Londonwide LMCs
The professional voice of London general practice

LONDONWIDE LMCs' FINAL RESPONSE TO NHS 10Y PLAN CONSULTATION
RESPONSE SUBMITTED CLOSE OF PLAY THURSDAY 28/11/24

- https://change.nhs.uk/en-GB/
- https://change.nhs.uk/en-GB/folders/organisations

The consultation has five questions to answer. These are included in .
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?

- **A full understanding of the role of general practice and local practices.**
- An acknowledgement that safe and strong general practice is essential as a means of providing cost effective health care and securing health improvement.
- Recognition that UK general practice is the bedrock of primary care provision in the NHS and the model of general practice and local, practice based, care is evidenced to lead to high patient outcomes and system financial efficiency.
- Addressing the sustainability of the GP workforce, fair funding, and operational autonomy within general practice and protecting the core characteristics of our "cradle to grave" system, including: holistic care, continuity of care, appropriately managing complex undifferentiated illness, simultaneously managing the acute and chronic health problems, coordinating care, and promoting the health and wellbeing of individuals and local communities and the prevention of ill-health.
- Putting more GPs and nurses into general practice, with each full-time-equivalent GP providing care to fewer patients, to be able to provide safe and effective patient care; satisfy patients and optimise health and wellbeing outcomes; and to enable the continued evolution of care and services to tackle the NHS' challenges and deliver an NHS fit for the future.

- Government needs to work with general practice to:
  - Give those closest to the challenges/problems– those delivering care, in collaboration with those receiving care – autonomy and ownership to identify well-informed solutions.
  - Create the conditions for innovation to thrive: thinking time to collaborate and develop new ideas, funding, the freedom to try, learn and adapt.
  - Widen strategic alignment: of elements such as contracts, national prioritisation, policy and regulation to enable adoption and spread of successful innovation.

Strong general practice is essential as a means of providing cost effective health care and securing health improvement. In the UK, general practice is the bedrock of primary care provision in the NHS and the model of general practice and local, practice based, care is evidenced to lead to high patient outcomes and system financial efficiency. With increasing talk of moral injury, attrition and burnout it is critical that the safety, workforce and commissioning concerns are addressed as a priority. Erosion of the model of general practice-based care impacts on patient outcomes and financial efficacy.

To secure the future of general practice and wider healthcare service in London and across England, the 10-Year Health Plan must address the sustainability of the GP workforce, fair funding, and operational autonomy within general practice.

Londonwide LMCs represents over 1,100 GP practices responsible for the care of over 9 million people in the Capital through a network of Local Medical Committees (elected groups of GPs and practice staff, funded directly by practices) who work hard to improve services for patients. In the words of Lord Darzi in his *2014 Better Healthcare In London report* "London should be a leader, not an exception". Yet the proportion of GPs making up the medical workforce in London is highlighted as dropping from 31% to 27% between 2003-2013 and continues to fall. Regarding general practice, the report acknowledges that: there has been significant underinvestment in workforce and funding; we have significantly fewer fully qualified GPs than other high income countries relative to our population and the number is falling, and; GPs are seeing more patients than ever before but waiting times are rising and patient satisfaction is at its lowest ever level. This echoes what LMCs have been saying for some time – that GPs and their teams are not able to deliver the quality care that they trained for and want to deliver, leading to dissatisfied/ unhappy patients and GP burn-out and retention problems.

Practices offer a very wide range of essential and preventative services to people of all ages, act as referers to, and gate keepers of, other parts of the health service, and manage complexity, uncertainty and risk on behalf of the NHS. Whilst our network works closely with local commissioners to highlight and address issues impacting on their patients and to advocate for the bespoke needs of their local communities in the planning and delivery of services and pathways, we hear immense concern that top-down initiatives are resulting in transactional encounters and eroding the core characteristics of our “cradle to grave” system. Given the increasing complexity of patient need and the NHS financial constraints, never has it been more important to champion these characteristics:

- holistic care,
- continuity of care,
- appropriately managing complex undifferentiated illness,
- simultaneously managing the acute and chronic health problems
- coordinating care, and
- promoting the health and wellbeing of individuals and local communities and the prevention of ill-health

The family doctor remains a vital role, and practices are increasingly under pressure to deliver more with fewer GPs; struggling to provide the type and standard of care that provides patient satisfaction and good health outcomes, that took years of study and training to develop, and that provides professional fulfilment. Conversely, untenable workloads are harming safe and effective patient care, resulting in staff overwhelm, low morale, distress and burnout. Positive grass roots innovation is suffocated and stifled. Staff are leaving, increasing the pressure on those who remain and leading to a spiral of further attrition.

We need more GPs and nurses in general practice, each full-time-equivalent GP providing care to fewer patients, to be able to provide safe and effective patient care; satisfy patients and optimise health and wellbeing outcomes; and to enable the continued evolution of care and services to tackle the NHS’ challenges and deliver an NHS fit for the future. In the ten years April 2014-April 2024, London general practice has seen a fall of nearly 15% FTE GPs, whilst the population has risen by over 21%, placing unsustainable pressure on staff and contract holders alike - see NHS digital figures in Beds&Herts GP dashboard. As a comparator: the nation number of FTE HCHS doctors has increased by over a third (36.5%) from Sept 2014 to end April 2024 (103,329.59 to 141,006.16); whilst the national number of FTE GPs dropped by nearly a sixth (16%) from April 2014 to end April 2024 (32,543.2 to 27,341.1).

We need the new Government to work with us to:

- Give those closest to the challenges/problems– those delivering care, in collaboration with those receiving care – autonomy and ownership to identify well-informed solutions;

Autonomy to manage local practices determined by local needs in partnership with patients, enabling GPs to respond to the unique health needs of their communities effectively; removing arbitrary ring-fences around funding and increasing the core finance available, giving GP partners and their teams the freedom and flexibility to offer services, hire staff, and shape access based on their unique and developed knowledge of their specific local patient needs. Improving workforce retention by increasing job satisfaction. Improving the doctor: patient relationship and supporting community-specific health initiatives by allowing practices to retain their workforce by more effectively aligning roles and resources by allowing bespoke services tailored to patients, rather than dictated by commissioners. And removing restrictions on currently ringfenced funds to cover the hiring of nurses and other vital practice staff and help practices meet their locally identified need.

- Create the conditions for innovation to thrive: thinking time to collaborate and develop new ideas, funding, the freedom to try, learn and adapt;

A more balanced distribution of NHS resources, recognising the critical role general practice plays in assessing, triaging and managing both patients and their conditions is essential. With practice resources dwindling incrementally as new demands and costs fall on the profession and the services they provide, it is increasingly difficult to find the staff, time, resource, energy or mental capacity to innovate. GPs are struggling to continually deliver more for less and have seen a proportionate real terms decline in funding in recent years. We believe that an incremental increase in the proportion of NHS funding allocated to general practice by 1% annually, with a goal of reaching 15% of total NHS spending, would go some way to stabilising general practice, and would in turn help provide the head-space to collaborate and explore innovations which would benefit patients, and improve staff retention.

It is not uncommon for imposed commissioning targets to create perverse incentives and result in negative outcomes for providers and their relationships with patients - see our recent QOF data and report re the absence of exception reporting. London practices express frustration at the lack of 'exception reporting' and the imposition of targets. These include no reflection of how London's many and varied health inequalities and challenges/ needs are being managed across the Capital's diverse and often marginalised patient communities. 81 practices recently reported a total estimated loss of £643,307.53 (with the highest single practice loss estimated as £34,575.00). The lack of consultation on imposed single access models for same day access in North-West London led to significant analysis of potential harm and inequity exacerbated by the model being financially incentivised - see our analysis of the potential harms resulting from the same day access model proposed in NWL.

- Widen strategic alignment: of elements such as contracts, national prioritisation, policy and regulation to enable adoption and spread of successful innovation;

Sustainable, thriving general practice is critical to patient satisfaction, the delivery of high-quality, cost-effective healthcare, and the success of all key health deliverables. Innovation is critical and can only truly be developed and delivered in a safe environment. The current fragmentation of contracting and accountability, resulting in commissioning gaps and significant variations in information and practise area to area, is fundamentally unsafe for GP providers and for patients, and an ongoing issue of concern for London general practice.

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The Londonwide LMCs' Workforce Survey is completed on behalf of a practice team by practice managers and GPs partners from member practices across London and conducted by Savanta. Last year, we began including questions about patient safety after widespread anecdotal concern from GPs. Typical response rate per wave is 22-25% of London practices. Practices in London feel unable to deliver care that is either safe for patients or staff. 81% of practices log monthly safety concerns from staff, 67% log weekly. Fewer than a fifth of London practices feel optimistic about their ability to deliver safe patient care over the coming month. Practices cite rising demand as a problem in our 2023 retention report and the recent GMC report on medical education and practice in the UK found 19% of doctors are reducing hours and 41% are declining additional work due to excessive workloads.

Three quarters of practices say the ability to deliver safe patient care is impacted by un/under-resourced or non-contracted workload shift from other providers. And 60% of practices say that current work pressures are impacting on the mental or physical health of their staff.

Practices provide a hidden buffer service due to 'rationing under the radar' and workload shift to help maintain patient safety. The absence of local and system-wide director(ies) of service confounds effective referral and patient choice, leading to rationing in various forms - see clinical cabinet paper - and commissioning gaps in critical areas, such as safeguarding - see Geddes letter. So often have these concerns been raised with us as the in-statute representative body, we have created specific safety resources to guide and support practices when they receive inappropriate/ un-resourced "requests".

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. 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 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?

- The shift from hospital- to community- based care is critical, but not achievable without significant investment:
  - Of time, to ensure that the pathways and models of care are appropriate and suitable to provide equity and recognise the differing needs of the disparate communities served by GPs and practice teams in neighbourhoods across the Capital and England;
  - Of trust, allowing practitioners the capacity to determine the actions and interventions that work for them and their localities rather than imposing rules from above, and;
  - Of funding, to enable the staff, premises, equipment and capacity meet patient needs appropriately, which in turn will help liberate capacity in secondary and tertiary care.

Critical to this is building a relationship of trust and respect which allows GPs freedom to practice as autonomous expert generalists whose decisions and primacy are recognised rather than continually challenged and undermined. Community-based general practice can deliver the continuity and preventive care needed to reduce hospital admissions. But not within the current envelope of workforce, estates, and funding. With increasing infrastructure programmes in the Capital, and a growing number of struggling practices closing year on year, we are seeing increasing pressure and rising Dr: patient ratios in those practices which remain. None of which is conducive to, or enabling of, general practices taking on additional activity.

In his report, Lord Darzi states that, since at least 2006, successive governments have promised to shift care into the community but failed, highlighting that both expenditure and staffing in hospitals have grown fast, but declined out-of-hospital. However, the experience of general practice is that despite the lack of funding and lack of investment in the workforce, there have been relentless, unsafe and unsustainable shifts of care into general practice from hospitals. As austerity measures and savings have been implemented, the mainstay of strategy and policy has been to move care from the more expensive, selective, hospital activity-based contract to the unlimited block general practice contract. As a direct result of this shift, practices are providing services that their patients need but that no one is any longer funded to offer, such as complex or post op wound care. With sicker and sicker people in the community, and thresholds for admission and discharge rising due to the increased pressure on beds, practices have been picking up the slack and trying to do their best for patients enduring increasingly long waits for the specialist care they need. And alongside these shifts in care and commissioning, practices have also had to try and adapt to managing the challenges of extremely complex co-morbid care without the adaption of the rest of system to support them, overcoming:

- the inadequacy of single disease clinical guidelines and referral pathways,
- contractual incentives that focus on disease parameters and not the parameters that matter to patients,
- fragmentation of services in secondary care by single disease, and lack of opportunity to have complex care discussions, weighing up risks, benefits and uncertainties.

Whilst GPs and general practice teams are community-based providers recognising the importance of the long-standing desire of policy makers to move hospital care closer to home, the sense is that it is only general practice that is being asked to develop and transform to achieve this. Which is ironic given that general practice is the most efficient and cost-effective element of the NHS, continuously evolving and already operating close to home.

The space between hospitals and general practice will develop and unintended consequences are inevitable. The future remit of general practice is unclear, with growing concern that GPs will be asked to supervise community staff as exemplified by recent experiences with London Ambulance Service, community cardiology nurses, and serious

mental illness management moving from hospital to primary care without the requisite infrastructure to enable integrated care.

For this to succeed, there is a fundamental need for more investment into the GP contract to increase GP numbers and improve premises.

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?

- Poor IT infrastructure; technology needs to support clinicians to be more effective and needs to be designed by those using it to avoid unintended negative consequences/ complications.
- Greater use of digital tools and technology across the healthcare system must be balanced with considerations around safety, privacy and inclusivity. Government should work with GPs and other health professionals to ensure that data is managed sensitively and that patients are clear on what is going to be done with their information.
- Evidence shows that primary care is best delivered by expert generalists working with registered lists in defined geographic communities. The core funding that allows and supports this care delivery at individual and population level must be maintained and, where possible, increased rather than diluted and supplemented with call-centre care.
- There are significant infrastructure issues relating to digital working that need to be addressed, with additional costs – often referenced as the "Market Forces Factor" – borne by GPs operating within the greater London area. There must be a full, independent and robust analysis of the clinical and cost effectiveness of diversion of funding, to any new delivery model, on all populations.
- Unresolved issues regarding historic records and redaction need to be considered, alongside the safeguarding of vulnerable patients who might be coerced into sharing access to their personal information, putting themselves at risk.
- Developments like the NHS App and e-consult can be assistive, but commissioners and providers must be mindful of equity challenges which can impact on access and accessibility, ranging from poverty and lack of financial access to technology through to limiting factors such as language barriers, literacy, sight or other disabilities. Services and access to them must be designed based on equity so all can access them with assistance/ adaptation, rather than based on equality, whereby all must overcome the same hurdles.
- AI technology, when deployed effectively and thoughtfully, can aid automation of tasks and analysis, but such technology must be introduced as a support, and not a replacement, and managed sensitively and cautiously so that the impact can be measured and assessed.
- For investment in digital health tools to fit with the values of general practice, tools must directly reduce health inequalities, or free up resource which can be directed to other methods of care delivery which are proven to do so.
- Consultations must not be automated – we are seeing the significant constraints of online mechanisms that force patients to force their issues into a transactional medical model of care, rather than reframing technological assistance to auto-populate the forms and referral process by taking consultation information and referring to access the most appropriate next service or step in care, without losing the human loop or failing to recognise the immense value of "Dr as a drug".

Greater use of digital tools and technology across the healthcare system has the potential to improve patient outcomes and access, but such tools are not a panacea. They must be balanced with considerations around safety, privacy and inclusivity. Eg tools could help with risk benefit analyses, but consultations must not be automated. We see the significant constraints of online mechanisms that force patients to shoe-horn their issues into a transactional medical model of care, rather than using automation to advise on the right pathway and auto-populate the forms and referral process by taking consultation information and referring to the most appropriate service once a clinician has assessed patient's needs. Government must work with health professionals to ensure data is managed sensitively and patients are clear on what is going to be done with their information. In general practice there is a strong commitment to patients being informed and comfortable with how their data is used which requires transparency and clear communication.

Evidence shows that effective primary care is best delivered by expert generalists working with registered lists in defined geographic communities. The core funding that allows and supports this care delivery at individual and population level must be maintained and, where possible, increased. GPs in London are adept at managing their practice resources and can adapt the services they offer to their practice lists, treating each patient as an individual, without the need to move patients between practices when their health care needs change. However significant workload pressures must be addressed to allow all patients appropriate access to their chosen GP.

There are significant infrastructure issues relating to digital working that need to be addressed, with additional costs – often referenced as the "Market Forces Factor" – borne by general practitioners operating within the greater London area, including elevated property and staffing costs, which are reflected in current resource weightings. There must be a full, independent and robust analysis of the clinical and cost effectiveness of diversion of funding to any new delivery model, and its effect on all populations.

The Covid pandemic saw a rapid uptake of technology and digitalisation in general practice. Many of those changes have continued to add value beyond the pandemic, such as patient remote monitoring and text communications direct to our patients, both on a doctor: patient basis and a whole community basis. But post pandemic the collaborative co-design of services ceased and general practice began to experience further top-down contractual measures, such as a new contractual requirement that all practices must offer and promote online consultation tools. This prompted concerns, as whilst online access and consulting can reduce the need for attendance at GP practices for appointments in the long term, a recent investigation by the Health Services Safety Investigation Body (HSSIB) highlighted that online consultations had been rolled out without:

- Specific training in making decisions based on the limited clinical information provided through an online tool;
- Identification and incorporation of the needs of users (both clinician and patient) into the design and configuration of online consultation tools;
- Practices being afforded the time and resources to undertake complex change management required to ensure safe and effective local implementation of major changes to their ways of working, and without;
- A clear, and specific, understanding of the local population's digital needs and capabilities.

Many practices unsurprisingly found that online consultations provided a fast access lane to those with lesser health need. People no longer had to hang on the phone for minor issues. Meanwhile the digital divide and the increased competition for appointments reduced access for those with the greatest need. HSSIB highlights that some practices were only managing to protect patient safety by limiting the number of daily online access requests.

Government plans to create a single patient record raise safeguarding and confidentiality concerns. There are a number of unresolved issues regarding historic records and redaction which need to be considered, and a need to consider safeguarding around vulnerable patients who might be coerced into sharing access to their personal information, putting themselves at risk (including those subject to coercive control, domestic violence, and/or those with concerns about privacy for accessing certain procedures or services).

There is increasing access to the GP patient record from a broader range of healthcare professionals, all adding data into the patient record, which adds to the GPs liability as Data Controller. Until the responsibility for data sharing is fundamentally reviewed, it is disproportionate for GPs alone to bear the liability for data sharing and governance. A change in legislation and indemnity is necessary to equitably share risk.

Developments such as the NHS App and e-consult can be assistive technologies, but commissioners and providers alike must be mindful of equity challenges which can impact on access and accessibility, ranging from poverty and lack of financial access to technology (no smart phone, no credit, no Wi-Fi) through to limiting factors such as language barriers, literacy, sight or other disabilities. Services and access to them should be designed based on equity so that all can access them with assistance/ adaptation, rather than based on equality whereby all must overcome the same hurdles. Designing appointment systems that are responsive to a variety of patient needs, such as accessibility options for elderly or differently-abled patients, is essential for equitable access to care. Technology can enhance healthcare only if it considers and serves the diverse needs of the patient population.

When deployed effectively and thoughtfully AI technology can automate some tasks and analysis, but it must be introduced on the basis that it supports, rather than replaces, a trained healthcare professional. Implementation must be done sensitively and cautiously so that the impact and risks can be continuously measured and assessed. For digital health tools to fit with the values of general practice, they must directly reduce health inequalities, or free up resource which can be directed to other methods of care delivery which are proven to do so. Any new delivery model must be designed with the aim of meeting the needs of people and communities. Commissioners are responsible for reviewing service provision, analysing needs and current legislation, performing a gap analysis, designing services to meet need and, once commissioned, commissioners must undertake thorough assessment and evaluation.

If funding is being diverted to deliver the new services, the impact on all populations must be evaluated. These processes have not, to date, been in place. Current evidence suggests that those with greater health need do not register with new digital first models, or re-register with their GP practice. Areas that are under-doctored may (and do) have patients with a high level of complex need, patients who may struggle to use a digital first model, issues regarding IT literacy, and infrastructure and access challenges which add to health inequalities. Digital services should be developed in an integrated way, alongside other services within existing practices so that they are there to be used if required.

For the potential of digital health to be realised, all practices need the infrastructure to provide it, the workforce and knowledge to use it effectively, and the patient demand to justify the investment of time/money in implementing new systems and training for new ways of working.

All proposals should be considered against the Quadruple Aim of i) care, ii) health, iii) cost and iv) meaning in work to prevent any unintended consequences which might destabilise existing general practice and patient care.

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 capacity/ capability mismatch within general practice, a system under immense pressure, is a significant challenge to the immediate introduction of new initiatives which will drive-up numbers of prospective/ opportunistic/ preventative appointments and divert resource from identified need.
- Without increased staff, premises, and capacity to deliver screening or other interventions new activity will be challenging to deliver.
- There is effectively "rationing" of safe care and access, on a number of levels, leading to further workload shift and greater demand on over stretched GP services. This results in people operating beyond the remit of GP expertise and, often, burning out and leaving the profession they spent years training for.

We currently have a capacity/ capability mismatch within general practice regarding proactive, preventative activity distinct from urgent and immediate patient care. GPs can occupy this prevention space: experienced GPs and their teams know how to influence prevention at individual and population levels, using their place in local communities, their understanding of health beliefs and cultural norms, and working alongside faith leaders and community champions.

Research into vaccination hesitancy shows that prevention requires a trusted healthcare professional, who has built up a relationship over time, spending time with individuals to ensure that they feel understood and providing a personalised response. However the loss of continuity of care and the overwhelming focus on the last Government's manifesto promise of increasing the number of appointments, rather than the quality of the engagement with patients, has eroded this.

Common barriers to effective and productive community engagement are lack of funding, lack of workforce and time, conflicting priorities and lack of system strategy. Austerity and system financial deficits have forced a focus on measurable in-year return on investment, often measured by activity or outputs rather than outcomes. Most prevention programmes cannot offer that and a truly innovative approach would be to establish measures that are outcome based and measurable across time rather than across budget rounds.

Time-limited, unsupported testing programmes which increase patient anxiety and then direct them to GPs or elsewhere to begin their NHS journey are unstable and poor vehicles for the provision of the continuous and effective health care relationships which are so beneficial to patients and staff. Considering the benefits of stable and continuous patient care and a sustainable and stable workforce, we believe that commissioners would see improved patient outcomes through increased investment and support for GMS contracts which are nationally negotiated and provide long-term stability for patients and staff.

Until we see a shift from demand to need, in a system under pressure, it is challenging to see how the introduction of new initiatives to drive up numbers of prospective/ opportunistic/ preventative appointments for those with lesser need, diverting resource at the expense of quality care for those with greater need, will achieve the goal of reducing pressure on health and care services. The principal challenge for general practice continues to be that of capacity and resource. Without more staff, premises, and capacity to deliver screening or other interventions it is challenging to envisage more activity than is currently taking place.

There is currently a significant challenge in that there is effectively "rationing" of safe care and access, on a number of levels, which leads to further workload shift, greater demand on over stretched GP services, and results in people operating beyond the remit of GP expertise and, often, burning out and leaving the profession that they have spent years training for.

- We see **rationing by denial**, when specific treatments are denied to patients through service restriction policies, referral reduction schemes, and de-commissioning of services.
- We see **rationing by selection**, where the eligibility thresholds are raised for admissions, discharge, procedures and access to outpatient appointments.
- We see **rationing by delay**, where access to the system is controlled by waiting lists and waiting times set by other providers.
- We see **rationing by deterrence**, when barriers are put up through impenetrable pathways and limiting information about ways in which a GP or patient can access a service, such as failure to produce and publicise an up-to-date Directory Of Services (DOS).
- We see **rationing by deflection** via increased workload transfer to general practice through pathway changes/ failure to commission appropriately to meet complex patient needs.
- We see **rationing by dilution**, where services are offered but with, for example, fewer staff resulting in errors and gaps with GPs as the safety net chasing secondary care follow-up or managing a process delay around timely/ important communications.

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

General practice has a rich history in evolution, innovation and entrepreneurship, and it must continue to evolve to meet the changing needs of our patients. We know that we need to embrace the advantages of delivering at-scale services where they make sense and the advantages outweigh the trade-offs such as continuity of care. And we are ready to embrace digital, AI, segmentation but not at the expense of holistic and personalised care and access to those who need it most. The risks and benefits of both safety and innovation need to be carefully considered.

Success happens when:

- Innovation meets a need identified by those closest to the problem that needs solving.
- New tools such as the texting service are continually developed and refined based on user experiences and need.
- National bodies removed the barriers and put in place enablers for adoption and spread of the solution determined by the front line.

Safe patient care is threatened when:

- The complexity of general practice is not understood by those imposing change.
- When there isn't a shared vision for the changes and tools are developed without consideration of the needs of the users.
- No provision has been made for the time and resources needed to implement change.

Government needs to:

- Give those closest to the challenges/problems– those delivering care, in collaboration with those receiving care – autonomy and ownership to identify well-informed solutions.
- Create the conditions for innovation to thrive, thinking time to collaborate and develop new ideas, funding, the freedom to try, learn and adapt.
- Widen strategic alignment of elements such as contracts, national prioritisation, policy and regulation to enable adoption and spread of successful innovation.

Short-term:

- Increase GP practice core funding to allow practices to cope with essential services demand, protect practice stability, support continuity of care, and stabilise the partnership model.
- Be open and transparent with the public about rationing decisions: eg the increase in demand for GP services, the worsening demand: capacity/ capability gap, and the safety impact of rationing (of all types).
- Provide additional capital funding to support practices in unsuitable NHS estates and allow GP premises costs, including management fees, to be reimbursed.

Medium-term:

- Employ robust clinical governance processes in deciding priorities, to address increased demand for GP services, worsening capacity/ capability gap, and safety concerns.
- Introduce legislation to ensure safe staffing levels across the NHS.
- Conduct regular workload and capability impact assessments on all providers when deciding priorities and consider operational deliverability before announcing structural or contractual changes that might increase demand for GP services.
- Develop long-term general practice investment plans, to secure GP practice stability and enable the shift to community-led care.
- Address historic pay erosion and ensure pay scales increase above RPI annually with associated funding in the annual contract for all roles in the general practice team.
- Assess and consider the impact on the different GP services within a practice (eg reactive care vs pro-active care vs preventative care, holistic care vs transactional care etc) of changing commissioning priorities or decommissioning services: eg Initiatives which would drive up the number of appointments required without increasing the number of required, appropriately qualified, staff available to meet that need.
- Employ robust clinical input and clinical governance processes when designing services and pathways, considering issues such as the unsafe transfer of clinical risk from secondary care to other areas of the health system, the practical and safety aspects of assumed, not agreed, shared care with general practice as a way of managing demand/ releasing capacity in other parts of the system, and investing in improvements to currently unsatisfactory communication processes at the interface between different services.
- Ensure that safety is pre-eminent, and that innovative delivery and structures are safety- assessed before introduction, including: are funded fairly; can be delivered safely with the workforce available; are clinically appropriate and do not exacerbate health inequalities; have appropriate outcome measures; are contracted at the right scale for function; do not involve needless bureaucracy, and; do not compromise the characteristics of effective general practice or the trusted relationship with patients.

Long-term change

- Renewed and continued focus on improving the interface between parts of the NHS, including genuine reform of the social care system.
- Provide long-term investment in IT infrastructure to enable the NHS to effectively adopt and use new technology.
- Increase capital investment to clear the maintenance backlog and modernise NHS estates.
- Ensure appropriate resourcing, support and time for change management processes, and ensuring that the change is a positive change for patients and the workforce, including but not limited to the introduction of new roles, the introduction of new technology, and the introduction of new ways of working (at scale and in other ways).