All-Party Parliamentary Health Group: Call for Evidence 2026

APPG for Health – Inquiry on Improving Access to Primary Care

Call for Evidence Overview

Primary care services remain the cornerstone of NHS provision but face significant and intensifying access challenges, driven by increased patient demand, persistent workforce shortages, inadequate funding, and stark regional disparities.

Robust evidence consistently identifies persistent workforce shortages, outdated infrastructure, patchy digital integration, structural health inequalities and barriers to access, and inconsistent funding streams as primary obstacles to effective service provision.

This inquiry into access to primary care by the All-Party Parliamentary Health Group (APHG) will critically assess and identify further actions required to ensure primary care becomes sustainably accessible, equitable, and responsive to the evolving needs of the UK population.

The inquiry aims to deliver evidence-based policy recommendations to ensure equitable, efficient and sustainable access to primary care including general practice, community pharmacy, dentistry, and optometry by 2035, in alignment with the Government's 10-Year Health Plan. This inquiry will develop a strategic recommendation that provide coordinated policy solutions, capable of delivering lasting improvements in primary care that transcend electoral cycles.

The inquiry is co-chaired by cross-party parliamentarians:

Dr Simon Opher MP (Labour), Jess Brown Fuller MP (Liberal Democrats), Lord Kamall (Conservative) and Sadik-Al Hassan MP (Labour)

Inquiry sponsors

The APHG's inquiry into improving access to primary care services is kindly being headlined sponsored by the Institute for Public Health and Wellbeing at the University of Essex and co-sponsored by Assura.

Policy Connect provides the secretariat services for the All-Party Parliamentary Health Group.

Instructions

Policy Connect is gathering evidence through ongoing roundtable sessions, interviews with expert stakeholders, and this written Call for Evidence. **We appreciate that you may prefer to respond only to the questions that align with your area of expertise.**

The questions are grouped into the following themes:

Theme 1. Reducing Health Inequalities and Access Barriers

Theme 2. Harnessing Digital Transformation and System Integration

Theme 3. Securing Long-Term Sustainability in Primary Care

- **Funding**
- **Commissioning & Contract Reform**
- **Estates**
- **Workforce**

Theme 4: Additional considerations

Please feel free to send any additional evidence or information that might support our inquiry but has not been covered in our research questions (please do this by attaching a separate document to your email in either Microsoft Word or PDF format). **We particularly welcome papers, datasets, evaluation reports, case studies demonstrating effective practices or highlighting persistent challenges. We also welcome opinions on specific policy interventions that will benefit the improvement of accessing primary care services**

The deadline for submission of evidence is 11:59PM on 27 February 2026. Evidence should be submitted to: PC.Health@policyconnect.org.uk

Case study templates

If you are providing an example of an initiative, please use the case study template below to structure your response. This may include implemented initiatives with measurable outcomes or proposed/planned initiatives with anticipated benefits and evidence base for expected impact. You may also attach supporting evidence such as reports, datasets, or evaluations.

- **Title & context:** Setting/region; profession(s); sector(s); population group(s)
- **Problem & baseline:** Barrier(s), challenges and starting metrics
- **Intervention/programme/initiative:** What changed; delivery partners; cost/resources; timeline; regulatory/funding context
- **Outcomes:** Quantitative results (before/after); qualitative feedback (learners/educators/managers); external validation if any
- **Enablers & risks:** What made it work; risks/unintended effects; mitigations
- **Scalability & transferability:** What's needed to scale or replicate elsewhere (people, funding, approvals, data, policy changes)
- **Contacts & evidence:** Named contact; data sources; links to documents

For more information about Policy Connect, the APPG for Health or this inquiry, please visit our website or contact the research lead jasmin.adebisi@policyconnect.org.uk

Research Questions

Theme 1. Reducing Health Inequalities and Access Barriers

1) What patient-centred indicators (experience, continuity, clinical outcomes etc.) should define "good access" across:
   a) General Practice,
   b) Community Pharmacy,
   c) Dentistry, and
   d) Optometry?

The Royal College of General Practitioners (RCGP) supports a definition of "good access" that is patient-centred, focuses on outcomes and fosters continuity of care, rather than driven primarily by speed of access or GP appointment volume. Defining "good access" should reflect whether patients have access to the right care, from the right professional, at the right time, in a way that improves patient outcomes and experiences.

The current political focus from the Government places a disproportionate emphasis on measuring rapid access to GP appointments. The public expectation and operational pressure towards short-term access targets that measure activity rather than value and outcomes, means that equivalent attention isn't given to continuity or quality of care which are highly valued by patients, and have significant benefits for the NHS generally. Over-prioritising rapid access targets and incentives risks introducing perverse incentives into the system, for both practices and patients and may unintentionally undermine quality, continuity, and professional judgement. For example, where same-day access is closely linked to the classification of clinical urgency, it is predictable that patients will frame concerns in ways they believe will secure timely care. This may also risk exacerbating health inequalities, as patients with greater health literacy, confidence, or resources may be better able to navigate or influence access pathways.

Good access is as much about being able to see one's preferred clinician, as it is about how quickly an appointment can be made. Relational continuity allows clinicians to build trusting relationships with patients, particularly those with complex health needs who need frequent treatment. Seeing the same patient on multiple occasions gives clinicians a greater holistic picture of their overall health, which can make taking preventative measures easier, allowing them to treat conditions before they have a chance to develop.

Relationship-based care is not just a 'nice to have', there is substantial evidence that the relational aspects of care – continuity, therapeutic relationships and person-centred care – offer tangible benefits to patients, GPs and to the wider health system. Research literature shows that continuity is strongly associated with increased patient satisfaction and experience,[i] while a person-centred care approach also appears to have positive effects on patient satisfaction.[ii] Patients' perceptions of their GP's ability to empathise have also been shown to be important,[iii] in particular their ability to respond to their patients' health-related concerns,

and to demonstrate that they understand the patient's problem, regard it as valid and that they are committed to finding a solution. Patients want to know that clinicians will engage emotionally – research has found that they look for clues to reassure themselves of their care-givers' competence and caring.[iv]

The GP partnership model, and the continuity of care it enables, are strongly associated with better patient experience and greater system efficiency. The Government's own review identified the partnership model as a 'cost-effective delivery model' that 'supports and enables continuity of care'[v]; and the Institute for Government found that GP partners are the members of staff associated with the largest increases in patient experience satisfaction, appointments and achievement against QOF targets.[vi] However, access, quality, and continuity ultimately depend on sufficient GP capacity, and urgent investment to recruit and retain more GPs remains one of the most important priorities.

A system which does not incentivise a well-rounded definition of "good access" risks promoting transactional care, undermining relationship-based care, and weakening long-term outcomes. To improve outcomes and efficiency, we must look at the whole person and care pathway, rather than focusing solely on the first point of contact.

Access metrics must therefore be redesigned to reward high-quality, relationship-based care, with continuity and patient experience treated as core measures of good access.

2) What population groups remain under-represented or face significant barriers in accessing primary care services, why do these barriers occur and in which regions are they most prevalent? Please outline the contributing factors, together with any evidence of effective approaches that have improved access for these groups.

Certain population face significant barriers to access primary care, with this pattern most pronounced in areas of socioeconomic deprivation. These groups are termed by the NHS as "inclusion health groups".

The RCGP's 'Breaking the Inverse Care Law' report highlights that practices in the most deprived communities often care for substantially more patients with greater complexity yet receive proportionately less funding and resources. Practices in the poorest areas have 14.4% more patients per fully qualified GP compared to wealthy areas,[vii] but receive 7% less funding after accounting for the additional needs of the population.[viii] This leads to poorer access to care and poorer outcomes for the patients who often need care the most.

This structural inequity reflects the broader inverse care law, that those with greatest need have the least access. As detailed in our report, registration and appointment booking processes, digital exclusion, lack of continuity of care and workforce shortages disproportionately disadvantage elderly patients, people in rural communities, and inclusion health groups, while digital pathways can exacerbate exclusion where non-digital alternatives are not maintained.[ix]

Barriers in accessing services occur because general practice funding and workforce distribution have not been adequately aligned with need. Core funding formulas and incentive schemes fail to reflect deprivation and complexity, and recruitment and retention programmes are less effective in under-doctored areas.

Our report also stressed that staff training on inclusive care and improved navigation support is essential to break down barriers for underserved groups, and that tailored interventions, such as streamlined registration, multiple access routes, continuity of care, and targeted outreach, are needed to improve access.

As set out in the report's recommendations, the RCGP would like to see proportionate universalism principles be used in resource allocation, and enhanced support for practices serving deprived and excluded populations, so that inequalities of access and outcomes can be reduced and the most vulnerable receive timely, equitable primary care.

3) What single policy change would most immediately improve patients' ability to be directed to the right primary care professional at their first point of contact, without the need for multiple appointments or repeated assessments and what evidence supports this?

Providing general practices with the resources and flexibility to prioritise continuity of care, rather than focusing solely on speed of access or activity targets, would significantly improve patient access and system efficiency. As mentioned above, there is substantial evidence demonstrating the benefits of continuity in general practice, including improved health outcomes, reduced hospital admissions, higher patient satisfaction and greater cost-effectiveness. Continuity enables clinicians to better understand a patient's history and circumstances, improving clinical decision-making and reducing unnecessary workload.

While timely access is important, simplistic access targets, may risk fragmenting care, increasing duplication, and driving further administrative burden. Simplifying navigation across the health system is not just a matter of convenience, it is essential to improving outcomes, reducing pressure on practices, and ensuring that every patient can access timely, appropriate and holistic, whole-person care. Access should not simply refer to speed of access, it must mean timely and appropriate access to care, based on clinical need, supported by effective prioritisation and continuity of care principles.

Improving access also requires the wider health system to be easier for patients to understand and navigate. The NHS is a complex system of organisations, but patients have the right to understand their care pathway. Too often, fragmented pathways, inconsistent information and bureaucratic barriers make it difficult for people to access care, particularly those with long-term conditions or additional accessibility requirements. Research has found that 64% of people in England who used the NHS, or arranged care for someone else, in the last year experienced at least one administrative or communication problem, such as missing test results, difficulty changing or cancelling appointments, or not being informed of next steps.[x]

Access should mean timely and appropriate care based on clinical need, supported by effective prioritisation and continuity of care. To support this, the RCGP recommends that:

- The NHS provides clear, consistent information so patients know where to go to access support and can act as partners in decisions about their care.
- Patients and GPs are equal partners in the co-design of care pathways so that services reflect real experiences and are easier to navigate.

- Patients with complex health or communication needs are supported to navigate NHS services and participate fully in decisions about their care.

4)

a) What practical steps are needed to ensure that digital booking, triage, and record-access systems (including the NHS App) deliver equitable access across GP, pharmacy, dentistry, and optometry services particularly for digitally excluded individuals, non-English speakers, older people, and visually impaired patients? Please include any case studies of effective practice.

b) What hybrid access models are required to ensure digital systems and the shift from analogue to digital do not contribute to a two-tier model of access?

Amid the increasing momentum to move more systems and processes online, there is also significant concern amongst patients that some will be "left behind".[xi] Many participants of our patient group convened as part of research for our report '*"It shouldn't be this hard"*: Solving the NHS maze for patients and GPs', and expressed that digital systems are not accessible for them, or for the people they care for. It is crucial that alternative, non-digital routes remain available so everyone can access the same information and services, regardless of digital access or skills, in order to prevent the exacerbation of health inequalities.

Nearly 8 million people across the UK say they lack the digital skills needed to fully engage with online services, with digital exclusion disproportionately affecting people aged over 65 (77%), individuals with disabilities or impairments (69%), and those without formal qualifications (47%).[xii] These groups are often those who rely most heavily on NHS services. This further highlights the risk that digital transformation could further entrench existing inequalities if digital inclusion is not prioritised.

By prioritising user-friendly, interoperable platforms, governments can empower patients, reduce administrative burdens on practices, and improve the overall efficiency and transparency of the NHS. Accessible information is not a luxury but a cornerstone of modern, accountable, patient-centred health services.

Governments and the NHS should embed co-design as a core principle of digital transformation. This could create a system which is fit for purpose, trusted by users, and capable of improving access to key information, ultimately supporting better outcomes for patients and more sustainable general practice services.

To achieve this, the RCGP recommends:

- Patients and GPs must be given the opportunity to design simpler, user-friendly systems which allow patients to see key information about their care, including being able to easily track specialist referrals. This can only be achieved with significant government investment in systems that are easier to use, better connected, and that reduce administrative burden.
- A diverse and representative group of patients must be involved in the co-production and review of the systems, including those who cannot access online systems, to mitigate digital exclusion.

5) With the proposed abolition of 153 local Healthwatch across the country, as well as the national body Healthwatch England, what mechanisms should be put in place to ensure meaningful patient voice and feedback are embedded in the design, delivery, and evaluation of neighbourhood health hubs and wider access reforms? What specific metrics and accountability frameworks should be developed to monitor and proactively respond to regional disparities in access to primary care?

The RCGP believes that the patient voice must remain central to the design and delivery of health services. With the abolition of Healthwatch England, it is critical that these changes do not diminish the voice of patients or weaken the mechanisms through which their experiences shape NHS services.

Patient Participation Groups (PPGs) play an important and valuable role in general practice by providing a direct route for patients to work with their practice to improve services and reflect the needs of their local community.

The RCGP is currently consulting with GPs and patient groups on the possible legislative role of PPGs in the health care system reforms set in the 10 Year Health Plan and the Health Bill.

6) What lessons or evidence can be drawn from local or regional models that have successfully improved access for underserved populations and what policy measures should be included in the 10-Year Health Plan to embed these approaches and reduce health inequalities?

Our report 'Breaking the Inverse Care Law' details multiple case studies which can be found here.

- Case Study: Cardiff and Vale Health Inclusion Service (CAVHIS) (page 10)
- Case Study: Multigenerational Household Outreach Programme in Slough – Frimley ICB (page 13)
- Case Study: Funding distribution in LLR ICS (page 18)

Theme 2. Harnessing Digital Transformation and System Integration

7)

a) What are the key structural or digital barriers that primary care providers face in achieving joined-up working and system integration, and what policy changes, innovations, or practical solutions would best support seamless and collaborative primary care?

b) What are the most significant barriers to interoperability across NHS digital systems and how can suppliers be better supported or required to enable real-time data exchange across all primary care providers?

Poor system working and challenges at the interface between primary and secondary care were identified as a key source of hidden workload in the RCGP-commissioned study on GP workload, conducted by Apollo Innovation and Here, which focused on understanding 'unnecessary' and 'hidden' tasks undertaken by GPs in England. The study also found that

digital infrastructure inefficiencies, including issues with access, quality and interoperability of IT systems, amplified workload pressures. These fundamental and basic components must be addressed to enable primary care capacity to expand and deliver 10YHP ambitions. Interoperability must be a requirement for any new system being commissioned by the NHS.

Issues with essential digital infrastructure is often a rate-limiting factor to efficient and effective system interoperability - including functional GP IT systems, appropriate access to patient records, streamlined referral pathways, and the ability to prescribe electronically. Our 2025 GP Voice Survey revealed that only 24% of respondents agreed that the ability of their GP system to exchange information with secondary care NHS Trusts is fit for purpose or of an acceptable standard. The same study found that 81% of GPs thought the introduction of e-prescribing in secondary care would help improve their workload and 73% believed the implementation of an integrated electronic shared patient record could help.

However, any expansion of shared record systems must recognise GPs' role as data controllers. Data security and governance barriers can also limit effective information exchange across the system and must be addressed alongside technical interoperability. As expectations on GPs to share patient information increase, strong and clear indemnity protections are also needed to support them in their role as data controllers.

Good processes and organisation of care across the interface between primary and secondary care are important to ensure a smooth and effective transition for patients during referral and discharge. When the interface works well, the patient experience of care is far more positive.

The RCGP has undertaken several initiatives to enhance the efficacy and efficiency of this interface, such as the 'Primary/Secondary Care Interface Guidance' (currently under review though still relevant). These initiatives involve evaluating specialised tools and recommending the most effective ways to collaborate for primary and secondary care.

We are soon to publish our recommendations to address workload burdens and bureaucracy, including interface issues, informed by our aforementioned "Uncovering the GP workload burden" research.

8) How should transparency, safety, and public trust be maintained when deploying AI or virtual tools in primary care, and what governance and regulatory safeguards are required?

Transparency, safety and public trust in AI deployed in primary care depend on clear national standards, robust regulation and meaningful professional involvement.

The national guidance currently available is not unified, nor sufficiently detailed or applicable to general practice. There should be consistent UK-wide guidance setting out expectations on safety, governance, accountability and liability, reducing reliance on variable local interpretation. This guidance should be developed with strong engagement from the GP profession (including the RCGP and BMA's Joint GP IT Committee) and should also consider environmental sustainability, aligning AI use with NHS net zero commitments. A use-case-by-

use-case approach, similar to NHS England's Ambient Voice Technology framework, would allow proportionate and context-specific oversight.

In line with Medicines and Healthcare products Regulatory Agency (MHRA)recommendations, AI tools used in general practice should be treated as no lower than Class II medical devices. Regulators should also specify when software updates, model retraining or evidence of model drift require revalidation or further regulatory review, ensuring ongoing safety rather than one-off approval.

Clear rules are needed on data governance. Clinicians and patients must understand how data used by AI systems is stored, controlled, retained and whether it is used for secondary purposes. Particular clarity is required for tools that record or transcribe consultations, including whether such material forms part of the medical record and is subject to rights such as Subject Access Requests.

Where AI involves recording, transcription, secondary data use or direct patient-facing content generation, patients and clinicians should be able to opt out and access a non-inferior alternative pathway. For AI embedded in core operational or safety functions where opt-out may not be feasible, patients should be provided with transparency, accessible explanations and routes to challenge or correct outputs.

9)

a) What national-level infrastructure, policy reforms or regulatory levers are required to ensure the implementation of shared patient records across GP, pharmacy, dentistry, and optometry services? Which governance bodies should oversee data sharing and record access?
b) Which regions or Integrated Care Systems (ICSs) are furthest ahead in developing shared primary care records and what common enablers and pitfalls should inform national scaling?

We are supportive of the greater record interoperability and transparency for patients that a shared patient record would bring. The 10YHP makes commitments on working towards a single patient record. There is a lack of clarity over whether the intention is for this to be one unified system across the whole of the NHS (which would likely be enormously costly and unwieldy) or significantly improving interoperability between different systems, which the RCGP has long supported and called for.

We have some concerns about a single patient record leading to the loss of GP data controllership and a corresponding loss of patient trust with risks that patients may not attend appointments or disclose key information if they are concerned about where this information may be shared.

General practice is well placed to curate patient records and, with the appropriate strategic guidance, funding and tools, can enable effective data sharing while maintaining high-quality records. While we support the benefits of data sharing and the importance of health research, any move towards a shared patient record must be delivered in a way that is transparent about the purposes of data use, respects patients' rights to be fully informed, protects privacy and consent, and ensures robust data security.

There should be systematic and standardised governance, under the supervision of the profession, including through the Joint GP IT Committee, with the involvement of the Information Commissioner's Office and the National Data Guardian. This must be accompanied by transparency to preserve the trust of both the public and the profession that their data is held safely and used appropriately.

10) How adaptable are neighbourhood digital models to rural, coastal, or highly deprived communities and what modifications are required to ensure equitable digital access?

Depending on how they are implemented, digital initiatives could have the potential to offer important opportunities to improve coordination and access as part of a neighbourhood health service - but they are not inherently equitable. The ability to access services remotely offers benefits for those in remote areas in terms of reduced travel and may offer flexibility for those unable to attend appointments in work hours for example. However, the adaptability of any kind of digital service to rural, coastal, and highly deprived communities depends on deliberate design, adequate infrastructure, and targeted support.

In rural and coastal areas, digital models are often constrained by poor broadband connectivity, limited mobile signal, workforce shortages, and long travel distances. In highly deprived communities, digital exclusion is more likely to stem from affordability, lower digital literacy, language barriers, unstable housing, and lower access to private digital space. Without modification, digitally driven access models risk widening existing health inequalities and reinforcing the inverse care law.

Digital innovation should support relational continuity and safe prioritisation, rather than focus on only increasing the number of digital entry points for patients to access care. For neighbourhood models to succeed across diverse communities, they must be flexible and properly resourced.

The GP partnership model, with its strong local leadership, enablement of continuity of care, and embedded knowledge of patient populations, is particularly well placed to support these digital initiatives. Partnerships can help tailor services to local needs, provide patient education on digital tools, and ensure blended access options remain available, mitigating the risk of exclusion.

11) As the NHS App expands to include more sensitive clinical information and referral tools, what governance, consent, and accountability mechanisms are needed to protect patient trust, particularly where AI or third-party systems are involved?

As the NHS App expands to include more sensitive clinical information, and referral and AI-enabled tools, strong governance, clear consent processes and robust accountability will be essential to maintain patient trust.

There is clear public support for the App's potential to improve continuity of care and give patients more control over how they access services.[xiii] However, concerns about privacy, data control, safety – and AI – remain.

Patients should be able to understand which data is being used, for what purpose and by whom. As mentioned above in response to Q. 8, clinicians and patients must understand how

data used by AI systems is stored, controlled, retained and whether it is used for secondary purposes. Where algorithms support triage, referral management or advice, it must be clear whether outputs are advisory and where clinical responsibility sits. There should be straightforward opt-out options for secondary uses of data.

The responsibilities of NHS bodies and suppliers must be clearly defined, with requirements for data security, performance monitoring and regular audits for safety and bias. Clinical decisions must remain the responsibility of clinicians, not the App. We have raised concerns about the branding of the NHS App's AI feature as 'My NHS GP', which risks misleading patients about its decision-making capacity.

Finally, there is a safety risk linked to incomplete information. Data shown in the NHS App may not be a full clinical record. If patients or clinicians assume that missing information means no information exists, decisions could be made on the basis of partial data, potentially leading to harm. The App should clearly signal its limits, including where information may be incomplete, and should not be relied on alone for clinical decision-making.

12)

a) What digital exclusion and digital literacy barriers are patients encountering as primary care services become increasingly digital?
b) What national policy frameworks, funding mechanisms, accountability arrangements, or system-wide interventions are needed to address these barriers and ensure that digital transformation enhances rather than restricts equitable access to primary care services?

As part of our ongoing campaign and report, *'It shouldn't be this hard:* Solving the NHS maze for patients and GPs', improving access to clear, timely patient information was consistently described by patients as one of the most practical and achievable changes the NHS could make.[xiv]

Patients in our focus group shared accounts of inconsistent and incompatible digital systems, often failing to provide accessible, reliable information. This made it difficult for patients to track referrals, follow treatment plans, or engage fully in their healthcare. Patients were clear that the priority is not just 'more digital', but systems that are easier to use, reduce uncertainty, and make it clear what happens next.

The patients in our focus groups were particularly concerned about referrals. We repeatedly heard that patients felt left in the dark, not knowing how their referral was progressing or if it had been made at all.

Wider studies support these accounts. Public polling found that 17% of patients in the UK have not known whether a referral made for them had been lost, 18% did not know who to contact about their care or treatment once a referral had been made, and 26% had to chase up referrals themselves to ensure they were seen.[xv]

As set out in our response to Q. 10, many patient groups are at risk of digital exclusion for a variety of reasons and patients we spoke to also expressed concern that increased digitisation will leave some groups behind. Nearly 8 million people across the UK lack the digital skills needed to engage fully with online services, disproportionately affecting older people, disabled people, and those without formal qualifications - often those most reliant on

NHS care.[xvi] Digital exclusion risks entrenching inequalities unless alternative routes remain available.

By prioritising user-friendly, interoperable platforms, governments can empower patients, reduce administrative burdens on practices, and improve the overall efficiency and transparency of the NHS. Accessible information is not a luxury but a cornerstone of modern, accountable, patient-centred health services.

Governments and the NHS should embed co-design as a core principle of digital transformation. This could create a system which is fit for purpose, trusted by users, and capable of improving access to key information, ultimately supporting better outcomes for patients and more sustainable general practice services.

To achieve this, the RCGP, jointly with the Patients Association recommends that:

- Patients and GPs must be given the opportunity to design simpler, user-friendly systems which allow patients to see key information about their care, including being able to easily track specialist referrals. This can only be achieved with significant government investment in systems that are easier to use, better connected, and that reduce administrative burden.
- A diverse and representative group of patients must be involved in the co-production and review of the systems, including those who cannot access online systems to mitigate digital exclusion.

Theme 3. Securing Long-Term Sustainability in Primary Care

Funding

13)

a) What are the main funding challenges affecting primary care service provision, including issues of allocation, timing, and stability. How do these challenges affect quality of service provision and workforce capacity?
b) What opportunities exist to use current resources more efficiently across the primary care sectors and what are the likely impacts of such changes? Please include case studies using the template provided and outline any system-level adjustments required.
c) What changes to GP funding models are needed to improve patient access to primary care, and how can additional investment be targeted, structured, and monitored to ensure it delivers measurable improvements in access, capacity, and outcomes for patients?

General practice is currently operating at the limits of capacity. General practice delivers the vast majority of NHS patient contacts for a relatively small proportion of the total NHS budget. Yet funding growth over the past decade has not kept pace with rising demand, complexity, workforce pressures, and estate constraints. The average full-time equivalent (FTE) fully qualified GP in England is now caring for approximately 15% more patients (2,228

patients per GP) than in 2015, and while this number has started to fall slightly over the last few years, there is a long way to go to reverse this trend.[xvii]

At the same time, consultation volume and complexity have increased, and workload per clinician is widely recognised as unsustainable. These trends are well documented in national workforce data and are increasingly associated with declining morale, challenges with recruitment and retention, and risks to the quality and safety of care.

There is a clear risk that, without a meaningful uplift in resources, further increases in workload or bureaucracy could worsen morale and undermine the very improvements in access and patient experience that the government seeks to achieve.

Placing disproportionate weight on speed of access risks creating a perverse incentive for practices to prioritise measurable access metrics, which can have unintended consequences including the reallocation of time and capacity in ways that could inadvertently undermine care quality, continuity, and perpetuate inequities, particularly for patients with complex or ongoing needs. There is substantial research evidence demonstrating the benefits of continuity in general practice, including improved health outcomes, reduced hospital admissions, higher patient satisfaction and greater cost-effectiveness.[xviii,xix,xx] Workforce constraints mean that, without significant additional GP capacity, prioritising faster access will inevitably involve trade-offs.

The RCGP also recognises the enduring strengths of general practice, particularly the GP partnership model and the continuity of care it enables. Both are strongly associated with better patient experience and greater system efficiency. The Government's 2019 GP Partnership Review identified the partnership model as a 'cost-effective delivery model' that 'supports and enables continuity of care'[xxi]; and the Institute for government found that GP partners are the members of staff associated with the largest increases in patient experience satisfaction, appointments and achievement against QOF targets.[xxii,xxiii] Protecting these foundations is critical if general practice is to remain resilient and responsive to patient need.

Furthermore, practices in the poorest areas have 14.4% more patients per fully qualified GP compared to wealthy areas,[xxiv] but receive 7% less funding after accounting for the additional needs of the population.[xxv] The College welcomes the Government's review of the Carr-Hill formula so that it better reflects deprivation, multimorbidity, and rurality to ensure more spending is channelled to areas of greatest need. However, we have been clear that this review must be accompanied by an overall uplift in general practice funding to ensure that no areas lose out as a result.

If the Government is to successfully deliver the shift of care from hospitals into the community, then the ambition must be matched with the necessary resources. To ensure resources continue to increase for general practice, the College recommends the Government replicates the Mental Health Investment Standard. For Primary Care this new standard would require central Government and Integrated Care Boards to increase spending on general practice and primary care year on year. As part of this, the Secretary of State should report annually to Parliament on the proportion of NHS spending in general practice and primary care, as is currently required for mental health spending. Similarly, each ICB would be required to report this proportion annually and held to account for ensuring this increases year on year.

d) Aside from funding, what system-wide reforms or policy levers would have the greatest impact on improving access to primary care and which should be prioritised?

While a significant increase in the number of GPs in the workforce is fundamentally required to improve access to primary, one of the most significant system-wide reforms in the shorter term would be reducing unnecessary administrative and compliance burdens that divert GP time away from patient care.

In December 2025, the Royal College of General Practitioners (RCGP) published the results of 'Uncovering the GP workload burden: A study of the drivers and costs of 'unnecessary' and hidden workload' research, conducted by Apollo Innovation and Here. The three-phased project examined the complex nature, scale and impact of unnecessary and hidden workload across general practice in England, estimating the average cost of unnecessary workload at £410 per GP per day. The research identified excessive non-clinical and administrative burdens, fragmented system processes, and regulatory requirements as major drivers of hidden workload. These pressures were associated with reduced time for patient care, increased stress and burnout, and eroded professional autonomy.

An excerpt from the research states: *"Regulatory frameworks also play a role, with compliance requirements, such as those linked to QOF and Care Quality Commission (CQC) inspections, placing substantial demands on GPs' time for documentation and data entry, often diverting attention away from direct, patient-centred care."*

The 2025 RCGP GP Voice Survey found that 69% of GPs believed a reduction in the number of QOF indicators would help improve their workload, and in 2024, 70% of GPs thought streamlining the QOF reporting process through automation would help improve their workload.

It is important to note, that whilst reducing unnecessary workload may help free up time for patient care, this should not be assumed to equate directly to more appointments. A proportion of the time spent on these unnecessary activities is likely to have been completed in overtime, i.e. beyond the GP's contracted hours, and therefore will not currently be funded, and could be contributing to high burnout levels amongst GPs.

Evidence also suggests that financial incentives alone are insufficient to drive sustained improvements in quality. A recent (unpublished) Scottish Government literature review examining QOF across the UK found that while the framework has been associated with improvements in some intermediate clinical outcomes and more structured care processes, many positive effects were not sustained over time. This indicates that performance management mechanisms must evolve beyond rigid, box-ticking approaches towards models that support professional judgement, continuity of care, and person-centred outcomes.

Prioritising regulatory simplification, reducing duplication, improving interoperability and automation of reporting systems, and redesigning incentive frameworks to focus on meaningful quality of care rather than process compliance would free up clinical capacity and have a direct impact on improving patient access to primary care.

Commissioning & Contract Reform

14)

a) The inquiry has heard concerns about 'competitive silos' across primary care. What commissioning approaches would most effectively promote collaboration, shared triage, and multidisciplinary working across GP, pharmacy, dentistry, and optometry services, rather than competition for activity and income? Please outline any evidence or examples that demonstrate how commissioning reform could support more integrated, patient-centred models of care.

b) How do current GP, dentistry, pharmacy, and optometry contracts encourage or inhibit expansion of NHS care particularly in underserved communities and what changes would mitigate postcode lottery access disparities.

In a resource constrained system, it is unsurprising that a degree of competition may emerge between different services. There is some potential in considering pooled budgets and primary-care wide commissioning as explored in the 10 Year Health Plan. Focussing on outcomes over activity and aligning incentive mechanisms across primary care could also promote collaboration. However, these approaches would need very careful consideration and negotiation to ensure they do not risk destabilising existing services. Consideration of how new approaches could seek to reduce rather than exacerbate existing health inequalities would also be critical.

As set out in our response to Q. 13, the funding formulae underlying current GP contracts, fails to appropriately account for deprivation. This means that practices in areas of higher need continue to face workforce shortages and heavier patient loads, perpetuating postcode lottery effects.

To mitigate these disparities, the RCGP recommends:

- Targeted funding reform to reflect deprivation, rurality, and population health need through a review of the Carr-Hill formula.
- Strengthened workforce support including flexible use of ARRS and other practice-based schemes to recruit and retain staff in high-need areas.
- Alignment of incentives across primary care sectors to promote collaboration and continuity of care.
- Long-term investment in estates, digital tools, and multidisciplinary networks to ensure sustainable improvements.

Contract reforms and targeted investment are essential to ensure NHS primary care delivers equitable access across all communities, reduces postcode lottery effects, and supports the most vulnerable populations.

15) Optometry and community pharmacy have one of the most geographically accessible networks in primary care. What lessons from its access and delivery model could be applied across other primary care sectors to improve integration, prevention, and first-contact care?

The RCGP recognises the benefits that the local accessibility of optometry and community pharmacy offers to patients in terms of prevention and first-contact care. General practices

are also embedded in communities and retaining these local footprints and connections will be critical for the future of the NHS and the exploration of neighbourhood working.

Appropriate integration and communication across primary care services is critical to success. When used effectively, Pharmacy First is a software tool which enables communication and record-sharing tool, ensuring that information about patient care is captured and shared appropriately across the system.

However, the benefits of such services depend on secure, interoperable systems and correct usage. If records are not properly linked, coding errors occur, or communication pathways are inconsistent, this can create additional administrative burdens, delay care, and increase the risk of patient harm.

16)

a) How can we integrate dental services more effectively with other primary care providers to support holistic patient care? Would co-location in hubs or improved GP–dentistry referral pathways support this? Please outline practical steps or incentives.
b) Given wide regional variation in access to NHS dentistry, what policy levers are most urgent to reduce inequalities and ensure consistent provision across England?

Estates

17)

a) How can the primary care estate be developed or used to improve access to care, particularly as services shift toward a neighbourhood model with an increased emphasis on community-based delivery?
b) How can local systems better repurpose void space within GP and primary care estates, and what examples of best practice already exist?

As the cornerstone of the NHS, estate investment must prioritise fixing and expanding existing GP premises, reflecting that 90% of NHS patient contacts are delivered in primary care, and that current constraints in space and building condition are already limiting access, continuity, workforce expansion and training.

There must be a clear priority to bring the existing general practice estate up to a safe, compliant and functional baseline, so practices can meet current demand and protect patient access. It is also essential that consideration is given to how current GP contractual and funding arrangements interact with the 10 Year Health Plan's (10YHP) premise expectations for modern, multidisciplinary working and service delivery, including current rent reimbursement rules, indemnity and GP exposure to long-term property liabilities.

Lord Darzi's 2024 Independent Investigation of the NHS in England concluded that the primary care estate is "*plainly not fit for purpose*" and that urgent reform of the capital framework is needed.[xxvi] It noted that 20% of the primary care estate predates 1948, 53% is more than 30 years old, and that LIFT (PFI-type) arrangements can leave GPs with limited control of space and high charges.[xxvii]

Inadequate GP premises limit how many patients can be seen safely and efficiently, and whether practices can accommodate trainees and MDTs as more care shifts into the community, particularly in areas of high deprivation. These pressures underline the need for clear criteria for prioritising capital investment, focusing on areas where estate constraints most undermine access, continuity, workforce sustainability and the ability to deliver the Neighbourhood Health Service model.

As addressed in our RCGP MP Briefing: Planning Infrastructure Bill, the limited physical capacity of GP estates hinders the service's ability to meet growing patient demand, which is particularly acute in areas of rapid housing growth. Therefore, it is essential that any new development is accompanied by sufficient primary care infrastructure to provide care to patients locally, and that this is mutually supported through planning rules and authorities.

As the Government look to deliver 1.5 million new homes during the current parliament, it is vital that local planning authorities and their planning teams are given the necessary powers and resources so they can properly hold developers to account and ensure that sufficient primary healthcare infrastructure is not only prioritised in the planning process but also delivered. Though not adopted, we supported an amendment to the Planning and Infrastructure Bill (now Act) to include a clause to explicitly include general practice clinics within the definition of “local infrastructure” and ensure that commitments to provide local infrastructure such as schools and GP clinics, approved as part of a development, are permanent and legally binding.

Funding must address the fact that GP premises are not currently in a fit state to meet demand; increased investment in infrastructure is necessary to achieve the Government’s vision. Even existing NHS premises that could be repurposed for neighbourhood healthcare will need refurbishing, as part of the Government's proposal to rollout Neighbourhood Health Centres.

As called for in previous submissions, the RCGP recommends:

- The Government must ensure every patient has access to a modern fit-for-purpose general practice building, by investing in infrastructure to address the longstanding underfunding in general practice premises.[xxviii]
- Investment should facilitate co-location of community and voluntary services with practices where this works for the local population and services.

18)

a) What are the main barriers to investment in the primary care estate (including ownership models, funding constraints, or maintenance liabilities), and what policy or system-level measures would be most effective in overcoming these obstacles?
b) How can capital allocations for primary care be better prioritised, protected, or expanded to ensure the estate is able to meet the ambitions set out in the 10-Year Health Plan, including co-location of services and modernisation of existing premises?

RCGP's 2025 poll of members revealed that a third of GPs say that their practice building is not fit for purpose. 56% of GPs said their practice requires additional works to improve or upgrade their premises in order to meet the needs of their patients. Our polling also revealed

that GPs felt there is a lack of available funding for these required structural improvements: of those who tried to apply for funding to improve their premises in the last year less than a third (32%) were successful.

Polling shows that access to general practice is the public's top NHS priority. But underinvestment in GP premises limits the ability of practices to expand access through growing practice teams and hiring more GPs to facilitate more appointments.

Capacity cannot be built without prior investment. Without capital funding, practices cannot be enabled to take on more staff to keep up with patient demand, deliver on the Government's plans to shift more services from hospital into the community or modernise their digital systems to utilise advancements in technology.

The Government's ambitions to move more care into the community rely on a properly resourced general practice with adequate infrastructure. The NHSE Long Term Workforce Plan (LTWP) also recognised the need for investment in GP infrastructure, stating that growth of the GP workforce can only be achieved by significantly investing in general practice buildings. However, capital is currently outside the scope of the plan, and no other plans have been published showing how these infrastructure needs are going to be met.

The RCGP therefore recommends:

- The proportion of capital spending available to general practice must reflect the fact that premises are not in a fit state to meet demand, and that investment in infrastructure is necessary to achieve this vision. This will also be essential in taking forward the Government's proposal to trial the introduction of neighbourhood health centres.
- Alongside the new 10 Year Workforce Plan we need a clear road map for the delivery of the additional capital that will be needed to ensure all GP practices have adequate space to both treat their patients and train the next generation of GPs we so desperately need.

Workforce

19)

a) What evidence-based staffing models or multidisciplinary workforce compositions best enhance primary care capacity, improve outcomes, and reduce pressure on GPs?

b) What role should accelerated training pathways and expanded scopes of practice (e.g. prescribing pharmacists, advanced nurse practitioners, dental therapists, independent prescribing optometrists) play in strengthening GP primary care?

The RCGP has long supported multi-disciplinary teams (MDTs) as the future of general practice and having much to offer for patient care. However, the value of MDT roles does not lie in the substitution of GP expertise but in well integrated team models that support GPs with defined responsibilities, effective governance, and alignment with patient needs.

MDT models have meant that patients have been able to access specialist expertise such as pharmacists, physical therapists, mental health workers and social prescribers within general practice expanding the scope of general practice significantly.

However, the implementation of MDT roles must be carefully considered and handled and the evidence on multidisciplinary workforce expansion in general practice is mixed. Large evaluations show that simply adding non-GP clinicians through schemes such as the Additional Roles Reimbursement Scheme (ARRS) has not consistently reduced GP workload with increased supervisory and delegation demands sometimes offsetting workload benefits.[xxix] Similarly, some analysis suggests that ARRS roles are associated with only small increases in patient satisfaction and perceived access, without clear impacts on clinical quality measures.[xxx]

Multidisciplinary teams do not automatically deliver improved patient satisfaction and care or workload relief. To realise the benefits, it is critical that roles are embedded purposefully within teams with strong governance, training, and alignment with clinical priorities.

20) How can reception and administrative staff in general practice, including those involved in NHS 111 and GP redirection, be better trained and supported to act as effective first points of contact and triage as digital access expands? What policies, training frameworks, or support systems are needed to help them guide patients through digital tools, care navigation, and appointment systems

When reforms are introduced or new expectations are placed on general practice it is important that the system provides practices with the necessary support to be able to deliver them. Often the focus is on ensuring that practices have the right IT or telephone systems, but not the training and time to be able to implement the changes.

The new contract expectation in England that all urgent patients are seen on the same day reinforces the need to have triage carried out by staff who are sufficiently trained. With practices dealing with an increasing number of contacts they need to be skilled to spot which ones are potentially dangerous and need urgent medical attention.

21)

a) Which policies, practices, or initiatives have been most effective in recruiting, retaining, and supporting the primary care workforce across GP, dentistry, pharmacy, and optometry? Please provide case studies using the template provided. (You can also provide examples from international systems, other UK regions or non-health sectors including evidence around their effectiveness and transferability in workforce development).

Demand for GP services has soared, but GPs haven't received the sufficient resources required to meet this demand. Consequently, GPs are experiencing significant burnout and are more likely to report high levels of stress and overload than any other doctor group.[xxxi]

Government investment into GP retention through mixed approaches is a cost-effective solution to safeguarding the NHS.[xxxii] In England, the financial cost to the public purse for losing and replacing a single experienced NHS GP has been estimated at a minimum of £295,000.[xxxiii] Furthermore, the full cost of training a doctor from the beginning of medical

school through to the end of GP training, a process that takes a minimum of ten years, is calculated at nearly £500,000.[xxxiv,xxxv]

The national New to General Practice Fellowship programme, launched in December 2019, supported over 2,400 GPs and 450 GP nurses as of 28 February 2023, with approximately 80% of respondents agreeing that the two-year scheme supported them to remain in their role.[xxxvi]

Yet NHSE's decision to cut national GP retention initiatives and devolve responsibility to Integrated Care Boards (ICBs) without ringfenced budgets has led to inconsistent support across regions. While local autonomy allows tailored approaches, financial constraints and a lack of national oversight often result in funds being diverted elsewhere, creating a "postcode lottery" for GP retention.

That is why the College is calling for:

- A cohesive national GP Retention Strategy, to provide consistent support across all regions and GPs at all career stages. Funding for GP-specific initiatives should be ring-fenced to prevent reallocation, and successful programmes should receive long-term funding.

Theme 4. Additional Considerations

22) Has the Government overlooked any significant issues in its approach to improving access to primary care? What additional priorities should be considered to ensure the 10-Year Health Plan is effective?

The RCGP believes the Government has identified many important themes in its approach to improving access to primary care but has overlooked or under-emphasised several significant issues that are critical to the success of the 10YHP.

The RCGP's 10 Year Health Plan consultation response stresses that general practice must be properly and proportionately resourced before it can deliver the shifts envisaged by the Government. Without meaningful, sustained investment in general practice funding, workforce, infrastructure and premises, access will not improve and pressures on GPs and patient satisfaction will worsen.

Modernisation of primary care cannot be delivered on the basis of current under-investment. The RCGPs surveys show overwhelming workload pressures, compromised patient safety, and insufficient time to deliver quality care because of excessive demand and insufficient GP capacity:

- 73% of GPs report that patient safety is being compromised by their workload pressures.
- 58% of GPs said they do not have enough time to adequately assess and treat patients during appointments.
- 57% of GPs do not have time to build the relationships with patients they need to deliver quality care.

These stark figures demonstrate the extent of the workload crisis in general practice – and that an increase in core GP funding will be vital to address this, as the Government begins the roll out of its 10YHP.

Specifically, the College has argued that key priorities have not yet been fully addressed in the Government's proposals:

- Funding must be shifted into primary care and community services now rather than delayed to 2035, with mechanisms such as introducing a Primary Care Investment Standard to increase the proportion of NHS spending on general practice.
- Workforce planning must be bolder and more balanced, with far greater growth in fully qualified GPs and stronger efforts on retention, making general practice an attractive career path.
- Primary care must have stronger voice and representation within Integrated Care Systems (ICSs), with explicit GP representation on Integrated Care Boards and mechanisms such as primary care forums to ensure frontline experience informs system decision-making.
- Infrastructure and premises improvements are essential to support expanded services, multidisciplinary teams and neighbourhood care models. Current premises shortcomings risk constraining delivery of expanded community-based care.
- Addressing health inequalities and the social determinants of health must be central to the Plan, with targeted support for inclusion health groups and socio-economically deprived populations where access challenges and unmet need remain greatest.

The 10YHP not only outlines visionary shifts but also embeds concrete, properly funded commitments on workforce, resourcing, infrastructure, and governance so that general practice is enabled to improve access and outcomes equitably across all communities.

23) What opportunities exist to integrate voluntary, community, and social enterprise (VCSE) organisations into prevention and primary care pathways and what case

Local VCSE organisations can have a major impact on their community's health. When GPs and general practice-based link workers are able to work with their local VCSE groups effectively it can strengthen the impact both sides can have.

One of the biggest barriers for joint working is the time it takes to establish these links. With GPs facing bigger demands then ever it is hard for practices to find the time to be able to carry out the necessary outreach to work well with VCSE organisations.

24) How should the Government ensure that the public are aware of the range of specialist services available to them in primary care to avoid over reliance on the current overburdened services, and to help them access care more quickly.

As part of our research into NHS navigation for patients and GPs, focus group members told us that the administrative and mental burden of navigating their healthcare is incredibly stressful, especially when combined with chronic illness and other life pressures. Focus group patients called for clearer guidance, more consistent points of contact, and reassurance about what will happen next in their care. They also emphasised that the system itself needs to be

easier to understand, while recognising that those with particularly complex conditions or communication needs may require additional support to navigate it.

The Government should ensure the public is aware of the full range of specialist services available in primary care through clear, consistent, and accessible information campaigns across multiple channels, including online NHS platforms, GP practice communications, and community outreach. Practices and Primary Care Networks (PCNs) should also be supported to provide proactive patient education, signposting, and digital tools that help people navigate services effectively.

Investment in public-facing directories, awareness campaigns, and local engagement initiatives can reduce inappropriate reliance on overstretched urgent and emergency services, while enabling patients to access the right care more quickly. Importantly, messaging should be inclusive, addressing language, digital literacy, and accessibility barriers, so that all communities, particularly those in underserved areas, can understand and make use of available specialist primary care services.

Simplifying navigation across the health system is not just a matter of convenience, it is essential to improving outcomes, reducing pressure on practices, and ensuring that every patient can access timely, appropriate care.

The RCGP recommends that:

- The NHS must provide clear and consistent information to support patients as active partners in decisions about their healthcare, including knowing where to go to get help

25) What role should local authorities play in neighbourhood health systems and preventive public health within primary care?

Local authorities have a key role in the delivery of preventative health services and should be key partners in new neighbourhood health systems. Many GPs work closely with their local authorities, and it is normally local authority run services that general practice based social prescribers refer patients to.

Local authorities are however working in severely financially restrained circumstances with the Public Health Grant received by councils being reduced in real terms by £858 million between July 2015 and 2024.[xxxvii] This makes it much harder for them to offer preventative health services and there are less places for link workers or social prescribers to send their patients.

One further fundamental barrier is the lack of dedicated funding. The ONS estimate that only 5% of health funding is spent on prevention, and public health grants to local authorities have reduced by 25% since 2015.[xxxviii] The separation of public health into Local Authorities, has risked limiting preventive medicine efforts and moving this responsibility back within the NHS should be explored.

26) What successful approaches to joined-up working, rapid access, or integrated service delivery during the COVID-19 pandemic should be re-adopted or scaled today? Please include case studies where relevant.

Please find the College's reflections on the role of general practice in response to the COVID-19 pandemic here.

Additional Evidence

Please feel free to send any additional evidence or information that might support our inquiry but has not been covered in our research questions, by attaching a separate document to your email in either Microsoft Word or PDF format. We are also keen to receive papers, data, or reports that you or your organisation have completed. We would appreciate any data submissions, statistics or case studies showing what works and what does not.

Submissions Permissions

In order for us to consider your evidence, please ensure that you answer the following questions as part of your submission:

1. Do you give permission for the report to quote your submission?
    a. Yes/No
2. May we attribute the submission to the organisation you belong to?
    a. Yes/No
    b. Name of organisation: Royal College of General Practitioners
3. May we attribute the submission to you personally, listing your job role?
    a. Yes/No
    b. Full name:
    c. Job role:
4. Would you be interested in providing further evidence via a short call or online interview?
    a. Yes/No

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