House of Commons Health and Social Care Select Committee: Clearing the backlog caused by the pandemic

September 2021

The RCGP is the largest membership organisation in the UK solely for GPs. Founded in 1952, it has over 54,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The RCGP is an independent professional body with expertise in patient-centred generalist clinical care.

What is the anticipated size of the backlog and pent-up demand from patients for different healthcare services including, for example, elective surgery; mental health services; cancer services; GP services; and more widely across the healthcare system?

1. GPs and practice teams have played a pivotal role throughout the COVID-19 pandemic. Practices have remained open to continue to provide care to patients and have taken a central role in the COVID-19 Vaccination programme. RCGP analysis of NHS England COVID-19 vaccination statistics and NHS Digital Appointments in General Practice to the end of July 2021 suggests that roughly 59% of vaccines having been delivered in general practice.[i] [ii]

2. The pandemic has shifted how GP care is delivered and is likely to have significant implications for future patient demand, both of which are not yet completely understood in terms of GP workload, and further research and evaluation will be needed. It is important to note that prior to the pandemic, GP services were already extremely over-stretched. This was acknowledged in the Conservative Party's 2019 manifesto, which specifically highlighted the need for at least 6,000 GPs and 26,000 other staff to deal with growing demand.[iii]

3. The pandemic has had considerable impact on the activity in general practice and this has fluctuated at different stages of the emergency period. From April 2020 to March 2021 inclusive, data from NHS Digital suggests that general practice delivered 275 million consultations in England. In the same period a year earlier (April 2019 to March 2020) it delivered 310 million, demonstrating that there has been roughly an 11% reduction of consultations.[iv] There are a range of factors that have contributed to this drop. Early on in the pandemic, a high proportion of patients put off accessing care due to the suspension of routine GP services, infection concerns and patients not wanting to trouble their GP or burden the NHS.[v] [vi] Activity recovered relatively quickly as the sector responded with a complete reorganisation of its delivery model, to ensure patients would only be seen face to face where clinically necessary - in line with national infection protocol guidance – however, activity remained below pre-pandemic levels. While organisations like the RCGP put out clear messaging that general practice was open, and that patients might need to talk to a clinician remotely first or instead, the message took some time to reach patients.

4. If we were to assume this 11% of missing consultations are essential, this implies that there may be around 35 million missed consultations that remain to be carried out. This is due to a number of factors including patient behaviours, as outlined in point 3, with many patients having chosen to stay at home due to infection concerns, while some have chosen not to seek care as they did not want to burden the NHS at a time of crisis.

5. Comparing referral rates between mid-March 2020, when the first lockdown was implemented, and January 2021 with referral rates in the same period 12 months earlier (March 2019 to January 2020), suggests that referral numbers were approximately a third lower for this period than usual. [vii] There are a range of factors behind this drop, including the reduction in consultations overall as explored above. Feedback from our members also suggests that some GPs may have been less likely to make non-urgent referrals where lists were closed or too long in secondary care, so other options were explored in the interim to ensure patients got the care they need. This leads us to believe that general practice is caring for a number of patients currently, who would otherwise have moved on in the system for specialist treatment. There will also be a proportion of patients who may not yet be known to the health service, because they haven't accessed care yet, but whom may still need a referral to specialist care in the future, however the numbers are unknown. Data from the Health Foundation shows that 6 million fewer patients started treatment pathways in 2020 than in 2019. [viii] While some of these patients will have come forward for treatment since January 2021, others will not have done so, meaning there will be some demand which has yet to enter the system, the scale of which will not be clear for some time.

6. Looking at annual rates of referral per person, this data suggests that over a 12-month period there were over 300,000 fewer 2-week referrals, 230,000 fewer urgent referrals and 4.9 million fewer routine referrals. In all, about 5.44 million fewer referrals. [ix] If all these referrals need to be caught up on, over a year this would mean general practice making an additional 100,000 referrals per week, on top of the usual 300,000 per week.

7. On top of this, GP services are managing care for those on waiting lists for secondary care. As of August 2021, 5.6 million people were waiting for elective care and 1.3 million people were waiting for diagnostics.[x] This additional workload from secondary care isn't static and continues to grow, putting even further pressure on general practice. It's very likely that with GP services dealing with 18 months of backlog, in addition to ongoing, appointments as usual and any workload that is added on as a result of the winter months, general practice will be pushed beyond its breaking point if the workload and workforce pressures are not urgently addressed.

What capacity is available within the NHS to deal with the current backlog? To what extent are the required resources in place, including the right number of staff with the right skills mix, to address the backlog?

8. It's essential to reiterate that even prior to the COVID-19 pandemic, and therefore prior to the 18-month backlog that primary care is currently managing, the GP workforce was depleted.

9. Targets to deliver more GPs continue to be drastically missed. We simply do not have enough GPs to meet the needs of a growing and ageing population, with increasingly complex needs, on top of managing the fallout from the pandemic. This includes increasing numbers of people experiencing 'long COVID' and mental health issues.[xi]

10. A high number of GPs are quitting the profession and we expect this problem to be exacerbated by the pandemic. A recent RCGP survey found that 34% of GPs expect to leave the profession within 5 years,[xii] which could lead to the loss of over 14,000 GPs to the workforce.[xiii]

11. NHS Digital has been keeping track of the GP workforce in England since September 2015. Despite commitments from the Government, GP workforce has declined – the number of qualified full time equivalent (FTE) GPs in England now stands at approximately 27,900. This is more than 1,500 (5.2%) fewer than in 2015.[xiv]

12. NHS Digital workforce data records are based on hours worked, 1 full time equivalent (FTE) being equivalent to 37.5 hours, and this does not tell us how much of this is direct clinical time. The GP work life survey shows that relative to the hours worked, GPs are delivering fewer clinical sessions now than in the past.[xv] This suggests that resource is being taken away from clinical sessions to do administrative work. This means that the number of sessions available to treat patients is declining at a more rapid pace than the FTE measure in hours implies. Set against this shrinking workforce, the population of England has grown about 4% since 2015.[xvi] As a result, there is now one FTE GP per 2,045 patients, this is an increase of 182, or 9.7% in six years.[xvii] It is likely that overall demand is being further exacerbated by the ageing population too.

13. As well as additional GPs, many more staff in the wider practice are urgently needed in order to help relieve workload pressures, and provide the most appropriate patient care. This includes nurses, as well as other key staff such as Pharmacists, Physiotherapists, Physician Associates, Mental Health Therapists and Social Prescribing Link Workers. The Government has rightly committed to delivering 26,000 additional clinical staff through primary care networks by 2024, although nurses cannot be recruited through this scheme - who are also in major shortage. Based on NHS Digital data, we estimate that approximately 8,400 staff have been recruited through PCNs between March 2019 and June 2021.[xviii] This increase in numbers is very welcome, but it falls short of providing the additional support general practice needs now, and the PCN funding scheme places unhelpful and arbitrary barriers on which staff can be recruited. Additionally, these staff cannot replace GPs. Rather they complement GPs, working with them to support patients, and proving skills within their own scope of practice.

14. In short, we did not have the required resources, particularly sufficient staff with the right skills mix, to address healthcare requirements prior to the pandemic, let alone in 2021 with an increased population, the ongoing Coronavirus pandemic and an 18-month backlog.

15. However, it's important that we emphasise it is not just about numbers, it's essential that primary care staff are equipped to do more through the provision of sufficient training, actions to boost morale and actively valuing their contributions to public health. Despite remaining open throughout the pandemic and continuing to deal with unsustainable workload in addition to understaffed practices, GPs have been subject to significant critique in the media and by the public. Front pages are damaging to hardworking GPs and this has a knock-on effect on staff morale. It is impossible to separate morale with dealing with the current backlog as a valued, respected workforce will always be willing to do more, when compared to an overworked, understaffed workforce that continue to be heavily criticised.

16. It must also be noted that introducing additional staff to general practice is not an instant-ready solution. Staff joining general practice for the first time will need training and support to integrate effectively into general practice. This is particularly important for many of the new roles funded through Primary Care Networks (PCNs), as staff in these roles may not have other people with experience of doing that job to turn to for advice and support. Inevitably, this means it is experienced GPs, nurses and other practice staff who must find the time to support new staff entering the practice, at a time when they are already under unprecedented pressure. It is therefore vital that PCNs are properly resourced to provide this training and support, so that new roles can rapidly

begin to add value and support patients, including those being treated in primary care, and those being supported while on waiting lists elsewhere in the system.

How might the organisation and work of the NHS and care services be reformed in order to effectively deal with the backlog, in the short-term, medium-term, and long-term?

17. To address staffing shortages in general practice over the long to medium-term, we are calling on the government to implement the key recommendations outlined in our action plan for general practice - General Practice in Crisis: An Action Plan for Recovery.[xix]

18. The Government must ramp-up efforts to deliver the 2019 Conservative manifesto target of 6,000 more FTE GPs before 2024 by:
    - Establishing an independent and authoritative NHS workforce planning body, to ensure that the healthcare system has the workforce it needs to meet growing demand and tackle health inequalities.
    - Allocating sufficient recurring funding for GP training in Health Education England's budget for at least 4,000 GPs per year, expanding towards 5,000 as soon as possible, to enable longer-term planning of training activity.
    - Developing a new GP retention strategy, reviewing, and revamping local and national retention schemes and approaches (for example by supporting agile working) and expanding access so that all GPs can be supported to remain in the workforce.
    - Invest in high-quality professional development opportunities for GPs through local 'training hubs' and provide back-fill funding for their development time.

19. A system-wide programme to eradicate unnecessary general practice workload by 2024 must be undertaken, to allow GPs more time to care and prevent GP burnout. This should include:
    - Implementing light-touch and risk-based regulatory models, reducing paperwork, and reporting requirements, enabling GPs to focus on delivering patient care.
    - Overhauling contractual requirements, such as QOF, in order to focus on high trust approaches to assuring high-quality care, with low administrative requirements.
    - Moving ahead with long overdue regulatory changes to allow more staff in the wider practice team to prescribe medications or sign fit notes for patients under their care, where this fits within their areas of competence.
    - Preventing workload being shifted from one part of the NHS to another unnecessarily. This needs to include improving communication and data flows between primary and secondary care, so that IT systems in one part of the NHS can talk to another.

20. At least 26,000 other members of staff must be recruited and properly integrated into the general practice workforce by 2024 by:
    - Improving the flexibility of the additional roles reimbursement scheme (ARRS) to facilitate employment across Primary Care Networks (PCNs) and increase support for proper integration of staff across practices.
    - Providing resources for adequate supervision and mentoring of new practice staff.
    - Improving access to structured training and induction programmes for these additional roles in general practice, drawing on the success of programmes such as 'Clinical Pharmacists in General Practice'.
    - Significant improvements should be made to support delivery of the New to Practice Scheme for nurses.

21. In order to effectively deal with the backlog in the short-term, it is essential that the resource, workload and workforce gap is addressed where possible, with urgency.

How much financial investment will be needed to tackle the backlog over the short, medium, and long-term; and how should such investment be distributed? To what extent is the financial investment received to date adequate to manage the backlog?

22. **Investment in training more staff:** In order to ensure GP services are well-staffed and resourced, the government must allocate sufficient funding for GP training in Health Education England's (HEE) budget for at least 4,000 GPs per year, estimated to cost £181 million per year. The following must therefore be considered:
    - Further expansion of the GP training capacity to 5,000 places per year, a sustainable funding settlement for undergraduate GP education, expansions of programmes to train more GPs in under-doctored areas and investment in education and training for the wider practice team, would take this total to £255 million per year.[xx]
    - While the Comprehensive Spending Review 2020 delivered a one-off budget uplift of £260 million for HEE, this was to cover all commitments (not just general practice), and as a single-year settlement, did not provide certainty to enable long-term planning. It is therefore vital that a sufficient, recurrent settlement is reached, which will enable a sustainable recovery of training capacity post-pandemic.

23. **In addition to training the future workforce, funding must also be provided to support GPs to remain in practice for as long as possible:** We are calling on the government to:

    - Review national retention strategies to ensure that they are flexible and meet the needs of a wide range of GPs, to keep as many GPs as possible in the workforce over the next few years.

    - Ensure funding for retention is ringfenced, rather than drawn from baseline funding, in order to prevent a "post-code lottery" in support. As of June 2021, 19 Clinical Commissioning Groups were not supporting any GPs through the national retention scheme, while 18 CCGs had at least ten retainers.

    - Provide additional funding within that ring-fence, to underpin an expanded retention strategy. The current national retention scheme supports around 600 GPs to remain in the workforce part-time, yet 14,000 GPs may be at risk of leaving the workforce within the next five years (or 2,800 a year) as found in our survey data outlined above. The current level of support could be provided annually to 2,800 GPs at a cost £56 million, while a broader, more flexible scheme could potentially support more GPs.

    - A comprehensive, state-backed occupational health service would support GPs and their teams to continue working while protecting their health as general practice recovers from the pandemic. We estimate this would cost £10 million per year

24. While we recognise that clearing the backlogs in elective care, diagnostics, cancer and other specialist areas requires investment, GPs are also being asked to do more, and this must be properly resourced. Good general practice can address health problems before they become urgent, which is better for patients, reduces pressures on secondary services and is more cost effective. But without proper support and funding, this service will not be able to deliver.

25. **Investment for better infrastructure:** The RCGP has consistently called for increased investment in digital infrastructure within general practice over the last few years - as outlined in our Digital Technology Roadmap published in 2019.[xxi] The need for this has become even more pressing in the light of the pandemic and seems to have been well received by patients as data suggests the vast majority of the public have had positive experiences of the increased use of technology for health during the COVID-19 pandemic.[xxii] High speed internet access, modern hardware and up to date software, access to laptops and remote log ins (particularly for locum staff), are therefore critical to ensuring GPs can continue to provide high-quality care for patients, many of which have appreciated the convenience of being able to access remote consultations. Further research, evaluation and support to practices must also be conducted about triage models and how to implement a system that works for practices and their patient population. This should include supporting shared decision-making between a patient and practice staff about the mode of consultation.[xxiii]

26. According to a recent RCGP survey, at least a third of GP premises are not fit for purpose, 90% of which are not able to accommodate the expanding staff team,[xxiv] and practice teams do not have adequate digital tools to deliver high-quality patient care. In order to effectively tackle the backlog, we are calling on the government to ensure infrastructure within general practice is fit for purpose by 2024. To allow GPs to deliver care, in a safe way using reliable technology, the government must:

    - Invest £1 billion to make general practice premises fit for purpose including sufficient space to accommodate expanded multidisciplinary teams, and deliver digitally-enabled remote care.

    - Ensure GPs and wider teams have access to the tools, training, guidance and support in routinely using digital tools in their practice.

What positive lessons can be learnt from how healthcare services have been redesigned during the pandemic? How could this support the future work of the NHS and care services?

27. Requirements around administration were significantly eased in general practice during the COVID-19 pandemic, allowing GPs and practice staff more time to focus on patients. Practices were also given the freedom to trial new methods of working with an additional understanding that these methods may or may not work. Introducing this permissive environment to innovate had a positive impact on practices and created incentives for further innovation, resulting in better ways of working for both staff members and patients. Some of the points outlined below form part of the key findings from the RCGP's report, General practice in the post Covid world, published in July 2020.[xxv]

28. **The burden of bureaucracy**
    - The beginning of the pandemic saw a pause on all administrative tasks that were not immediately necessary, to enable GPs to prioritise clinical needs of patients while changing practice in light of COVID19. As we moved away from the initial stages of the pandemic, some necessary bureaucracy has rightly resumed. However, as we work to address the backlog of care, the need to reduce unnecessary administrative demands is more important than ever.
    - DHSC and NHSE commissioned a review of bureaucracy for GPs as part of a commitment in the 2020 GP contract. This review had a limited focus on work already happening to reduce some centrally driven processes but has done nothing to address the underlying causes of an overly bureaucratic system.

- Government and NHSE must undertake longer term national programmes to eradicate unnecessary general practice workload at all levels.
    - Implement light-touch and risk-based regulatory models, and reduce paperwork and reporting requirements, enabling GPs to focus on delivering patient care.
    - Overhaul contractual requirements, particularly QOF in England, in order to focus on high trust approaches to assuring high-quality care, with low administrative requirements.
    - Move ahead with long overdue regulatory changes to allow more staff in the wider practice team to prescribe medications or sign fit notes for patients under their care, where this fits within their areas of competence.
- Work is also needed to prevent workload being shifted from one part of the NHS to another unnecessarily. This needs to include improving communication and data flows between primary and secondary care, so that IT systems in one part of the NHS can talk to another.
- There must be a clear commitment that all clinical activities prescribed through national or local guidance, or in contractual terms, are evidence-based and benefit patients.

29. NHS and local authority volunteers

- A good example of redesigned healthcare services resulting in positive lessons during the pandemic is the new cohort of NHS and local authority volunteers that were recruited to provide support for patients on shielded lists as well as other vulnerable groups, e.g. elderly and housebound people. Volunteers have helped vulnerable patients who have had to self-isolate at home with shopping, collecting and delivering prescribed medicines and by providing emotional support and much needed social contact over the phone or online. In this way, primary care has played a vital role in and mitigating the potentially damaging risk of increased social isolation during lockdown.[xxvi]
- A plan is needed for how we better support and find new opportunities for local health and care volunteers to contribute to their communities.

30. Innovation in general practice

- General practice is hugely innovative and GPs are continually looking at ways to improve efficiencies and patient care, despite extremely challenging time and resource pressures. One example of this is the work that many practices carried out to support those who are homeless during the pandemic.[xxvii] Although this work is not currently resourced properly in general practice, many practices found innovative ways to ensure people could access care, regardless of their living situation. This type of activity should be better supported looking forwards.

31. Remote and digitally enabled patient care

- Remote and digitally enabled patient care have been important elements of general practice for some time, but they were rapidly expanded at the outset of the pandemic to protect patients, their carers and healthcare staff from risks of infection. Alongside the widespread use of remote consultations, new models for 'triage' including digital platforms were rapidly rolled out to support screening patients for potential COVID-19 symptoms, to triage patients' needs, and to determine how, and by whom, these can best be met. These formed a key part of the 'total triage' model that was set out in national guidance for general practice and adopted across the country, which also included telephone and other methods for screening and signposting patients.[xxviii]

- Remote consultations will remain an important way of delivering general practice services in the future, both as we continue to manage COVID-19 and more generally, but as we look beyond the pandemic, we expect a rebalancing between face-to-face and remote consultations. Face-to-face appointments will always remain a major element of general practice, and remote consultations will continue to be delivered where appropriate and useful. Given the speed and scale at which new systems were implemented in some areas to deal with COVID-19, there have understandably been some kinks that need to be worked out. Further research, evaluation and support to practices must also be conducted about triage models and how to implement a system that works for practices and their patient population. This should include supporting shared decision-making between a patient and practice staff about the mode of consultation.[xxix]

How effectively has the 111 call-first system for A&E Departments been? What can be done to improve this?

32. A key component of the Covid-19 Response Service is the COVID-19 Clinical Assessment Service (CCAS). The CCAS offers a clinical review to the assessment of patients presenting with Covid-19 symptoms following their use of NHS111.[xxx]

33. GP's are required to deliver this service and must provide 1 in 500 slots for calls from 111 to book in to. Though this works well for the system to spread workload, in an attempt to reduce pressures on A&E, this has added further workload for GPs and therefore additional pressure on primary care to deliver care on behalf of secondary care services.

34. Though one of the cohorts targeted for recruitment to CCAS were retired GPs, according to data from NHS Digital, only 35% of the CCAS GP workforce was aged 60 or above and some of these were still active in the NHS GP workforce. The data also shows that between March 2020 and March 2021, 581 GPs involved with CCAS were already working in general practices and continued to work in their practices, delivering substituted or additional hours for CCAS. 114 other GPs were also based in hospitals, such as within A&E departments, while 406 GPs working for CCAS can also be seen to have been working in other community-based settings such as walk-in centres, out-of-hours services or other specialist provision. [xxxi]

35. It is difficult to determine how effective the 111 call-first system has been for A&E Departments, as although we understand an evaluation into the pilots has been carried out, it is yet to be published. We are calling on NHSEI to publish this research in order to better understand how effective the 111 call-first system has been.

What can the Department of Health & Social Care, national bodies and local systems do to facilitate innovation as services evolve to meet emerging challenges?

36. According to a recent RCGP survey, at least a third of GP premises are not fit for purpose, 90% of which are not able to accommodate the expanding staff team, and practice teams do not have adequate digital tools to deliver high-quality patient care.[xxxii] We are calling on the government to ensure infrastructure within general practice is fit for purpose by 2024, to allow GPs to deliver care, in a safe way using reliable technology by:

    - Investing £1 billion to make general practice premises fit for purpose including sufficient space to accommodate expanded multidisciplinary teams, and deliver digitally-enabled remote care.

- Ensuring GPs and wider teams have access to the tools, training, guidance and support in routinely using digital tools in their practice.

37. General practice is hugely innovative and GPs are continually looking at ways to improve efficiencies and patient care, despite extremely challenging time and resource pressures. One example of this is the work that many practices carried out to support those who are homeless during the pandemic.[xxxiii] Although this work is not currently resourced properly in general practice, many practices found innovative ways to ensure people could access care, regardless of their living situation. This type of activity should be better supported looking forwards.

To what extent is long-covid contributing to the backlog of healthcare services? How can individuals suffering from long-covid be better supported?

38. Dealing with health-related issues relating to the COVID-19 pandemic has very much shifted from being primarily secondary care focused to more people being unwell in the community, with those in primary care, particularly GP's, responsible for managing patients experiencing these issues.

39. Data from the Office of National Statistics (ONS) shows that there are increasing numbers of patients with disease lasting longer than 12 months, with an estimated 380,000 people with symptoms over 12 months.[xxxiv] These patients will be based in primary care and will go through initial review, investigations, and tests, of which there is an existing mounting back log and waiting times for. Patients will then be referred to a clinic, if there is one, and whilst waiting for the clinic, remain the responsibility of primary care. For context, the waiting times before being seen by a clinic at this stage typically last several weeks, if not months. Patients then remain under primary care through treatment and are discharged back to GPs.

40. To address the expected challenges associated with long-covid, the RCGP are calling on the government and healthcare systems to:
    - Increase investment in community rehabilitation services, and ensure they are integrated across primary, community and secondary care. This will need to include training for rehabilitation workers to upskill practitioners.
    - Improve direct access for general practice to tests and investigations in the community relating to long-covid, so that practices can better support patients who are showing possible symptoms of post-acute covid.

41. Finally, in addition to the existing workload and workforce challenges outlined throughout our response, GPs are also dealing with the pressures of managing health-related issues as a result of long-covid, and the backlog. GP workload has become unsustainable and is having a significant impact on healthcare staff with a recent survey conducted by the RCGP suggesting that just over 60% of GPs have seen their mental health deteriorate significantly in the last year.[xxxv] The RCGP urge the government to act now, to tackle the workforce and workload challenges in general practice - the nations front door to the NHS - to enable GPs to continue doing what they do best - ensuring high quality care for patients.

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