Written evidence submitted by Dr Emma Watts (FGP0373)

It feels we have reached a critical point, and the NHS is not sustainable in its current form
As a GP, I see four main problems in the NHS:

- Hospitals
- Management Culture
- A lack of understanding of general practice's role in the system
- Problems with the GP Contract

Hospitals are a problem because they

- Are an incredibly inefficient way to deliver most forms of care. Most of outpatients, for example, could be delivered far more cheaply in a community setting, with high levels of patient satisfaction (following European models and following the model of our community gynaecology service, run by Shere Surgery and covering all of G&W in an one stop community model, which has won a National GP Award for innovation, and is used as an example of excellence in multiple toolkits- including the Rural Toolkit for Health).
- Have become 'too big to be allowed to fail'.
- Are treated as 'untouchable' by politicians and the public.
- Have been protected from a need to evolve into more efficient forms by repeated financial bailouts and by a complicit management culture. Example: Digital requesting of investigations such as blood tests. The Royal Surrey County Hospital system is set up to allow for this, we use the same system as the hospital to request our tests, yet for reasons only understood by management, hospital doctors aren't expected to use the system. Instead, they fill out blood test forms. This became a significant issue at the start of the pandemic when this workload all shifted to us overnight with clinic letters from phone appointments saying 'GP to request the following bloods' etc. This needs to stop as we aren't resourced for this, but the hospital is, and more crucially, it is a shift of medicolegal accountability. The doctor requesting the test is responsible for outcomes from it, so it is an easy solution to pass this all to GP but is not sustainable. Simply enforcing the use of the digital system they already have in place(and have logins for and are trained to use it as they use it to view results every day) would reduce primary care workload shift overnight. If they really can't be convinced to move to digital requesting then, as per their contract, they should send out blood forms in the post by Royal Mail, it just feels a bit old fashioned.
Another similar example is prescribing: secondary care is paid as part of their contract to provide the prescription (and take medicolegal responsibility for it) that arises from their consultation. They do this by writing on a pad of paper and putting it in the post, but it is easier to just write to the GP and tell them to do it. This saves the hospital time and money and removes medicolegal responsibility from them. What possible motivation could they have to change this? However, the pressure of this workload shift is felt in GP. A shift to prescribing digitally would resolve this problem overnight, with prescriptions being issued from secondary care direct to our dispensary or a pharmacy of the patient's choice. This would be convenient for patients & hospital doctors and resolve the workload shift. It would also make things safer, as all prescribing could be audited at any point, and medication clashes would flash up, like in our system. I am staggered that this hasn't happened yet, when we have been issuing computerised prescriptions for years, and moved to digital signing of them some years ago too. However, there is no motivation within the hospital system to do this because shifting into GP saves them money and responsibility.
- Have become unquestionably the dominant players in all local healthcare systems and have used this power in organisational self-interest. Example: workload shifting- see the examples above. There

is no motivation for a hospital system to address these safety and operational problems when there is secondary gain to be had (in terms of budget and accountability) to leave things as they are.

Management Culture is a problem because

- Training is brief and insufficient – there should be a clear and ongoing management training programme right up to CEO level, and that should involve extensive experience in commissioning and providing, and both primary and secondary care.
- Accountability is poor. Example: winter pressures funding to GP. This was commissioned in Surrey to the private provider Livi. We would have preferred to have been given the money to pay for locums to backfill when we are struggling, like now, with me off sick. Livi promised the world and the contract was signed. Winter pressures money was to help us from 1st Dec 2021 onward. So far, there has been NO Livi provision against this contract. All this money lost to the front line into a contract that has so far delivered us nothing. We become more exhausted, headlines say money is being thrown at us, it isn't seen at the working end, and where is accountability?
- Poor levels of productivity are accepted as the norm.
- There is a poor understanding of general practice, community services, and social care – even by those who commission it. Example Improved Access funding: this was to provide additional appointments 8-8 7 days a week. This has been set up locally in a way that simply doesn't work for us as a rural practice. Central funding to try to help us manage demand and capacity is again not seen where we need it. The centres to provide this service are urban, we asked to be a centre and were refused. Our patients can't get to them as they are rural, isolated, poor transport links, less neighbourly lift offering due to covid rules/fear about giving vulnerable people covid. Our patients rarely use these appointments, not because we don't need them or need the help, quite the contrary. In September 2021, one Guildford surgery used 900 IA appointments which ought to be equitably shared to reduce the pressure on all of us. The same month Shere used 0 IA appointments. This is a very good example of the lack of understanding by management systems of how General Practice works, the differences within it, and our lack of power to be able to do anything about it.
- There is a clear and bewildering prejudice against general practice, that dates to the 2003-4 contract, and is now culturally embedded.
- There is clear and equally bewildering favouritism towards hospitals, leading to poor controls over contracts and oversight of investment.
- Managers are obsessed by governance and see perpetual reorganisation as meaningful work even when it has no purpose and delivers no worthwhile change.
- Management Consultants with equally little understanding of systems are repeatedly called in to offer solutions which will not work in the existing context.

A lack of understanding of General Practice's role in the system is a problem because:

- There is a sense in senior management that the NHS can manage without us, somehow, when the reality is that we see 90% of patient contacts each day. That capacity will not be easily or cheaply replaced.
- General practice operates a different culture to hospitals: we solve problems and close them down rather than simply pass them around. Part of this is that we manage and accept risk and are the only part of the system to do so; other parts of the system and other clinicians over-manage, over-refer and over-investigate in order to minimise risk. This is also a fundamental problem with the concept of staffing PCNs with auxiliary staff.
- We are also self-managing and the only part of the system that operates within budget, because we have to. This is under-appreciated.

- Digital solutions have been over-promoted and cannot replace us without massively increasing expense in the system (as they are risk averse) and/or morbidity and mortality rates (as they will get things wrong). Note that even the 'two-week cancer' referral guidelines have been shown to be less accurate in diagnosing cancers than a simple GP opinion: medicine cannot be reduced to simple algorithms. Having said that, our AskmyGP model achieves the best of both in terms of digital provision, in our opinion and in the majority opinion of our patients- this allows an 'open' front door in reality and digitally, giving patient choice as to how they wish to be managed. We pay additionally for this system because we see its success, and we have masses of data (prepandemic to date) demonstrating effectiveness.
- Our evolution as a service and productivity gains have not been matched by the rest of the system.
- Our ability and speed innovating is not understood. If it works, we implement it quickly from the ground-up. NHSD imposing unworkable 'solutions' does not work.
- The lack of understanding and appreciation is fuelling an exodus from the profession. Most GPs I know have a plan B career. I did an MSc in Ultrasound a few years ago but am currently studying again for a non-medical plan C.

Problems with the GP Contract:

-Partnership is unattractive. We have to work in unlimited liability partnerships which means new partners are fearful to join, nervous about implications on their personal mortgages and finances if the partnership fails, or the partnership model is replaced with a salaried workforce. The financial reward of partnership isn't worth the risk anymore which is why many partnerships have failed and closed, and more will follow. The obvious alternative is the salaried workforce, run by a private company. Clearly, I am a partner so this would lose me my business, but objectively it remains unlikely to be successful. The amount of goodwill hours put in by myself and my colleagues is just not affordable in a salaried service. With salaried provision comes working rights/hours/safety. To provide what we currently have would need far more GPs than exist even if current GPs took the move to salaried rather than moving to their plan B career. If the EU safe maximum for a GP to see is 25 patients per day, but sometimes we see 60-70, how could this possibly be worked into a salaried service, and how much would it cost if the workforce was available? Backfilling with ancillary staff is being tried via PCNs, but the failure always comes down to accountability and medical responsibility, and only GPs are really prepared to take this.

-Estates: We are all working in buildings that are too small. Our CCG recognises our building is too small for our population but each patient is now demanding more appointments per year, and this is not yet factored in to calculations on building size (I have loads of data showing demand per patient, some of our frequent flyers are young people in their 20s with NO chronic health conditions, requesting GP input >52x a year) There are no funds to help us expand. We are putting in 3 phone box booths (arriving soon) which are literally sound proofed boxes the size of a phone box, to house GPs that don't have rooms, and we share consulting space, booking a room for face-to-face appointments. Sometimes I have to bring my camper van in and work from the car park, seriously. We want to expand, and we would take the financial hit of building ourselves…BUT… the future of our business is at risk, and we are an unlimited liability partnership, so we can't. If we could, and our community are in support of this as we have had meetings to discuss, we would expand incorporating an NHS Dentist (we have a dentist ready and willing) and capacity for community specialist clinics (Cardiology are really interested in duplicating our Gynaecology model, and we would love to partner with them but hospital management are too fearful to allow it to progress). Expansion of estates now could enable cheaper care in communities, where patients want it, whilst reducing the inefficiency and size of hospital systems, allowing them to streamline.

-Private work: Our contract doesn't allow us to do any private work. I would love to understand the motivation behind putting this in the contract for GPs, when Hospital Consultants, Dentists, Pharmacists all are seemingly freely able to manage the potential probity issues that arise. This seems overtly punitive and discriminatory. If we were allowed to do private work as well, I don't think you would see an exodus of GPs to a private system as GPs who were this way inclined would have moved to this model already, and some have. However, you would see better care. Example is our patient whose sister died of cervical cancer. She would like annual smears and knows she can't on the NHS. She would like to pay us for the interim ones. Why shouldn't this be possible? Screening scans: NHS offer a screening aortic aneurysm scan for all men aged 65. I personally scan all our at-risk patients earlier than this age, and females at risk at any age. I also scan all our population at risk of testicular cancer using European guidelines. I do this for free in my own time. This is fine for our patients, but it isn't fair for others not getting the same service. One of our patients has personal risk factors for AAA and his father died of the same. I have him covered with repeat scans, but his brother (lives elsewhere) can't get an NHS scan and can't afford to pay for a private one. Frustratingly in this case, I can't even offer to scan him for free as I'm not covered by CQC to do so for a non-patient. Lumps and bumps not covered for removal by the NHS contract. I could do this simply for our patients for a very small fraction of the fee they end up paying to an external surgeon that they have no ongoing relationship with. It feels as though this would be a simple factor to resolve and comes from what patients are asking for, rather than desire for profit.

-PCNs: These don't work nationally, albeit they may work reasonably in some cities. For our PCN with some urban, some rural it is impossible to agree solutions to fit all within the limits of the rules applied to the money. For example, we can use the money to buy a First Contact Physio who will share their fulltime around 6 practices. Moving around and not 'belonging' in any one surgery, not getting to know teams, be part of them, understand where support lies, is professionally demoralising, so recruitment and retention within these roles is appalling and the money is lost. Also, estates are a problem, there is no room for them. If the intention was to force partnerships into groups with the idea of them becoming superpractices sold off to a private provider, I would hope that PCN evolution (lack of) thus far, has demonstrated that this would be unpopular to both patients and staff.

Rural Dispensing: Whilst I note in your previous email you aren't intending to address the problem of the sudden 24% drop in dispensing fees, and I completely understand this, it serves as a very good example about the lack of voice experienced by rural dispensing doctors. 15% of the UK population is registered with a dispensing doctor, so we are a large majority, but our voice is unheard. Maria Caulfield has taken an oblique and deflective stance to efforts by dispensing doctors, and Huw Merriman MP, who have tried to challenge this. The issue has arisen due to increased prescribing demand generally, and has been worsened by secondary care workload shifting, expecting GPs to do 2ndry care prescribing. Dispensing doctors are therefore doubly discriminated against as they are doing 2ndry care's prescribing from their primary care drug budget and then dispensing at a loss. The prescribing should remain in secondary care who hold the budget and the workforce for this, but when it does come to GP it should be resourced effectively.
Dispensing rules haven't changed for many years and are not fit for purpose. We hold dispensing rights because we are too small for a pharmacy to be financially viable, but we can't operate under similar rules. Again, this feels discriminatory as we can't for example, sell first aid items, suncreams, other items you might buy at a chemist, that our patients want to buy from us as there is no pharmacy locally. This item is here to highlight the point that rural dispensing doctors feel voiceless and unrepresented, working within out-of-date regulations that are not fit for purpose. With the pressures of Brexit and the pandemic on drug prices, this leads our businesses to becoming closer to non-viable, and again this is destabilising. We need a mechanism to have our voice heard, as do other GPs serving specific populations (asylum seekers, prisoners etc).

Funding/Resourcing: GP is unattractive because it has become a responsibility dumping ground where every other stakeholder can seemingly discharge patients into. It holds everything that doesn't fit elsewhere and has no control of demand. It is paid a small, fixed fee to provide all of the above, in a system where demand keeps rising. If we were paid on a pay by results format this would be much fairer, but it would cost a lot more. However, this could be stripped from the hospital budgets if the issues above were addressed.

Continuity of Care: Rather than try to explain the full value of this, I hope you will have seen the value of it first-hand. The concept was written far more eloquently than I can in The New Statesman last month. It is well written and has some interesting insights into why the Face-to-Face argument became such a big topic last year. Knowing patients well can be life-saving. But family GPs like me fear our days are numbered - New Statesman

Potential Solutions:
1. The future of hospitals is that they should be allowed to evolve to become smaller, leaner and more efficient organisations, delivering only those aspects of clinical care that require hospitals: surgery, obstetrics, acute in-patient care, ITUs. Hospital boards should have GP and patient representatives to ensure accountability to their local clinicians and populations.
2. Everything else should be delivered in a community setting, under the auspices of GPs. This would include the bulk of outpatients, ideally in community specialist clinics to enable close working between GP and our consultant colleagues as this is safer, more efficient and patients like it.
3. Community services should be delivered by trusts whose board has a majority of GPs, with significant patient representation.
4. Commissioning boards should be similar to previous CCG structures, but with more secondary care clinician involvement. Managers must not be allowed to sabotage them as they sabotaged CCGs. PBR should continue (and general practice should be similarly costed) but only as a way to understand funding streams within the NHS, and as a way of redirecting funding alongside workload.
5. There should be a 5-year evolutionary plan to get to this point, with structured redirection of workload and investment into community settings.
6. NHS Management training needs a complete re-think in order to make it fit-for-purpose.
7. Hospitals should be contractually forced to modernise systems, starting with digital requests for investigations and digital prescribing. This would halve the primary:secondary care interface issues overnight.
8. Partnerships should be allowed the right to practice privately in line with other similar professions and they should be able to work in a limited liability partnership in order to re-energise entry into the partnership model for newer recruits. This would lead to stability of the workforce and enable good continuity of care.
9.Provide minority GP groups (such as Rural Dispensing in my case, but would also apply to any minority, such as Asylum GPs/Prison GPs etc) a mechanism through which their voice is heard and so the needs of their specific patient groups can be met.
10. Invest in Estates
11. Resource the Partnership model appropriately to address recruitment and retention problems, and to recognise the societal value of continuity of care.
12. Apply financial penalty to workload shifting in either direction across the primary:secondary care interface.

Potential problem:

Hand complete control to NHS senior managers. This would ossify the system in its least-efficient state, allow hospitals to continue to dominate, and see the end of NHS general practice. I have heard that NHS senior managers are presenting the White Paper as 'the changes that the NHS itself wishes to see'. This is not true – this is managers presenting their self-interest as the interests of the wider NHS.

Lansley was largely correct in his diagnosis and plans, but they were hijacked by people with other agenda, and sabotaged by the managers themselves who prevented the evolution in efficiency he quite reasonably expected to follow. He wrote quite eloquently about it last year.

Whilst the purpose of your inquiry is to address the future of General Practice, this is not possible without addressing issues within the wider healthcare system and freeing up finances by doing so. I hope you are able to consider some of the above problems/potential solutions as part of this.

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