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REFORM of GENERAL PRACTICE IS ESSENTIAL.

During the pandemic, there has been a groundswell of critical public opinion of general practice. The main concern is of access to routine and urgent care.

The model for providing primary care in UK is irreparably broken and reform is essential. The British Medical Association (BMA) and the Royal College of General Practitioners (RCGP) are offering no solution other than more GPs and more resources. They have wrongly assumed that the structure of general practice is vital and irreplaceable and that it will remain a cornerstone of the NHS and the gateway to hospital care. Impervious to criticism, they have failed to heed the extent of discontent and be the architects of reform.

WHY IS THE MODEL BROKEN?

1. GPs account for 20-25% of doctors licensed to practice but since 2004, they only work office hours and have no contractual obligation to provide urgent care at night, on weekends or bank holidays.

2. Accident and Emergency services are at breaking point but the President of RCGPs said recently the there is no “evidence" that this is because GPs are not involved in out-of-hours urgent care. A&E consultants say the opposite. The truth is obvious.

3. About 70-80% of GPs work part time and 50% of these work 3 days or less. GPs can do this because they are essentially self-employed at public expense. They control their own contracts with little scrutiny. The result is a fragmented and inefficient service for patients.

4. Possibly the worst predictor for the future of quality and continuity of care in general practice is the rapid progress being made by the National Association of Sessional GPs. (NASGP). Their website describes 5,000 members who are organised into chambers with a management structure. It also states: “The RCGP and NSAGP have partnered to offer RCGP members a special offer to join the NASGP”. Surely if RCGP was committed to best practice, they should have rejected this partnership?

5. In it’s publication on the cancer backlog during the pandemic, the National Audit Office (1.12.21) estimated that between March 2020 and September 2021 there were between 240,000 and 740,000 ”missing” urgent GP referrals for suspected cancers.
A study from Oxford University reports a 63% reduction in the monthly number of GP referrals of patients with possible bowel cancer.
Clearly there are many reasons for these missed opportunities to detect early and more curable cancers, but included must be the reluctance of GPs to provide access, either remotely or in person and their failure to identify “red flag” symptoms.
In January 2022, the government announced a pilot study in England to allow patients with cancer symptoms to bypass their GP and contact a helpline manned by cancer nurse specialists for onward referral to diagnostic centres which are being introduced. Does the need for this initiative not amount to a shameful admission of a failed GP model?

6. I lost faith with GPs while being the first and eventually the senior of four surgeon on the sarcoma and melanoma unit at Royal Marsden Hospital in London for almost 30 years. Our catchment area

was the whole of the south of England. I realised early on that the challenge would be to maintain contact with GPs given that all patients were referred from secondary care. Naively, I thought that if I sent copies of all letters, operation notes and histologies to the named GP, they would help with postoperative care given the distances patients needed to travel. I soon realised that GPs rarely had their own lists of patients. When my letters arrived at the practice, they would be scanned onto the computer system by office staff, to be read by any GP only when the patient made an appointment at the surgery. To my mind, that amounts to an unforgiveable lack of continuity of care.

7. Sadly, any attempt at continuity of care has been abandoned by most British GPs citing overwhelming workload as the reason and ignoring part-time working as a contributing cause. This is despite the result of a Norwegian study published in October 2021 in the British GP Journal which showed that continuity of care by a named GP reduces out-of-hours demand, results in fewer hospital admissions and even reduces patient mortality.
More recently, a study from Exeter has shown that if patients with dementia see the same GP, this improves safe prescribing, health outcomes and reduces treatment costs and care needs.
Multiple other benefits of continuity of care are described in a King's Fund report (2010). Most GPs are happy to ignore this evidence.

8. An editorial in the Times recently described general practice as a "cottage industry". I can understand the frustration felt by some GPs which must translate into the oft-mentioned "burn-out". Most patients present with transient or trivial problems, often non-medical. Yet patients have a right to consult their GP as often as they wish for whatever reason. Medical students on their GP modules must spot this immediately and realising that it is so far removed from hospital medicine, shun general practice as a career option.

SUGGESTIONS FOR REFORM. (These suggestions are discontinuous and could be integrated to a greater or lesser extent.)

1.The NHS is composed of two distinct medical manpower components, namely hospital and general practice, with different patterns of work and little staff overlap. For example, hospital doctors work in a more professionally nourishing team environment with daily contact between specialists, specialist trainees, with access to research projects, postgraduate meetings and especially MDTs. Rapid laboratory and diagnostic services are also available.
With minor exceptions, general practitioners have none of these benefits which must contribute to professional isolation, "burn-out" and de-skilling. Of great importance, this reality must be discouraging to many potential recruits into general practice. In order to benefit patients, this model of work must change to create joint posts between hospital and general practice. But how?

2. My radical solution, previously suggested, would be to integrate GP training with A&E training. Then to create jobs across the divide, a solution that would benefit both specialities. For example, after F2, all trainees would follow A&E training for 3 years at which point those choosing the GP option would transfer to general practice for their final year of training. The other cohort who choose to become A&E consultants would train for another 3 years to gain the necessary experience in anaesthetics, ITU, complex resussitation etc.
The same model could apply to those choosing to train in emergency medicine before a similar divide, again designed to enhance expertise and job satisfaction in general practice.

3.This suggestion is not far removed from the model of Urgent Care Centres where many junior doctors also work part-time in general practice, fashionably developing what is called a "portfolio career". The difference is that Urgent Care Centres are privatized.

4.Speciality-specific clinical nurse specialists (CNSs) would play a greater role in general practice. For example, in diabetes where the numbers of patients are growing and where treatments are getting increasingly complex. A CNS in diabetes would be employed in the local hospital supporting the diabetic service but would spend one or two days in general practice. This would provide continuity of care and a conduit between general practice and hospital. The CNS could discuss any problems with the diabetic specialist and either resolved, or a hospital appointment arranged.
A similar model would provide contemporary expertise for other chronic conditions such as care of the elderly, palliative care or dementia.

5.We would need fewer GPs but allow them to give more time to new patients and hopefully greater participation in urgent care.

6.Some aspects of reform would be more difficult and would inevitably be resisted by the BMA and RCGP. For example, GPs should be employed rather than contracted to the NHS They should have a job plan like hospital consultants which could be flexible but scrutinised. Having trained for 3 years in A&E or emergency medicine, GPs would have to commit part of their time to out-of-hours care. Part-time working should be no less than four full days per week distributed across the divide. When manpower allows, locum work should be discouraged and certainly as a career option.

7. On 14.12.21, I debated "jabs versus cancer backlog" with Professor Martin Marshall on ITV's Good Morning Britain. I proposed that to regain public trust lost during the pandemic, part-time GPs could temporarily work an extra session or two every week, paid from Mr.Sajid Javid's £250million (intended to improve GP services) to get us over the pandemic backlog. I was told that GPs working a 3-day week already do the equivalent of a full-time working week.

CONCLUSION

The NHS is paid from the public purse and should be run for the benefit of patients and not for the benefit of doctors. The cost of general practice is rising and the quality of care is falling. The problems are too fundamental and entrenched to be improved simply by additional funding. The priorities are to improve out-of-hours urgent care and to make general practice a more attractive career option for British graduates. The BMA and RCGP have failed to recognise, even discuss the problems or to provide leadership for reform. Surely now, there must be intervention from parliament.

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