Written evidence submitted by NHS Providers (FGP0304)

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

Trust leaders recognise primary care as one of their most important partners, particularly in the context of system working. A significant number of trusts within our membership also directly provide primary care services. NHS Providers works closely with primary care stakeholders and partners at a national level, including a group of 'at scale' primary care providers, and the National Association of Primary Care (NAPC) to mirror the partnerships trusts are forming at the frontline and to support effective partnerships at place and system levels. We are grateful for the input of those partners to our response.

Key messages

- General practice forms "the bedrock of the NHS" and the wider health and care system.[1] Secondary and primary care have more in common than that which differentiates them.

- In common with the wider service, trust leaders and primary care colleagues tell us that the workforce issues faced by general practice are the dominant issue that needs to be addressed. Sustained and measurable action is needed to retain experienced clinicians, support substantive recruitment, better integrate flexible working options, and develop roles that are rewarding.

- The Health and Care Bill will establish the statutory footing for integration care systems (ICSs) across the NHS in England. Ensuring a clear voice for primary care within these new structures will be critical to improving person-centred care. This means the right balance must be struck between local practice service models and at-scale infrastructure. In our view, there are a wealth of models which support integration between secondary and primary care, and serve the patient interest, including 'at scale' delivery models covering larger geographical footprints, greater support from trusts to general practice where appropriate, and engagement with primary care networks (PCNs). We are keen to avoid a prescriptive 'one size fits all' approach and to sustain an enabling framework which is responsive to local needs.

- A thriving primary care model is needed if we are to move to an approach based on population health with a greater emphasis on preventative care. General practice will be an instrumental force in this. For example, improvements in some health indices over the last two decades have benefitted from more systematic approaches to disease management in primary care. High quality IT and joined up approaches to data are essential to going further and faster.

- High quality local leadership drives improvement. It will be important that the review being led by Claire Fuller for NHS England creates credible options for local practices, PCNs, partner trusts, and Integrated Care Boards (ICBs) to promote local primary care leadership. PCNs should be one option, among others, through which such leadership could come.

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

1. Access to general practice covers several categories of need. Patient-initiated demand, sometimes for an urgent concern, must be met alongside long-term treatment and preventative work. Emphasis on one of these three needs should not prevent access for those with complex

[1] Our plan for improving access for patients and supporting general practice, NHS England and NHS Improvement, October 2021, p3.

multiple long-term conditions or impede general practice from supporting care homes and key points of community need.

2. In the short-term, general practitioner numbers will not grow markedly, even though training entry numbers have shown promising growth.[2] This means that practices will need to work together to increase clinical contact time and prioritise technology which makes booking, record transfer, and clinical administration for onward care as straightforward as possible. Systems should also be working with practices to help increase nursing and Allied Health Professional (AHP) numbers by supporting non-primary care staff to consider rotations and long-term roles within general practice. This practical help is what practices need from system working.

3. Coordination at a level of scale, often larger than a PCN footprint, offers a way to best match demand and supply on a daily or weekly basis. This can be aided by smart use of booking technology and also in how the system directs people to where local availability exists and what is clinically necessary.

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

4. There is welcome targeted investment of £250m in the plan announced in October 2021 and maintenance of £10m of tapered support.[3] The additional roles, key partnerships, and good quality telephony emphasised in the plan are all key ingredients to tackle access. The newly statutory ICSs will have many calls on their time in this period, not least the newly accelerated COVID-19 vaccination campaign. At the right time, given the booster rollout, sustained attention is needed to ensure that material capacity expansion is achieved. This must be the critical focus, with proportionate attention to tackling the balance between remote and face-to-face contacts.

5. What is not quantified within the plans is the estimated scale of the gap between current provision and future need. In October 2021, the same month that the plan for expansion was launched, general practice delivered the second highest volume of patient contact on record.[4] Each ICS needs to be explicit about how much more capacity is needed to achieve good quality care and satisfactory access. This should include an assessment of whether primary care demand will return back to pre-pandemic levels. This will enable a focus on results rather than on measuring inputs and initiatives.

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

6. It is often suggested or assumed that a lack of access to primary care drives demand on the emergency care pathway. There is limited empirical evidence published to substantiate this, and attendance patterns for different services reflect a variety of needs. Primary care activity, NHS 111 calls, ambulance call outs, and urgent hospital activity are all at record levels. Trust leaders and primary care partners are similarly reporting increased complexity and acuity among a number of patients who may have held back from seeking treatment or been unable to access it during the pandemic.

7. Clinical risk arises when patients cannot navigate a complex NHS system or become invisible in the system. An improved pending/waiting list model would allow those in need of help to be

[2] Our plan for improving access for patients and supporting general practice, NHS England and NHS Improvement, October 2021, p17

[3] Our plan for improving access for patients and supporting general practice, NHS England and NHS Improvement, October 2021

[4] NHS Key Statistics: England, October 2021, House of Commons Library

offered services from across the primary care multi-disciplinary team. Practices need to be supported locally to have contact and booking systems which meet these norms, as many already do. A solely "eight o'clock telephone" model does not. Common standards would benefit from an NHS-wide expectation which the wider public can relate to.

8. It will be the case that some people prefer not to access healthcare using remote methods. Choices can be influenced by experience and information and if the NHS seeks a more digitally enabled health delivery model, it will need to invest time and attention in influencing beliefs and behaviours. It will be important for ICSs to take seriously their responsibility for framing this environment to avoid digital exclusion.[5]

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?

9. Evidence on the merit of continuity of care for some patients is compelling and can be measured.[6] This varies by individual and condition. It will be important that necessary continuity is not eroded by changes designed to improve practice-level access performance. In secondary care this balance is struck by giving patients information about waits to see named individuals and the next-available appointment. Immediate access urgent primary care does not typically require this continuity, which is why provision between practices is seen as an effective scaled model.[7] The introduction of named general practitioners in patients over 75 has been subject to analysis, which commends satisfaction but challenges whether having a named GP is sufficient to improve continuity of care.[8]

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

10. The challenges faced by general practice reflect those faced by the system as a whole: an ageing population creates changed demands and needs; an internationally in-demand workforce places pressure on retention and recruitment; digital transformation which creates opportunities and frustrations; and a need to nurture person-centred care and avoid the impression of a series of transactional appointments. Better integration of teams and sectors would help tackle these factors.

11. The overwhelming challenge is to have in place the workforce to meet need. This means stemming the loss of clinicians as well as building on rising trainee numbers. GP roles sit within practice teams with vacancy challenges in each discipline, and attention needs to be paid in equal measures to that wider team if general practice roles are to remain rewarding.

12. The *Five year forward view*, *NHS long term plan* and Health and Care Bill all depend on moving care upstream. This is not a new narrative nor one unique to the NHS among international health systems. Primary care is an essential component of a wider neighbourhood strategy to tackle wider social determinants of health and support a more preventative health approach.

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[5] Watts G, 'COVID-19 and the digital divide in the UK', *The Lancet,* 2(8):E395-E396 (August 2020)

[6] Jeffers H et al, 'Continuity of care: still important in modern-day general practice', *British Journal of General Practice,* 66(649):396-7 (August 2016); and Sidaway-Lee K et al, 'A method for measuring continuity of care in day-to-day general practice: a quantitative analysis of appointment data', *British Journal of General Practice,* 69(682) (May 2019)

[7] Turner et al, 'Do patients value continuity of care in general practice? An investigation using stated preference discrete choice experiments', *Journal of Health Services Research & Policy*, 12(3):132-7 (July 2007)

[8] Barker et al, 'Effect of a national requirement to introduce named accountable general practitioners for patients aged 75 or older in England: regression discontinuity analysis of general practice utilisation and continuity of care', *BMJ Open*, 16;6(9) (2016); and Pereira Grey et al, 'Having a named doctor in general practice is not enough to improve continuity of care' *BMJ*, 367:l6106 (October 2019)

While primary prevention may be offered in a consultation room, tackling neighbourhood health requires greater collaboration locally among practices and with partners including trusts. The skills to implement change at scale differ from those needed to make change in one's immediate team. This improvement skill needs to be sourced within an ICS. That capacity to build capability is widely needed.

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

13. The model of general practice will need to vary depending on local needs. Rurality certainly is one of the factors where different demographics, distances and disease patterns can shape service needs. Similarly, urban environments and coastal communities generate specific issues, notably high list turnover. These subtleties suggest a need for some local variation in how services are provided. It is not presently the case that the distribution of the primary care workforce reflects greatest need.[9]

What part should general practice play in the prevention agenda?

14. It is essential that general practice has capacity built in to support primary prevention and social prescribing among a registered population. For this to happen effectively, practices need to have the most up to date view of the data about their population. The pandemic has re-illustrated the galvanising impact of lean, purposive data. GPs' role can be both direct, in giving care and advice, and directive in coordinating the efforts of others. Some preventative services will be organised at neighbourhood level or targeted at patients who experience registration difficulties.

15. Trusts can support general practice in this work by scanning attending patients and identifying those where something may have been missed – for example, screening for dementia in eye or hearing clinics. This collaboration should not be viewed as failure by one part of the system and payments should flow from the population impact not solely from who has provided the intervention. Vaccination during hospital contact is a good example of this opportunity to work as one NHS.

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

16. Primary care colleagues tell us that uncertainty among patients waiting for secondary care has increased the demand for appointments in general practice for advice and reassurance. Trusts must now demonstrate that they have accessible routes for patients to enquire directly about their queue status while recovery takes place. Data on live wait status should be available to practices, for example as seen in Croydon.[10]

17. Recent plans from NHS England set out steps to reduce the administrative burden on practices from beyond the NHS and from within it.[11] For example, there is a case to provide a generalised access to NHS systems for all practice employees: general practice relies on high quality ancillary staff to undertake its administration, and their lack of access to the benefits of NHS service remains a potential barrier to recruitment and retention. Creating a more equitable approach to workforce terms and conditions between primary care and trusts will avoid grade inflation and bidding wars for scarce staff.

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[9] Nussbaum C et al, 'Inequalities in the distribution of the general practice workforce in England: a practice-level longitudinal analysis', *British Journal of General Practice,* Oct 26;5(5) (2021)

[10] Croydon Health and Care Transformation Plan 2019/20-2024/25

[11] Our plan for improving access for patients and supporting general practice, NHS England and NHS Improvement, October 2021

How can the current model of general practice be improved to make it more sustainable in the long term? In particular:

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

18. Those considering general practice may not seek the career-long commitment implied by partnership nor suggested by property ownership. Salaried models may appeal to some, but where this has been adopted at scale, the evidence is not clear that it alters recruitment patterns. In discussing primary care provision with trusts who are recruiting GPs on a salaried basis, it remains clear that they face considerable turnover and challenge. A mixed economy may well best reflect the diversity of opinion in the profession.

19. In most clinical disciplines, not just medicine, the dominant training model remains hospital based and hospital first. There is a need to ensure training reflects a more preventative and 'home first' approach, and a more assertive national effort to embed training time among new entrants in nursing, therapies, and medicine within primary care. Change will require regulatory support from registering bodies as new educational providers are required to mirror the approach of established institutions.

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

20. ICSs and trusts are moving away from payment by results towards more population-based budgeting. General practice has a mixed model of capitation and incentives for scale and quality. Incentive design therefore needs to examine the system as a whole, not primary care in isolation. This is a major change to historic practice which has viewed these issues by sector.

21. Local variation in contracting models to date has typically sought to remove long term security of tenure in return for altered payment models such as the primary medical services (PMS) model. Any reform or localisation of contracting should be mindful of the fact that tenure under existing general medical service (GMS) contract is valued by GPs, as it gives the ability to plan with confidence about income.

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

22. Joint working at scale offers benefits including spreading good practice and supporting the workforce. In particular it can bring expertise in back office functions and support rapid-access clinical care. PCNs represent one model by which this can be achieved. It is worth noting that various models of delivery exist across the country including structural integration with trusts, partnerships with federations, and at-scale partnerships or corporate bodies. It may be that PCNs evolve to perform a distinct function of local accountability across a given geography, but there is merit in supporting practices to collaborate using a range of models that create access to expertise and investment. We welcome the review by Claire Fuller exploring the full range of options which ought to be available to support GPs and the role that PCNs will play as partnerships at the level of system (ICS) and 'place' evolve further. One size is unlikely to work well everywhere, and flexibility within an enabling framework will be key.

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?

23. The relationship between general practical and community pharmacy should be a pillar of local neighbourhood healthcare. The Community Pharmacist Consultation Service (CPCS) provides the latest example of concerted effort to make use of the skills of independent and large-multiple

providers. The substitution effect from general practice could be quantified and tracked on a local basis. Pharmacy integration into primary care networks has been given insufficient emphasis and this is now being addressed as a qualifying-criteria to the Winter Access Fund 2021.

24. Operating practices in a system can shift time and workload between parties. GPs who choose not to use digital triage systems for advice and guidance can contribute to workload in trusts. It is also the case that trusts need to pay attention to behaviours which cause workload within general practice. The 2021/22 national contract reflects the needs to focus on this. Historic commissioning policies can mandate re-consideration by GPs prior to 'tertiary referral' between specialties or prior to cross referral from emergency departments. The structure of discharge letters or outpatient correspondence can be framed in such a way as to create workload. This requires local leadership and there are digital support solutions, such as triage tools, which can reduce errors.

25. The interface between primary care and social care remains critical. For example, at-risk registers of children within the care protection system are not routinely viewable electronically inside the NHS. Data sharing and technology integration here merits renewed attention, with ICSs playing a crucial role.

26. For trusts, the challenge of innovation is to be able to adopt new clinical guidelines or operating practices and apply them consistently across all general practice partners locally. Having multiple interface models is costly and confusing. There are numerous examples of successful interface working, as we highlighted in our report on waiting list backlogs within secondary care.[12] Data sharing between practices and trusts should be routine and the interoperability of primary care IT systems likewise.

[12] Primary care must be helped to work with hospitals in driving the NHS recovery