

The Future of General Practice

December 2021

About us

The NHS Confederation is the membership organisation that brings together, supports, and speaks for the whole healthcare system in England, Wales, and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care, and reducing health inequalities.

Summary

General practice has been experiencing a surge in demand for appointments, which it does not have the capacity to meet due to a lack of workforce and poor infrastructure.

Simultaneously, general practice's workload has increased in size and complexity as well as supporting patients on waiting lists as a result of the pandemic.

However, primary care can – and has – been overcoming these challenges by working together at scale at neighbourhood, place and system level. So, with further support and investment in primary care, we can create additional capacity at scale to manage transactional, low complexity care whilst greater investment in primary care management infrastructure could help relieve the administrative burden. This would create capacity in general practice to concentrate on complex, person-centred care and long-term condition management where continuity of care is important.

Introduction

1. As the only membership body for [Primary Care Networks \(PCNs\)](#) and [Primary Care Federations](#), we have been actively engaging with NHSEI and government on the development of primary care at scale. As such, we do not seek to represent general practice,

which is the bedrock of primary care and the wider NHS, but to outline the opportunities for a more efficient, patient-responsive service through the delivery of services at scale.

2. Primary care 'at scale' service delivery already exists, although it is not a uniform picture. Primary Care Networks (PCNs) cover most of the population registered on GP lists and are mandated by NHSEI via the [Network Contract Directed Enhanced Service](#). They operate at 'neighbourhood level' in [Integrated Care Systems \(ICSs\)](#) - a level above general practice level and below the 'place' level. Primary care federations – sometimes called GP Federations - also exist operating at the 'place' – and sometimes system – level within ICSs, delivering services at scale. There is not national coverage of GP Federations, and they are not mandated by NHSEI.
3. This inquiry comes at a time of both strain and reform within the NHS in England. Although the pandemic has laid bare historic challenges across the NHS, it has also presented an opportunity to innovate and modernise NHS services out of necessity. Pre-pandemic, structural change was already underway, for example, with the development of Integrated Care Systems (ICSs) and PCNs. In many areas of the country primary care providers operating at place (GP Federations) emerged organically to deliver services such as [Extended Access](#) and support to the wider health and care system. In many respects however, the pandemic has accelerated the pace of change and driven the need for a more collaborative approach to dealing with the challenges.
4. During the pandemic, general practice changed the way it worked overnight, adopting new technologies to ensure patients could continue to be seen safely whilst organising hot and cold sites to curb the spread of infection. General practice, through PCNs and GP Federations has been at the forefront of delivering the vaccination programme, administering the vast majority of primary and second doses, as well as boosters and vaccinating the housebound and care home residents. The success of the vaccination programme is a result of primary care working at scale, and of the whole primary care ecosystem being used to best advantage.
5. It is in this context that general practice must be considered. Its experience of at scale working, whilst pre-dating the pandemic has been brought into sharp focus as result of the resilience it has provided throughout Covid, not least with the vaccination programme demonstrating its value. If these lessons can be applied and further support given for at scale working, then capacity will be created in general practice.
6. Our submission is the result of engagement sessions with around 100 PCNs and federations.

Investment in primary care workforce, particularly GPs and nurses, is needed to respond to increasing demand

7. General practice now delivers approximately 10% more appointments than pre-pandemic¹, standing at 30 million in October 2021, with almost two thirds of these appointments being in person². Primary care workload has increased due to pent-up demand for services; increased presentations with increased complexity (physical and social) as a result of the pandemic and lockdowns; the vaccination programme; managing patients as they wait for treatment in

¹ <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice>

² [Appointments in General Practice, October 2021 - NHS Digital](#)

secondary care – to name a few. If not remedied, these challenges will only increase in severity, leading to worse patient outcomes, over the next five years.

8. This coincides with underlying supply-side pressures, chiefly a falling number of GPs, exacerbating the situation. The number of full time GPs in England has fallen from 0.52 per 1,000 patients in 2015 to now being 0.45.³ Indeed, the government is aware of this, pledging that there would be an additional 6,000 GPs by 2024-25 – an ambition it now admits will not be met.⁴
9. Further to this, working patterns are changing for GPs. Many are opting to work reduced sessions, anecdotally citing ‘working conditions’ as the reason, or as locums, and therefore exiting from the full-time workforce. This reduction in the number of GPs is felt more sharply in deprived areas where there are fewer GPs per 10,000 patients.⁵ We hear that it is more difficult to attract, recruit and retain GPs in rural areas. Others are looking for portfolio careers where they can use their clinical expertise to support work in the wider health and care system – a key part of the new strategy for integrated care. Yet, formal NHS investment in primary care leadership, as an alternative or supplementary career path, is lacking. We know the number of students entering GP training has increased with a record 4,000 being accepted onto placements at the end of 2021⁶ but we do not know the conversion rate into GP partnership or salaried roles.
10. Whilst the GP partnership model holds the risk within primary care, attaining partnership remains an attractive career goal (despite the pressure the sector is under). However, more must be done to encourage doctors into and to retain them within the profession, especially in areas that struggle to recruit, such as deprived and rural areas. Attracting a future primary care workforce requires greater opportunity for portfolio working and the retention of enhanced skills. This includes a more integrated approach to clinical pathways between generalists and specialists in tandem with specialist training, enhancing a joint workforce strategy across primary and secondary care.
11. Another historic challenge to GP practices – and wider primary care – is a lack of adequate infrastructure. This includes estates and technology, with both having laborious and variable commissioning/procurement processes, as well as access to data and business intelligence/analytics. This lack of infrastructure translates to a lack consulting space, to expand consulting capacity, a lack of/sub-optimal technology, with no uniform provision⁷, from which to provide remote consultations and a lack of tools to manage and analyse patient flows.

General practice can provide complex, person-centred care and the prevention of worsening conditions

12. General practice is best suited to the management of people with complex needs who require continuity of care to prevent their conditions from worsening. This is where the skills of highly

³ <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice#:~:text=There%20are%20now%20just%200.45,or%2016%25%20%2D%20since%202015.>

⁴ <https://www.gponline.com/government-not-track-deliver-6000-gps-2024-admits-javid/article/1732134>

⁵ [Inequalities in the distribution of the general practice workforce in England: a practice-level longitudinal analysis | BJGP Open](#)

⁶ <https://www.hee.nhs.uk/news-blogs-events/news/record-number-4000-gps-accepted-training-placements>

⁷ <https://www.nhsconfed.org/sites/default/files/2021-08/Primary-care-networks-two-years-on-01.pdf>

trained generalist doctors add the most value, being able to observe a patient and evaluate their care in a holistic way, managing risk and uncertainty and making appropriate treatment recommendations based on their relationship with the patient.

Encourage economies of scale in general practice operations

13. Much of the management and business functions of general practice could be undertaken at scale - HR, finance, estates – to ensure clinical time is spent where it is needed, and general practice can benefit from dedicated expertise. For example, the introduction of the [PCN Additional Roles Reimbursement Scheme \(ARRS\)](#) has seen the workforce shared across the PCN member practices with the employment being managed by the PCN or in many cases, the GP federation. Similarly, we have seen many examples of GP Federations delivering a complete back-office function to their PCNs.
14. This can create capacity in general practice by freeing them from administrative and bureaucratic burdens. With the dissolution of clinical commissioning groups (CCGs), when Integrated Care Boards (ICBs) are given statutory footing (anticipated currently in April 2022) general practice looks set to lose many support functions that are currently delivered by CCGs⁸. This also presents an opportunity to rectify discrepancies in provision, specifying functions and services. Existing examples include:
 - Workforce pools e.g., GPs, paramedics - both in hours and out of hours
 - Virtual multi-disciplinary team to support care homes
 - Vaccination workforce pool
 - Extended access workforce pool
 - Project management of programmes e.g., vaccinations
 - Data-sharing and systems synchronisation
 - Human Resources (HR) support
 - Communications support
 - Training hubs

Clinical Services should be delivered at a scale that aligns with population health and operational needs

15. General practice can be supported by delivering clinical services at the scale appropriate to the population health need and can benefit from economies of scale. This can allow for services to be delivered at practice, neighbourhood (PCN), place or system level (Federation), balancing acuity and continuity. Increasingly, as the 'out-of-hospital' workforce expands and there is greater integration of care in line with national policy, there are significant opportunities to deliver more care closer to home. This could create capacity in general practice to concentrate on complex, person-centred care where continuity of care is valued and leads to better health outcomes.
16. Examples of at scale service delivery abound but many have arisen out of necessity and only in times of crisis. Schemes such as the Winter Access Fund, outlined in NHSEI's plan for 'Improving patient access and supporting general practice' illustrate this.⁹ The Winter Access Fund seeks to encourage same day, urgent primary care at a scale above general practice, yet it provides no funding or support beyond the winter. Not only does this risk any gains and

⁸ <https://www.nhsconfed.org/sites/default/files/2021-08/Primary-care-networks-two-years-on-01.pdf>

⁹ <https://www.england.nhs.uk/coronavirus/publication/our-plan-for-improving-access-for-patients-and-supporting-general-practice/>

innovations being lost, but it also illustrates the sporadic and reactionary approach to supporting general practice.

17. Through at scale clinical service delivery, capacity can be created in general practice to contend with the challenges the NHS now faces. The pandemic has led to increasingly complex patient presentations, often involving physical and mental issues and increasing waiting lists for secondary care. Even before the pandemic, people were living longer and with increasingly complex needs. Given these challenges, capacity must be made available for general practitioners to rise to them.
18. The actions taken now in response to the pandemic are an opportunity to rethink service delivery and establish solutions that not only deal with current issues but also prepare for tomorrow's; building resilience in general practice, primary care and the wider NHS so it is better able to deal with future crises. This requires honest engagement with primary care to understand existing 'at scale' projects and programmes, as well as the wider value-adding primary care ecosystem. It also requires investment and support for primary care at scale indefinitely.

At scale delivery of primary care services is for transaction, low complexity care or low population incidence care

19. Some clinical services are already delivered at the neighbourhood level via PCNs themselves. Moving forward, it may be beneficial to deliver more clinical services at this scale, or indeed at 'place' level. This includes PCNs working together as 'networks of networks' across neighbourhoods or primary care federations delivering at scale clinical services. There may also be services that are best suited to delivery at system level or remotely via digital channels.
20. High volume and transactional primary care services are best delivered at scale. This includes vaccinations, for instance, and same day, urgent care that does not require continuity. It also includes low population incidence conditions, requiring a specialist service, such as respiratory hubs, for instance. Furthermore, these services require working closely with other parts of the NHS, such as community and mental health services, and even the local authority or voluntary sector.
21. There are many examples of at scale service delivery. Beyond that incumbent on PCNs to deliver or specified in other general practice contracts however, they have developed organically, and their existence is a 'postcode lottery'. Existing examples include:
 - A service for housebound diabetes patients that takes account of deprivation scores
 - Cervical screening services
 - Immunisation services
 - Integrated working with the hospital, community care, out of hours GP provider to provide a wound care pathway
 - 24/7 GP appointments service
 - Drop-in GP appointments service
 - Integrated urgent care services with secondary care
 - Integrated primary and community mental health services with secondary care
 - Respiratory services hub
 - Phlebotomy hubs
 - Medicines discharge hub
 - Health and wellbeing hub

Creating capacity in general practice (and easing access challenges) requires support for primary care at scale

22. General practice is the foundation of primary care and of the wider health and care system. It is the front door of the NHS and its proper-functioning leads to the better-functioning of the wider NHS and care system.
23. It is therefore imperative to support the development of at scale primary care to create capacity in general practice, ensuring it can care for the patients most suited to its skillset with clinicians using their expertise.
24. There has been a lack of organisational development for primary care in the way we have seen in the secondary care sector and a lack of nationally funded leadership programmes that equip primary care leaders with the skills they need to manage multi-disciplinary teams, build relationships beyond general practice and primary care and effectively contribute to the work across the health and care system.
25. Given workload pressures, many clinical directors, which include GPs, nurses, pharmacists and paramedics, are under strain. The role has expanded significantly and yet there is still under investment in the infrastructure to support them. Appropriate support and reimbursement for the full workload associated with existing at scale arrangements should therefore be provided.
26. These pressures are going to be further compounded over coming weeks following the government's announcement on their aim to ensure all under 18s are offered a COVID-19 booster or third dose by the end of the year in light of the Omicron variant. It is critical that a crystal-clear message is given that whilst the NHS will remain open for business including for urgent treatment, this enhanced focus on vaccinations could lead to disruption elsewhere in the service.¹⁰
27. We need to remove duplication of effort, deliver more cost-effective services and realise the opportunities for at scale provision – whether clinical services or operational capacity – either through supporting networks of networks or through GP Federations.
28. As it stands, the development of place level arrangements provides nothing concrete. Instead, it is left to the discretion of the Integrated Care Board (ICB) whether it establishes arrangements within its constitution - if the Health and Care Bill passes without further mandate on the issue - whilst NHSEI guidance also leaves the continuance of any operational support at place level to the discretion of the ICS¹¹.
29. Therefore, there should be explicit recognition within NHSEI guidance that, where primary care place level arrangements exist, whether for clinical service delivery or operational support, they should be maintained. Furthermore, NHSEI guidance should be explicit that ICBs must support the organisational development of primary care and provide sufficient investment to achieve it.

¹⁰ <https://www.nhsconfed.org/news/response-omicron-booster-expansion>

¹¹ <https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf>

30. Commissioning and contract architecture must also be considered. Firstly, ICBs should include the same outcomes across the services it commissions, which would encourage co-operation and collaboration across system partners. The ability of system partners to mobilise around a shared goal and outcome is well-demonstrated by the success of the vaccination programme in primary care - delivered by practices, PCNs and primary care federations. ICSs need to be enabled to commission primary care services that meet the needs of their local population – whether that be through practices, PCNs, at-scale providers such as Federations. These commissioning arrangements should reflect those that exist for the rest of the NHS with longer-term contracts that enable effective planning of workforce and service delivery.
31. Finally, there must be honest and clear communications from the government to the public regarding the challenges general practice faces. This includes in relation to the enhanced rollout of the booster programme, but also more widely in terms of the pressures general practice was already under.