GENERAL ELECTION

What health and care need from the next government

General practice and dentistry

Briefing 3

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nuffieldtrust

The NHS and social care in England are struggling. A combination of the sudden shocks from the Covid-19 pandemic and high inflation, and the longer-term pressures of poor workforce planning, morale problems, failure to deliver promised efficiency savings, and decades of delay to social care reform are all taking their toll. Strain and dysfunction are deeply rooted and will not immediately improve, and the public see this clearly: satisfaction with both services is at historic lows. Credible long-term plans to improve this situation are vital for any political leader who wants to gain the trust of the British people.

This series of briefings sets out particular issues where we believe there is clear evidence that the UK's new government must act in order to meaningfully improve the English health and care system for which it is responsible. This is presented as a series of tests that a policy programme during the next Parliament should meet. They often address less visible, easily overlooked decisions which work behind the scenes to shape the care people experience. We hope these briefings will **inform** the public debate that MPs, journalists, experts and institutions shape over the coming months, and **influence** the policy formation decisions of the national political parties as they draw up a platform to put to the British people.

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Overview

Part 1: General practice

The NHS was designed to have general practice as the point of connection between people and almost all the care they might need – from basic check-ups to lifesaving operations. In England, this critical point is under immense pressure. The number of full-time equivalent GPs per person has fallen, leaving more and more care to each doctor. Patients struggle to access care and staff risk burnout with ever longer, more packed days.

Easy access to general practice is the public's single top priority for the health service, according to our analysis of the British Social Attitudes survey.[1] This will rightly weigh on the minds of campaigning parties during a General Election. The fact that GP funding has risen more slowly than hospital funding since 2016/17 seems at odds with the public's priorities and will need to be confronted in the coming years. When adjusted for population need and inflation, spending has grown only half as fast as the hospital sector (10% as opposed to 21%) from 2016/17 to 2022/23.[2]

But a simplistic approach that pushes all resources towards appointments as soon as possible is not the answer – many patients do not want or need this. Getting the most out of general practice means enabling it to offer the right kind of appointment in the right timeframe for the many different types of needs that patients have, without unnecessary referrals to the rest of the NHS.

We believe an agenda to achieve this by an incoming government must meet the following tests:

1. The next government must commit to an increase in people having access to their own doctor – the GP they prefer – as measured by the patient survey. This should start with groups with complex or changing health

1 www.nuffieldtrust.org.uk/research/public-satisfaction-with-the-nhs-and-social-care
2 www.nuffieldtrust.org.uk/resource/where-does-the-nhs-money-go#toc-header-0

problems, or with multiple illnesses. The evidence shows that seeing the same professional over time has benefits including reduced mortality and lower A&E admissions, but fewer patients have been able to do this. Practices should be incentivised to deliver continuity, and there should be a benchmark they have to meet.

2. With a serious workforce squeeze, clinicians in general practice must be able to take a decision as to who needs an urgent appointment and who should be booked in further out, as well as who needs face-to-face care or could more quickly get what they need online. There should not be a blanket target for GPs to offer all appointments within a certain number of days or hours. This is not relevant to many groups of patients, and distorts how available capacity is used, leading to frustrating restrictions on patients such as the 8am rush for slots. Offering face-to-face appointments to every patient is a waste. Instead, general practice should be judged on how happy patients are overall with their access to care, as measured by the Patient Survey.

3. Better data and digital technology is crucial to support clinicians in making sure patients get the appointments they need, and monitoring those with ongoing conditions. General practice must get its share of the £3.4bn technology funding planned from next year, as well as more support for training staff in the use of digital tools.

4. The steady decline in GP numbers must be urgently addressed, both through measures to improve retention, such as loans forgiveness, and better support to experienced GPs, and through policies that address wide regional disparities in the numbers of GPs.

5. The huge expansion of additional roles in general practice – social prescribers, pharmacists, care navigators, physiotherapists and more – needs to be accompanied by measures to safely manage the impact of this without disrupting patient care and further driving down satisfaction. GPs and GP nurses need time carved out to support and supervise their new colleagues; staff should be appropriately regulated; and the public should be better informed about the varied professionals they may expect to see in general practice.

6. Government must resist the temptation to forcibly restructure the operating model of general practice in order to deal with the many problems of the existing partnership model. Instead, the government should clearly set out the core functions that general practice should deliver but allow flexibility in the exact form that GP services take, and incentivise the emergence of innovative models in pursuit of those core functions, holding them to account appropriately.

Part 2: Dentistry

NHS dentistry is also supposed to serve as a universal front door to dental care, available to everybody in England. Yet satisfaction has fallen to an all-time low of 24%, the lowest of any part of the health service, amidst a crisis which has left most of the adult population going without the NHS check-ups recommended for good oral health. This problem has been decades in the making. The next government must take bold actions and tough decisions given how far NHS dentistry is from being able to meet everybody's needs:

1. Government must urgently embark upon a programme of dental contract reform to move away from an outdated inflexible approach that rewards activity over outcomes and disincentivises undertaking more complex care. A new approach should be developed whereby dentists are reimbursed for work carried out for a particular list of patients, weighted according to need.

2. Until this is delivered, the government must deal with the immediate shortage of staff in two ways: extend the time between routine checkups in line with official guidance, unless clinically indicated otherwise; and make careers more attractive for dental nurses, hygienists, therapists and other professions who can take on more extensive roles.

3. A means-tested NHS dental offer that prioritises the allocation of scarce resources for those that need them most – children, pregnant women, older people and those who cannot afford private care – should be considered unless there is a credible plan to fully fund and restore universal NHS dentistry.

General practice

Test 1 Restore the ability of patients to access their own doctor

Twenty years of policy to improve access to GP appointments has prioritised the speed of getting an appointment over seeing a doctor who knows you. The 2023 national GP patient survey shows that while the proportion of people in England getting an appointment the same day has held steady at around one-in-three, the proportion who can see their chosen doctor has rapidly declined. 41.5% of people said they had a preferred doctor. But only 35% of those people said they usually saw them, down from 50% as recently as 2018,[3] as shown in Chart 1 below.

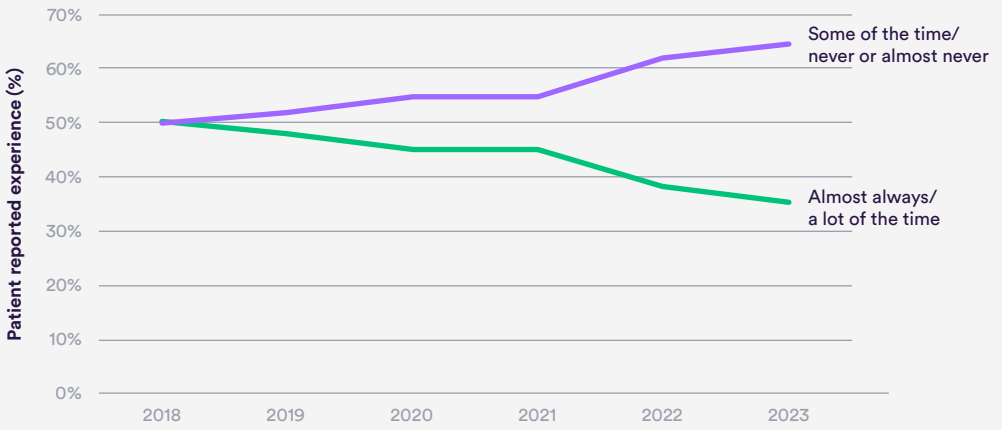
Yet more and more research is showing that "continuity of care" with a doctor who knows you leads to better outcomes for patients[4] and improved job satisfaction for clinicians.[5]

Seeing the same GP over time can also be more efficient and can contribute to the productivity of general practice.[6] Research shows it reduces use of out-of-hours services and A&E admissions by 25-30% and reduces demand for appointments to a level that is equivalent to a 5% increase in GP workforce.[7]

3 https://gp-patient.co.uk/surveysandreports
4 https://bmjopen.bmj.com/content/8/6/e021161
5 www.nuffieldtrust.org.uk/research/improving-access-and-continuity-in-general-practice
6 https://pubsonline.informs.org/doi/abs/10.1287/mnsc.2021.02015?journalCode=mnsc
7 https://bjgp.org/content/bjgp/early/2021/08/26/BJGP.2021.0340.full.pdf

Seeing the same doctor is not the only form of "continuity" – information can be kept for a patient through a continuous medical record, and they can be managed continuously across a group of professionals and services. But seeing the same clinician is an area where there is clear evidence of benefits, and of a worrying decline within England.

Chart 1: Patients' experience of being able to see or speak to their preferred GP



Source: Nuffield Trust analysis of NHS General Practice Patient Survey over a six-year period from 2018 to 2023, using data from more than 6,000 GP practices in England. Data shows percentage of patients aged 16+ who report being able to see or speak to their preferred GP, among those who have a preferred GP. Question asked of patients: How often do you see or speak to your preferred GP when you would like to? Analysis excludes patients who selected 'I have not tried'.

With a growing proportion of part time GPs working in general practice, seeing the same person can be a logistical challenge for patients if their usual or preferred GP's appointment capacity is very limited. But although expanding the number of permanent FTE GPs will take time, this does not mean that nothing can be done in the short term as there are many ways to support continuity.[8] Policy should focus initially on improving continuity for patients with complex or ongoing clinical problems – approximately 20% of the list in one large practice – who will most benefit.[9]

8 www.nuffieldtrust.org.uk/sites/default/files/2019-01/improving-access-and-continuity-in-general-practice-evidence-review-final-update-01-2019.pdf

9 www.health.org.uk/improvement-projects/relational-continuity-for-general-practice-patients-with-new-and-changing

What needs to happen?

After decades of focus on rapid access, restoring continuity will require the next government to introduce a credible and feasible set of measures to ensure that GPs are rewarded for passing an appropriate proportion of patients into continuous care with the same doctor.

- The next government must work with national bodies and professional organisations to deliver a **demonstrable and measurable increase in patients who see their own preferred doctor**. A straightforward measure of success would be patient-reported continuity in the national patient experience survey (General Practice Patient Survey).

- Introduce a **benchmark reporting system** to provide transparency about how individual practices are performing on continuity with the same doctor, so patients can choose between practices. This could use established benchmarks where GPs are well-equipped to analyse and understand them.

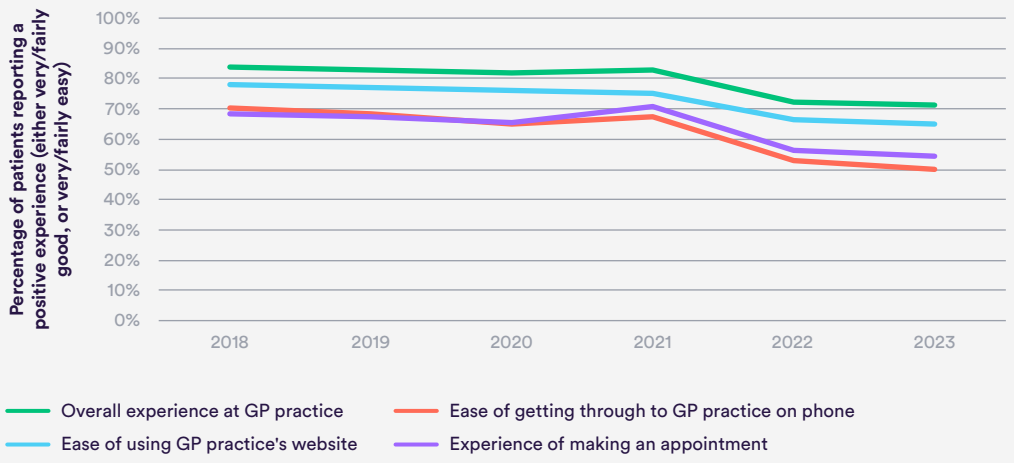
- Introduce **payments to improve continuity with the same doctor** through the "Quality and Outcomes Framework" which will incentivise practices to identify and tag the notes of patients who are judged to need continuity the most.

- General practices need **support to use technology and data analytics** to identify patients with undiagnosed problems, or those with complex or longer-term needs, and steer these patients to a doctor who knows them. Test 3 sets out measures to improve the use of technology in general practice.

Test 2 Tackle patients' poor experience of accessing general practice

Making it easier to get a GP appointment is now the single highest priority the public have for the NHS.[10] Data from the national General Practice Patient Survey shows the proportion of patients who report that it is easy to get through to their GP practice by phone has dropped from 70% 'easy' (2018) to 50% 'easy' (2023) – a 20 percentage point drop over six years[11] (see Chart 2).

Chart 2: Patients' experience of access to general practice, 2018–2023



Source: Nuffield Trust analysis of NHS General Practice Patient Survey over a six-year period from 2018 to 2023, using data from more than 6,000 GP practices in England. Data show percentage of patients aged 16+ who reported a positive experience (either 'very easy'/'fairly easy', or 'very good'/'fairly good').

10 www.nuffieldtrust.org.uk/sites/default/files/2024-03/BSA%20Survey%202023_FINAL.pdf
11 https://gp-patient.co.uk/downloads/2023/GPPS_2023_National_report_PUBLIC.pdf

Around 30 million appointments in total are delivered each month by GP practices in England: this figure is broadly consistent over time with a similar number of appointments delivered in March 2024 compared to October 2021 (when NHS Digital began publishing this data). Over time, however, patients have become less likely to get an appointment specifically with a GP when they visit their general practice. National survey data show the proportion of patients who reported that their last appointment in general practice was with a GP fell from 71% in 2018 to 62% in 2023, showing the impact of employing different types of staff and of a persistent shortage of GPs.[12]

Understanding the problem

Governments and political parties have often simply seen this as a problem of getting appointments as fast as possible, promising them within time limits of 24 or 48 hours. But different people need different things from their GP practice. With insufficient GP capacity, too many people are funnelled through a daily 8am logjam, regardless of whether this is inconvenient; whether they just need a follow-up appointment or a prescription renewed, or they would rather wait to see their usual doctor.

According to the 2023 GP patient survey, 40% of appointments at GP practices took place on the same day that they were booked as shown in Chart 3 on the next page. NHS digital data suggests a slightly higher figure (44%). The survey also shows that nearly one-in-four patients (23.2%) want the choice to book ahead for a non-urgent appointment, but one quarter of these (25%) report being unable to do so.[11]

NHS England have made it a priority to tackle the "8am rush for GP appointments"[13] in their delivery plan for recovering access to primary care,

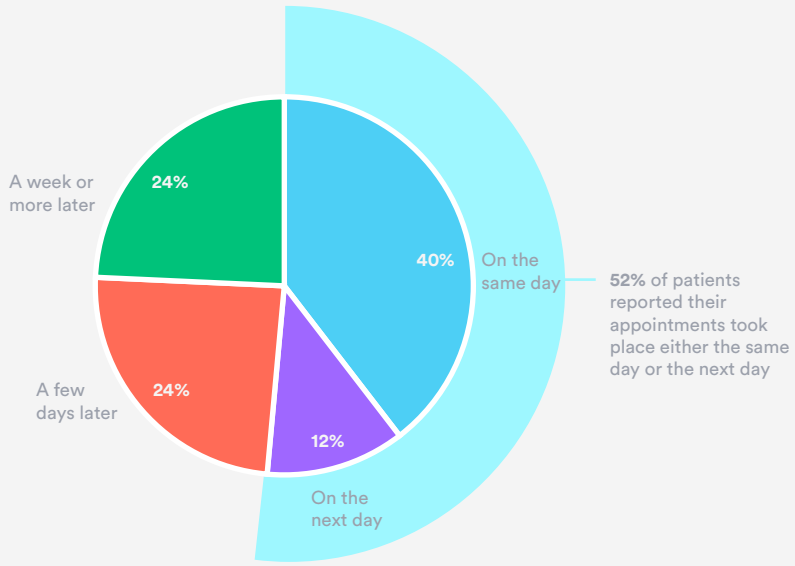
12 https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

13 https://news.sky.com/story/health-secretary-pledges-end-to-8am-scramble-for-gp-appointments-with-240m-funding-12875422

and this is a good start, but more work needs to be done to successfully tackle poor access to care at GP practices in England.

Nuffield Trust analysis of the General Practice Patient Survey 2023 data shows that access to care and the experience of making an appointment is often worse for those people who need care most. Among patients who were of Asian or Black ethnicity, living with a disability, and providing unpaid care of 50+ hours a week, almost one-in-four (24%) described their experience of making an appointment as 'very poor' – compared to just 13% of patients in the same survey who were white, in full-time work, not a carer, and with no long-term health condition.

Chart 3: Length of time between making a GP appointment and when the appointment took place



Source: Nuffield Trust analysis of data from the General Practice Patient Survey 2023. Data show time between making a GP appointment and when the appointment took place as reported by patients aged 16+ who had their last appointment with a GP. Analysis excludes patients who selected 'Can't remember'.

What needs to happen?

Improving access will be an uphill struggle while GP numbers remain too low. But the next government could still make the experience and outcomes of patients significantly better with a comprehensive plan that lets general practice make the most of what it has while workforce improvements increase the actual amount of care available. This would require:

- **No blanket target for GPs to offer all appointments within a certain number of days or hours**. This is not relevant to many groups of patients, and distorts how available capacity is used, leading to frustrating restrictions on patients such as the 8am rush for slots. The decision on who to see quickly must be based on individual clinical need and judged by clinical staff. This is in line with advice from the patient charity National Voices.[14]

- On-the-day appointments for patients with urgent problems, but a **requirement for all GP practices to provide patients the option to book certain appointments in advance**. This should enable those needing planned, preventative care such as smears, medication reviews, or vaccinations to find a convenient time and allow people with complex, ongoing health conditions to find a time that suits them ideally with a GP they already know.

- **Increased funding for IT tools which help professionals to "triage" patients and give them the right kind of appointment** to suit their need. Sorting patients into different types of appointment that provide the right kind of access for their needs is crucial to offering the best possible experience for each patient, and technology can help. Funding must cover not only buying new tools, but also building capacity to use data well to support triage, as well as training and cover to support practices to work in a new way. There are excellent examples of where this is done well in

14 https://s42139.pcdn.co/wp-content/uploads/a_vision_for_the_future_of_primary_care.pdf

different places, but it is currently patchy and people in some areas are being left behind.

- **No blanket obligation that all patients must be offered face-to-face care for any interaction**. This isn't needed for some routine checks, appointments and discussions where a patient is able to use a telephone or fill out an online form. A blanket requirement limits the ability of GPs to use strained capacity as wisely as possible to meet patient needs and preferences.

- **Practices to be held to account based on overall patient satisfaction with making an appointment, and with the appointment they were offered,** as measured by the annual GP patient survey. Other policies to hold them to account should focus on making sure they offer access across the board, for immediate and longer-term appointments for different groups.

- National bodies to **promote inclusive access for example by continuing to maintain non-digital ways to contact a surgery** (including the ability to walk in, or phone in) for people who need or prefer this. Some people are not equally able to use apps or websites to contact their local surgery, for example due to poverty or ill health. These will often be the people who need care most.

Test 3 Use digital technology to support better access, while avoiding known risks

Research is showing how the shift towards digital technology in general practice can have a real impact for patients and staff – for both better and worse.[15]

The positive effects include easier access for some patient groups; more efficiency in routine work like monitoring long-term illness; and better communication with patients. However, there is also evidence of risks to patient safety and confidentiality,[16] missed and delayed diagnosis,[17] and worsening inequalities in access to care.

While policy has strongly promoted a 'digital first' approach that encourages patients to seek access to care online, national data from the General Practice Patient Survey shows patients' experiences of using GP practice websites to access care over the last five years has got worse, not better. More than one-in-three patients (35%) reported in 2023 that they didn't find this easy, up from less than one-in-four (22%) in 2018.

Research undertaken through the Remote by Default study in which Nuffield Trust is a research partner highlights that getting the best out of digital technology in general practice will take a sustained period of investment which covers improved infrastructure for digital general practice; training

15 www.researchgate.net/publication/355463306_Unintended_consequences_of_online_consultations_a_qualitative_study_in_UK_primary_care
16 https://bjgp.org/content/72/716/e199
17 https://qualitysafety.bmj.com/content/early/2023/11/26/bmjqs-2023-016674

for both staff and patients; and significant support for practices to redesign services to take advantage of new digital technology and digital triage.

What needs to happen?

Based on our research, achieving meaningful change for the better use of digital primary care will require the following steps from a new government:

- **Give general practice its share of infrastructure money**. A commitment that the recently announced £3.4bn investment in digital technology for the NHS from 2025–26 will include high speed broadband to be available in all GP practices for use by both staff and patients, along with up-to-date computers to support digital services.

- **A new approach to training for staff and patients on digital technologies**.[18] This is critical to successful deployment. The 2019 Topol Review[19] outlined what is needed and must be actioned and this should be part of a broader manifesto vision to support skills development of digital citizens. Our research has shown that the most successful countries in digital health care are those where the public is used to using and trusting digital access to public services.[20]

- Digital policies for primary care must adopt a much **stronger focus on user experience and user-led design** to ensure digital solutions fit with the needs of both staff and patients.[21]

- **Proposals must have ambitions and timescales which will not risk overwhelming practices, primary care networks and community service providers** because digital change requires significant design and implementation work, and a realistic timescale for organisational change. We will be looking for commitment from a new government to provide

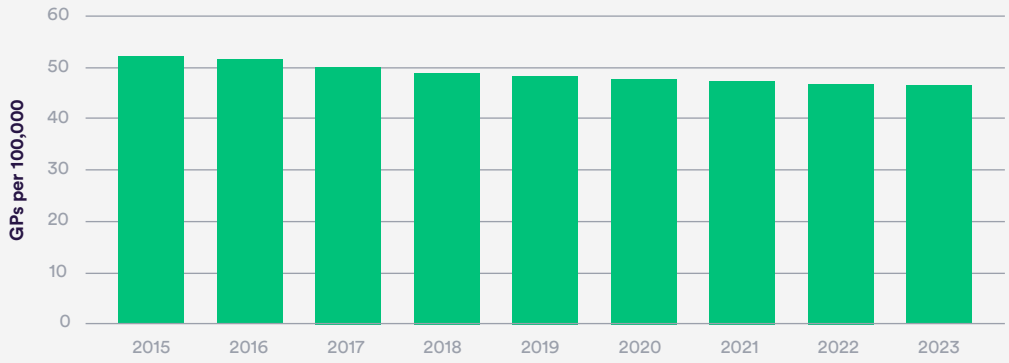
18 https://pubmed.ncbi.nlm.nih.gov/35834301
19 https://topol.hee.nhs.uk/the-topol-review
20 www.nuffieldtrust.org.uk/news-item/what-can-we-learn-about-digital-health-care-from-other-countries
21 www.designcouncil.org.uk/fileadmin/uploads/dc/Documents/DC_design_in_publicsec_WEB.pdf

the development support to achieve this through local NHS bodies (ICSs) having resources to support change, rather than simply paying incentives for delivering highly specific tasks.

Test 4 Address the problem of declining GP numbers

The numbers of fully qualified GPs in England have been falling since data collection started in 2015: in December 2023 there were 27,584 full-time equivalent qualified general practitioners, which represents a fall of 1,963 compared to eight years prior (March 2016). This fall in total GPs is despite pledges to increase numbers, most notably in the 2019 Conservative Manifesto commitment to introduce an additional 6,000 doctors into general practice – and has occurred alongside the growth in size and age of the population. Chart 4 shows the number of FTE GPs per head of population in England from 2015–2023.

Chart 4: Number of GPs per 100,000 population



Note: Data show the number of full-time equivalent GPs (excluding GPs in Training and Locums) per head of population in England. Mid-year population estimates have been used for all years except 2023 – which uses projected values – so comparisons must be treated with caution.

Source: Nuffield Trust analysis of NHS Digital and ONS data.

As well as declining numbers of GPs, there are real problems in attracting GPs to the profession and keeping them after they join. A large expansion in GP training places since the mid-2010s has not translated into more FTE qualified GPs, despite incentives such as a £20,000 salary supplement[22] to attract GPs into hard to recruit areas. Much of the increase in trainees has been driven[23] by international medical graduates, but there is evidence that these trainees are likely to leave the NHS earlier than UK trainees.[24]

The number of GP registrars – qualified doctors who are training to become GPs – has increased by 3,272 over the course of the parliament. However, recent Nuffield Trust analysis highlighted[25] the high drop-out rates from GP training, with around two training places needed to get one full-time equivalent joiner into general practice. This is especially concerning given the proposals under the NHS Long-Term Workforce Plan[26] to further increase training places by 50% by 2031/32. And when GPs do join the workforce, retention is still a challenge: 1-in-12 (8.3%) of the under-40 GP workforce left the service in the 12 months to March 2024.

Meanwhile GPs are on average working less than full-time and many are retiring early. Those that do join are contracted to work around two-thirds of a full-time contract, on average. Data from the NHS authority which handles pensions, obtained by the BMJ, shows that the number of GPs leaving before retirement age rose from 198 in 2008 to 867 in 2023.[27] GP workload is also likely to be a factor in this: the GP WorkLife survey in 2021 found that eight out of 10 GPs reported experiencing considerable or high pressure from increasing

22 www.england.nhs.uk/gp/the-best-place-to-work/starting-your-career/recruitment
23 www.instituteforgovernment.org.uk/publication/performance-tracker-2023/general-practice#the-nhs-is-increasingly-relying-on-international-recruitment-to-fill-trainee-roles
24 www.gmc-uk.org/-/media/documents/workforce-report-2022---full-report_pdf-94540077.pdf
25 www.nuffieldtrust.org.uk/research/waste-not-want-not-strategies-to-improve-the-supply-of-clinical-staff-to-the-nhs
26 www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/#2-train-growing-the-workforce
27 www.bmj.com/content/381/bmj.p1450

workloads and increased demands from patients, which backs up earlier analysis on workloads.[28,29]

These trends – declining GP numbers, large numbers dropping out of training, and problems of retention – are driving a mismatch between patient need for GP appointments and available capacity which is predicted to become worse.[30] They are inextricably linked to the problems people face in getting access to care, and not having enough GPs is likely to be a contributor to declining productivity: fully qualified GPs have a vital role in managing clinical risk and holding many patients in the community without onward referral to hospital.

As well as problems in attracting and retaining enough GPs overall, there are real disparities in GP numbers per patient in different parts of the country, as documented in our briefing on the NHS workforce. Even when taking account of patient need, the numbers of patients per GP ranges from 2,702 in Kent and Medway to 1,868 in Gloucestershire.[31] This is partly driven by an inequitable funding model which does not provide adequate funding for GP surgeries in areas of deprivation. Reports[32] of newly qualified GPs not being able to find jobs in particular areas – perhaps driven by the rapid expansion of additional roles in general practice (see below) – raise additional concerns about the effectiveness of the labour market for GPs, though there is limited evidence on the scale of this.

28 https://prucomm.ac.uk/assets/uploads/Eleventh%20GPWLS%202021.pdf
29 www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00620-6/fulltext
30 www.health.org.uk/publications/reports/projections-general-practice-workforce-in-england
31 www.nuffieldtrust.org.uk/resource/what-health-and-care-need-from-the-next-government-1-nhs-staffing
32 www.pulsetoday.co.uk/news/workforce/thousands-of-new-gps-could-be-unemployed-this-summer-warns-bma

What needs to happen?

- Government must work with national bodies to develop **creative and credible plans for the retention of GPs and to keep new starters in the NHS**. These might include the introduction of a loans forgiveness scheme for GPs, whereby their student loans are gradually written off over time, as well as improved support for retaining newly-practicing GPs. For GPs late in their career, retention may best be achieved if they are supported to branch out into different types of care.

- **Future training plans promised under the NHS Long-Term Workforce Plan should prioritise training GPs in areas of the country where there is greatest need** and protect and pay for time, for support and supervision for newly qualified GPs.

- The new government needs to **urgently identify a blend of policies to ensure workforce is matched to population need**. This might include the use of golden hellos for early career GPs in targeted areas or an expansion of training places in deprived areas. Funding for primary care networks needs to reflect deprivation better.

- **The ratio of GPs to patients should be formally monitored** and attention given to the potential unintended consequences of new roles in general practice squeezing GPs out of the workforce.

Test 5 Make sure the addition of new types of staff to general practice is safe, fair and efficient

GPs themselves make up a minority of the total practice workforce and more than half of all appointments in GP practices are now not with a GP.[33] As the numbers of GPs have declined in England, there has been a significant increase in the numbers of staff who are not doctors.

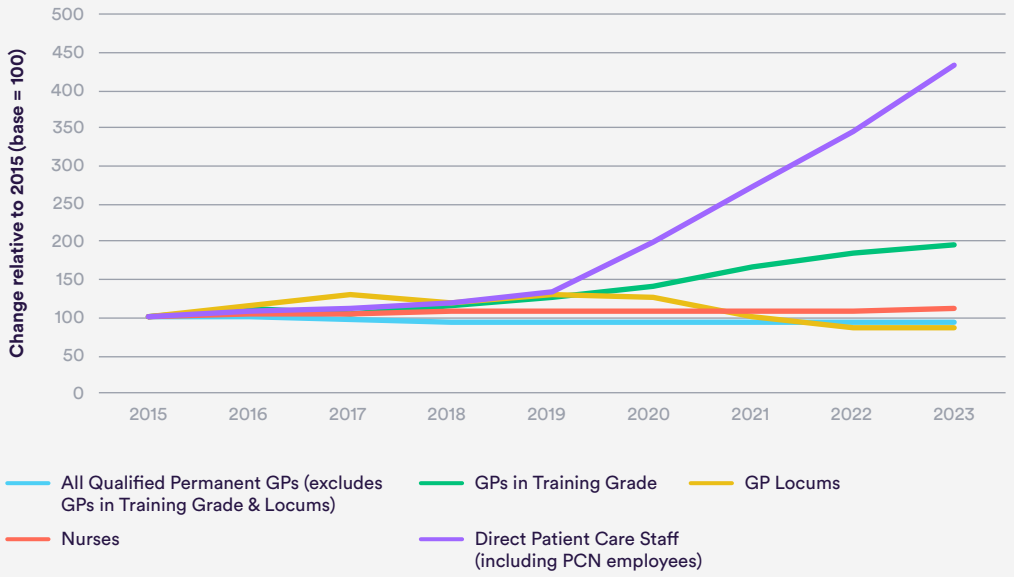
The pace of change

The 2019 Conservative manifesto committed to improve access to general practice through a huge expansion of 26,000 "additional roles" by March 2024 – including pharmacists, social prescribers, dieticians and care co-ordinators – and the delivery of 50,000 more appointments in general practice. The Additional Roles Reimbursement Scheme (ARRS) set out to deliver this change, through allowing primary care networks the chance to recoup the salary costs of these posts – and the scheme more than exceeded its goals. It recruited 29,000 of these new roles into general practice by May 2023. The most recent data suggests there are now almost 40,000 of these roles in general practice in England.[34] A total of £1.4bn was made available to fund the roles in 2023/24.[35]

33 www.nuffieldtrust.org.uk/nhs-staffing-tracker/general-practice
34 https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-workforce-quarterly-update?
35 www.england.nhs.uk/long-read/update-to-the-gp-contract-agreement-2023-24-financial-implications/#

Around one-third of the new roles brought into general practice since 2019 are a largely non-clinical mix of receptionists, care coordinators, social prescribing link workers and managers.[36] Pharmacists are the largest additional clinical group, followed by paramedics, physiotherapists, pharmacy technicians and others. Chart 5 below shows how the number of different FTE staff working in general practice has changed over time.

Chart 5: General practice workforce by staff group



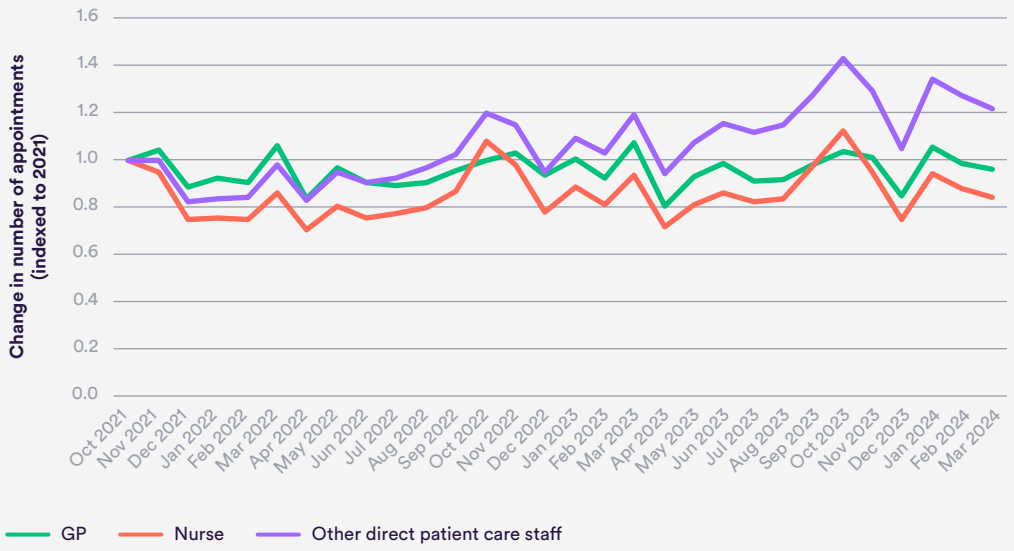
Note: Data show the changes in the number of full-time equivalent staff working in general practice relative to 2015. The underlying values show the number of staff in post as of December each year, with the exception of 2015 and 2016, which were as of September (due to lack of comparable published data). Staff within 'Direct Patient Care' include healthcare professionals such as physiotherapists, pharmacists, social prescribing link workers, among others. The number of these staff working in Primary Care Networks has also been included as they typically carry out work within general practice.

Source: Nuffield Trust analysis of NHS Digital data.

36 www.nuffieldtrust.org.uk/news-item/more-staff-in-general-practice-but-is-the-emerging-mix-of-roles-what-s-needed

This has caused a direct shift over the last two years in who patients see at their local practice. The percentage of appointments delivered by GPs has fallen by 5% even as the total number of appointments has stayed steady. This change equates to about 1.4 million fewer appointments delivered each month by GPs in March 2024 (45.1% of all appointments) compared to March 2022 (50.1%). Chart 6 shows the number of appointments delivered in general practice by staff role (from October 2021 – March 2024).

Chart 6: Appointments delivered in general practice by staff role



Source: Nuffield Trust analysis of NHS Digital data. Data show change in number of appointments delivered to patients at GP practices in England separately for three different staff groups: GP, Nurse, and Other direct care professional (for example physiotherapist, health visitor, link worker) indexed to October 2021. Analysis uses monthly national data published as 'experimental statistics' by NHS England and excludes appointments where the staff role was unknown and where data quality was inadequate.

The further development of additional roles is a key part of the NHS Long-Term Workforce Plan, which commits to increasing the number of non-GP direct patient care staff by around 15,000 and primary care nurses by more than 5,000 by 2036/37.[37]

37 www.england.nhs.uk/publication/nhs-long-term-workforce-plan

What are the advantages and disadvantages of this?

Where new clinical roles are introduced into well-designed clinical pathways and triage systems overseen by experienced clinicians, they help to restore the balance between need and capacity. There are many good examples of how these roles can enhance the care provided by general practice in an area.[38,39] Evidence suggests they can contribute positively to the distribution of work and add clinical expertise when used in the context of bringing in new professional expertise, for example mental health nursing, pharmacists doing medicine reviews or dieticians adding an extra service.[40]

But these roles have been introduced at speed to a service facing a crisis in GP recruitment and retention and with many experienced GP nurses close to retirement. A study[41] of the new roles reported that these new staff members may not be being utilised effectively and that the extra time GPs must now spend managing and supervising the safe practice of these new staff is potentially taking away from the time that doctors have to see patients themselves. The analysis suggests changes in skill mix are not straightforwardly achieving better outcomes in general practice. A study looking at skill mix changes between 2015 and 2019 found that the introduction of new roles in general practice was negatively associated with patient satisfaction and it increased capacity as well as health system costs.[42] Another study showed mixed impacts but no increase in patient satisfaction and no reduction in emergency hospital admissions.[43]

38 www.nuffieldtrust.org.uk/news-item/general-practice-case-studies-of-gp-organisations-working-at-scale-to-deliver-access-and-continuity
39 www.nhsconfed.org/publications/assessing-impact-and-success-additional-roles-reimbursement-scheme
40 https://qni.org.uk/news-and-events/news/new-roles-in-general-practice-not-addressing-workload-issues
41 www.kingsfund.org.uk/insight-and-analysis/reports/integrating-additional-roles-into-primary-care-networks
42 https://pubmed.ncbi.nlm.nih.gov/35872540
43 www.ncbi.nlm.nih.gov/books/NBK580322

And it is not just GP workload that has been affected by this rapid expansion in additional roles in primary care. A recent study[44] by the Queen's Nursing Institute on the impact on GP nurses (GPNs) describes the introduction of ARRS roles as "a major workforce change, with little or no consultation with GPNs despite potentially impacting on their work". It highlighted examples of GPNs needing to perform rescue work, complete the episode of care or teach colleagues when those performing additional roles lacked knowledge or scope to do the work. Interestingly, this study also linked these roles to the increased "taskification" of general practice work, defined as "task orientated, disjointed care, repetition of work (for workforce and patients) and subsequent risk as care became fractured."

Moreover, different GP organisations need a deep understanding of their patients' needs to train and recruit this new workforce accordingly – but with many facing squeezed leadership and management capacity, this is a real challenge.

What needs to happen?

- Government must work with national bodies and professional organisations to **ensure that clinicians other than doctors or nurses can practice safely and have appropriate training and supervision**. This might focus on developing a shared understanding across practice staff of what the different "scope of practice" is for these different roles – what they can and cannot take on.

- Consideration should be given to **earmarking some of the funding for ARRS roles to cover the additional supervision and training they require**.

- Government should launch an **extensive communications campaign programme to improve public recognition and understanding of different roles**. They should draw up consistent ways that GP staff can talk to patients about new roles in their practice and what they do. People

44 https://qni.org.uk/wp-content/uploads/2024/01/ARRS-Workforce-Impact-Survery-2024.pdf

should know and understand who is treating them and have a clearer idea of their skills and responsibilities.

- Government should work with professional bodies, patient groups and others to **make urgent progress to ensure appropriate regulation – whether statutory or not – is in place for emerging staff groups**. While this is under way for physician associates, not covering some of these roles or making progress too slowly risks losing public confidence and failing to build any awareness.

Test 6 Don't force through a new structure for general practice – just ensure it delivers its functions

Since 1948, NHS general practice has been based around the model of small partnership businesses, owned and run by one, two or a handful of GPs who assume unlimited liability for its finances. But the partnership model is challenged and under scrutiny, driven by a range of factors including:

- Declining numbers of GP partners overall and a very steep (45%) drop[45] in the number of partners under the age of 40 between 2016 and 2023, with younger GPs put off becoming partners by the financial risks associated with the unlimited liability model.

- Increased financial risks and pressure arising from the 2024/25 contract settlement not covering increased costs faced by practices, as well as the burden of complying with regulation, and the need to spend more on IT and management to deliver modern, efficient services.

- The difficulty in securing capital funds to upgrade and improve GP premises, of which 40% are not fit for purpose, or to invest in digital technology.

45 www.instituteforgovernment.org.uk/publication/performance-tracker-2023/general-practice#the-nhs-is-increasingly-relying-on-international-recruitment-to-fill-trainee-roles

- The need for practices to participate in wider NHS policies or initiatives like being on local committees and integration boards, which is harder to do if a practice is small.

In response, there have been calls for new types of GP organisation or new ways of employing GPs. Some have suggested NHS trusts should take over – others that GPs must pool together into bigger businesses.

Indeed, the way general practice works is already changing quickly, and national policy has long promoted the benefits of scaled up general practice, whereby partnerships join together with others either informally or in formal groups to tackle some of the problems detailed above. Scale can have clear and significant benefits for practices. Yet often the most innovative and successful changes have been driven not by national policy but the need to meet obligations and survive as businesses with scope to innovate. As we have previously documented,[46] changes to the organisational model of general practice does not guarantee better outcomes. And bigger is not always better – larger scale can detract from continuity of care and patient experience.

An enforced move away from the current contract arrangements and governance of general practice towards a single organisational type or employment model could also have unintended consequences on staff – either through distracting staff from patient care, or by driving GPs and practice nurses into earlier-than planned retirement. As the Health Foundation recently argued in the BMJ: "the profession must be convinced that any change would benefit patients and staff – and policymakers will need to recognise the importance of creating options that can be adapted to fit local context and GP preferences. Big-bang changes would be a massive distraction."[47]

There is therefore a risk that focusing on the *model* through which GP care is delivered ends up detracting from clarity of purpose about what the *functions* general practice should carry out.

46 www.nuffieldtrust.org.uk/news-item/general-practice-case-studies-of-gp-organisations-working-at-scale-to-deliver-access-and-continuity

47 www.bmj.com/content/380/bmj.p134

What needs to happen?

- **Government must resist the urge to reach for top-down structural answers** to the many problems with the current model of general practice. Doing so risks imposing a one-size fits all structure to a service that needs to innovate and adapt to local circumstances.

- Instead, policy should focus on solutions that allow different types of GP organisation to provide the **key functions of general practice**. Drawing on work by Reeves and Byng,[48] as a minimum these key functions could be described as:

  - rapid access to appointments for acute illness;
  - standardised interventions like immunisations and smears, provided at predictable times;
  - access to a known and trusted doctor or other clinician to assess, diagnose and manage more complex illness requiring an understanding of family and social context;
  - extended care coordination for people with complex problems.[47]

- **GP organisations should be held to account for the delivery of these functions** alongside broad goals such as equity of access and other agreed standards which are clearly specified and communicated.

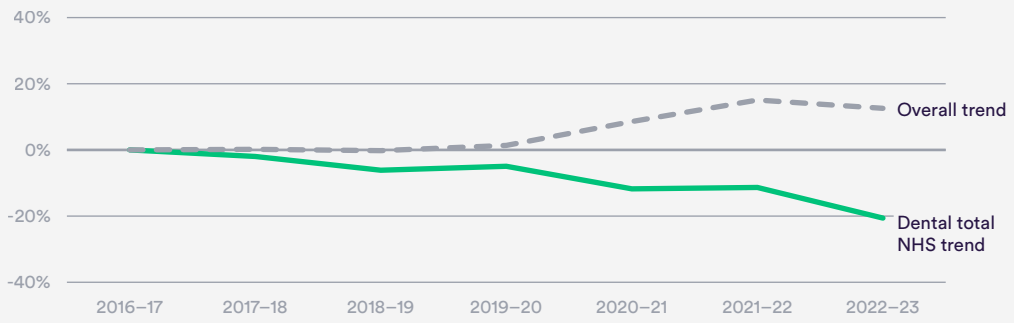
48 https://bjgp.org/content/67/660/292/tab-article-info

Dentistry

NHS dentistry faces an existential crisis following decades of policy neglect. Only a minority (41%) of adults in England have seen a health service dentist in the last two years, a time frame in which every adult should have had a checkup.[49] Tooth extractions remain the most common reason for a hospital admission among 6–10-year-olds. Problems with NHS dentistry are hitting the most vulnerable hardest: 5-year olds living in the most deprived parts of the country are more than twice as likely to experience tooth decay than peers the same age living in the most affluent areas.[50]

Funding for NHS dentistry has fallen in real terms over the past decade. Recent Nuffield Trust analysis found that funding for NHS dentistry fell by 12.3% between 2016/7 and 2022/23.[51] When adjusted for patient need, this is a 20.5% reduction in funding per person as shown in Chart 7.

Chart 7: Changes in real terms funding for dentistry, adjusted for population need



Source: Nuffield Trust health and care finance tracker

Our 2023 report[52] argued that NHS dentistry is gone for good in many areas, with the gradual drift to the private sector meaning that it is likely to be disproportionately expensive to restore universal NHS access.

49 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2022-23-annual-report
50 www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2022
51 www.nuffieldtrust.org.uk/resource/health-and-care-finance-tracker
52 www.nuffieldtrust.org.uk/research/bold-action-or-slow-decay-the-state-of-nhs-dentistry-and-future-policy-actions

Test 1 Address the failed dental contract

A key factor in the policy failures of NHS dentistry is the dental contract, which is failing to attract dentists to carry out NHS dentistry work, or to keep them. The current contract was introduced in 2006 and was intended to be a transitional step to longer-term arrangements with a greater emphasis on prevention and maintenance – it was never fit for purpose as a long-term solution.

The system of fixed payments by "Units of Dental Activity", or UDAs, rewards quantity over quality and fails to recognise that some patients cost more to treat. In addition, the huge variation in the value of UDAs is largely unadjusted since 2006, although a minimum UDA value was introduced in 2022 and raised again in 2024.

Because the contract does not attract dentists to do enough NHS work, hundreds of millions of pounds that should be going on to deliver care for people who need dentistry care goes unspent – about 13% of the total NHS budget for NHS dentistry each year. Meanwhile the public remain largely unaware that even if they're lucky enough to have an NHS dentist, their dentist has no contractual list of NHS patients, hence no obligation to continue to treat them beyond completing a course of treatment once started.

The 2024 Dental Recovery Plan promised a consultation on contract reform, continuing changes to the contract embarked upon by NHS England in 2022.[53] The 2019–2024 government ruled out full-scale contract reform and a move away from the contract based on Units of Dental Activity and towards the kind of list-based contract we and others had argued for. Addressing the question of the dental contract is an urgent imperative for any new government.

53 www.gov.uk/government/publications/our-plan-to-recover-and-reform-nhs-dentistry/faster-simpler-and-fairer-our-plan-to-recover-and-reform-nhs-dentistry

What needs to happen?

- The government should urgently begin a programme of dental contract reform, where **dentists are funded for each person on their list** and with payment weighted to take account of patient need, as GPs are. This will not deliver improvements directly but will allow local NHS organisations to flexibly buy care and spend the whole dental budget to ensure local dentists provide checkups for everyone, and extensive care for those in need.

- Alongside contract reform, the government and NHS England should work with local health systems to **balance the twin goals of securing high quality and intensive treatment for those that need it, as well as prevention for groups at high risk**.

Test 2 Expand the NHS dental workforce

The immediate reason NHS dentistry fails to provide services for so many people is a lack of staff delivering treatment. Because the dysfunctional contract and a flatlining budget have driven so many dentists away from doing NHS work, there were the equivalent of only 9,000 full time health service dentists working in England in 2021/22[54] – even though there were 34,000 dentists in the country.[55]

Changing the contract so that it is more attractive is the only lasting solution. The recent dental recovery plan will slightly raise payments in the areas that pay least, which may attract more NHS work here, but not dramatically. The NHS Long-Term Workforce Plan sets out a massive increase in training, but this will take time and meanwhile immigration is not forecast to provide a short-term boost as it has for nurses and doctors.[56]

To bring improvements as soon as possible, more could be done to make the most use of the other professionals who work with dentists – for example dental hygienists, therapists and nurses. The NHS Long-Term Workforce Plan has the right ambitions here and sets out training increases. However, it identifies only a few specific actions to make sure new staff work in the NHS and it does not cover dental nurses. The next government should look at ways to make dental careers appealing, with a progression and training offer like other attractive NHS careers.

54 www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/#annexb
55 www.gdc-uk.org/docs/default-source/registration-reports/registration-report---april-2022.pdf?sfvrsn=7d768c55_3
56 www.england.nhs.uk/publication/nhs-long-term-workforce-plan

What needs to happen?

- The government should **ensure that the NHS career pathway for dental therapists, hygienists and nurses is appealing**, to help expand the workforce more quickly and avoid losing the increasing number of trainees to the private sector.

- To address the acute shortage of dentists the government and professional organisations should **consider moving checkups further apart**, in line with official guidance which states that two years for adults and one year for children younger than 18 years old are permissible intervals between them, unless clinically indicated otherwise. For adults this might mean extending the recall notice from the current six months period to one year, or perhaps longer – while recognising the need to communicate well with the public over any proposed changes.

Test 3 Rebuild a basic service for those who need it most

The slow decline of NHS dentistry has created a three-tier dental system in England: those who can afford private care, those lucky enough to find access to scarce NHS services, and then those shut out of dental care entirely.

But the hard truth is that fully restoring NHS dentistry to cover the whole population would carry very large costs. The current budget of £3 billion is only providing what is meant to be basic required care to fewer than half of adults, and slightly more than half of children.[57]

It may be time to re-evaluate whether the financial choices made by the next government will be able to support a universal NHS dentistry offer of comprehensive care for all patients. An alternative may be to limit the NHS offer and introduce means tested eligibility.

What needs to happen?

- If the next government does not put in several billion in extra funding to restore universal dentistry, they should consider **prioritising a basic service for vulnerable people and preventive care for children**. This means incentivising a targeted and immediate focus on delivering

57 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics

comprehensive, high quality dental care for children, pregnant women, older people and those who cannot afford private care.

- In the long run, unless far more money is put in to restore a universal service, a logical path would be to **restore basic check-ups and preventive care for everyone** while means-testing more advanced treatments.

Nuffield Trust is an independent think tank. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

Nuffield Foundation

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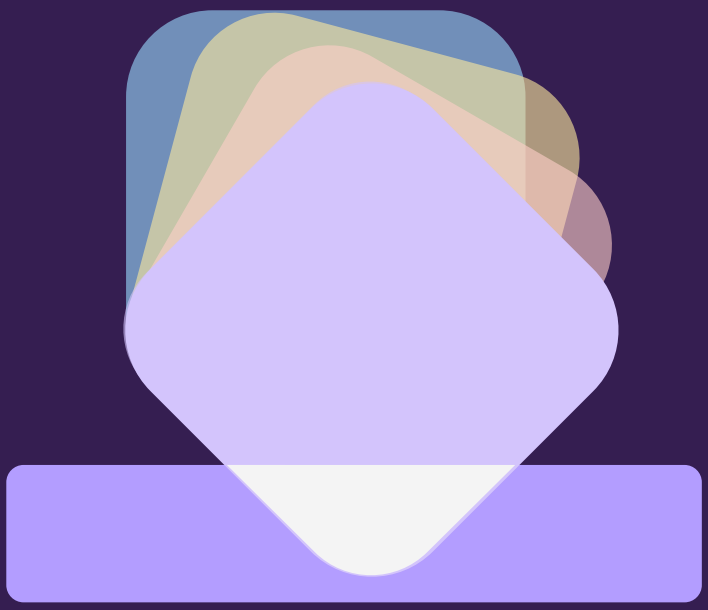

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