Written evidence submitted by Prof. Chris Salisbury, University of Bristol (FGP0390)

This evidence is provided in my personal capacity.

Who I am:

Professor of Primary Health Care, University of Bristol. A GP since 1985; working entirely in academia since 2017.

I have conducted research on several topics relevant to this call for evidence:

- Evaluation of the 'Advanced Access' initiative[1]
- Evaluation of NHS walk-in centres[2-5]
- Remote consultations in primary care,[6-10]
- Evaluation of Babylon GP at Hand[7,11]
- Telephone triage in general practice[12]
- Changes in GP workload[13] and consultations[14,15]
- Continuity of care[16-19] and the named GP scheme[20]
- Strategies to retain GPs in the workforce[21,22]
- Increasing prevalence of multimorbidity[23] and the primary care response.[24]
- I delivered the 2018 RCGP James Mackenzie lecture, summarising my vision for the future of general practice.[25]

Summary

1. Under-investment in primary care has led to a mismatch between supply and demand and problems with access to care. This (amongst other factors) led to policies which have undermined the 'raison d'être' of general practice. This has led to an exodus of GPs, making it impossible for those remaining to do a good job, resulting in further problems with recruitment and retention. This vicious cycle will get worse unless there are radical changes and a commitment to general practice in line with the principles outlined in this paper. However, if such changes are made soon the situation is remediable, because general practice remains potentially a satisfying career that would meet the aspirations of many doctors.

Background

2. Problems with access to general practice cannot be addressed without clarity about the purpose of general practice within the health care system and the organising principles that enable that purpose to be delivered.
3. The purpose of general practice is to provide 'proactive, personalised, coordinated and integrated care'. General practice is the front-door to the NHS. It needs to be accessible and comprehensive so that most people's problems can be addressed most of the time. It should provide high quality care which maximises outcomes and patient experience in an equitable way, while minimising costs.
4. Key organising principles include:

    4.1. A single, easily accessible, entry-point to NHS care - reducing confusion for patients, attendances at inappropriate services, and inefficiencies through cross-referrals.

4.2. Embedded in local communities – so that clinicians understand the socio-economic circumstances of their patients and are familiar with local resources.

4.3. Responsibility for a defined population, enabling provision of preventative care.

4.4. Strong relationships, developed through continuity of care so that patients know and trust the clinicians caring for them and clinicians offer care that is personalised to each patient's situation.[26] Patients who trust their doctor are more likely to follow their advice and avoid seeking care elsewhere e.g. in A&E.

4.5. An important role of general practice is to be the patient's advocate, co-ordinating care offered by other health care providers. This requires clarity of responsibility: patients knowing who is responsible for their care, and clinicians feeling responsible for individuals.

4.6. Comprehensive. Everything that *can* be done in primary care *should* be done in primary care. This promotes integration around the patient. Resource-intensive environments (hospitals) should be reserved for situations requiring facilties or specialist expertise not available in primary care.

4.7. This requires availability in primary care of a wide range of clinical professionals, services, and diagnostic tests. Multidisciplinary teams are most likely to be effective when professionals know each other, work within the same organisation and where possible from the same building.

4.8. Excellent records and data management systems, shared by all those providing care.

5. Many of these principles are related and mutually re-inforcing; ignoring one of them weakens others.

6. These principles inform my responses below and lead to conclusions that diverge from those of some other respondents. They also suggest a different direction from some recent NHS policies which have undermined the principles that make general practice effective and have led to the crisis in morale and recruitment.

Barriers to accessing general practice and how can these be tackled?

7. Access can be conceptualised as the fit between supply and demand.[27,28]
8. Inadequate supply: Between 2016 and 2021 the number of full-time equivalent GPs decreased while the size of the population increased, representing a 6% reduction in the number of GPs per 1000 population.[29]
9. Increased demands due to an increasingly elderly population, many with multiple long-term conditions,[23] increasing policy expectations about quality of care, transfers of work from hospitals, and increasing public expectations of convenient access. These demands are unachievable unless either resources to meet them are increased, and/or are used more efficiently.
10. Some have argued that demand should be reduced by campaigns to lower public expectations or by promoting self-management. In general, evidence suggests that these strategies will have little effect on demand.
11. Some of the most commonly advocated approaches to increase efficiency are not supported by evidence:
    11.1. Triage: The limited research on telephone triage suggests that it does not reduce GP workload.[12,30]

11.2. Remote consultations: modelling conducted by me indicates that remote consultations are only likely to reduce GP workload under optimistic scenarios; under many scenarios are likely to increase workload.[6]

11.3. Non-medical practitioners: The employment of non-medical clinicians should be encouraged, but there is little evidence that it will reduce workload pressures on GPs. This is the subject of current research.

12. Productive ways to increase efficiency could include:
    12.1. 'Personal Assistant' support, to whom GPs delegate non-clinical work.
    12.2. Ensuring that services interfacing with general practice negotiate (rather than dictate) changes to referral pathways, discharge arrangements etc.
    12.3. Improvements in IT and data. Current systems are cumbersome through lack of investment in both hardware and software. Data about activities in general practice needed to inform service planning is seriously deficient.
13. Improved efficiency cannot solve the mismatch between supply and demand without increased investment in general practice. This is not unaffordable, but requires a new appreciation of the value of investing in general practice.
14. The 2016 GP Forward View (GPFV) committed to reversing the expansion in the number of hospital specialists at the expense of funding primary care. However in just 6 years since the GPFV was published, the number of FTE GPs has decreased 4%[29] while the number of FTE Consultants has increased by 20%.[31] Primary care represents only about 8% of the NHS budget.[32] A shift of 2% of the NHS budget would therefore increase primary care funding by a quarter and have an enormous impact. Shifting even a small amount of resources from secondary to primary care will undoubtedly meet political and institutional resistance, which has to be faced to restore primary care (which will also help hospitals).

The Government and NHS England's plan for improving access

15. As well as recognised the need for greater investment, the GPFV included plans for a wider workforce, reduced bureaucracy, requirements on hospitals to change discharge arrangements, extended hours and working at scale across practices. Although welcome, implementation of many these changes has been slow or non-existent. NHS England published refreshed plans in October 2021, based on similar proposals. However, it is uncertain whether they are any more likely to be delivered and are of sufficient scale.
16. One initiative is the extended hours scheme. Research suggested it had only a minimal impact on patient's experience of access.[33] Extended hours are unlikely to have an impact if the limiting factor is the number of available GPs.
17. The GPFV also promoted Primary Care Access hubs. This exemplifies an initiative that undermines the core principles by which general practice exerts its effects, and (like NHS walk-in centres) is likely to be inefficient and ultimately detrimental to primary care.

Impacts when patients are unable to access general practice using their preferred method

18. If patients contact other services, this is likely to increase the cost to the NHS compared with increasing capacity in general practice. 111 refers a high (and increasing) proportion of patients to emergency care, potentially increasing pressures in the NHS (although evidence is inconsistent).[34,35] My research showed that the cost of a walk-in centre consultation is considerably higher than a consultation in general practice,[36] while attending an emergency department is much more expensive.

19. Delays in obtaining health care could have adverse impacts on on patients' health and poor access will reduce patient satisfaction. Since general practice accounts for the vast majority of patients' contacts with the NHS, poor experience could undermine support for the NHS in general.

Role of a named GP play in providing patients with continuity of care

20. There is strong evidence for the benefits of continuity of care, including: greater patient satisfaction, improved health promotion, improved medication adherence, reduced hospital use and reduced mortality.[37]
21. Despite this, continuity of care in general practice has declined rapidly.[17] This is due to a lack of policy support (with some policies directly undermining continuity), the shortage of GPs and an increase in part-time working, and ambivalence within the medical profession itself.[19]
22. Continuity of care is likely to promote a sense of commitment, responsibility and job-satisfaction amongst clinicians.[19,26] The loss of continuity and relationships with patients, leading to impersonal 'call-centre' transactions, is a key factor in the decline in professional morale.
23. The 2014 'named GP' scheme was a well-intended initiative which was badly implemented. It was imposed rapidly and without sufficient effort to gain support from the profession or to discuss implementation. Many patients were allocated to 'named GPs' irrespective of their preferences or previous consulting patterns. Our research showed that the policy had no impact on continuity of care or hospital admissions.[20]

Challenges facing general practice in the next 5 years

24. The aging population means a substantial increase in the number of people with multiple long-term conditions. My research showed that 44% of patients over 75 years have at least two of the major conditions covered by the Quality and Outcomes Framework.[23] The proportion of people with complex multimorbidity (4+ conditions) will almost double by 2035, and two-thirds will have dementia or mental health problems.[38]
25. If these are not managed in general practice, the demands on secondary care and the costs to the NHS will be unsustainable. Because of the difference in consultation volumes, if just 5% of the people consulting in general practice attended hospital instead, it would lead to a 20% increased demand on out-patient departments.
26. Recruitment difficulties in general practice are creating a vicious cycle. Fewer doctors entering general practice, more retiring early and more working part-time increases pressure on those that remain.

What part should general practice play in the prevention agenda?

27. A registered list of patients held by GPs is an enormous asset in ensuring that everybody, including vulnerable groups who do not seek care, has a doctor responsible for offering them prevention and screening. Because patients trust their local doctors, uptake of preventive activities such as vaccinations is much more likely when offered by general practice. GPs are able to undertake prevention (e.g. discussing obesity) opportunistically when patients attend for other reasons, and this is effective.[39]
28. Some have argued that general practice does not have sufficient resources to offer prevention as well as illness services. However, prevention is one of the key principles for effective general practice described in paragraph 4. The most cost-effective solution would be to re-invest in general practice rather than set up alternative services.

29. Seeking to limit the scope of general practice by carving off services (e.g. prevention, vaccination) undermines comprehensive generalist care, weakens the added value that general practice brings to the NHS, and will ultimately be self-defeating by making general practice less effective, GP careers less fulfilling, and the NHS less efficient. Walk-in centres provide another example.

Reducing bureaucracy and burnout, and improving morale, in general practice. How can the current model of general practice be improved to make it more sustainable?

Recruitment

30. Most GPs complain that their working day is long and arduous. This leads to burn-out and problems of recruitment and retention. An increasing proportion of GPs work part-time, exacerbating problems with continuity, and few want to take on the responsibilities of partnership. Attempts to resolve these problems have included recruitment drives, financial incentives and support packages. These are unlikely to be effective.
31. General practice is potentially a very attractive career. It can provide enormous job satisfaction, helping people at important moments in their lives. There is huge variety in the work. It is possible to work flexibly, making it 'family-friendly'. However, many of the factors that make general practice enjoyable have declined. The ability to get to know patients over time is threatened by the loss of continuity. Many GPs feel worn down by long hours, leading to 'caring fatigue'. The unrelenting demands and time pressure mean they feel unable to do their job well, which is unsatisfying and feels unsafe and stressful.
32. The solution to the recruitment problem is not to provide support and incentives to help GPs cope with an impossible job, but to make it possible for them to do a good job. The recruitment problem would then largely solve itself.
33. This requires a clear vision of what general practice can and should look like, in line with the principles in paragraph 4. This vision needs to be clearly articulated and vigorously implemented in discussion with the profession. Crucially there needs to be a substantial re-balancing of resources in favour of primary care. Finally, there need to be a new employment model for GPs.

The partnership model, salaried doctors and 'portfolio careers'

34. The fundamental problems in primary care are related to a lack of investment and a lack of policies that support primary care principles (e.g. continuity), leading to a shortage of GPs. These problems could be reversed within the current partnership model or an employed GP workforce model. Both models have advantages and risks.
35. The partnership model of general practice has advantages in terms of flexibility, innovation and entrepreneurship, and commitment to a practice over time. However, these advantages have become less relevant, since increased centralised direction (e.g. QOF) has meant that GPs have little discretion over the range of services they provide, how they provide them, or how they generate income.
36. The partnership model is also associated with variations in the quality of care, and long-term financial and clinical commitments that fewer doctors are willing to take on.
37. Partners have an open-ended responsibility to provide care, which leads to excessive working hours and burnout. It has also led to unhealthy working practices – partners employ salaried doctors to see patients, but with minimal time allocated (either for themselves or salaried doctors they employ) to wider professional needs, including continuous education, management or teaching.

38. The widely held concept of the 'portfolio career' illustrates this short-sighted approach to GP careers, since it implies that a doctor is only being a GP while they are consulting patients and other activities are not an intrinsic part of general practice.
39. The different employment models for GPs, and the fact that they are responsible to different organisations from other primary care professionals, hinders team effectiveness.

Alternative model of organisation and employment

40. The principles for effective general practice could be delivered within a range of organisational structures including the partnership model. However, the decentralised nature of partnerships is probably one reason for the decline of general practice. Governments are unlikely to commit the resources required without stronger oversight, and general practices and networks are unlikely to have the necessary management systems. Primary care networks and federations have demonstrated benefits of sharing resources across practices, but they are too small and informal to be treated as equal partners with hospital trusts, and to have a unified voice in national policy. Integrated care systems need general practice to be an intrinsic part of the system, not a loose collaboration of small organisations.
41. One model would be GPs and other professionals working within multidisciplinary teams in health centres, each with a medical director, and all employed by the same organisation. Health centres, each responsible for 10-20,000 patients, would work together in community organisations covering populations of 100,000-500,000 people, led by a board. The trust would provide financial, HR, IT, and clinical governance structures. This is similar to the NHS Plan 'Multispecialty Community Provider' concept, except that all professionals would be employed by one organisation, and primary care services would be aligned around health centres providing comprehensive care, not segmented (e.g. into illness services and preventive services).
42. There are considerable risks to advocating employment of GPs by larger organisations. This model assumes that the organisation would act as a good employer, investing in the career development and well-being of its staff. In many NHS organisations these are squeezed out by workload pressures. It also assumes that the organisation will commit to principles for effective primary care, while many GPs fear that instead the focus would be on protecting hospitals. For this reason, the constitution of these new organisations must focus on improving health care in the community, and they should not be led by hospital trusts.

Shape of a new employment model to sustain GP careers

43. Salaried GPs working for large organisations offers opportunities to improve GP careers which would help resolve the recruitment crisis (if accompanied by re-investment). The organisation would have a responsibility to develop the workforce by offering sustainable careers, including support and training. The workload of an individual GP would be limited. A new form of contract is required, modelled on the NHS Consultant Contract.
44. A typical full-time GP contract might include 10 four-hour sessions: 6 patient-facing, 1 administration, 1 personal professional development, and 2 sessions to be involved in leadership, management, research, teaching or a specialist clinical interest e.g. minor surgery. This varied working week, with defined hours, would probably be attractive to many doctors and encourage more to work full-time. All doctors should have a line manager with responsibility to support their career development. This structure provides opportunities for career progression, as doctors change the balance of their work over time, or move into senior leadership. The current lack of opportunities for ambition and career progression is a demotivating factor for GPs.

45. Making the problem of improving access and balancing supply/demand a responsibility of the organisation rather than individual GPs would remove an important source of stress, and require providers and policy-makers to explore system-wide solutions.

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