Kent Local Medical Committee

General Practice Survey 2023 Report

Introduction

Kent LMC surveyed our constituents over 5 weeks across June and July 2023. 229 responses were received. 42% of responses were from GP contractors, 24% from Practice Managers, 20% salaried doctors and 9% locum GPs. A number of the GP respondents also work as clinical directors. We received responses from some practice nurses and ARRS roles.

We asked your age and job title: 73% of survey responses are age 46 and above, compared to 53% of responses in our 2017 survey, an increase in GPs who are in their 40s. The number of GPs aged 50 and above has remained static.

Executive Summary

Kent's general practice landscape is at a tipping point according to the first survey of GPs and practice managers across the county in five years. Declining GP numbers look set to worsen as surging workloads correlate with significant GP stress levels. Fairer and immediate funding redress, urgent infrastructure investment, and manageable workload are critical for the survival of General Practice in Kent and Medway.

Key Concerns:

1. **Workforce Dynamics:** We face a black hole of GP attrition – up more than ten percentage points since the last survey in 2017, 30% nearing retirement age and a further 27% planning to reduce hours or voluntarily leave the profession within five years. Compounding the crisis is the high vacancy rate, lack of applicants, financial challenges and estates leading to 44% of responding practices to stop advertising roles.

2. **Patient Care:** Particularly concerning is the GP to patient ratio in Kent and Medway, which trails the national average by a staggering 18%. Estates challenges widely reported by GPs mean that expansion of premises to support more staff and increase capacity is being stifled.

3. **Overburdened GPs:** General Practice staff reported working 38% above their contracted hours in a typical week with GP partners working a staggering 53% above their contracted hours and an alarming 82% of respondents reporting significant stress – improving work-life is the most powerful lever to keep GPs in role.

4. **Complicating Factors:** Inappropriate workload transfers from secondary care, increased regulation, increased bureaucracy linked to the changing funding landscape and multiple information requests have exacerbated GPs' workload. Moreover, with inflation and wage cost pressures, general practice funding is felt to be increasingly lagging behind. Inconsistent and inadequate NHS funding support for premises and IT infrastructure is deepening the problem.

5. **PCNs and Their Impact:** The implementation of PCNs has brought additional administrative and clinical burdens as well as complex financial and legal arrangements. PCN's, coupled with the global pandemic and NHSE restructuring, have added to the complexity, bureaucracy and challenges of general practice.

We urgently call for:

1. **Workforce:** Expand recruitment and retention schemes to cover the whole of Kent and Medway; simplify educational requirements to support the development of GP trainers; improve retention of our existing workforce with funded training opportunities; continue to develop peer support networks.

2. **Estates:** Whether it's about the physical premises where GPs work or the digital infrastructure supporting them, there needs to be a significant increase in investment in both. Make existing funding such as S106 and CIL funding easily accessible to General Practice. Support practices with expertise, funding and by streamlining processes to plan and meet their estate needs.

3. **Funding:** Reduce the administrative burden of managing multiple and opaque funding streams. Increase funding in enhanced services in Kent & Medway in line with the national average; ensure primary care underspend is reinvested in primary care.

4. **Digital:** recognition of the impact of inadequate IT infrastructure and its impact on capacity on general practice; prioritisation of current performance problems with ICB commissioned IT providers.

5. **Workload:** other providers to be held to account to deliver their contractual obligations and reduce the transfer of work to general practice. Practices must have control over online consultation platforms to enable responsive approaches to demand and capacity. The ICB need to review all requests to practices to minimise bureaucracy.

We thank all participants that took the time to complete our survey and to share their feedback and join them in calling for recognition of the continued, unsustainable pressures on general practice and for support for a patient-centric approach to general practice, underpinned by appropriate and urgent investment.

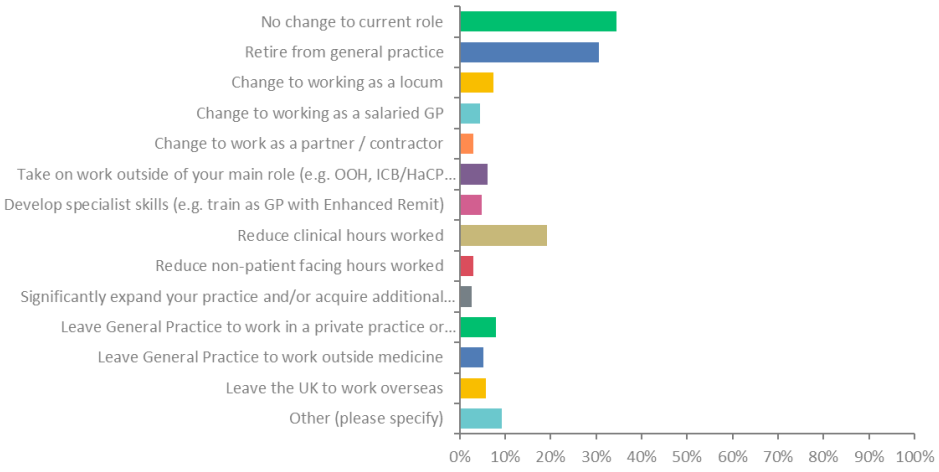
Workforce and Retention

The NHS is one of the largest employers in the country. Over recent years NHS Digital have been collecting statistics which are building a detailed picture of what is happening in all parts of the NHS. As of July 2023, nationally there are 27,177 fully qualified equivalent GPs, 3.4% less than in December 2019 (and 7.4% less than in 2015)[i]. While GP numbers are falling, trainee numbers have been increasing. As we see later in the report practices report challenges associated with this, including supervision for trainees and estates.

In Kent and Medway, the current population is 1,966,153. There are 182 GP practices which are grouped in to 41 Primary Care Networks (PCNs). Not all practices participate in the delivery of the Primary Care Network Directed Enhanced Service (PCN DES), where a practice does not their patients still receive PCN services from a nearby PCN. Since our last survey in 2017, the population has increased by almost 128 000 people, GP numbers are falling, and the number of GP practices have reduced by 45, there are fewer GPs treating more patients. Kent and Medway have the lowest GP to patient ratio in England, 18% below the England average of 45 GPs per 100 000 [ii]. Research from the Health Foundation in 2021 showed that GPs in deprived parts of England received 7% less funding per patient than GPs in affluent areas[iii]. As of October 2022, practices in areas with the highest levels of income deprivation have on average 300 (14.4%) more patients per fully qualified GP than practices with the lowest levels of income deprivation. This discrepancy has increased 50% since October 2018.[iv]

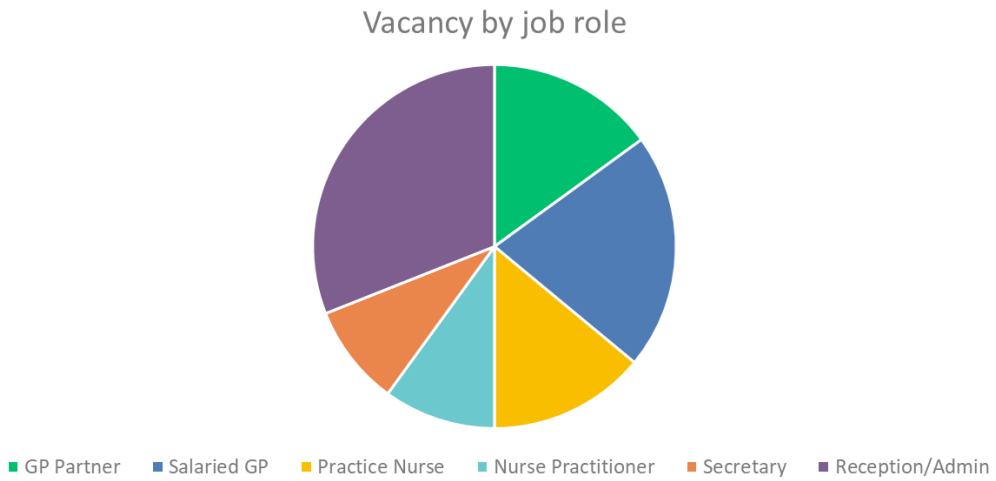
NHS digital figures show almost 49% of GPs in Kent and Medway are aged 45 years and older. This means that almost 1 in 2 GPs are within 10 years of the minimum retirement age. General Practice's total nursing workforce is 7% below the national average while other staff roles involved in direct patient care exceeds the national average by 7%.

Our survey asked what your career intentions are for the next 5 years:



34% plan to make no change in your current working arrangements. **30.5% plan to retire** and **19% plan to reduce their clinical hours** worked, this compares to **8%** in our 2017 survey. Of the 30% who plan to retire 33% are GP partners, 30% practice managers and 27% are salaried GPs. The intentions of the locum workforce are worth highlighting, **45% of locums who responded plan to reduce their clinical hours in the next 5 years, and 29% plan to leave General Practice altogether**. When we compare our data with our survey **in 2017 2% planned to leave general practice, compared with 8% in 2023.**

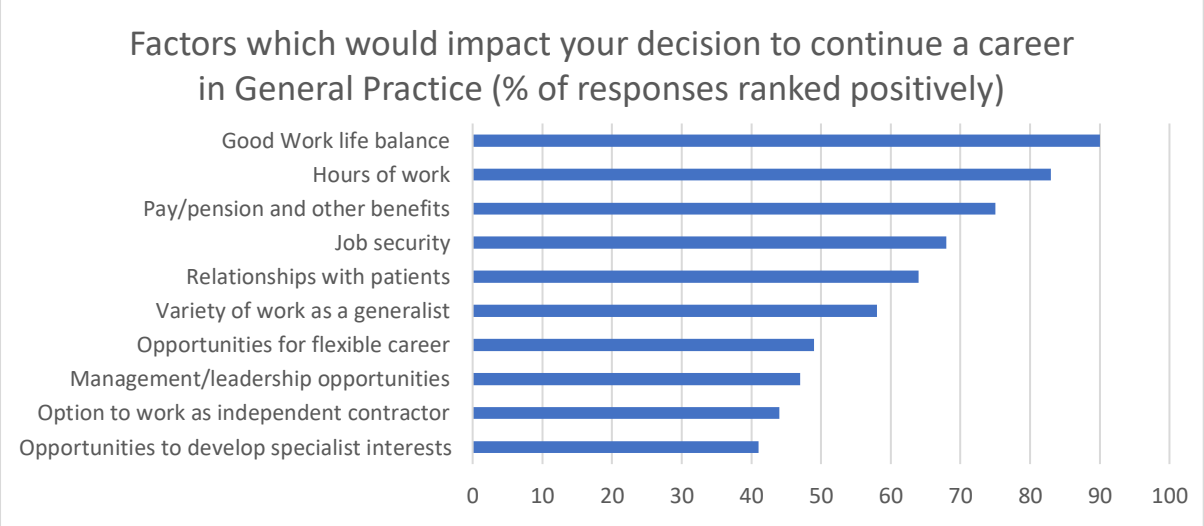
Our survey asked for a practice level response to the survey to tell us the current vacancy rates in their practices. **70 responses to this question showed that the highest vacancy rates are in reception and administrative staff, followed by Salaried General Practitioners, GP partners, and Practice nurses. The aggregate GP vacancy rate accounts for 36% of the total.**



44% have stopped advertising roles. Our survey invited free text responses to explain why, several commented **freezing on recruitment due to financial constraints and 30% have ceased recruitment due to financial uncertainty**. Increasing staffing costs and practice running costs have meant that finances for practices are squeezed. There remains uncertainty about the future of PCNs and General Practice funding as current contract negotiations are underway, as ever late in the day with no definite outcome in sight for practices to plan for the future. A significant reason was **lack of room for staff.** Free text comments described many have advertised and not had any applicants, even when paying large amounts of money to recruitment agencies staff are not recruited.

Retention

What would help practice staff to continue working in General Practice? Responses in the graph below demonstrate that **work life balance and hours of work have the biggest impact.** With pay and pension benefits coming in third. Job security, relationships with patients over time and job variety all evenly split in terms of value they bring to individuals. Opportunities to develop specialist interests, portfolio careers and management opportunities rated as having the least impact.

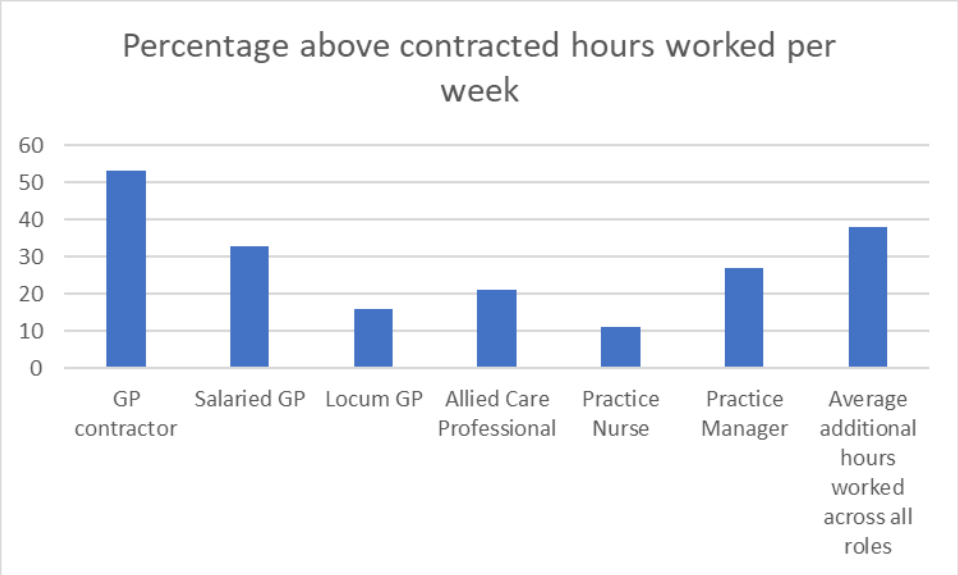


We believe further investment is needed to reduce workload burden in General Practice and enable a better work life balance of staff. The key to these are discussed further in the next section.

Workload/Interface

All working clinicians have reported a rise in demand for NHS services and the NHS digital figures show that General Practice is delivering more with less GPs. 912,263 (NHS digital) appointments were delivered by General Practice Kent and Medway in June 2023, compared to 632,391[v] in June 2019, a 31% increase in activity, despite having 977 fewer full time equivalent (FTE) GPs.

How many hours are staff in General Practice working? We found across the roles which responded the contracted hours per week totalled 6273, in practice the hours actually worked per week totalled 8644, a staggering **38% above**.

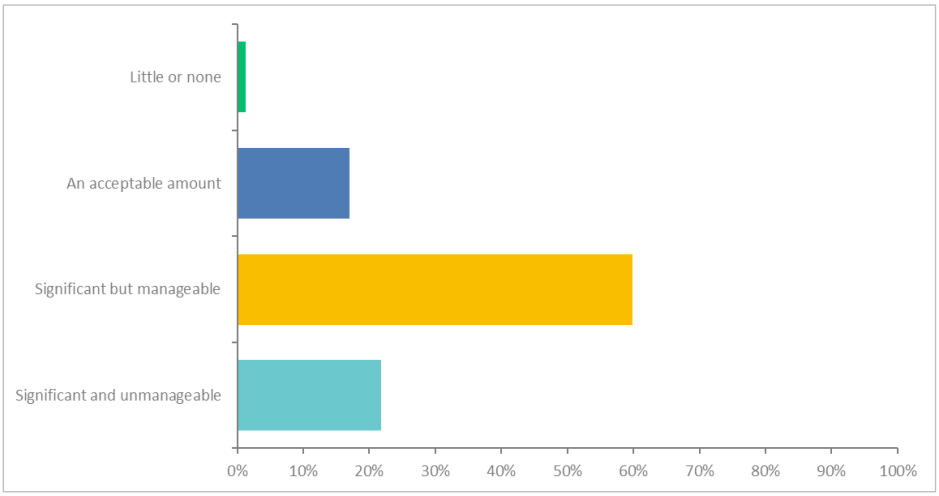


The table above shows the additional hours worked by job role, **GP contractors worked 53% above their contracted hours and salaried GPs 33%**. A demonstration that GPs are filling the workforce gap by working longer hours.

Despite this sustained increase in activity, general practice is unable to meet patient demand. Patient satisfaction in GP services fell from 71% in 2021 to 56% in 2022[vi]. Meanwhile, a national study by the Institute Fiscal Studies published December 2022 has shown that staffing in other parts of the NHS before the pandemic has increased while productivity has decreased. The decrease in productivity has direct implications on general practice, as patients waiting for treatment in secondary care rely on general practice for ongoing support.

In practice and as our survey demonstrates GPs and their staff are working harder longer hours and experiencing greater workplace stress. Stressed and Overworked a report released by the Health Foundation in March 2023 stated 'High GP stress and workload are a major threat to the future of the NHS. The experience of GPs in the UK should ring alarm bells for any government. Stress is up 11 percentage points since 2019 and satisfaction has fallen – now among the lowest of any country, despite UK GPs having been among the most likely to report high job satisfaction a decade ago in 2012.'[vii]

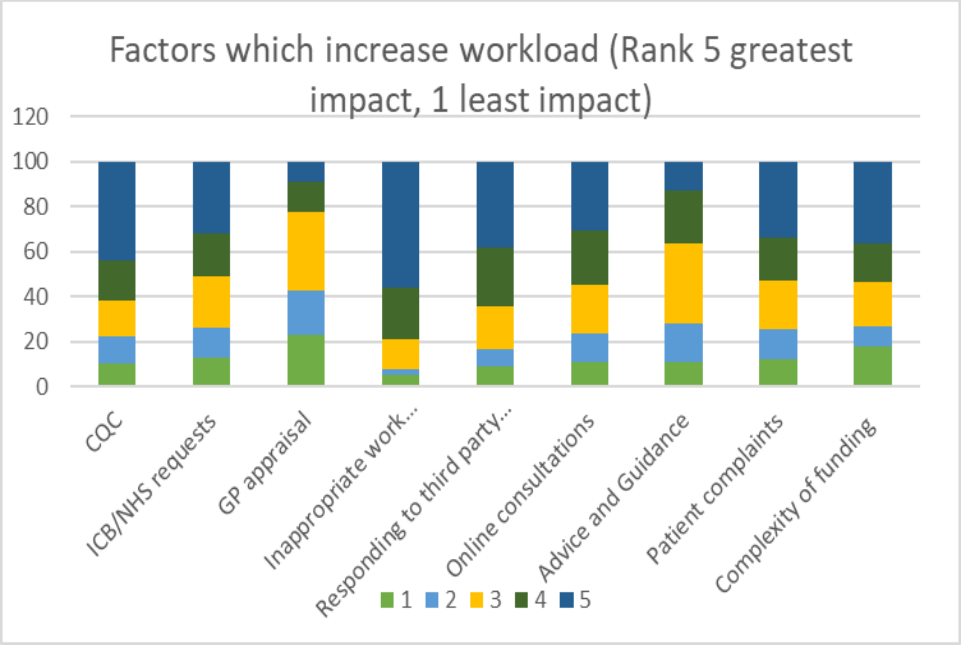
When asked about the experience of work related stress, **82% reported significant stress**:



Of the 22% reporting significant and unmanageable stress, a third were GP partners and a quarter were Practice Managers, practice nurses who completed the survey reported to have manageable and acceptable amounts of stress. This correlates with the additional hours worked, practice nurses completing the survey reported working 10% above their contracted hours vs 53% and 27%.

Worryingly of the 82% reporting significant stress, 22% reported significant and unmanageable levels of stress. This is not a sustainable position for any worker to be in. We would suggest this demonstrates a culmination of the pressures we describe in the survey which have the greatest effect on the senior leadership within General Practices.

How would you describe your **current workload** in General Practice? **50% responded that it is rarely manageable or unmanageable. This compares to 41.5% in our 2017 survey**. Of those who responded the split between GP partner and Salaried GP in terms of description of workload is even with a third of both responding that workload is rarely manageable.



The graph above shows the impact of factors which increase workload and shows **inappropriate workload transfer from secondary care is having the greatest impact on workload**. NHSE have tried to tackle this in the GP Access Recovery Plan[viii], recognising a large amount of appointments are

taken up with issues which do not relate to General Practice or acute clinical need but are related to administrative queries and requests from other parts of the healthcare system passed on to General Practice. Until we see system wide change in attitudes and training amongst all colleagues – clinical and managerial, we do not feel that the situation is set to improve. The survey demonstrates the impact of commissioning changes, the move away from funding core GMS work and the creation of the PCN DES mean that large amounts of practice time is spent ensuring that complex funding streams are being claimed and reimbursed. At the same time increasing regulation means **the impact of CQC actions and inspections ranked the second highest in terms of workload burden**.

Complaints continue to be a cause of considerable stress and worry for GPs, particularly GP partners. A less combative and fairer approach to regulation and local resolution is strongly recommended with a focus on supporting resolution.

As practices feel the increasing demand on services the BMA have responded with advice from 'Safe working in General Practice'[ix] to 'Controlling workload in General Practice Strategy'[x], to assist practices. The main aim is to agree quantitative limits on what can be expected to be delivered and maintain safe patient care. As patient complexity increases so does the need for highly skilled GPs to increase the amount of time spent with patients. Our survey asked how many have used these resources 46% of you responded that you have. This ranged from using template letters provided by the BMA and LMC to respond to requests, to reducing the number of appointments to recommended safe working limits and increasing the appointment length to 15 minutes. Comments also indicate that some practices have stopped using the resources due to increasing patient complaints and practices feeling that it is not helping. This demonstrates the need for a system approach to the problem rather than individual clinicians exchanging letters and generating increasing administrative flows. **Action is needed at ICB level** to ensure that large secondary care providers have systems in place to support secondary care colleagues to arrange and review their own investigations, recall patients and prescribe medication electronically to community pharmacies, investment is required to support these changes which will free up appointments and capacity in primary care and improve patient safety and experience.

It is clear that interface challenges have a negative impact on the working environment of GPs and that this is significant. If changes do not occur the retention crisis in General Practice will continue.

Financial Security

Core funding of all General Medical Services (GMS) practices is based on the global sum allocation formula. The global sum payment to practices per patient per year started as £102.28 for 2023/24, with a 6% uplift being applied to part of the payment half way through the year this has increased to £104.73. In addition to this the Quality Outcomes Framework (QOF) incentivises activity and changes every year. There are 635 points available which are awarded on achievement, worth £213.43 per point for 2023/24.

The 5-year PCN DES contract deal, implemented in 2019 as part of the NHS Long Term Plan, has led to the erosion of core practice funding, with the 2.1% annual GMS uplift for 2023/24 failing to address inflation peaking at 11.1% in October 2022, the minimum wage increase of 9.7% in April 23 and a DDRB recommended salary uplift of 6% from April 23. In this context, in August 2023, NHSE chose to offer the covid vaccination DES to practices with a 25% year on year decrease in funding.

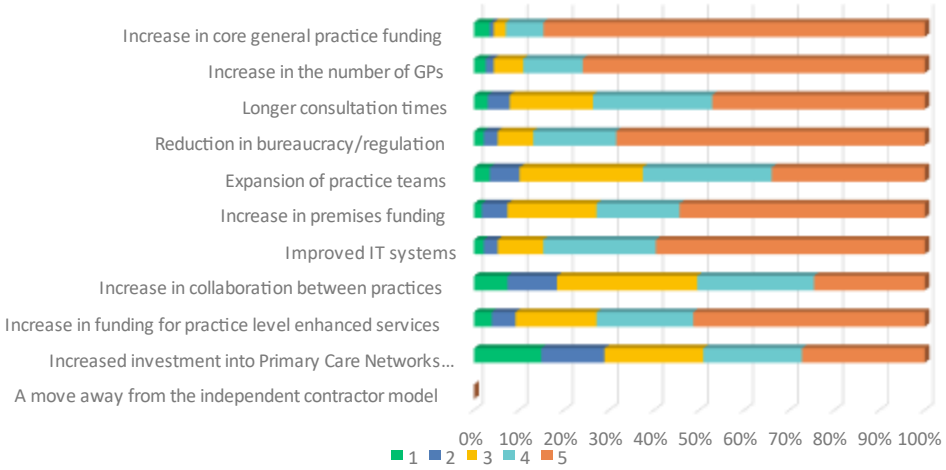
Practices can also sign up to Local enhanced services (LES), defined by the commissioner to meet specific patient needs, in Kent and Medway these have been uplifted in 23/24 by 1.8%,

compounding the deflation of tariffs, which would require an uplift of 28% restore funding to their previous levels. The national ICB average spend on LES's is £10.93 per patient; Kent and Medway ICB spend only £7.65.

Our survey suggests that practices are feeling the strain of declining investment in general practice with 93% indicating that an increase in general practice funding and 73% that increased funding in enhanced services are essential to deliver general practice. In contrast, 49% stated increased funding in PCNs is essential. None of the GP staff surveyed answered the last question indicating that a move away from the independent contractor model would not be considered a helpful step in delivering general practice.

How essential are the following resources to delivering general practice (5 = most essential / 1 = least essential)

Answered: 229 Skipped: 0



This lack of financial security has wide reaching implications for the future of general practice, with **30% of practice managers saying they have ceased recruitment** specifically due to lack of financial security. **On being asked if they have reduced or considering stopping services, 30% responded that they had**, citing financial pressures as a reason, with comments about services that had been impacted:

'Minor surgeries, joint injections'

'Phlebotomy as it no longer covers staff costs'

'Ended warfarin monitoring as not financially viable'

'Stop offering non-compulsory services'

Lack of clarity about what contract and funding will follow the current 5-year deal, can only exacerbate a sense of financial insecurity in general practice.

Estates/Premises/IT

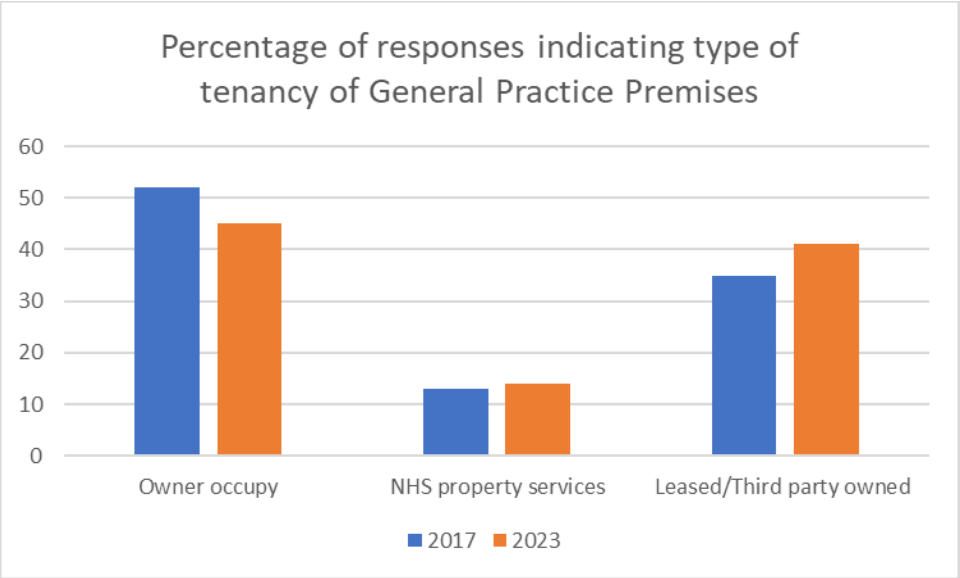
Throughout our survey there were opportunities for individuals to provide free text comments. It is telling that 96 comments were left relating to premises. Recent publications such as The Fuller Stocktake[xi] have identified premises as a key challenge in General Practice.

Premises in General Practice are complex, as independent contractors some partnerships are property owning, relying on NHS rent reimbursement and practice income to maintain buildings, other premises are under tenancy agreements with organisations such as NHS Property Services and third parties who purchase GP premises and then rent back the space to GP partnerships. The complexity has arisen as GP partnerships seek increased financial security at a time when NHS support to develop and maintain premises has been inconsistent and inadequate. Rent reimbursement assessments are overly bureaucratic and take years to reach conclusion. GP contracts are not offering long term security for practices to be assured and so financial risks of investing in extensions/new premises are too great. NHS schemes to support development of estates are released with fanfare to the media and then quietly shelved or greatly reduced by the current government[xii].

Many practices are not property owning and this adds further complexity, having to seek permissions from landlords to apply for changes or look for alternative premises (which requires massive investment – strategic planning, financial, commissioner permissions). Respondents spoke of their frustration of not having control and waiting on property owners to respond to their requests when there are issues (for example air conditioning not working etc). Requests to extend premises which are third party owned are time consuming and lack incentives for landlords.

NHS Property Services have increased service charges without explanation and this has destabilised practices further. The BMA mounted a legal challenge[xiii] against NHS Property Services as a result of unfair increases in service charges. NHS property services own numerous buildings in Kent and Medway.

Rents, energy and service costs for all practices have increased with inflation. Inflationary pressures have not been acknowledged by NHSE who have refused to provide additional support with this for practices. The consequent interest rate rises will have a longer term effect on property owning partnerships, some of the impact is being felt now. Where partners have mortgages/loans on their property some lenders are now reviewing CQC inspections before they agree to lend, also looking at the ages of the partners in the partnership to determine if the loan is secure. Most partnerships are not limited liability and so partners are considering similar risks such as if the partnership were no longer viable would their home be at risk. Interest rate rises will be inhibitory to expanding existing premises. Our survey asked contractors to describe their current situation, we have compared the responses to responses in our 2017 survey:



It is no surprise that since our last survey in 2017 the percentage of respondents who are property owners has reduced and leased premises has increased, with NHS property services properties remaining static, this is a snapshot of our responses and further analysis is needed to tell us the Kent and Medway position.

Our survey went on to ask if staff felt their current premises supported good quality, safe services and enable list growth, **65% of respondents** feel that practice premises do not support this. We invited free text comments to explain why, responses included:

'We have double the number of registered patients that we should have for the size of premises. No funding or support available to move or extend. Not able to take more than 1 trainee at a time due to space issues (when otherwise we could take at last 2 at a time). Unable to fit in PCN staff required. Extensive improvements required to fulfil CQC requirements including new flooring and replacing all the sinks. This is proving very difficult not just due to cost, but as all rooms are in constant use making it virtually impossible to close areas for the required improvement work.'

'Building is 20 years old and the list size has grown by 50% across that period. No longer have the space to provide the level of clinical service required for our existing list size, never mind with the population increase coming due to new estate builds in the area. No space for ARRS staff or PCN staff. No space for registrars or med students to support the development of the next generation of clinicians.'

'Running out of space- all rooms occupied all the time, can't develop new services'

'We have totally inadequate facilities. We are all fed up of hot desking etc'

Comments express a desire to expand, train new staff and the next generation of health care professionals. **At a time when practice patient list sizes are increasing financial support to improve practice premises to expand to meet demand is essential**. Without investment in premises practices will be unable to train additional medical students promised by the NHS Long Term Workforce Plan[xiv], GP trainees, host Additional Roles Reimbursement Staff and continue to deliver care locally where patients need it most. We note with concern the impact of Reinforced Autoclaved

Aerated Contract (RAAC), while the vast majority of General Practices will not be directly affected, the cost to the NHS budget to correct RAAC issues across the NHS estate mean that General Practice will likely be left with little or no investment over the coming years.

Digital

IT as in all industries is increasingly important to the smooth running of healthcare services. The LMC have observed the catastrophic impact of IT failures on practices. In terms of resources rated as being essential to delivery general practice IT ranked second highest (with increased core funding coming top).

Practices are dependent on software applications, which across Kent and Medway are supplied by EMIS, Docman, cloud based telephony and online consultation programmes – to receive and make phone calls, book patients, enter patient consultations, prescribe medication, process patient investigations – view and process accordingly and communicate within practice teams. Docman is a letter filing system, all patient correspondence flowing into practices is sorted to be filed or viewed by clinicians and actions flow from this such as booking of appointments, investigations, medication changes and coding of diagnoses onto the patient record. There is a further computer programme to request blood tests and then separate mechanisms to request imaging. The applications are independent of each other and purchased separately and responsibility for their running are held across the healthcare system with complex contracting arrangements with the software suppliers.

In recent years EMIS has moved from a local host to cloud based. While there will be benefits associated with this, enabling wider interface functionality, the downside is that when there is a software problem centrally this leads to widespread failure which prohibits usual activity from occurring in General Practice. Recently we have seen failures such as these increasing in frequency and this is adding to the already high workload as the work does not stop when the computer fails to work. Partners are catching up in their own time putting in additional hours across evenings and weekends to ensure that patient safety is maintained. Practices have reported problems with software providers such as EMIS not being responsive enough to resolve technical problems and interface challenges between providers.

To add to the complexity since our last survey online consultations have been introduced as a contractual requirement. **54% of you reported that online consultation provision is causing a high and very high burden of work for practices.** Online consultations as with face to face or telephone consultations require the same amount of time from the clinician to manage. They are another form of consultation, with the same clinical burden. Online consultations can be used for patients to request administrative tasks be done, such as issuing Fit Notes and requests for letters, internally practices are having to employ additional staff to direct the flow of work to the right person and complete the online consultation. Just like estates, the infrastructure of our IT needs constant attention, something as simple as a software upgrade can cripple PCs sitting in consultation rooms.

COVID prompted an acceleration in remote working capabilities. This has enabled clinicians to work remotely, to take an iPad or laptop with access to patient records with them on home visits. At a time when we have huge pressure on estates this ability to remotely worked has enabled practices to manage this. The downside is that work is never far from the partners fingertips and many GP partners spend their evenings processing patient results, prescription requests and letters. The long term impact on the health of our workforce is unlikely to be good.

IT can improve working conditions. The NHS is relatively behind other industries when it comes to the use of technology such as AI (Artificial Intelligence). The focus of the government has been to improve patient access to medical records, this is only one part of the picture. There are many issues which IT solutions could improve. One area is the interface between different parts of the NHS. Implementing IT to measure workload transfer and enable resources to follow work would improve efficiency and be more cost effective in the long term. In 2023 we have the technology to allow a consultant in outpatients to send an electronic prescription to community pharmacy for the patient they are consulting, and yet it is not being implemented. Investigations should be requested on a central system across Kent and Medway which would allow patients to choose where to get their tests done and not be limited to hospital requests being met in the hospital. Simple applications which would improve patient experience and reduce silo working between providers.

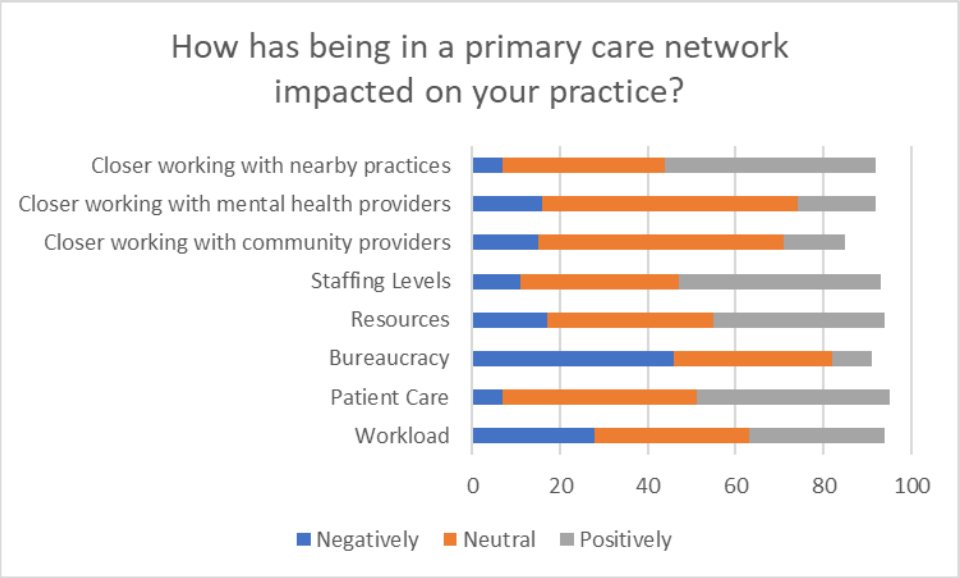
Impact of PCNs

In 2019 the introduction of the Primary Care Network DES meant than practices who opted in to deliver the network requirements were required to work in groupings known as Primary Care Networks. Not all practices signed up, where a practice is not part of the PCN the delivery of PCN services to their patient population is taken on by the PCN which covers their geographical boundary. The PCN DES has changed over the last few years and is due to come to an end in April 2024. At the time of writing this report uncertainty remains over what the future contracting arrangements will look like. Negotiations have begun between GPC England and NHSE.

We could not have predicted that shortly after the roll out of the PCN DES we would face a global pandemic. This coincided with a significant reorganisation in NHSE commissioning structures as Clinical Commissioning Groups were phased out and Integrate Care Systems phased in.

Our survey did not specifically ask for Clinical Director views, we invited all staff including Clinical Directors to respond, 4% of responses were from Clinical Directors and 0.5% (1) is an ARRS staff member. We looked to establish how PCNs are viewed at practice level and have GPs and practice staff felt the benefits. When the PCN DES was originally introduced the stated aims were to stabilise general practice, and to support core practices, at the same time to reduce health inequalities and to reduce the divide between community and primary care. The DES offered a massive expansion of the primary care workforce with originally 70% funded Additional Roles Reimbursement Scheme staff moving to 100% reimbursement in 2020. Funded roles have not included GPs, through the additional roles NHSE have looked to diversify the GP workforce and change the way patients consult with General Practice. It has been disappointing that while the DES was negotiated for 5 years NHSE have imposed changes in recent years which have expanded the scope and ask of PCNs. Infrastructure such as employment mechanisms, pension provision, tax liabilities, and simple things like bank accounts were not thought through at introduction and have caused GPs to take on risks to support the development and implementation of PCNs.

Our survey asked how has being in a Primary Care Network impacted on your practice? Responses are shown in the graph below:



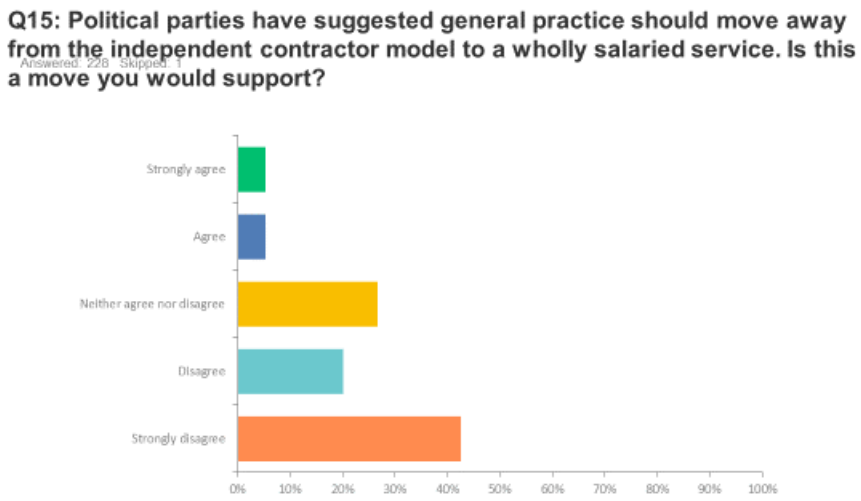
The results indicate that **working with nearby practices (48% report positively), staffing levels (46% report positively) and patient care (44% report positively, 44% neutral)** have all been impacted positively by PCNs. In terms of negative impact **bureaucracy stands out with 46% of responses reporting this to have been negatively impacted by PCNs**. When considering reducing divides and improving working relationships with other providers the questions relating to this show when looking at one of the main aims of the introduction of the DES, improved **working with community providers just 14% of you felt this had been impacted positively, with 56% reporting neutral**. **There was a similar distribution when looking at mental health providers (18% positively and 58% neutral).**

Our survey asked **how essential increasing investment into PCNs would be to deliver General Practice, 29% of responses indicated Not Essential and 49% Essential**.

We are at a pivotal crossroads for PCNs. What is clear from our responses is that while some aims have been achieved at practice level they are not universally felt positively. Our recommendation from our responses is that NHSE look closely at the burden of bureaucracy associated with PCNs and reduce this. We note with caution the response regarding patient care, given the investment that 44% report neutral and 7% negative impact this response is worthy of further exploration to establish the view of patients. We are left wondering had this investment been put directly into practices would the impact have been greater for patients and staff working in General Practice and delivered with less bureaucracy?

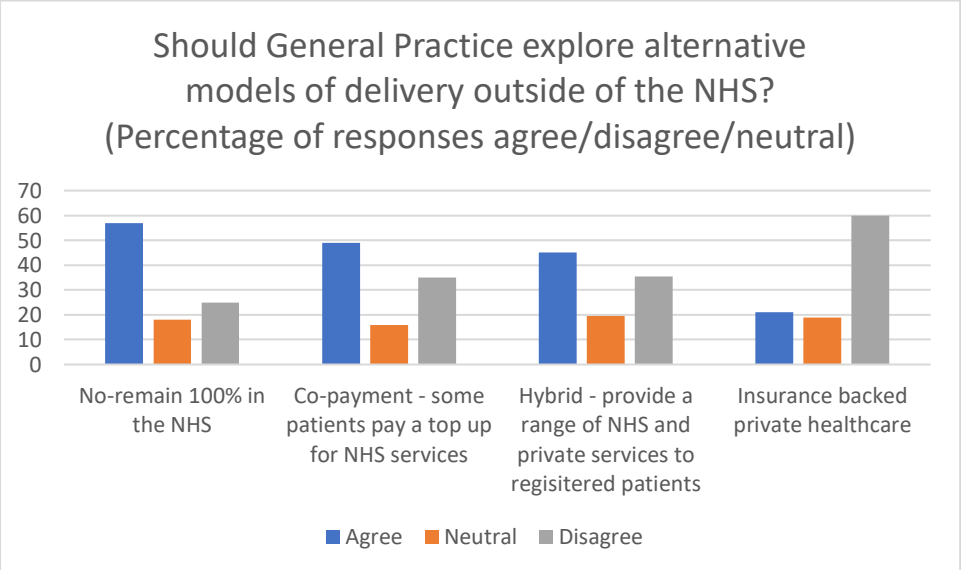
Future of General Practice

The last few years have been extremely hard for General Practice. One element of this has been the relentless negative media attention often fuelled by political narratives regarding future models of General Practice. The current Independent Contractor model has untold benefits for the NHS in terms of value for money and reflects values which were held dear at the inception of the NHS of continuity of care and a family practitioner. Population rates were lower, burden of disease was lower which reflected the limits of medicine. Investigation, diagnostics and treatments which we take for granted today simply were not available. We asked if you felt the political narrative was an idea you would support.



62% of you disagree with a move to a wholly salaried service, with just 10% agreeing. 28% of general practice staff are neutral.

In response to debates we have heard in political forums we asked participants to consider whether General Practice should consider alternative models outside of the NHS.



Responses indicate a strong desire to remain in the NHS. When asked if general practice should explore a co-payment model almost half of responses (49%) would support this and 39% would not. The survey asked whether General Practice should explore potential levels of privatisation, Hybrid-

(NHS and private services to the registered population) and Insurance backed private health care. 45% of respondents would agree to exploring a hybrid model, and 35% disagree. Regarding privatisation, the result is more polarised, with 59% of respondents disagreeing that this model should be explored.

In summary, our survey shows that General Practices and their staff are working harder and delivering more with less. However, this position is not sustainable. 82% of GP staff responding are experiencing significant stress and is it any wonder when the responses show that staff are working an average of 38% above their contracted hours each week, with GP contractors working 53% above their core contracted hours.

Our recommendations are:

WORKFORCE

1. Expand the current GP recruitment scheme to cover the whole of Kent and Medway with increased investment in areas with the lowest GP:Patient ratios.
2. Simplify requirements to become a GP trainer and bring these in line with neighbouring deaneries
3. Continue work to improve retention in Kent and Medway, including focus on mid career GPs, and funded training opportunities with locum cover
4. Invest in Practice Manager development and support

FUNDING

5. Uplift the tariff for Kent and Medway LES's to match the national average
6. Ensure primary care underspend is invested back into primary care, focusing on recruitment and premises
7. National uplift in Global Sum funding, with year on year inflationary increases

ESTATES

8. Investment in GP premises (S106 and CIL funding should be easily accessible to General Practice with ICB premises team support to practices) and national reimbursement of management charges and utility bills
9. ICB should be able to hold leases for GP practices
10. Challenges with NHS property services need to be mitigated locally by the ICB and resolved nationally by the Department of Health
11. District Valuer assessments are overly bureaucratic; delays in valuation of premises and rent reviews need to be urgently addressed

DIGITAL

12. Investment in IT infrastructure across the General Practice estate to update hardware
13. Urgently address the current problems with providers such as EMIS
14. ICB ensure that large secondary care providers have systems in place to support secondary care colleagues to arrange and review their own investigations, recall patients and prescribe medication electronically to community pharmacies

WORKLOAD

15. Urgent reduction in bureaucracy from ICB and other stakeholders
16. NHSE look closely at the burden of bureaucracy associated with PCNs and reduce this
17. Practices must have control over the online consultation platforms to flex according to practice capacity

18. Elimination of inappropriate transfer of work from other providers, looking at key interface issues such as referral mechanisms, patient clinic letters, prescriptions and investigation requests and discharge summaries

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[iv] (Office for National Statistics, 'Trends in patient-to-staff numbers in General Practices in England:2022') https://tinyurl.com/39wuhypn
[v] GP_APPT_Publication_June_2019.xlsx (live.com) https://tinyurl.com/5x7nahhw
[vi] Statistics » GP Patient Survey 2023 (england.nhs.uk) https://tinyurl.com/jht3x9a5
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