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We are a group of patients in north London, concerned about the crisis engulfing general practice, and have ideas about how this could be tackled.

1. Barriers to access

The barriers are resource driven and attitudinal. The latter appears reflected in the Committee's call for evidence. We worry that the short timescales, 16/11 to 14/12, and lack of publicity, or obligation to effectively inform organisations representing patients, local authorities, and other partners, will result in a narrower response, less likely to deliver a patient orientated service. This is a lost opportunity, and we hope that the deadline can be extended and publicised.

- Patients rely on a skilled, high quality, reliable, accessible general practice, as this is the main arm of the NHS patients contact (90% of patient contacts are with primary care).
- Barriers to access include difficulties contacting GP practices by any means, long waits for an appointment, talking to different clinicians for every contact who know little about them, repeated telephone triage, frustration with e- consult and Patient Access, and delayed referrals and long waits for secondary care. (Healthwatch and others).
- **The underlying cause of the barriers is that demand for care outstrips supply, and the pandemic has only exacerbated this imbalance, with increasingly restricted access to General Practice, undermining of clinical standards, with lethal consequences *(1)*.**
- **There is a huge shortage of GPs, nurses and other primary care staff, and major difficulties with recruitment and retention. Funding for primary care has shrunk as a percentage of healthcare spend (10%) and is well below the OECD average (14%). GPs and other members of primary healthcare teams are facing a massively increased workload, political and media attacks, and are responding by working part time, leaving the profession, or retiring early.**
- The increase in demand, partly because of a growing and ageing population, rising health inequalities, as well as the pandemic and vaccination rollout, has not resulted in a concomitant increase in resources.
- **Thus, general practice and patients are potentially pitted against each other, facing a problem that is unsolvable, unless government finally addresses years of underinvestment, and lack of a funded and delivered workforce strategy.**

Effectiveness of NHSE's plan

- The proposals in NHS Plan's *Improving Access for Patients and Supporting General Practice*, *141021*, on funding, workforce and reducing bureaucracy, whilst welcome, are a drop in the ocean compared with what is needed. Also local systems were expected to bid for small pots of money and be able to demonstrate value and increased capacity by mid-December. **This stop - start, over controlling approach to resourcing does not work; sustainable, predictable funding is needed, with greater local discretion on spend and longer timescales.**
- The changes to QOF, scrapping the need for checks for older people, has led some older patients to feel abandoned by GPs.
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Impacts of restricted access

- Patients may divert to unscheduled care e.g. A&E, 111, UTCs. Some give up and do not seek health care, resulting in **delayed and more serious presentations**, and potentially devastating physical and psychological impacts, effects on employment and family life, or death. Other may seek private care, but there are limits to the

numbers for whom this is possible, and private care is not useful for emergencies, chronic long-term conditions etc All result in service fragmentation and discontinuity of care.

- Role of named GP in continuity of care
- **Continuity of care with a known doctor facilitates timely diagnosis and reduces the need for unnecessary referrals to acute care and diagnostic tests, over-diagnosis and treatment, reduces the chance of missed symptoms, increases patient compliance with treatment, and reduces mortality**. *(2)* Fragmented care, with patients seeing different clinicians, accessing different services, and an over reliance on remote and digital contact, results in the opposite, so is counterproductive.
- Of course there are situations e.g. emergencies, when seeing an unfamiliar clinician is fine, and patients should be allowed to change their named GP.
- **Continuity can also improve GP job satisfaction, which in the UK is lower than in international counterparts, and consultation lengths are much shorter in the UK than in other high-income countries.**

2. Challenges for the next 5 years

These are long term underfunding, serious workforce shortages, coping with the continuing pandemic and its legacy of unmet need, escalating workloads, lack of capacity in allied services, low morale, loss of influence, privatisation, and government policy. Somehow the government must be persuaded that **investment in the NHS and services impacting the social determinants of health, is infrastructure investment, essential for the economy as well as health, providing immediate increases in employment and therefore tax revenues.** It needs to publicly support General Practice rather than issuing threats, and rapidly contradicted instructions.

The crisis is now so bad with LMCs reporting in August that some practices might close because of staffing and workload pressures that **the only option now is for the NHS to buy its way out of trouble, with a massive and sustained investment in workforce, premises, and equipment; the most urgent is workforce, and that means funding. Tackling the backlog will be one of the major challenges for the next 5 years**

Funding: a year's worth of GP care per patient, costs less than two trips to A&E, so increasing GP's proportion of NHS spend makes economic sense. Of the extra £60b funds apparently allocated the NHS between 2019/20 and 2020/21, about £47b went to the Test and Trace and PPE provision, i.e. not to the NHS and general practice, which has misled patients into thinking general practice is better resourced, and should be able to see them.

Workforce: The Number of FTE GPs per 1000 population has decreased, with recruitment initiatives to encourage doctors into general practice and post graduate practice-based training places insufficient to meet replacement demand, let alone an increase. The commitment to 6000 more GPs and 26000 more other primary care staff is outstanding, and must be delivered within an annually reviewed workforce strategy.

Workload: under capacity and cuts to other services generates massive workload burdens for General Practice. Spending on most services impacting the social determinants of health – housing, education, employment, income, and the environment, has fallen substantially (*3). T*he grant to Local Authorities, for Public Health has fallen by 15% from 2013/4 to 2019/20, and the pressures on social care, also spill over into the General Practice workload.

Primary/secondary care interface: There is an over emphasis on symptoms and pathways, rather than the whole patient, with referred patients often returned to primary care with negative test

results, but with the same problem, or returned with a host of new tasks for primary care, for which it is under -resourced to deliver. It is too early to assess whether the 2021/22 NHS Standard Contract stipulation, that secondary care providers must address certain processes that generate avoidable administrative burdens for GPs, will improve the situation.

The reduction in general and ICU hospital beds has led to pressure on discharges with the UK having far fewer beds per head of population in 2021 than comparable countries, and all year-round winter pressures, with no spare capacity. Transition from hospital to home results in nearly 20% adverse incidents for patients, including avoidable symptoms, additional A&E visits, hospital readmissions and death. *(4).* **Earlier discharge and recovery at home to GP care is enshrined in Discharge to Assess and included in the Health and Care Bill, with no allowance made for the parlous state of primary and social care**.

Privatisation: there is a danger with the growth of APMS contracts, of primary care becoming like social care, a failing market, with heavily leveraged private companies, seeking opportunities to make quick, low risk profits and using loss leader strategies, until profits are made, and they sell, or quit because they cannot generate sufficient profit, resulting in poor quality care, and provision instability. (See Q8).

Private providers on APMS contracts are also offered more money for provision than the NHS GMS/PMS practices for the same service.

Influence: in the new ICS structure proposed in the Health & Care Bill, GPs have only one seat on the ICS Board. They need to be given much greater representation on all the ICS committees to play a major role in shaping local healthcare.

3. Regional variation challenges

- There is variation in both provision and need. Need tends to be higher in disadvantaged areas and/or those with older populations. Provision tends to be more adequate in more affluent area and less geographically remote ones. **The funding formula needs to be changed to align more closely with need; to avoid areas losing out, the overall GP funding needs to be boosted which is long overdue. Levelling up and tackling health inequalities requires levelling up of General Practice.** *(5)*
- Some countries use more effective incentives/restrictions to ensure doctors set up in under-doctored areas.
- General practice needs to be made more attractive, better supported, celebrated, and rewarding for GPs and other staff, if general recruitment issues and particularly those in poorer and remote areas are to be tackled.
- Practices should ideally service small geographic areas within walking distance, and in rural areas where this is unrealistic, larger practices should devolve to micro teams; so within the wider team, patients would have a named doctor, but be managed by the micro team -e.g. Ty Doctor N Wales - a better option than closing practices where recruitment is difficult.

4. Role in prevention

- It should play a huge role, for if general practice fails, so does the whole NHS. Robust primary care delivers regular, preventive, and patient focused care, long term relationships, an easily accessible entry to the health system, and ensures that patients' worries, and potential health problems or chronic conditions are identified and managed early.
- Investment in primary is one of the four features highlighted as crucial in top performing health care systems; the UK now comes 9/11 for health care outcomes. *(6)* Also, evidence

suggests that **collaborative initiatives between primary care and public health deliver positives at an individual and population level, e.g. chronic disease management and disease control.**

- Practices could be clustered into health and wellbeing hubs, offering a wider range of preventive, advice, and community services, placing general practice firmly at the centre of the NHS in local communities e.g. Bromley by Bow. (7)
- Improved community care could be achieved by introducing a version of the Buurtzorg scheme, *a* successful Dutch primary care, nurse led service, providing high levels of holistic, coordinated care with patient /nurse continuity, to patients living at home; there are UK sites that have adapted and adopted the model. *(8)*

5. Bureaucracy and morale

- **Reducing workload is key to improving staff retention and morale. More needs to be done urgently, and on a sustainable basis, to speed waiting times for GP appointments, either telephone or face to face, and reduce waiting times for secondary referrals. This requires increased capacity and workforce in primary and secondary care.**
- Increased investment and support by PCNs and Federations is required to: expand the extended hours hubs scheme to ease waits for GP appointments; promote collaboration and support for joint projects between practices and between primary and secondary care; fast track new initiatives proposed by Federations or practices; facilitate mergers and partnering; enable PCNs, Federations or larger practices to provide 'back office' services to others, thereby delivering economies of scale, but preserving clinician/patient relationships.
- Workflow could be improved with better signposting by super-administrative and reception staff, patient management reminders to reduce DNAs and facilitate access, more effective social prescribing, harnessing technology to assist with administrative tasks, and appropriate use of telemedicine.
- Review of CQC and QoF arrangements to reduce the administrative burden for the average practice, ensuring a focus on performance, safety and quality, and a greater emphasis on within-profession assessment and mentoring for all staff; for solo professionals, the PCNs or Federations should arrange this across their area.
- Expanding the capacity of existing initiatives between primary and secondary care e.g. the patchy Consultant Connect, ambulatory care and 2 week wait schemes, is essential.
- A rapid workforce plan might include: improved returnee schemes; better terms for part timers; salary supplements for GPs in less popular areas and possibly London weighting; increases in practice based GP training places with some trainees subsequently more likely to join the practice; expanded Additional Roles Reimbursement Scheme; creation of clinical promotional grades for non-medical professions, fast tracking refugee and asylum seekers with medical or other health qualifications, although general practice can be challenging for newer arrivals, and assisting practices to deliver attractive staff remuneration and support packages, to permit the recruitment of e.g. experienced senior practice managers/super administrators and others.

6. The future

There needs to be a major review of primary care, to ensure it has a far more central role, with an expanded remit, fully resourced and skilled up, to undertake a wider preventive role addressing health inequalities, some of the work now referred to secondary care, e.g. outpatients (tests, initial consultations), and that of some of the services established to relieve pressures on A&E and provide instant access to a GP service. These resources should be (re)invested in primary care to provide a one-stop shop model, to deliver local, timely, joined up healthcare, greater job satisfaction and opportunities to specialise and collaborate for primary care staff, and a better use of resources.

The boundary between primary and secondary care should be blurred with more services e,g. dermatology and muscular skeletal, diagnostic test centres and specialist clinics and treatment, currently undertaken in hospital, transferred to primary care. More specialists would be co- located in GP clusters, with GP generalist clinics in hospital. This would reduce weighting times and inefficiencies.

With the proposals on the preventive agenda (see Q4), this would be a game changer for general practice, popular with patients and primary care staff, freeing secondary care for more complex cases, genuinely beyond the scope of a well-resourced primary care service, and securing better health outcomes.

7. Partnership model

- Partnership is at its lowest level and salaried GPs at its highest. Partnership because of the responsibilities, administration, and workload can be increasingly unattractive. However a hybrid model for the medium term would probably be less disruptive to General Practice, as the move to salaried posts increases.
- More important than the model is probably the support and appropriate regulation for practices so that they are less burdened and in firefighting mode. (See Q5)
- **Increasing the quantity and quality of support to NHS practices i.e. those on GMS or PMS contracts, by PCNs and Federations, is crucial to ensure that practices do not avoidably close, as can happen to smaller practices, those facing recruitment difficulties and partner retirements, unmet training needs, or unsuitable premises.**

8. Contracting and payment systems

We consider that General Practice is more cost effective when the **NHS is the default provider with GP run practices on GMS or PMS contracts, or salaried options.** The introduction of APMS contracts opened the door for the Centene type takeovers, and one of these practices, previously rated good, has already been judged unsafe by the CQC. One of the difficulties for GP partnerships or even GP Federations when bidding for contracts, is that large private corporations produce deceptively polished tenders, and threaten, or actually sue, if they fail to win contracts. (See Q2) Research suggests that **patient satisfaction levels are lower for very large and private company practices, as compared with smaller 'NHS' practices, so the type of primary care contract matters to patients.** *(9)*

- The awarding of 20-year APMS contracts to Digital First providers in under-doctored areas if they promise to bring new doctors into the area and offer some face-to-face contacts, is destabilising to primary health provision. The companies often fail to deliver. poach already scarce GPs from other practices and cherry picking younger, fitter patients, leaving the sicker ones to the NHS practices, thereby exacerbating the original problem.
- The move to supersize practices, relying heavily on e-consult and other remote services can also be problematic and Healthwatch findings indicate an association between e-consult and increased A&E attendance. While *e-consult* and other remote contacts is convenient for some patients and some routine appointments, it is not easy or appropriate for others, and not just the elderly and non-tech savvy.
- When mega practices sell to a large private company, as with AT Medics and Centene, (judicial review pending), the **NHS should be empowered to recoup some of the purchase value, given its significant investment in such practices, and a judgment made as to whether such sales are in the interests of patients and the NHS.**
- **An alternative is for Federations, PCNs, NHS /Foundation Trusts and other practices to be awarded contracts if practices close/fail and the Health & Care Bill and Provider Selection Regime provisions, permit ICSs to roll over or directly award contracts, rather than tendering them.**

- If tendering is essential, the **Social Value Act (2012) provisions could ensure that contract winners were organisations that provided local social and economic benefits as well as good healthcare.**

9. Primary Care Networks

PCNs were still new and developing their role when the pandemic arrived, and were trying to support practices with the covid restrictions, escalating workload and vaccination programme. They would need greatly increased resourcing to deliver for practices. (See Q5)

10. Partnership with other professions

GPs are so overwhelmed, that the time to nurture relationships with other professionals or community groups seems minimal, and other professions also experience high turnover levels. There is a lack of capacity in many practices to successfully recruit, induct, support, and integrate other staff, or assess the skill and seniority level required for them to work relatively independently. This could be a role for PCNs.

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