

Royal College of General Practitioner's Submission to Comprehensive Spending Review

1. The Royal College of General Practitioners (RCGP) welcomes the opportunity to submit evidence to the Comprehensive Spending Review.
2. The RCGP is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 54,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The College is an independent professional body with expertise in patient-centred generalist clinical care.

Executive Summary

3. Throughout the COVID-19 pandemic, the vast majority of patient care was delivered in general practice, which saw more than 123 million appointments over the last six months.ⁱ Practices transformed the way services are delivered to ensure patients, GPs and their teams are safe, limiting the spread of COVID-19. General practice staff ran 'hot-hubs' to triage those with symptoms of COVID-19, whilst caring for patients in care home settings and supporting shielded patients, and many GPs worked in the COVID-19 Clinical Assessment Service. An RCGP survey found that across the UK, 59% of GPs took on new roles outside of core general practice or increased their hours in these other roles to support the pandemic response.ⁱⁱ
4. At the outbreak of the COVID-19 pandemic, the number of patient consultations dropped dramatically, largely as a result of fewer patients seeking appointments, for fear of infection and patients not wanting to trouble their GP, as well as the initial suspension of routine services. However, our Research and Surveillance Centre data indicates that workload in general practice is now reaching levels seen in this period of 2019, with clinical administration (including workload such as referrals and communications with secondary care, requesting tests, reviewing and issuing prescriptions) exceeding 2019 levels since June, and over 30% of appointments now being delivered face to face.ⁱⁱⁱ A recent RCGP survey found that 94% of responding GPs expect demand to increase over the coming months. This is attributed to a range of factors, including the direct health impacts of COVID-19; an anticipated rise in mental health issues relating to the COVID-19 fallout; those on longer waiting lists to receive specialist treatment due to the backlog; and people who had postponed seeking treatment during the height of pandemic now coming forward.^{iv}
5. RCGP has long argued that at least 11% of the NHS budget needs to be spent within general practice, but in 2018/19, only 9.26% of NHS spend was invested in general practice in England.^v While recent increases through the GP contract and NHS Long Term Plan have been welcome, it is not at all clear whether this will be sufficient to enable the expansion we need to see in primary care, particularly given the fallout from COVID-19.
6. Major constraints on the ability of primary care to expand its services remain, due to limited workforce numbers and underinvestment in infrastructure. Addressing these constraints requires investment in the health education and training and capital budgets, at least equivalent to increases in the NHS service delivery budget. This additional investment is essential to enabling the government to meet its commitments to expanding the GP workforce by 6,000 and the wider team in general practice by 26,000 by 2023/24.
7. Health Education England (HEE) received a spending uplift of 3.4% through the 2019 spending review. While this offset the real-terms cuts in HEE's budget since 2013, it fell far short of the £900 million estimated as necessary to tackle staffing shortages.^{vi} The NHS England premises review in 2019 revealed significant gaps in capital funds to bring the primary care estate up to

standard, and considerable deficiencies remain in creating digitally enabled general practice services.^{vii} Primary care's digital infrastructure also requires significant capital funds to meet the needs of patients and our workforce. Increases in funding for NHS services will not be successful without the workforce and infrastructure to deliver those services.

8. Community services more broadly also require additional funding, particularly targeting those who are more socio-economically disadvantaged within our communities, who have been hit hardest by COVID-19 and the effects of lockdown,^{viii} and are likely to have less access to health professionals in their area.^{ix}
9. In the short term, urgent investment will be needed within primary care to effectively manage COVID-19 patients in the community, including dealing with 'Long-COVID-19'; to help manage any potential winter flu outbreak through expanded vaccination programmes; and to address with a backlog of new and existing health issues caused by the national lockdown and impacts of the pandemic more broadly.
10. Over the medium to long-term, a multi-year funding settlement is needed to ensure that the NHS has the workforce and infrastructure to sustainably deliver primary care services for years to come. Investments in infrastructure, education and training must be aligned with recent investment in service delivery, delivering a skilled workforce with the tools, support and working environments which are needed to treat patients at the right time, in the right place, achieving the best possible outcomes. Primary care must be empowered to truly improve the health of populations. To achieve this, we need to see much greater investment within primary care, the community and supporting services.
11. Priority areas of investment must include:
 - **Targeted urgent investment in primary care to improve health outcomes.** Primary care must be effectively supported to deal with both COVID-19 related health issues and non-COVID-19 health issues within the community, and this will require new investment in the short-term.
 - Extension of the COVID-19 fund for general practice, including additional GP backfill costs for the winter months;
 - Commissioning of a significant expansion of the range and volume of diagnostic services within the community;
 - Investment in the NHS@Home programme, with priority roll-out of pulse oximeter equipment and virtual ward capacity to support effective COVID-19 management;
 - Roll-out of post-acute / Long-COVID-19 clinics, and commissioning of urgent research and guidance into effective diagnostics and treatment of Long-COVID-19;
 - Workforce recruitment support for practices, of up to £19.5 million for 2020/21, to accelerate recruitment of approximately 6,500 staff.
 - **Building our workforce through investment in training.** In order to deliver on its manifesto pledges for 6,000 additional GPs and 26,000 other staff working in general practice by 2023/24, the government needs to invest in the health education and training budget, as well as targeting staff retention. A multi-year settlement for HEE's budget, taking it up to the £900 million that has been

estimated as required to support the NHS overall, including (though not limited to) ringfenced funding for the following within primary care:

- £181 million to deliver the expansion of GP training places to 3750 in 2020/21, to 4,000 in 2021/22, and further funding in subsequent years to move towards 5,000 places;
 - Expansion of funding for initiatives to recruit GPs to under-doctored areas;
 - Adequate funding for medical student training in primary care, through an additional £15.5 million per year;
 - £22 million per year to fund Training Hubs to support high-quality training in general practice.
- **Looking after the wellbeing of our workforce and supporting retention.** GPs and their teams must also be supported to stay well and to remain in the workforce for longer. Investment in their wellbeing will be crucial in the COVID-19 recovery period. This must sit alongside significant efforts to reduce unnecessary workload.
 - Funding to underpin commitments in the *NHS People Plan*, including the range of initiatives to support the wellbeing of the general practice workforce;
 - Ringfenced funding of at least £12.8 million per annum to retain GPs in the workforce through the GP Retention Scheme (alongside funding for a range of other retention initiatives);
 - Occupational health services should be commissioned for general practice staff, particularly to protect staff at higher risk of COVID-19, which should be backed by approximately £10 million funding per year.
 - **Resourcing the public / community health role of general practice.** This requires investment in improving data and analytic capability within primary care, as well as an expansion of the workforce. We also need greater investment in programmes to reach out to communities worst affected by the pandemic. Targeted investment in tackling the root causes of poor health across local systems will improve patient outcomes and reduce the need for acute treatment.
 - Significant investment to improve data and enhance analytic capacity within general practice to support deployment of proactive population health strategies;
 - Increased funding for Clinical Directors working to transform services across Primary Care Networks (PCNs), at 0.5 FTE instead of the current 0.25 FTE, an additional cost of approximately £40 million per annum;
 - Deployment of senior clinical public / community health lead roles across PCNs (at 0.5 FTE) at a cost of approximately £80 million per annum;
 - Roll-out of a health inequalities fund for general practice to support activity contributing to system-wide efforts, which are needed to tackle growing health inequalities.

- **Ensuring fit-for-purpose, digitally-enabled GP premises and home working.** It is essential that there is sufficient capital investment to ensure GP premises and digital technology are fit for purpose, to meet evolving patient needs and provide effective equipment and working environments for staff.
 - A capital commitment to the delivery of a £1 billion Primary Care Infrastructure Fund between 2020/21 - 2023/24, provided through low-bureaucracy processes for practices to enable real and rapid improvements to the primary care estate, alongside a comprehensive costed evaluation of the state of IT and digital infrastructure and upgrades needed for total digital transformation. Significant and flexible investment in general practice premises would support:
 - Infection control within practice premises,
 - Improving the wellbeing of staff through their working environments,
 - Improved space for training,
 - Integration of other services and diversification of the workforce within general practice premises.
 - Funding within CCG budgets should provide practices with long-term access to high-quality digital platforms which enable effective remote triage and consultations and facilitate communications between primary and secondary care which benefits patients;
 - Targeted funding should enable significant advancements in IT interoperability across patient pathways;
 - Investment to enable practices to upgrade telephony and IT software and hardware within practices and to improve access to high-speed broadband.
- **Building the evidence base to drive innovation and high-quality healthcare.** Research based within primary care has played a pivotal role in the COVID-19 response and has demonstrated the importance of investment in this for supporting our population's health. As well as funding for research into effective treatment for Long-COVID-19 in primary care highlighted in the first section, we need:
 - Protected investment for disease surveillance in primary care;
 - Investment to increase the capacity for research and innovation in general practice;
 - Investment in high-quality general practice data and analytical capability.

Royal College of General Practitioner's Submission to the CSR

Targeted urgent investment to improve health outcomes

12. General practice has played an important role during the pandemic. Its services have been open for all essential care throughout, and practices have rapidly adapted to delivering remote care to reduce infection risks for patients and staff, while continuing to provide face to face care where clinically necessary. General practice ran 'hot hubs' to treat patients with COVID-19 symptoms and provided support to care homes as well as extremely clinically vulnerable shielding patients.
13. Recent funding released by Treasury for costs incurred in general practice during the first phase of the pandemic, including for PPE and staff backfill, has been very welcome. However, this only includes costs incurred until July 2020, and we are not yet out of the woods, as indicated by recent rises in COVID-19 infection rates. This needs to be extended to cover the winter months and meet anticipated surges in patient demand, including backfill for additional GP locum cover where needed.
14. Additional diagnostic services with rapid access for practices need to be commissioned within the community to enable GPs and their teams to deal with the indirect consequences of the pandemic on non-COVID-19 health issues. We know that patients were less likely to reach out to their practice during the peak of the pandemic for non-COVID-19 health issues and this will have a knock-on effect on patient outcomes. In parallel, secondary care paused or reduced many routine services due to infection concerns and COVID-19 pressures. This means that a greater amount of care, and therefore risk, is being managed by GPs, as patients are facing longer waiting times for specialist treatment.
15. To enable GPs and their teams to get the tests and treatment patients need, as well as easing the burden on secondary care and reducing waiting times for patients to access tests through acute services, the roll-out of expanded community-based diagnostic pathways is urgently needed. This should include a comprehensive and integrated range of investigative technologies. While some community diagnostics are already available, these are highly variable across the country, and access through GP referral is often limited. A greater volume and variety of diagnostic services need to be commissioned within the community, and direct access improved for general practice across the country to provide a consistent service for patients. This will require investment in both the equipment and the right workforce to deliver diagnostics working within the community. Where GPs feel they have the evidence and information to make decisions about whether to refer patients for relevant tests, they should be better supported to do so.
16. Within the current development of the NHS@Home programme led by NHSEI, explored further below, investment should focus on the urgent roll-out of pulse oximeters and virtual clinics to support monitoring of COVID-19 patients at home, including those with prolonged symptoms. While this programme will require ongoing evaluation, it is important that we are able to move quickly, building on early evidence which suggests positive patient outcomes, as patients are alerted to effectively manage their condition themselves and/or to reach medical attention before they reach a crisis point, which in turn reduces pressures on emergency services. The national roll-out of this programme will require investment in both the equipment itself, and relevant staff time to work within virtual clinics.
17. Early evidence indicates that a wide spectrum of symptoms and conditions can emerge as a result of the long-term direct health impacts of COVID-19.^x Ongoing symptoms can include respiratory,

cardiac or neurological symptoms, which will require diagnosis and treatment through a range of different services. Specialist clinics will be needed, into which patients can be referred where necessary, as well as additional support and resource for general practice to enable rehabilitation for patients to former levels of health within the community, thereby reducing pressures on the acute sector. In particular, patients who have treated in intensive care are likely to require significant rehabilitation to manage the physical, cognitive, and emotional consequences of treatment, and primary care has a role to play in this which will need to be resourced. Emerging research (ongoing by the University of York), indicates a lack of services currently available for COVID-19 post-ICU care.

18. Appropriate treatment and guidance are not yet available to support the large number of patients seeking medical care for 'Long-COVID-19'. Two thirds of GPs responding to a recent RCGP survey said they are looking after patients that have had COVID-19 for more than 12 weeks,^{xi} and other early research indicates that approximately 10% of people experience prolonged illness, beyond three weeks of contracting COVID-19.^{xii} Half of the GPs we surveyed said they do not have access to the diagnostics they require to treat Long-COVID-19 in the community, only 24% had access to a Long-COVID-19 clinic to which they can refer patients (where appropriate), and 74% wanted more research into effective treatment for Long-COVID-19.
19. Research needs to be urgently commissioned into effective diagnosis and treatment of Long-COVID-19. Investment should also be targeted at establishing appropriate diagnostic and support services for Long-COVID-19, as well as rehabilitation services for those recovering, including from ICU treatment. Practices urgently need greater support to deliver ongoing care for Long-COVID-19 patients, and a national network of 'post-acute / Long-COVID-19' clinics must be rapidly established so that primary care can refer patients for specialist treatment, where appropriate.
20. Additional support will be required within primary care for the delivery for vaccinations at-scale, both for flu this coming winter and COVID-19 once available. Significant planning is underway, but additional funding is likely to be required within CCG budgets to fund a sufficient stock of vaccine where needed, as well as to rapidly develop capacity for the delivery of vaccinations to meet local needs. This is likely to necessitate a flexible budget for the short-term hire of suitable premises for delivery, expanded immuniser workforce, and additional staff hours to deal with medical queries.
21. Greater investment also needs to be dedicated to public campaigns and outreach to communities who are not accessing public health messages through the standard channels, and in particular, to encourage those in most need of vaccinations (children and vulnerable groups) to access them.
22. The social and economic impact of lockdown, for example social isolation and unemployment, will also have adverse health consequences,^{xiii} and the mental health implications are likely to be far-reaching. There are already lengthy waiting lists to access talking therapies in many areas of the country, and this needs to be urgently addressed, through increasing capacity in primary care as well as expanding community mental health services.
23. Current funding for workforce recruitment in 2020/21 needs to be urgently adapted and increased in the short-term, to allow local areas to rapidly meet the changing needs of their patient communities. Nearly a quarter of practices had to delay recruiting staff during the height of the pandemic, due to infection concerns, prioritising urgent patient care, or (in many cases) a lack of applicants for vacancies.^{xiv} We also expect workload to increase rapidly in volume and complexity as we approach the winter months, as detailed above. Therefore, additional resource should be made available to support practices with rapid recruitment exercises. This can be achieved through a multi-pronged approach:

24. Firstly, the offer of support for the recruitment and induction costs (including associated administration) for Social Prescribing Link Workers, at £3,000, should be extended to cover the other roles within the Primary Care Network Additional Roles Reimbursement Scheme (ARRS). If applied to all roles, this would cost an estimated total of £19.5 million for 2020/21 (based on the recruitment of a quarter of the 26,000 staff recruitment target overall). Further work to train the range of staff also needs to be prioritised to increase the pool of available staff (see next section).
25. Secondly, flexible additional funding should be made available for practices through CCGs to employ additional GP locums and salaried GPs over the winter months to deliver additional proactive care, building on the excellent examples of activity seen during the peak of the pandemic. This could be rolled out through the extended COVID-19 fund, mentioned above.
26. Thirdly, the Primary Care Network ARRS should be flexed. GPs and their teams are already seeing an increase in mental health issues for their patients, and this is likely to continue to increase with the impact of lockdown and the pandemic on the social determinants of health. Nine out of ten GPs who took part in a recent RCGP survey said they were likely to need more mental health therapists working in their practice to deal with the direct and indirect impacts of COVID-19, 72% said more nurses, and a majority said they still need the other roles that can already be recruited through ARRS.^{xv} PCNs should therefore be able to recruit mental health therapists immediately through the ARRS rather than having to wait until April 2021, alongside investment in wider community programmes to support early-stage mental health interventions. Funding should also be available for recruitment of other roles such as Advanced Nurse Practitioners.

Building our workforce through investment in training

27. The GP workforce has been under pressure for some time. Despite commitments in the 2016 General Practice Forward View to increase the number of GPs, the number of fully qualified, full-time equivalent GPs in England fell from 29,564 in 2016 to 27,605 in 2020,^{xvi} while the population and their health needs have continued to grow. We need urgent progress on the recruitment of an additional 6,000 GPs and 26,000 FTE members of the wider team within general practice. This will require investment in the health education and training budget, primarily via Health Education England (HEE), targeted at primary care.
28. HEE received a one-off spending uplift of 3.4% through the 2019 spending review, consisting of £150 million for continuing professional development for nurses and other clinical staff, and £60 million for priorities set out in the People Plan. While this offset the real-terms cuts in HEE's budget since 2013, it fell far short of the £900 million estimated as necessary to tackle staffing shortages.^{xvii} Furthermore, as it takes a minimum of ten years to train a GP, the single year settlement provided did not allow for HEE and others to develop vital, long-term workforce plans. This situation must be rectified by the provision of a clear, multi-year funding settlement, so that primary care can invest in the workforce it needs.
29. Over recent years, good progress has been made to increase the number of filled GP training places in England, from 2,671 in 2016 to 3,540 in 2019.^{xviii} HEE estimates it can fill 3,750 places in 2020/21, and government has committed to expanding training further, to 4,000 places in 2021/22. In addition, from 2022, 24 months of GP specialty training will be spent in general practice (up from a current proportion of 18 months). HEE estimates that £181 million will be needed to deliver these training commitments sustainably, which must be provided as a matter of priority. This will aim to equip and support GPs to manage the increasingly complex multiple conditions they are seeing, as well as meeting the challenges of healthcare delivery post-COVID-19, including remote care delivery and the increasing need for data analytical skills.^{xix}

30. As set out in our December 2019 report, *Fit for the Future: Workforce Roadmap*, we estimate that the number of GP training places needs to be further increased to 5,000 as soon as possible over the next few years.^{xx} Currently just over 30% of UK trained doctors go into GP Speciality Training within 1-3 years of completing the Foundation Programme, which should be expanded to at least 50% over the next few years. This should sit alongside additional support for doctors from other areas of medicine, who may be looking for a career change and who may be well suited to general practice, to become a GP. There also needs to be sustained efforts to recruit more international doctors into GP training, which may need further support due to the possibility that the COVID-19 pandemic and Brexit may add further barriers. Further expansion of GP training places should be accompanied by expanding training infrastructure, particularly in understaffed areas. This includes urgent capital investment in premises, as discussed in the penultimate section of this submission.
31. There are also clear disparities in the distribution of GP trainees across the country, and under-doctored areas are increasingly reliant on International Medical Graduates to fill training places.^{xxi} Additional support will be needed to boost recruitment to these areas and to address systemic problems. This should include through programmes such as the Targeted Enhanced Recruitment Scheme, as well as rolling out other successful initiatives. Currently the TERS costs approximately £5.5 million for 276 posts across England, and the GP contract commits to expanding this to 500 places in 2021 and 800 in 2022. This will cost of an additional £4.5 million in 2021 and £10.5 million per year thereafter. While TERs will help, it will not entirely solve the issue for acutely understaffed areas of the country, over the long-term. Further funding should be allocated to build initiatives that provide a 'wrap around' package of incentives and support for staff to work and remain in certain areas of the country, drawing on the examples such as the Welsh government's 'Train, Work, Live' programme, and the 'GP Pioneer Scheme' in Scotland. Initiatives should also pay particular attention to supporting international GPs training and working in the UK, who are likely to need additional support.
32. In order to recruit a higher number of GP trainees on a sustainable basis over the longer-term, it will be necessary to expand the rest of the medical training pipeline. The RCGP has estimated an additional 20% expansion would be needed, just to meet the needs of general practice.^{xxii} Other professional bodies looking across the whole system believe the number of medical students needs to be doubled.^{xxiii} The recent removal of the cap for medical student places demonstrates that there is capacity for expansion, and this should be built upon. A proportionate expansion will also be needed of Foundation Programme places in the near future, to make sure all medical students can progress into the workforce. This would need to be delivered after the expanded undergraduate cohorts complete their medical degrees, which takes on average five years.
33. High-quality placements in general practice can significantly impact on future career choices and ensure that the doctors of tomorrow have the generalist skills they need to succeed.^{xxiv} While the introduction of a minimum tariff of £28,000 per student per annum for undergraduate medical placements in general practice this year is welcome, it remains far short of the full cost of placements (approximately £40,700), and short of the current minimum secondary care tariff of £33,286.^{xxv} A fair national tariff across primary and secondary care is therefore needed to ensure that all students can access excellent general practice education. This would require an additional £15.5 million per annum (based on 7500 students, across three clinical years, at 13% of their time spent in general practice). This should be coupled with efforts to further expand the number of medical student placements within primary care, so that every medical student gains exposure to general practice.
34. To ensure a pipeline of staff to sustain general practice for the future, training capacity in primary care needs to be significantly expanded. This will enable more nurses and allied health professionals (AHPs) to pursue a career in general practice, helping to deliver the government target of 26,000 more staff in primary care. HEE has estimated that primary care placements for

physician associates cost £530 per student per week,^{xxvi} but currently adequate funding is not available for most roles in general practice. Costs for placements for other clinical staff training in primary care are likely to be comparable, and this needs to be provided as additional funding within the health education and training budget for primary care.

35. It is also vital that new staff joining the general practice workforce are properly supported to transition into primary care, a working environment which is often very different from other clinical settings, requiring more independent working, and it is important that all staff are supported to have long-term careers in the NHS. All clinical staff working in general practice for the first time should have access to structured programmes of clinical and non-clinical training or preceptorships. This should build on the recent work to establish non-clinical 'fellowship' programmes for newly qualified nurses and GPs. Preceptorships can be locally developed but should be fully-funded nationally, at an estimated cost of £5,000 per head based on similar programmes being rolled out.^{xxvii} To deliver this for the additional anticipated 26,000 staff in general practice overall, this would cost on average £32.5 million per year (based on recruitment of 6,500 new staff each year).
36. Similarly, staff at all levels need access to high-quality training and development, for example to us emerging digital technology effectively. Improving continuing professional development opportunities will enhance staff skills, allowing them to provide better care to patients, and boosting individual career prospects, which will in turn benefit retention.
37. Locality training hubs are crucial in supporting local workforce planning, identifying training needs, and making appropriate training is made available to staff in general practice as outlined above. Training hubs must therefore receive recurrent, sustainable funding, at an estimated cost of £22 million per year of additional investment.^{xxviii} This should include funding for costs to expand the trainer workforce and to cover supervision costs, which are crucial to meet training needs within general practice.

Looking after the wellbeing of our workforce and supporting retention

38. Providing high-quality healthcare relies on the contributions of every single staff member. Staff with higher likelihood of burnout are more likely to make errors,^{xxix} or to leave the workforce altogether. Yet for too long, NHS staff wellbeing has not been prioritised. We know from previous pandemics that burn-out within the healthcare service is likely, and without support it will be harder to retain the workforce we need, making these efforts crucial as we look towards the winter months.
39. NHS England and Improvement has responded to this challenge by focussing the 2020/21 NHS *People Plan* on wellbeing, and launching a welcome suite of wellbeing initiatives, including provision of helplines, wellbeing apps, coaching and training resources. Investment in sustaining these efforts should now be provided to ensure these have a long-term impact on the wellbeing of our workforce in primary care, and this should include evaluation of interventions to establish continual improvements. Wellbeing initiatives should be tailored to local areas, as our diverse workforce means that needs will differ.
40. Across general practice, there is currently no standardised approach to the commissioning of occupational health services, which support staff to remain in employment and to look after their health at work. Fully-funded occupational health services must be rolled out for general practice, including to support COVID-19 risk assessments in practices, as called for by the British Medical Association. This will be particularly important to support staff struggling with burnout and possible PTSD for those who have worked in 'hot-hubs', urgent settings or other highly stressful situations during the pandemic. As called for the British Medical Association, funding should be provided on a recurring basis to provide occupational health services, at an estimated cost of

around £10 million per year. This is based on the comprehensive occupational health service for primary care staff in Scotland, which is backed by £920,000 per year.^{xxx}

41. The NHS Practitioner Health Service provides specialist support to GPs (as well as other doctors and dentists) who are dealing with mental health issues, and whose needs have perhaps progressed beyond the scope of lower level wellbeing support initiatives. We have heard positive reports about the effectiveness of the service and would like to see the service made available to all clinicians working in general practice.
42. As well as increasing the pipeline of GPs in training, it is essential that we improve retention of GPs and their teams if government workforce targets are to be met. A recent RCGP survey found that 24% of GPs expect to decrease their sessional commitment over the next 12 months, while a further 7% plan to leave the profession completely.^{xxxii} Additional support is therefore needed to retain experienced staff at all levels and in roles across the primary care workforce.
43. Additional investment should be targeted at sustaining and boosting successful retention initiatives, to keep as many GPs in the workforce as possible. The national GP retention scheme currently supports almost 600 individual GPs at particular risk of leaving the profession, through additional support and training.^{xxxii} Practices can receive up to £16,000 to support each retained GP each year, with the retained GP receiving up to £4,000 for professional expenses. However, this funding is not ringfenced, and the RCGP has received reports of GPs struggling to access the programme in certain areas of the country where funding is reportedly not sufficiently available. To ensure that any GP who needs this support can access it, additional ringfenced funding should be provided. If we increase the number of retainers by approximately 7% (reflecting the number who told the RCGP they are likely to leave the profession altogether), the total cost would be approximately £12.8 million. This should be provided on top of expanding funding for the wider retention initiatives which are proving to be successful. "Top-up" funding should also be provided to the most disadvantaged and understaffed areas, to support the retention of GPs and to help address health inequalities, building on learnings from initiatives such as the Targeted Enhanced Recruitment Scheme to target under doctored areas.

Resourcing the public / community health role of general practice

44. General practice has long contributed to public or 'community' health management, including prevention. The embedding of social prescribing and the planned changes to England's public health infrastructure present an opportunity to support GPs and their teams to take on a broader role in planning and delivering activity to support their communities' health through holistic and proactive approaches. However, this must be underpinned by adequate resourcing, as well as significant efforts to expand the workforce, as outlined above. Many practices simply will not be able to take on additional workload in the context of current pressures and workforce numbers. As workload demands rise across the NHS during the recovery period and beyond, prevention and supporting patients to self-care will also be more important than ever.
45. GPs and their teams need to be better supported with the right tools – including high-quality data, training, digital technologies, and time. Further resource should also be targeted at facilitating collaboration across sectors within local communities on public health issues.
46. A key enabler to this activity is ensuring practices across the country have access to high-quality data and the analytical tools to facilitate understanding of a community's health, and this is currently highly variable across the country. Investing in improved data and better supported analysis of information about community health would make it easier for the workforce to deploy population health strategies in the most effective ways, supporting them to identify and stratify populations with data derived from patient clinical records, combined with public health data covering wider determinants of health e.g. housing, social deprivation, loneliness and isolation. Alongside this, investment should be made in both upskilling the workforce with the necessary

analytics skills, as well as deploying additional analytical support where it is needed, and this will need to vary to meet local needs.

47. Primary Care Networks (PCNs) are an important enabler to the transformation of primary care services. However, the Clinical Directors who have been given responsibility for strategically leading the development do not have sufficient time to dedicate to this, at just 0.25 FTE of funding. This is supported by early research by the RCGP on the development of PCNs, and a recent survey data by the BMA which found 49% of clinical directors classed their workload as unmanageable.^{xxxiii} Funding should be provided to enable Clinical Directors to work up to 0.5 FTE, doubling the available funding for these roles at an estimated cost of £40 million per annum across approximately 1,250 PCNs.
48. Additional resources should also be made available to fund public/community health leads within primary care, who can bring together practices and connect them at a strategic level with other local services, to address health inequalities as part of a place-based approach. A designated senior clinician leading on this, equipped with dedicated funding and time, is vital to drawing activity together, building relationships within local areas between services, and maintaining strategic focus over the long-term. These would be based in primary care working across practices at a network level, supporting PCN clinical directors, for 0.5 FTE at a cost of approximately £80 million per annum in total across approximately 1,250 PCNs.
49. Limited resources in local authorities for public health and the separation of budgets has made collaboration, and long-term planning, more challenging, and it is important this is reviewed. Public health, local authorities, and health and social care should be supported to co-commission services, underpinned by long-term funding streams. This would help to build shared goals, avoid duplication, and meaningfully address issues that affect the population's health.
50. It is also essential that public health activity within general practice is better resourced, both in terms of the expansion of workforce outlined above, and additional dedicated funds, particularly in enabling activity which helps to tackle health inequalities. Current funding allocations do not take account of increased needs in local areas due to deprivation. An immediate increase in primary care resources should be rolled out as a dedicated fund to directly support practices in serving the most vulnerable and deprived populations, over and above the current settlement. This should be tailored to supporting practices to develop appropriate strategies and initiatives to address health inequalities at the local level. Participating practices should be supported to share learning and best practice about how the funding has been spent. There needs to be better support overall for the spread and integration of excellent and innovative approaches to care within general practice. Excellent examples of such activity emerged during COVID-19, for example through support for vulnerable patients.

Ensuring fit-for-purpose, digitally-enabled GP premises and home working

51. As highlighted in our recent report, *General practice in the post-COVID world*, there is a window of opportunity over the coming months to make significant progress on IT interoperability and improving digital communications between primary, secondary and community care, building on progress made during the COVID-19 pandemic, and ensuring patients are always at the centre of the decisions about their care.
52. Improved communication lines, supported by functioning technology and systems, such as online chat functions and resources to automatically and securely share information between primary and secondary care, would promote better patient referral processes. An integrated patient record across providers of NHS care – primary care, secondary care, and community settings – would improve patient care, save patients and staff time, and ensure secure, accurate transfer of data.

Barriers to information sharing can unnecessarily complicate patient pathways and, at worst, jeopardise patient care. Digital platforms that facilitate GPs to access specialist advice, where appropriate, have proven very useful during the pandemic, and funding should be provided to ensure access to these continues in the future.

53. In order to deliver the high-quality of digital service patients need in the medium to long-term, general practice will require investment to enable them to upgrade telephony and IT software and hardware within practices and to provide access to high-speed broadband and high-quality digital triage services. Over the last 6 months, the way general practice operates has been rapidly and radically reshaped, moving from a situation where 70% of appointments were face to face, to one where approximately 70% are currently remote.^{xxxiv} GPs and their teams delivered this transformation while relying on outdated hardware and software. While deployment of laptops and other hardware to support staff to work from home has been a positive and necessary move, technology and licenses will need replacing in years to come, and equipment within practices and the quality of video communications and connectivity remain a major barrier to effective delivery of care. An RCGP survey on enablers to remote care delivery found that more than three quarters of GPs identified better hardware and broadband infrastructure as very important, while 71% highlighted better interoperability between primary and secondary care systems and higher quality video consulting as very important to continuing to deliver high-quality remote consultations.^{xxxv}
54. To continue to enable and improve remote care, both from home and from practices, GPs and other practice staff will need funding to build the digital infrastructure. For example, additional funding should be provided within CCGs baselines for practices to draw down, to ensure they can maintain access to products which facilitate remote communications – both in terms of video and online consultations. During the pandemic these were made freely available by relevant companies, but in the longer-term, funding will be needed to maintain their implementation. Telephone appointments also remain a crucial part of general practice care, and currently make up 63% of appointments.^{xxxvi} Funding should allow for investment in telephony upgrades. As the number of clinicians using phone lines has increased, it is likely that some patients are having to wait for longer to get through to practices. As well as maintaining effective ways of working, investment in digital infrastructure should aim to allow staff to continue working from home to keep those in higher COVID-19 risk groups safe in the short-term, and to provide opportunities for staff for improved work-life balance and ultimately retention in the workforce over the long-term.
55. Patients need to be better supported to monitor their health at home in order to get the most out of remote consultations. This should include investment in the rapid roll-out of equipment and apps to enable the remote monitoring of patients with long-term conditions through the NHS@Home programme led by NHSEI. The urgent focus should be on widely distributing properly evaluated and easy to use equipment such as pulse oximeters (as described above) and wearables such as biosensors and digital blood pressure cuffs. Information from these devices will need to be linked to GP record systems so that it can be meaningfully utilised. Alongside this, investment in effective patient education will be needed to ensure all patients are able to use these tools appropriately.
56. It is also vital that general practice remains able to offer excellent face to face care, which means that general practice must be able to plan and deliver future-proof premises upgrades and transformations to meet the needs of patients and staff. An RCGP survey found that GPs estimate 59% of appointments in general practice need to be face to face (looking beyond immediate COVID-19 infection concerns).^{xxxvii}
57. Although there is limited comprehensive national data on the condition of general practice estates, the Naylor review suggested it is in no better condition than the secondary care estate, 42% of which is over 35 years old.^{xxxviii} A British Medical Association premises survey reported that 50% of

GPs felt their premises were not suitable and had identified improvements needed.^{xxxix} The pandemic has further revealed that many surgeries are not fit for purpose and require urgent investment, with unsuitable fixtures, fittings and furnishings which may inhibit effective infection prevention, or for example lacking space to enable social distancing. To allow for the much-needed expansion of the general practice workforce (discussed above), practices must also be equipped with modern teaching space, including additional consulting rooms for trainees and group teaching space.

58. In order to support the wellbeing of our workforce, we also need to ensure there are appropriate spaces for staff to take breaks and to manage the physical and psychological demands of their work. This has been recommended by the NHS *People Plan* for 2020/21, while the GMC's 2019 report, *Caring for Doctors, Caring for Patients*, called for the introduction of "minimum standards" for premises, including provision of places and time to rest and sleep, and to access to nutritious food and drink.^{xl} These improvements are currently heavily underfunded.
59. Between 2015 and 2019, the government committed to a £1 billion Primary Care Infrastructure Fund. However, much of the funding earmarked for premises upgrades was not accessed by practices, and early surveys indicated that low take-up was in part due to the complexity of the application criteria.^{xli} A new capital commitment is needed for the delivery of a £1 billion Primary Care Infrastructure Fund over 2020/21 – 2023/24 for practices to upgrade the primary care estate. This would make up for previous investment commitments that did not make it through to practices, enabling essential upgrades to half of practices which are currently deemed unfit for purpose, as well as keeping up momentum on essential improvements in digital infrastructure. This must be easily accessible for practices with minimal bureaucracy applied to any application process. This should sit alongside a comprehensive costed evaluation of the state of IT and digital infrastructure within primary care, to monitor progress of upgrades and quantify gaps in investment needed to enable total digital transformation.

Building the evidence base to drive innovation and high-quality healthcare

60. The primary care sector has a long history of success in disease surveillance, and more recently this has played a pivotal role in the COVID-19 response. The infrastructure required for disease surveillance, such as the RCGP Research and Surveillance Centre (RSC), has existed for decades on a small scale. Early investment and expansion in this network during the outbreak of the pandemic delivered virology and serology samples as early as February, directly informing Public Health England activity and COBRA meeting decision-making. To maintain public protection and ensure a rapid response to emerging contagious diseases, funding for disease surveillance infrastructure and its extension to cover COVID-19 should be guaranteed throughout the proposed movement of activity from Public Health England to within the Government's new Institute for Health Protection, which we understand will focus on health protection and infectious disease capability. Opportunities should also be sought to further develop disease surveillance in primary care, through additional funds, to support the understanding of changing contagious diseases and ongoing vaccine development efficacy and public immunity.
61. Primary care research networks such as the RSC also contain rich and largescale datasets which can provide powerful insights linked to clinical activity. Data analysis in primary care has already played an important part in understanding socio-economic determinants of health and the inequalities in health outcomes of COVID-19. As GPs continue to work to establish effective ways of treating this new disease and its long-term impacts, and as vaccines are rolled out, the scale of these datasets can enable robust assessments of the relative effectiveness of different treatments. Ongoing targeted investment should be made available to ensure rich data and emerging clinical experience can be analysed to develop best practice guidance and clinical policy that supports effective long-term impacts of COVID-19. Better data would also support improved workforce

planning and changing health and social care delivery models, including being able to meaningfully track and analyse primary care activity, which currently has significant gaps.

62. Investment is also needed to increase the number of GPs actively involved in research based within general practice at a local level, including resource to facilitate translation and adoption of positive research findings, as well as increasing resource to support nationally organised research programmes.

ⁱ NHS Digital, *Appointments in General Practice - Weekly MI* (September 2019)

ⁱⁱ RCGP survey data of 859 GPs, in field 8 July to 23 July 2020.

ⁱⁱⁱ RCGP Research and Surveillance Centre 'Workload Observatory' data, 2020. Note: RSC analysis is based on extracts from the clinical computer systems of approximately 500 practices in England, with a patient cohort broadly representative of the England population.

^{iv} RCGP survey of 859 GPs, in field 8 July to 23 July 2020.

^v RCGP analysis of NHS Digital and NHS England investment data.

^{vi} Health Foundation/Kings Fund/Nuffield Trust, *Closing the gap: Key areas for action on the health and care workforce* (March 2019), <https://www.health.org.uk/publications/reports/closing-the-gap>

^{vii} NHS England, *General Practice Premises Policy Review* (2019), <https://www.england.nhs.uk/wp-content/uploads/2019/06/general-practice-premises-policy-review.pdf>

^{viii} For inequalities in the health impacts of COVID-19, see: Office for National Statistics, *Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 31 July 2020* (August 2020),

For inequalities in the socio-economic impact, see:

P. Scott, "Local data reveals the boroughs "left behind" by the government's Covid-19 response", *New Statesman* (July 2020), <https://www.newstatesman.com/politics/2020/07/local-data-reveals-boroughs-left-behind-government-s-covid-19-response>

^{ix} RCGP analysis of 2019 *English Indices of Deprivation* and *General Practice Workforce* data has found that the most deprived 10% of CCGs have, on average, 600 more patients per permanent GP than the least deprived 10% CCGs. This will be further exacerbated by the impact of socio-economic factors on morbidity and mortality rates, as recently highlighted by *Health Equity in England: The Marmot Review 10 years on*.

NHS Digital, *General Practice Workforce - 30 September 2019* (2020),

Ministry of Housing, Communities and Local Government, *Clinical Commissioning Group (CCG) IMD 2019* (2019).

Institute of Health Equity, *Health Equity in England: The Marmot Review 10 Years On* (2020),

<http://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-executive-summary.pdf>

^x T. Greenhalgh et als., "Management of post-acute covid-19 in primary care", *British Medical Journal* (August 2020), <https://www.bmj.com/content/370/bmj.m3026>

^{xi} RCGP survey data of 300 GPs, in field 27 August to 8 September 2020.

^{xii} T. Greenhalgh et als., "Management of post-acute covid-19 in primary care", *British Medical Journal* (August 2020), <https://www.bmj.com/content/370/bmj.m3026>

^{xiii} M. Douglas et als., "Mitigating the wider health effects of covid-19 pandemic response", *British Medical Journal*, (April 2020), <https://www.bmj.com/content/369/bmj.m1557>

^{xiv} RCGP survey data of 859 GPs, in field 8 July to 23 July 2020.

^{xv} RCGP survey data of 300 GPs, in field 27 August to 8 September 2020.

^{xvi} NHS Digital, *General Practice Workforce* (30 June 2020)

^{xvii} Health Foundation, Kings Fund, Nuffield Trust, *Closing the gap: Key areas for action on the health and care workforce* (March 2019), <https://www.health.org.uk/publications/reports/closing-the-gap>

^{xviii} GP National Recruitment Office, *General Practice ST1 Recruitment Figures* (2016), <https://gprecruitment.hee.nhs.uk/resource-bank/recruitment-figures>;

Health Education England, *Specialty recruitment: round 1 - acceptance and fill rate* (July 2020),

<https://www.hee.nhs.uk/our-work/medical-recruitment/specialty-recruitment-round-1-acceptance-fill-rate>

^{xix} NHS England, British Medical Association, *Update to the GP contract agreement 2020/21 - 2023/24* (6 February 2020),.

^{xx} RCGP, *Fit for the Future: Workforce roadmap* (December 2019), <https://www.rcgp.org.uk/representing-you/future-of-general-practice>

^{xxi} The most 'advantaged' 10% of CCGs have, on average 2,023 patients per permanent GP, and, among the trainee GP workforce, 19% hold a primary medical qualification (PMQ) from outside the UK. In contrast, the most 'disadvantaged' 10% of CCGs have, on average, 2,605 patients per GP, and 32% of registrars hold a PMQ from outside the UK, suggesting a greater reliance on non-UK trained doctors. A similar picture is seen for all permanent GPs, with only 12% holding a non-UK PMQ in the most 'advantaged' CCGs, compared to 29% in the most 'disadvantaged' CCGs.

RCGP Analysis of NHS Digital, *General Practice Workforce - 30 September 2019* (November 2019), Ministry of Housing, Communities and Local Government, *Clinical Commissioning Group (CCG) IMD 2019* (2019).

^{xxii} RCGP, *Fit for the Future: Workforce roadmap*, (December 2019), <https://www.rcgp.org.uk/representing-you/future-of-general-practice>

^{xxiii} Royal College of Physicians, *Double or quits: calculating how many more medical students we need?* (2018), <https://www.rcplondon.ac.uk/news-and-media/news-and-opinion/>

^{xxiv} Health Education England/Medical Schools Council, *By choice – not by chance* (2016), RCGP/Medical Schools Council, *Destination GP* (2017),

Health Education England, *The Future Doctor Programme A co-created vision for the future clinical team* (2020), <https://www.hee.nhs.uk/sites/default/files/documents/Future%20Doctor%20Co-Created%20Vision%20-%20FINAL.pdf>.

^{xxv} J. Rosenthal et al., "The real costs of teaching medical students in general practice: a cost-collection survey of teaching practices across England", *British Journal of General Practice* (2020), <https://bjgp.org/content/70/690/e71>.

The secondary care tariff also receives an additional weighting or "Market Force Factor", to account for the higher costs of delivery in some parts of the country. This has not been included in our calculations above but should be reflected in a new flat national tariff for primary and secondary care.

^{xxvi} Health Education England, *New Models of Care: Physician Associates* (2018), <https://bucks.ac.uk/>

^{xxvii} GP nursing "fundamentals" courses, which support newly qualified nurses to gain clinical skills needed in general practice typically cost £3,000 - £5,000, while non-clinical "New to Practice Fellowships" for GP nurses are funded at £3,000 for delivery of training plus £3,800 to cover backfill for the time staff. Similar costs have been estimated for Physician Associate preceptorships.

NHS England and NHS Improvement, *General Practice Fellowships for GPs and Nurses: New to Practice Programme Operational Guidance 2020/21*, (August 2020),

Health Education England, *New Models of Care: Physician Associates* (2018), <https://bucks.ac.uk/>

^{xxviii} The figure of £22 million per annum was provided by Ian Cumming, then Chief Executive of Health Education England, during an oral evidence session of the Health and Social Care Select Committee.

Health and Social Care Committee, *Oral evidence: Budget and NHS long-term plan, HC 1712*, (January 2019), <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/budget-and-nhs-longterm-plan/oral/95804.html>.

^{xxix} C. West, "Association of Resident Fatigue and Distress With Perceived Medical Errors", *JAMA* (2009), <https://jamanetwork.com/journals/jama/article-abstract/184625>.

^{xxx} Scottish Government, *Extra support for GPs and practice staff* (2016), <https://news.gov.scot/news/extra-support-for-gps-and-practice-staff>

^{xxxi} RCGP survey data of 859 GPs, in field 8 July to 23 July 2020.

^{xxxii} NHS Digital, *General Practice Workforce, June 2020* (August 2020)

^{xxxiii} British Medical Association, *Exploring the early challenges facing Primary Care Networks Survey of PCN Clinical Directors* (2020)

^{xxxiv} RCGP Research and Surveillance Centre 'Workload Observatory' data, 2020.

^{xxxv} RCGP survey of 615 GPs, in field 10 to 21 September 2020.

xxxvi RCGP Research and Surveillance Centre 'Workload Observatory' data, 2020.

xxxvii RCGP survey of 615 GPs, in field 10 to 21 September 2020.

xxxviii R. Naylor, *NHS Property and Estates Why the estate matters for patients* (2017),

xxxix British Medical Journal, *Half of GP premises are not fit for purpose, finds BMA survey* (2019),

xl General Medical Council, *Caring for Doctors, Caring for Patients* (2019), <https://www.gmc-uk.org/>

xli RCGP, *General Practice Forward View Annual Assessment Year 2* (2018),
<https://www.rcgp.org.uk/representing-you/future-of-general-practice>