Fit for the Future

A vision for general practice

Royal College of General Practitioners

#FutureVisionGP

Fit for the Future

A vision for general practice

#FutureVisionGP

RCGP Royal College of General Practitioners

Contents

Foreword 2
Professor Helen Stokes-Lampard

Fit for the future 3
A vision for general practice

Our vision for general practice in 2030 4
A summary

Introduction 7

General practice in 2030 10

What patients want from general practice 12

General practice 13
A revitalised profession

Rethinking medicine and person-centred care 23

General practice 24
An expanded team

The digitally-enabled practice 31

General practice 33
The bedrock of a sustainable NHS

Enablers 41

Conclusion 44

Appendix 45
Analysis of responses to our consultation

Endnotes 48

Foreword
Professor Helen Stokes-Lampard

Our National Health Service is treasured by the public and highly respected worldwide, and general practice is quite rightly described as its bedrock – the jewel in its crown. Our service is only as revered as it is through the hard work and vision of generations of extraordinary GPs. Now it is our turn – as the voice of UK general practice – to look ahead to see how we can make our service **fit for the future**.

More than 3000 people – GPs, other healthcare professionals, and patients – have fed into this piece of work, and we have listened. We see a general practice in the future that is forward thinking whilst maintaining what we know patients value: continuity of care, a truly holistic approach to medicine that treats the whole person, not just their condition and that is rooted in the community.

But we recognise that the NHS is changing, our patients are changing, and society is changing – so general practice needs to change and evolve too. We agree with the Chief Executive of NHS England, Simon Stevens, that 'there is arguably no more important job in modern Britain than that of the family doctor' – but we won't be able to sustain the care we deliver to over a million patients every day on our own.

We need to work together better and differently – within the practice, between practices, and across the NHS – to ensure that we have the time to deliver the care our patients need, which is becoming ever more complex.

We're at a moment of change for general practice and we must embrace it.

After years of underinvestment and neglect, Government and NHS leaders are finally starting to address the financial and workforce challenges facing general practice. The future is looking much more positive.

It's been an absolute privilege to lead this College for the last three years. When I started I said that amongst other things, I wanted to bring the joy and sparkle back to the profession. I hope I have made some progress with that. I believe that this document provides the blueprint that will set up the profession for the challenges the future holds.

The NHS is more than 70 years old – we all want it to be around in another 70 years and beyond. That will only happen with a strong, robust and sustainable general practice at its heart, delivering care free at the point of need, to future generations of patients.

Fit for the Future
A vision for general practice

General practice is the bedrock of the NHS. It is the first point of contact with the health service and is highly valued by patients. But it is also under immense strain.

If we are to meet the health challenges of the 21st century and put the NHS on a sustainable footing, we need a positive vision for the future of general practice, and to support GPs and their teams to achieve it.

GPs know how to deliver high quality, person-centred care; they know their patients and understand the communities they serve. The core values of general practice are as relevant as ever. However, as patient and professional needs change, we must learn to apply them in new ways.

The College is setting out its vision for the future of the profession because we believe that, with the right tools, skills and investment, general practice can continue to deliver world class patient care and being a GP can be the best job in the world.

Our vision for general practice in 2030
A summary

General practice: A revitalised profession

- General practice in the UK will be recognised as a high-status and rewarding profession. It will be the career of choice for growing numbers of ambitious and talented medical students and foundation doctors.
- With the right staffing levels, GP workload will be manageable, which in turn, will reduce stress and burnout. Retention rates and job satisfaction will be higher.
- The delivery of relationship-based, whole-person care will be at the heart of general practice. GPs will have more time to care for those patients with the most complex needs and will work with extended practice teams to provide enhanced continuity of care.
- Patients will have more choice over the length, time and method of consultation. The standard face-to-face consultation length will be at least 15 minutes and more consultations will be delivered remotely through digital and video channels. GPs will have access to a wider range of data sources and diagnostic tools, and shared decision-making with patients will be the norm.
- The skills of the GP as an expert medical generalist will be more highly valued than ever before. There will be more time and better support for training and professional development, and GPs will be able to take on extended roles and develop additional areas of expertise.

General practice: An expanded team

- Care will be delivered by multidisciplinary practice teams, comprising a range of clinical and non-clinical roles and offering a wider range of services.
- New roles will complement the skills of the GP, enabling practices to better support patients to manage their conditions and to remain in good health. Multidisciplinary teams will work together to provide enhanced care to patients with the most complex needs.
- GPs will provide leadership, advice, training and mentoring to their practice teams and will retain ultimate responsibility for the care of their patients. General practice will be the career destination of choice for growing numbers of NHS professionals.

General practice: The bedrock of a sustainable NHS

- GPs will work at scale in collaboration with neighbouring practices to proactively improve the health outcomes of the populations they serve, enhance access, and tackle health inequalities. The values of continuity and person-centred care will be at the heart of these new collaborations.
- GPs will deliver care around the clock and across the traditional organisational boundaries between hospitals, primary care and social care. They will be influential system leaders both locally and nationally.
- Practices will evolve into wellbeing hubs, hosting a range of wellbeing and community services to prevent ill-health and help build strong, resilient communities.
- General practice will be at the core of a revitalised, well-resourced primary and community care sector, which delivers care closer to home, improves health outcomes and supports patients to self-care and lead healthier, more independent lives.

How we developed our vision

To inform the development of this vision, we consulted over 3,000 patients, GPs, health professionals and other primary care stakeholders in one of the largest engagement exercises ever undertaken by the College (see page 45). We also commissioned the King's Fund to test our emerging thinking with GPs, practice staff, patients and system leaders.

Enablers

Our vision for the future is achievable, but only if we equip general practice with the resources, infrastructure and skills that it needs. There are six key enablers which are essential to realise our vision:

Funding

Is essential to ensure that general practice has the workforce capacity, skills and tools to meet rising patient demand, deliver preventative and anticipatory care and, consequently, relieve pressure on the acute sector. At least 11% of the NHS budget must be spent on general practice.

Workforce

To ensure primary care has the capacity to deliver our vision, we need to increase the number of full-time equivalent (FTE) GPs in practice, reduce the rate of GPs quitting the profession or retiring early, and significantly expand the wider practice workforce.

Modernised GP premises

The expansion of practice teams and co-location of a wider range of clinical and wellbeing services in primary care will require upgrading the existing estate or moving to purpose-built surgeries.

Training and education

GP specialty training must be extended and enhanced, there must be more positive exposure to general practice at medical school and during foundation training. There must be improved training and development opportunities for members of the practice team.

Digital technology and know-how

To harness the benefits of digital technology and deliver more telehealth and digital services, we need to upgrade IT infrastructure and skills in primary care and ensure that IT systems across the NHS are interoperable.

Research and innovation

Delivering world class primary care depends on a strong evidence base, better data and a step change in the capacity, capability and knowhow of general practice to undertake research and drive innovation.

Introduction

Challenges facing the NHS

The NHS is facing considerable challenges. Life expectancy growth in the UK has slowed in recent years, and reductions in mortality have not been matched by similar declines in morbidity.[1] The total burden of ill-health, measured by the number of years lived with a disability, has increased by over a sixth between 1990 and 2016, driven by a growing and ageing population.[2] Between 2003–04 and 2015–16, the number of people with a single chronic condition grew by 4% a year, and the number with multiple chronic conditions grew by 8% a year.[3] By 2035, the proportion of over 65s with two or more long-term conditions is projected to rise to over two thirds.[4]

These pressures have generated increasing demands on the NHS. Between 1998–99 and 2016–17 inpatient admissions per person rose by 33% in England, and between 2003–04 and 2016–17 consultant-led outpatient attendances per person increased by 57.9%. Patients with long-term conditions account for around 50% of all GP appointments and over 70% of all inpatient bed days.[5]

Health inequalities are not only entrenched but widening in some cases. Across the UK, the gap in healthy life expectancy at birth between the best and worst performing areas in 2015–17 was 21.5 years for females and 15.8 for males.[6] People in the most deprived areas remain significantly more likely to die prematurely,[7] and, on average, can expect to develop multiple conditions 10–15 years earlier than those in the least deprived areas.[8] In England, the gap in life expectancy between the least and most deprived areas has increased since 2010–12, with the most deprived areas showing an absolute decrease in female life expectancy.[9]

Don Berwick's 'Triple Aim' sets out three interlinked goals as necessary for health system transformation: improving the individual experience of care; improving the health of populations; and reducing the per capita cost of care – to which a fourth, of improving the experience of providing care, has subsequently been added.[10] While the NHS compares favourably with other health systems internationally across many dimensions of care, it compares less favourably on healthcare outcomes,[11] and is subject to similar upward cost pressures, such as higher input costs and advances in medical technology.

Successive studies have highlighted the extent to which population health is determined by factors such as behavioural patterns and social and environmental context,[12] despite this, only 5% of public funding on health is currently spent on prevention.[13] The overall proportion of the disease burden in England attributable to preventable causes declined

between 1990 and 2013 but at the end of this period, behavioural risk factors still accounted for 28% of disability-adjusted life years, compared to 19% for metabolic risks.[14]

General practice in 2019

General practice is the bedrock of the NHS. It is the first point of contact with the health service for millions of patients. In England,[15] 83.8% of patients rate their practice as 'fairly good' or 'very good', and 95.8% had confidence and trust in the last professional they saw in their GP surgery. In Scotland,[16] 83% of people rate the overall care provided by their GP practice positively, and in Wales[17] 86% of patients say that they are satisfied with the care they received from their GP.*

General practice remains a varied and rewarding career, with growing numbers of medical students and foundation doctors choosing to train as GPs across most parts of the UK. Over 90% of GPs feel that their patients trust their generalist skills and more than 80% say that their job provides them with interesting variety.[18] The profession is more diverse than it has ever been and increasing numbers of GPs are choosing to take up the opportunities that it offers to work flexibly and to pursue portfolio careers. Practice teams are also expanding. New roles, such as practice-based pharmacists and mental health therapists, are being introduced across the UK.

Despite these positives, general practice is currently under huge strain. The volume of patient contacts is greater than 10 years ago – between 2007 and 2014, clinical workload rose by at least 16%.[19] However, between 1996 and 2016 the number of FTE GPs per 1,000 people declined by 5%, while the equivalent figure of hospital doctors per 1,000 people rose by 72%.[20] As more patients present with multiple and complex conditions, the intensity of the work has also grown,[21] and practices have taken on responsibility for activities previously undertaken in secondary care, for example, the monitoring of drug regimes, disease-specific follow-up and post-operative care. A 2013 study found that an average GP consultation involves a discussion of approximately two and a half different problems, across a wide range of disease areas, in just 12 minutes, with each additional problem being discussed in just two minutes.[22]

Unsurprisingly, these factors are having a negative impact on patients and their GPs. Half of younger GPs and two fifths of older GPs say that at least once a week, insufficient time with a patient affects their quality of care, and 58% of younger GPs say that they are referring more cases compared to two years ago as a direct result of higher workloads.[23] Despite evidence of a strong association between continuity of care and lower mortality rates,[24] the number of patients able to see their preferred GP in England fell by 27.5% between 2012 and 2017.[25] At the same time, ease of access to general practice has been declining across most parts of the UK.[26]

*Patient satisfaction data for general practice is not available in Northern Ireland at time of writing

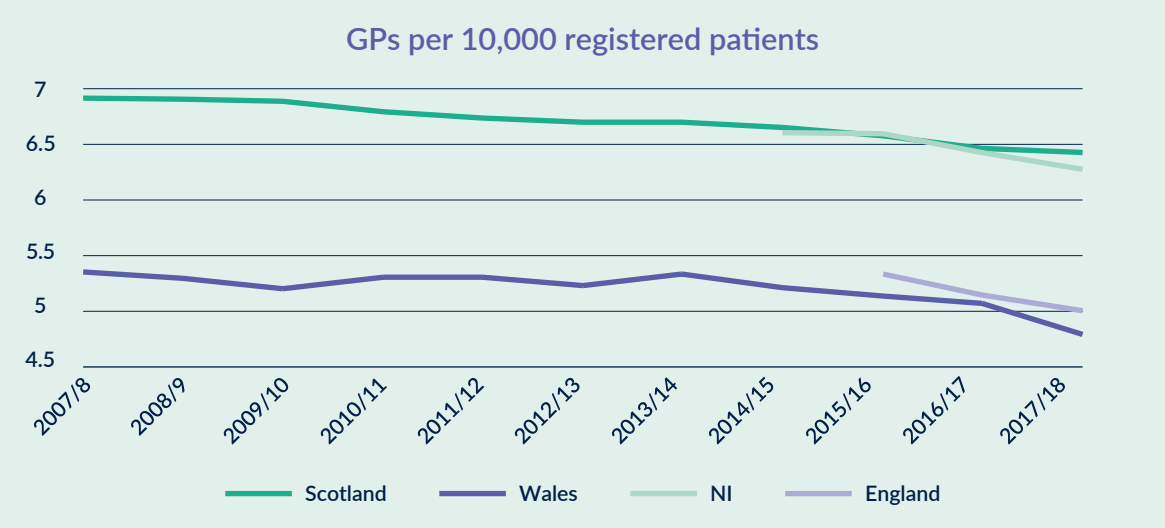


Figure 1: NB. England-only statistics are only comparable from 2015/16 due to changes in methodology[27]

The same pressures are also having an adverse impact on GP wellbeing and retention, driving an overall decrease in the size of the GP workforce. 92% of GPs say that they are under high or considerable pressure as a result of increasing workloads,[28] and just over a third say that a least once a month they consider leaving the profession as a result of the pressures they face.[29] Many GP practices and out-of-hours services are struggling to recruit and fewer GPs are choosing to be partners.

Research has found that countries with a robust primary care system have better health outcomes and lower rates of unnecessary hospitalisation.[30] Yet the proportion of NHS spending on both primary care and general practice has declined in recent decades. In England, primary care expenditure fell by 4% in real terms between 2011–12 and 2016–17,[31] whilst expenditure on general practice declined from 10.95% in 2005/6 to 8.41% in 2012/13. Across the UK, the share of the NHS budget spent on general practice stood at 9.22% in 2016/17.[32]

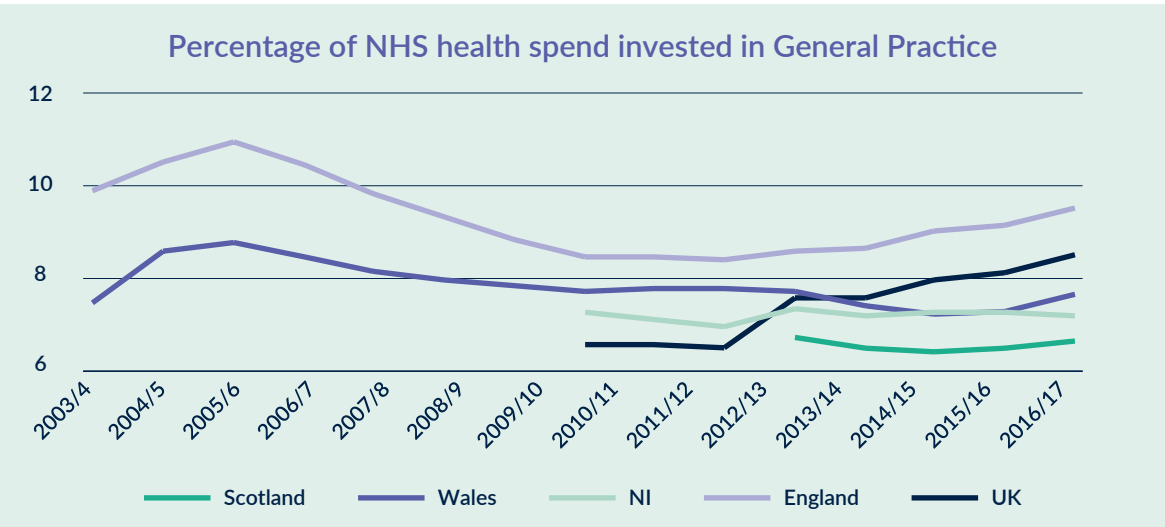


Figure 2: RCGP estimates of NHS health spend invested in general practice

General practice in 2030

By 2030, general practice will be a revitalised and growing profession. With the right staffing levels, GP workload will be manageable and job satisfaction rates will have increased.

The status of the profession, and the trust with which it is viewed by the public, will be at an all-time high. GPs will receive enhanced training and support and will have access to a wider range of career development opportunities.

The patient consultation will remain at the heart of general practice, but its form and content will have evolved. Shared decision-making will be the norm and GPs will be empowered to respond to the needs and preferences of their patients, while unwarranted variations in the quality and safety of care will have reduced. The standard face-to-face appointment time will be at least 15 minutes, with longer and shorter options available to suit the needs of individual patients. Consultations will be delivered in a range of ways: face-to-face in surgery or remotely through video, online or telephone. There will be enhanced access to appointments in the evenings and at weekends.

The local GP surgery will continue to be the first point of contact with the NHS for most patients but it will look very different in 2030. Patient care will not just be delivered by GPs but by multidisciplinary practice teams. The expansion of the practice workforce will improve patient access as well as widen the range of clinical services delivered in primary care. The general practice estate will have been comprehensively upgraded to house these expanded practice teams. GPs will deliver care in modernised, tech-enabled premises, offering a range of digital services such as video consultations and remote monitoring.

Primary care will provide more than just clinical treatment. Clusters of practices will serve as wellbeing hubs which will aim to address patients' broader psychosocial needs. Social prescribing schemes will offer parallel support to core general practice, helping to address social isolation and connect patients to community services. Tomorrow's GP surgeries will routinely host a wider range of prevention, wellbeing and social action projects and services, all of which will help to tackle health inequalities and build strong, resilient communities. In this way, general practice will be the bedrock, not just of the NHS, but of the very communities they serve.

By 2030, general practice will be at the heart of a well-resourced, revitalised primary care sector which will deliver high quality care close to home. GP practices will not be operating in isolation. They will be collaborating with other practices in networks, clusters, federations and super partnerships. They will be harnessing the benefits of collaborating at scale by pooling expertise, resources, back office functions and staff. Collaborating at scale will also ensure more equitable provision of care and a wider range of primary care services in a defined geography. General practice will take a proactive approach to improving the health outcomes of its local population. GPs will deliver more preventative and anticipatory care, actively managing patients with the most complex needs and supporting patients to self-care, to live as healthily as possible and to stay out of hospital.

While general practice will be operating at scale, the experience of care will not feel impersonal to patients. Continuity of care will remain a core value of general practice. GPs will still provide hands-on care and establish long-term, therapeutic relationships with patients, particularly with those with complex needs or multiple health conditions. Practice teams will work together to provide new forms of relational continuity – for example, between patients and micro-teams or named keyworkers – and all professionals involved in a patient's care will be able to access their electronic care record.

By 2030, the traditional boundaries between primary and secondary care will have become much more blurred. More services, diagnostic tests and treatments, currently delivered in hospitals, will be provided closer to home in community settings. There will be more specialists attached to groups of practices operating at scale. As care becomes more unified across traditional health and social care boundaries, GPs will continue to be powerful and independent advocates for their patients; they will be influential system leaders who will have a strong voice at all levels of NHS decision-making, locally and nationally. GPs in the UK will continue to deliver high quality patient care that is the envy of the world.

What patients want from general practice

We consulted extensively with patients, and their experiences, needs and preferences are at the heart of our vision for general practice.

Patients told us they want to be treated as equal partners working together with their practice teams. They don't want to be treated as a set of symptoms; they want to be treated as individuals.

Patients want their care to be joined up. They want to know that all the health professionals involved in their care are fully informed about their medical history. They want their care records to be shared so they do not have to keep repeating 'their story' at every appointment.

Patients want flexibility in how and when they see their GP. Whether it is a face-to-face, video call or over the phone, patients want to select the consultation method that suits them best. They also want to trust in the technology that supports their care.

Patients say they want to know how to look after themselves, to reduce the risk of developing serious health conditions, to spot the signs of illness, and to treat their symptoms before seeing a doctor.

General practice
A revitalised profession

General practice will be recognised as a high-status and rewarding profession. It will be the career of choice for growing numbers of ambitious and talented medical students.

With the right staffing levels, GP workloads will be manageable which, in turn, will reduce GP stress and burnout. Retention rates and job satisfaction will be higher.

The delivery of relationship-based, whole-person care will be at the heart of general practice. GPs will have more time to care for those patients with the most complex needs and will work with extended practice teams to provide enhanced continuity of care.

Patients will have more choice over the length, time and method of consultation. The standard face-to-face consultation length will be at least 15 minutes and more consultations will be delivered remotely through digital and video channels. GPs will have access to a wider range of data sources and diagnostic tools, and shared decision-making with patients will be the norm.

The skills of the GP as an expert medical generalist will be more highly valued than ever before. There will be more time and better support for training and professional development, and GPs will be able to take on extended roles and develop additional areas of expertise.

Benefits for patients

- Patients feel in control of their own health
- Patients have a better quality of life
- Patients are treated as individual, not as a set of symptoms
- Patients can make informed decisions about their care

Benefits for GPs

- GPs feel valued
- GPs have higher job satisfaction
- GPs have more time to care for their patients
- GPs will have time for career development
- GPs will have a range of career pathways

Benefits for the wider healthcare system

- Improved GP retention rates
- Lower utilisation of acute care
- Improved patient outcomes
- Cost-effective care delivered in general practice

A revitalised profession

In 2030, general practice will be a revitalised profession. The current trends of practice closures, partner resignations and GPs quitting the profession will all have been reversed. General practice will, once again, be regarded as a high-status profession and will be rewarding both financially and in terms of job satisfaction. GP workloads will be manageable which, in turn, will reduce stress and burnout and improve the retention of experienced doctors.

GPs will still be expert generalists with the advanced consultation skills to manage uncertainty and undifferentiated symptoms. But, as practice teams grow and become more multidisciplinary, they will also be leaders, advisers, teachers and mentors, who are able to support their practice teams and nurture the next generation of GPs. The diversity of the profession, and the range of opportunities that it offers, will be greater than ever.

The essence of general practice

There are various definitions of the core values of general practice. Barbara Starfield defined the four pillars of primary care as first-contact care, continuity of care, comprehensive care, and co-ordination of care.[33] The King's Fund has also articulated the four core attributes of general practice as person-centred holistic care, accessible care, co-ordination and continuity and community focus.[34] Although it might be expressed in different ways, common to these definitions is the strong relationship between GP as expert medical generalist and the patients, families and communities they serve. While care will be delivered in different ways in the future, and more tasks will be performed by other members of the extended practice team, relationship-based care will remain at the heart of general practice.

The evolution of the GP consultation

Patients say they want to access their GP surgery in a range of ways and they want flexibility in the length of consultations. By 2030, patients will have far greater choice in the length, form and time of consultations. Patients with urgent needs will be able to obtain easy access to GP care around the clock and more appointments will be provided in the evenings and at weekends. There will be an increase in the proportion of consultations that are conducted remotely by video calls, telephone or online. GPs and their practice teams will have the time and skills to conduct consultations through a range of communication channels.

> **I like that I can choose my GP and pick the one I can form a relationship of trust with. I accept seeing anyone if I need to in a hurry but like the ability for continuity in a non-urgent situation.**
>
> Patient from Hampshire

By 2030, the standard 10-minute consultation will be a thing of the past. The average length of GP consultations in the UK is currently 9.2 minutes, one of the lowest amongst economically advanced nations.[35] In order to give GPs more time to care, the standard length of a face-to-face consultation will increase to at least 15 minutes. Patients will be able to select the consultation length they require, allowing longer appointments for those with multimorbidity or complex needs.[36]

Consultations will not only take different forms; the relationship between doctor and patient will be recast. In future, patients will be treated as equal partners in their own care, with shared decision-making the norm (See 'Rethinking medicine and person-centred care' on page 27). There will be a cultural shift in the focus of healthcare: from treating disease and prescribing medication to address patients' psychosocial needs improving quality of life. GPs and their teams will support patients to take greater control and responsibility for their own health and equip them with the tools to manage their own conditions and live as well as possible.

> **Building a relationship and trust with my patients is really important to being able to help. This is particularly important for patients with mental health-related symptoms but who are struggling to accept that the problem isn't a physical one. Continuity of care is something that we really pride ourselves on in our practice.**
>
> GP from North Wales

Longer consultations – The Haxby Group

Haxby Group serves a population of 60,000 patients across York and Hull from 11 sites with approximately 30 GPs and 60 other primary care clinicians. The practice aims are to improve the experience of care, address the increasingly complex needs of its population and to have a focus on improving the experience of delivery of care – the latter has enabled GPs to provide longer consultations with 15 minutes as standard.

The redesign of the service began 2 years ago, from piloting in smaller sites to roll-out across the wider group, and is ongoing. The practice identified which tasks could be safely handed over from GPs to members of the wider team. The multiprofessional team consists of advanced nurse practitioners, physiotherapists, physician associates and paramedics, and is supported and supervised by GPs who are available to discuss and review patients. Further support comes from the practice nurse and healthcare assistant team. Competency frameworks have been developed to support the development of these teams and to support their introduction into the practice. Patient engagement was essential as this was implemented and progress was guaged by a quality improvement team looking a wide range of parameters including patient and staff experience with an analysis of the impact of the team on patient outcomes.

As the teams have become established GPs have been able to extend the length of routine consultations to 15 minutes. The changes have resulted in an improvement in staff morale as workload has become more manageable. Patients have been happy to see members of the wider team, and GPs feel that they are better placed to address the complex needs of their patients. The result is a sense that the attractiveness and sustainability of a career in general practice is improving.

Continuity of care reimagined

Continuity of care will remain at the core of general practice. But, as multidisciplinary team working becomes the norm, continuity will be developed in new ways. Triage, first-contact care and basic diagnosis will typically be shared with other members of the practice team, drawing on the skills of the GP as required. GPs will continue to provide hands-on care but will focus their surgery time more – though not exclusively – on providing enhanced relational continuity and holistic care to patients with more complex needs and multiple health problems.

Not every patient will need or want to see the same GP every time they visit their surgery. However, all patients will have a named GP, accountable for their care, whom they can choose to see if they prefer. Patients will have a shorter wait to see a GP but will be aware that, if they want to see their named GP, it may take longer.

All patients will benefit from organisational forms of continuity: their care will be co-ordinated and seamless, they will be supported to navigate through the health system (e.g. the interface between primary and secondary care), their electronic care records will be accessible to all professionals involved in their care and, consequently, they will not have to keep repeating their story. Providing continuity will be an integral part of the role of every member of the practice team. New forms of relational continuity, which are compatible with multidisciplinary team working, will be developed, for example, building a trusting relationship with a micro-team or a named keyworker in the practice team.

> **If we can go to a GP of our choice, nurse, phlebotomist, clinic or chiropodist at the same surgery, talk to the same receptionists and office staff, there is a strong sense of continuity which contributes to our healthcare. This cannot be under-rated as a factor in trusting the GP and the practice as a whole.**
>
> Patient from London

Figure 3: Continuity of care

Continuity of care and remote consulting – Pier Health

Pier Health is one of five projects funded by the Health Foundation to test new approaches to increasing continuity of care. The group of practices in North Somerset is looking to use an online tool – 'Ask my GP' – alongside matching patients to GPs to improve continuity between the patient and their preferred clinician. The project also aims to reduce GP workload and improve the service and experience for GPs and patients.

Patients will access care through an online tool and are asked to describe their problem, what they would like done and how best to contact them. Non-GP problems can be quickly identified and resolved by the practice team. Of the rest, it is estimated that only one third of patients need to see their GP face-to-face, with a third managed by email and the remainder over the phone.

In participating practices, a patient-GP matching process is taking place to distribute patients fairly between GPs and ensure all patients have a named usual GP. The online tool highlights the usual GP and will enable higher levels of relational continuity to be delivered.

By reducing the overuse of face-to-face appointments, managing more patients by online messaging and phone, and maximising continuity of care, the team at Pier Health expect to reduce GP workload by 10–20%.

Smarter workload management

A day in the life of a GP in 2030 will be busy, but structured and varied, allowing time for the individual to address the many competing demands for their attention whilst maintaining a healthy work-life balance. In future, practices will have the tools, support and structures in place to be able to manage their workloads much more effectively. GPs will be able to use real-time data to monitor demand and service, as well as technology to help direct patients to the most appropriate service or healthcare professional. Patient education will be delivered through both new and traditional communication models to enhance the ethos of self-care and optimise every consultation.

Manageable workloads will enable GPs to refocus their surgery time on patients with more complex needs and to devote more time to continuing professional development, their own wellbeing and quality improvement.

Smarter workload management – Harford Health Centre[37]

The Quality Improvement Team at Harford Health Centre in Tower Hamlets noticed they were dealing with a very high volume of documents including unnecessary correspondence. The practice identified that this was due to a lack of formal process and workflow, variation in who dealt with the correspondence, and inconsistent standards of training.

To address the problem, the practice undertook a quality improvement initiative that aimed to reduce the volume of correspondence handled by GPs by 50% over a six month period. After collecting baseline data, the practice created a categorisation list to help administrative staff identify what type of letter should go to which clinician, implemented scanning protocols, provided training for the reception team, including teaching them how to code diagnoses and introduced new safety processes.

They met their target within three months and have now managed to reduce the amount of correspondence being routed to GPs by 70%. The practice plans to demonstrate cost savings in time spent by locums managing correspondence, as well as increased appointment capacity – meaning the initiative is better for patients as well as practice staff.

Continuous improvement

While the personal interaction between doctor and patient will remain at the heart of consultations in 2030, GPs will also have a personalised data dashboard for every individual patient. In addition to an integrated digital care record, which will document the full range of a patient's interactions across the health system, the GP will draw on data from the patient's genomic profile, remote monitoring 'wearable devices' and automated, AI-supported, triage tools, to gain a richer picture of an individual patient's health status.

Quality of care will be driven up by a culture of continuous learning, not by externally imposed standards. GPs will have the time, skills and tools to routinely use data, clinical audits and patient feedback to review practice and continuously improve how patient care is delivered, and to ensure that as science and technology are applied in new ways, this is done in line with the highest ethical principles.

The data readily available to the GP will provide insights into symptoms, conditions, causes and inform treatment and care plans. It will allow the GP to access information about what is achievable and realistic for the individual patient and highlight best practice. As technology continues to advance, for example as genomic profiling moves from targeted parts of the genome to the whole individual genomic sequence, this process will become more precise and efficient.

Genomics

The use of personal genomic information in the delivery of healthcare is one of the most exciting advances in recent medical history. The widescale use of genomics in general practice will enable patient care to be individually tailored. By 2030, GPs will be routinely using genomic data to inform decisions on optimum treatment pathways.

Genomic data will:

- Target medications and treatments based on likely response to them;
- Assist in the diagnosis of very rare diseases;
- Predict conditions that patients are at risk of developing based on their genetic history;
- Facilitate the development of new medicines and therapies based on genomic research;
- Help patients become more aware of their own genetic history and, consequently, improve self-management.

General practice as a career destination

In the future, general practice will be the career destination of choice for a growing number of medical students and foundation doctors. The skills and expertise required to be a GP will be understood and more highly valued than at present. Formal recognition, through the inclusion of GPs on the specialist medical register, will enhance the status of general practice, help it acquire genuine parity of esteem with secondary care specialities and, consequently, make it a more attractive career option.

The appeal of general practice as a career choice lies precisely in the flexibility of working options and the wide range of career pathways it offers. As primary care develops in size and scale, the potential career opportunities for GPs will be wider than ever (see Figure 4), and GPs will be able to build portfolio careers or pursue different career options depending on their aspirations and life circumstances. There will be more opportunities to work in a variety of settings alongside core general practice, for example alongside secondary care physicians in acute care settings and within the voluntary or social care sectors.

Figure 4: GP career development opportunities

Training and career development

A GP's core skill set is the ability to assess undifferentiated symptoms, explore potential underlying causes, make diagnostic and referral decisions and manage the care of patients with multiple long-term health problems. In 2030, GPs will have the same generalist focus as today but will need to develop new areas of expertise in order to respond to the increasingly diverse and complex needs of their populations and to provide a greater range of services in the community. This 'stretch' in skills will include, for example, confidence in working in out-of-hours settings, meeting the needs of disadvantaged communities and the ability to consult effectively through new digital communication channels. Moreover, GPs will require leadership and educational skills to support and develop multidisciplinary teams and to train and mentor the next generation of GPs.

GPs will receive enhanced and extended specialty training, with the current mandatory three years increasing to at least four years. A greater proportion of this will take place within general practice, allowing trainees the opportunity to experience a range of different practice settings and models of care delivery. The focus will be on training GPs in the delivery of holistic care based on the needs of local populations, giving them more time to develop their expertise across the vast breadth of complex conditions that they will deal with in the future and equipping them with the skills and confidence to resolve more issues in general practice settings.

Doctors who are training or have trained in other specialities who want to retrain to become GPs, will find it easier to transfer, and recognition of their relevant experience will be more readily obtained. Newly qualified GPs will have access to structured fellowship programmes to enable them to explore the range of career pathways in primary care and gain ongoing support including mentoring and coaching by more experienced GPs. GPs at the middle stages of their career will also have new opportunities to undertake fellowships, to further develop their careers in primary care.

By 2030, every GP will have protected time to devote to their continuing medical education (CME) and career development more widely. GPs will be able to spend more time keeping abreast of the latest developments in medical science and clinical care across a broad range of topics or else develop more extensive expertise in a specific clinical area. They will also have protected time to develop their non-clinical skills such as leadership, education, business management and IT.

Rethinking medicine and person-centred care

By 2030, general practice will have been at the forefront of a radical cultural shift away from the conventional 20th century biomedical model of healthcare, towards a more holistic approach which considers people's physical health in the context of their broader life circumstances and has the aim of enabling people to live as well as possible for as long as possible.

For patients, particularly those with multimorbidity, it means no longer being treated as a set of symptoms or attending multiple appointments for each health condition. Healthcare will cease to be 'done to' them; instead they will be equal and active partners in their own care. Medication will no longer be the default option. Instead, GPs and their practice teams will have the time and the skills to explore the values and preferences of patients and plan their care together, in ways which reduce the burden of treatment, fit around their lives and are, therefore, easier to adhere to.

Patients will be supported by their practice teams to understand the potential risks and benefits of different treatments and to make lifestyle changes or adaptions to manage their own health. The ethos of shared decision-making will be woven into the medical curriculum from undergraduate level and will inform clinical practice across the healthcare system.

The wider system will facilitate rather than hinder holistic care; for example, the way that GPs are currently incentivised to manage patients with multiple health problems in separate disease-specific silos via the Quality and Outcomes Framework (QOF) in England, will have been replaced by quality improvement initiatives underpinned by a more sophisticated, person-centred approach to care. This approach values the GP who works with the patient to achieve what matters to them, rather than imposing what a pathway or protocol insists is 'best' for them.

The wider health system will be responsive to the needs and preferences of the population. GPs are currently fearful of criticism and litigation if they deviate from recommended protocols and pathways.

By 2030, service design and quality improvement will be genuinely co-produced by GPs, their practice teams and the communities they serve. The local NHS architecture will permit rather than restrict this bottom-up approach to service improvement, harnessing the skills and expertise of the people both delivering and using the service, and will be flexible enough to celebrate rather than supress conscious deviation from 'ideal pathways' of care.

General practice
An expanded team

Care will be delivered by multidisciplinary practice teams, comprising a range of clinical and non-clinical roles and offering a wider range of services.

New roles will complement the skills of the GP, enabling practices to better support patients to manage their conditions and to remain in good health. Multidisciplinary teams will work together to provide enhanced care to patients with the most complex needs.

GPs will provide leadership, advice, training and mentoring to their practice teams and will retain ultimate responsibility for the care of their patients. General practice will be the career destination of choice for a growing number of NHS professionals.

Benefits for patients

- Patients will be able to access a member of the practice team quickly
- Patients will benefit from a wider range of services from their practice
- Patients will have the tools and motivation to self-manage their conditions
- Patients will be in control of their healthcare

Benefits for GPs

- Reduction in GP workload and stress
- GPs' can refocus their time on clinical leadership and patient care, particularly on more complex cases
- Practice staff will feel well-supported and part of a team

Benefits for the wider healthcare system

- Expanded capacity in primary care
- Services delivered in primary care are more cost-effective
- Anticipatory and preventative care reduces pressure on acute services
- Improved patient activation

Expanding the practice workforce

A step-change in the evolution of general practice is the expansion of the practice team. By 2030, general practice will be delivered by multidisciplinary practice teams, comprising a range of clinical and non-clinical roles. The skill mix in the traditional practice team has increased in recent years, but progress has been variable in different parts of the UK and

from one practice to the next. Funding for these additional roles has often been time-limited and channelled through a range of funding streams, which can be onerous for GPs to access.

By 2030, extended teams in general practice will be the norm throughout the UK. The multidisciplinary practice team of tomorrow will have a broader scope with a wider range of roles than at present. Patients will understand and trust the skills and expertise of each member of the practice team. With the right funding in place, we will see a much more stable general practice workforce, which in turn will ensure greater relational continuity between practice teams and their patients. There will be an increase in both the number of GPs and the number of staff working in other roles. Staff satisfaction will be higher and staff turnover lower.

England	The practice workforce has grown over the last three years, but practice nurse numbers have fallen. 45% of GPs say they find it difficult to recruit nurses.[38]
Scotland	Numbers of nurses increased by 7% between 2009–17, whilst the number of health support workers (HSW) has increased by 37% from 2013–17. Other health staff most commonly working in practices are pharmacists, health visitors and midwives.[39]
Wales	Practice nurse numbers increased by 10.8% from 2013 to 2017, and the number of staff involved in the delivery of direct patient care increased by 11.9% during the same period.[40]
Northern Ireland	The Health and Social Care Board says that 100% practices have access to a practice-based pharmacist. A recent survey by RCGP Northern Ireland showed that 81% have access to practice nurses and 17% or fewer practices have access to occupational therapists, physiotherapists, paramedics or physician associates.[41]

Figure 5: The multidisciplinary workforce in primary care across the UK

The benefits of multidisciplinary teams

The expansion of practice teams will mean better access for patients, who will be able to see the health professional that is most appropriate for their needs, rather than having to wait for a GP appointment. It will ease the workload of GPs and help to reduce the stress and pressure many GPs feel when working in isolation. Expanded teams will have the capacity and skills to deliver patient education and support for self-management and behavioural health improvements – tasks which currently GPs often do not have time to undertake.[42] New roles bring additional skills, expertise and fresh approaches to care into the practice. For example, pharmacists will bring significant expertise on medicines management, and mental health therapists can improve understanding of mental health across the wider practice team.

> **If it works well it provides a wraparound health and wellbeing service and makes accessing healthcare and support easier**
>
> Patient from England

Practices will assess the needs of local populations and implement appropriate skill mixes with support from other practices within their network. These roles will complement rather than replace the GP's expertise – through task substitution not role substitution. There will be new roles which widen the range of services delivered in general practice. Some of these are already being more widely rolled out, such as pharmacists, while others are introduced in some locations, such as physiotherapists and mental health therapists. By 2030, a wider range of roles will be based in general practice, for example occupational therapists, vocational rehabilitation advisers, dieticians or health coaches.

GPs will have closer links with secondary care and some of these services will also be delivered in primary care settings: for example, a practice may run musculoskeletal and dermatology clinics or offer near-patient testing. Networks or clusters will, as they mature, assume responsibility for a wider range of community healthcare services, such as district nursing.

In addition to patient-facing roles, we will see significant development and further professionalisation of practice management and back office functions, such as finance, IT and human resources. These non-clinical roles will evolve – for example, some receptionists will also become care navigators, who will be able to route patients to the right professional or service. As with patient care roles, some of these may be located physically in practices, depending on the size of the practice, or else pooled across networks and clusters of practices.

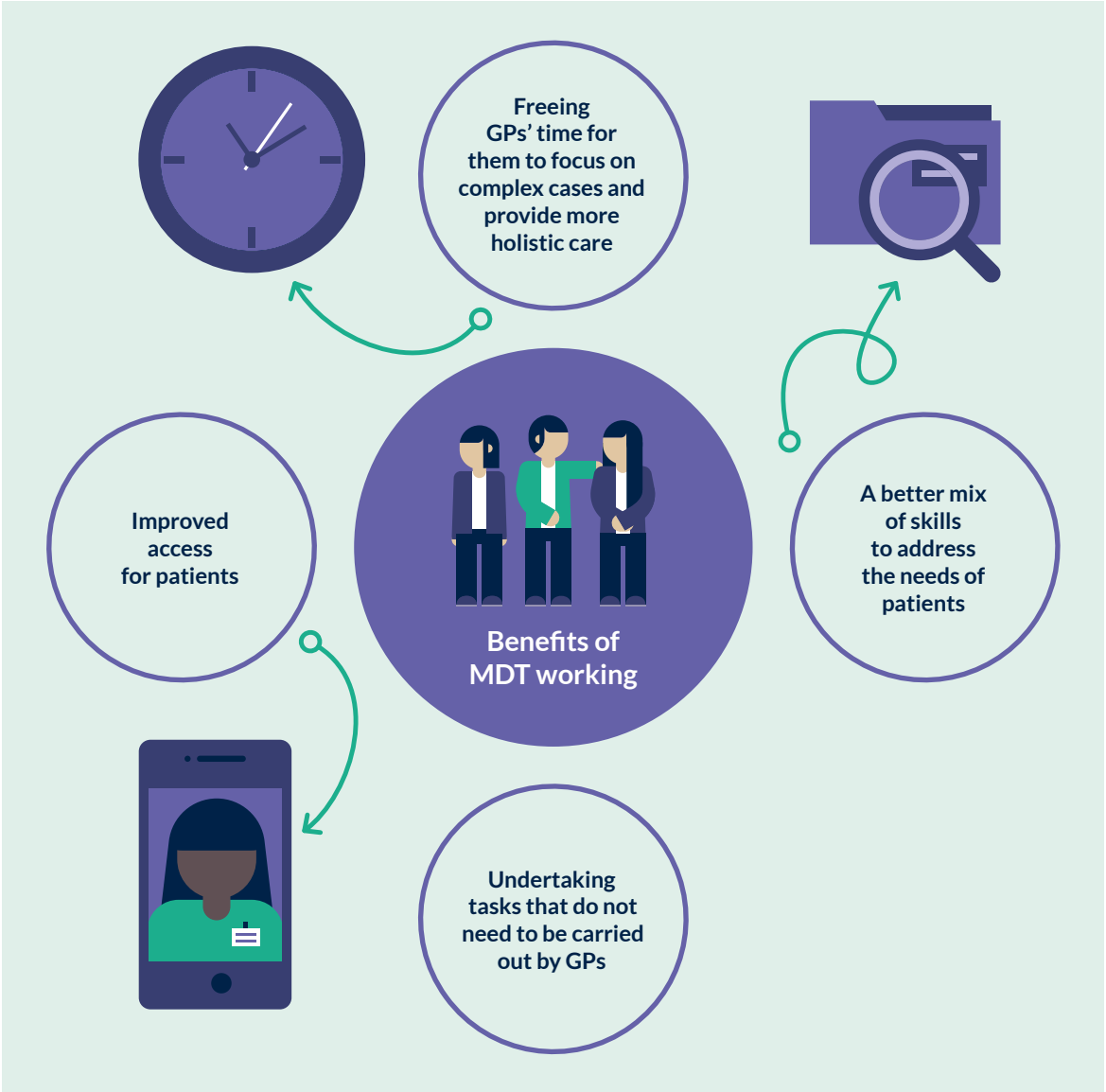


Figure 6: Benefits of multidisciplinary team working

Micro-teams and continuity of care – One Care

In 2018, the Health Foundation launched a programme to test innovative ways of increasing continuity of care in general practice. Two of the five projects are being supported in their delivery by One Care, a GP Federation in Bristol, North Somerset and South Gloucestershire.

One Care aims to strengthen continuity of care in a general practice environment, characterised by an increase in part-time and portfolio working, and at scale delivery. The programme helps practices to identify their most vulnerable patients. It upskills receptionists and other administration staff who, as the first point of contact with patients, are integral to ensuring relational continuity.

Micro-teams will be established, comprising clinicians (GPs, ANPs, nurses, healthcare assistants and clinical pharmacists), receptionists and administrative staff. Patients will be made aware of who is ultimately responsible for their care, even if they do not see their named GP at every appointment.

Figure 7: Expanded teams: what patients and GPs told us

Roles and responsibilities

The expert generalist skills of GPs, together with the core values of holistic, relationship-based care, will remain at the heart of multidisciplinary teams. GPs will lead practice teams, hold risk and retain overall clinical responsibility for their patients. They will continue to provide hands-on patient care, where their expertise and skills are needed most, managing multimorbidity, undifferentiated illness and making diagnosis and referral decisions. Other members of the practice team will undertake a range of tasks which need not be performed by a GP. Some practitioners will have a high degree of independence, for example, being able to prescribe, whereas other roles will require more supervision. The GP will also play a role in upskilling and supporting their practice staff to develop generalist skills.

While clinical teams will be led by GPs, there will also be new leadership roles for other primary care professionals, for example, larger practices or primary care networks are likely to have nurse directors. Each MDT will have a care co-ordination or case management function which will ensure that patient care is joined up. Teams will review and discuss the cases of specific patients – for example, patients with complex needs receiving palliative care. The respective roles and responsibilities within an MDT will be collectively defined by the team.

GP-led teams - Ty Doctor, North Wales

Several retirements left Dr Arfon Williams the 'last partner standing' in his practice in Nefyn, North Wales. Rather than close the practice and further reduce access to healthcare in the area, the team made radical changes to the skill mix in the practice, optimising workloads, triaging and signposting all phone calls and upskilling every member of staff.

Extra training was provided to all staff, arrangements for cross cover were made and an advanced nurse practitioner (ANP) was employed. Locating the practitioners in adjacent rooms allows the ANP to ask for advice when needed. Receptionists received additional training, enabling them to confidently direct patients to the appropriate member of the wider practice team, which included, amongst others, a physiotherapist, an audiologist and a social worker. In addition to this, the practice offers onward referrals, for example to a minor injury unit or local pharmacist. Access to the wider practice team was ensured through the practice's enrolment in relevant pilot schemes run by the health board.

Regular communication was provided to patients, who have received the changes positively and are satisfied that they can be seen by a suitably qualified clinician in a prompt manner through pre-booked or on-the-day appointments. Staff morale has improved, patients have enjoyed improved access and, on average, the GPs and ANP have 14% spare capacity.

Team development

Practice staff will work in a collaborative and supportive environment. All new practice staff, whatever their role, will feel that they are valued members of the team with an important part to play. They will receive supervision, support and career development, as well as protected time to engage with their professional networks. General practice will be just as much a career destination of choice for members of the wider practice team in both clinical and non-clinical roles as it will be for aspiring doctors. This will be underpinned by first class training, which gives trainees clinical exposure to general practice, and by ongoing continuous professional development. There will be a recognised framework of competencies for different roles and opportunities for progression into leadership positions.

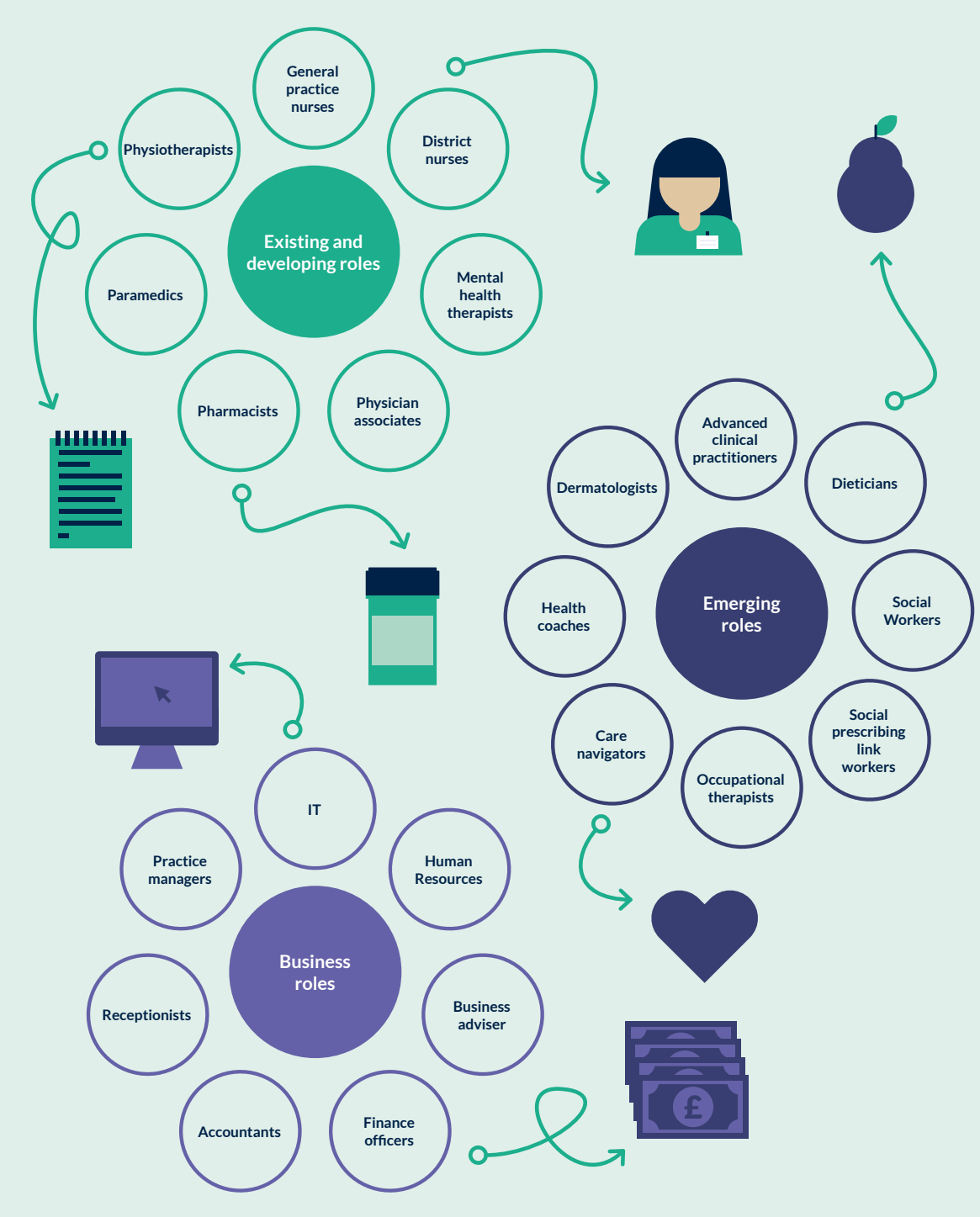


Figure 8: Tomorrow's practice teams

The digitally-enabled practice

Over the next decade, advances in digital technology will have transformed how GPs care for their patients. If the potential benefits of this technology are harnessed properly – and safely – it will significantly improve the provision of holistic, personalised care, help in reducing health inequalities and significantly enhance the services available to patients out-of-hours or in remote locations.

GPs have always been a step ahead of the wider NHS in embracing digital technology and many emerging technologies have already been adopted by digitally-savvy practices, whilst others have been held back by procurement barriers and resource constraints. By 2030, all practices in the UK will be digitally-enabled to deliver care safely in ways that will facilitate improved access for patients and equip GPs to do their jobs more effectively.

GPs will use digital technology to deliver more proactive and preventative care. Remote monitoring of patients' conditions and adherence to medication, through home testing and wearable technology innovations, will be the norm. The 'internet of things' – linking wearables to smartphone apps and patient-held electronic records – will empower patients to better manage their own care, check their current health status and quickly alert them and their GPs when they are at risk.

Artificial Intelligence (AI) will also have a transformative impact on the way that care is delivered, on the day-to-day life of GPs. AI will assist GPs in a range of different tasks:

- Improving triage for patients presenting to acute settings and those with long-term conditions who require regular contact with their GP
- Flagging 'at risk' patients automatically
- Enhancing diagnostic decision-making
- Identifying potential treatment pathways along with their risks and benefits
- Assessing the severity of needs and suggesting treatment options
- Automating routine administrative tasks

Digital technology will improve patient care overall, support continuity and self-care and make GPs' working lives easier and more rewarding. By 2030, the NHS will have the right processes in place to ensure that digital innovations in healthcare are safe, effective and can be quickly scaled up. GPs who wish to specialise in digital technology will have opportunities to engage in the development of AI and other digital innovations.

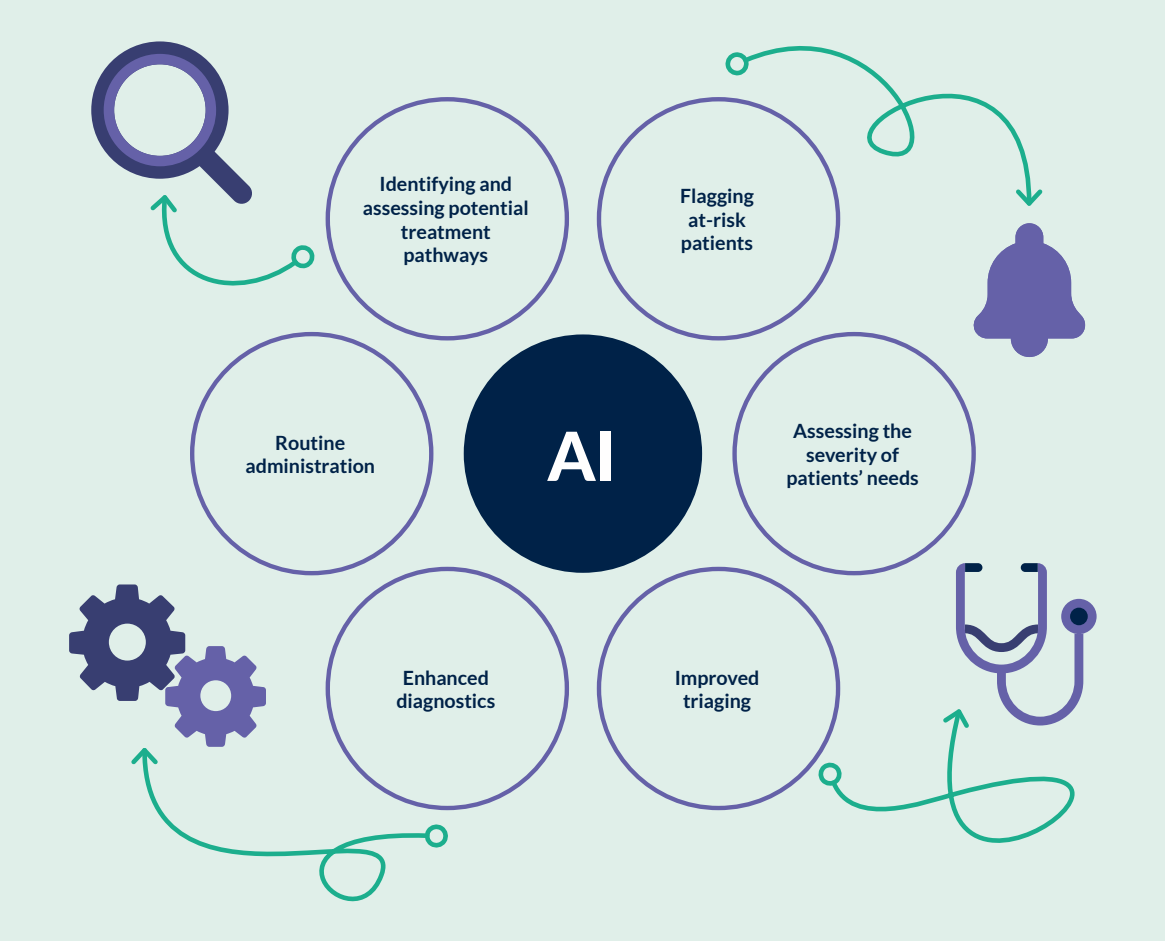


Figure 9: The benefits of AI in primary care

Online access – Blithehale health centre

Increased demand from patients had increased the reception's workload to the point that it was unsustainable. The practice launched a project to increase patient use of online services by 50% over a six month period, with the ultimate aim of reducing the number of telephone calls and lowering staff stress levels.

Through promotion of its online services, the practice encouraged patients to take responsibility for booking and cancelling appointments and ordering scripts. They advertised these services within the practice, developed a new patient information leaflet and promoted e-consult services and access to online records. All staff – including clinicians – got involved to bring about the culture shift, talking to patients about online access and encouraging them to register.

This activity resulted in a 38% increase in active online users, an increase a 20% increase in the use of the electronic prescription service, and an overall saving of 13 appointments per week.

General practice
The bedrock of a sustainable NHS

GPs will work at scale in collaboration with neighbouring practices to proactively improve the health outcomes of the populations they serve, enhance access, and tackle health inequalities. The values of continuity and person-centred care will be at the heart of these new collaborations.

GPs will deliver care around the clock and across the traditional organisational boundaries between hospitals, primary care and social care. They will be influential system leaders both locally and nationally.

Practices will evolve into wellbeing hubs, hosting a range of wellbeing and community services which prevent ill-health and help to build strong, resilient communities.

General practice will be at the core of a revitalised, well-resourced primary and community care sector which delivers care closer to home, improves health outcomes and supports patients to self-care and lead healthier, more independent lives.

Benefits for patients

- Wider range of health and wellbeing services available
- Improved access to services
- More equitable provision of services
- Improved quality of life

Benefits for GPs

- Economies of scale
- Greater financial security
- Sharing of expertise
- Improved data analytic capability
- Division of labour enabling GPs to focus their time on clinical care
- Opportunities for career development in leadership and business management

Benefits for the wider healthcare system

- Reduction in unscheduled hospital admissions
- Reduction in the incidence of preventable diseases
- Improved population health outcomes
- People taking more responsibility for their own health
- Reduced pressure on primary and secondary care

At scale but with a personal touch

A growing number of practices are recognising the advantages of collaborating at scale to improve services and patient outcomes, and to relieve the pressures they are under. While practices will still vary in size and shape depending on local populations and geography, by 2030 all GPs will be collaborating at scale across groups of practices. But the core values of continuity and holistic care will remain at the heart of these new collaborations. General practice will be delivered at scale but will still have a personal touch. Practices will continue to be at the heart of their communities and, indeed, will become hubs for a wider range of health, wellbeing and community services, which will strengthen their connection to the populations they serve.

These at scale collaborations of the future will not be imposed on practices from above. Rather, they will be co-created by GPs, allowing smaller practices to retain their independence and responsibility for the patients on their lists, and will be known by a variety of names, including networks, clusters and federations. GPs will harness the benefits of operating at scale, for example by pooling expertise, resources, back office functions (e.g. administration, business intelligence, IT, HR) and practice team staff (e.g. pharmacists and social prescribing link workers).

In 2030, general practice will continue to be a mixed economy of business models, ranging from relatively small practices to social enterprises and super-partnerships. With the right level of funding and appropriate incentives, the financial risks of owning a practice will no longer outweigh the rewards, as they have done for many GPs in recent years. The partnership model will attract a new generation of GP partners, who are drawn to the autonomy and opportunity to innovate and to shape their own services that partnership offers, with the support of wider networks.

Collaborating at scale does not just make good business sense, it benefits GPs, practice staff and patients. It means that patients will have faster access to a wider range of services closer to home and there will be a reduction in unwarranted variation in care delivery between local practices. It will ensure all GPs and their teams are well supported in delivering continuity of care to all their patients. It means innovative quality improvement ideas can be more quickly spread across a group of practices. It will provide all practice staff with professional networks, peer support and opportunities for career progression. GPs will be able to become directly involved in the business development side of general practice, if they wish to, or be supported by in-house business intelligence functions.

Locum pooling at scale - Newry and District Federation of Family Practices

Newry and District (N&D) Federation of Family Practices in Northern Ireland is comprised of 31 practices and serves 150,000 patients. Some practices have had exceptional difficulty obtaining locum cover, as a result of which GPs were unable to take holidays for over two years. The Federation obtained pump prime funding to establish a new locum pool. Locum posts were funded for two sessions a week, including maternity pay, sick pay and superannuation. Practices now pay for the service and this money is reinvested back into the Federation.

Initially, 10 GPs were recruited providing 15 days' cover in total. Although the Federation was aiming to recruit GPs who had just completed their specialty training, the pool now has a diverse mix of experienced GPs and new recruits. The scheme has worked well to date but, understandably, meeting demand from practices has been challenging. The locums have some choice over which the practice they work in, but they also understand that, where possible, services must be shared equitably.

There have been unexpected benefits of this initiative. One newly qualified GP now represents her area on the Local Medical Committee (LMC) and two of the experienced GPs, who had been considering leaving general practice altogether, have, as a result of the scheme, taken up permanent posts. The locum pool model has also been replicated in the establishment of a central Practice Improvement and Crisis Response Team, which provides specialist support, advice and locum cover to struggling practices.

Population health

By 2030, GP networks will be able to consistently take a proactive 'population health' approach, rather than reactively struggling to manage demand. Evidence from at scale care models across the UK and abroad highlights the vital importance of investing in real-time data analytics. With the aid of insight from health data, GPs will have a comprehensive understanding of the health needs of the populations they serve, undertake risk stratification and work at both an individual and community level to tackle health inequalities. Networks will design preventative and anticipatory care services to help achieve desired patient outcomes – for example, falls prevention services or comprehensive community matron services, which can reduce the risk of unscheduled hospital admissions.

Managing demand also means encouraging and supporting patients to take more responsibility for their own health. In England, it is estimated that one in four GP appointments are potentially avoidable.[43] Patient demand for GP consultations will, in future, be moderated through social marketing campaigns which will encourage patients to self-care or visit their pharmacist for minor illnesses or conditions where appropriate.

Practices will play their part by using methods such as providing self-care advice on their websites, employing care navigators and equipping patients with the skills and tools to self-manage many health and care situations. These actions will support patients to use these services in a responsible manner, improving sustainability across the NHS as a whole.

Use of data to improve population health – Newham LTBI screening

Newham CCG in East London had the highest tuberculosis (TB) rate in England. In 2014, they worked with GP practices to launch an innovative programme to raise awareness of latent TB infection (LTBI) among the local community, and to screen and treat patients in primary instead of secondary care.

The programme targets people aged 16–35 from high-risk countries who have been in the UK for under five years. When they register with a GP, they are offered a blood test to check for LTBI. If they test positive, they are given a chest X-ray, blood tests and a three-month course of treatment, mainly provided through local pharmacies.

The approach is part of a three-year trial designed to identify whether a primary care model for LTBI screening and treatment is more effective than secondary care. Since 2014 over 10,000 patients have been screened and over 400 people treated for LTBI in primary care. Newham now has one of the fastest reducing rates of TB in the country – dropping from 77 per 100,000 to 48 per 100,000 in 2017/18.

Prevention and wellbeing

By virtue of the high levels of public trust they enjoy, GPs are uniquely placed to contribute to the broader prevention agenda. The traditional strength of general practice lies in the strong trusting relationship between GPs and their communities. Collaborating at scale does not mean that relationships will inevitably be weakened or that GP services will feel more impersonal to patients. In fact, it presents new opportunities to strengthen the community focus by widening the range of services delivered in primary care. In 2030, clusters of practices will not only deliver medical care, they will evolve into wellbeing hubs offering a range of services which address both clinical and non-clinical needs.

GPs spend an estimated 19% of their consultations dealing with non-clinical issues – most commonly relationships, housing, isolation, work and financial problems.[44] In future, social prescribing will be a key part of the extended general practice offer. All clusters or networks of practices will offer social prescribing services in parallel to traditional clinical care, in which link workers will have the time and skills to explore and understand patients' life

circumstances and signpost them to appropriate local services which address their non-clinical needs.

As well as signposting, GP surgeries will host a range of prevention or wellbeing schemes and social action projects. These will include initiatives which enable people to lead healthier lifestyles, for example cookery courses, exercise classes or walking groups. The Marmot report, Fair Society, Healthy Lives, highlighted the association between social isolation and health inequalities.[45] One study found that weakened social relationships have a comparable influence on mortality to smoking and alcohol.[46] In future, interventions which combat social isolation at key life moments – teenage pregnancy, leaving home, retirement or disability in old age – will be delivered or co-located in primary care. In this way, general practice will play a pivotal role, not only in preventing ill-health but in reconnecting people with social networks and building active and resilient communities.

Deep End GP Pioneer Scheme – Glasgow

The Deep End GP Pioneer scheme was set up in 2016, with funding from the Scottish Government, to address longstanding workforce challenges in the most deprived urban areas. The scheme aimed to recruit younger GPs and retain experienced GPs in six practices in Glasgow.

Posts were designed to attract younger GPs, for example, by including protected time for personal development, and were advertised through various channels including social media. The recruitment of six Deep End Fellows provided additional capacity to the host practices which, in turn, gave more experienced GPs protected time to focus on issues facing deprived communities, such as low take-up of cervical screening.

Now in its third year, the scheme has given the practices involved a significant lift, with reduced stress levels. GPs who had been considering early retirement reported a renewed enthusiasm for their work. Four of the first five fellows recruited to the scheme have taken up salaried or partner positions within the Deep End practices.

Outreach to vulnerable groups

GP practices will, in future, provide more outreach services to vulnerable groups. These will include more home visits for disabled and frail patients, care for prisoners, and drop-in clinics for the homeless at hostels and shelters. These groups often experience multiple barriers to accessing routine GP services – for instance, due to the lack of a permanent address or access to IT – leading to lower standards of care.

Social prescribing – Healthier Fleetwood

Fleetwood is a small town on the Lancashire coast with a population of around 30,000. Life expectancy rates are much lower than the England average and the prevalence rates for all long-term conditions are at least twice the national average.

Between 2014–2016, eight GPs retired or left the town and only three could be recruited. In response, practices decided to work in partnership with other health and care providers and local residents, and the Fleetwood Primary Care Home was created. As well as managing illness – both acute and long-term – there has also been a focus on wellness and resident empowerment through the 'Healthier Fleetwood' movement, which has seen a wide variety of activities and social groups set up by residents.

Healthier Fleetwood aims to improve and maintain the mental and physical health of local people, boosting their confidence by encouraging them to take control of their own health and wellbeing, instead of relying on professionals to manage it for them. This is done by connecting residents to the many activities on offer as part of the social prescribing path now being developed in the town. These include arts and crafts, fitness and sports, friendship groups and much more with activities run by partner organisations or often the residents themselves. Healthier Fleetwood provides practical support and advice in areas such as funding, promotion and administration without taking the lead, so the groups develop naturally and become sustainable for the long-term benefit of the community.

Round the clock care

By 2030, urgent and out-of-hours care will be sufficiently resourced, funded and equipped with the technology and infrastructure needed to deliver high quality 24/7 care. Patients will find it easy to identify and access the right service for their particular needs. GPs working in out-of-hours and urgent care services will have access to rapid response services, such as home support for the frail and mental health intervention teams. All out-of-hours services will have access to comprehensive shared electronic patient records so that they are fully informed about their medical history, allergies, anticipatory care plans or end of life preferences.

Integrated care

By 2030, the traditional organisational boundaries between acute, primary and social care will have become blurred as integrated care models are rolled out and more specialist services are moved into community settings, for example multidisciplinary diagnostic centres

for cancer and community-based specialist clinics. GPs will directly consult with a wide range of secondary care specialists quickly and easily. Secondary care specialists will regularly be co-located with GPs in surgeries as well as acute settings, or attached to networks and clusters, while more GPs will be providing expert generalist clinics in hospitals. A higher number of GP practices will either have local access to or on-site access to diagnostic laboratories. The integration of these services with primary care will reduce patient waiting times and assist in the removal of barriers between primary and secondary care.

> **Regular telephone/VC case conferences with speciality consultant colleagues at our main referring hospital and our GPs has vastly improved both our confidence in complex case management and reduced hugely time consuming (due to great distance) hospital appointments. It has also ensured referrals made are more appropriate.**
>
> GP from Scotland

Integrated Care - Health 1000

The Health 1000 pilot aimed to show that a co-located multidisciplinary team, with GPs in the driving seat, could have a significant, positive impact on patient outcomes. The three-year project was targeted at patients from across Barking and Dagenham, Havering and Redbridge, with five or more long-term conditions and complex needs.

A team of healthcare professionals including GPs, a consultant geriatrician, physiotherapists, occupational therapists, social workers and pharmacists, worked together in a health and social care practice based at King George Hospital.

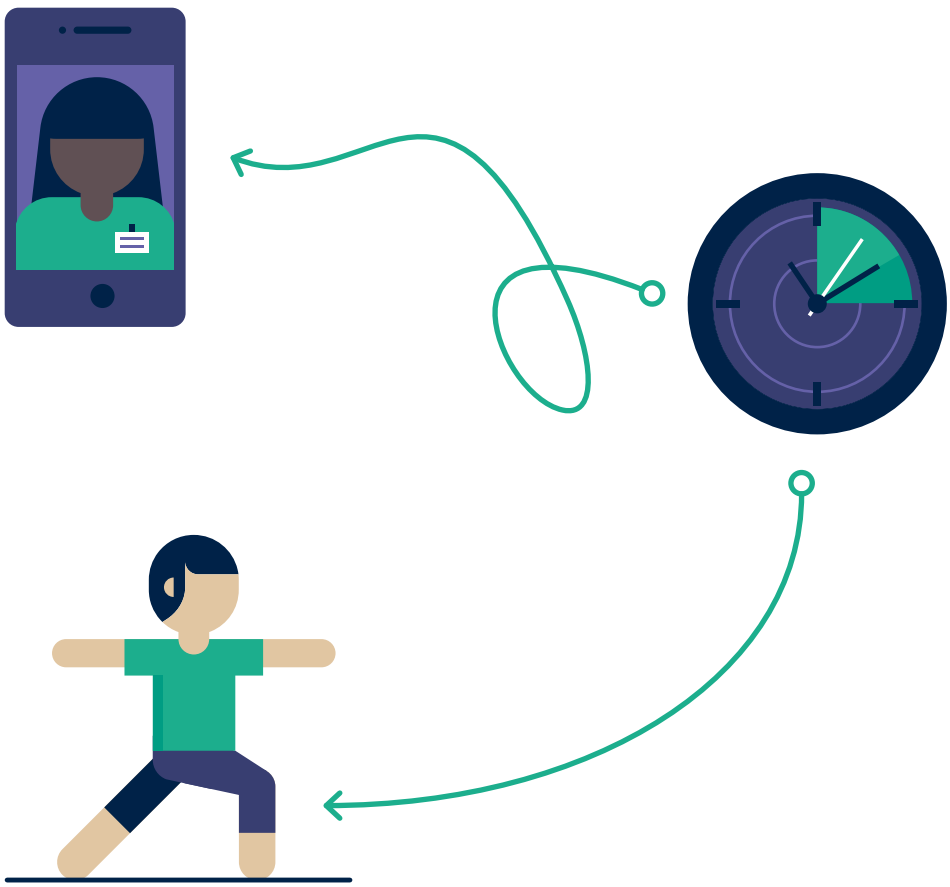
The team delivered integrated, personalised care seven days a week to over 700 patients, each of whom had a named personal care co-ordinator. Care plans were co-created with patients, helping them to manage their health, stay out of hospital and maintain their independence for as long as possible. Clinicians also worked with Age UK to develop wellbeing services, and with local care homes to support and train staff.

The pilot was shown to have had a positive impact on the working experience of staff as well as reducing emergency admissions and the number of bed days. There were also reductions in A&E attendance.

There is no one-size-fits-all model of integrated care. In some parts of the UK, integration of primary and acute care may take legal and contractual forms; in other parts, cross-sector collaboration will be voluntary and not contractually bound. In developing integrated ways

of working, the function of what is needed must come before organisational form. The question 'What outcomes do we want to deliver?' must take priority over the contractual and structural form of integration.

Whatever organisational forms these new integrated care models take, our vision is for GPs to have a significant say in their design and delivery. More broadly, general practice will be a powerful and influential voice at all levels of NHS decision-making, locally and nationally. This is the only way to ensure that the primary and community sector, so long starved of investment, is reinvigorated and has the capacity to deliver preventative care and enable patients to live as well as possible and stay out of hospital for as long as possible.



Enablers

There are six key enablers which are vital for realising our vision for general practice. The College will work with key stakeholders to leverage these enablers and ensure that, by 2030, all UK practices are delivering world class patient care.

As part of this, we will be working to develop roadmaps to set out how how we will be playing our part in taking these enablers forward, and what action is needed from policy makers, system leaders, professional bodies and others.

Funding

Funding is essential for revitalising general practice and ensuring that it has the capacity, skills and tools to meet rising patient demand, deliver preventative and anticipatory care and, consequently, relieve pressure on the acute sector. At least 11% of the NHS budget must be spent on general practice. Significant investment is needed to build the necessary infrastructure – modernised, digitally-enabled premises, IT interoperability and expanded programmes for education and research. Stable, long-term funding is also necessary to minimise the financial risk of running a practice, train and expand the practice workforce, reduce staff turnover, ease GP workload, and ensure that GPs and their teams have protected time for professional development, innovation and quality improvement.

Workforce

To ensure a workforce that has the capacity to deliver our vision, we need to increase the number of FTE GPs in practice, stem the flow of GPs quitting the profession or retiring

early and significantly expand the wider practice workforce. This means we need to promote general practice as a career and develop effective strategies for retaining the existing workforce, attracting GPs to return to the profession, and remove unnecessary barriers to working as a GP in the UK. If we want to expand the practice workforce, we need similar strategies to deliver a supply line of practice nurses, pharmacists, physiotherapists, paramedics, physician associates and other practitioners.

Modernised GP premises

80% of GPs say their premises are not fit for the future.[47] To enable the expansion of practice teams and co-location of a wider range of clinical and wellbeing services in primary care, the GP estate requires a significant upgrade – through modernising existing premises or moving to purpose-built surgeries. Practices will need more consultation rooms as well as larger, multipurpose spaces which can be used for team meetings, consultations, specialist clinics, training, workshops and community services. Primary care premises will also need space to deliver minor surgery or to house additional diagnostic equipment.

Training and education

Training and education is essential for equipping the general practice workforce of tomorrow with the skills to deliver holistic, person-centred care. Medical schools and foundation training programmes must provide positive exposure to general practice. GP speciality training must be extended to at least four years and enhanced to better prepare the GPs of tomorrow for the complexities that they will face. This must in turn be backed up by a growing supply of high-quality, adequately funded training placements in general practice. To facilitate the expansion of the multidisciplinary general practice workforce and support continuing professional development, there must be well-defined career pathways, supported by consistent competency frameworks and well-resourced access to training opportunities. GPs themselves will play a key role in training the next generation of GPs and upskilling members of the wider practice team.

Digital technology

General practice will require significant investment in both IT hardware and software to harness the benefits of digital technology. This means putting the basic IT infrastructure right: ensuring the interoperability of IT systems across the NHS and equipping all GP surgeries with high-speed secure broadband. This IT infrastructure will enable the sharing of electronic patient records, the delivery of care through online channels and the automation of administrative tasks (e.g. scheduling surgeries, processing prescriptions, logging medical notes). In addition, GPs will need state-of-the-art digital tools to remotely monitor patients, for example, through wearables or patients self-monitoring and submitting home-readings online. They will also require digital tools – including AI-powered applications – to mine and understand the needs of their patient populations, undertake risk stratification and deliver precision medicine and personalised care.

Research and innovation

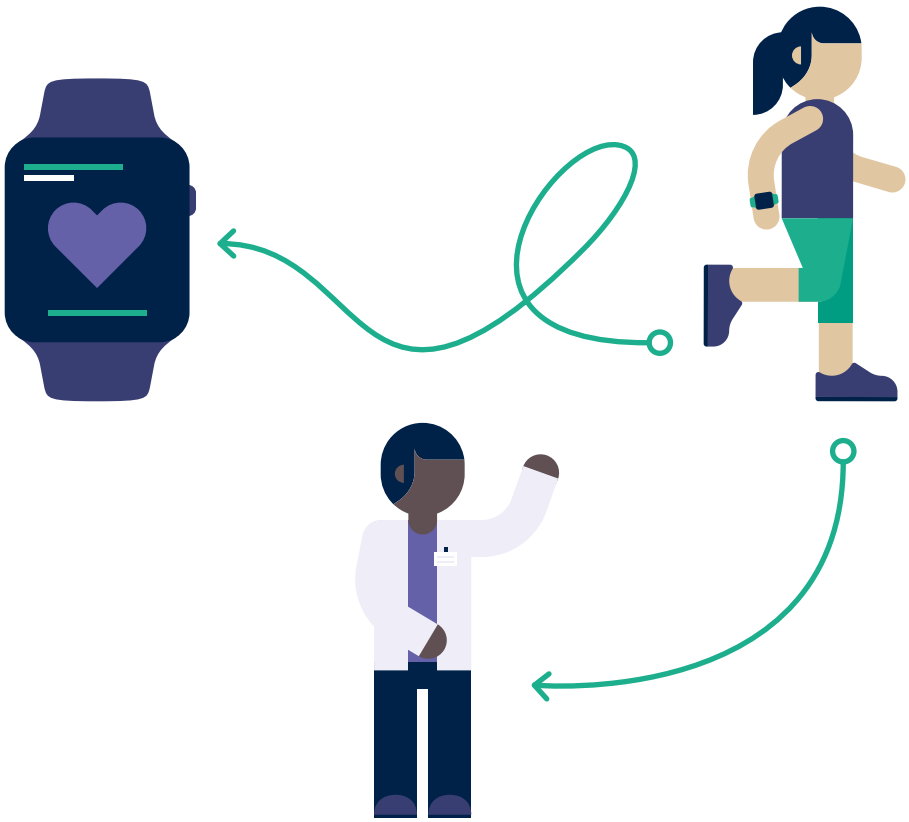
To deliver world class primary care we need a stronger evidence base and better data, as well as ensuring that general practice has the capacity and skills to undertake evaluation and research. It is vital that a 'test and learn' approach is employed so that we evaluate and learn as we develop new roles in practice teams, at scale collaboration, new forms of relational continuity, and improved clinical approaches to managing multimorbidity and delivering holistic care. We also need a step-change in the quality and availability of data, so we have a better understanding of activity in general practice and can more easily measure the impact of new clinical interventions or care models through routine data collection.
If we want better evidence and data it will be necessary to increase support for academic general practice, and to grow the capacity, capability and knowhow in primary care to undertake research.

Conclusion

Our vision is that by 2030, general practice will have the skills and resources it needs to meet the healthcare needs of the population by preventing more illness, diagnosing and treating disease and empowering patients to live healthy, fulfilling lives.

Working with their teams, GPs will continue to deliver the best possible care to patients in their communities, improving health outcomes and underpinning the sustainability of the wider NHS. They will work with their patients to handle uncertainty, make complex decisions based upon what really matters and advocate for the individual.

This will make general practice the career of choice for the next generation of bright, articulate, compassionate clinicians who can deal with complexity and are committed to forming longstanding relationships with their patient population.



Appendix

Analysis of responses to our consultation

In order to develop and test our vision for general practice, the College ran an extensive programme of engagement with over 3000 grassroot GPs, patients and health sector stakeholders. This included polls on Twitter and Instagram, focus groups with College members, hackathons with students, and events with politicians and health experts. As part of the engagement exercise we conducted an online consultation from June to November 2018. We received 2082 valid responses through the online survey form with an additional 10 submissions received by email and a further 13 through the online discussion forum survey.

Of the 2082 valid responses, 30.69% were from GPs, 50.05% from patients, 6.92% from medical students or trainee GPs, and 12.34% from health service staff, retired professionals and others. We undertook an analysis of these consultation responses which has, in turn, helped to shape our thinking about what general practice should look like in the future.

Q1. What do you value most about the GP patient relationship?

Respondents told us that what they valued most about the GP-patient relationship was continuity. A large number of patients said they wanted to be seen by the same GP for their health conditions to ensure continuity in their treatment. GPs valued the longevity of relationships built with patients in the community and gained great satisfaction from seeing people through all aspects of their lives. Both patients and doctors valued the GP's knowledge, not only of the individual patient, but also of their family, which gave them a better understanding of the patient's personal circumstances. Trust, the expertise of the GP, access and the personal nature of the relationship, were also highly valued by both GPs and patients.

Q2. Is there anything you feel could enhance what a GP does for their patient?

A large number of respondents said they wanted easier access to their named GP in order to improve continuity. Patients, in particular, said that the GP-patient relationship could be improved through better access to general practice. Patients reported a number of frustrations including:

- Inadequate booking systems
- Short consultation lengths
- Lack of confidentiality with receptionists

- Explaining private medical issues to receptionists in order to get an appointment, seeing them as 'gatekeepers'
- Long waiting times for appointments
- Not being able to see the same GP

GPs identified the need for better support from well-trained members of the MDT, particularly in relation to the amount of administration GPs have to undertake. Echoing what patients told us, GPs identified the need for longer consultations for patients who need them, so to appropriately address patients' concerns. Many GPs said they wanted better access to diagnostic technology, either in their surgery or in community settings. Central to all of the concerns raised was the need for more funding, without which the required improvements will not be possible.

Q3. What do you think is a benefit of patient care being provided by a range of staff alongside a GP?

The key benefits, identified by respondents, of GPs working in expanded practice teams alongside other health professionals, were:

- Undertaking tasks that do not need to be carried out by GPs
- Freeing GPs' time to focus on complex cases and provide more holistic care
- A better mix of skills to address the needs of patients
- Improved access for patients

The main practice team roles that were identified by the respondents as being particularly beneficial, were district nurses, paramedics (particularly for home visits), mental health therapists and pharmacists. Respondents also identified a growing role for social prescribers and care navigators working alongside the clinical practice team. Some respondents expressed concern that care could become more fragmented as other members of the practice team took clinical responsibility for patient care. Other respondents said that GPs needed to be the leader of the team and emphasised the contribution that training receptionists in care navigation and a good triage system could make to the success of team working.

A strong theme to emerge from the consultation was the need to train, invest in and support members of the wider practice team to ensure they feel supported, valued and have the skills to deliver safe patient care. There was also a strong consensus that expanded practice teams were understaffed and that more time was needed for practice staff to function properly as a team. Respondents felt that the GP needed to be the voice and hold ultimate responsibility for the patient.

Q4. How can the way in which general practice works with other parts of the healthcare system be improved?

Respondents told us that the interface between primary and secondary care – in particular, communication between these sectors – was the key area for improvement in respect of how general practice works with other parts of the healthcare system. GP trainees and trainers said that greater exposure to general practice in training could help foster this understanding earlier, while shared IT systems and more streamlined referral pathways were seen as key enablers of more joined-up care. Respondents also saw general practice as, potentially, a community hub, and the role of social prescribers was considered valuable. Respondents also felt that general practice could be better connected to prisons, schools, and homeless centres and that social care and older people's care were areas which were more integrated models of care were required.

Q5. What change, initiative, idea or process has changed general practice for the better for you?

The greater use of technology was identified as a key driver which has changed general practice for the better and, specifically, the use of electronic records, electronic prescriptions, email and telephone triage/consultations. The ability to email and quickly obtain advice from secondary care consultants was also seen as positive change. The other significant positive change was the expanded practice team, particularly greater access to pharmacists and nurses (specifically in the management of chronic disease). Social prescribing schemes and greater focus on integrated and preventative care were also seen as beneficial developments, but it was felt that far more could be done in respect of both. There were mixed views about at scale working with some doctors supporting the idea of 'small and coherent' teams that could meet the needs of patients, while others expressed fears about the potential for at scale working to lead to 'impersonal care'.

Endnotes

1 Prof J N Newton, A D M Briggs, Prof C J L Murray, et al *Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013*, The Lancet 2015

2 Public Health England, *Health Profile for England*, 2018

3 P Johnson, E Kelly, T Lee, et al *Securing the future: funding health and social care to the 2030s*, Institute for Fiscal Studies and The Health Foundation, 2018

4 A Kingston, L Robinson, H Booth, et al, *Projections of multi-morbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation (PACSim) model*, Age and Ageing, 2018

5 Department of Health, *Long Term Conditions Compendium of Information: Third Edition*, 2012

6 Office of National Statistics *Healthy Life Expectancies, UK:2015–17*, 2018

7 *Health Profile for England*, Public Health England 2018, *Scottish Burden of Disease Study 2016 – Deprivation Report*, NHS Health Scotland, 2018, *Health and its determinants in Wales: Overview*, NHS Wales Public Health Wales Observatory, 2018; Dr C Bell, Dr M Duffy, A Robinson, C Laverty, *Health Inequalities Annual Report 2018*, NI Health and Social Care Inequalities Monitoring System, 2018

8 K Barnett, S W Mercer, M Norbury, G Watt, et al, *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study*, The Lancet, 2012

9 Public Health England, *A review of recent trends in mortality in England*, 2018

10 D M Berwick, T W Nolan, J Whittington, *The Triple Aim: Care, Health, And Cost*, Health Affairs, 2008; R Sikka, J M Morath, L Leape, *The Quadruple Aim: care, health, cost and meaning in work*, BMJ Quality & Safety Online First, 2015

11 E C Schneider, D O Sarnak, D Squires, et al, *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care*, The Commonwealth Fund, 2017

12 J M McGinnis, P Williams-Russo, J R Knickman, *The case for more active policy attention to health promotion*, Health Affairs, 2002; D Kuznetsova, *Healthy places: Councils leading on public health*, New Local Government Network, 2012; J P Bunker, H S Frazier, and F, Mosteller, *The role of medical care in determining health: Creating an inventory of benefits*, International Epidemiological Association, 2001

13 Department of Health & Social Care, *Prevention is better than cure*, 2018

14 J N Newton, A D M Briggs, C J L Murray, et al, *Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013*, The Lancet, 2015

15 NHS England, *GP Patient Survey 2018*, 2018

[16] Scottish Government, *Health & Care Experience Survey*, 2018

[17] Statistics for Wales, *National Survey for Wales, 2017–18: Hospital and GP services*, Welsh Government, 2018

[18] J Gibson, M Sutton, S Spooner, K Checkland, *Ninth National GP Worklife Survey 2017*, Policy Research Unit in Commissioning and the Healthcare System, 2018

[19] Prof F D R Hobbs, C Bankhead, T Mukhtar, et al, *Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14*, The Lancet, 2016

[20] P Johnson, E Kelly, T Lee, et al *Securing the future: funding health and social care to the 2030s*, Institute for Fiscal Studies and The Health Foundation, 2018

[21] General Medical Council, *The state of medical education and practice in the UK 2018*, 2018

[22] C Salisbury, S Procter, K Stewart, et al, *The content of general practice consultations: cross-sectional study based on video recordings*, British Journal of general practice, 2013

[23] General Medical Council, *The state of medical education and practice in the UK 2018*, 2018

[24] D J Pereira Gray, K Sidaway-Lee, E White, et al, *Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality.* British Medical Journal, 2017. No comparable data is available for Scotland, Wales and Northern Ireland.

[25] L S Levene, R Baker, N Walker, et al, *Predicting declines in perceived relationship continuity using practice deprivation scores: a longitudinal study in primary care*, British Journal of general practice, 2018

[26] B Baird, *Shaping the future of general practice: a report for the Royal College of General Practitioners*, King's Fund, November 2018

[27] England data; Scotland data, estimated the data using ISD Scotland and NHS Digital data sets; Wales data used estimates from Scottish headcount to FTE ratios to calculate their FTE figure; NI data, not published at time of writing, approval given for use by NIMDTA.

[28] J Gibson, M Sutton, S Spooner, K Checkland, *Ninth National GP Worklife Survey 2017*, Policy Research Unit in Commissioning and the Healthcare System, 2018

[29] General Medical Council, *The state of medical education and practice in the UK 2018*, 2018

[30] D S Kringos, W Boerma, J van der Zee, P Groenewegen, *Europe's Strong Primary Care Systems Are Linked to Better Population Health but Also to Higher Health Spending*, Health Affairs, 2013; B Starfield, L Shi, J Macinko, *Contribution of primary care to health systems and health*, The Milbank Quarterly, 2005; J Macinko, B Starfield, L Shi, *Is Primary Care Effective? Quantifying the health benefits of primary care physician supply in the United States*, International Journal of Health Services, 2007

[31] P Johnson, E Kelly, T Lee, et al *Securing the future: funding health and social care to the 2030s*, Institute for Fiscal Studies and The Health Foundation, 2018

[32] RCGP analysis of NHS Digital, ISD Scotland, Stats Wales and Northern Ireland HSCB data

[33] B Starfield, *Primary Care: Concept, Evaluation, and Policy*, Oxford University Press, 1992,

[34] Beccy Baird, *Shaping the future of general practice*, The King's Fund commissioned by RCGP, 2018

[35] G. Irving, A L Neves, H Dambha-Miller, *International variations in primary care physician consultation time: a systematic review of 67 countries* BMJ Open, 2017

[36] R Sampson, J O'Rourke, R Hendry et al, *Sharing control of appointment length with patients in general practice: a qualitative study*, British Journal of general practice, 2013; L Lowenthal, E Bingham, *Length of consultation: how well do patients choose?*, The Journal of the Royal College of General Practitioners, 1987

[37] This initiative is part of EQUIP, a quality improvement programme designed for general practice in Tower Hamlets: http://equiptowerhamlets.nhs.uk/

[38] NHS Digital, *General and Personal Medical Services, England: Final 31 March and Provisional 30 June 2018, experimental statistics,* , 2018; RCGP *Royal College of General Practitioners – Membership tracking survey* ComRes, 2019

[39] *Primary Care Workforce Survey Scotland 2017* NHS National Services Scotland, 2018

[40] Welsh Government *GPs in Wales, 2016 General medical practitioners (GP)*, 2016

[41] RCGP *Royal College of General Practitioners – Membership tracking survey* ComRes, 2019

[42] L Schottenfeld, D Petersen, D Peikes, et al, *Creating Patient-Centered Team-Based Primary Care*, Agency for Healthcare Research and Quality, 2016

[43] NHS England *1 in 4 GP appointments potentially avoidable*, October 2015

[44] Citizens Advice, *A very general practice: How much time do GPs spend on issues other than health*, 2015

[45] The Marmot Review, *Fair Society, Healthy Lives*, Strategic Review of Health Inequalities in England post-2010, 2010

[46] Holt-Lunstad J, Smith TB, Layton JB *Social Relationships and Mortality Risk: A Meta-analytic Review*, PLOS Medicine, 2010

[47] GP Premises Survey 2018, British Medical Association

The Royal College of General Practitioners is a network of over 53,000 family doctors working to improve care for patients. We work to encourage and maintain the highest standards of general medical practice and act as the voice of GPs on education, training, research and clinical standards.

@rcgp
RCGP.org
@RoyalCollegeofGPs

www.rcgp.org.uk

Royal College of General Practitioners
30 Euston Square, London NW1 2FB

Royal College of General Practitioners