is punishing and unsustainable at present. All these factors combine to a lack of continuity of care. Continuity is important and should be the focus of this enquiry. However, it is simply not possible given the scarcity of doctors and the large list sizes and rapid staff turnover. A recent study showed a direct dose response relationship of continuity of care with mortality rates[5]. The already existing named GP is currently tokenistic rather than achieving true continuity, a named GP is assigned but patients often prefer GPs they feel they have rapport with. About 40% of patients reported seeing their preferred GP almost all of the time and 23% a lot of the time in 2014[6]. Patients were more likely to attend A&E if they were unable to see their preferred GP[7]. A&E attendance for deprived areas was reduced by increasing the number of GPs[8] .

An innovative model developed in Glasgow in 2011called 'GPs at the deep end' found significant benefits managing complex clients with longer appointment times and continuity of care. The most challenging patients in primary care require a deep understanding of patients' lives, including their housing and environment, currently impossible within a totally unrealistic ten minute consultation period[9].

How can these issues be tackled?

We propose a whole redesign of primary care particularly reconnecting with the core principles of Primary Care. The Community Health Worker (CHW) model in Brazil (Brazilian Family Health Strategy) has been proposed to create equitable access, ensure continuity of care, comprehensive needs assessment, coordination of care. CHW, who are integrated into general practice and the local authority and come from the community they serve, provide monthly outreach to a geographical

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[4] europe-doctors-per-1000-people-1.png (1601×1440) (wordpress.com)

[5] Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway | British Journal of General Practice (bjgp.org))

[6] Cowling et al. Importance of accessibility and opening hours to overall patient experience of general practice. 2018, BJGP

[7] Cowling et al. Patient experience of general practice and use of emergency hospital services in England, BMJ Quality and Safety 2017

[8] (Are more GPs associated with a reduction in emergency hospital admissions? A quantitative study on GP referral in England | British Journal of General Practice (bjgp.org))

[9] GPs at the Deep End | Glasgow Centre for Population Health (gcph.co.uk) last accessed 10.12.21

area regardless of need and include the entire household. Each CHW would look after between 80 to 100 households on a regular basis and provide the eyes and ears of the GP in the community.

We believe it to be a cost effective and unique solution to deal with all of these entrenched issues based on the Brazilian experience, where it was rolled out at scale. The CHW as part of the Brazilian Family Health Strategy cover about 70% of the Brazilan population and in the last 20+ years have seen remarkable health improvements that have been documented including, but not limited to, an impressive 34% reduction in cardiovascular mortality[10], reduced racial inequality[11], improved child health[12], improved chronic disease management.[13] increased equitable access to health care[14] and reduced unscheduled hospital admissions[15].

To cover the population of England, the cost of a CHW workforce has been estimated to be around 2.2bn annually[16], less than the ARRS underspent of 3bn for this financial year. If this intervention was aimed only at geographical areas of high deprivation, we predict it would cost even less while having a dramatic impact on levelling health inequalities.

We hypothesize that this CHW workforce would also have a profound impact on the effectiveness and efficiency of primary care. Conservative modelling suggests that if CHW engage with and successfully refer 20% of eligible unscreened or unimmunised individuals, an additional 753,592 cervical cancer screenings, 365,166 breast cancer screenings and 482,924 bowel cancer screenings could be expected within respective review periods. A total of 16,398 additional children annually could receive their MMR1 at 12 months and 24,716 their MMR2 at five years of age. Community health workers would also provide home-based health promotion and lifestyle support to patients with chronic disease. [15]

We will set out in detail below how the CHW workforce as part of a national Family health and wellbeing strategy similar to Brazil can address all of the issues listed above.

(1) Reducing workload for GPs

SP evidence has shown that social prescribing initiatives are supported and welcome by clinicians as a way to reduce non-medical workload[17]. CHW are ideally positioned to deal with wider determinants of public health effectively.

The Brazilian CHW model is currently piloted in a UK context and early signs are that the CHW are able to uncover unmet need, connect up services efficiently, address wider determinants of health, provide continuity of care and address the entire family or household. (CHW pilot interim report) The CHW were able to resolve issues GPs would currently deal with such as medication compliance, health promotion, loneliness, social prescribing, connecting up to services, helping with triage, therefore releasing the capacity for the GP to focus on medical issues more appropriately.

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[10] Rasella et al BMJ 2014
[11] Hone at al PLOS Medicine 2017
[12] Lewin et al Cochrane Database of Systematic Reviews 2010
[13] Viswanathan et al Agency for Healthcare Research and Quality. AHRQ 2009
[14] Macinko and Lima-Costa International Journal for Equity in Health 2012
[15] Macinko et al 2010, Health Affairs
[16] Hayhoe et al 2018, JRSM
[17] BBBC SurveyMonkey Analyze - Export (bbbc.org.uk)

(2) Addressing health inequalities and complex needs and improving outcomes
Evidence from Brazil shows that the Family Health Strategy has increased equity of access to Primary Care there[13] at scale.

(3) **Rapid creation of a workforce to counteract the lack of skilled workforce**
The CHW are not technically skilled but are members of the community they serve and are able to connect patients to the right service and are fully integrated in primary care as well as the local authority. Given the low skills requirements the CHW can be recruited to create employment and to upskill the community and overcomes the issue of vacancies due to unavailability of skilled staff. Rapid recruitment and training could make this a very nimble and feasible policy option to put into practice quickly.

Opportunities of formalised and standardised training exist with the newly created NHSE CHWW apprenticeship[18] and a training programme is being piloted at present in Westminster as part of the CHW pilot. CHW could be recruited from Community champions, health trainers and other similar community roles.

This approach is currently trialled in Westminster in a deprived area and gaining traction nationally with further pilots underway in Thanet, Bridgewater, Calderdale and Kensington and Chelsea and others showing interest. Early findings from the Westminster trial, which we are happy to share, show that this model can be operationalised in the UK context, and is feasible and acceptable.
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Further information and resources:

Video on 'Community Health Workers – Learning from the Brazilian Model':
https://youtu.be/EW7dnzh2MqI

Presentation about the interim pilot report in Churchill gardens
https://prezi.com/view/rGNzEiAX9FJ00uGJjjWA/

[18] Apprenticeships that support public health careers: November 2019 update - GOV.UK (www.gov.uk)