House of Commons

Health and Social Care Committee

The future of general practice

Fourth Report of Session 2022–23

Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 11 October 2022

HC 113
Published on 20 October 2022
by authority of the House of Commons

Health and Social Care Committee

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Summary

1. Every working day more than one million people attend an appointment at their local GP surgery: general practice is the beating heart of the NHS and when it fails the NHS fails. We know up to 90% of healthcare is delivered by primary care. Yet currently the profession is demoralised, GPs are leaving almost as fast as they can be recruited, and patients are increasingly dissatisfied with the level of access they receive.

2. The root cause of this is straightforward: there are not enough GPs to meet the ever-increasing demands on the service, coupled with increasing complexity of cases from an ageing population. In May this year there were an estimated 27.5 million appointments in general practice, more than two million more than in 2019. Yet over the same period, the number of qualified, full-time equivalent GPs working in the NHS has declined by nearly 500 from 28,094 to 27,627.[1] This gap between demand and capacity leaves GPs working harder and facing more burnout as patients find it harder than ever to see them.

3. One result of this has been high reliance on the use of locum doctors, and the number of newly qualified GPs choosing to work in such roles rather than as salaried GPs or as partners. This is a symptom rather than the cause of the problem. Urgent work needs to be done to stop a bidding war for the services of locums and establish requirements for a minimum fair share of administrative duties.

4. Alongside worsening access to care, the decline of continuity of care in general practice is one of the most concerning impacts of the pressure on general practice. Since 2004 the majority of GPs have not had individual lists of patients even though there is clear international and UK research showing that seeing the same GP over a long period of time leads to fewer hospital visits, lower mortality and less cost for the NHS. Recent pressures have made it even less likely people will see the same doctor regularly and even more likely for patients to depend on overstretched emergency services. The fundamental division of labour between emergency and non-emergency care has broken down.

5. There can sometimes be a trade-off between access and continuity, and we believe that the balance has shifted too far towards access at the expense of continuity. Seeing your GP should not be like phoning a call centre or booking an Uber driver who you will never see again: relationship-based care is essential for patient safety and patient experience. It is also much more motivating for doctors.

6. Improving the accountability of care for individual patients through GP lists should not replace the team-based approach that is becoming increasingly important. It will not always be appropriate for GPs to provide care personally when, for example, it could be done so more efficiently by a practice nurse or a physician associate. But from the patient's point of view it should always be clear where responsibility for their care lies, which outside hospital will normally be their GP.

7. The Government and NHS England have made several changes over recent years to help general practice become more sustainable and change the way patients receive

1 NHS Digital, General Practice Workforce, June 2022, 28 July 2022

care, such as the creation of Primary Care Networks and the introduction of a range of new professionals into general practice. However, our inquiry has found that these developments, while welcome, are not yet making a meaningful impact on the future sustainability of general practice. Instead, we heard that patients can become confused over who they are signposted to and why, leaving GPs dealing with multiple complex cases one after another and as a result, contributing to clinician burnout and concerns by the clinicians they might make mistakes or not be able to practise safely. This combination of intensely complex cases, done at speed, with fear over reprisals on the individual clinician is driving a systemically toxic environment in primary care.

8. Instead, the Government and the NHS should be bolder. We recommend abolishing the Quality and Outcomes Framework (QOF) and Impact and Investment Framework (IIF) which have become tools of micromanagement and risk turning patients into numbers. GPs should be treated like professionals and incentivised to provide relationship-based care for all patients by restoring individual patient lists. The Government's decision to introduce an additional two-week wait target for GP appointments, while well-intentioned, does not address the fundamental capacity problem causing poor GP access.

9. To help achieve this the Government should examine the possibility of limiting the list size of patients to, for example, 2500 on a list, which would slowly reduce to a figure of around 1850 over five years as more GPs are recruited as planned. These numbers should reflect varying levels of need in local populations. This would draw us closer in line with our European counterparts, and help improve access and continuity. It should only be implemented in a way that does not undermine the fundamental rights of patients to access a GP.

10. Continuity of care is beneficial for all patient interactions even if it cannot always be offered. It should not therefore be available only for patients with complex needs, because part of the purpose of a long-term relationship between a doctor and patient is to prevent chronic or long-term illness before it happens.

11. Historically one of the key drivers of innovation and improvement in general practice has been the GP partnership model, which gives GPs the flexibility to innovate with a focus on the needs of their local population. We know there are significant pressures on GP partners at the moment but the evidence we received was clear that the partnership remains an efficient and effective model for general practice if properly funded and supported. It is important that the model of general practice can vary according to local needs, so other models of delivery should also continue to be explored where this works for local communities. Whether or not in a partnership model, the professional status of GPs should not be undermined by the inappropriate refusal of GP referral decisions.

12. Rather than hinting it may scrap the partnership model, the Government should strengthen it. For GP partners at the end of their careers, one of the biggest barriers to staying on longer is the huge pensions tax bills that many face. We continue to call for the Government to take specific action to allow senior doctors, including GPs, to carry on working without facing these tax bills. We welcome the focus on this issue in the Government's Plan for Patients but the Government must provide further detail on what changes it will introduce. Partnerships as entities also need support with complex

issues around premises they own which may not be fit for purpose. The Government should consider adopting the approach taken on this issue in Scotland which allows a route for GP partners to remove the property risk from their businesses.

13. As part of a broader overhaul of primary care, the NHS should dramatically simplify the patient interface. Currently patients with urgent care needs are left wondering whether to call their surgery, the out of hours service, 111 or to go to A&E. Many people are not clear about the difference between such services and the most appropriate option, further adding to the pressures on general practice.

14. We also heard very clearly that the issues facing general practice are not equal everywhere in the country. In some parts of the country challenges such as workforce shortages are significantly more acute, and these are often areas where there are already higher levels of ill-health and deprivation. The Government and NHS England must develop a better mechanism to award funding to more deprived areas to replace the Carr-Hill formula which is insufficiently weighted for deprivation at present. This funding change should be used to support further work to ensure equal access to general practice across the country.

15. Finally, it is time to recognise the need to make the job not just manageable but once again fulfilling and enjoyable. General practice really should be the jewel in the crown of the NHS, one of the services most valued by its patients. For doctors it should allow a cradle to grave relationship with patients not possible for other specialties but for many infinitely more rewarding. To do that general practice needs to have its professional status restored with a decisive move away from micromanagement and short staffing to a win-win environment in which investment in general practice reduces pressure on hospitals and saves resources for the NHS.

1 Access to general practice

Demand in general practice is rising

16. It is well established that demand for healthcare is rising as the population ages and health needs become more complex. This is as true in general practice as in the rest of the NHS, as Professor Martin Marshall, Chair of the Royal College of GPs (RCGP), told us:

> In a whole range of ways what we do in general practice is more complex, beyond just the simple workload and the number of patients we are seeing. We know that the population is older. We know that they are more likely to have multiple medical conditions. We are more likely to see greater ethnic diversity in populations as well, particularly where I work in east London. All of those factors together mean that the kind of problems that we are seeing in general practice, as well as medical advances, are far more complex than they were when I first started my career.[2]

17. As well as care in general practice becoming more complex, GPs and their teams are also simply seeing more people than ever. For example, the estimated total number of appointments in general practice in England in June 2019 was 23,800,000 - by June 2022 this had risen to 25,910,000, an 8.9% increase without including covid-19 vaccination appointments.[3] The number of patients registered with a GP is also growing: 59,901,236 people were registered at GP practices in July 2019, compared to 61,768,942 in July 2022, a 3.2% increase.[4]

18. The shortage of GPs is exacerbated by the number of doctors choosing to work part time. In August 2022, just 23.2% of doctors in general practice worked full time, and in 2021 58.4% worked three days a week or less.[5] During our inquiry into clearing the backlog caused by the pandemic, we heard evidence from Professor Martin Marshall, Chair of the RCGP, that one of the reasons some GPs feel unable to work more hours is due to the workload and pressures they are under.[6] The Government should look at what support and incentives can be introduced to encourage GPs to increase the number of sessions they work, including flexible and home working for people with caring responsibilities. This would help encourage more GP hours to be worked and therefore make the system more productive.

19. Even though GPs are now more likely to work fewer sessions, this does not automatically reflect their true workload. For example, according to the GP worklife survey, while the proportion of GPs working between six and seven half-day sessions per week has increased from 9.6% to 13.4%, the average hours worked for GPs working these session patterns has increased from 39.4 hours to 42.5 hours.[7] GPs also often work outside

2 Q44
3 NHS Digital, Appointments in General Practice, June 2022 and June 2019.
4 NHS Digital, Patients registered at a GP Practice, July 2022 and July 2019, 14 July 2022
5 British Medical Association, Pressures in general practice data analysis, Accessed 11 October 2022; University of Manchester, Policy Research Unit in Commissioning and the Healthcare System, 'Eleventh National GP Worklife Survey 2021', 13 April 2022
6 Oral evidence taken before the Health and Social Care Committee on 21 September 2021, HC599 (2021–22), Q111
7 University of Manchester, Policy Research Unit in Commissioning and the Healthcare System, 'Eleventh National GP Worklife Survey 2021', 13 April 2022

of their paid sessions in order to complete administrative work - such as Dr Kate Fallon, who told us she works two unpaid sessions per week just to complete the paperwork required following her clinical sessions.[8]

The NHS does not have enough GPs

20. While demand has increased, the number of GPs has failed to keep pace. The Government has made a commitment to recruit 6,000 additional GPs, but the then Secretary of State for Health and Social Care, Rt Hon Sajid Javid MP, admitted in June 2022 that the Government was not on track to meet this target:

> The 6,000 target that you just mentioned is still going to be incredibly tough. I have always been very straightforward with your Committee. It is a very difficult target to reach. We are doing everything we can and being very focused not just on that, but more broadly on primary care.[9]

In his evidence to our inquiry on workforce the Secretary of State stated that there was a full-time equivalent increase in GP numbers of 1,672 between March 2019 and March 2022.[10] However, headline GP numbers released by NHS Digital include GP trainees, who as well as not being fully qualified are also supernumerary, meaning that they should be seen as additional to the core workforce of their practice rather than part of it. When looking at fully qualified GPs only, there were 717 *fewer* full-time equivalent GPs in March 2022 compared to March 2019.[11]

21. In this context, GP practices continue to rely on locum GPs to fill staffing gaps. While the numbers of GPs working as locums has reduced, in June 2022 there were still 1,404 GP locums in total, 70% of whom were working in no other general practice role.[12] Rates of pay for locum GPs tend to be higher than for salaried GPs which makes reliance on them poor value for money. Added to this, locum GPs are unlikely to see the same patients over a longer period of time, undermining continuity of care. This was specifically highlighted by attendees at our roundtable with GPs in the south-west.[13] There are several reasons why GPs are choosing locum work, but one of these is that locum work offers more flexibility. Dr Nikki Kanani, Medical Director of Primary Care for NHS England, acknowledged the need to provide a better offer on flexibility to retain GP locums in the regular GP workforce:

> 70% of our locum workforce are female. They are mainly ethnically diverse and mainly working in carer-responsible roles. We need to bring them back into the workforce as well. We need a workforce model that works flexibly for people who cannot quite work in the way that traditional general practice describes.[14]

22. A further concern raised by Dr Andrew Green was the fact GPs were choosing to locum to manage their workload and work-life balance, and to ensure they felt safe to

8 Q6
9 Oral evidence taken before the Health and Social Care Committee on 7 June 2022, HC 115, Q334
10 Oral evidence taken before the Health and Social Care Committee on 7 June 2022, HC 115, Q334
11 NHS Digital, General Practice Workforce, June 2022, 28 July 2022
12 NHS Digital, General Practice Workforce, June 2022, 28 July 2022
13 Private roundtable held with GPs in the south-west in June 2022
14 Q269

deliver care to their patients.[15] This was in essence a self-imposed regulation to allow practising in a safe and manageable way, but as a result at a cost to the system of primary care as a whole. This trend appears to be symptomatic of the difficulties faced in GP surgeries when it comes to a national lack of staffing.

Patients face poor access

23. The consequence of this mismatch between demand and capacity in general practice is that patients are facing ever poorer access to general practice. The 8am phone queue to try to get an appointment is well documented at many practices, and in the latest GP Patient Survey only 52.7% of patients said that they found it easy to get through to their practice by phone, compared to 67.6% in 2021.[16]

24. Written evidence we received highlighted further evidence of poor access. For example, a survey conducted by The Patients Association before Christmas 2021 found that 50% of patients had struggled to access a GP appointment, while the Alzheimer's Society highlighted some of the specific problems that patients with dementia face, such as particular difficulties using the telephone and inappropriate triaging by GP receptionists.[17] National Voices, the patient charity coalition, told us that:

> Too many people are finding it difficult or impossible to get the help and support they need in a timely manner, and the problem is now so systemic and far-reaching that it threatens the very fabric of the health system's claim to be a 'universal' service.[18]

25. Over several years the GP Patient Survey has shown declining access standards, albeit with satisfaction rates remaining high: from 2018 to 2020 the proportion of people who reported having a good overall experience of making an appointment fell slightly from 68.6% to 65.5%, but the proportion of people rating their care as good overall remained 81.8% in 2020.[19] In the latest GP Patient Survey, however, the results are significantly worse and shows the level of difficulty patients now face when trying to access general practice: the proportion of people who had a good experience of making an appointment has fallen sharply to 56.2% and the proportion of people rating their overall experience as good has also fallen significantly to 72.4%.[20]

26. The Government and NHS England acknowledged the poor access that patients face; the primary care Minister, James Morris MP, told us:

> As we have discussed today, clearly it would not be correct to assert that we have anything other than a major challenge in this area. The pandemic, rising demand and issues to do with the workforce are all big issues that need to be addressed over the long term.[21]

15 Q13
16 NHS England, GP Patient Survey, 2022 National Report, 14 July 2022
17 Patients Association (FGP0133); Alzheimer's Society (FGP0292)
18 National Voices (FGP0275)
19 NHS England, GP Patient Survey, 2022 National Report, 14 July 2022; previous results available at https://gp-patient.co.uk/surveysandreports
20 NHS England, GP Patient Survey, 2022 National Report, 14 July 2022
21 Q282

Similarly, Dr Amanda Doyle, Director of Primary Care for NHS England, told us that "it is really difficult for both GPs trying to manage demand and people trying to access general practitioners in some parts of the country at the moment."[22] In October 2021 NHS England published its plan for improving access to general practice, including a £250m winter access fund.[23] However, we heard that this plan was not sufficient to make a meaningful difference to patients.[24]

GP workloads are unsustainable

27. Part of the reason that patients are receiving poor access at present is that GPs are facing unsustainable workloads, which increase burnout and make GPs more likely to leave the profession. This creates a vicious circle of workforce and workload pressures for the GPs who remain and worsens patient access. Various surveys of GPs highlight the problem:

- An RCGP survey of GPs and GP trainees found that 42% of respondents were likely to leave general practice in the next five years.[25]
- The General Medical Council's annual survey found that 31% of GPs are fairly or very likely to leave the profession in the next year compared to 24% of other specialists.[26]
- Manchester University's 11th GP Worklife Survey found that the proportion of all GPs intending to leave direct patient care within five years grew from 21.9% in 2008 to 33.4% in 2021.[27]

28. As well as the workload pressures caused by growing demand, GPs also face significant administrative workloads and workload created by the interface between primary and secondary care. Manchester University found that both of these sources of workload pressures had increased in recent years: on a scale of one to five, the reported level of stress created by "Dealing with earlier discharges from hospital" had grown from 3.23 in 2008 to 3.67 in 2021, while stress created by paperwork had grown from 3.97 to 4.1 across the same period.[28] This was also borne out by the testimony of individual GPs; for example, Dr Kate Fallon described what her typical administrative workload is like:

> I have a list on my toolbar with all the blood results that have come in from all the patients, letters that have come in from consultants, discharge letters and anyone else who wants to write to us, which all has to be looked at and put into the patient record. There are other things like insurance reports,

22 Q281
23 NHS England, 'Our plan for improving access for patients and supporting general practice.' 14 October 2021
24 For example, Dr Kieran Gilmartin (FGP0001), Dr Simon Hughes (FGP0011), Winchester Rural North and East Primary Care Network (FGP0030)
25 Royal College of General Practitioners, 'Fit for the future', 2022
26 General Medical Council (FGP0367)
27 University of Manchester, Policy Research Unit in Commissioning and the Healthcare System, 'Eleventh National GP Worklife Survey 2021', 13 April 2022
28 University of Manchester, Policy Research Unit in Commissioning and the Healthcare System, 'Eleventh National GP Worklife Survey 2021', 13 April 2022

> DVLA reports and that sort of thing. […] Prescriptions? It is 60 to 100 [per day]. Blood results? Again, 60 to 100 [per day]. Letters? It is 20 to 30 a day. Maybe two or three reports a week.[29]

29. Some work will always be required in order to care for patients moving between primary and secondary care, but many of the GPs who gave evidence to our inquiry were clear that the workload transfer from secondary care to general practice is increasingly inappropriate, with many citing long "GP to do lists" produced by hospital consultants, requesting that GPs conduct tasks on their behalf such as arranging blood tests.[30] Dr Kieran Sharrock, Deputy Chair of the British Medical Association's General Practitioners' Committee, also highlighted the workload caused by the lack of electronic prescribing in hospitals:

> At the moment, a patient in hospital, either in outpatients or being discharged because they have been in hospital, goes out and the medication does not follow them, for whatever reason.
>
> They come to the practice and request the medication. We do not know what they have been on in hospital. We do not know why it has been changed. It creates a huge bureaucratic burden for us to try to find out.[31]

30. The twin pressures of increasing demand and complexity as well as the growing administrative burden on GPs leads to them often having less time with patients than they feel is clinically necessary - sometimes less than they feel is safe. Dr Andrew Green, a GP who recently retired before his 60th birthday, told us how the 10-minute consultation standard is no longer fit for purpose, and that this had an impact on his willingness to remain in practice:

> The only way that you can run a 10-minute appointment surgery on time is by cutting corners. Experience helps in that process, but we are deluding ourselves if we think that we are always safe. One of the things that made me finally give up normal clinical work was the feeling at the end of the day that I was not happy with the work I had done, because I could not fit what the patients needed into 10-minute appointments.[32]

31. Despite all this, witnesses from the Government and NHS England refused to use the word "crisis" to describe the situation in general practice. This is in stark contrast to Professor Martin Marshall, who told us:

> Yes, the profession is in crisis. It is a massive concern. I have been a GP for just over 30 years. I have seen ups and downs over that time in the status of general practice and general practice's ability to do its job, but I have never seen things as low as they are now.[33]

It is also in contrast to many frontline GPs who gave evidence to our inquiry, such as Dr Lucy Davies, a GP in Wiltshire, who said that the GP workforce is in crisis, Dr Luke

29 Qq.3–4
30 For example, Dr Pauline Grant (FGP0024); Hurley Group (FGP0155); Professor Roger Jones (FGP0200)
31 Q59
32 Q13
33 Q34

Sayers, a GP partner in the North East, who told us that "general practice is in crisis in the UK" and Dr Bryan Togher, a GP partner in Swindon, who stated: "We are in the midst of a recruitment and resource crisis which shows no signs of improvement."[34]

32. **The first step to solving a problem is to acknowledge it and we believe that general practice is in crisis. It is clear from the latest GP Patient survey results that despite the best efforts of GPs, the elastic has snapped after many years of pressure. Patients are facing unacceptably poor access to, and experiences of, general practice and patient safety is at risk from unsustainable pressures. Patient access is at the heart of NHS general practice and we are very concerned about this decline in standards. Given their reluctance to acknowledge the crisis in general practice we are not convinced that the Government or NHS England are prepared to address the problems in the service with sufficient urgency. The Government's Plan for Patients places a welcome emphasis on improving access to general practice but the measures set out so far will not be sufficient to make a meaningful difference to patient access and do not deal sufficiently with how to improve outcomes.**

33. ***In response to this Report the Government and NHS England should be clear in acknowledging that there is a crisis in general practice and set out in more detail the steps they are taking in response to this crisis in the short term, to protect patient safety, strengthen continuity, improve access and reduce GP workloads.***

34. ***The Government should commission a review into short-term problems that constrain primary care including, but not limited to: the interface between primary and secondary care, prescribing from signing to dispensing, administrative tasks e.g. reports and sick notes, day-to-day usability of IT hardware and software, and reviewing of bloods, pathology and imaging reports.***

GP recruitment is increasing

35. James Morris MP, the primary care Minister, told us that the Government was making progress on GP recruitment. This can be seen in welcome expansions of GP training numbers as well as high fill rates for these places: in 2021 all 4,000 GP training places in England were filled, which represents a marked improvement on previous recruitment rounds: in 2015 only 88.84% of places were filled, meaning only 2,769 out of a possible 3,117 GP trainees accepted places.[35]

36. However, the effectiveness of GP recruitment is not the same across the country. Dr Margaret Ikpoh, Vice Chair for Professional Development for the RCGP, described to us what she termed the "inverse education law," whereby international GP trainees are significantly more likely to undertake training in areas that are more deprived and currently under-doctored. While she welcomed the recruitment of international trainees, Dr Ikpoh highlighted the problem:

> 47% of our trainees are from the international community, and in places such as Hull and Grimsby in the north, up to 70% are from the international community. While that is a good thing, ultimately what we are doing is putting trainees who are not particularly familiar with the nuances of the

34 Dr Lucy Davies (FGP0080); Dr Luke Sayers (FGP0093); Dr Bryan Togher (FGP0109)

35 Health Education England, General Practice ST1 recruitment figures 2009–2021, Accessed 16 August 2022.

> NHS into a system that is already under-doctored and stressed and which perhaps does not have the capacity or the premises to provide the training that they need to become partners.[36]

37. Moreover, despite progress made in expanding the number of GP trainees, there is still room for further improvement. While Dr Margaret Ikpoh praised the existing GP training programme, she nonetheless highlighted the potential for GP training to be expanded to better prepare GPs to enter practice.

> We need some understanding that perhaps we need to move forward to a longer training programme, for four years, that makes sure that trainees have at least two of those years in general practice so they can understand what it means to become a partner, should they wish to choose that route.[37]

In particular, extending the GP training programme from three to four years would give GP trainees more opportunities to work in general practice, improving their readiness for their early careers, and allow for more focus to be given to the management and system working elements of a GP's role. The RCGP in particular have also called for the further expansion of GP training places, calling for the number of training places to be expanded to 5,000.[38]

38. **GP recruitment is essential to resolving the crisis in general practice, and while it is disappointing that the Government remains off track to meet its target to recruit 6,000 additional GPs by 2024, the growth in the number of GP trainees over recent years is encouraging. Nonetheless, there are further steps the Government can take both to increase GP recruitment and improve the outcomes of GP training.**

39. ***The Government should provide the funding necessary to create 1,000 additional GP training places per year and consider extending the GP training scheme to four years, to allow GP trainees more time to develop their skills in practice as well as learn the skills required to enter a GP partnership.***

40. ***The Government and NHS England should identify mechanisms to distribute GP trainees more equitably across the country so that under-doctored areas receive a balanced proportion of domestic and international GP trainees. The Government should explore schemes that incentivise GP trainees to settle in the areas they train; this could come in the form of improving opportunities to become GPs with Special Interests, incentivising GPs to join partnerships in understaffed areas, and look to create easier ways for GPs to set up their own practices in primary care "black spots".***

Other professionals can help

41. While the Government admitted slow progress against its target to recruit 6,000 GPs, it also highlighted progress made in recruiting other staff in general practice, particularly those recruited through the Additional Roles Reimbursement Scheme, which provides funding to Primary Care Networks to hire additional professionals in primary care, such as first-contact physiotherapists, clinical pharmacists and others.[39] In February 2022 the

36 Q167
37 Q167
38 Royal College of General Practitioners (FGP0363)
39 NHS England, 'Expanding our workforce', Accessed 16 August 2022

Government told us that 14,353 full-time equivalent staff had been recruited to general practice through this programme, against a target of 26,000. In June 2022 the Secretary of State for Health and Social Care told us that the number of staff recruited through this programme had again increased to around 18,000 staff.[40]

42. There is a high level of consensus about the potential benefits of an array of professionals working in general practice, and Beccy Baird, Senior Fellow at The King's Fund, described these:

> There are a couple of reasons for expanding the primary care team. One is to provide a fuller range of services to patients, particularly as people live longer with more complex conditions. Having staff like physiotherapists, pharmacists, health coaches and social prescribers adds to the totality of the care that people are getting in primary care. […] All of the evidence suggests that where it works well—I will caveat that to where it has been implemented properly—teamworking in general practice provides much better care for patients.[41]

43. However, several witnesses highlighted limitations in the scheme. For example, as Beccy Baird also highlighted, the funding covers only the salaries and national insurance contributions of the staff employed. It does not pay for additional costs such as training or supervision costs, or management resource required to change services to effectively utilise new professionals. GPs who attended our roundtable in Bristol also highlighted the lack of time and funding to provide supervision for new staff. Again, Beccy Baird described the impact of this lack of funding:

> [Our findings] are that if we do not invest in that kind of stuff—the leadership, the change management, the HR and the organisational development—the money is in danger of being wasted because they are not satisfying jobs. People get thrown into the deep end, it is fragmented, it does not work well and people get frustrated.[42]

44. We also heard about a lack of flexibility in terms of the staff who could be recruited under the scheme: many GPs told us that because practices had to choose from a prescribed list of professionals, they were unable to recruit based on local need.[43] Moreover, the funding does not include any specific uplift for deprivation, as Beccy Baird noted. This means that for areas with existing staff shortages across workforce groups, there are greater struggles with recruitment but limited flexibility to offer better terms and conditions to attract staff because of the lack of additional funding.[44]

45. We heard that heavy workloads, burnout and poor retention are also affecting other general practice staff as they are GPs. For example, GPs including Dr Kate Jenkins highlighted growing difficulties in recruiting and retaining GP receptionists due to the job being "hard and stressful," while Dr Kate Fallon, a GP partner near Bristol, told us how a physician associate hired through the ARRS was initially unable to cope with

40 Department of Health and Social Care (FGP0392); Oral evidence taken before the Health and Social Care Committee on 7 June 2022, HC 115, Q334

41 Qq.137–139

42 Q147

43 For example, Dr Claire Kendrick (FGP0094); The Avenue Surgery (FGP0195)

44 Q160

the workload in general practice.[45] In particular, Heather Randle, Professional Lead for Education at the Royal College of Nursing, told us that general practice nurses are facing significant challenges:

> We have evidence that shows that people are leaving the profession. […] One of the things that our nurses say quite strongly is that they have felt invisible, and that they are stressed and anxious about what is going on in general practice and the care that needs to be done that is being left undone as part of that. They are struggling, the same as our general practice colleagues.[46]

For nurses working in general practice, these challenges are exacerbated by the fact that terms and conditions as well as employment practices vary significantly between practices and that general practice nurses generally do not have parity with nurses in secondary care hired under the NHS-wide Agenda for Change contract. Heather Randle explained:

> In general practice, we need to make it a more attractive position to go to. You lose so much going into general practice. You lose maternity pay; you lose sick pay; you lose your education and your release to study because you are not a part of the NHS any more. In some practices they provide it, but in a lot of services you do not get that.[47]

46. **We welcome the progress made in recruiting additional professionals to general practice and recognise the potential they have to improve the range of services on offer in general practice and to ensure patients are able to see the right professional at the right time. We are also pleased the Government has committed to increasing the flexibility of staff recruited under the Additional Roles Reimbursement Scheme. However, we are concerned about some gaps within the scheme, particularly the lack of funding for supervision and the absence of any uplift for areas of high need. At present it appears that some staff are not regularly being effectively integrated into general practice and do not receive adequate supervision.**

47. ***NHS England should set out how it plans to increase the flexibility of the Additional Roles Reimbursement Scheme to allow Primary Care Networks to hire both clinical and non-clinical professionals other than those set out in the current guidance, according to local need.***

48. ***Receptionists play an incredibly important role in primary care that often goes unrecognised. Given they are often the first point of contact with primary care for most patients, NHS England should review and consider providing standardised national training to drive up standards and equip receptionists with the skills required to navigate and signpost in a 21st century NHS.***

49. ***The Government and NHS England should explore the possibility of providing an uplift to the Additional Roles Reimbursement Scheme to support non-staff costs such as supervision and training or to provide weighted salaries in areas where the cost of living is high or it is hard to recruit. Consideration should also be given to allowing staff to be employed on Agenda for Change terms and conditions as soon as resourcing allows.***

45 Dr Kate Jenkins (FGP0360); Dr Kate Fallon (FGP0039)
46 Q140
47 Q152

GP retention needs to be improved

50. Despite increases in the number of people entering GP training, the number of fully-qualified GPs continues to decline: this is due to poor retention of current GPs. For GPs of all ages one of the greatest pressures is the workload, the extent of which we have already noted. Administrative workload is a significant driver of workloads in general practice: for example, the University of Manchester's GP worklife survey found that the impact of paperwork on job stress significantly increased from 2008 to 2022, while the proportion of time spent on direct patient care fell from 63% in 2008 to 59.9% in 2021.[48] The Government has taken some action on sources of administrative workload such as by enabling more professionals to issue fit notes, but we heard that both necessary but inefficient clinical admin such as processing test results, and other non-clinical admin tasks continue to create a heavy burden.

51. We heard some mixed views about the potential for new technology, particularly artificial intelligence (AI), to reduce the workload on GPs. For example, one surgery in Buckinghamshire described adopting an AI-powered triage tool but finding that it made inappropriate recommendations to patients and increased workload.[49] Nonetheless, we also heard in written evidence, and in a roundtable we held with GPs in Bristol, that there is a clear opportunity for more effective forms of AI to supplement the GP and reduce workload, for example by helping them to process test results more accurately and quickly, or clinical support tools which can help to reduce the number of tests ordered.[50]

52. As we noted in paragraph 29, the interface between general practice and secondary care is also a significant driver of workload. This was further echoed in written evidence; for example, Jenny Whittle, a practice manager in Dorset, reported that "it is not uncommon for consultants to ask GPs to follow up test results, arrange tests for patients, refer patients to other services."[51] GPs who attended a roundtable with us in Bristol earlier this year also told us this was a significant problem. There is some effort being made to address the issue; for example, some Integrated Care Systems including Cheshire and Merseyside have adopted new principles for reducing workload caused by the primary and secondary care interface, and Dr Pauline Grant did acknowledge in her oral evidence that relationships with secondary care in her area have improved because of the Primary Care Network.[52] Nonetheless, we heard that the interface remains a significant driver of workload and therefore a detriment to the retention of GPs.

53. As noted in paragraph 21, the use of locum GPs continues to be common, with evidence we received suggesting that a significant motivator for GPs working as locums is a more flexible work life balance.[53] In our recent Report on *Workforce: recruitment, training and retention in health and social care* we called for a review of flexible working arrangements in NHS Trusts to help make regular employment in the NHS as attractive as working locum shifts or working for an agency; the evidence we have received suggests

48 University of Manchester, Policy Research Unit in Commissioning and the Healthcare System, 'Eleventh National GP Worklife Survey 2021', 13 April 2022

49 The Simpson Centre and Penn Surgery (FGP0250)

50 Dr Tim Howard (FGP0104), Summerton, N. and Cansdale, M., 2019. 'Artificial intelligence and diagnosis in general practice', British Journal of General Practice 69 (684)

51 Jenny Whittle (FGP0138)

52 Q90; Cheshire and Merseyside Health and Care Partnership, Consensus on the Primary and Secondary Care Interface, 24 June 2022

53 Londonwide Local Medical Committees (FGP0302), Cambridgeshire LMC (FGP0319), Policy Exchange (FGP0323)

that a similar issue exists in general practice.[54] In general practice reliance on locum GPs is particularly problematic due to the fact that GP practices are individual employers and can pay different rates to each other, creating competition for locum GPs, driving up prices and potentially worsening workforce gaps.[55]

54. Workload issues apply to all GPs but for older GPs there is one specific issue that has a seriously negative impact on retention: pensions taxation. GPs towards the end of their career, who have reached the pensions lifetime allowance, are increasingly facing expensive tax bills on their pension contributions, which acts as a strong disincentive to continue working. Dr Kieran Sharrock, Deputy Chair of the British Medical Association's GP Committee, explained the impact on experienced GPs:

> On the pension issue, there is a situation whereby financial advisers go to GPs towards the end of their career and advise them to leave work. We know that, last year, 55% of doctors retiring were taking voluntary early retirement. That is because the pension taxation situation makes it as if they were paying to work.[56]

This issue is having a serious impact on the retention of older GPs, with surveys suggesting that as many as 60% of GPs aged over 50 are likely to leave direct patient care within five years.[57] GPs who attended our roundtable in Bristol also told us that pensions were a significant barrier to retention.

55. In his evidence to our inquiry on the NHS workforce, the Secretary of State for Health and Social Care noted that "something like 96% of GPs and doctors [are] inside the £200,000 level" at which the tapered annual pension allowance applies, following changes he made to the tapered allowance as Chancellor of the Exchequer.[58] However, as the Association of Independent Specialist Medical Accountants points out, many GPs still face significant tax bills due to what they describe as the doubling-up of taxation, where GPs towards the end of their career may exceed the limit for tax relief on both the annual and lifetime allowances for pensions and therefore receive significant pensions tax bills even for small amounts of pensionable earnings.[59]

56. Our Report on *Workforce: recruitment, training and retention in health and social care* recommended that a national retire and return policy, enabling experienced staff to retire and return to work without disadvantaging their pensions, should be developed, and that NHS Trusts should be required to follow pension recycling guidance, which allows experienced staff to opt out of the NHS Pension Scheme and receive the unused employer contributions as additional salary.[60] These are also options for experienced GPs, but GP partners are themselves NHS employers and pay their own employer pension contributions, making these options practically more difficult for a GP partner than for a doctor directly employed by the NHS.

54 Health and Social Care Committee, Third Report of session 2022–23, Workforce: recruitment, training and retention in health and social care, HC 115, para 89
55 Lighthouse Medical Practice (FGP0332), Dr Karim Adab and Dr Vish Mehra (FGP0353)
56 Q43
57 University of Manchester, Policy Research Unit in Commissioning and the Healthcare System, 'Eleventh National GP Worklife Survey 2021', 13 April 2022
58 Oral evidence taken before the Health and Social Care Committee on 7 June 2022, HC 115, Q345
59 Association of Independent Specialist Medical Accountants (FGP0276)
60 Health and Social Care Committee, Third Report of session 2022–23, Workforce: recruitment, training and retention in health and social care, HC 115, para 105

57. **The Government and NHS England have made a start on reducing the administrative workload in general practice, and it is also encouraging to see some Integrated Care Systems agreeing to try to reduce the amount of work that is inappropriately transferred from secondary care to primary care. However, it is clear that there is still a long way to go to make GP workloads more sustainable.**

58. ***NHS England should take further steps to address the administrative workload in general practice, including by introducing e-prescribing in hospitals and focusing on the primary-secondary care interface by encouraging ICSs to provide a reporting tool for GPs to report inappropriate workload transfer.***

59. ***The Government should also fund research into the specific role that machine learning can play in the automation of reporting and coding test results to reduce clinical admin in general practice.***

60. ***The Government should undertake a full review of primary care IT systems from the perspective of the clinicians with an emphasis on improving the end user interface. Making the working life of each clinician that bit easier will drastically improve morale and efficiency.***

61. **As we said in our recent Report on the NHS workforce, no NHS employee should be forced to choose to locum or work for an agency to regain control over their working life. This is equally true in NHS general practice. As well as this, GP practices should not be forced to outcompete each other to be able to ensure adequate staffing cover to provide care for their patients.**

62. ***As part of ongoing efforts to improve the retention of GPs, NHS England should include a specific focus on encouraging locum GPs back into regular employment by supporting GP practices to offer more flexible working patterns.***

63. ***Urgent work needs to be done to stop a bidding war for the services of locums and establish requirements for a minimum fair share of administrative duties.***

64. **Older GPs continue to face prohibitively expensive pensions tax bills which act as a significant disincentive to them staying in practice. Efforts taken to date to reduce the impact on GPs have not been sufficient to prevent experienced GPs from leaving the profession in significant numbers, however we note the Government's recent consultation on extending 'retire and return' arrangements into next year. Experienced GPs are also likely to be employers which may make their pensions arrangements more complicated.**

65. ***The Government and NHS England should adopt the recommendations related to NHS pensions in our recent Report on* Workforce: recruitment, training and retention in health and social care. *In developing short and long-term solutions to the NHS pensions issue the Government and NHS England must specifically account for the status of GP partners as employers, for example by providing specific guidance and support for GP practices to help them adopt pension recycling and retire and return approaches. We welcome the focus on this issue in the Government's Plan for Patients but the Government must provide further detail on what changes it will introduce.***

2 Continuity of care

Continuity is no longer standard

66. Continuity of care, the ongoing relationship between a GP and their patients over a period of time, is one of the defining features of general practice. Professor Martin Marshall, Chair of the RCGP, stated that "the trusting relationship between the GP and their patient is probably one of the most effective interventions we have" while Professor Steinar Hunskår, a GP and Professor of Primary Care at the University of Bergen in Norway, quoted the UK's first Professor of General Practice Richard Scott in stating:

> [T]here are two characteristics of general practice which distinguish the GP from every other professional: first, access and, secondly, continuity of care. That is all there is and everything else supports that.[61]

67. Despite being a fundamental characteristic of NHS general practice, continuity of care has been in decline for several years. Personal lists, where GPs have an individual list of patients for whom they are accountable and deliver the majority of their care, are considered the gold standard of continuity. The number of practices using this system is not routinely measured but estimates suggest that it is now fewer than 10% of practices, despite once being the norm, suggesting that the provision of high levels of continuity is no longer standard.[62]

68. This decline is also shown by the GP Patient Survey. While the survey does not measure continuity for all patients, it does ask patients whether they have a preferred GP and how often they see them. In 2022, the proportion of patients who saw their preferred GP always, almost always or a lot of the time had declined to just 38.2% from 45.2% in 2021, demonstrating a rapid and marked decline in continuity.[63]

69. Some efforts have been made to reverse the decline in continuity, specifically the requirement for all patients to be assigned a 'named GP', introduced in the 2015 GP contract. However, we heard that this requirement has not necessarily made a significant difference to continuity as there is no requirement in practice for patients to see their named GP regularly. Dr Jacob Lee, a GP partner at Horfield Health Centre, stated that "having a named accountable GP in itself does not change who the patient sees. It is about supporting the practice to have the processes at its front door that enable the patient to get to the right clinician."[64]

70. We also heard about the importance of other forms of continuity, particularly management continuity and informational continuity. Where present, these forms of continuity ensure that even when patients are not seeing their named or regular GP, the clinician who sees them has access to all of their information (and feeds information back to their named GP), and the patient is reassured that their named GP retains overall responsibility for their care. Dr Becks Fisher, senior fellow at the Health Foundation and a GP, described this: "Continuity of care is, of course, not just about relational continuity with patients. It is about informational continuity across records. It is about

61 Q36; Q106
62 Q37; Q107
63 NHS England, GP Patient Survey, 2022 National Report, 14 July 2022
64 Q99

managerial continuity with colleagues."[65] Similarly, Matthew Taylor, chief executive of NHS Confederation, said: "One of the bits of continuity failure that most annoys people is around continuity of information. It is not so much seeing the same person; it is having to repeat the same details again and again."[66]

71. As well as this, Heather Randle highlighted the role that Advanced Nurse Practitioners can also take in co-ordinating care and leading teams within general practice:

> One of the skills of the nurse is being able to work in a team, and to lead teams. It is not always appropriate for the GP to be the person in charge of the care of a patient. If they have chronic diseases, or if it is something related to their personal health, a nurse could be the person in charge of their care and could be the person who looks at it holistically. We are autonomous practitioners. We can manage the care of patients and escalate as we need to, or refer on.[67]

72. In large part continuity of care has been a casualty of the pressures outlined above: with demand for appointments significantly outstripping capacity, it is understandable that GPs should find it harder to ensure that patients are regularly seeing the same GP. However, it has also been suggested that the focus on access in national policy, while understandable given the importance of access to general practice, has been at the detriment of continuity of care. For example, Dr Rebecca Rosen, senior fellow at the Nuffield Trust and a GP, argued that:

> We are where we are because we have had two decades of very, very relentless focus on rapid access. It goes right back to advanced access, as it was called, in the early 2000s. We have been relentlessly pushing on rapid access rather than the right access for your needs.[68]

This was echoed by Dr Jacob Lee, who told us:

> In what we can do nationally to try to support continuity, you can make continuity and trust in your GP, which is a more understandable way of explaining it, part of the national agenda, and a priority area. We have done that very successfully with access, so we can do the same with continuity.[69]

73. **We are extremely concerned about declining provision of continuity of care in general practice. We recognise the enormous pressure that GP services are under but it is unacceptable that one of the defining standards of general practice has been allowed to erode in this way. While we recognise the importance of continuity of information and accountability, and the important role that other professionals can play in providing continuity, we believe the ongoing relationship between a GP and their patients is uniquely important. The Government and NHS leaders have not paid sufficient attention to continuity of care or prioritised it effectively in national policy, which has hastened its decline.**

65 Q50
66 Q186
67 Q149
68 Q113
69 Q98

Continuity brings benefits to patients and GPs

74. This decline in the provision of continuity of care comes despite the fact that high rates of continuity have been consistently shown to improve outcomes for patients. For example, a 2022 study in the British Journal of General Practice found that high levels of continuity for patients with dementia improved the effectiveness of prescribing as well as reducing the risk of delirium and emergency hospital admissions.[70] Similarly, a 2017 British Medical Journal study found that patients with higher levels of continuity of care had fewer unplanned admissions for conditions that can be effectively treated in the community, and a 2017 Swedish study found that higher continuity was linked to lower use of emergency services.[71]

75. We also heard from Professor Steinar Hunskår, a GP and Professor of Primary Care at the University of Bergen in Norway, who described the findings of his group's major study into the impact of the Norwegian regular GP scheme. In 2001, the new general practice contract in Norway allowed all patients to register with a regular named GP, who is accountable for their care and provides the majority of their consultations. Professor Hunskår studied the impact of the length of a patient's relationship with their GP on their health outcomes:

> We have investigated the association between having the same doctor over time and what we call hard end points: mortality, risk of death, hospitalisation for emergency reasons and issues for EDs or out-of-hours care […] What we found was the same as other studies have shown; there is a clear association between continuity and hard end points. 11 of 11 studies show reduced mortality. There is an association with reduced emergency admittance to hospitals. There is a clear association between less use of emergency services like out-of-hours services. Over time, it shows a reduction of roughly 25% to 30% in all hard measures.[72]

76. As well as a clear benefit in patient outcomes, including a reduction in what Professor Hunskår called "hard measures" such as mortality, continuity of care also has benefits for GPs and the wider system. Dr Jacob Lee described how having a personal list of patients made his work more efficient:

> The processing of blood test results and letters is no longer looking at the blood test result and having to look back through the notes about why it was done. I requested the test and I know what was happening. I can recognise when test results or letters are abnormal for the patient and that enables me to function much more efficiently.[73]

70 Delgado, J et al., 2022. 'Continuity of GP care for patients with dementia: impact on prescribing and the health of patients', British Journal of General Practice 72 (715)

71 Barker, I et al., 2017. 'Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data', British Medical Journal (356); Kohnke, H and Zielinski, A., 2017, 'Association between continuity of care in Swedish primary care and emergency services utilisation: a population-based cross-sectional study', Scandinavian Journal of Primary Health Care 35 (2)

72 Q102; Sandvik, H., Hunskår, S. et al., 2022. 'Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway' BJGP 72 (715)

73 Q70

Similarly, Dr Pauline Grant, also a partner at a practice using personal lists, described how continuity enables her to manage demand for urgent access:

> Somebody rang in with a sore throat. They had just woken up with it that morning. Because of my relationship with them, I was able to say, "You could have waited three or four days; you do not need to ring me on day one complaining of a sore throat."[74]

77. This impact has also been demonstrated by research. For example, Professor Sir Denis Pereira Gray, a long-standing expert in continuity of care, highlighted studies from Belgium and the United States which showed that higher rates of continuity of care were associated with an overall reduction in healthcare costs.[75]

78. GPs we heard from were also clear that not only does providing continuity of care make their practice more effective and their lives easier, it is also more professionally and personally rewarding. For example, Dr Cym Ryle, a senior GP who has worked in a variety of settings, described the importance of a continuous relationship with his patients:

> For me, and anecdotally for all the GPs I know who have enjoyed the job, continuity of care, and the complex evolving relationship between doctor and patient, are of central importance. These relationships give a human meaning to the work.[76]

This was echoed by other GPs, such as Dr Anna Graham, who highlighted the value to her professional learning as a GP in being able to follow up on her actions with patients, and Dr Joanna Bircher, who has worked in the same practice for 22 years and told us that long-term relationships leads both to better care for patients and job satisfaction for GPs.[77]

79. **We believe that continuity of care is one of the most important goals for NHS general practice. There is a wealth of evidence that higher levels of continuity of care in general practice are better for both patients and GPs themselves. Continuity of care is more efficient for GPs, improves their shared decision making with patients, and provides them with greater professional satisfaction and development. More importantly, it improves patients' experience of their care and leads to significantly improved outcomes including reduced hospital and A&E attendances. And rather than being impossible given current pressures there is also evidence to suggest that high continuity is also a more efficient use of resources. One way to improve continuity would be to cap individual GP list sizes, which we believe is a pragmatic solution that should be explored as outlined later in this report.**

Continuity is good for everyone

80. In the context of the pressures outlined above, some witnesses suggested that it was no longer necessary to provide continuity of care to everyone because some patients, especially younger patients, value quick access for transactional care needs over continuity. For example, Dr Claire Fuller, CEO of Surrey Heartlands ICS and a GP, though she emphasised the importance of continuity in general, stated:

74 Q73
75 Professor Sir Denis Pereira Gray and Professor Philip Evans (FGP0151)
76 Dr Cym Ryle (FGP0075)
77 Dr Anna Graham (FGP0130); Dr Joanna Bircher (FGP0034)

> There are the urgent transactional interactions where people genuinely do not mind. My children do not care who they see; they just want to be seen quickly. If you have a rash and you just want to know if it is infectious, or if you have a baby with a really high temperature, you just want to be seen.[78]

This was partly echoed by Dr Jacob Lee, who said, "the patients who get more benefit from it are those who go to the GP more often. If you go only once every couple of years for an acute illness, it probably does not matter who you see."[79]

81. There is evidence that some patients value continuity more than others. For example, the GP Patient Survey shows that 62% of people aged 85 or over have a preferred GP, compared to 43.4% of the general population and 39% of people aged 16–24.[80] Similarly, 72% of deaf patients using sign language and 51% of people who have at least one long-term condition report having a preferred GP.[81]

82. However, as Dr Jacob Lee also stated, "everybody values and gets benefit from continuity," and as Professor Steinar Hunskår put it, "'[continuity] is for everyone, but not for everything.'"[82] While it is partly possible to target continuity in the way that many witnesses have described, this is not fool proof. As Professor Martin Marshall pointed out, a fever could be indicative of both a minor, self-limiting condition or something more serious:

> Every young child I see with a fever could have meningitis. The vast majority of them do not have meningitis. What I do is make a clinical assessment and live with the uncertainty that very occasionally I might have got it wrong.[83]

As Dr Pauline Grant highlighted, this process of managing uncertainty is made much easier by having an ongoing relationship with a patient:

> With a personal list, over time you get to know lots and lots of facts about people, not just that kind of thing. […] I know what their medical condition is likely to be. […] I have one patient who frequently ends up in A&E, but if he speaks to me he does not because I know that is what happens.[84]

83. It is in this area of uncertainty that catastrophic mistakes can occur, because although most people are generally well, if there is no existing relationship based on continuity it can be difficult to spot issues when they occur. Dr Rebecca Rosen said:

> Although the prevalence of complex illness is low [among mainly healthy adults], it amounts to quite a lot of people because they are a big proportion of the list size and they develop significant problems. That has been a real blind spot of policy, partly because they create the medico-legal catastrophes where they go around six or seven different doctors and nobody notices that they have gone from being normally fit and well to being quite unwell.

78 Q205
79 Q74
80 NHS England, GP Patient Survey 2022, national report and analysis tool, 14 July 2022.
81 NHS England, GP Patient Survey 2022, national report and analysis tool, 14 July 2022.
82 Q74, Q124
83 Q45
84 Q72

> Many months will have gone by before the penny can drop and therein you have missed and delayed diagnoses—catastrophe at times for the patient but also medico-legal problems.[85]

84. This was the experience of Jessica Brady, who sadly died of cancer aged 27 in November 2020, and whose mother Andrea gave evidence to our inquiry into cancer services. Andrea described how Jess contacted her GP practice nearly 20 times, seeing four different GPs without success, ultimately having to pay for a private referral to receive a diagnosis for her cancer, which by that time was incurable.[86] Andrea Brady told us that she felt there was "no one person [looking] at the whole picture and putting the pieces of the jigsaw together."[87]

85. Dr Kate Sidaway-Lee, an academic working on continuity in general practice, also pointed out that it is not simple to identify when someone will transition from needing mostly transactional care to benefiting from continuity:

> It is quite hard to predict who is going to have a long-term condition in the future. Ideally, you would have continuity of care established before they had that condition. If you had the chance for the doctor to get to know the patient before they started to have the long-term health condition, it would be much better.[88]

A GP who attended our roundtable in Bristol similarly offered the example of a woman diagnosed with cancer in her 40s: if, for example, the same GP has seen her to prescribe her contraceptive pill during her 20s, and to help her manage her pregnancy and her children's health in her 30s, the GP will be able to offer her better care during her cancer diagnosis and treatment than if there was no existing continuity.

86. **We recognise that continuity of care is valued differently by different patients. However, just because a patient does not necessarily express a preference for continuity of care, it does not mean that they will not benefit from receiving it. It is clearly the case that even a patient who is young and generally healthy would be better served, in the event that they did develop a serious condition, by receiving care from a GP with whom they have an ongoing relationship. Patients should always be given the choice to receive quicker access if they feel they need it, but we believe the ambition should be to provide continuity to all patients as much as possible.**

Continuity can be achieved

87. Our inquiry found that there are opportunities to improve the level of continuity of care provided in general practice, despite the current pressures caused by workforce shortages and high and growing demand. Indeed, some witnesses argued that increasing continuity of care is not only possible but desirable given current pressures, because of the increased efficiency and effectiveness afforded by high levels of continuity of care. Dr Kate Sidaway-Lee argued:

85 Q110
86 Oral evidence taken before the Health and Social Care Committee on 14 September 2021, HC551 (2021–22), Q69
87 Oral evidence taken before the Health and Social Care Committee's on 14 September 2021, HC551 (2021–22), Q69
88 Q109

> While I agree that we need more GPs, and that is fairly well established, I would argue that if we have a shortage of GPs it makes more sense to use them as efficiently as possible. That would be with patients they know well; it means they can work better and more efficiently.[89]

Similarly, Dr Becks Fisher highlighted that the Health Foundation had managed to improve continuity of care through quality improvement projects even in difficult circumstances:

> At the Health Foundation we have done a lot of work looking at how you can preserve and improve continuity of care. We know that, even in challenging circumstances, quality improvement approaches in particular can be used to maintain continuity of care and improve it.[90]

88. As we have noted, an important component in declining levels of continuity of care has been the lack of priority attached to it in national policy making: several witnesses called simply for continuity of care to be made an explicit priority by NHS England and the Government.[91]

89. ***The Government and NHS England must acknowledge the decline in continuity of care in recent years and make it an explicit national priority to reverse this decline.***

90. At present there is no routine measurement of levels of continuity of care provided in NHS general practice: the GP Patient Survey asks respondents whether they have a preferred GP, and if so whether they see them regularly, but this is self-reported and not a contemporary measure of how often patients see their preferred or named GP. However, there are options for regularly measuring continuity of care: the St Leonard's Medical Practice in Exeter, for example, has developed the St Leonard's Index of Continuity of Care (SLICC), which measures the proportion of appointments given by a usual GP, for example for specific patient groups or for an individual doctor. This is similar to the Usual Provider Continuity index (UPC) which is used in Norway.[92]

91. Witnesses told us that introducing the regular measurement of continuity of care was an important first step to improving it. For example, Dr Kate Sidaway-Lee told us:

> My first priority would be to get practices measuring continuity. I would want that in the GP record systems so that practices could just do it with a click of a button. We have our own measure of continuity, called SLICC, which uses personal lists or a named GP system. It is very simple; it just looks at the percentage of appointments that are with a patient's own GP for a whole list. It is particularly useful because you can look at it in chunks of a month, so you can see how it is changing over the course of a year by looking at it every month. Having that in GP systems would be very helpful.[93]

This was echoed by Dr Jacob Lee, as noted above, and by Professor Steinar Hunskår, who recommended the UPC.

89 Q108
90 Q38
91 For example Dr Jacob Lee (Q98), Dr Rebecca Rosen (Q113)
92 Q112, Q102
93 Q112

92. **Unless continuity of care is routinely measured GP practices and Primary Care Networks will be unable to identify where to focus improvement efforts. NHS England will also be unable to effectively target support without establishing a baseline for the provision of continuity of care. Measuring the proportion of appointments delivered by a named GP is simple and easily understood and could potentially allow for some international comparisons to be made. While this would introduce an additional reporting requirement on GPs, we believe this is proportionate to the importance of continuity of care and would be accounted for by implementing our other recommendations on the GP workload. This could initially be rolled out at Primary Care Network level to allow support and then be phased into individual practices by 2024.**

93. ***NHS England should introduce a national measure of continuity of care to be reported by all GP practices by 2024. The new measure should be based on existing models such as the Usual Provider Continuity index and the St Leonard's Index of Continuity of Care and in the short term should be based on measuring either continuity delivered by a named GP (in pooled list practices) or by a personal GP (in personal list practices). The measure should be reported quarterly at practice, Primary Care Network and Integrated Care System level as well as nationally.***

94. While continuity of care is efficient and is likely to make general practice more sustainable over time, we also heard that it is important for practices to have sufficient organisational and management support in order to make changes to the way they deliver services: this applies to continuity of care as it does to the introduction of additional staff and other changes taking place in general practice. Dr Jacob Lee, for example, described what practices have been able to achieve with sufficient support:

> You can provide operational and financial incentives to support and encourage practices to want to move to that way of working. It is not always the money, but having the headspace. One thing the Health Foundation did really well was to provide headspace and project management support to help practices move in the direction they wanted to go. You can provide training on the benefits of continuity in the GP training scheme and try to ensure that all trainees have access to work in a practice that works with personal lists or values continuity. Those are things that will take us a long way.[94]

95. Additional resource is being provided to Primary Care Networks in order to change the way that care is being delivered; we have already noted the funding being provided to expand the general practice team, for example. However, we have not received any evidence of any specific organisational or change management resource being provided to general practice in order to promote continuity of care.

96. ***NHS England should provide Primary Care Networks with additional funding to appoint a 'continuity lead' for at least one session per week, and additional admin staff funding to support the lead in the role. The role of the continuity lead GP would be to support practices within their network to increase the proportion of patients consulting with their named or regular GP, learning from best practice around the country. There should be a specific uplift for areas of high deprivation.***

94 Q98

97. We heard that personal lists, where individual GPs are assigned a list of patients and deliver the majority of their care, are the gold standard of continuity of care, and the personal list practices that we heard from delivered significantly higher self-reported continuity rates in the GP Patient Survey, and also had better satisfaction overall both within their local area and nationwide.[95] Dr Jacob Lee also shared his practice's contemporary continuity data showing that the practice consistently delivers 50–60% continuity.[96]

98. However, we did hear the view that not every practice is currently capable of working on a personal list basis; for example, Dr Amanda Doyle, Director of Primary Care for NHS England, told us that the main blocker to returning to individual lists was resources rather than the GP contract:

> The blocker is not that we do not have contractual ability to tell practices that they have to do this. […] It is not that GPs and practices do not want to deliver [continuity]. In the current situation, where we are struggling to retain GPs in the workforce in the numbers we need, it is very difficult to deliver it through a contractual route.[97]

Similarly, Dr Claire Fuller, a GP and Chief Executive of Surrey Heartlands Integrated Care System, argued that personal list practices we heard from are "very fortunate" and that "we do not have enough GPs to work in that way."[98]

99. Nonetheless, it is still possible to achieve high rates of continuity even in practices operating a pooled list, as even though patients are not directly assigned to an individual GP, patients can be encouraged to see the same GP depending on their needs. Dr Jacob Lee told us:

> It is important to disaggregate continuity and personal lists. Personal lists are the gold standard of continuity. You can provide continuity to groups of individuals. You can have all palliative patients, or all patients who are frequent attenders. You can start to provide continuity for specific groups if you need to.[99]

100. **Personal lists are the best way to deliver continuity of care and are therefore an essential component of improving the levels of continuity provided in NHS general practice. We recognise the pressures in general practice but we believe that delivering high levels of continuity will reduce pressure on GPs rather than increase it by enabling them to be more efficient. Moreover, as patients are already assigned a named GP, implementing personal lists in the short term can be a matter of changing consultation habits and patterns rather than requiring a contractual change.**

101. ***As part of wider efforts to improve continuity of care NHS England should champion the personal list model rather than dismissing it as unachievable. NHS England should set a stretching ambition that by 2027 80% of practices have returned to personal list continuity and provide support for practices to do so.***

95 NHS England, GP Patient Survey Results: St Leonard's Medical Practice, Horfield Health Centre, Cheviot Road Surgery, 14 July 2022
96 Dr Jacob Lee (FGP0254)
97 Q233
98 Q207
99 Q98

102. ***The Government should examine the possibility of limiting the list size of patients to, for example, 2500 on a list, which would slowly reduce to a figure of around 1850 over five years as more GPs are recruited as planned. These numbers should reflect varying levels of need in local populations. This would draw us closer in line with our European counterparts, and help improve access and continuity. It should only be implemented in a way that does not undermine the fundamental rights of patients to access a GP.***

103. ***NHS England should re-implement personal lists in the GP contract from 2030 onwards.***

3 General practice and new NHS organisations

Integrated Care Systems and Primary Care Networks have potential

104. Following the recent Health and Care Act 2022 the NHS in England formally established 42 Integrated Care Systems which are responsible for improving the health of their population. They will do this by bringing together relevant NHS, local authority and other partner organisations to plan and commission NHS services to meet population needs.[100] Within ICSs, GP practices are also being brought together into groups called Primary Care Networks. These Networks serve around 30,000 to 50,000 people and are intended to help GP practices collaborate better to provide care for their patients.[101]

105. Dr Claire Fuller, Chief Executive of Surrey Heartlands ICS, recently published a review, commissioned by NHS England, which set out recommendations for how general practice and primary care will operate within the new ICSs in the NHS and deliver more integrated care. The main recommendations in the report relate to the creation of 'neighbourhood teams' which the report states will "work together to share resources and information and form multidisciplinary teams dedicated to improving the health and wellbeing of a local community and tackling health inequalities."[102] The report set out several key actions for ICSs and PCNs including better job planning for members of staff working across organisational boundaries and shared data and other infrastructure.

106. We heard strong support for Dr Claire Fuller's vision for general practice and wider primary care, and for the potential of the new NHS organisations to achieve meaningful outcomes for patients. Matthew Taylor, Chief Executive of NHS Confederation, which represents both Primary Care Networks and Integrated Care Systems, called the premise of Dr Fuller's report "powerful" and Matthew Style, Director General for NHS Policy and Performance at the Department of Health and Social Care, called the review a "really important platform."[103]

107. Dr Claire Fuller told us about several areas of care where this integrated approach across organisations is having an impact, for example in Frimley Health in Surrey where patients with significant co-morbidities or frailty but who have not attended their GP in the past six months are assessed by a multi-disciplinary team which provides the patient with holistic care but requires them to attend fewer appointments. Similarly, she highlighted work in her area which uses school data to identify at-risk children for child and adolescent mental health services early intervention.[104]

108. Throughout our inquiry we heard about the difficulty patients face in knowing where to go first if they have a new or urgent health concern, given the prevalence of different organisations who represent the "front door" of the NHS such as GP practices, NHS 111, urgent care services and emergency departments. Sir Robert Francis, then Chair of Healthwatch, described the impact this has on patients:

100 NHS England, 'What are integrated care systems?', Accessed 16 August 2022
101 NHS England, 'Primary care networks', Accessed 16 August 2022
102 Dr Claire Fuller, 'Next steps for integrating primary care', 26 May 2022
103 Q184, Q253
104 Q210, Q212

> Yes, [patients] find [the primary care landscape] confusing. Then they find that, when they try one or other of those potential solutions, they are kept on the phone forever or they cannot get through. Then they really do not know what to do. It is undoubtedly one of the factors that leads to people going to A&E, which we all know is the wrong place for almost all such people, but it is absolutely the case.[105]

109. Dr Claire Fuller's review highlighted simplifying access to care as a priority and she described to us what changes should be made for patients wanting to access healthcare within an ICS:

> From a patient point of view, [access] should make it easier. That is what we are looking at. At the moment it is incredibly complicated, and the piece about being able to access care in different ways is about making sure that, whichever route people choose to say, "I need help"—whether that is through an e-consultation, a phone call or walking in—we can direct them to the people that are available to provide that care. It is not up to the patient to get it right; it is up to us as professionals working together in teams to make better use of community pharmacy, better use of the optometrists, better use of the dentists, better use of sexual health.[106]

110. **Primary Care Networks and Integrated Care Systems offer an opportunity to better integrate care around people. It should not be the case that patients face so much uncertainty about where to turn to if they have a new or urgent care need and it is particularly unacceptable if the number of different organisations involved in providing first-contact services to patients makes it harder to patients to access the care they need. It is welcome that Dr Claire Fuller's review for NHS England has made this a priority.**

111. ***Integrated Care Systems should prioritise simplifying the patient interface with the NHS by improving access, triage and referral across first-contact NHS organisations including general practice.***

There are too many micro-incentives in primary care

112. Despite the potential of these new organisations, current incentives in general practice and wider primary care are not aligned with the outcomes that matter to patients and do not encourage GPs to use their judgement to focus on what would most benefit their populations. Examples of these incentives include the Quality and Outcomes Framework (QOF), which accounts for around 10% of practice income based on achievement against process targets, and the new Investment and Impact Fund, which is worth £225m in 2022/23 and similarly awards funding for achievement against process targets.[107]

113. Dr Rebecca Rosen described the impact of micro-incentives in general practice and argued that simply adding more targets to general practice would not help GP practices to achieve transformation:

105 Q161
106 Q210
107 NHS England, Investment and Impact Fund, Accessed 16 August 2022; The King's Fund, GP funding and contracts explained, 11 June 2020,

> I had a conversation with a GP last week who described himself as being on the hamster wheel of doom, which I thought was a great phrase, because he is micro-incentivised for so many different things. Paying for another extra thing is probably not the way to [achieve whole-scale transformation], but rather building a vision for the kind of range of functions that have to be delivered[.][108]

Professor Martin Marshall also told us that there was a need for significant changes to the way that GPs are incentivised, particularly the removal of QOF:

> When QOF was introduced in 2004, it served some really important functions […] but now we see the downsides, particularly the bureaucratic and low-trust approach to managing professional behaviour. Our view is, yes, it is fundamentally important to have a different kind of contract which is higher trust and less about box-ticking and more about professionals being able to make the right decisions for their local community and their local patients.[109]

114. The Government and NHS England both acknowledged that there were opportunities to improve the use of targets in general practice, and said in particular that there was a need to develop targets which were more focused on outcomes.[110] However, neither the Government or NHS England committed to the removal of any specific targets.

115. We heard that the way that targets and incentives operate will partly determine the success of new organisations. Dr Claire Fuller told us:

> [I]n England more than anywhere else in the world we have relied upon centralist financial incentives to drive change, and there is very little evidence that it actually drives change. It does drive an increase in activity but does not necessarily drive change in outcomes. Actually, the way to drive change is to create teams, give them a clear remit, create the environment for them to succeed and leave them alone.[111]

Similarly, Dr Hugh Porter, Clinical Director of Nottingham City Integrated Care Partnership, argued that there were opportunities to better align accountability and incentives to enable systems to focus on population health management:

> The move to ICSs, with this system working and population health management, is actually welcomed by most places involved and by general practice. General practice has been in a holistic, [population health management] sort of world throughout, and that is the way it has always operated, so the system is moving closer to how general practice thinks, and there are real opportunities. […] [General practice] is a very highly managed environment that I work in, and I certainly think it would be grown up of us to think about where some of those are adding value and where some of them are not adding value.[112]

108 Q122
109 Q64
110 Q249, Q252, Q258, Q283
111 Q202
112 Q209

116. **Accountability and quality improvement are both extremely important in the NHS but it is clear that the current system of targets and incentives in general practice is overly bureaucratic, is not having the desired effect on outcomes, and will not enable GPs to change the way care is delivered. In particular, the current system of incentives does not encourage GPs to deliver high levels of continuity and also does not fund GPs for the additional work that will be required to manage more care in the community and reduce hospital admissions. Moreover, the Government's decision to introduce an additional two-week wait target for GP appointments, while well-intentioned, does not address the fundamental capacity problem causing poor GP access. The Government and NHS England need to be bolder and empower GPs to exercise their professional judgement in the best interests of their patients.**

117. ***NHS England should abolish the Quality and Outcomes Framework and Impact and Investment Framework and re-invest the funding in the core contract, weighted to account for patient demographics including deprivation, to incentivise continuity of care.***

118. ***In particular, NHS England should focus on significantly improving the outcomes data provided to GPs by focusing data collection and analytical resource on outcomes measures rather than the process data and reporting required by these micro-incentives.***

119. ***NHS England should support Integrated Care Systems to implement gain sharing so that Primary Care Networks and individual practices that support the reduction of secondary care expenditure, such as through reducing unplanned admissions, are able to share in the financial gains.***

Regional variation has not been accounted for

120. We also heard that a key problem with current funding models in general practice, including both financial incentives and core funding, is the lack of accounting for regional variation. Dr Becks Fisher described the current situation in regard to regional variation in general practice:

> These problems are not the same everywhere. General practice in this country in areas of high deprivation is underfunded and under-doctored relative to need. That is a persistent problem. It is not a new one. At points in time, particularly in the noughties, we were getting somewhere, particularly on workforce. Since then, under-doctoring has widened again. We are in a position now where, relative to need, general practice in areas of high deprivation has on average 7% less funding in practices, and a GP working in an area of high deprivation will be responsible for, on average, 10% more patients.[113]

Dr Fisher also explained how core funding, particularly the Carr-Hill formula, which is used to determine the funding allocated to practices as part of the General Medical Services (GMS) contract, perpetuate these challenges by awarding less funding to practices in deprived areas:

113 Q38

> The vast majority of funding for general practice comes directly to practices through, mostly, the GMS contract. The majority of practices use that contract type. About half of their practice funding will be determined by something called the global sum formula, which uses a formula colloquially known as Carr-Hill. […] When the global sum formula was brought in, in 2004, it was in theory meant to account for the different needs experienced by different patient populations, but it did not include any adjustment for deprivation. For example, if you have a 10% increase in deprivation, according to the Carr-Hill formula you get 0.06% extra funding.[114]

121. Despite this, we also heard that new funding mechanisms introduced through the Primary Care Networks contract have also failed to account for variation. For example, as we have noted, the Additional Roles Reimbursement Scheme does not account for deprivation, meaning that places which already have existing need of staff may find it more difficult to recruit.[115]

122. Similarly, the new Investment and Impact Fund is weighted according to prevalence and list sizes; for example, a practice with a higher number of patients aged 65 will be paid more for achieving 77% coverage of season flu vaccines among this age group than a practice with fewer patients aged 65. However, other factors are not accounted for: for example, flu vaccine uptake is significantly lower among patients with Black and Pakistani ethnicities compared to people with White British or Irish ethnicity, which means areas with a larger BAME population are also likely to have to work harder to achieve high coverage than other areas.[116]

123. We have also heard that continuity of care is harder to achieve in some areas than others. For example, analysis by the Nuffield Trust in May 2022 found that in Hull there were 2485 patients for every single GP, the worst proportion in the country.[117] At the same time, data from the Office for Health Improvement and Disparities shows that Hull Clinical Commissioning Group has a significantly higher deprivation score than the England average, has a higher unemployment rate, significantly higher smoking rates, higher obesity rates as well as more new cancer diagnoses and more coronary heart disease.[118] In areas such as these, where existing GP shortages are compounded by the high and complex health needs of the population, high levels of continuity of care are likely to be more difficult to achieve.

124. **It is unacceptable that areas already under significant pressure due to high levels of deprivation, ill health and under-doctoring have these pressures compounded by unfair funding mechanisms which fail to take account of deprivation. It is particularly concerning that new funding mechanisms in the Primary Care Network contract repeat this failing and risk entrenching regional variation in the establishment of PCNs.**

114 Q39
115 Q160
116 NHS England, Investment and Impact Fund 2020/21: guidance, 17 September 2020
117 Nuffield Trust, NHS staffing tracker: general practice, Accessed 16 August 2022
118 Office for Health Improvement and Disparities, National General Practice Profiles, Accessed 16 August 2022

125. ***NHS England should revise the Carr-Hill formula to ensure that core funding given to GP practices is better weighted for deprivation. NHS England must also review new PCN funding mechanisms to ensure that they do not inadvertently restrict funding for areas which already have high levels of need.***

GP organisations need more headspace and organisational support

126. Finally, we also heard that GPs and their staff need sufficient "headspace" to change the way they work and make new organisations work effectively. At its simplest headspace can mean time for GPs to design new systems and processes, but it has also been used to refer to organisational development support such as data and analytics or business management capacity. As we have noted, Beccy Baird highlighted this issue in relationship to the Additional Roles Reimbursement Scheme and summarised the problem as follows "When people are stressed and do not have the headspace to really think about the change management, the redesign of processes and how it is actually going to work, that is when it falls down".[119] This was echoed by Matthew Taylor, who argued that while Primary Care Networks have potential advantages, there has been insufficient investment in these areas:

> We have created primary care networks; I do not think we have invested in the right way in terms of management capacity, organisational development and the space for primary care networks to innovate, but I still think it is the right idea.[120]

127. Dr Claire Fuller's report also specifically identified several areas where ICSs required further support in order to integrate primary care effectively, and particularly highlighted support required from NHS England and the Government around estates, workforce and data:

> There is real commitment, but there is still an understanding that there are some things we need to put right, which is around the workforce, around the estates and around the data. We need to put those in place, and ICSs need to create the right environment and to focus on delivering care in this team-based way rather than in the siloed way.[121]

Dr Fuller was very clear in her evidence to us that this support is a precondition to her vision for primary care being deliverable.[122]

128. **With general practice currently in crisis it is important that GPs are given the headspace that they need to work differently and improve services, or the potential advantages of new Primary Care Networks will not be realised. Giving GPs time to focus on improvement projects is an important component of this, but so too are important back-office functions like HR support and data analytics.**

129. ***The Government and NHS England should increase the level of organisational support provided to GPs with a particular focus on important back-office functions such as HR, data and estates management.***

119 Q147
120 Q184
121 Q221
122 Q222

4 The GP partnership

The GP partnership model is innovative and efficient

130. Throughout our inquiry we heard about the benefits of the GP partnership model, whereby GPs operate as independent contractors who hold contracts with the NHS to deliver core general practice services. For example, Professor Mike Holmes, a senior partner of the Haxby Group in Yorkshire, described the benefits:

> From my perspective, the strengths are that I am in a very supportive environment. There has been career progression. I have learned from colleagues. I have been able to commit to a registered list of patients. We have been able to innovate.[123]

Dr Margaret Ikpoh similarly valued the partnership model because of the link it afforded her with her community:

> The difference that I have felt personally, moving from being salaried to being a partner, is that I am more accountable to my population. I am not—forgive the term—clocking off when it is time to go, because I am committed to the people I care for. For me, that has been the profound difference as a partner.[124]

131. Importantly, witnesses also told us that the partnership model was not a barrier to achieving meaningful reform in general practice and cautioned against undermining it unnecessarily. Matthew Taylor told us:

> I do not think the partnership model is in any way in tension with primary care networks or federations operating at scale. […] I do not think that the major reforms we need to achieve are unachievable with the partnership model, so why would you want to take on something that a lot of people care about , that matters to them and that motivates them?[125]

This was echoed by Saffron Cordery, then Chief Executive of NHS Providers, who said:

> [W]e should be really clear that we should not be jumping to a single solution to solve a big challenge here, because I do not think the partnership model is what is creating the challenges that exist in primary care and GP practices […] we should think really carefully before jumping to a solution that says all GPs should be salaried and that the partnership model is dead.[126]

132. However, during the course of our inquiry the then Secretary of State did cast doubt on the future of the partnership model, firstly by providing the foreword to a Policy Exchange

123 Q162
124 Q166
125 Q186
126 Q187

report which called for the partnership model to be phased out and subsequently stating in a speech to NHS ConfedExpo, "I don't think our current model of primary care is working."[127]

133. Dr Pauline Grant described the impact of this uncertainty on her own partnership:

> [W]ho will buy into a partnership if it will not be there in 2030? Nobody. We have partners leaving at the top and none coming in at the bottom. Whenever anybody leaves at the top, I have to buy their share. I brought £60,000 into the practice. Each time a partner leaves I have to put in another £10,000, another £12,000 or another £20,000. […] Nobody will want to be a partner.[128]

Professor Mike Holmes similarly voiced his concerns about the possibility of the end of the partnership model.[129] Following the departure of the previous Secretary of State, both NHS England and the Department of Health and Social Care confirmed that there was no policy to end the GP partnership model.[130] However, there was considerable concern among GPs in the meantime.

134. **It is regrettable that during a time of intense pressure for GPs, following a massive effort by GPs to lead the vital covid-19 vaccination programme, that GP partners were subjected to such open speculation and uncertainty about their futures. It is welcome that the Government and NHS England have confirmed that there is no policy to end the partnership model, which is a positive first step to reassuring GP partners.**

135. ***In response to this Report the Government should reaffirm its commitment to maintaining the GP partnership model and explain how it will take forward our recommendations to better support the partnership model, alongside ongoing work to enable other models of primary care provision.***

Premises costs are a significant issue

136. Nonetheless, our witnesses did acknowledge that there are issues with the GP partnership model as it currently stands, some of which were also highlighted by Dr Nigel Watson's independent review of the GP partnership model, which was published in 2019.[131] In particular, the level of premises costs incurred by GP partners has become a significant driver of GPs leaving partnerships as well as difficulty recruiting to partnerships. Dr Peter Holden, an expert on GP premises issues, described the issue:

> At the other end, the problem is the question of last man standing. […] The problem is that, if you get a practice that starts to fall over, you get a domino effect. The last person standing is left holding the debt for the business. Let's say that you have premises worth £1 million. You could have a four-partner

127 Policy Exchange, 'At Your Service', 4 March 2022; Department of Health and Social Care, Secretary of State for Health and Social Care speech to NHS ConfedExpo, 15 June 2022
128 Q96
129 Q164
130 Q271, Q272
131 Dr Nigel Watson, GP Partnership Review final report, 15 January 2019

> practice where two of them retire. That leaves the other two having to find £500,000. Then the third one goes off with stress because of that. That leaves the last guy having to find £750,000. No bank is going to lend him that.[132]

137. NHS England has proposed some steps to try to ameliorate the impact of premises costs on GP partners, including assigning leases for strategically important elements of the primary care estate to NHS organisations, supporting GPs to decouple property ownership from entering a GP partnership, and promoting better professional standards for property ownership in general practice.[133]

138. However, so far the NHS in England has rejected calls to adopt a premises model similar to the one used in Scotland, whereby the Sottish Government has agreed to purchase the GP-owned primary care estate by 2043.[134] Dr Peter Holden described the principles behind this scheme:

> The principle was that in Scotland they realised that they had a major recruitment and retention problem, all tied up with last person standing and things like the problem, particularly in rural and remote areas, of cost never coming up towards market value. […] Secondly, they saw that premises were the rate-limiting factor in getting recruitment going. Premises were the problem causing instability.[135]

139. Moreover, as well as being a barrier to GPs entering partnerships, a lack of focus on and investment in GP premises is a barrier to effective primary care provision: as Dr Claire Fuller described it, "every GP will have a story about when they have done a consultation in a cupboard."[136] Dr Peter Holden emphasised the fact that premises are fundamentally a "healthcare cost" and witnesses pointed out that the poor state of the primary care estate is a barrier to the effective training of GPs and to using other professionals in primary care.[137]

140. **Despite the risk associated with GP premises continuing to be a significant burden on existing GP partners and a barrier to entry for potential new partners, little progress appears to have been made on this issue. Until the Government grips this issue properly it will continue to seriously undermine GP retention as well as patient care.**

141. ***The Government should consider adopting the approach to GP premises taken in Scotland and conduct its own analysis of whether this would be viable for general practice in England. More widely the Government must make additional investment available for the general practice estate to enable integrated care to be effectively delivered.***

Unlimited liability prevents GPs from joining

142. Premises costs are one of the most significant liabilities that GP partners face, but more broadly GP partners face unlimited liability for other costs such as staff redundancy

132 Q168
133 NHS England, General Practice Premises Policy Review, June 2019
134 Scottish Government, National Code of Practice for GP Premises, 13 November 2017
135 Q176
136 Q212
137 Q168, Q175, Q239

costs in the event of a practice failure and any other losses the practice may incur. Dr Grant described the issue of the "last partner standing" whereby every departure of a GP partner requires the remaining partners to put more money into the partnership to make up for the shortfall, causing anxiety, significant financial risk, and a significant deterrent to remaining in partnerships.[138]

143. The Watson review of the GP partnership model recommended that the Government and NHS England allow GP partnerships to operate as a Limited Liability Partnership or another similar liability-limiting model. Currently LLPs are not able to hold a GMS or PMS (Personal Medical Services) contract with the NHS. Professor Holmes suggested that this recommendation had not yet been implemented, despite the ongoing risks to GP partners:

> [The recommendations have been implemented] in some places. Reducing the risk for GPs of taking up partnerships is difficult. Clearly, the partnership model has unlimited liabilities, but there are models around, including our own, where we have created other vehicles to take on riskier projects and have been able to limit the liability, while still using the partnership model to drive care, to commit to registered lists of patients and to improve quality.[139]

144. ***The Government should accelerate plans to allow GP partners to operate as Limited Liability Partnerships or other similar models which limit the amount of risk to which GP partners are exposed.***

138 Q96
139 Q163

Conclusions and recommendations

Access to general practice

1. The first step to solving a problem is to acknowledge it and we believe that general practice is in crisis. It is clear from the latest GP Patient survey results that despite the best efforts of GPs, the elastic has snapped after many years of pressure. Patients are facing unacceptably poor access to, and experiences of, general practice and patient safety is at risk from unsustainable pressures. Patient access is at the heart of NHS general practice and we are very concerned about this decline in standards. Given their reluctance to acknowledge the crisis in general practice we are not convinced that the Government or NHS England are prepared to address the problems in the service with sufficient urgency. The Government's Plan for Patients places a welcome emphasis on improving access to general practice but the measures set out so far will not be sufficient to make a meaningful difference to patient access and do not deal sufficiently with how to improve outcomes. (Paragraph 32)

2. *In response to this Report the Government and NHS England should be clear in acknowledging that there is a crisis in general practice and set out in more detail the steps they are taking in response to this crisis in the short term, to protect patient safety, strengthen continuity, improve access and reduce GP workloads.* (Paragraph 33)

3. *The Government should commission a review into short-term problems that constrain primary care including, but not limited to: the interface between primary and secondary care, prescribing from signing to dispensing, administrative tasks e.g. reports and sick notes, day-to-day usability of IT hardware and software, and reviewing of bloods, pathology and imaging reports.* (Paragraph 34)

4. GP recruitment is essential to resolving the crisis in general practice, and while it is disappointing that the Government remains off track to meet its target to recruit 6,000 additional GPs by 2024, the growth in the number of GP trainees over recent years is encouraging. Nonetheless, there are further steps the Government can take both to increase GP recruitment and improve the outcomes of GP training. (Paragraph 38)

5. *The Government should provide the funding necessary to create 1,000 additional GP training places per year and consider extending the GP training scheme to four years, to allow GP trainees more time to develop their skills in practice as well as learn the skills required to enter a GP partnership.* (Paragraph 39)

6. *The Government and NHS England should identify mechanisms to distribute GP trainees more equitably across the country so that under-doctored areas receive a balanced proportion of domestic and international GP trainees. The Government should explore schemes that incentivise GP trainees to settle in the areas they train; this could come in the form of improving opportunities to become GPs with Special Interests, incentivising GPs to join partnerships in understaffed areas, and look to create easier ways for GPs to set up their own practices in primary care "black spots".* (Paragraph 40)

7. We welcome the progress made in recruiting additional professionals to general practice and recognise the potential they have to improve the range of services on offer in general practice and to ensure patients are able to see the right professional at the right time. We are also pleased the Government has committed to increasing the flexibility of staff recruited under the Additional Roles Reimbursement Scheme. However, we are concerned about some gaps within the scheme, particularly the lack of funding for supervision and the absence of any uplift for areas of high need. At present it appears that some staff are not regularly being effectively integrated into general practice and do not receive adequate supervision. (Paragraph 46)

8. *NHS England should set out how it plans to increase the flexibility of the Additional Roles Reimbursement Scheme to allow Primary Care Networks to hire both clinical and non-clinical professionals other than those set out in the current guidance, according to local need.* (Paragraph 47)

9. *Receptionists play an incredibly important role in primary care that often goes unrecognised. Given they are often the first point of contact with primary care for most patients, NHS England should review and consider providing standardised national training to drive up standards and equip receptionists with the skills required to navigate and signpost in a 21st century NHS.* (Paragraph 48)

10. *The Government and NHS England should explore the possibility of providing an uplift to the Additional Roles Reimbursement Scheme to support non-staff costs such as supervision and training or to provide weighted salaries in areas where the cost of living is high or it is hard to recruit. Consideration should also be given to allowing staff to be employed on Agenda for Change terms and conditions as soon as resourcing allows.* (Paragraph 49)

11. The Government and NHS England have made a start on reducing the administrative workload in general practice, and it is also encouraging to see some Integrated Care Systems agreeing to try to reduce the amount of work that is inappropriately transferred from secondary care to primary care. However, it is clear that there is still a long way to go to make GP workloads more sustainable. (Paragraph 57)

12. *NHS England should take further steps to address the administrative workload in general practice, including by introducing e-prescribing in hospitals and focusing on the primary-secondary care interface by encouraging ICSs to provide a reporting tool for GPs to report inappropriate workload transfer.* (Paragraph 58)

13. *The Government should also fund research into the specific role that machine learning can play in the automation of reporting and coding test results to reduce clinical admin in general practice.* (Paragraph 59)

14. *The Government should undertake a full review of primary care IT systems from the perspective of the clinicians with an emphasis on improving the end user interface. Making the working life of each clinician that bit easier will drastically improve morale and efficiency.* (Paragraph 60)

15. As we said in our recent Report on the NHS workforce, no NHS employee should be forced to choose to locum or work for an agency to regain control over their working

life. This is equally true in NHS general practice. As well as this, GP practices should not be forced to outcompete each other to be able to ensure adequate staffing cover to provide care for their patients. (Paragraph 61)

16. *As part of ongoing efforts to improve the retention of GPs, NHS England should include a specific focus on encouraging locum GPs back into regular employment by supporting GP practices to offer more flexible working patterns.* (Paragraph 62)

17. *Urgent work needs to be done to stop a bidding war for the serrvices of locums and establish requirements for a minimum fair share of administrative duties.* (Paragraph 63)

18. Older GPs continue to face prohibitively expensive pensions tax bills which act as a significant disincentive to them staying in practice. Efforts taken to date to reduce the impact on GPs have not been sufficient to prevent experienced GPs from leaving the profession in significant numbers, however we note the Government's recent consultation on extending 'retire and return' arrangements into next year. Experienced GPs are also likely to be employers which may make their pensions arrangements more complicated. (Paragraph 64)

19. *The Government and NHS England should adopt the recommendations related to NHS pensions in our recent Report on Workforce: recruitment, training and retention in health and social care. In developing short and long-term solutions to the NHS pensions issue the Government and NHS England must specifically account for the status of GP partners as employers, for example by providing specific guidance and support for GP practices to help them adopt pension recycling and retire and return approaches. We welcome the focus on this issue in the Government's Plan for Patients but the Government must provide further detail on what changes it will introduce.* (Paragraph 65)

Continuity of care

20. We are extremely concerned about declining provision of continuity of care in general practice. We recognise the enormous pressure that GP services are under but it is unacceptable that one of the defining standards of general practice has been allowed to erode in this way. While we recognise the importance of continuity of information and accountability, and the important role that other professionals can play in providing continuity, we believe the ongoing relationship between a GP and their patients is uniquely important. The Government and NHS leaders have not paid sufficient attention to continuity of care or prioritised it effectively in national policy, which has hastened its decline. (Paragraph 73)

21. We believe that continuity of care is one of the most important goals for NHS general practice. There is a wealth of evidence that higher levels of continuity of care in general practice are better for both patients and GPs themselves. Continuity of care is more efficient for GPs, improves their shared decision making with patients, and provides them with greater professional satisfaction and development. More importantly, it improves patients' experience of their care and leads to significantly improved outcomes including reduced hospital and A&E attendances. And rather than being impossible given current pressures there is also evidence to suggest

that high continuity is also a more efficient use of resources. One way to improve continuity would be to cap individual GP list sizes, which we believe is a pragmatic solution that should be explored as outlined later in this report. (Paragraph 79)

22. We recognise that continuity of care is valued differently by different patients. However, just because a patient does not necessarily express a preference for continuity of care, it does not mean that they will not benefit from receiving it. It is clearly the case that even a patient who is young and generally healthy would be better served, in the event that they did develop a serious condition, by receiving care from a GP with whom they have an ongoing relationship. Patients should always be given the choice to receive quicker access if they feel they need it, but we believe the ambition should be to provide continuity to all patients as much as possible. (Paragraph 86)

23. *The Government and NHS England must acknowledge the decline in continuity of care in recent years and make it an explicit national priority to reverse this decline.* (Paragraph 89)

24. Unless continuity of care is routinely measured GP practices and Primary Care Networks will be unable to identify where to focus improvement efforts. NHS England will also be unable to effectively target support without establishing a baseline for the provision of continuity of care. Measuring the proportion of appointments delivered by a named GP is simple and easily understood and could potentially allow for some international comparisons to be made. While this would introduce an additional reporting requirement on GPs, we believe this is proportionate to the importance of continuity of care and would be accounted for by implementing our other recommendations on the GP workload. This could initially be rolled out at primary care network level to allow support and then be phased into individual practices by 2024. (Paragraph 92)

25. *NHS England should introduce a national measure of continuity of care to be reported by all GP practices by 2024. The new measure should be based on existing models such as the Usual Provider Continuity Index and the St Leonard's Index of Continuity of Care and in the short term should be based on measuring either continuity delivered by a named GP (in pooled list practices) or by a personal GP (in personal list practices). The measure should be reported quarterly at practice, Primary Care Network and Integrated Care System level as well as nationally.* (Paragraph 93)

26. *NHS England should provide Primary Care Networks with additional funding to appoint a 'continuity lead' for at least one session per week, and additional admin staff funding to support the lead in the role. The role of the continuity lead GP would be to support practices within their network to increase the proportion of patients consulting with their named or regular GP, learning from best practice around the country. There should be a specific uplift for areas of high deprivation.* (Paragraph 96)

27. Personal lists are the best way to deliver continuity of care and are therefore an essential component of improving the levels of continuity provided in NHS general practice. We recognise the pressures in general practice but we believe that delivering high levels of continuity will reduce pressure on GPs rather than increase it by enabling them to be more efficient. Moreover, as patients are already

assigned a named GP, implementing personal lists in the short term can be a matter of changing consultation habits and patterns rather than requiring a contractual change. (Paragraph 100)

28. *As part of wider efforts to improve continuity of care NHS England should champion the personal list model rather than dismissing it as unachievable. NHS England should set a stretching ambition that by 2027 80% of practices have returned to personal list continuity and provide support for practices to do so.* (Paragraph 101)

29. *The Government should examine the possibility of limiting the list size of patients to, for example, 2500 on a list, which would slowly reduce to a figure of around 1850 over five years as more GPs are recruited as planned. These numbers should reflect varying levels of need in local populations. This would draw us closer in line with our European counterparts, and help improve access and continuity. It should only be implemented in a way that does not undermine the fundamental rights of patients to access a GP.* (Paragraph 102)

30. *NHS England should re-implement personal lists in the GP contract from 2030 onwards*. (Paragraph 103)

General practice and new NHS organisations

31. Primary Care Networks and Integrated Care Systems offer an opportunity to better integrate care around people. It should not be the case that patients face so much uncertainty about where to turn to if they have a new or urgent care need and it is particularly unacceptable if the number of different organisations involved in providing first-contact services to patients makes it harder to patients to access the care they need. It is welcome that Dr Claire Fuller's review for NHS England has made this a priority. (Paragraph 110)

32. *Integrated Care Systems should prioritise simplifying the patient interface with the NHS by improving access, triage and referral across first-contact NHS organisations including general practice*. (Paragraph 111)

33. Accountability and quality improvement are both extremely important in the NHS but it is clear that the current system of targets and incentives in general practice is overly bureaucratic, is not having the desired effect on outcomes, and will not enable GPs to change the way care is delivered. In particular, the current system of incentives does not encourage GPs to deliver high levels of continuity and also does not fund GPs for the additional work that will be required to manage more care in the community and reduce hospital admissions. Moreover, the Government's decision to introduce an additional two-week wait target for GP appointments, while well-intentioned, does not address the fundamental capacity problem causing poor GP access. The Government and NHS England need to be bolder and empower GPs to exercise their professional judgement in the best interests of their patients. (Paragraph 116)

34. *NHS England should abolish the Quality and Outcomes Framework and Impact and Investment Framework and re-invest the funding in the core contract, weighted to account for patient demographics including deprivation, to incentivise continuity of care.* (Paragraph 117)

35. *In particular, NHS England should focus on significantly improving the outcomes data provided to GPs by focusing data collection and analytical resource on outcomes measures rather than the process data and reporting required by these micro-incentives.* (Paragraph 118)

36. *NHS England should support Integrated Care Systems to implement gain sharing so that Primary Care Networks and individual practices that support the reduction of secondary care expenditure, such as through reducing unplanned admissions, are able to share in the financial gains.* (Paragraph 119)

37. It is unacceptable that areas already under significant pressure due to high levels of deprivation, ill health and under-doctoring have these pressures compounded by unfair funding mechanisms which fail to take account of deprivation. It is particularly concerning that new funding mechanisms in the Primary Care Network contract repeat this failing and risk entrenching regional variation in the establishment of PCNs. (Paragraph 124)

38. *NHS England should revise the Carr-Hill formula to ensure that core funding given to GP practices is better weighted for deprivation. NHS England must also review new PCN funding mechanisms to ensure that they do not inadvertently restrict funding for areas which already have high levels of need.* (Paragraph 125)

39. With general practice currently in crisis it is important that GPs are given the headspace that they need to work differently and improve services, or the potential advantages of new Primary Care Networks will not be realised. Giving GPs time to focus on improvement projects is an important component of this, but so too are important back-office functions like HR support and data analytics. (Paragraph 128)

40. *The Government and NHS England should increase the level of organisational support provided to GPs with a particular focus on important back-office functions such as HR, data and estates management.* (Paragraph 129)

The GP partnership

41. It is regrettable that during a time of intense pressure for GPs, following a massive effort by GPs to lead the vital covid-19 vaccination programme, that GP partners were subjected to such open speculation and uncertainty about their futures. It is welcome that the Government and NHS England have confirmed that there is no policy to end the partnership model, which is a positive first step to reassuring GP partners. (Paragraph 134)

42. *In response to this Report the Government should reaffirm its commitment to maintaining the GP partnership model and explain how it will take forward our recommendations to better support the partnership model, alongside ongoing work to enable other models of primary care provision.* (Paragraph 135)

43. Despite the risk associated with GP premises continuing to be a significant burden on existing GP partners and a barrier to entry for potential new partners, little progress appears to have been made on this issue. Until the Government grips this issue properly it will continue to seriously undermine GP retention as well as patient care. (Paragraph 140)

44. *The Government should consider adopting the approach to GP premises taken in Scotland and conduct its own analysis of whether this would be viable for general practice in England. More widely the Government must make additional investment available for the general practice estate to enable integrated care to be effectively delivered*. (Paragraph 141)

45. *The Government should accelerate plans to allow GP partners to operate as Limited Liability Partnerships or other similar models which limit the amount of risk to which GP partners are exposed*. (Paragraph 144)

Formal minutes

Tuesday 11 October 2022

Members present:

Jeremy Hunt, in the Chair

Dr Luke Evans

Mrs Paulette Hamilton

Marco Longhi

Rachael Maskell

Taiwo Owatemi

Laura Trott

The future of general practice

Draft Report (*The future of general practice*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Summary agreed to.

Paragraphs 1 to 144 agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjourment

Adjourned till Tuesday 18 October 2022 at 11.00 am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 15 March 2022

Dr Kate Fallon, GP Partner, Somerton House Surgery; **Dr Andrew Green, Retired GP** Q1–33

Dr Becks Fisher, Senior Policy Fellow, The Health Foundation; **Professor Martin Marshall**, Chair, Royal College of General Practitioners; **Dr Kieran Sharrock**, General Practitioners Committee (England), British Medical Association (BMA) Q34–69

Wednesday 18 May 2022

Dr Pauline Grant, General Practitioner, Cheviot Road Surgery; **Dr Jacob Lee**, General Practitioner, Horfield Health Centre Q70–101

Professor Steinar Hunskår, Professor of Primary Care, University of Bergen; **Dr Rebecca Rosen**, Senior Fellow, Nuffield Trust; **Dr Kate Sidaway-Lee**, Research Fellow, St Leonard's Medical Practice Q102–136

Tuesday 14 June 2022

Beccy Baird, Senior Policy Fellow, The King's Fund; **Sir Robert Francis QC**, Chair, HealthWatch England; **Mrs Heather Randle**, Professional Lead for Education and Primary Care, Royal College of Nursing Q137–161

Dr Peter Holden, GP Partner, Imperial Road Surgery; **Dr Margaret Ikpoh**, Vice Chair Professional Development, Royal College of General Practitioners; **Professor Mike Holmes**, GP Partner, Haxby Group Q162–181

Tuesday 28 June 2022

Saffron Cordery, Interim Chief Executive, NHS Providers; **Sarah Sweeney**, Head of Policy, National Voices; **Matthew Taylor**, Chief Executive, NHS Confederation Q182–201

Dr Claire Fuller, Chief Executive-designate, Surrey Heartlands Integrated Care System; **Dr Hugh Porter**, GP and Clinical Director, Nottingham City Integrated Care Partnership Q202–226

Tuesday 12 July 2022

Matthew Style, Director General for NHS Policy and Performance, Department of Health and Social Care; **Dr Amanda Doyle**, Director of Primary and Community Care, NHS England; **Dr Nikki Kanani**, Medical Director of Primary Care, NHS England; **James Morris MP**, Parliamentary Under-Secretary and Minister for Patient Safety and Primary Care, Department of Health and Social Care Q227–283

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

FGP numbers are generated by the evidence processing system and so may not be complete.

1 Adams, Dr Julian (GP partner, St Alban's Medical Centre) (FGP0062)

2 Ahmad, Dr Farhat (GP Partner, GP trainer, GP Appraiser, Clinical Director of CHAW PCN Care Community,, Wilmslow Heath Centre, HEE England, NHS England, East Cheshire ICP); and Ahmed, Dr Amar (GP Partner, GP trainer, , Wilmslow Health Centre, Health Education England) (FGP0331)

3 Aiming for Health Success (FGP0035)

4 Akerman, Dr S (FGP0091)

5 Aldred, Dr Nicholas (GP Partner, Talbot Medical Centre, Bournemouth) (FGP0291)

6 Alford, Dr Paul (GP, SWT Faculty) (FGP0101)

7 Allan, Brenda (Volunteer, Haringey Keep Our NHS Public (HKONP), North Central London NHS Watch (NCL NHS Watch)); Morton, Alan (volunteer, KONP, NCL NHS Watch); and Wells, Rod (volunteer, KONP) (FGP0377)

8 Allingham, Dr John (GP, Alwoodley Medical Centre, Leeds) (FGP0150)

9 Altmeyer-Ennis, (FGP0023)

10 Alzheimer's Society (FGP0292)

11 Anonymised (FGP0347)

12 Anonymised (FGP0272)

13 Anonymised (FGP0286)

14 Anonymised (FGP0230)

15 Anonymised (FGP0229)

16 Anonymised (FGP0193)

17 Anonymised (FGP0188)

18 Anonymised (FGP0173)

19 Anonymised (FGP0161)

20 Anonymised (FGP0145)

21 Anonymised (FGP0149)

22 Anonymised (FGP0139)

23 Anonymised (FGP0078)

24 Anonymised (FGP0063)

25 Anonymised (FGP0049)

26 Anonymised (FGP0048)

27 Anonymised (FGP0043)

28 Anonymised (FGP0041)

29 Anonymised (FGP0008)

30 Anonymised (FGP0006)

31 Ashington House Surgery Swindon (FGP0086)

32 Ashworth, Dr Mark (Reader in Primary Care, King's College London); and L'Esperance, Dr Veline (PhD student, King's College London) (FGP0385)

33 Association of Independent Specialist Medical Accountants (FGP0276)

34 Assura plc (FGP0210)

35 At Scale Primary Care Networking Group (FGP0238)

36 AXA UK & Ireland (FGP0368)

37 Bache, John (Retired Consultant in Accident and Emergency Medicine, with 35 years experience of working in the front line of the NHS, NHS) (FGP0127)

38 Baker, Professor Richard (Professor Emeritus, University of Leicester) (FGP0088)

39 Ball, Dr S (FGP0257)

40 Bartlett, Mr Paul (Chair, Health Overview & Scrutiny Committee, Kent County Council) (FGP0012)

41 Bateman, Dr Alastair (CCG GP Clinical Lead , Salaried GP and previous GP Partner for 26 years, HSIOW CCG and Vine Medical Group) (FGP0134)

42 Bayliss, Dr Catherine (Portfolio General Practitioner, NHS) (FGP0146)

43 Bedfordshire & Hertfordshire Local Medical Committee (FGP0287)

44 Berkshire West Primary Care Networks (FGP0313)

45 Besley, Dr Charlie (GP, Hampshire, Southampton & Isle of Wight CCG) (FGP0065)

46 Bilbrook Medical Centre (FGP0252)

47 Bircher, Dr Joanna (GP Partner, Lockside Medical Centre) (FGP0034)

48 Bosch, Michael (GP, Smallfield Surgery) (FGP0386)

49 Boultham Park Medical Practice Patient Participation Group (FGP0258)

50 Bourne Galletly Medical Practice (FGP0050)

51 Brad, Dr Lawrence (GP, Westbourne Medical Centre, Bournemouth) (FGP0242)

52 Bradford on Avon and Melksham Health Partnership (FGP0221)

53 Branston and Heighington Family Practice (FGP0106)

54 Breast Cancer Now (FGP0374)

55 British Medical Association (BMA) (FGP0366)

56 British Psychological Society (FGP0305)

57 Brogan, Mrs Catryn (FGP0273)

58 Brown, Dr Alison (GP Partner, St melor House Surgery) (FGP0196)

59 Bryant, Dr Laura (GP Partner, Waterside Medical Practice) (FGP0232)

60 Burville, Dr Ben (GP Partner , Coquet Medical Group) (FGP0297)

61 Butterfield, Mr Mark (FGP0336)

62 Cambridgeshire Local Medical Committee (FGP0319)

63 Campbell MBE MD FRCGP, Professor John L (FGP0325)

64 Cancer Research UK (FGP0320)

65 Care Quality Commission (CQC) (FGP0364)

66 Carradale Futures (FGP0345)

67 Carroll, Mr Paul (Practice Manager, GP Practice) (FGP0225)

68 Challens, Dr Alison (GP Partner and Joint Clinical Director for PCN, Rowden Medical Partnership) (FGP0220)

69 Chawton Park Surgery, Alton, GU34 1RJ (FGP0076)

70 Checkland, Professor Kath (Professor of Health Policy & Primary Care, The University of Manchester); Hammond, Dr Jonathan (Research Fellow, The University of Manchester); and Warwick-Giles, Dr Lynsey (Research Associate, The University of Manchester) (FGP0322)

71 Cheshire Local Medical committee (FGP0179)

72 Christchurch Medical Practice (FGP0071)

73 Colin-Thom, Doctor David (independent Healthcare Consultant, DCT Health Consulting Ltd) (FGP0154)

74 College of Medicine (FGP0185)

75 Colvin, Dr David (GP, Whitley Bay Health Centre, Tyne & Wear); and Sayers, Dr Luke (GP, Whitley Bay Health Centre) (FGP0380)

76 Company Chemists' Association (FGP0327)

77 Corke, Ali (GP, NHS- primary care) (FGP0060)

78 Covent Garden Medical Centre (FGP0014)

79 Cox, Dr (GP, Wyre Forest Health Partnership) (FGP0126)

80 Crickmore, Dr Tracy (GP, Wareham Surgery, Dorset) (FGP0111)

81 Crutchfield, Dr (FGP0207)

82 Curtis, Dr Adrian (GP Partner and Trainer and GP Training Programme Director, Spa Medical Centre & Bath GP Training Programme.) (FGP0136)

83 Darko, Dr Julia (General Practice Specialty Trainee, King's College VTS Scheme); and Williams, Dr Lucy (FGP0248)

84 Davies, Dr Lucy (GP, Castle PRactice) (FGP0080)

85 Davies, Dr Peter (Clinical Adviosr, Local Care direct,) (FGP0333)

86 Dementia UK (FGP0288)

87 Department of Health and Social Care (FGP0392)

88 Diabetes UK (FGP0361)

89 Digital Healthcare Council (FGP0268)

90 Dispensing Doctors' Association (FGP0214)

91 Dobbs, Dr Jeremy (GP, Cerne Abbas Surgery in Mid Dorset Locality in Dorset CCG) (FGP0044)

92 Dock, Jennie (Practice Manager, Hedge End Medical Centre) (FGP0105)

93 Doctors in Unite (The doctors branch of Unite the Union) (FGP0096)

94 Doctors' Association UK (DAUK) (FGP0346)

95 Downey, Dr Paul (Portfolio GP, NHS England) (FGP0190)

96 Edwards, Dr Laura (GP, Hedge End Medical Centre) (FGP0352)

97 Elder, Dr Andrew (FGP0054)

98 Elliott, Dr Kate (GP, Adelaide Medical Centre, Andover) (FGP0103)

99 Elmham Group of Practices (FGP0068)

100 Elphick, Andrew, CEO and Quartley, Toby, Joint Chair & Medical Director (FGP0362)

101 Evans, Dr Peter (GP, Abbottswood Pershore) (FGP0033)

102 Evans, Professor Chris (Independent researcher, Visiting Professor, UDLA, Quito, Ecuador & Honorary Professor, University of Roehampton, UK., PSYCTC.org) (FGP0089)

103 Ewing, Dr Peter (GP (Senior Partner), The Red Practice Crieff) (FGP0028)

104 Fallon, Dr Katherine (GP, Somerton House Surgery) (FGP0039)

105 Ferguson, Dr Jeremy (GP, Blackmore vale practice, Dorset) (FGP0157)

106 Findlay, Dr James (FGP0201)

107 Finney, Brian (N/A, n/a) (FGP0148)

108 Follows, Izzie (Salaried GP and lead for Womans Health for WFHP, WFHP) (FGP0002)

109 Foster, (FGP0079)

110 GP Survival (FGP0355)

111 Gallagher, Sue (volunteer) (FGP0018)

112 General Medical Council (FGP0367)

113 Giffords Suregry (FGP0318)

114 Gilmartin, Dr Kieran (Clinical Director, Fareham & Portchester Primary Care Network) (FGP0001)

115 Gloucestershire Local Medical Committee (FGP0356)

116 Godwin, Dr Raymond (FGP0375)

117 Gooderham, John (FGP0005)

118 Graham, Dr Anna (GP Partner, Horfield Health Centre) (FGP0130)

119 Grant, Dr Pauline (Doctor, GP partner at Cheviot Road surgery Southampton SO16 4AH I am also a clinical director of Southampton West PCN) (FGP0397)

120 Grant, Dr Pauline (GP partner, Cheviot Road surgery Southampton SO16 4AH I am also a clinical director of Southampton West PCN) (FGP0024)

121 Gray, Ms Anne (FGP0262)

122 H&F Partnership (FGP0174)

123 Hanks, Mrs Joanna (Advanced Nurse Practitioner, Tower House Surgery, Ryde, Isle of Wight) (FGP0058)

124 Hanna, Dr Stephen (GP Partner, Escrick Surgery) (FGP0025)

125 Harpenden Health PCN (FGP0186)

126 Harptree and Cameley Surgeries (FGP0085)

127 Harring, Dr Hannah (GP ST3, Gratton Surgery) (FGP0069)

128 Hart, Dr (Primary Care Network Clinical Director, Didcot Primary Care Network) (FGP0235)

129 Harvey, Dr Jane (General Practitioner, Dukinfield Medical Practice and Hyde Primary Care Network) (FGP0169)

130 Hawthorne, Professor Kamila (General Practitioner and Head of Graduate Entry Medicine, Swansea University, Meddygfa Glan Cynon Surgery, Mountain Ash, South Wales.) (FGP0383)

131 HealthWatch England (FGP0310)

132 Heath, Dr Iona (FGP0381)

133 Heiden, Mr Philip (FGP0339)

134 Helyar, Dr Simon (GP, Coastal Medical Practice) (FGP0256)

135 Herefordshire General Practice; Herefordshire Clinical Directors on behalf of all our practices; and Herefordshire Local Medical Committee (FGP0329)

136 Hobbs, Dr Alison (GP partner, Forge Health Group, Sheffield) (FGP0140)

137 Hodges, Mr Mike; Adams, Mr Paul; Dibben, Mrs Sylvia; Hales, Mr Stephen; Hills, Mr Roger; Pryor, Mr Martin; Quinn, Mrs Kathy; Samuels, Mrs Linda; Snell, Mr MIke; and Strange, MS Barbara (FGP0152)

138 Holden, Dr Peter (Doctor, Imperial Road Surgery) (FGP0398)

139 Holden, Dr Peter J.P. (General Practitioner Principal and Senior Partner, Dr P J P Holden & Partners, The Matlock & Ashover Practice Imperial Road MATLOCK DE4 3NL) (FGP0247)

140 Holdsworth, Dr Tom (FGP0167)

141 Hook, Dr Richard (GP Partner, Kennet & Avon Medical Partnership, George Lane, Marlborough, Wiltshire SN11 8XP) (FGP0206)

142 Hornby, Dr Simon (GP, Giffords Surgery) (FGP0084)

143 Hornsey Pensioners Action Group (FGP0158)

144 Howard, Dr Tim (GP (retired). Chair, GMC Fitness to Practice Tribunals, The Hadleigh Practice, Dorset. General Medical Council) (FGP0104)

145 Hughes, Dr Simon (GP, Dr S P Hughes and Partners) (FGP0011)

146 Hurley Clinical Partnership known as the Hurley Group (FGP0219)

147 Hurley Group (FGP0155)

148 IC24 (FGP0172)

149 Ide Lane Surgery (FGP0160)

150 Independent Age (FGP0282)

151 Institute for Employment Studies (IES) (FGP0299)

152 Isaac, Ms Jane (Practice Manager, Charlotte Keel Medical Practice) (FGP0137)

153 Jacobs, Ian (FGP0121)

154 Jahfar, Dr Sarah (GP Partner, Wellspring Surgery) (FGP0278)

155 Jarrett, Dr Penelope (Doctor, The Corner Surgery) (FGP0357)

156 Jenkins, Dr Kate (GP partner, Combe Down Surgery, Bath) (FGP0360)

157 Jewell, Dr David (General practitioner and editor, now retired) (FGP0255)

158 Jitan, Dr John (GP , Ammonite Health) (FGP0067)

159 Johnston, Dr David J (FGP0267)

160 Jones, Dr Nicholas (General Medical Practitioner, St Chads Surgery, Midsomer Norton) (FGP0110)

161 Jones, Dr Rowan (GP (partner), Dorchester Road Surgery) (FGP0358)

162 Jones, Mrs L (Receptionist, Upperthorpe Medical Centre) (FGP0251)

163 Jones, Professor Roger (Emeritus Professor of General Practice, King's College London) (FGP0200)

164 Jubilee Field Surgery (FGP0245)

165 Judd, Mrs Julia (Nurse Practitioner / Nurse educator, Portsmouth CCG / J2S Training Ltd) (FGP0132)

166 Junghans, Dr Cornelia Minton (Senior Clinical Fellow and General Practitioner, Imperial College London); Harris, Dr Matthew (Clinical Senior Lecturer and Honorary Consultant in Public Health, Imperial College London); Lang, Dr Nicky (Director of Public Health, London Borough of Hammersmith and Fulham Council); Razak, Dr Yasmin (GP Principal, Clinical Director and training lead, Golborne Medical Centre); Neogi, Dr Sheila (Senior GP Partner, Clinical Director, Pimlico Health at the Marven Medical Centre); Taylor, Dr Caroline, GP, Calderdale CCG Mental Health clinical lead and Chair of NAPC; and Chana, Dr Nav, National PCH Clinical Director, NAPC (FGP0216)

167 Kanneganti, Dr Chandra (GP Partner, Secretary of North Staffs LMC , North Staffordshire Local Medical Committee , North Staffs GP Federation) (FGP0170)

168 Kalia, Dr Rajiv (Deputy Chief Medical Officer, Primary Care Clinical Leadership Executives for BCWB CCG) (FGP0391)

169 Kamau-Mitchell, Dr Caroline (Doctor, Birkbeck, University of London) (FGP0388)

170 Kelly, Dr James (GP, Kingsnorth Medical Practice) (FGP0017)

171 Kendrick, Dr Claire (GP partner , St Chad's Surgery) (FGP0094)

172 Kent Local Medical Committee (FGP0203)

173 Killick, Dr Fran (GP Partner, Lawn Medical Centre) (FGP0246)

174 Kimber, Doctor Timothy (Senior partner, Park Surgery, Littlehampton, West Sussex) (FGP0378)

175 Konig, Dr Dirk (General Practitioner, The Bosmere Medical Practice) (FGP0010)

176 Konig, Mrs Sarah (Practice Nurse, North harbour medical group) (FGP0223)

177 LIVI (FGP0316)

178 Lambert, Dr Michael (Fellow in Social Inequalities, Lancaster University) (FGP0269)

179 Lazarus, Dr J (GP, Giffords Surgery) (FGP0338)

180 Lee, Dr Jacob (GP , Horfield Health Centre) (FGP0254)

181 Lee, Mr. Paul (FGP0239)

182 Leeds Local Medical Committee (FGP0053)

183 Leeper, Dr Ken (General Medical Practice principal, Billinghay Medical Practice) (FGP0037)

184 Lees-Millais, Dr J (GP, NHS) (FGP0354)

185 Lewis, Dr Marc (GP, NHS) (FGP0365)

186 Liam, Dr (GP, Retired GP Principal, Current Locum GP & OOH GP.) (FGP0108)

187 Lighthouse Medical Practice (FGP0332)

188 Lincolnshire Local Medical Committee (FGP0036)

189 Litchfield, Dr Matthew (GP / PCN CD, University of Nottingham Health Service / Unity (Nottingham) PCN) (FGP0124)

190 Liverpool LMC (FGP0343)

191 Livesey, Dr StJohn (both a Salaried GP and a Clincial Director, Jaunty Springs Health Centre and NHS Sheffield CCG (respectivuely)) (FGP0159)

192 Iliffe, Emeritus Professor Steve (Emeritus Professor of Primary Care for Older People, University College London); and Manthorpe, Professor Jill (Director of the NIHR Policy Research Unit in Health & Social Care Workforce, Kings College London) (FGP0176)

193 London South Bank University (FGP0217)

194 Londonwide LMCs (FGP0302)

195 Lupton, Dr Susie (GP principal and PCN CD, Norwood Medical Centre, Sheffield and SAPA5 PCN); Jones, Dr Sarah (GP principal, Norwood Medical Centre); Parker, Dr Deborah (GP principal, Norwood Medical Centre); Offutt, Dr Emily (GP Principal, Norwood Medical Centre); Lawton, Dr Craig (GP principal, Norwood Medical Centre); and Kellett, Dr Harriet (GP principal, Norwood Medical Centre) (FGP0074)

196 Lyness, Dr (GP, The Hadleigh Practice) (FGP0171)

197 Macmillan Cancer Support (FGP0306)

198 Magee, Dr Lucia (GP, St Chad's Surgery) (FGP0233)

199 Mansfield, Sue (Practice Nurse, Old Town Surgery, Swindon) (FGP0113)

200 Marshall, Dr Ann (GP Partner, Wareham Surgery) (FGP0045)

201 Mason, (FGP0189)

202 Matthews, Dr Philippa (Medical Director, Islington GP Federation) (FGP0129)

203 McEwan, Dr Tom Lorne (GP, Gratton Surgery, Sutton Scotney, WInchester) (FGP0055)

204 McKenna, Dr Kate (GP Partner, Crown Heights Medical Centre) (FGP0072)

205 Medical and Dental Defence Union of Scotland (MDDUS) (FGP0341)

206 Mehra, Dr Vish (GP / Chair, Manchester GP Board); and Adab, Dr Karim (Deputy Medical Director, Manchester LCO) (FGP0353)

207 Meridian Health Group Primary Care Network (FGP0387)

208 Michael, Dr. (Private General Practitioner, GP Private) (FGP0022)

209 Mikhail, Dr (Retired GP, NHS) (FGP0026)

210 Miles, Dr Debbie (GP , Coastal Medical Partnership) (FGP0335)

211 Modality Partnership (FGP0237)

212 Moore, Dr Daniel (GP, Self-employed) (FGP0003)

213 Moore, Dr Nick (GP, Derby Road Group Practice & Health Education England) (FGP0153)

214 Morton, Dr Sebastian (Gp, Wyre Forest Health Partnership) (FGP0165)

215 Moseley Avenue Surgery, Coventry (FGP0032)

216 Mount, Dr Laura (GP and Clinical Director , Central and west warrington PCN) (FGP0379)

217 Myers, Dr J.Helen (General Practitioner, St Pauls Surgery. Winchester.) (FGP0337)

218 NHS Confederation (FGP0289)

219 NHS Providers (FGP0304)

220 National Association for Patient Participation (CIO) (FGP0199)

221 National Association of Link Workers (FGP0293)

222 National Pensioners' Convention (FGP0324)

223 National Voices (FGP0400)

224 National Voices (FGP0275)

225 New Springwells Surgery Patient Participation Group (FGP0209)

226 Noel, Mr Robin (Managing Partner, Tinkers Lane Surgery) (FGP0057)

227 North & South Essex Local Medical Committees Ltd (FGP0184)

228 Northamptonshire Local Medical Committee (FGP0314)

229 Nuffield Trust (FGP0349)

230 Nurton, Dr George (FGP0122)

231 ONeill, Dr Finola (Sessional GP, Barnstaple surgeries, North Devon) (FGP0102)

232 OneMedical Group (FGP0326)

233 Oviva (FGP0384)

234 Owen, Mrs Denise (FGP0382)

235 Paddington Green Health Centre (FGP0013)

236 Paediatric Continence Forum (FGP0271)

237 Park Lane (FGP0202)

238 Partridge, (FGP0095)

239 Peckham, Professor Stephen (Professor of Health Policy, Director Centre for Health Service Studies; Director, NIHR Policy Research Unit in Health and Social Care Systems and Commissioning; Director NIHR Applied Research Collaboration Kent, Surrey and Sussex, University of Kent/London School of Hygiene and Tropical Medicine); and Checkland, Professor Kath (Professor of Health Policy and Primary Care: Associate Director, Policy Research Unity in Health and Social Care Systems and Commissioning; and General Practitioner, University of Manchester) (FGP0147)

240 Pereira Gray, Professor Sir Denis; and Evans, Professor Philip (FGP0151)

241 Perkin, Malcolm (FGP0227)

242 Pharmaceutical Services Negotiating Committee (FGP0308)

243 Phillips, Dr Corrin (GP Partner (and Trainer), Centre Practice Fareham) (FGP0064)

244 Policy Exchange (FGP0323)

245 Porter, Dr Hugh (Clinical Director and Interim Lead , Nottingham City Place Based Partnership (previously called Nottingham City Integrated Care Partnership)); and Crowe, Dr Mike (PCN Clinical Director , Hucknall Road Medical Centre) (FGP0228)

246 Primary Care 24 (FGP0370)

247 Primary Health Properties (PHP) (FGP0394)

248 Reed, Dr Timothy (GP, Orchard Medical Practice) (FGP0073)

249 Reeve, Professor Joanne (Professor of Primary Care, Hull York Medical School) (FGP0218)

250 Reeves, Dr Margaret (Recently stepped down as GP Partner., Until 30th September 2021, of Cowley Road Medical Practice, East Oxford Health Centre, Manzil Way, Oxford OX4 1XD) (FGP0236)

251 Reid, John (Honorary Scientist, Rutherford Appleton Laboratory) (FGP0328)

252 Richards, Carrick (GP, SKC CCG) (FGP0016)

253 Richards, Dr Carrick (GP, SKC CCG) (FGP0031)

254 Richmond Medical Practice Patient Participation Group (FGP0156)

255 Rickenbach, Professor Mark (General Practitioner, Park and St Francis Surgery) (FGP0249)

256 Ridgmount Practice (FGP0270)

257 Robinson, Dr Samuel (GP Partner & Clinical Director of Minerva PCN, Combe Down Surgery & Minerva PCN Bath.) (FGP0047)

258 Roland, Professor Martin (Emeritus Professor of Health Services Research, University of Cambridge) (FGP0259)

259 Rose, Dr Alex (GP Partner and PCN Clinical Director, St Pauls Surgery) (FGP0027)

260 Ross, (FGP0198)

261 Roulstone, Mrs Roberta (Retired midwife, NHS) (FGP0182)

262 Rowland, Dr Marc (Retired GP and Chair Lewisham CCG and London CCG, Lewisham CCG and London CCG Chairs) (FGP0177)

263 Royal College of General Practitioners (FGP0363)

264 Royal College of Nursing (FGP0399)

265 Royal College of Nursing (FGP0208)

266 Royal College of Nursing (FGP0135)

267 Royal College of Occupational Therapists (FGP0123)

268 Royal National Institute for Deaf People (FGP0181)

269 Royal Pharmaceutical Society (FGP0312)

270 Ryle, Dr Cym (Locum GP, after a 33 years as a partner in an urban practice, n/a) (FGP0075)

271 Salford and Trafford Local Medical Committee (FGP0317)

272 Salmon, Dr Rebecca (GP , NHS) (FGP0082)

273 Sastry, Dr Ravi (GP Partner , Penny's Hill Practice - NHS Dorset CCG) (FGP0284)

274 Sayers, Dr Luke (GP, Whitley Bay Health Centre) (FGP0093)

275 Scott, Dr Kathryn (General Practitioner, Dorset CCG) (FGP0274)

276 Sefton Local Medical Committee (FGP0281)

277 Shah, Mrs Amita (Nurse Development Lead, Clinical Commisioning, Training Hub) (FGP0081)

278 Sharp, Ms Barbara (First Contact Practitioner, Physiotherapist, Isle of Wight NHS Trust) (FGP0142)

279 Shaw, Dr Elizabeth (GP locum, appraiser, Wiltshire and Hampshire) (FGP0059)

280 Shemtob, Dr Lara (GPST3 and Academic Clinical Fellow in General Practice , Imperial College London); Martin, Dr Martha (GPST2 and Academic Clinical Fellow in General Practice, Imperial College London); Junghans, Dr Connie (GP and Senior

Clinical Fellow, Imperial College London); Painter, Dr Annabelle (GPST2 and AI and Workforce Fellow, Imperial College London, Health Education England and NHSx); Gopal, Dr Dipesh (GP and NIHR In-Practice Fellow, Queen Mary University of London); and Razai, Dr Mohammad (GP and NIHR In-Practice Fellow, St George's University of London) (FGP0222)

281 Sherlock, Dr William (FGP0087)

282 Shoreham and Southwick PCN; Arun Integrated Care PCN; Central Worthing PCN; Regis PCN; Chanctonbury PCN; Coastal and South Downs Partnership PCN; Cissbury Integrated Care PCN; Angmering Coppice & Fitzalan PCN; CHAMP PCN; and Lancing & Sompting PCN (FGP0090)

283 Sidaway-Lee, Dr Kate (Research Fellow, St Leonard's Practice, Exeter) (FGP0213)

284 Smith, Dr Laura (GP Partner, Elm Tree Surgery); Campbell, Dr Francis (GP Partner, Elm Tree Surgery); and Downing, Dr Abigail (GP Partner, Elm Tree Surgery) (FGP0226)

285 Smith, Dr Simon (GP partner, Whiteparish surgery) (FGP0042)

286 Somerset Local Medical Committee (FGP0125)

287 Speakman, Dr Helen (FGP0231)

288 Specsavers Group (FGP0100)

289 Spooner, Dr S (Clinical Lecturer, University of Manchester) (FGP0175)

290 Spooner, Mrs Ann (Practice Manager, Stockbridge Surgery) (FGP0021)

291 Spoonley, Neil (FGP0376)

292 St Chads Surgery; and 3 Valleys Health PCN (FGP0205)

293 St Mary's Surgery, Timsbury (FGP0240)

294 Staffordshire Training Hub (FGP0294)

295 Staveley, Dr Imogen (FGP0211)

296 Stocker, Dr John (GP Locum exPrincipal In General Practice, General practicer Locum ltd) (FGP0046)

297 Stockport Local Medical Committee (FGP0253)

298 Sue Ryder (FGP0369)

299 Syed, Dr. Zishan (GP , Mote Medical Practice) (FGP0162)

300 Symphony Healthcare Services (FGP0321)

301 The Avenue Surgery Warminster (FGP0195)

302 The Barcroft Medical Practice (FGP0285)

303 The Chartered Society of Physiotherapy (FGP0372)

304 The Drayton Surgery (FGP0260)

305 The Group Practice at River Place (FGP0224)

306 The Health Foundation (FGP0396)

307 The Health Foundation (FGP0141)

308 The Healthcare Improvement Studies Institute (FGP0215)

309 The King's Fund (FGP0359)

310 The Middlewood Parnership (FGP0166)

311 The New Springwells Practice (FGP0197)

312 The Patients Association (FGP0133)

313 The Practice Management Network (FGP0295)

314 The Simpson Centre and Penn Surgery (FGP0250)

315 The Society for Academic Primary Care (FGP0234)

316 Thomas, J Meirion (FGP0389)

317 Thompson, Dr (FGP0348)

318 Thorp, Dr Russell (The Old Links Surgery) (FGP0019)

319 Thurleigh Road Practice; Dr Ismat Nasiruddin; Dr Catherine Ellis; Dr Jonathan Christopher; Dr Eva Liu; Mrs Tor Godfrey; and Mrs Sandra Reeves (FGP0371)

320 Thurleigh Road Patient Participation Group (FGP0083)

321 Tindell, Mr David (FGP0194)

322 Togher, Dr Bryan (GP, Priory Road Medical Centre, part of Wyvern Health Partnership) (FGP0109)

323 Tresidder, Dr Andrew (Clinical Lead South West, NHS Practitioner HEalth) (FGP0204)

324 Trueman, Dr Richard (GP Principal, Crown Heights Medical Centre) (FGP0264)

325 Tuppen, Dr Jon (Just Retired Principle GP. , Derby RoaD sURGERY .iPSWICH) (FGP0168)

326 UCL Partners Academic Health Science Network (FGP0393)

327 UK Faculty of Public Health (FGP0261)

328 UK Health Coaches Association (FGP0309)

329 University of Bristol (FGP0390)

330 University of Exeter Medical School; and Sussex NHS Commissioners (FGP0191)

331 University of Manchester - Centre for Primary Care (FGP0187)

332 Urgent Health UK (FGP0263)

333 Urology Trade Association (FGP0280)

334 Vidovic, Dr Dragana (Senior Research Officer, University of Essex); and Yannitell Reinhardt, Professor Gina (Professor , University of Essex) (FGP0279)

335 Voorhees, Dr Jennifer (National Institute of Health Research (NIHR) Clinical Lecturer, University of Manchester); Checkland, Dr Kath (Professor of Health Policy and Primary Care, University of Manchester); and Hammond, Dr Jonathan (Research Fellow, University of Manchester) (FGP0330)

336 Ward, Dr Alastair (General Practitioner, Wareham Surgery) (FGP0131)

337 Ward, Dr Roisin (GP partner, The Clift Surgery, Bramley) (FGP0004)

338 Warrington, Dr Rachel (FGP0241)

339 Warwickshire Local Medical Committee; and Coventry Local Medical Committee (FGP0066)

340 Watts, Emma (Doctor, Shere Surgery & Dispensary) (FGP0373)

341 Wessex Local Medical Committees Ltd - Hampshire & IOW Local Medical Committee; Dr Jon Evans (Chair, Wessex Local Medical Committees Ltd - Dorset Local Medical Committee); and Dr Anthony Downey (Chair, BSW Committee Chair/Wessex Local Medical Committees Ltd - Bath & North East Somerset, Swindon & Wiltshire (BSW) Local Medical Committee) (FGP0178)

342 Whitaker, Dr Phil (Senior Partner, Westfield Surgery) (FGP0119)

343 Whittle, Mrs Jenny (Practice Manager, Wareham Surgery) (FGP0138)

344 Williams, Dr Mark (GP Partner, Testvale Surgery) (FGP0340)

345 Winchester Rural N&E PCN (FGP0051)

346 Winchester Rural North and East Primary Care Network (FGP0030)

347 Wolstanton Medical Centre (FGP0107)

348 Wong, Dr Toh (General Practitioner (Senior Partner), Westbank Practice) (FGP0099)

349 Woods, Dr Anne (GP Partner, Old School Surgery) (FGP0143)

350 Worcestershire Local Medical Committee (FGP0020)

351 Wright, Dr Catrinel (FGP0243)

352 Wright, Dr Stuart (GP, Bridgnorth Medical Practice) (FGP0009)

353 Zoom (FGP0265)

354 eConsult (FGP0120)

355 Swallow, Dr Joanna (GP Partner, The Porch surgery and HEE) (FGP0128)

356 Wilde, Doctor James (GP, Moordown Medical Centre) (FGP0144)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2022–23

Number	Title	Reference
1st	Pre-appointment hearing for the Government's preferred candidate for the role of Patient Safety Commissioner	HC 565
2nd	The impact of body image on mental and physical health	HC 114
3rd	Workforce: recruitment, training and retention in health and social care	HC 115
1st Special	Cancer Services: Government Response to the Committee's Twelfth Report of 2021–22	HC 345
2nd Special	Government Response to the Expert Panel's Report on Government commitments in the area of cancer services in England	HC 346
3rd Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce in England	HC 112
4th Special	The treatment of autistic people and people with learning disabilities: Government Response to the Committee's Fifth Report of Session 2021–22	HC 631

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and people with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96
8th	Children and young people's mental health	HC 17
9th	Clearing the backlog caused by the pandemic	HC 599
10th	Pre-appointment hearing for the position of Chair of NHS England	HC 1035

Number	Title	Reference
11th	Pre-appointment hearing for the position of Chair of the Care Quality Commission	HC 1091
12th	Cancer services	HC 551
13th	NHS litigation reform	HC 740
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18
2nd Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England	HC 612
3rd Special	Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report	HC 1125
4th Special	Expert Panel: evaluation of the Government's commitments in the area of cancer services in England	HC 1025

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311