Health and Social Care Select Committee - Inquiry on the future of general practice - Submission by the Royal College of General Practitioners

December 2021

The future of general practice

The RCGP's vision for the future of general practice is one where the personal relationship between GP and patient is still at its core but the way the service is delivered will be transformed:

- Patients will be seen as equal partners in their care and there will be more focus on promoting self and shared care.
- Care will be delivered by multidisciplinary practice teams with the expert medical generalist playing a leadership role, focusing on complex care and population health.
- GP surgeries will be digitally-enabled, with technology harnessed to support triage, digital consulting, remote monitoring and better communication across the health and care sectors.
- While the front end of general practice will remain personal, the back-office functions - IT, data analytics, HR, business support - will increasingly be pooled as primary care operates at increasing scale.
- General practice will be more integrated into the wider health and care system and will play a growing role in improving the health of the communities it serves.

Why we need a new 'Promise to Patients' in general practice

General practice is the cornerstone of the NHS. It is where most NHS patient contacts take place with the majority of these patients helped without the need for any other individual or intervention.

In many ways the COVID-19 crisis highlighted how resilient general practice is. Seeing 305 million patient consultations over the last year, as well as helping to provide 48 million COVID-19 vaccinations. Over 8 out of 10 patients report that they were satisfied with the experience of their GP and over a third were seen on the same day they requested an appointment. Only 16% had to wait a week to have a consultation with their GP[i].

These successes should not distract from the challenges facing general practice. With demand for GP appointments increasing at a time when the number of Full Time Equivalent (FTE) qualified GPs is 5% lower than it was in 2015. This makes it extremely difficult to give patients the access and care they need, and we wish to provide.

We need the Government and the profession to come together to make a renewed 'Promise to Patients', setting out an ambitious plan for the future of general practice. Learning the lessons from COVID-19 and embracing new technologies and ways of working, without forgetting the traditional principles that care is best when GPs and their teams are able to form trusting relationships with their patients. The value of general practice, after all, lies in its ability to provide whole-person care, understanding not just a patient's illness but their health in the broader context of their life, family and socio-economic circumstances.

At the heart of this new 'Promise to Patients' needs to be a commitment to take significant measures to increase the number of GPs and wider workforce. The UK has fewer doctors per head of population than nearly any other European or OECD country[ii] and none of the other reforms will work if there are not enough staff to deliver the care that is needed.

The new 'Promise to Patients' is a commitment to move away from the piece-meal fragmented reforms and implement a system-wide strategy to improve patient care in general practice. This should include;

- **A focus on patients, not targets**

We need an independent review of how to better ensure vulnerable patients get the care they need without resorting to some of the box ticking exercises in the current Quality Outcomes Framework (QOF).

- **Enable GPs to break down the barriers in the NHS**

GPs can play a key part in the new NHS Integrated Care Systems, breaking down traditional barriers in the system including establishing closer working between generalists and disease-based specialists, working in the community to proactively plan patient care. But to do this we need to make sure the voice of GPs and primary care is not lost when CCGs are abolished, as a result of the Health and Care Bill.

- **Cut red tape and free up GPs to care for patients**

Administrative tasks have become increasingly burdensome over the last decade, with red tape and tick box exercises taking GPs away from dealing with patients directly. To support GPs and prevent further burnout, it's essential that the government implements a light-touch and risk-based regulatory model, to reduce paperwork and reporting requirements and enable GPs to focus on delivering patient care.

- **Bring GP surgeries up to the 21st Century**

Follow up and implement the recommendations of the GP Premises Review,[iii] which showed that practices are not fit for purpose, improve the technological infrastructure to

better deliver remote care and redesign the 'front door' to general practice (telephony, triage tools and processes) so that it works for both GPs and patients. This will need to include funding to help practices with change management.

- **Equip primary care to play a role in improving the health of local communities**

Every local network of practices needs funding for a dedicated community / public health role so they have the time and space to build relationships at a local level, while maintaining close links to primary care. They also need better data and analytical capacity to inform proactive activity in practice.

- **Ramp-up efforts to recruit more GPs**

Despite a record number of GP trainees this year, there are still not enough doctors to meet recruitment needs. We need sustainable funding for over 5,000 GP training places. To ensure there is a pipeline of doctors being trained to meet the needs of general practice as well as other medical specialties, medical school capacity should be significantly increased as soon as possible, with equitable funding for undergraduate education in general practice.

- **Do much more to retain the staff we have**

An RCGP survey found that 34% of GPs expect to leave the profession within 5 years, which could mean the loss of over 14,000 GPs to the workforce. Despite this, around one in five CCGs are not reporting helping a single GP through the NHSEI National GP Retention Scheme. Other retention efforts, such as the fellowship programme for early career GPs, are also struggling to get off the ground. Current retention programmes should be reviewed to ensure they are effectively implemented and accessible to those who need support, and NHSEI should work with the RCGP, BMA and others to create a universal offer to enable flexible and sustainable careers in general practice for all GPs.

- **Improve recruitment into general practice teams**

Many GPs already work alongside nurses, pharmacists, first contact physiotherapists, paramedics, physician associates and social prescribing link workers, and funding has been made available to support recruitment of certain roles across Primary Care Networks. However, this funding needs to be made more flexible, as well as longer term, to provide assurances for staff contracts. Further support is also needed for effective integration of staff into practice teams, and premises need to be fit for purpose to house a wider range of staff.

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

Throughout the COVID-19 crisis general practice has remained open, seeing 305 million patient consultations over the last year, as well as helping to provide 48 million COVID-19 vaccines. Moving to a hybrid model with increased use of remote consultations has helped speed up access, with over a third of appointments taking place on the same day and the share of patients waiting for a week or more falling by 10 percentage points, according to the 2021 GP Patient Survey.

Despite this progress, patients continue to report difficulties in accessing general practice. With rising demand and a smaller FTE workforce it is always going to be a challenge to provide patients with the care they deserve. Indeed, the increase in activity in general practice has relied upon many GPs working harder than ever, a pattern which will not be sustainable over the long-term.

Access is a fundamentally important pre-requisite for high quality care, but it isn't care in itself. There is a danger that policy makers focus too much on speed and type of access rather than quality of care.

Barrier 1: A broken 'front door' to general practice

One of the biggest complaints is that patients struggle to get in contact with their GP. Some of this is because demand massively outstrips supply, but the problems are exacerbated because many GPs don't have the resources to invest in up-to-date call handling and triage systems.

The Government has signalled plans to embed 'total triage' models in general practice in England beyond the pandemic through planning guidance. Evaluation is needed to establish what 'good' looks like for triage systems for both patients and staff, in order to capitalise on their potential. This must ensure that systems do not exacerbate health inequalities.

Triage systems need to be co-designed with patients and clinicians to iron out the challenges associated with current approaches to triage. Given the difficult circumstances and speed at which many of these systems were introduced or adapted during the pandemic it is understandable that further work needs to be done to address these challenges.

The work to co-design triage systems must take into account that some patients don't have good IT access or digital literacy, and will always need to be able to get an appointment through traditional routes such as over the telephone or in person.

Recommendations:

- Invest to make general practice premises fit for purpose, including sufficient space to accommodate expanded multidisciplinary teams, and deliver digitally-enabled remote care.
- Ensure GPs and wider teams have access to the tools, training, guidance and support in routinely using digital tools in their practice.
- Commission local transformation support for practices to enable them to evaluate and implement 'front doors' and triaging systems which meet patient and staff needs.
- Launch a large-scale marketing campaign to ensure the public understands the range of access routes to primary care and the range of multidisciplinary team members a patient might see and why, as well as the benefits of remote care where appropriate.

Barrier 2: Fewer GPs and not enough other healthcare professionals to help patients with increased demands

We simply do not have enough GPs and other healthcare professionals to cope with the increasingly complex needs of a growing and ageing population.

The latest data from NHS Digital shows that FTE fully qualified GPs has fallen by 5% between September 2015 and 2021.[iv] At the same time, the population of England has grown about 4% since 2015.[v] Though we are now seeing an increase in the number of trainee GPs, this is not enough to have a big enough impact on the workforce.[vi]

This problem could be made significantly worse with a 2021 RCGP survey finding that 34% of GPs expect to leave the profession within 5 years, which could mean the loss of over 14,000 experienced GPs to the workforce. These are likely to be the most experienced doctors who do the most clinical sessions and are most likely to be partners.

We also need to significantly expand the wider practice team. This will help ensure that patients are seen by clinicians with the right training, skills and expertise to support them (for example, physiotherapists for musculo-skeletal problems). While the wider team in general practice is expanding, this growth must be accelerated to meet the government's commitment to 26,000 additional staff by 2024, and more support is needed to ensure these clinicians are fully integrated into primary care teams.

To overcome these barriers, the Government needs to take urgent action on workforce planning and expansion. Evidence from the Netherlands suggests that Governments, working in alliance with key stakeholders must take a 20 year look ahead and model workforce on all the data available.

Recommendations:

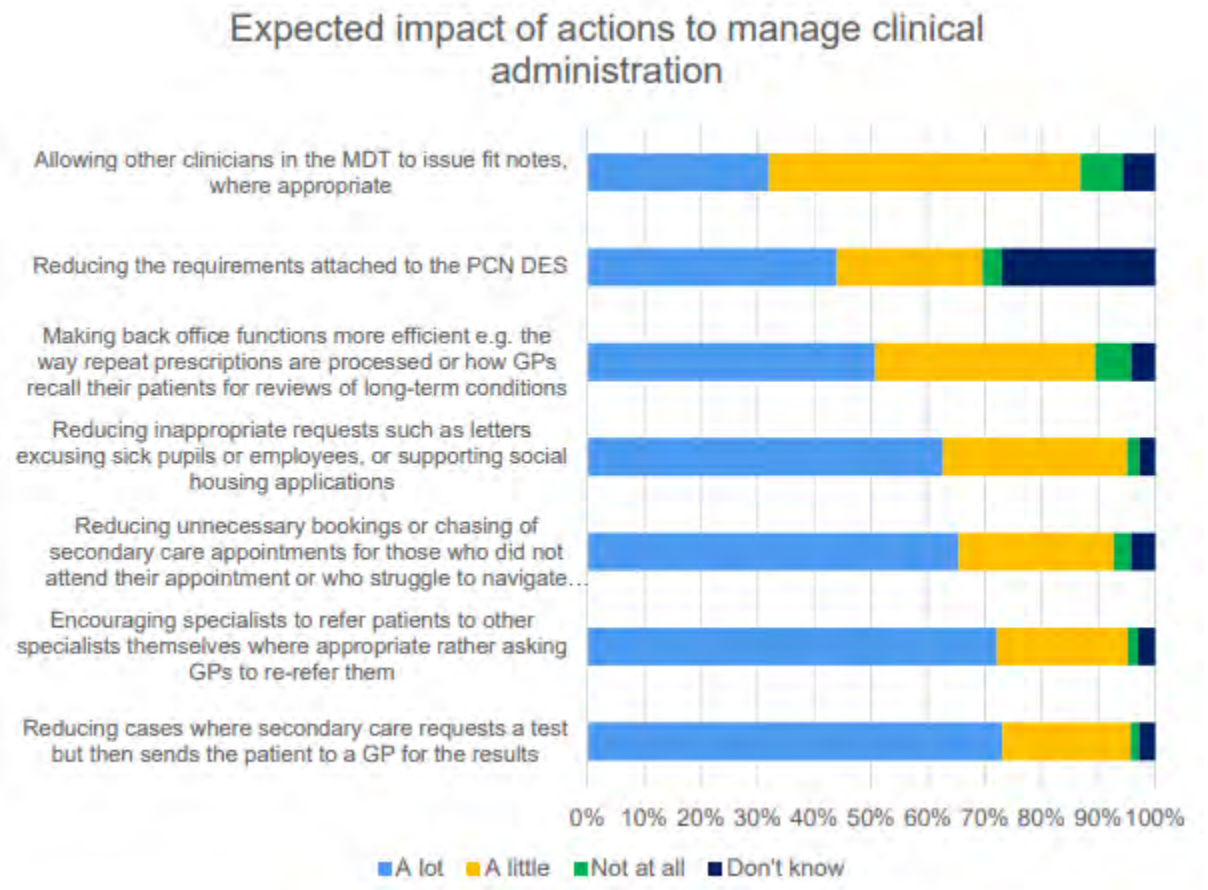
- **Efficient workforce planning:** every 2 years, the Secretary of State for Health & Social Care must publish assessments of the healthcare workforce numbers required to deliver the work that the Office for Budget Responsibility (OBR) estimates will be carried out in future. The OBR's estimates will look at the next 5, 10 and 20 years and will be based on projected demographic changes, the growing prevalence of certain health conditions and the likely impact of technology.
- **Sufficient funding for training:** allocate sufficient and consistent funding for GP training for at least 4,000 GPs per year, expanding towards 5,000 as soon as possible. This must be accompanied by appropriate investment in training capacity.
- **Enhance the medical education pipeline:** To deliver the future workforce for both general practice and the wider NHS, the undergraduate medical pipeline must be significantly expanded. Currently, there are 9,000 medical school places available per year, while current estimates put the required capacity at around 15,000. This should be accompanied by a commensurate expansion in the medical foundation programme for new doctors. To reach the long-term targets, we need at least 50% of newly qualified doctors to enter GP specialty training across the UK.

- **National GP Retention Scheme places in every ICS:** As of September 2021, data suggests that nearly 20% of CCGs in England are not supporting any GPs through the National GP Retention Scheme. Access to such schemes, which offer intensive support to those GPs most in need, is uneven across the country and it is therefore essential that this is prioritised, and that in the future, every ICS is responsible for a retention programme with ringfenced funding, which is monitored and reported back to the Secretary of State.
- **A systematic review of current retention programmes:** a systematic review of the roll out of current programmes of targeted support (e.g. fellowships, local GP retention schemes, the national GP retention scheme etc) is necessary to better understand what aspects of these programmes are working well and where reform is needed.
- **Develop a universal offer to enable flexible and sustainable careers:** a universal retention offer must be developed to enable flexible and sustainable careers in general practice and so that GPs are better supported to remain in the workforce. We are calling on the government and NHSE to invest in high-quality professional development opportunities for GPs through local 'training hubs' and provide back-fill funding for their development time.
- **Improve the flexibility of the additional roles reimbursement scheme (ARRS) to facilitate employment across Primary Care Networks (PCNs),** for example to enable the recruitment of nurse practitioners or the direct employment of mental health therapists. Increase support for proper integration of staff across practices. Government should also provide resources for adequate supervision and mentoring of new practice staff. Action is also needed to expand the wider primary and community care workforce, including district nurses.
- **Improve access to structured training and induction programmes for these additional roles in general practice**, drawing on the success of programmes such as 'Clinical Pharmacists in General Practice'. Significant improvements should be made to support delivery of the New to Practice Scheme for nurses.
- **Maintain funding for PCN clinical directors at 1FTE over the long-term**, so that they are able to focus on workforce planning and development.

Barrier 3: Too much GP time spent on unnecessary work

The GP Worklife survey suggests about 9% of GP time is spent on non-clinical administrative tasks, and data from the Research and Surveillance Centre suggest that clinical administrative workload has gone up by 30% over the last year.[vii]

The chart below shows a range of key issues where our members think there is significant potential for reducing their workload, if these issue areas are tackled. This includes preventing work being inappropriately passed on from secondary care, such as follow up on tests or referrals which should be dealt with elsewhere. The 2021 RCGP tracking survey found that 61% of GPs thought reducing the burden of CQC inspections would reduce their workload a lot, other findings include:



In 2020, the then Health Secretary launched a new strategy to streamline processes and reduce bureaucracy in England, and NHS England and Improvement launched a specific review into reducing bureaucracy in general practice. However, both of these programmes have, to date, yielded very little impact on the daily working lives of GPs. With the NHS review doing little to address requirements on GPs or cutting any red tape outside of what had already been planned or adopted.

Recommendations:

- Implement light-touch and risk-based regulatory models, reducing paperwork and reporting requirements, enabling GPs to focus on delivering patient care.
- Implement the recommendation from the 2020 bureaucracy review for the inclusion of a clause in the standard contract to ensure NHS Trust processes do not generate additional workload in primary care. This should ensure meaningful action is taken to support implementation across the country.
- Rapid improvement on technology interoperability between all health and care providers. Barriers to information sharing can unnecessarily complicate patient pathways and, at worst, jeopardise patient care. The College would like to see improved communication lines, supported by functioning technology and systems, such as online chat functions and resources to automatically and securely share information between providers and promote better patient referral processes.
- Integrated patient records across providers of NHS care – primary care, secondary care, and community settings – to improve patient care, save patients

and staff time, and ensure secure, accurate transfer of data. This should be coupled with investment into digital solutions in all care settings, which can support the delivery of best practice to reduce unnecessary administration and bureaucracy for all parties.

- Overhaul contractual requirements in order to focus on high-trust approaches to assuring high-quality care, with low administrative requirements. An independent review should be carried out, including approaches from the devolved nations, looking at how to better ensure vulnerable patients get the care they need without resorting to some of the box ticking exercises in the current Quality Outcomes Framework (QOF).
- Move ahead with long overdue regulatory changes to allow more staff in the wider practice team to prescribe medications or sign fit notes for patients under their care, where this fits within their areas of competence. Though some of these calls were addressed in the NHSE/DHSC winter plan, further information is required on when and how these changes are to be implemented.

2. To what extent does the Government and NHS England's plan for improving access for patients and supporting general practice to address these barriers?

NHSEI's publication in October 2021 'Our plan for improving access for patients and supporting general practice' does not address these barriers in a meaningful way. While we recognise that this particular plan was never intended to solve all the challenges facing general practice, it was a missed opportunity to improve the quality of care delivered to patients, at a time where it was needed most.

It doesn't address the long-term workforce challenges which are at the root of the access problem. It says nothing about retention and doesn't go far enough to cut bureaucracy in general practice.

The £250 million funding is however welcome and could make a small difference to some practices. The suggestion that enhanced funding would be withheld from practices not meeting certain criteria - likely to be the practices in greatest need of support - is not a logical step in seeking to improve patient experience and access and suggests a lack of understanding of the challenges experienced by struggling providers.

For example, practices in areas where there are many people who call 111 are being identified as having " unacceptable variation" in levels of access to general practice. This ignores that there is no evidence that areas with higher 111 usage have worse levels of access to GPs and the fact that GPs have been previously been asked to join the 'Help Us Help You campaign to promote the use of 111. It is an insult to GPs who have been involved in this campaign to be 'named and shamed' because of its success.

3. What are the impacts when patients are unable to access general practice using their preferred method?

Good access is the starting point for high quality care but good access does not guarantee that the resulting care will be safe, effective, patient centred, equitable or efficient. Policy makers and system leaders need to be more focused on all dimensions of high-quality care.

Despite the additional demands from the pandemic and the need to support the vaccination drive, GP surgeries are seeing the same number of patients as before the pandemic, while also significantly cutting waiting times. However, with ever-growing demand for general practice, it will always be a challenge to ensure everyone can access care when they need it.

The latest data from NHS Digital demonstrates that, in addition to continued involvement in delivering 3.5 million COVID-19 vaccinations, more than 30 million patient consultations were conducted in general practice in England in October, around the same level as before the pandemic.[viii]

It is important that patients get appointments when they need them or when their GP feels it is clinically appropriate to reach out to them. Unfortunately, the current QOF system incentivises check-ups based on a strict artificial calendar determined nationally, rather than on the needs of individual patients. In Scotland they have managed to scrap this system and put greater faith in patients and clinicians to make judgements. Learning from models across the UK should form part of a review into the ideal model for England.

According to the 2021 General Practice Patient Survey (GPPS), 7.6% of patients who didn't get an appointment with their GP subsequently went to A&E (equivalent to only 0.8% of patients who called their GP seeking an appointment).[ix]

Some of these patients will not have needed treatment at all, and others will have been correctly told by their GP to seek urgent care through A&E, but some others would be better seen by a GP. The fact they have not been able to access care - whether it was a perceived barrier or a practical one - is a symptom of a system at breaking point as already outlined in this response.

When the pandemic hit, GPs were told by Government to quickly move to an operating model of largely remote consultations, with the then Secretary of State declaring that after the pandemic, 'all consultations should be tele-consultations unless there's a compelling clinical reason not to'.[x] Now, much of the media and politicians are calling for a rapid return to "normal" (pre-pandemic ways of working). The real answer is that whether a patient is seen face to face or remotely needs to be a shared decision between clinicians and patients, informed by both clinical need and patient preferences. The proportion of each mode will vary significantly across different local areas according to population demographics.

There is significant demand for remote consultations as many patients find it more convenient and can reduce barriers for people to access care especially for people who

don't drive or those in rural areas. It is suitable for a significant number of appointments especially those where patients have simple inquiries.

It would however be disastrous if general practice was reduced to being a purely remote service. An RCGP survey also found that 88% of GPs think face-to-face consultations are important for building and maintaining trusting patient relationships and 60% GPs said remote consultations are more effective for monitoring and following up with existing patients than for new patients.[xi] GPs should therefore be able to work with patients to identify when care should be face to face and when it can be provided safely remotely.

While this inquiry is rightly forward facing, the Omicron variant of COVID-19 clearly demonstrates that we still have a long way to go in this pandemic and the government has begun to reinstate precautionary infection control measures.

Recommendations:

- We need a review of triage processes and tools and the way patients access general practice should be co-designed by GPs and patients
- Establish an independent review the QOF system to one that is based more on an individual's needs rather than a nationally determined box ticking exercise.

4. What role does having a named GP—and being able to see that GP—play in providing patients with the continuity of care they need?

The RCGP considers the relationship between doctor and patient to be the defining characteristic of general practice. The ability to foster and realise the benefits of strong, trusting relationships - what the RCGP refers to as relationship-based care (RBC) - continues to be critically important within general practice.[xii]

As outlined in the RCGP report, 'General practice COVID-19 recovery: the power of relationships', the term 'relationship-based care' encompasses both long-term continuity of care as well as fostering trust and empathy in shorter-term episodes of care. There is a significant body of research evidence which demonstrates the benefits of these different elements of relationship-based care, for patients in terms of outcomes and satisfaction, for practitioners in terms of job satisfaction and retention, and for the whole NHS in terms of fewer A&E visits, fewer unplanned admissions, better adherence to medication and reduced overall costs.

The current system of 'named doctors' in England, Scotland and Wales, means patients are allocated a specific GP but this is effectively a purely administrative process which does little to increase continuity of care. What is required is for policy makers to recognise the health and system benefits of relational care and put in place a policy framework which will help to reinvigorate relationship-based care. This means looking to a range of levers - training, consultation length, metrics, clinical guidelines - which can support and incentivise relationship-based care. We also need to change the public conversation about access to general practice. The political debate around access has focused too narrowly on waiting times for appointments or else, during the pandemic, on

the mode of consultation (remote vs face-to-face). We need a broader definition of what good access looks like which is also about patients being able to see the most appropriate member of the practice team or the clinician of their choice.

5. What are the main challenges facing general practice in the next 5 years?

Many of our members are concerned that general practice is on the brink of collapse. An RCGP survey found that 34% of GPs expect to leave the profession within 5 years, which could lead to the loss of over 14,000 GPs to the workforce.

Without a strong functioning general practice system patient care would severely suffer. It would drive up health inequalities and have a devastating impact on communities and the rest of the NHS.

As stated elsewhere in this submission, the biggest challenge facing general practice is that the general practice workforce - GPs and practice staff - is not sufficient to meet growing patient demand.

We are also in the next five years likely to see a significant reduction in the ability of GPs to speak up for primary care patients in the NHS structures. With Clinical Commissioning Groups (CCGs) being abolished and their roles transferred into larger integrated care systems, we will no longer have primary care at the heart of NHS decision making. The new Health and Care Bill says that when the new Integrated Care Boards prepare their five-year work plans and their capital plans, they need to do so with their "partner NHS trusts and NHS foundation trusts". This puts NHS trusts right at the heart of decision making while primary care is relegated to the outside being consulted.

6. How does regional variation shape the challenges facing general practice in different parts of England, including rural areas?

There is significant variation between the populations that general practices serve, and the assets available to care for them. The inverse care law, whereby the availability of good medical care tends to vary inversely with the need for it in the population served, is just as applicable now as it was when it was first described in the early 1970s.[xiii] For example, once you account for the different levels of need:[xiv]

- General practices serving more deprived populations receive around 7% less funding per patient than those serving more affluent populations.
- A GP working in a practice serving the most deprived patients will on average be responsible for the care of almost 10% more patients than a GP serving patients in more affluent areas.

In addition to this, the recent Additional Roles Reimbursement Scheme (ARRS) implemented as part of the PCN Direct Enhanced Service in 2019 did not take deprivation into account when allocating funding to pay for new roles. This means that

GPs and their teams serving populations that are socio-economically deprived are being asked to do more work for less money, which makes it harder to recruit new team members and harder to retain staff already employed.

7. What part should general practice play in the prevention agenda?

As the nation's front door to the NHS, it's important that general practice plays a significant part in the prevention agenda. However, this doesn't necessarily mean that GPs and their teams have prime responsibility for this work. A lot of this work can be carried out by others such as pharmacies, but GPs are integral in managing these working relationships and coordinating measures to enable better public health overall.

There are a growing number of practices developing their community health focused activity. With the right conditions, resources, training and support in place within general practice, there is potential to expand these activities, and for primary care to have an even greater impact on the health of local populations, including address long-standing inequalities.

The RCGP continues to call for investment in the MDT roles that can be embedded in communities and contributing to this work. The Social Prescribing Observatory shows high regional variation of uptake of social prescribing services across England, which is likely to be linked to variation in workforce and services available, though further research is needed here.[xv]

It would also be prudent to provide resources to allocate community / public health leads based within general practice for each local area, with flexible funding should be made available for a dedicated community / public health role for each locality at group, network or cluster of practices. These roles could be recruited from a range of the primary care workforce including GPs, advanced nurses, clinical pharmacists and other Advanced Clinical Practitioners.

The roll-out of a dedicated community / public health lead in primary care would create a clear point of contact within the team, and a lead to guide and develop activity within the locality, including building relationships with wider public health services and relevant bodies. A crucial element to the success of many community health improvement activities, is having someone within the general practice team with the protected time and space to build these.

Recommendations

- We need investment in community / public health leads based within general practice for each local area, and flexible funding should be made available for a dedicated community / public health role for each locality at group, network or cluster of practices.
- Ensure practice teams across the country have access to high-quality data and the analytical skills and tools to facilitate understanding of their community's health. This should include building analytical capability within primary care and this

needs to be accessible at practice, group, network or cluster level. Practices need access to high-quality, and effectively coded data, as well as the tools and other resources to analyse and understand the data, to enable them to put strategies in place which meets the needs of their communities.

8. What can be done to reduce bureaucracy and burnout, and improve morale, in general practice?

It is essential that we tackle the problem of low morale in general practice or we will continue to lose talented and experienced staff. We need radical action now before it is too late.

In the face of increasing workload and hostility from sections of the media, morale is at an all-time low amongst GPs and they feel burnt out. The upcoming survey by the GMC found that 32% of GPs reported they are at high risk of burnout – this was the highest amongst all doctors, about twice as likely as other doctors.

It is essential that bureaucracy and burnout in general practice is addressed to improve morale and ensure our workforce feel they can provide care in a safe way. With the current suspension of some aspects of QOF the Government should take the opportunity to see how we can better protect vulnerable groups in a less bureaucratic manner.

In addition to workload and retention challenges, it is essential to address the impact that criticism of GPs from the media and politicians is having on staff morale. A survey conducted by the RCGP suggests that just over 60% of GPs have seen their mental health deteriorate significantly in the last year.[xvi] The RCGP urges the government to act now, to tackle the workforce and workload challenges in general practice and to enable GPs to continue doing what they do best - ensuring high quality care for patients.

Recommendations:

- DHSC should work with NHSEI, the RCGP and others to produce a national, public facing campaign on how to access primary care which takes in to account the pressures GPs are under.
- Clear messaging should be developed which supports patients to understand the changes in the way care is delivered in general practice, including increased use of remote consultations, total triage and the expansion of the wider practice team.
- There needs to be a system-wide programme to eradicate unnecessary general practice workload by 2024, to allow GPs more time to care and prevent GP burnout.
- The government must develop a new GP retention strategy, reviewing and revamping local and national retention schemes and approaches and expanding access so that all GPs can be supported to remain in the workforce.
- The government must invest in high-quality professional development opportunities for GPs through local 'training hubs' and provide back-fill funding for their development time.

- Overall, further research is needed in this area, to better understand and therefore address the problems in general practice.

9. How can the current model of general practice be improved to make it more sustainable in the long term?

- **Is the traditional partnership model in general practice sustainable given recruitment challenges, the prioritisation of integrated care and the shift towards salaried GP posts?**

The sustainability of the traditional partnership model has been a source of debate for some time, as numbers of GP partners have declined, and in 2018, Dr Nigel Watson was asked by the Secretary of State and Chief Executive of the NHS to lead an Independent Review of GP Partnerships. The RCGP fed into this review alongside key partners such as the BMA.

The review's report set out some of the key strengths and benefits of the partnership model of general practice, including:

- It supports freedom to innovate to improve the delivery of care
- It provides clinicians with relative autonomy in decisions relating to patient care, supporting the ability to act as powerful independent advocates for patients
- It means being part of, and accountable to, a community
- It helps create the desire to succeed as business owners (and therefore deliver the best possible service)
- It provides value for money for the NHS.[xvii]

To overhaul the partnership model of general practice would likely require significant resource, and there is no evidence that this would have a positive impact on the delivery of care. Instead, there are a number of actions needed to better support the sustainability of the partnership model, as part of a 'mixed economy' of contractual models for the delivery of care in general practice.

The GP Partnership Review found a number of challenges facing partnerships in many areas of the country, and many of these related to wider issues facing the whole of general practice, not just partnerships, including significant workload challenges and workforce shortages. There were also a number of challenges identified relating to financial risk and specific costs associated with partnerships. The review made a set of recommendations to address these challenges, while retaining the key benefits of the partnership model. Some of these actions have been delivered, at least in part, such as the implementation of a state backed indemnity scheme in England, and the introduction of workforce recruitment support for Primary Care Networks, but many others remain unresolved.

Key remaining issues for many partnerships are the high risks and costs associated with general practice premises - around half of which are unlikely to be fit for purpose.[xviii] In

2019, NHS England embarked upon a review of GP premises,[xix] but this failed to address fundamental issues of underinvestment and high-risks associated with partnerships.

Recommendations:

- Revisit outstanding recommendations from the GP Partnership Review and implement solutions to support the sustainability of the partnership model, particularly relating to reducing personal risks with partnerships.
- Launch an independent review of GP premises to identify actions to reduce associated risks for partnerships, building on the insights from the initial NHSE premises review, and significantly invest in premises so they are fit for purpose, for both patients and staff.

- **Do the current contracting and payment systems in general practice encourage proactive, personalised, coordinated and integrated care?**

This area is predominantly within the remit of the BMA GPC and not an area that the RCGP gets heavily involved in in terms of the contractual details. However, as the professional body for GPs we do believe there is room for improvement in the current contracting and payment system in general practice, which would enable the system to focus on higher-trust approaches to assuring high-quality care.

The RCGP is calling for an independent review of contractual requirements, such as the Quality Outcomes Framework (QOF). Reforming contractual requirements such as QOF will not only enable high-trust environments that encourage quality improvement processes and professional judgement, rather than top-down edicts which perversely incentivise tick-box approaches to medicine.

Approaches such as the Quality Assurance and Improvement Framework (QAIF) in Wales reduce the administrative requirements for practices which frees up clinician time to focus on patients' clinical needs. It also incentivises the implementation of systematic quality improvement work that enables practices to deliver higher quality care for their patients. A similar approach is taken by the quality clusters that have been established in Scotland. Learnings from other areas of the UK need to be considered as part of an independent review into the ideal way to ensure vulnerable people get the care they need.

- **Has the development of Primary Care Networks improved the delivery of proactive, personalised, coordinated and integrated care and reduced the administrative burden on GPs?**

The development of PCNs has been hugely varied across the country. Practices that were already operating at scale or in networks have been better able to leverage the resources allocated to them as part of the PCN Directed Enhanced Service (DES). Many practices are new to the at scale network approach, and consequently need more time to develop the relationships and services that PCNs are being asked to deliver.

The COVID vaccine programme used PCNs as a core delivery unit in primary care. This was a hugely successful approach, as practices focused all their efforts on delivering the vaccination to the most vulnerable in the population. However, as practices return to prioritising important non-COVID work, the previously seen variation in maturity and integration between practices within a network will have a significant impact on a PCN's ability to deliver on the requirements of the PCN DES.

There needs to be a stronger commitment to support clinical directors, for PCNs to realise the improvements envisioned for them in the Long Term Plan and transformation of the health care system in the Health and Social Care Act. The original contract committed to fund a clinical director for only 0.25 WTE, approximately 5 days a month, to establish networks and build the relationships necessary to make a PCN work. This has been increased to 1.0 WTE in 2021, in recognition of the work that is required to bring practices together to deliver services across the network. This additional funding should be made permanent rather than only running to March 2022, as is currently stated. This will enable clinical directors to capitalise on the gains made in delivering the COVID vaccination programme, engage with the new ICS structures, and ensure primary care is adequately resourced to address the ongoing impact of the pandemic.

- **To what extent has general practice been able to work in effective partnerships with other professions within primary care and beyond to free more GP time for patient care?**

Many GPs already work alongside nurses, pharmacists, first contact physiotherapists, paramedics, physician associates and social prescribing link workers. This needs to be enhanced by the continued addition of other roles such as occupational therapists, dietitians, podiatrists and dermatologists. Practices also need support to work with community nurses and others who work across different care settings, in order to improve continuity of care.

The expansion of practice teams will improve patient access and widen the range of services delivered in primary care settings. It will also reduce GP workloads and enable them to focus their expert generalist skills where they are needed most – with complex cases, multimorbidity and managing undifferentiated illness.

Supporting teams to work differently, addressing traditional cultures and hierarchies, will however require investment in organisational development support.

The RCGP has been supportive of the roll-out of the Community Pharmacist Consultation Service (CPCS), which allow community pharmacists to support general practice by undertaking minor illness consultations after referral. Some pilots have suggested that 10% of GP appointments could be referred to community pharmacists via the CPCS. This system has not however taken off as well as hoped and we need Government action to better support effective implementation.

Recommendations:

- **NHSE need to carry out research to better understand the impact of an expanded team in general practice:** there remains a lack of data on the impact that an expanded team is having on GP workload. This data is necessary to better understand the impacts of multi-disciplinaries working in GP practices on GP workload and patient care.

- **Improve access to structured training and induction programmes for additional staff:** by drawing on the success of programmes such as 'Clinical Pharmacists in General Practice', additional staff in general practice can better integrate in a team and essentially provide better quality care for patients. Significant improvements should also be made to support delivery of the New to Practice Scheme for nurses.

- **Expand prescribing powers rights to enable additional members of the practice team to take on some of the workload from GPs:** GP workload has reached unsustainable levels, and allowing more staff in the wider practice team to prescribe medications for patients under their care, where this fits within their areas of competence, will in turn enable GPs more time to spend with patients.

- **To make CPCS a success** we need additional investment in local systems to drive CPCS implementation, streamlined referral pathways to make it easier for patients and staff, engagement and communications to support uptake of CPCS, an expansion of the role of community pharmacists in the management of minor illness and finally an evaluation of CPCS service and its impacts on general practice workload, patient outcomes and health inequalities.

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