RCGP organisational response to NHS England Creating a New 10 Year Health Plan consultation
December 2024

Overview
The government has made it its mission to fix the NHS, but it can't do it without your help and expertise; it wants to hear your views from the outset as it begins work to develop the 10 Year Health Plan for England.

You are therefore invited to respond to this survey by Monday 2nd December at 17:00. This is an early opportunity to share your insights as we begin an extensive programme of engagement to develop the 10 Year Health Plan.

There are five questions to answer. Please keep your total response to the questions to 5,000 words overall. Links to reports or supplementary evidence are not included in the word count should you wish to include these as part of your response.

The 10 Year Health Plan for England
The government has promised to put in place a 10-Year Health Plan to fix the NHS in England. We want to hear what your priorities are for this plan as interested organisations. Tell us what your organisation wants to see in the 10 Year Health Plan, and why this is important.

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

The supportive role of general practice:
The RCGP welcomes this consultation and the three shifts proposed for the new 10-Year Health Plan (10YHP). GPs are consultants in general practice, with distinct expertise and experience in providing whole person medical care, whilst managing the complexity, uncertainty and risk associated with the continuous care they provide. As such, GPs will be central to the success of the 10YHP. This response will outline that it is critical that movement of care into the community, and the other interrelated shifts, include accompanying investment so that a greater proportion of the NHS budget is spent on community services and on general practice in particular. Many years of underfunding along with poor workforce planning mean that general practice needs significant investment to be able to support and respond to the 10YHP.

The RCGP's latest survey highlights the consequences of pressures on general practice for patients. Over 76% of GPs say that patient safety is being compromised by excessive workload, 60% that they don't have enough time to adequately assess and treat patients during appointments, and 62% feel they don't have enough time during appointments to build the relationships with patients they need to deliver quality care. Without sufficient funding, struggling practices will continue to close, patient access and experience will be poorer, continuity of care will decline, and the number of full-time equivalent GPs will continue to fall. However, given the proper investment, GPs could be enabled to embed care and prevention in the community, alleviating pressures across the health service and building the healthy society needed for a healthy economy. Increasing the number of GPs, and investing in greater support for the existing workforce, will enable general practice to offer improved personalised continuity of care while improving access.

As general practice does not have access to large HR or other management departments, it also requires appropriate funding and training opportunities to build internal capacity and sufficient management support to engage with and adapt to new ways of working.

Similarly, it is important that the voice of general practice within Integrated Care Systems (ICSs) is embedded at all levels and given equal footing with secondary care. While Integrated Care Boards (ICBs) are required to have one member representing primary care, this does not necessarily mean that general practice is well represented. The RCGP believes that ICBs should have a specific GP representative in addition to a wider primary care representative, and that Boards should be required to ensure there is balance between any additional representatives from secondary care with those from primary and community care. We would also like to see primary care forums, as suggested by the Fuller Stocktake, or similar, implemented within all ICSs to ensure that there is a clear mechanism for staff working in general practice to feed in their experiences and views.

Facilitating change:
The 10YHP must recognise general practice and primary care more widely as the most cost-effective way to invest in the NHS and support public health and wellbeing. The recent Darzi review stated that "as independent businesses, General Practices have the best financial discipline in the health service family as they cannot run up large deficits in the belief that they will be bailed out".

Underpinning this investment must be a focus on addressing health inequalities. To meet the Government's commitment to halve the gap in healthy life expectancy, the plan must be carefully designed and implemented to support inclusion health groups and those in socio-economically deprived areas.

To ensure general practice can support all our patients equitably, alongside increased overall investment, we need a review of all general practice funding streams - including the Carr-Hill formula and the Quality and Outcomes Framework (QOF) - to channel more spending to areas of greatest need. Recent data has shown that English practices in areas with the highest levels of income deprivation have on average 300 more patients

per fully qualified GP than practices with the lowest levels of deprivation. Action to address the social determinants of health will also be critical to the success of the 10YHP, with a cross-government strategy and a focus on clean air, warm homes and good nutrition as priorities.

While it is important that detailed workforce plans are set out separately in the update to the Long-Term Workforce Plan (LTWP), consideration of the general practice workforce will be critical to the success of the 10YHP. The LTWP as it stands would only increase the number of fully qualified GPs by 4% compared to a 49% increase for secondary care consultants. This balance must be shifted to meet the Government's commitment to transfer care into the community. A significantly increased focus on GP retention and making general practice somewhere healthcare professionals aspire to work is also needed.

A significant commitment to improving general practice premises will also be needed to support all aspects of the 10YHP. 84% of general practice staff say a lack of physical space limits their practice's ability to take on GP trainees or other learners. Space is required to accommodate expanding practice teams and will be a critical limiting factor for moving care into the community and supporting co-location of services where this meets local population needs.

Additionally, GPs need support to improve their premises to utilise advances in technology, and to deliver on the NHS's sustainability commitments. 57% of GPs say their practice requires additional improvement works to meet patient needs. Approximately 16% of general practice's emissions come from energy use. Improving energy efficiency has concurrent benefits for practices, staff, patients, and the NHS, by reducing energy costs and ensuring more comfortable healthcare environments. The budget announcement of a dedicated fund to improve 200 GP practices is a good first step. However, this equates to just 3% of the over 6,000 practices in England. The RCGP therefore recommends a ringfenced investment of at least £2 billion in GP infrastructure to address the longstanding underfunding in general practice premises.

Introducing the three shifts

The next questions relate to 3 'shifts' – big changes to the way health and care services work – that doctors, nurses, patient charities, academics and politicians from all parties broadly agree are necessary to improve health and care services in England:

- Shift 1: moving more care from hospitals to communities
- Shift 2: making better use of technology in health and care
- Shift 3: focussing on preventing sickness, not just treating it

In answering the following questions on the 3 shifts, we'd welcome references to specific examples or case studies. Please also indicate how you would prioritise these and at what level you would recommend addressing this at, i.e. a central approach or local approach.

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Shift 1: moving more care from hospitals to communities
This means delivering more tests, scans, treatments and therapies nearer to where people live. This could help people lead healthier and more independent lives, reducing the likelihood of serious illness and long hospital stays. This would allow hospitals to focus on the most serious illnesses and emergencies.

More health services would be provided at places like GP clinics, pharmacies, local health centres, and in people's homes. This may involve adapting or extending clinics, surgeries and other facilities in our neighbourhoods, so that they can provide things that are mostly delivered in hospitals at the moment. Examples might include:

- urgent treatment for minor emergencies
- diagnostic scans and tests
- ongoing treatments and therapies.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Moving care from hospitals to communities has great potential to allow patients to access more joined up care closer to home. General practice is ideally placed to be at the core of a revitalised, well-resourced primary and community care sector. However, this shift will need to be carefully managed to ensure it delivers for patients. While some hospital services could be transposed to community settings, for example as specialist clinics, many would be improved by being better integrated with existing community services.

Resourcing of community care:
It is critical that any shift in care is accompanied by a shift in resources. Investing in primary care leads to better health outcomes and delivers value for money to the NHS, the economy and society. For every additional £1 invested in primary care, research has shown that at least £14 is delivered in productivity across the local community. The average 10-minute face-to-face GP consultation costs £49, compared to £91 for the lowest level of treatment at an urgent care centre and £147-£445 for more complex treatment in A&E. Analysis shows that increasing primary and community care spend can reduce non-elective admissions by up to 15% and ambulance conveyances by up to 10%.

A well-funded general practice is a sound investment in the health of our nation and our NHS. However, as noted in the Darzi report, successive governments have promised to shift care into the community but instead the proportion of NHS funding spent in general practice and primary care more widely has declined. The RCGP would like to see a duty for the Secretary of State (SofS) to report annually to Parliament on the

proportion of NHS spending in general practice and primary care, as is currently done for mental health spending. Similarly, each ICB should be required to report this proportion annually and held to account for ensuring it increases year on year.

Vision for neighbourhood working:
Another key factor to ensuring the success of this shift will be defining a clear, national vision for neighbourhood working. This must be accompanied by the ability to offer local flexibility within a set of principles, so that neighbourhood working can be tailored to the needs of local populations while avoiding a postcode lottery.

The RCGP would like to see general practice teams at the core of a neighbourhood service, underpinned by the wider primary healthcare team and seamless integration with community teams such as social care, citizens advice, benefits and voluntary services. The RCGP would expect that the approach to neighbourhood working would work best if it is based on Primary Care Network (PCN) footprints of 30-50,000 patients. Within this model, practices would largely retain their existing patient list sizes and geographical locations, to maintain connections to local populations and ensure that patients do not need to travel excessive distances, but they would be much better connected to and integrated with a wider range of services. This may involve co-location where possible and appropriate but where practices are physically remote to other primary and community services - for example in rural communities - investment in digital technology and dedicated staff resource will be needed to build relationships, support information sharing and integrate services.

Many existing practices and PCNs are already working closely with wider community services. There is also significant history of building integrated neighbourhood working around general practice with community nurses, health visitors and social workers, for example, having been based within practices in some areas in the past. The RCGP would like to see these ways of working enhanced rather replaced them with more centralised hubs.

Working at too large and scale or removing certain services, such as urgent care, from general practice could disrupt relationships between staff and patients, leading to worse experience and outcomes. Relational continuity is a critical part of the Government's ambitions to 'bring back the family doctor', and neighbourhood working must be delivered in a way which safeguards these relationships. Continuity of care has a strong association with reduced hospital admissions, patient morbidity and mortality, adherence to medical advice and patient satisfaction. However, only 29% of GPs say they can deliver continuity of care for their patients in a way which meets their needs. Access targets alongside workforce and workload pressures are leading to more transactional care. General practice must be supported to reverse this trend to promote effective care in the community.

Team working:
The ability for GPs to work closely with a range of colleagues, including social workers, pharmacists, district nurses and consultants will be a key enabler. Joint working, whether

via face to face or virtual discussions, or as part of specialist clinics in the community, will require shifting away from current poor practice where patients are bounced back to the GP if a new referral is needed, for example, to a more collaborative approach that allows for smoother referrals between different professionals working in the community, and with other healthcare settings.

There is also significant potential through social prescribing and collaboration within a neighbourhood service to offer a wider range of support to patients. For example, pilots of Community Health and Wellbeing Workers, embedded within primary care teams to proactively assist in providing health and wellbeing services to communities, have led to increases in vaccination and screening, and reductions unscheduled care, as well as increases in wellbeing.

Relationship building and connection between services will require time and space, with organisational development support being critical, as well as protected contractual time for building neighbourhood teams. Commissioning arrangements will also require consideration, with GP contracts and contracts for community services reviewed to ensure they support integrated working.

Premises improvement:
The current poor state of general practice premises will be a key barrier. 34% of GPs say that their practice building is not fit for purpose and 60% of GPs say their practice does not have space to accommodate new MDT staff. Delivering appropriate premises that can support co-location while not being too distant from local communities is integral to successfully shifting care into the community.

Shift 2: Analogue to Digital

Improving how we use technology across health and care could have a big impact on our health and care services in the future.

Examples might include better computer systems so patients only have to tell their story once; video appointments; AI scanners that can identify disease more quickly and accurately; and more advanced robotics enabling ever more effective surgery.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

The RCGP sees significant opportunities to use technological innovation to improve efficiency (e.g. reducing unnecessary paperwork or automating routine administrative tasks), patient experience (e.g. expanding access and continuity of care) and patient empowerment (e.g. the use of wearables to support self-care), as well as to promote more sustainable healthcare delivery (e.g. reducing the use of paper prescriptions and unnecessary travel). However, the risks associated with technology, such as reduced face-to-face contact, reliability, data security issues, and the environmental and ethical implications of data storage and innovations such as AI must also be considered.

Care must be taken to ensure that the implementation of new technology does not exacerbate health inequalities, for example, for those without access to smart phones and reliable internet, or those lacking digital literacy. Such digital exclusion is often most seen in rural areas, amongst the elderly, and the most socially excluded groups.

Over several years, the RCGP has worked closely with NHS bodies, providing strategic insights to support the delivery of impactful solutions in the technology space, including GP2GP - which allows the digital transfer of medical records from one practice to another - and the Electronic Prescribing System - which transfers prescriptions from practices to pharmacies. We are keen to continue to support such developments.

Basic IT provision:
It is critical that there is a focus on getting the basics right in the first instance. Many practices across the UK struggle with poor IT infrastructure. In our latest member survey, 30% said that their computer software was not fit for purpose and 40% said the same of their Wi-Fi quality or speed. By improving speed and reducing faults, valuable clinical time can be redirected, resulting in better patient care and staff satisfaction.

Many GPs have also reported poor interoperability between the many digital systems holding patient information across the NHS. In our member survey, 55% of GPs said that their ability to exchange information with secondary care was not fit for purpose, and 64% said the same of exchanging information with mental health trusts. This emphasises the need for investment on IT infrastructure to make the shift of care from hospitals to communities possible.

Expanding use of the NHS App will also be key to promoting better patient care as well as the interface between parts of the healthcare system. Information should made available to patients via the NHS App to support with referrals, provide visibility on waiting lists and guidance on preparing for an appointment or operation.

Similarly, implementing electronic prescribing in secondary care would be a key step in reducing bureaucracy, unnecessary shifts of additional workload from secondary to primary care and reducing the environmental impact of paper prescriptions.

Strategic approaches:
Beyond these improvements, to implement new technology, an open and strategic approach should be taken. This must include consideration of why new technological developments are being invested in, what the benefits are for patients and the wider system, and if they are viable and financially sustainable in the long term. Any new interventions should be piloted and assessed to ensure positive impact before it is scaled up. This needs to be accompanied by structures to reassure clinicians and other NHS staff that different technologies are safe and effective (e.g. having NHS and MHRA validation of new technologies and devices).

The time and resource required to engage with and implement new technologies and ways of working must also not be underestimated. To ensure general practice can make better use of technology, overarching workload pressures must be considered and protected time for training for practice staff will be required, alongside implementation support as appropriate.

Data sharing:
Effective and safe data sharing across different parts of the system is also critical to ensuring technology uptake and better patient care. Without greater interoperability and sharing of records across healthcare settings, none of the three shifts will be deliverable. General practice's decades long creation and maintenance of digital patient records means these are now able to serve needs well beyond individual practices, such as in data shared for direct care, for planning purposes, and research. However, data sharing remains a complex issue with varying strong views amongst clinicians and patients as to the appropriateness of sharing information for different uses. GPs report concerns that if the public lack confidence that records will be kept confidential, this may create barriers to patients sharing important health information, which can lead to poorer health outcomes and care experiences. Additionally, as acknowledged in the Sudlow Review, the regulations regarding the use and sharing of confidential health data are complex and variable, and this can create a tendency in clinicians to avoid risk. Consideration should be given to clear and effective indemnity systems to protect GPs as data controllers.

To support the sharing of data, and the Government's ambition of creating an integrated patient record, we must ensure the trust of the public and clinicians, by improving transparency in data sharing processes and their governance. The RCGP can help build that trust amongst the profession by participating in defining and assuring robust governance frameworks. General practice is well placed to curate patient records, and with the appropriate strategic guidance, funding and tools, it can enable not only the sharing of data, but also ensure those data are of good quality.

The RCGP is supportive of the benefits of data sharing and the importance of health research. However, this must be delivered in a way which is transparent about the purposes of data sharing, respects patient rights to be fully informed, privacy and consent, and ensures data security.

Shift 3: Sickness to Prevention

Spotting illness earlier and tackling the causes of ill health could help people stay healthy and independent for longer, and take pressure off health and care services.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

The RCGP supports this ambition and is undertaking work on preventive medicine. The Darzi report noted the potential of health promotion and there has been progress with rates of smoking in England falling, reducing the incidence of cardiovascular disease and

cancer. However, rates of other largely preventable health issues such as obesity and diabetes continue to grow.

Previous NHS plans, such as the Five Year Forward View, highlighted the need to shift towards prevention, stating that focusing efforts in primary and community care is the most effective way of preventing illness and reducing the need for secondary care intervention.

Despite this, one fundamental barrier is the lack of dedicated funding. The ONS estimate that only 5% of health funding is spent on prevention, and public health grants to local authorities have reduced by 25% since 2015. The separation of public health into Local Authorities, has risked limiting preventive medicine efforts and moving this responsibility back within the NHS should be explored.

Similarly, long waiting times for services such as mental health, drug and alcohol and weight management can limit the effectiveness of preventive efforts by general practice.

GP consultations:
GPs have a wide exposure to the general population and are ideally placed as expert generalists to deliver preventive medicine, with a unique ability to consider the whole person. GPs are trained in and have provided this type of care for a long time, often capitalising on opportunities to provide targeted patient education and discuss lifestyle changes with patients. Research has shown that most patients are willing to accept behaviour change interventions from their GP during routine consultations, something which is further enhanced by relational continuity.

The GP-patient relationship can also help support people to get back to work more quickly after periods of ill health, enabling GPs to identify barriers and work alongside job coaches to propose solutions. Significantly more could be done in general practice to support this with appropriate resourcing.

Opportunistic interventions are limited by unmanageable workload in general practice. GPs believe around 44% of their patients would benefit from health advice but do not feel able to deliver that advice to most of those patients. The biggest barrier to this is the limited time in consultations resulting in unavoidably narrow and focussed discussions. 60% of GPs report they don't have enough time to adequately assess and treat patients during appointments, and 62% don't have enough time to build the relationships with patients needed to deliver quality care. The preventive power of the GP consultation should be recognised and supported with appropriate resources.

Incentive schemes such as the QOF are meant to encourage GPs to focus on preventive, proactive care, but the current system can have the opposite effect. A 2017 systematic review of QOF concluded that there was no convincing evidence that QOF promotes better integrated, personalised care or improves any other outcomes for people with long-term conditions. Instead, QOF can lead to box ticking and unnecessary workload. GPs say that 1/4 of their time is spent on work generated by QOF that is unnecessary

and/or does not have a positive impact on patient care. Similarly, the current scheme can be seen to result in reduced payments in socioeconomic deprived areas as it rewards chronic disease management more than prevention and early intervention in high-risk populations. Putting in place incentives which are impossible to achieve within certain communities can have the perverse effect of reducing motivation to work towards them.

Targeted prevention strategies:
The wider strategic approach to prevention must also be considered. There is significant value in appropriately deployed, evidence-based health checks. However, it is critical that these are specific and risk stratified, and any new approaches to prevention should be carefully evaluated. Overemphasis on health checks for the whole population risks overmedicalisation, pick up of spurious findings, and inefficient use of resources. Instead, an approach which targets specific, high impact diseases (e.g. cardiovascular disease, diabetes, mental health, substance issues and non-communicable diseases) and vulnerable populations is likely to be more effective. Additionally, immunisation programmes are vital for the prevention of a range of childhood and adult health conditions, reducing disease morbidity and mortality, and are crucial for reducing disease burden, improving health outcomes, cutting healthcare costs, and optimising resource use.

Social determinants of health:
Beyond health checks and other specific interventions, earlier, non-medical interventions must be considered. Joint working with public health and patient facing campaigns, schools, faith and community leaders, and the voluntary sector are key to primary prevention. Similarly, social determinants of health are key factors in shifting towards a preventive model. Factors such as housing, air quality, access to nature and good nutrition must be addressed to support people to live healthier lives and reduce pressure on the healthcare system. Evidence from a pilot in Sunderland showed that prescribing people with COPD who were unable to heat their homes with boilers reduced GP appointments by 60%, and emergency hospital admissions by 25%. Additionally, the 'Bridging Gaps' project, a collaboration between healthcare staff, researchers, charities and women with lived experience of severe and multiple disadvantage (SMD), who often have high health needs but poor access to primary care, was co-produced to improve access to general practice for people with SMD, by facilitating collaborative service improvement.

Early years prevention and investment in child health must be a fundamental part of this approach and the RCGP supports the need to appropriately fund children's health services and consider child health in all government policies. Similarly early interventions in the community are critical to preventive efforts. The falling numbers of community nurses and nurses in settings such as schools is of significant concern. Greater investment in this area would likely offer significant potential in tackling the causes of ill health.

An overarching enabler to this work will also be a clear, shared vision of prevention, which seeks to target premature disease and inequalities in outcomes, life expectancy and quality of life.

Ideas for change

We're inviting everyone to share their ideas on what needs to change across the health and care system. These could be:

- Ideas about how the NHS could change to deliver high quality care more effectively.
- Ideas about how other parts of the health and care system and other organisations in society could change to promote better health and/or improve the way health and care services work together.

Ideas about how individuals and communities could do things differently in the future to improve people's health.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

- **Quick to do, that is in the next year or so**
- **In the middle, that is in the next 2 to 5 years**
- **Long term change, that will take more than 5 years**

Short term:

General practice resourcing:

- The SoS should report annually to Parliament on the proportion of NHS spending in general practice and primary care, as is currently required for mental health spending. Similarly, each ICB should be required to report this proportion annually and held to account for ensuring this increases year on year.
- Protect patient safety by introducing a national alert system to flag unsafe workload levels and allow practices to access additional support.
- Provide organisational development support to general practice to implement new ways of working, building on the General Practice Improvement Programme.
- Free up GPs to spend more time with patients by reducing top-down contractual requirements and bureaucracy and preventing the inappropriate transfer of workload from the rest of the health system.

Continuity of care:

- Deliver support for general practice to provide continuity of care to patients through quality improvement approaches that properly resource continuity as a core part of general practice.

GP workforce:

- Undertake a comprehensive review of the LTWP with a focus on GP retention.

- Develop a National Retention Strategy for general practice that ensures national consistency via ring-fenced national funding, oversight, and guidance.
    - Each ICB should appoint a local GP retention lead and NHS England (NHSE) should link them together to support collaboration.
- Evaluate existing GP recruitment and retention schemes to ensure they focus on supporting socioeconomically deprived areas. Implement additional schemes where needed.
- Fund the roll out of the People Promise across general practice.
- The Home Office should grant IMGs across the UK the right to apply for Indefinite Leave to Remain once they qualify as GPs, and NHSE should reinstate the IMG practice matching service.

Ways of working:

- Increase the use of group consultations in general practice to support patients with similar conditions to learn from each other with clinical support.
- Continue to expand community diagnostic hubs, making services more accessible to patients.

Medium term:

General practice resourcing:

- Ensure patients get the care they need, closer to home, by increasing the share of NHS funding for general practice.

GP workforce:

- Establish an independent workforce projection statutory body.
- As part of negotiations between the Government and the BMA, protected learning time for GPs should be incorporated into a future iteration of the GP contract.
- Guarantee ongoing funding for Practitioner Health services for all health and care professionals employed in the NHS.
- Expand training capacity in general practice - physical space and capacity of educators/supervisors - to allow for increased GP numbers above and beyond current Government targets, particularly in socioeconomically deprived areas.

Ways of working:

- Review the GP contract and commissioning arrangements across primary and community services to allow for smooth referrals and coordination between teams, particularly for vulnerable patients or those with multiple conditions.
- Empower patients with greater access to a wider range of services using a piloted and evidence-based approach, as is done in some services (e.g. primary mental health, smoking cessation, drug and alcohol, physiotherapy, pharmacy and ophthalmology).
- Strengthen patient voice in general practice and any future neighbourhood service, building on Patient Participation Groups, to ensure a say in local ways of working for the benefit of communities.

- Adopt the principles of realistic medicine and prudent health, which promote shared decision-making between healthcare staff and patients, and to minimise unnecessary medical interventions.
- Explore moving public health responsibility back within the NHS to promote and facilitate prevention efforts.
- ICBs should have a specific GP representative in addition to a wider primary care representative, and Boards should be required to ensure there is balance between any additional representatives from secondary care with those from primary and community care.

Community care:

- Increase funding for expanding the number of community nurses and nurses in settings such as schools to promote early prevention and child health.
- Expand Community Health Wellbeing Workers as piloted in over 25 sites in the UK to proactively provide health wellbeing services within local communities.

Digital services:

- NHSE should invest in upgrading the current general practice IT infrastructure. This should include ensuring practices have access to sufficient PCs and laptops, high-quality software, fast broadband, and modern functioning booking systems.
- Increase investment in digital innovation and the organisational support to implement improvements to how practices operate, enhancing patient experience, efficiency, and connectivity with other parts of the healthcare system.
- Expand the information available on the NHS App to support with referrals and waiting list management so that patients can see the status of their referral, and advice on how to improve their health prior to being seen in secondary care.
- Improve data interoperability between different parts of the NHS, particularly primary and secondary care, to ensure information is more easily accessible for direct care.
- Implement electronic prescribing across all NHS settings to reduce the use of paper prescriptions, support continuity of care, and reduce bureaucracy.

Health inequalities:

- Review all general practice funding streams to better match resources with patient need, alongside increased investment across general practice.
- Site new medical schools in socioeconomically deprived areas where possible.
- Ensure all practices across England have access to high-quality data and analytical tools that facilitate understanding of their community's health needs.
- Produce a cross-government strategy to reduce health inequalities, which commits funding to reduce the impact of social determinants on population health.

GP premises:

- Give every patient access to a modern fit-for-purpose general practice building, by investing at least £2 billion in infrastructure.

- Provide a flexible framework, streamlined processes, and adequate ringfenced funding, for practices to retrofit, improve energy efficiency and reduce their carbon footprint.

Sustainability:

- All NHS medicine procurement should include an environmental impact assessment, requiring the pharmaceutical industry to provide standardised environmental impact information.
- Medicines recycling and re-use schemes should be expanded across the UK, particularly focusing on inhalers.
- NICE should include information about the environmental impact of medicines in their guidelines and publications.
- NICE should update their guidelines to incorporate non-medical and nature-based interventions as a specialised category, where evidence of benefit is available.
- Adapt GP incentive schemes to encourage a stronger focus on delivering quality improvement approaches to sustainable healthcare.

Long term:

- Ensure long term significant investment into primary care, hardwiring the importance of resources following any shift of care into NHS planning.
- Reducing the risk of premises ownership and lease holding for GP Partners by ensuring NHS premises payments and reimbursements meet full practice costs.
- As suggested by the 2019 Independent Partnership Review, introduce the option for GP Partners to shift to a different legal model, such as Limited Liability Partnerships.