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Rejuvenating general practice

Ensuring a resilient future for primary care

Contents

Foreword

Welcome to our report, *Rejuvenating general practice: ensuring a resilient future for primary care.* This report analyses the challenges and opportunities facing general practices today and how they might use the levers in the government's 10-Year Health Plan to ensure that general practice and the wider primary care system can play a critical role in a productive, resilient and patient-centred neighbourhood health service.

This report analyses the current state of and prospects for general practice in England, drawing on surveys, interviews with GPs and practice leaders, and secondary research, including the expectations for general practice in the government's Fit for the Future: 10-Year Health Plan for England, published in July 2025.

Our research finds the traditional model of general practice, that has evolved gradually over the past 70 years, at a tipping point. Historically, the UK's general practice model has been lauded for providing cost-effective, continuity of care through its role as a healthcare provider and gatekeeper to and navigator of, most other healthcare services. However, following a decade of receiving an ever-reducing share of the NHS budget, unrelenting increases in the scale and complexity of demand and a radical change in the composition of the general practice workforce, with a concerning decline in experienced GPs, especially GP partners, the current model appears unsustainable.

Despite the identified challenges, the Plan envisages that revitalised, digitalised, larger scale general practices have a pivotal role to play in the development of a new Neighbourhood health service. The Plan sets out a trajectory for the NHS predicated on three strategic shifts: hospital to community, analogue to digital and treatment to prevention. It also envisages a care model that offers continuous, accessible, and integrated care based on digital transformation, enhanced data utilisation, sharing patient information through a single patient record and democratising access to information, support and services through an enhanced NHS App. A resilient and productive general practice model will be essential in helping deliver this vision.

Our GP interviews and survey results show that although their sentiments about general practice today were predominantly negative, they also displayed substantial optimism, positivity, and innovative thinking; and a belief that general practice could not only survive but thrive. Our report therefore explores the tactics needed to bridge the gap between the reality of today and the ambition for tomorrow and rejuvenate general practice so that it is fit for the future.

As always we welcome your feedback and are happy to discuss our views and potential solutions to a situation that we all have a vested interest in resolving.

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Executive summary

General practice has evolved gradually over the past 70 years, yet the critical relationship between general practitioners (GPs) and their patients remains steadfast. This "cornerstone relationship" is critical to a resilient and revitalised model of primary care. Our report assesses the current state and prospects of general practice in England and highlights the need for urgent transformation. While the current model has historically been widely acclaimed, it has become increasingly unsustainable. Challenges include insufficient funding and a beleaguered workforce struggling to meet rising and more complex patient needs, substandard premises and inadequate digital transformation with suboptimal use of IT and digital technologies. GPs express a mix of frustration and hope and identified opportunities for improvement through new ways of working, use of population health management, adoption of AI-enabled digital technologies, data sharing and a more integrated, multidisciplinary approach to care.

The current state: the rationale for a new model of general practice

The current system of general practice is overburdened. It handles 55 per cent of out-of-hospital consultations, with nearly 1.5 million daily appointments (a 22.5 per cent increase since the pandemic), yet patient satisfaction is at its lowest ever level. Funding remains critically low at 5.5 pence per NHS pound (the annual funding for each registered patient is £112.50 per patient), a 2.5 per cent decline in real terms since 2018-19. While the number of appointments has increased, many of the additional appointments are now being delivered by non-GP practitioners, leading to role ambiguity and concerns over liability around clinical risks.

The most notable change in general practice is the composition of the workforce. which is markedly different in 2025 compared to 2015. While the number of appointments being delivered has increased dramatically, many are now provided by nurses and a growing number of other allied healthcare professionals (termed direct care staff). Meanwhile, patient satisfaction has fallen to its lowest ever level, albeit it varies by region, levels of deprivation and the likelihood of seeing a GP. Significant workforce shortages, which are particularly acute for GPs, practice nurses and pharmacists, mean general practices are struggling to meet the rising expectations of patients, many of whom have increasingly complex conditions. These shortages, together with unrelenting workloads and declining job satisfaction are driving experienced GPs to leave the profession (40 per cent expect to leave within five years). This loss of experience is having a negative impact on patient and staff satisfaction, with repercussions for other healthcare services.

Successive initiatives during the 2010s emphasised that digital transformation and technology adoption were critical in meeting the rising demand and constrained supply of resources. The 2019 NHS Long Term Plan expected that in return for more investment and more staff, services would be delivered differently. It proposed investing £4.5 billion over five years in primary medical and community services to expand community multidisciplinary teams aligned with new primary care networks (PCNs) typically covering 30-50,000 people. General practices within each PCN were expected to deliver digital-first primary care, via on-line digital platforms, underpinned by new financial incentives as part of a new five-year framework for GP contract reform.

Our review Realising digital-first primary care, in February 2020 acknowledged the entrepreneurial nature of general practice, including the early adoption and maintenance of electronic patient records since the early 2000s. However, we also found wide variation in the digital maturity of practices including the use of online services and, consequently, patients' ability to access services and input relevant clinical information digitally. The COVID-19 pandemic in early 2020 accelerated digital first access and patient triaging. However, many practices since then have been cautious about investing in digital solutions, with obstacles including the cost of technology, bureaucracy and finding suitable, trusted solutions.

Over the course of the past three years two landmark reviews identified the growing challenges in general practice:

- In May 2022, Next Steps for Integrating Primary Care (the Fuller report), identified the inception of integrated care systems (ICSs), under the 2022 Health and Care Act (HCA), as providing an opportunity to radically change the way services were designed and delivered, putting primary care at the heart of each ICS.

- Lord Darzi's independent review into the current state of the NHS in September 2024 identified a range of system-wide issues. Its findings on general practice included highlighting the significant frustration felt by GPs who saw more tasks being shifted from secondary care together with increased acuity of patients requiring follow-ups but without a commensurate increase in funding.

Our GP interviews and surveys in Spring 2025, reflected most of the previous review findings. While the sentiments expressed about the state of general practice today were predominantly negative, they also displayed a cautious optimism that general practice could be revived. Their views on the state of general practice in five years' time were almost entirely positive believing that general practice would survive and thrive. They identified the top three challenges as over-worked, stressed practice staff, workforce shortages and increasingly complex patient needs. They also expressed feeling undervalued but derived job satisfaction from having sufficient time to help patients. They also accepted the need for more sustainable models of general practice but considered that there was "no one size fits all solution".

Respondents identified challenges in technology adoption, citing lack of trust and understanding of its capabilities, insufficient training, inadequate system interoperability and concerns over data sharing. They told us that general practice funding had reached crisis level and that there had also been limited scope for population health management and planning. Moreover, that resolving these issues required investment in the technology infrastructure and staff training together with increased funding commensurate with the growing expectations and rising demands being placed on them.

We identified a lack of sufficient investment in the general practice estate with a quarter of premises rated as unfit for purpose. Indeed, the size and state of the building is a limiting factor in being able to increase workforce capacity together with limited consideration of how the estate could support new models of care. Solutions included tailoring the ownership model to incentivise investment and making better use of the existing estate through co-ordinated estates planning and investment.

We identified five core trends that are changing the health landscape of general practice today: the need for a place-based preventative approach, human centric design, digitalisation, improved productivity and health equity. And four constraints that need to be addressed so that they become enablers for a resilient and sustainable general practice system (workforce, funding, digitalisation and estates).

What next: designing a future proof primary care system

While the level of challenges currently facing general practice appears more severe than ever before, many more appointments are being delivered and practice staff are working harder than ever, but staff and patient satisfaction at its lowest ever level. At the same time there is a tangible measure of optimism that general practices can survive and thrive and once again become the cornerstone of an efficient, and cost-effective healthcare system. The missing ingredient is how to realise this ambition.

The Plan provides a pivotal opportunity for general practice and the wider primary care system to shape its own future and adopt new operating models to improve outcomes for patients and staff. These new operating models need to be population-led and digitally enabled. We have identified six actions crucial for a resilient and sustainable future: patient activation; embedding digitalisation and an integrated data ecosystem; adopting next-generation flexible workforce models; establishing outcomes-based performance monitoring and aligned financial and other incentives; modernising the estate; and developing proactive, preventative equitable delivery models. Implementing these actions requires:

- **System redesign:** moving from top-down mandates to locally led digital transformation, prioritising interoperability, utilising AI for efficient task automation, and integrating care models based and technology-enabled clinical pathways.
- **New ways of working:** building sustainable, relationship-based care models, GPs expressed a mix of frustration tempered by hope and identified upskilling staff, including continuity of care for patients with more complex needs, investing in leadership development and building trust, embracing patient activation and empowering people to manage their own health, co-designing digital services and care plans and establishing real-time performance monitoring using population health data.
- **Reformed funding models:** adequately compensating general practices for the increasing scope and complexity of tasks, replacing outdated contracts and ensuring equitable funding distribution together with clear responsibilities and accountabilities of all system partners for how funding is spent.

Conclusion

While significant challenges exist, there is a strong sense of optimism about the future of general practice. Indeed, the government's 10-Year Health Plan envisions general practice playing a pivotal role in the new neighbourhood health service; and, with the right enablers, having a central role in delivering the Plan's three shifts, especially the shift to preventative care. The last five years have proven GPs to be versatile, adaptable and ready to rise to the challenges ahead. General practices know their patients like no other service and are effective system integrators. Indeed, there is a crucial opportunity for general practices to play a leading role in the development of the new neighbourhood health system.

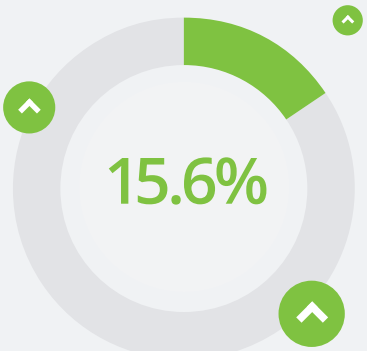
Successful transformation hinges on embracing multi-year planning, data-driven decision-making, digitalisation and a multi-professional approach to care, which, for the most part, should be delivered at-scale. It also requires general practices to take on a system leadership and collaboration role, underpinned by new operating and funding models, including transformation funding, alongside ongoing longer-term investment commensurate with the requirements envisioned for a rejuvenated general practice.

Key facts and findings

Impact of workforce composition, funding and estate capacity

There were 59.3 million registered patients in September 2018, rising to 63.7 million by December 2024, **an increase of 7.4% (4.4 million).**

7.4%



In 2019, general practice delivered on average 5.0 appointments per patient: **rising to 5.8 in 2024, an increase of 15.6%.**

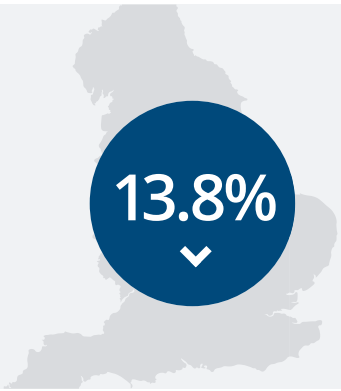
By **December 2024 there were 14.4% fewer qualified full time GPs** (the proportion of fully qualified permanent GPs fell from 33.4% in March 2016 to 18.7% in December 2024) – the GPs working part-time include many pursuing 'portfolio' careers or reducing their hours because the job is so demanding or to improve work-life balance.

14.4%

This aggregate drop in fully qualified permanent GPs disguises a more radical, **27% decline** in GP partners (from FTE of 21,655 in September 2015 to 15,703 in December 2024.)

The decline has been greater among young GP partners (a drop of 56.7%).

In September 2015, there were 50.2 fully qualified permanent GPs per 100,000 patients in England. **This fell by 13.8%** (to 43.4) by December 2024, driven by a mixture of an increase in patients registered in general practice (+12.0%) and a decline in the number of fully trained permanent GPs (-3.4%).

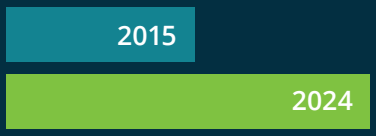


This is a trend that has happened in an unplanned and haphazard way.

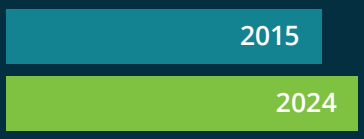
Since 2019 the general practice workforce has included a significant increase in direct patient care (DPC) staff (such as pharmacists, paramedics, care coordinators and physiotherapists) many hired under the Primary Care Network (PCN) managed Additional Roles Reimbursement scheme (ARRs).

Source: Deloitte secondary research of published materials from The Health Foundation, Royal College of General Practitioners and The Institute for Government.

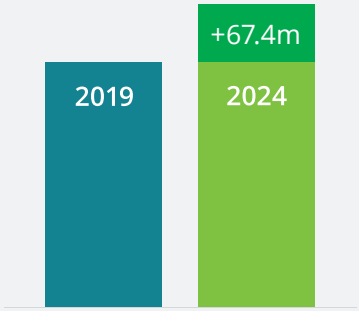
FTE DPC staff increased from **9,372 in 2015 to 17,437** in 2024...



...meanwhile **practice nurses** increased from **15,196 to only 16,884** over the same period.



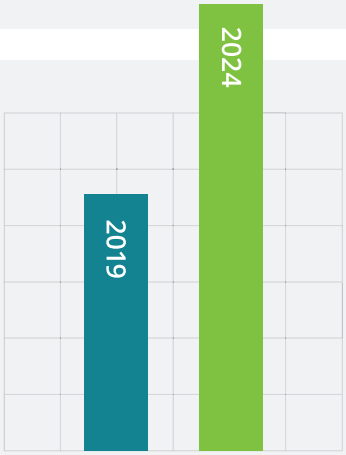
There were **367.4 million appointments** delivered in 2024 **compared to 300 million in 2019** (an increase of 22.5%); of these 67.4 million additional appointments 56.2 million were provided by nurses and DPC staff.



At an individual patient level, the average core contract payment for general practices in 2024 equated to only **£112.50 per patient**, per annum. Moreover, overall investment in general practice declined **2.5 per cent** in real terms between **2018-19 and 2022-23.** At the same time the funding to PCNs has increased.

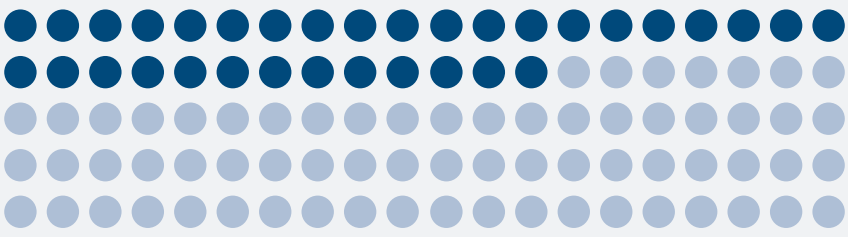
The physical constraints and lack of investment in many GP premises means that funding provided by PCNs to take on different types of healthcare professionals (HCPs), known as direct care staff (DCS) has left practices without the physical capacity (or funding) to take on GPs.

The number of GP-led appointments delivered in a practice has a strong statistically significant relationship with patient satisfaction; salaried GPs and GP trainees have reasonably strong significance; more nurses show a weak significance, but there appears to be no significance in having more DPC staff.



The number of appointments delivered virtually have **grown from 19.3% in 2019 to 33.8% in 2024**, with many patient interactions mediated through an online platform.

In 2022 there were 8,911 premises used by general practice in England, 22% were pre-1948 and **a third of premises identified by GPs as not fit for purpose.**



The rationale for a new primary care model of general practice

The performance of the UK's general practice system, once lauded internationally as the cornerstone of a comprehensive, cost-effective and resilient healthcare system, has deteriorated due to persistent workforce challenges, funding gaps, inadequate facilities and uneven digital adoption. Despite general practice being seen as fundamental in the Health and Care Act 2022, the situation has worsened, with growing demand, fewer GPs per registered patient, reduced capital investment in digitalisation and premises, and declining patient satisfaction. However, the NHS 10-Year Health Plan provides a unique opportunity to rejuvenate and restore general practice so that it again becomes 'the jewel in the NHS crown'.

The general practice model has evolved slowly but steadily over the past decade

All UK citizens resident in the UK are entitled by law to access NHS healthcare, including registering with a dedicated general practice. Historically, general practice provided unfettered access and continuity of care to their registered list of patients while acting as the navigator of and gatekeeper to other health and care services.[1]

GP partners traditionally own and manage a practice and hold a capitation-based contract with the NHS to deliver a defined set of services to their registered list of patients. Operating as small, independent business owners, partners bear significant financial and clinical risks. Salaried GPs employed by partners share clinical risks but not the same liabilities and work alongside GP trainees, practice nurses and increasingly other types of direct patient care (DPC) staff forming multi-disciplinary teams.

Our previous reports on general practice, in 2012, 2016 and 2020, highlighted persistent challenges in accessing general practice services and declining patient satisfaction. Few of the numerous policy initiatives launched over this period, attempting to reverse the decline in performance, were evaluated before new policies were introduced. Likewise, few evidence-based, solutions were implemented at anything approaching scale.[2, 3, 4]

The 2019 NHS Long-Term Plan (LTP) provided further levers to improve primary care. It proposed that most care should continue to be provided through list-based general practice but with an expectation that in return for more investment and more staff, practices should implement digital-first access advice and support using on-line services connected to their own practice.[5]

The LTP proposed that £4.5 billion would be invested in primary and community care services over five years, to expand community multidisciplinary teams, aligned with new primary care networks (PCNs), bringing together neighbouring GP practices typically covering 30-50,000 people. It expected primary care to create joined-up systems and digital patient records, link genomic and clinical data, improve the use of apps and adopt advanced technologies such as AI. Moreover, digital-first general practices working as part of new PCNs would lead the transition to preventative and personalised medicine and identify innovative ways of managing rising demand from an ageing population and an increased prevalence of chronic diseases.[6]

The state of digitalisation of general practice in 2020

Our February 2020 report, **Realising digital-first primary care** (published a month before the onset of the COVID-19 pandemic), uncovered wide variation in the digital maturity of practices including in the use of online services and consequently in patients' ability to access services digitally. Challenges included uncertainty over which technology to buy, inadequate training, low and fragmented adoption, a lack of data interoperability between general practices and other parts of the health system, and GP and patients continued preference for face-to-face care. Our methodology included a survey of some 240 GPs and 260 practice nurses with sixty-seven per cent of respondents believing that it would take more than ten years to achieve a fully digital system.[7]

The pandemic accelerated the uptake of technologies to deliver primary care differently, including video consultations, expanded use of telephone consultations and adoption of digital triage. General practices were able to adapt quickly due to streamlined procurement processes and a burning platform around safety that overcame some of the previous cultural barriers to change. Implementation was supported by suppliers who were able to roll out solutions quickly. By April 2020, 90 per cent of consultations were conducted remotely compared to 33 per cent in April 2019. By July 2020, as the threshold for seeing patients face-to-face was lowered, the number of consultations conducted remotely dropped to 85 per cent.[8]

Post-pandemic, demand-capacity mismatches intensified, exacerbated by the rising complexity of patient requirements and the global inflation shock in 2022 which eroded the real-terms value of the GP contract. In 2025, patients are more likely to contact a practice through a digital platform and be triaged using proforma questionnaires, when they access a service they are more likely to have a remote appointment, either by phone or through a digital consultation. Respondents to the GP survey report they now find it difficult to see their preferred GP.[9]

The Fuller stocktake, the Health and Care Act 2022, and the Darzi report

By November 2021, concerns over declining levels of patient satisfaction and growing levels of discontent and burnout among practice staff, led NHS England (NHSE) to commission a major stocktake of primary care. Its May 2022 report, Next Steps for Integrating Primary Care (known as the Fuller report), stated that the inception of integrated care systems (ICSs), under the 2022 Health and Care Act (HCA), provided an opportunity to radically change the way services were designed and delivered. It proposed that primary care should be at the heart of each new ICS, noting that some, but not all, of the changes would need investment in primary care capacity, and that new multiprofessional partnership working and thinking differently about how to design integrated primary care services were needed.[10]

ICSs have existed in one form or another since 2016, but were formalised as legal entities with statutory powers and responsibilities by the **2022 Health and Care Act** (HCA). ICSs comprise two key components: integrated care boards (ICBs) statutory bodies responsible for planning and funding most NHS services; and integrated care partnerships (ICPs) statutory committees bringing together a broad set of partners (including NHS organisations local government, the voluntary, community and social enterprise sectors (VCSE), across a defined geographical area. The formation of ICSs was part of a fundamental shift that removed the emphasis on competition and the separation of commissioners and providers and introduced the need for collaboration and a focus on place to improve outcomes in population health, tackle health inequalities in outcomes, improve patient experience and access, enhance productivity and support broader social and economic development.[11]

However, the pressures on general practice intensified, including unrelenting increases in the volume and complexity of demand and growing waiting lists. In 2024, the incoming Labour government commissioned Lord Darzi to review the current state of the NHS. His September 2024 report revealed a system struggling financially and operationally, with areas such as digital transformation, capital investment, workforce capacity, pandemic response and health outcomes, lagging other countries. It identified the frustrations felt by GPs and staff who saw more tasks being shifted from secondary care to primary care, together with increases in acuity of patients requiring follow-ups, but without a commensurate increase in funding. He also noted an uneven geographical distribution of GPs and that England had almost 16 per cent fewer GPs than other high income countries, yet are expected to manage and co-ordinate increases in demand and complexity of care. Moreover, the resources, infrastructure and authority to do so was lacking. Although the report highlighted serious problems, it also identified optimism and real potential to transform performance, concluding that "the NHS was in a critical condition, but its vital signs were strong".[12]

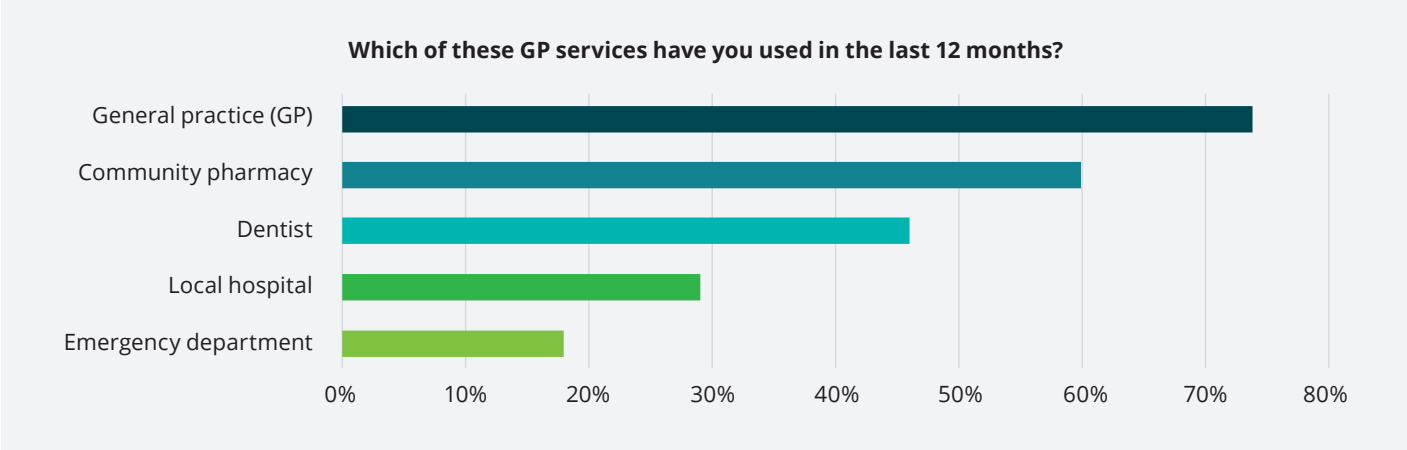
Crucial facts about the state of general practice at the end of 2024

In general, 90 per cent of all patient contacts occur in out-of-hospital settings, with 55 per cent of out-of-hospital consultations with general practices. Across England, practices are working at an unprecedented level of activity with daily appointments running at almost 1.5 million a day in 2024, 22.5 per cent more than in 2019.[13]

The Health Foundation's public perception survey on the use of NHS services during 2024 found that general practice was by far the most used service (74 per cent). Only 29 per cent had been to a local hospital for a routine procedure or appointment, while just 18 per cent had attended an emergency department (see Figure 1). Consequently, patients' experience of general practice is most likely to influence their views of the NHS.[14, 15] It also demonstrated the importance of community pharmacists and dentists and the scope to use them more effectively.

By the end of 2024 the level of funding for general practice "was at nadir" with the general practice contract providing just 5.5 pence from every NHS pound.[16] At an individual patient level, the average core contract payment in 2024 equated to only £112.50 per patient, per annum (31 pence per patient per day). Moreover, overall investment in general practice declined 2.5 per cent in real terms between 2018-19 and 2022-23 (see Figure 2a). At the same time the funding to PCNs has increased (see Figure 2b).[17]

Figure 1: Findings from the Health Foundations survey question on the publics use of NHS services in 2024



Note: For the first time in the Health Foundations polling series (wave 7), the public's top priority for the NHS is making it easier to get appointments at GP practices (38%). This is followed by improving waiting times for A&E (33%) and reducing the number of staff leaving the NHS by improving working conditions (29%). However, ending backlogs for routine hospital procedures tops the government's list of priorities for the NHS (Do the government and the public share the same priorities for the NHS? - The Health Foundation).

Source: Base: Respondents in the UK n= 2198. Conducted online via Ipsos Knowledge Panel UK between 21–27 November 2024. Question asked as part of a series of questions on public perceptions of health and care

Figure 2a: Annual investment in general practice in England (excluding COVID-19 costs) - £ billions

	2018/19	2019/20	2020/21	2021/22	2022/23
Cash terms	£11.271	£12.343	£13.387	£14.236	£14.821
% change	3.05%	9.58%	8.53%	6.18%	4.11%
Real terms	£12.881	£13,780	£14.175	£15.197	£14.821
% change	0.92%	6.98%	2.86%	7.22%	-2.47%

Note: The increase in cash terms includes payments to PCNs. These payments are not available for GP practices to decide how to use but are only available for Additional Roles Reimbursement Scheme (ARRS) services, which until January 2025 excluded GPs meaning practices have had real terms cuts in income. While PCNs used these funds to increase the number of direct care staff working in general practices; the funding constraints overall meant the numbers of GPs employed reduced with many practices struggling and some practices closing.

Source: NHS England

While activity has increased in general practice, staff job satisfaction and the public's perception of general practice have deteriorated. Reasons for this include a decade of underfunding, recruitment and estates challenges, increasing patient complexity and rising bureaucracy drawing on research and analysis by The Health Foundation, Royal College of General Practitioners (RCGP) and the Institute for Government (IFG) to show how the pressures facing general practice have escalated over the past five years (see infographic on pages 6 and 7).[18, 19, 20]

The IFG considered that the most radical change in general practice was the composition of the workforce which was markedly different in 2025 compared with 2015 (when the GP workforce dataset started). While the number of appointments being delivered had increased dramatically, many were now provided by nurses and DPC staff. Patient satisfaction had also fallen to its lowest ever level albeit this varied between practices' workforce composition, and levels of deprivation. For example, satisfaction is highest in practices with more GPs (particularly GP partners) per 1,000 patients (see infographic).[21]

There is a disconnect between the public perception of access to general practice and the reality of the workload and complexity involved in meeting demand led access. A comprehensive analysis by the IFG, published in 2025, noted that judging quality in primary care is difficult as much of the publicly available data, including Quality and Outcomes Framework (QOF) data measures activity, with limited information available on outcomes. This has led to the conundrum that despite practices delivering record numbers of appointments, increasing numbers of patients report dissatisfaction due to difficulties making appointments and longer waiting times.[22]

The IFG research also found a clear trend of increasing satisfaction as the number of GPs per 100,000 weighted patients increased. In 2024, in practices with between 70-72 GPs per 100,000 weighted patients, 81.5 per cent of patients reported having a good experience; practices that had 20-22 GPs per 100,000 patients, only 70.6 per cent reported a good experience. Having a high number of GP partners in a practice had the highest positive correlation with patient satisfaction. Salaried GPs, GP trainees and nurses had a weak statistical correlation but having more DPC staff was not significant.[23] This further consolidates the importance of the GP led general practice.

Figure 2b: How the investment in general practice has been allocated 2020-21 to 2022-23 - £ billions

	2020/21	2021/22	2022/23
Global sum	£3.854	£4.142	£4.435
Quality and Outcomes Framework	£0.756	£0.818	£0.788
Total enhanced services (ES, LIS, GP extended hours etc)	£1.128	£1.143	£1.096
Premises	£0.940	£0.985	£0.981
IT	£0.558	£0.520	£0.499
Total transformation investment (improving access, workforce etc)	£0.707	£0.795	£0.487
PCN Directly Enabled services (DES)	£0.568	£1.017	£1.673

Source: NHS England Investment in general practice in England, 2018/19 to 2022/23 and General practice funding saw 2.5% drop in real terms after Covid - Pulse Today)

The government's 10-Year Health Plan for England: a new era for general practice

The government's July 2025, Fit for the future: 10 Year Health Plan for England (the Plan) is intended to provide a blueprint for recovery, reform and long-term sustainability. It is wide ranging and ambitious and presents a stark choice: that the NHS needs to "reform or die" and that "continuing to tweak an increasingly unsustainable model is unsustainable and requires a new approach, reimagining the NHS through transformational change".[24]

The Plan confirmed that the NHS's founding principles of universal care, based on need and funded through general taxation, remains; but how care is delivered needs to change by giving patients more choice and control over their health and care. It proposes three interdependent shifts from hospital to community, analogue to digital and treatment to prevention. The analogue to digital shift is fundamental to the whole Plan with technology expected to: change the way people access and interact with services; take over many administrative tasks to release staff time; and prevent ill health by providing people with better information, support and predictive, personalised care based on genetic sequencing.[25]

What does the Plan mean for general practice?

The Plan acknowledges that general practices provide the largest number of patient contacts at a neighbourhood level and are "the public's most valued way of contacting the NHS and provide cost-effective models of joined-up care for complex patients and reduce overall levels of admissions to emergency care." It therefore aims to revitalise general practice, increase GP numbers, reduce administrative burdens and implement new care models. Two new provider contracts are planned: Single Neighbourhood Providers (around 50,000 people) and Multi-Neighbourhood Providers (250,000+ people). The Plan acknowledges the value of the traditional GP partnership model but offers alternatives. Its goal is a Neighbourhood Health Service, incorporating genomic data and digital tools by 2035, enabling personalised predictive care and a shift towards prevention. This requires increased spending on prevention and addressing social determinants of health. Transforming general practice is crucial to realising the Plan's vision.[26]

The Plan proposes a more simplified approach to collaboration and integration to overcome the traditional silos that have beset the NHS with the "modern general practice" having a central role to play. The focus will be on convening a diverse mix of professionals into new neighbourhood teams that will optimise the full range of talents across primary, community and acute settings – but with the flexibility to include staff from other sectors where they are involved in a patient's care. This approach will also include scaling new roles such as advanced nurse practitioners, community health workers and peer support workers, and ensuring 95 per cent of people with complex needs have a co-created, high quality care plan by 2027 and a million people offered a personal health budget by 2030.[27]

It expects general practices to move from being small, independent practices reacting to illness, towards a new model of large-scale, digitally integrated practices focused on proactive population health. It acknowledges that where the traditional GP partnership model is working well it should continue, but alternatives will be created "giving practices an option to lead, join or compete" with these new entities. It envisages these larger practices being enabled by modern AI-enabled digital back-office systems from rota management to finance and HR. This redesign will be underpinned by concrete changes in funding, with an extra £889 million additional budget, including £102 million for upgrades to 1,000 GP surgeries.[27]

> "The NHS needs to "reform or die" and that "continuing to tweak an increasingly unsustainable model is unsustainable and requires a new approach."
>
> **Fit for the future: 10 Year Health Plan for England**

The Plan sees revitalised general practice models as central to the establishment of Integrated Neighbourhood teams (INTs) combining the best of autonomous local primary care teams with the benefits of larger scale working (see Figure 3, next page). Integrated Care Boards (ICBs) have been asked to continue to support general practices with the delivery of the modern general practice to improve access, continuity and overall experience for people and carers. The Plan also gives ICBs the freedom to contract with other providers for neighbourhood health services, including NHS trusts.[28]

Today, the definition of neighbourhood health is still evolving with different interpretations in many geographies and a lack of consistency in implementation and limited evaluations. More importantly, the core functions and enabling behaviours that underpin successful neighbourhood working including governance and accountability are often missing, something that will need to be addressed in the implementation phase of the NHS Plan.

Figure 3: Revitalised general practice models are central to the establishment of integrated neighbourhood teams

Multi neighbourhood providers

Shared electronic patient record and single point of access, with digital command centres signposting citizens, Place based services at sufficient scale operating between acute, community, mental health and primary care providing at/ near home care, supported by virtual care technology.

Scaled interoperable care which is coordinated, planned, responsive and supported by digital technologies and data.

Patients and communities

Individuals are empowered by technology and personalised care plans, benefiting from efficient access to general practice services, including preventative services, supported by easy access to the NHS App and Single Patient Record and digital tools for communication, engagement, and treatment. Patients expect seamless transitions between different levels of care.

Individuals are registered with a local general practice of their choosing which helps keep continuity of care paramount

Specialist, acute, mental health and community hospital services

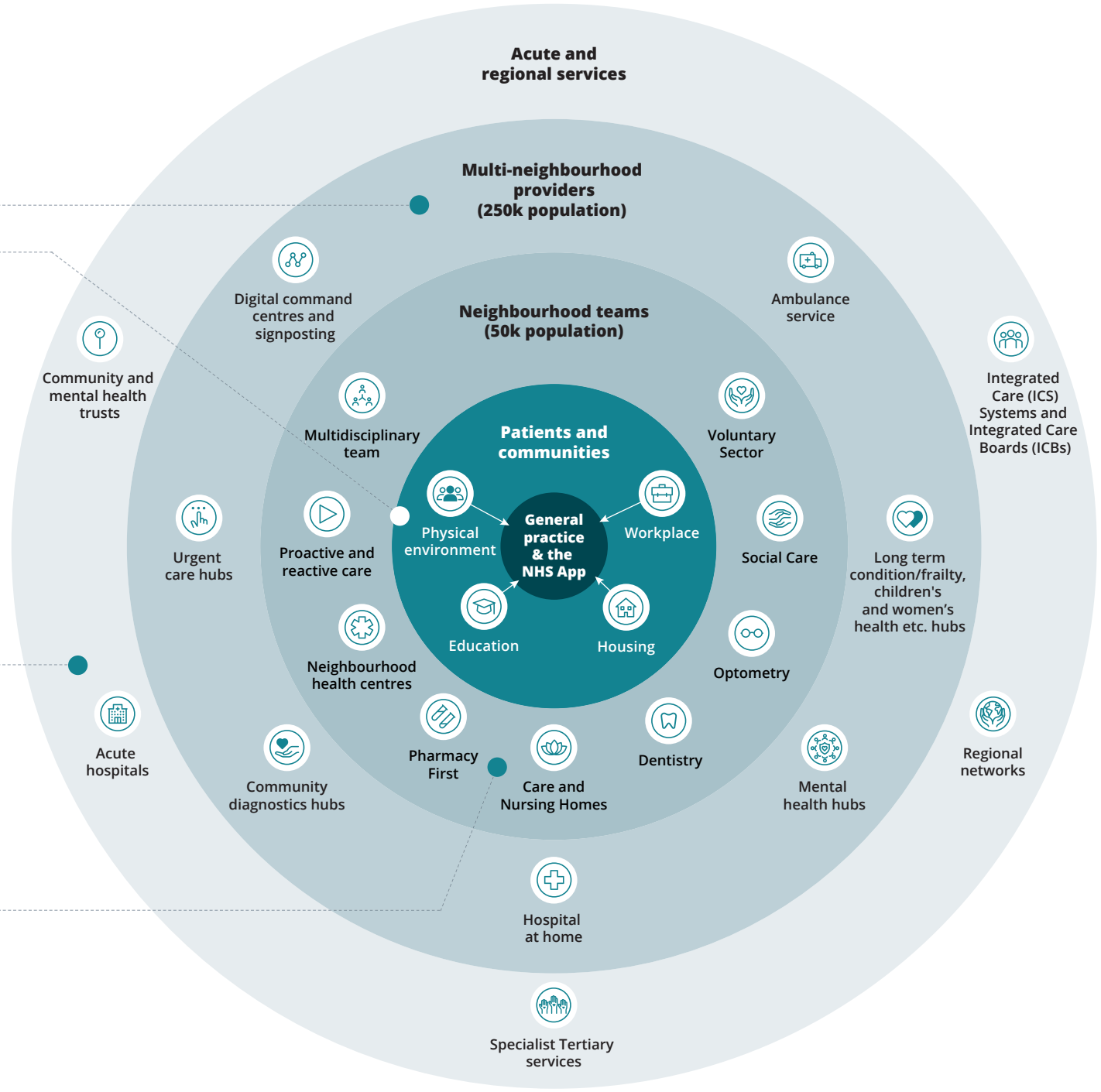
General practice working closely with acute and other community–based and neighbourhood services, proactively collaborating to provide the right care in the right place at the right time, with clear clinical pathways and investment to safely support the increased capacity needed.

Strategic commissioning by ICBs to support community-based neighbourhood schemes.

At scale general practices are central to the development of neighbourhood health teams

In which at-scale general practice is responsible for the health of a registered list of patients, providing continuity of care close to people's homes and acting as the gatekeeper to and navigator of other health and care services.

Networked teams working between individual practices providing local care.



Key Enabling Functions

- Digital integration
- Estates
- Funding and finance
- Leadership development
- Workforce coordination

Public health and secondary prevention are a critical focus for primary care

The government's long-term health mission is not only to build an NHS fit for the future, but also to build a fairer country, one where fewer deaths are lost to the biggest killers, and everyone lives well for longer. Its aim is to drive work across government and beyond to improve life expectancy for all and halve the gap in healthy life expectancy between different regions of England.[29]

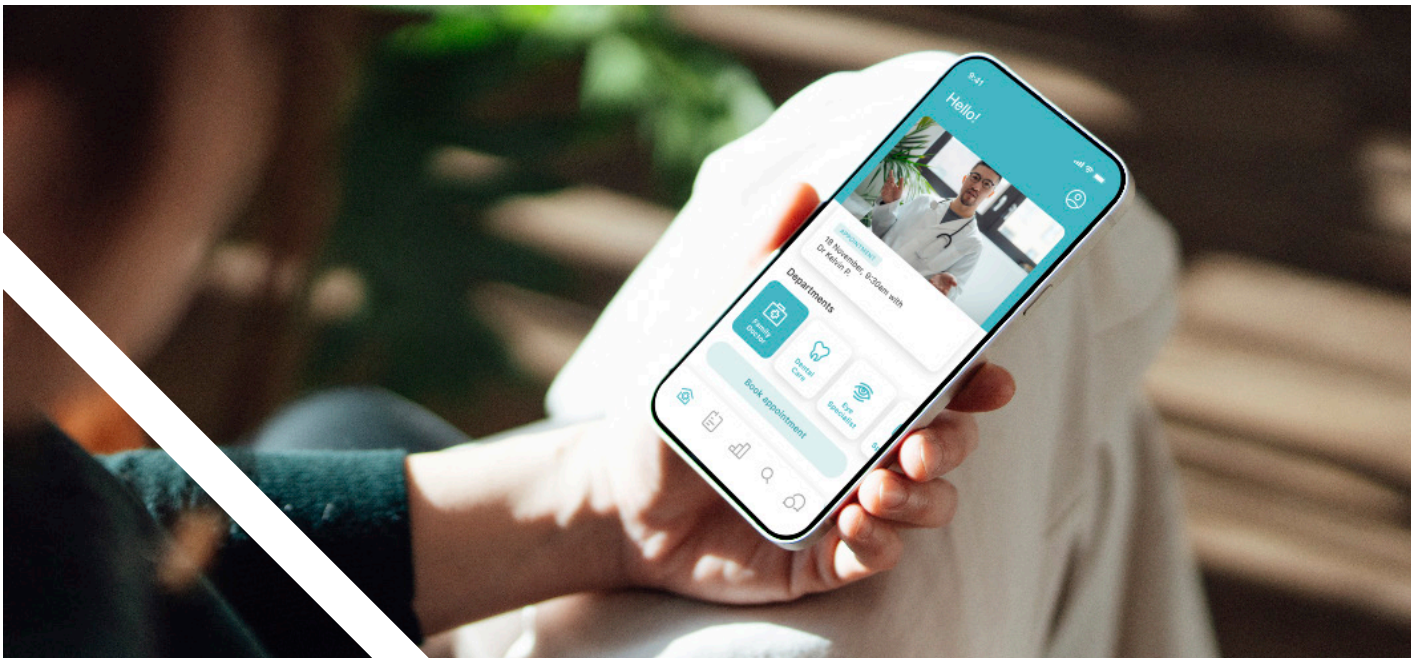
Achieving these ambitions is dependent on achieving the three fundamental shifts in the Plan including harnessing cross-societal energy on prevention and working with businesses, employers, investors, local authorities and mayors to create a healthier country together. The mission recognises that certain public health services delivered by general practices and community care services, are critical to the endeavour including health checks, childhood and adult immunisation programmes, and screening programmes across the life course. These services are vital to protecting and improving population health, working alongside NHS services to prevent avoidable ill health, achieve earlier diagnosis with positive health outcomes, boost the labour market, narrow inequality and reduce NHS costs.

However, the Plan acknowledges that the 28 per cent decline in preventative spending over the last decade, coupled with rising out-of-pocket spend on prevention (2.7 times more in 10 years), is exacerbating health inequalities. It emphasises the importance of the social determinants of health (food, exercise, housing and employment) and sets ambitious goals for preventative services in the NHS predicated on the need for increased spending on health promotion, prevention and protection.[30]

About this report

If the vision in the Plan is to be realised, transforming general practice is a particularly urgent priority and will require commitment and leadership from GPs, the wider general practice workforce and the new neighbourhood health service. It will also need a clear strategy and funding alongside data driven planning and measurement of outcomes. Addressing current concerns will be crucial.

In support of implementation and delivery of the Plan, the next section of this report examines the current views and experiences of the GP workforce, from newly qualified GPs to the lead partners of practices of varying sizes and how the Plan proposes to address the problems identified. The final section discusses solutions for bridging the gap between the expectations in the Plan and the challenges today with actionable insights and ideas based on research evidence, national and international examples of good practice, together with an understanding of how to deliver the transformation that is needed. Case studies on evidence-based examples of good practice are published in a separate compendium.



General practice today and tomorrow

The government's 10-Year Health Plan acknowledges that the current model of general practice is unsustainable but recognises that their role and responsibilities in providing continuity, access and preventative health services to a registered list of patients remains essential. Indeed, the need for a resilient and sustainable model of general practice is undisputed. In addition to detailed secondary research, we conducted two surveys and interviews of a cross-section of GPs and other general practice leaders to better identify the challenges and obtain insights on what can be done in practical terms to ensure general practice is fit for the future.

Deloitte interviews and surveys with GPs

We interviewed over 30 general practice leaders and practicing GPs who between them had a wide range of experience across different models of general practice. We also conducted two surveys of a cross-section of GPs from next generation leaders to partners and salaried GPs working in everything from small to hyper scale practices and practices serving a mix of urban, rural, coastal, deprived and affluent populations. Many of the respondents had additional primary care and system leadership roles and a few interviewees had moved into general practice from other industries. Our research was conducted between March and June 2025 (before the publication of the Plan).

We asked interviewees and survey respondents what three words they would use to describe the state of general practice today and how they hoped to describe it in five years' time. We combined their responses into word clouds (see Figure 4). These reveal that the sentiments expressed about today are predominantly negative with "Confused, Challenged, Broken", the most frequently mentioned, along with some cautious optimism and a belief that general practice could be revived. When asked about the state of general practice in five years' time, positive comments dominated along with hope that general practice will have survived and thrived.

To identify the specific challenges that general practices were experiencing we asked interviewees and survey respondents to identify the top three challenges undermining their practices' ability to meet patient needs and expectations. Consistently, across all three groups, the top three challenges were: over-worked and stressed practice staff, workforce shortages and the ability to deal with increasingly complex cases (see Figure 5). Interviewees attributed these challenges to a decade of underfunding, recruitment and estates challenges, increasing patient complexity and rising bureaucracy. The policy drive to move more care into the community without increased funding was cited as a significant contributor to workforce stress and concerns about psychological safety.

Our interviewees also expressed feeling undervalued, both in terms of funding and societal recognition. The overarching view was of significant pressure and frustration stemming from a combination of unrelenting demand pressures, under-resourcing, outdated systems and systemic challenges. Despite these pressures, a strong commitment to patient care and a desire for a more sustainable model of general practice was evident. Many interviewees highlighted the importance of continuity of care and need for diverse care models to reflect varying geographical and demographic needs.

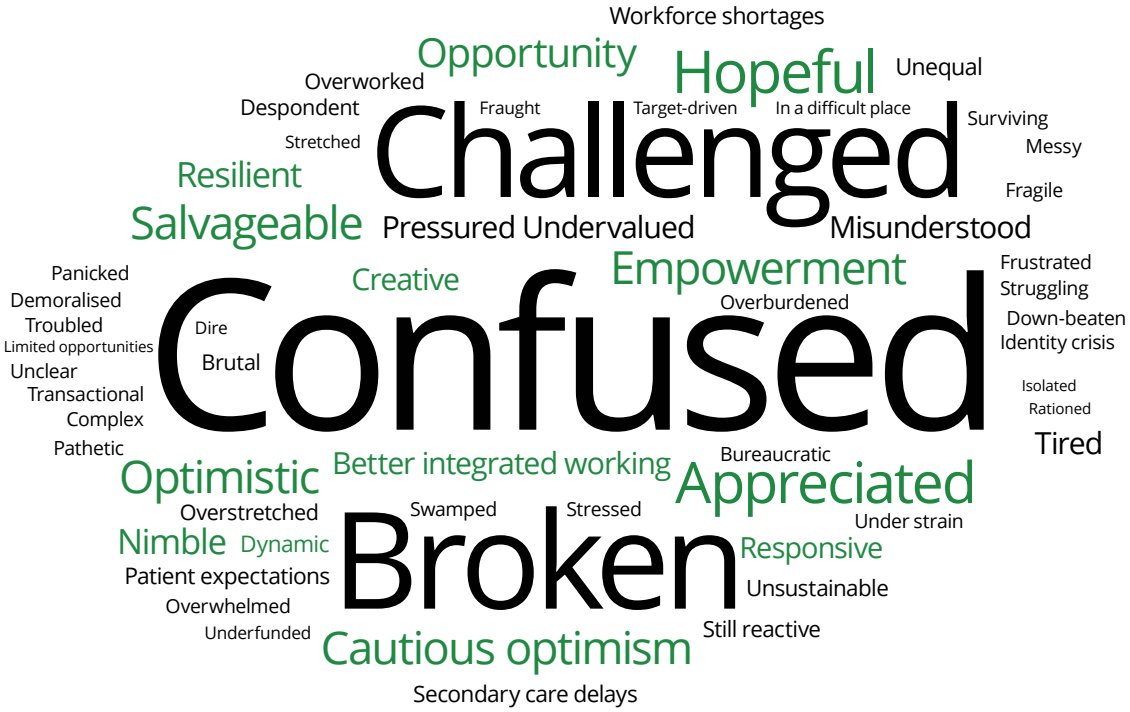
Difficulties attracting and retaining GPs were identified as a major challenge, exacerbated by the demanding nature of the work, negative press and inadequate compensation. The increasing involvement of other DPC roles, while helpful had also increased the complexity of cases managed by GPs, with DPC staff adding to the pressures by regularly seeking GP support before deciding on a course of action and patients often requesting the GP's input or making a follow-up GP appointment. This raises questions over roles, responsibilities and accountabilities, while creating role ambiguity and concerns over indemnity for clinical risks which ultimately rests with the GPs.

The current GP contracts and QOF funding approach were increasingly seen as too bureaucratic with a high administrative burden, Interviewees suggested that while capitation was cost-effective in principle, the Carr-Hill formula was insufficient in supporting the rising number of elderly comorbid patients. ICBs also varied in the funding provided for enhanced services. Likewise, the lack of longer-term funding settlements and the short-term nature of contracts hindered effective workforce planning and service delivery. Furthermore, although there was support for the impact that targets (like QOF) had achieved there were also concerns that it detracted from providing more holistic and preventative care.

Source: Deloitte interviews and surveys of GPs

Figure 4: GPs' views on the state of general practice today and tomorrow

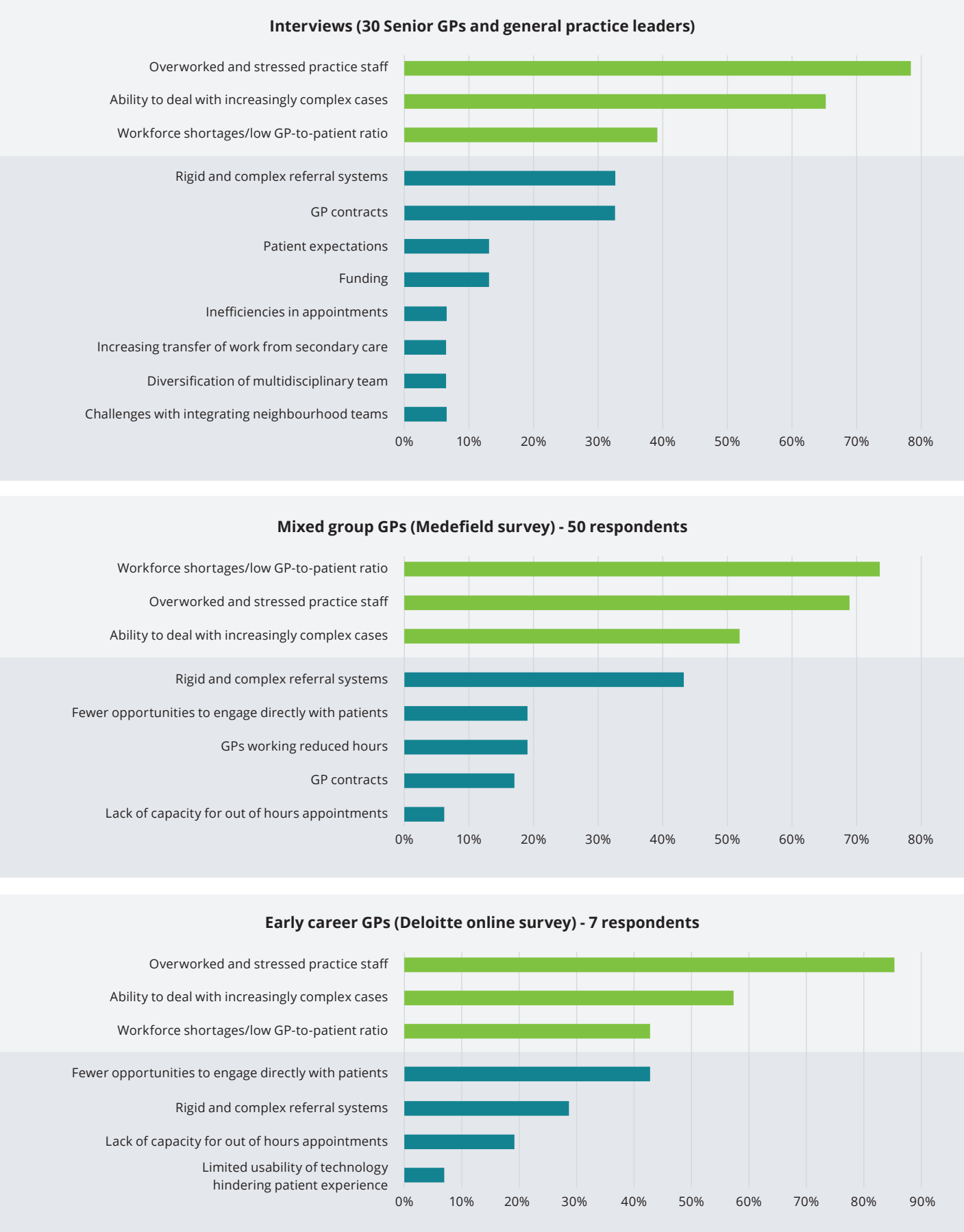
State of general practice today



State of general practice in 5 years' time

Source: Deloitte interviews and surveys of GPs

Figure 5: What are the top challenges that undermine the practice's ability to meet patient needs and expectations?



Source: Deloitte research conducted between March and May 2025

Drivers of job satisfaction and dissatisfaction

We asked our interviewees and survey respondents what top three factors contributed most to their job satisfaction. The responses showed that understanding staff motivation at different stages in their careers is important (see Figure 6). For example, the GP leaders who we interviewed identified a sense of fulfilment, making a difference and working within a team or community as the top two factors whereas early career GPs identified work-life balance and flexibility of working patterns as their top two and the online survey of a cross-section of GPs identified recognition and appreciation, and wider opportunities as their top two. Unsurprisingly, pay was a higher driver of job satisfaction for early career GPs but less so for the online respondents and not an issue for leaders. The importance of support from immediate team members and chance to progress were also important for the latter two groups. Understanding and addressing these different needs and expectations are crucial for building resilience.

Figure 6: What are the top three factors that contribute most to your job satisfaction?

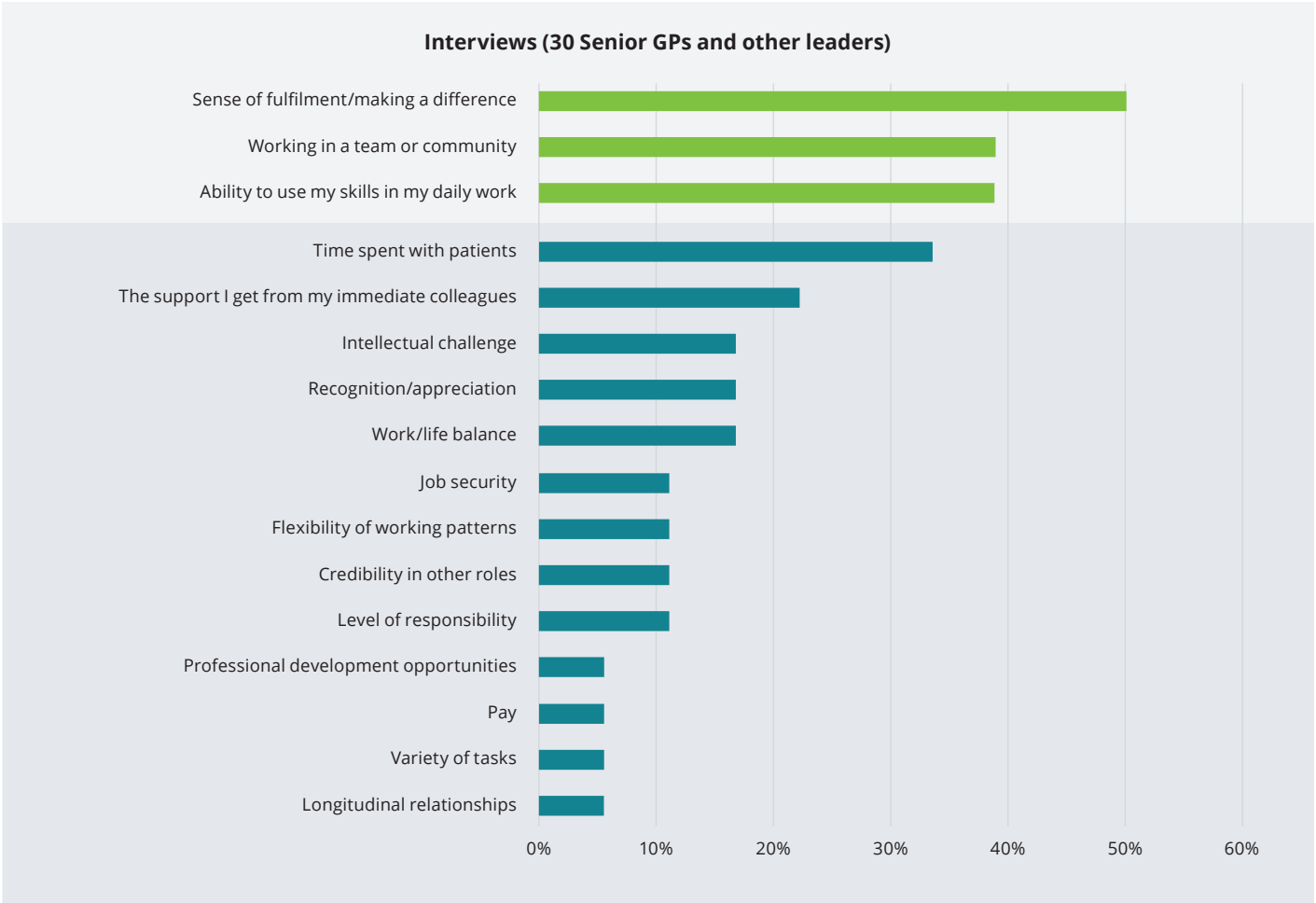
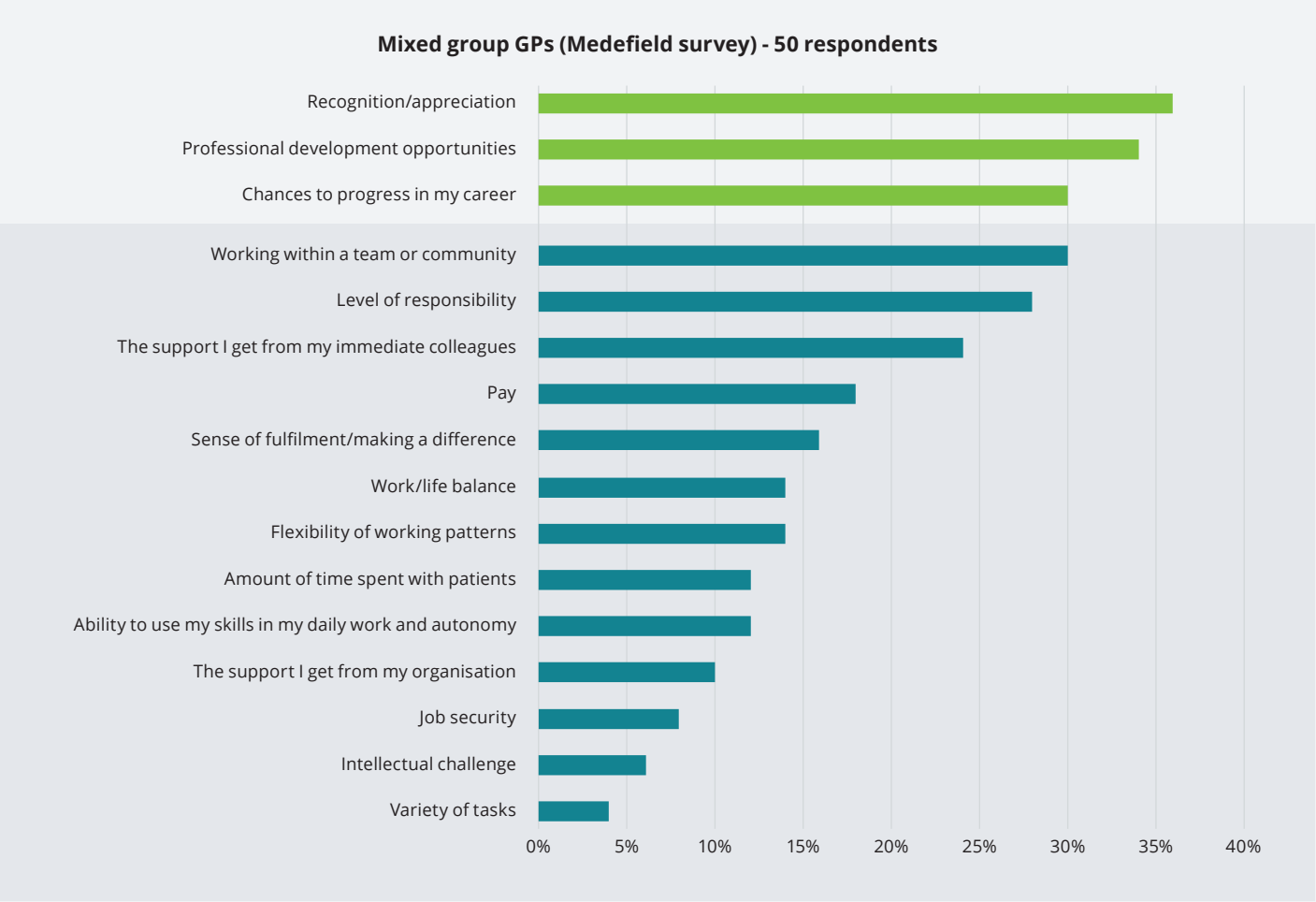
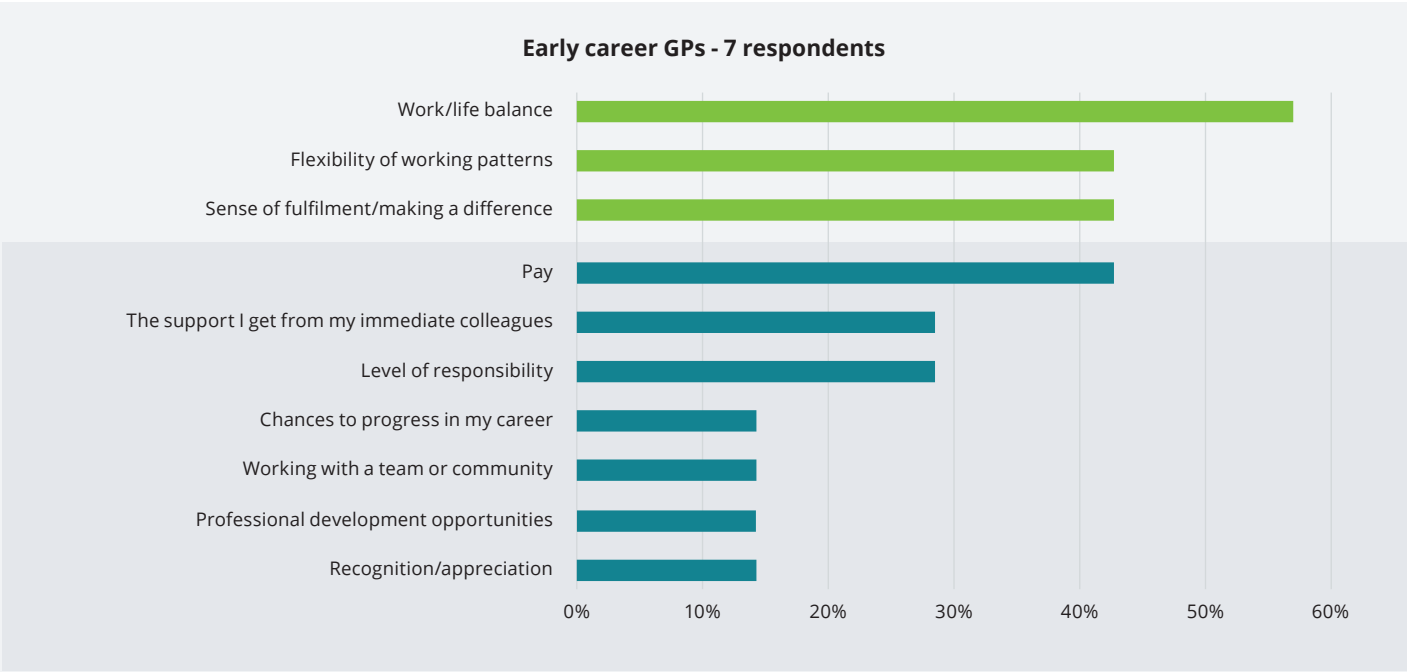


Figure 6 (cont.): What are the top three factors that contribute most to your job satisfaction?





Source: Deloitte research conducted between March and May 2025

Likewise, understanding the drivers of job dissatisfaction is equally important. Interviewees and both groups of survey respondents identified the unrelenting increase in demand as the greatest factor contributing to their lack of job satisfaction. While, interviewees identified patients increasing expectations and insufficient recognition/appreciation in their top three concerns; the on-line survey respondents and early career GPs included pay in their top three drivers (see Figure 7). Other notable differences include early career GPs' concerns over job insecurity and lack of chances to progress their careers and on-line survey respondents' concerns over work-life balance and lack of support from their organisation.

Apart from pay, the other drivers of job satisfaction and dissatisfaction are issues that primary care leaders address.

Figure 7: What are the top three factors that contribute most to your lack of job satisfaction?

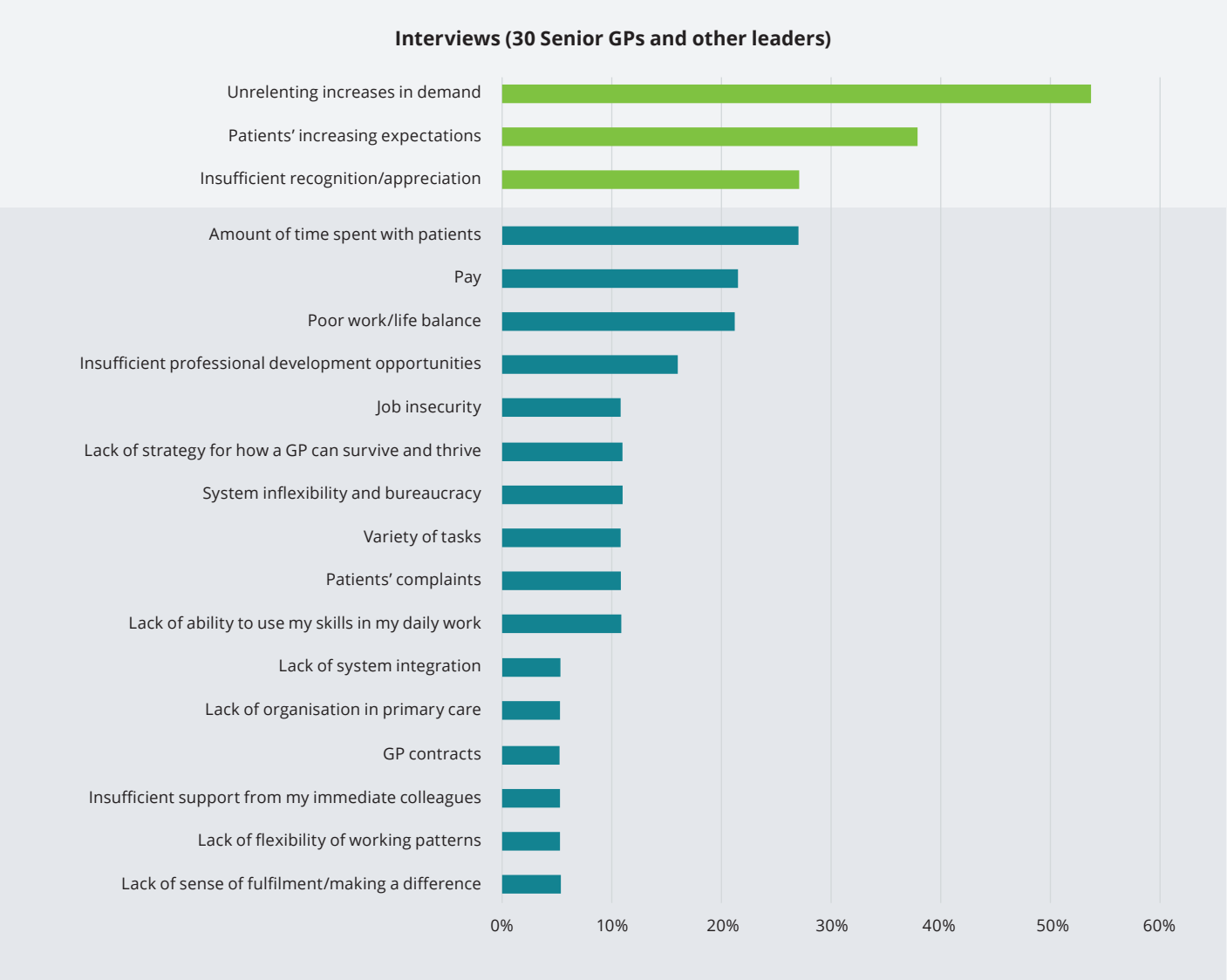
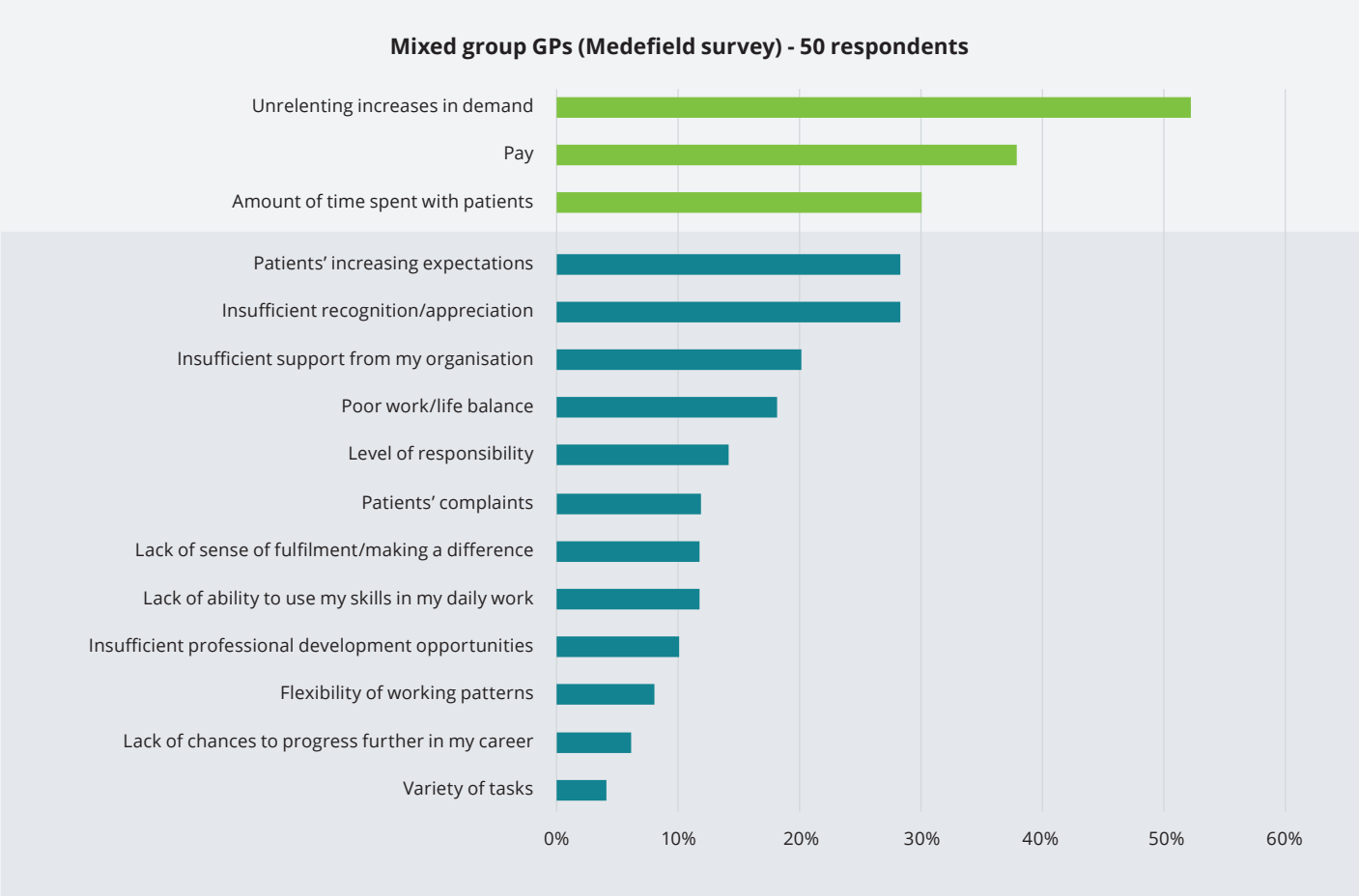
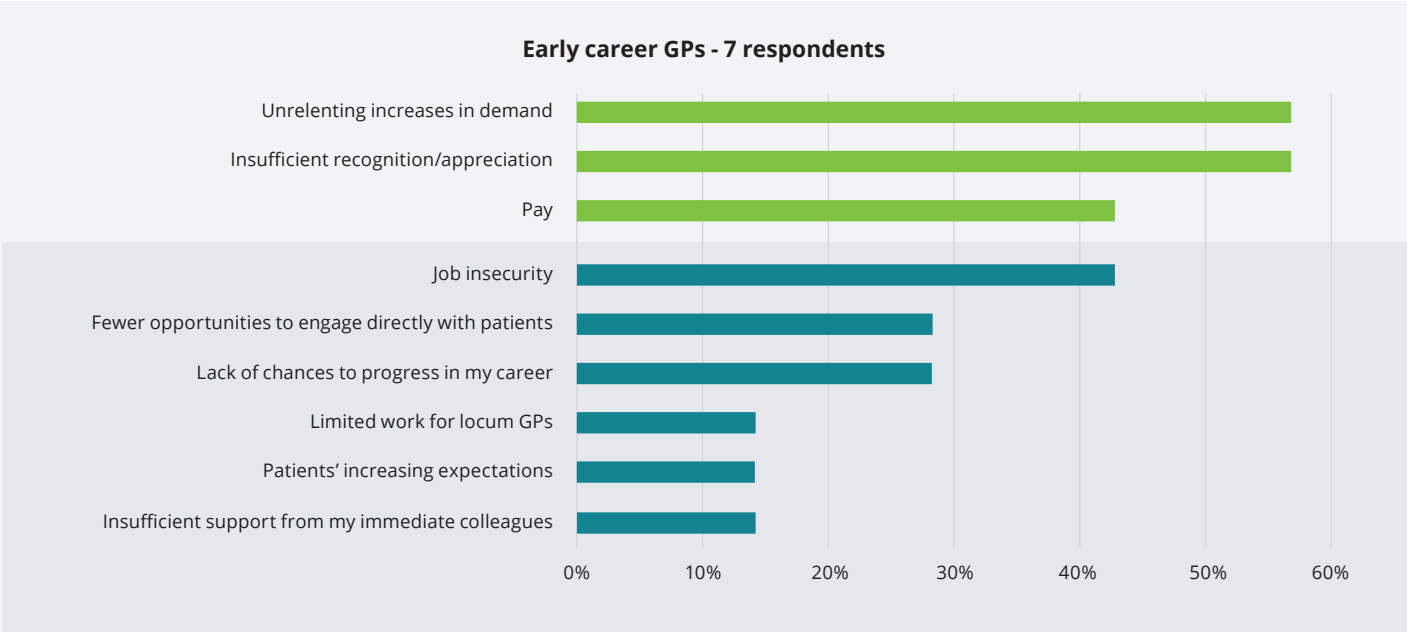


Figure 7 (cont.): What are the top three factors that contribute most to your lack of job satisfaction?





Source: Deloitte research conducted in the UK between March and May 2025 comprising interviews with senior GPs, and survey of GPs with a range of experiences.

Figure 8: Health trends and the key constraints that need to be addressed to enable a sustainable and resilient future for general practice

Critical trends impacting healthcare today*

Move to a place based preventative approach: focusing on how organisations can work differently together to provide services more effectively to those who need them – shifting the mindset from organisational boundaries to those defined by the people and places served and shifting from a treatment service to a proactive preventative service.

Human centric: the opportunity to transform service delivery across health and social care should put patients at the heart of new service design, to deliver more cost-effective services and better outcomes that will help to challenge organisations to move from maintaining the status quo.

Move to digital: expectation that more services will be delivered through technology where appropriate. This will drive efficiency, promote patients taking greater control of their wellbeing and reduce the demand on general practoces and the wider primary care system.

Improve productivity: changing demographics, higher levels of complexity in health and wellbeing and greater patient expectations are driving up demand. System capacity is constrained with human resources and, funding finite. There is a need to identify ways to improve productivity or change service and delivery models to close the capacity and productivity gap.

Health equity: recognising that certain groups experience health disadvantage and the existence of a postcode lottery, which requires the neighbourhood health system to proactively address the need for improvements to the social determinants of health and to design appropriate services for all groups in the community.

Key constraints that need to be addressed to enable a resilient future for general practice

Workforce

Constraint: escalating staffing issues compounded by increasing demand from patients with more complex requirements and increasing expectations

Enabler: a dynamic and flexible workforce model that addresses the drivers of job satisfaction, improves staff wellbeing, productivity and effectiveness. Dynamic, fluid and data-driven workforce planning, profiting from a wider MDT, aligned governance and shared decision-making.

Funding and financials

Constraint: outdated funding models and difficulties quantifying the true cost/ benefits of providing a cost-effective, proactive preventative general practice model

Enabler: new transparent funding models that increase budget for primary healthcare and provide general practice with a budget that enable them to reduce health inequalities, tackle prevention and improve outcomes for patients with complex conditions.

Digital and data

Constraint: siloed technologies that are often underutilised and which are designed more for administration than focused on clinicians' needs, and which fails to enable data-driven decision-making

Enabler: AI-enabled technologies that optimises the use of data and seamlessly connects services and includes clinician and patient technologies that integrates into the clinical workflows while empowering patients to self-care.

Estates

Constraint: much of the primary care estate is not fit for purpose with costly buildings, constrained capacity and outdated equipment.

Enabler: the patient becomes the centre of care, not the buildings housing general practice and other elements of primary care enabling organisations to pull together/ share resources as part of integrated neighbourhood teams, utilising a flexible workspace and advanced technology to help deliver care in the right place at the right time.

Note: These trends unsurprisingly resonate with the issues identified in the 10-Year Health Plan. **Source:** Deloitte insights

Health trends and key constraints that need to be addressed

Our wider research and insights, informed by our interviews and surveys, have identified five core trends that are changing the health landscape of general practice today, and four key constraints that need to be addressed so that they become enablers for a resilient and sustainable general practice system (see Figure 8). We explore each of these constraints in turn, which, if addressed successfully, would become enablers of resilient, rejuvenated, general practice.

1. Workforce

A critical workforce shortage has plagued general practice for over a decade, particularly shortages of GPs, nurses and pharmacists. The findings of a comprehensive white paper on the General practice workforce, by Cogora, mirror the views of our GP interviewees. Specifically that there has been a reduction in partner GPs and an increase in less experienced GPs, with rising numbers of GPs, particularly newly qualified GPs, unemployed due to lack of funding and space in premises to house them. Other findings included a steady increase in the number of patients per full time equivalent (FTE) GPs, and that despite an increase in the number of general practice appointments per patient per year, a growing number of patients struggle to get an appointment especially with their preferred GP. Practice nurses and pharmacists feel they are taking on higher levels of responsibility as practices struggle to recruit nurses and pharmacists. Moreover the PCN managed Additional Roles Reimbursement Scheme (ARRS) that provides direct care staff (DCS) to practices has made DCS a far cheaper option. However, DCS do not carry the same level of clinical responsibility and legal liability. The white paper concludes that there is still a long way to go before the general practice workforce is fit for purpose.[31]

Moreover, a RCGP survey of more than 2,000 GPs in September 2024 found that some 40 per cent expected to leave general practice with the next five years with the highest rate of GPs considering leaving in the East of England and the Southeast (47 per cent), and the lowest in the Northwest (36 per cent). More than half of GP respondents (51 per cent) said that finding the job too stressful was a key reason for considering leaving, 38 per cent were retiring and 13 per cent planned to leave the UK. Seventy-one per cent of GPs believed that their practices could alleviate pressure from hospitals if they had more staff and resourcing.[32]

Several of our interviewees also worked as locum GPs, as this gave them more control over their workload, career flexibility and work/life balance. However, they reported rising income insecurity due to difficulties in getting shifts and, if they did, they usually had to reduce their hourly rates and travel much farther incurring higher travel costs. Estimates by the National Association of Sessional GPs suggest that some 21,000 GPs were doing some form of locum work in 2024 (5,000 more than five years ago). However, over the past year there have been an increase in reports of locums feeling marginalised and demoralised by NHS decision-making, including the ARRS scheme, which has excluded locum GPs and often left practices without the funding necessary to continue employing them.[33]

The government has acknowledged these issues and extended PCNs' ability to appoint nurses and newly qualified GPs to their practices, with NHS England paying the salaries.[34] In addition, the Plan acknowledged that more capacity is needed with a proposal to train thousands more staff over the course of the Plan. It also aims to free up GP capacity by tackling the burden of bureaucracy which "steals joy from work and time from patient care" by cutting down central targets and delivering the recommendations of the 'Red Tape Challenge' – aimed at identifying and cutting needless bureaucracy.[35]

"A critical workforce shortage has plagued general practice for over a decade, particularly regarding GPs, nurses and pharmacists."

Deloitte interviews

The Plan also proposes to roll out technology to cut unnecessary administrative and clerical work. Ambient voice technology ('AI scribes'), digital triage and the Single Patient Record are targeted at ending the need for clinical note taking, letter drafting and manual data entry. Estimates suggest that saving 90 seconds on each appointment would generate over 2,000 FTE worth of GP capacity a year, and ambient voice technology could free up 1-2 minutes per GP appointment and enable more appointments, at more convenient times, with better continuity of care for those with complex needs. In parallel, the Plan proposes building AI-powered online advice into the NHS App and embedding digital telephony to ensure all phones are answered quickly.[36]

The government has announced its intention to publish a new 10 Year Workforce Plan that will reflect the changes expected from digitalisation and answers the questions: "what workforce do we need, what should they do, where should they be deployed and what skills should they have?". It anticipates needing a very different and smaller workforce than projected in the NHS Long Term Workforce Plan in 2023, with staff being better treated, more motivated, better trained and having greater scope for career development.[37]

2. Funding and financing general practice

General practice is mostly compensated using a blend of capitation, fee-for-service, and pay-for-performance. This capitation funding model has been relatively unchanged since 2004, as it has traditionally been seen as the best way of addressing the fact that GPs undertake a complex mix of tasks, are responsible for longitudinal care and delivering therapeutic interventions that can be difficult to measure and monetise. In 2023-24, the share of total NHS spend planned for primary care was 8.4 per cent. This is the lowest share since figures began (in 2015-16), with growth in primary care spend falling below inflation, and represents a fall from the high point of 9.2 per cent in 2019/20. The 2024–25 GP contract, imposed in March 2024, contained a 1.9 per cent baseline uplift, which was again below inflation. Over the past decade, however, activity growth has outstripped funding growth, meaning most general practices are doing more for less.[38]

While recent funding increases are welcome, concerns remain about the long-term sustainability of the model. The 2025-26 contract, agreed in February 2025, represented a 7.2 per cent cash growth on the contract funding element (estimated 4.8 per cent real growth on 2024-25 contract costs).[39] While the contract terms were accepted by GP leaders, concerns remain about the long-term sustainability of the model.

Although ICBs can commission some additional services from general practices our interviewees told us that these discretionary contracts had resulted in variations in services available and a post-code lottery.[40] An investigation by the British Medical Association published in September 2024 found that four-fifths of ICBs had frozen or reduced discretionary budgets for enhanced services.[41] Our interviewees told us that since then many of these additional payments had been withdrawn to help ICBs meet their 50 per cent funding cuts.

In finalising the 2025-26 contract, the government announced increased funding to general practice of £889 million a year across core practice contracts and the Network Contract Directed Enhanced Service, taking the combined total estimated contract value from £12.287 billion in 2024-25 to £13.176 billion in 2025-26. Changes include increasing the global sum per weighted patient from £112.50 per patient in 2024 to £121.90 and the fee for routine childhood vaccinations by £2 to £12.06 with locum reimbursement payments increased in 2025-26 by between 15.9 per cent and 17.1 per cent. Other funding increases include continuing the funding for the cohort of ARRS GPs recruited during 2024-25 into 2025-26, and funding for GPs employed under the scheme to be increased by £9,305 to £82,418. Practice nurses who have not held a post within the PCN, or its member practices, within the last 12 months will also be included to the ARRS scheme.[42]

Moreover, several QOF indicators were retired.[43] Our interviewees had mixed views about the QOF (see Figure 10). The government also proposed to review how health need is reflected in nationally determined contracts, such as the Carr-Hill formula.[44] While acknowledging its flaws, many nevertheless saw its merits, particularly in combination with capitation and Enhanced Services. However, they acknowledge the need for significant reforms with a key area for improvement being to update the contract to reflect the current demands on general practice, including specifying minimum appointment numbers and addressing the financial vulnerabilities of GP partners.

It is too soon to evaluate the impact of the funding increases. While welcoming the increases our interviewees felt they would deliver only marginal improvements due to the historic underfunding, workforce challenges and lack of physical space in many practices. Consequently, their concerns remain noting that funding constraints, outdated contracting models and cumbersome procurement practices were also impeding the development of new models of proactive and preventative care. Our literature review highlighted wide variability in the income of GP partners, with a notable minority of GP partners among the NHS's highest earners, but some partnerships no longer financially viable leading GPs to hand back their contracts.[45] Indeed around a fifth of GP surgeries have closed since 2015 (overall number of surgeries declined from 7,623 in September 2015 to 6,227 in December 2024 (almost 1,400 or a fifth fewer surgeries).[44]

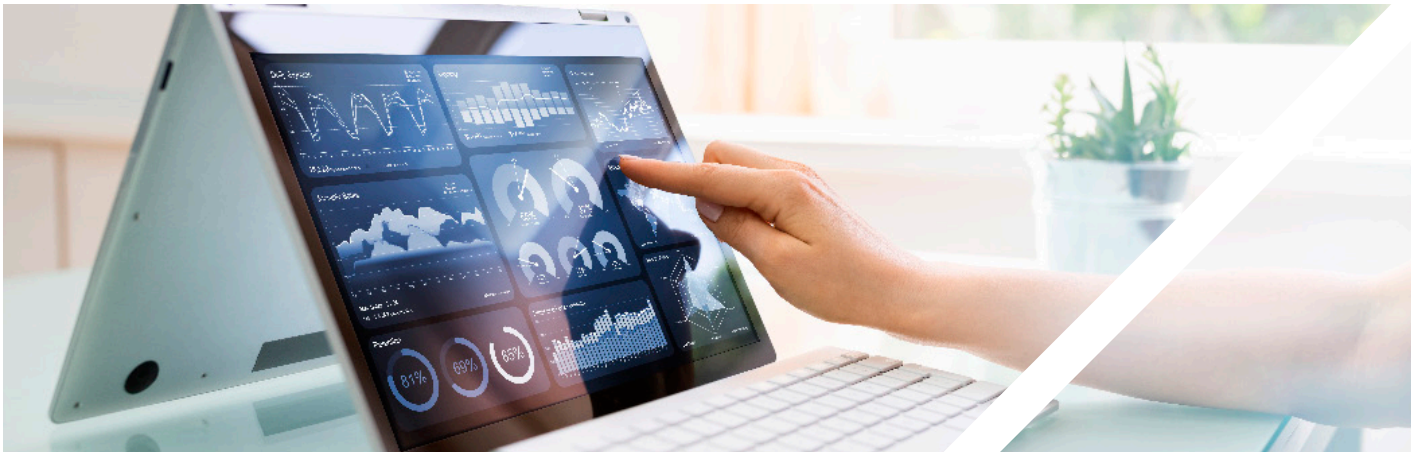


Figure 9: GPs have mixed views on the Quality and Outcomes Framework (QOF)

Source: Deloitte analysis of GP interviews

3. Digital and data

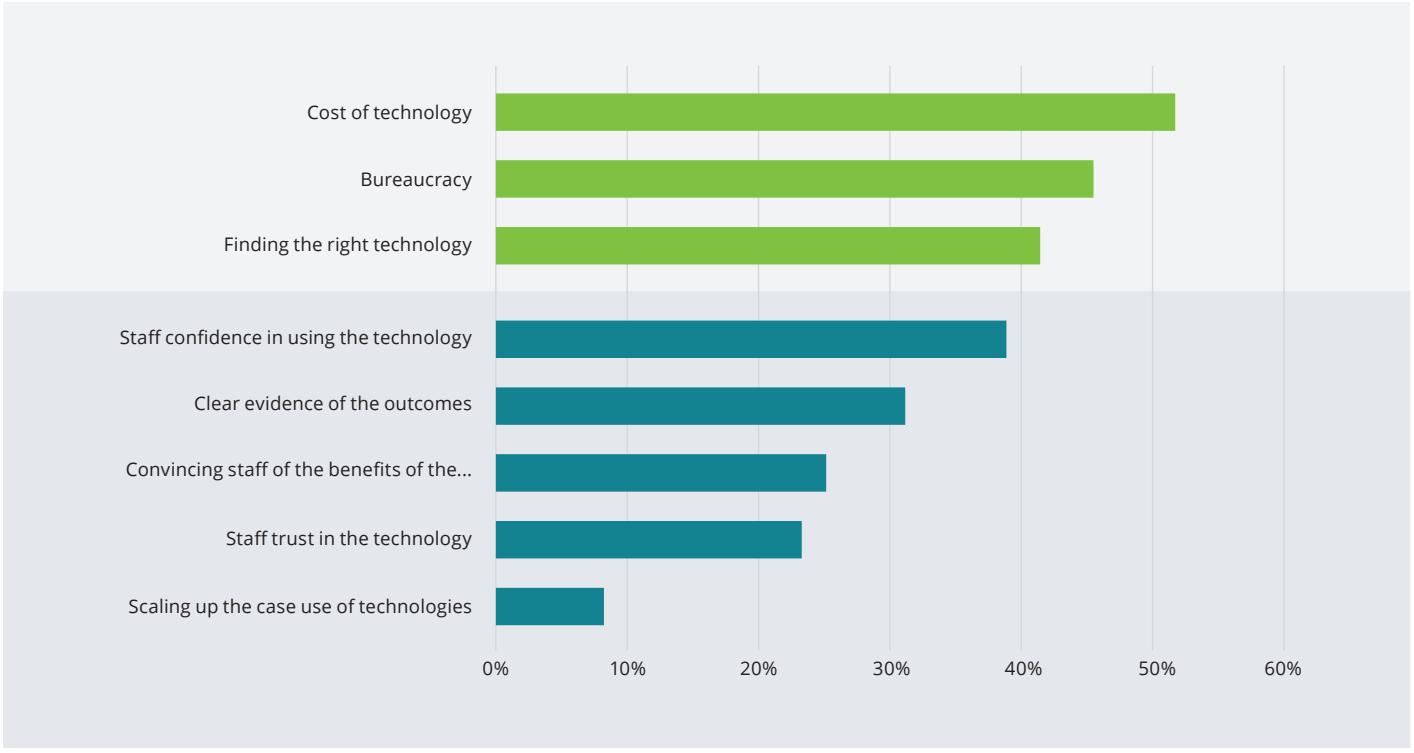
Over the past decade, the rising demand combined with capacity problems have led to a consensus that data and digital technologies are critical requirements to help bridge the gap between demand and supply of general practice services. Digital-first primary care has been shown to improve access. It also has the potential using technologies like the enhanced NHS App, ambient AI and digital technologies that monitor vital signs remotely to support the transition to preventative and personalised health and care and to provide innovative ways of managing the growing demand from an ageing population and increased prevalence of chronic diseases.

Our 2019 report, *Closing the digital gap*, acknowledged that almost all general practices had benefited from having an electronic patient record (EPR) since the early 2000s, but that 80 per cent of these systems would soon be outdated and unsuitable for the future models of care delivery. We also found that primary care funding models meant that GPs lacked the financial incentives to invest in digital technologies that could accelerate the digital transformation of their services. Key barriers were the lack of interoperability including difficulties integrating data from digital technologies into the workflow and patient record, and the resistance of GPs to sharing data.[48]

In our 2025 survey for this report, we asked respondents to identify what they saw as the top three barriers to wider adoption of digital technology in general practice. Their responses were similar to the findings in our 2019 report. Indeed, the top three challenges identified by the 240 GP respondents in 2019 were: the cost of the technology, finding the right technologies and bureaucracy.[49] In our 2025 survey the top challenges were the same but in a different order: the cost of the technology, bureaucracy and finding the right technologies (see Figure 10). This suggests that ways of addressing these challenges have eluded policy makers, those responsible for implementation, despite numerous funding initiatives to improve digitalisation.

We explored the reasons behind these challenges with our interviewees. They told us that while they believed in the transformative power of digitalisation most admitted that they often struggled to get their partners to adopt digital solutions that they knew were working effectively elsewhere. They identified the need to streamline triage, enhance AI integration and train GPs to make optimum use of their EPR functionality. They also acknowledged their fear of automation undermining their roles, the need for robust governance and protecting patient confidentiality. We identified four concerns that needed to be addressed to improve the wider adoption of digital technology and the actions to address them (see Figure 11). Several interviewees mentioned their colleagues' concerns that automation would have a detrimental impact on the psychological safety of practice staff. However, research published in 2020 estimated that while it is possible to automate approximately 44 per cent of administrative tasks in primary care, no single role can be entirely automated.[50] This finding needs to be updated given the fast pace of development in AI-enabled technologies, especially Agentic AI, and the results more clearly communicated.

Figure 10: The top three barriers to the wider adoption of digital technology in general practice



Source: Medefield survey of 50 GPs (May 2025)

Figure 11: The four concerns that need to be addressed to improve the wider adoption of digital technology and the actions needed to address them

Usability and relevance

- **Solutions looking for problems:** technology is often implemented without a clear understanding of the specific challenges faced by GPs, the need for robust governance and adherence to clinical safety standards, leading to tools that are not fit for purpose.
- **Poor usability:** complex and difficult to use interfaces create frustration and resistance among clinicians.
- **Lack of effective training and upskilling:** insufficient investment in training prevents GPs from maximising the potential of new technologies.

Data management and Interoperability

- **Information overload ("data waterboarding"):** existing systems often overwhelm GPs with excessive data, making it difficult to find relevant information efficiently. A single, unified patient record is seen as a potential solution.
- **Limited interoperability:** the current primary care EPR duopoly and development of bespoke local solutions restricts integration and hinders innovation, making it difficult to share information seamlessly between different systems.

Funding and resources

- **Lack of funding for innovation:** securing funding for new digital initiatives is a major obstacle.
- **Bureaucracy:** administrative hurdles and complex approval processes slow down the adoption of new technologies.
- **Digital divide:** unequal access to technology among patients risks creating disparities in care and increasing health inequalities.

Behaviours that need to change

- **Patient resistance:** some patients are hesitant to embrace digital health solutions, either due to lack of digital literacy or concerns about privacy and security.
- **Clinician resistance:** some GPs are resistant to change, due in part to a lack of digital literacy but also preferring GP-led triage and face-to-face consultations alongside other more traditional methods of practice.
- **Managing patient expectations:** The hype around digital health can lead to unrealistic expectations among patients, requiring careful management.

Addressing these concerns requires a multi-faceted approach involving:

- **User-centred design:** Prioritising the needs and preferences of GPs and patients in the development and implementation of digital health solutions.
- **Simplified interfaces and improved usability:** Making technology easier to use and integrate into existing workflows.
- **Investment in training and support:** Providing adequate training and ongoing support to clinicians.
- **Addressing the digital divide:** Ensuring equitable access to technology for all patients.
- **Streamlined funding processes:** Simplifying the process for securing funding for digital health initiatives.
- **Promoting interoperability:** Encouraging greater integration between different systems to enable seamless data sharing.
- **Managing expectations:** Educating patients and clinicians about the realistic benefits and limitations of digital health technologies.

Source: Deloitte analysis

The Plans' proposals on digital transformation have profound implications for primary care

The Plan proposes a major role for digital transformation, including the rollout of AI-powered tools, digital triage and a Single Patient Record (SPR). The NHS App is also earmarked for significant expansion, becoming a comprehensive digital front door to the NHS. However, concerns remain about data quality, standardisation, accessibility and the potential for digital exclusion.

A Single Patient Record (SPR)

The Health Plan envisions the introduction of a SPR that will bring together and give patients control over a single, secure and authoritative account of their medical data via the NHS App, and plan to legislate to give patients access to their SPR by default. This "patient passport" will also provide clinicians across primary and secondary care services a full picture of the patients they treat. The Plan sees this revolution in access to health data as crucial to each of the three fundamental shifts (not only the analogue to digital shift but also hospital to community and sickness to prevention shifts).

The Plan proposes to link clinical trial recruitment to the NHS App and SPR so patients can be proactively notified of clinical trials that might benefit them. As genomics and predictive data analytics advance, these data will also be integrated to help unlock the potential of predictive prevention and precision medicine.[51] The Plan highlights the government's intention to reform the legal framework to allow for anonymised health data to be used to improve the NHS and for research that benefits its patients through the Health Data Research Service.[52] Subject to parliamentary time, the ambition is that from 2028, patients will be able to view all their health data securely on the NHS App.

The introduction of a SPR alongside development of the NHS App will have profound implications for general practices that have largely been the gatekeeper to patients' primary care records. It will enable all clinicians to see every interaction that a patient has had with the NHS and will likely obviate the need for expensive fragmented investment to reform out-of-date electronic patient record systems. However, past experience demonstrates that there is usually a gap between ambition and implementation. And that the time and resources required to change practices and establish clear governance and accountability arrangements can be problematical and require compromise.

The NHS App

The NHS App, launched in January 2019, has provided a secure way to access various NHS services in England for users aged 13 and above who are registered with a GP. Initially, it offered users functions such as booking appointments, ordering repeat prescriptions, accessing GP records, using NHS 111 and setting data sharing preferences.[53] Today, millions use the NHS App monthly for services like prescription ordering and symptom checking, but far fewer can use it to book appointments. Indeed, downloads and registrations, as well as usage varies across sociodemographic groups. Key challenges include inconsistent access to test results and personal health records across GP practices, and difficulties with App registration and login. The NHS App's future success hinges on addressing equitable access and broader adoption aimed at improving patient activation.[54]

The 10 Year Health Plan is predicated on a significant increase in the functionality, usability and interoperability of the NHS App. The Plan envisions the NHS App as a 'gold standard' tool, transforming it into a comprehensive digital front door to the entire NHS by 2028. Expanding the role for the NHS App means transforming it from a tool for accessing specific services to become a digital front door to the entire NHS by 2028, aligned to changes in pathways, roles and ways of working. Figure 12 summarises the main ambitions for the NHS App. In addition, the NHS plans to use the App to collect patient-reported experience measures (PREMs) in a systematic and comparable way. Its intention is that by 2029, both patient reported outcome measures (PROMs) and PREMs will be published, helping patients choose their provider on the NHS App.[55]

Access to secure interoperable data

Digital technologies, particularly AI-enabled technologies, are only as effective as the data they can access and utilise. High quality, interoperable data therefore needs to be at the heart of efforts to improve healthcare delivery and reduce health inequalities. While the technology to deliver timely and actionable data already exists, challenges persist around data quality, standardisation and accessibility as well as workforce readiness. Addressing these issues and providing access to integrated datasets require cultural change, including improved training for health and care professionals. Digital technologies also need to demonstrate the ethical and transparent use of data that is verifiable, explainable, unbiased and compliant with open data and interoperability standards (including the established General Data Protection Regulations and the emerging regulatory framework for medical devices, AI and software).

Our interviewees and survey respondents considered that integrating primary care data with secondary, community and mental health services data was still some way off. Data sharing remains a major hurdle, with limitations in current systems and a lack of seamless information flow between providers. The inconsistent implementation of digital platforms across different regions further complicates matters. Indeed, data sharing has been an intractable challenge for more than 20 years and while the Plan touches on this it is not clear how this will be achieved in practice, nor the extent to which lessons from previous attempts at data sharing (for example care.data) have been learned.[56]

Figure 12: Summary of the Plan's proposals for an expanded role for the NHS App by 2028.

Enhanced access and choice
The NHS App (App) will facilitate booking, amending, and cancelling appointments across all settings through My NHS GP, a new AI-enabled tool, guiding patients to the most appropriate care pathway for non-urgent care and identifying the most appropriate services. It will help them choose their preferred provider through My Choices, including self-referrals to specialist care, through My Consult, where clinically appropriate.
This virtual triage tool will "transform GP workloads - letting them "focus on care where they provide the highest value-add".

Proactive and personalised care
The App will help people manage their prescriptions through My Medicines; book and track vaccinations, through My Vaccines; and receive timely reminders and updates and support to help manage long-term conditions through My Care. It will integrate genomic data with relevant clinical and diagnostic data, linked to the SPR. Patients will be able to view a complete account of their risk of major conditions and the NHS App will use this information to deliver personalised health coaching, recommend healthier choices and provide reminders and alerts to participate in risk-stratified screening and other diagnostic tests.

Improved communication and feedback
The App will allow patients to book, move or cancel an appointment, it will enable direct communication with HCPs and enable patients to provide feedback on their care experiences. In many case this may obviate the need for a GP call, or face–to-face consultation, but, when necessary, will provide context and insights for these consultations. A direct messaging functionality will obviate the need for SMS and letters.

Health data integration
The App will integrate with wearable devices and biosensors, allowing patients to track their health data in real-time and share this information with their healthcare providers to enable more proactive and personalised care. GPs will be able to automate these data and get alerts when intervention may be needed.

Remote monitoring
Remote monitoring of patients' health will become a standard part of NHS care, particularly for those with long-term conditions, utilising wearable technology and the App for data collection
and communication.

Addressing health inequalities
There is an explicit requirement to ensure equitable access to the App and its features, including proactive identification and support for individuals with lower digital literacy skills. Health information will be tailored to the needs of people from diverse backgrounds with accessibility features including British Sign Language support and screen readers for visually impaired users. My Companion will help people articulate their health needs, preferences and provide information about health conditions and treatments including translation into people's first language.

Implementing effective digital transformation including improving digital literacy

Data sharing and digital transformation are about trust and establishing a robust governance framework to support culture change. Digital leadership skills and improving the digital literacy of staff and patients are also important as is effective collaboration between the health, business and education sectors, to identify and develop the competencies needed for the future workforce.

Our interviewees considered that the underlying assumption of practices was that buying and installing the software is all that is needed, ignoring the need to redesign how the practice works and, importantly, training staff. The NHS's 2023-24 Delivery plan for recovering access to primary care included funding to enable all practices with analogue telephony to move to high quality digital telephony, a key aspect of improving services for patients.[57] This formed part of its modernising general practice initiative and included detailed guides and tools to improve: care navigation to align capacity to demand; the working environment for staff and the patient experience.[58]

There is also a need to rethink incentives, engage the public and address concerns about digital exclusion. However, the risks of inaction are greater, with inclusive design and strong public engagement needed to mitigate concerns over exclusion. A key requirement is to move the focus from continually pursuing novel technologies to optimising and embedding existing innovations, building on and better utilising existing systems to optimise care pathways and improve the quality and safety of care.

4. Investment in the primary care estate is crucial

Our interviewees and secondary research identified the need for increased investment in the general practice estate, noting that the configuration and size of practice is often a limiting factor in increasing the capacity to meet rising demand. A 2024 report by the IFG, 'Delivering a general practice estate that is fit for purpose', acknowledges that there has been limited focus on how the estate can support new models of care. It notes that around a quarter of the current estate was built before the NHS was established "leaving the workforce working in buildings that are often too cramped, too old and too inflexible for a modern health service". It calls for a detailed audit of existing space and creative approaches to estate planning, including co-location opportunities, repurposing existing space and innovative financing models.[59]

The IFG report identifies several actions to support the delivery of the required estate, from tailoring the ownership model to incentivise investment; to making better use of the existing estate with support to co-ordinate estates planning and investment and removing financial and accounting barriers to investment and providing private investors with increased certainty over the returns they can expect.[60] There are also opportunities for locating general practices on the high street as part of local economic regeneration initiatives including transferring ownership to public or commercial system partners.[61]

The 10-Year Health Plan does not explicitly address general practice estates but acknowledges that much of the primary care estate is not fit for modern requirements referencing the IFG report. The Plan acknowledges that as well as generating new capital investment, there is much that can be done to support the NHS to do more with the infrastructure it already has but that general practice is more challenging as the NHS does not have direct control with GP partners either renting their premises or buying their buildings outright. In either case, the NHS reimburses them for the specific cost of operating in the property (either the rent or the mortgage cost), but does not, cover any maintenance or repairs, instead, maintenance costs are expected to be funded from any surplus from the GP contract, after covering other expenses.[62]

The Plan stipulates that the proposals for a new programme to establish a neighbourhood health centre (NHC) in every community means that in some of the most deprived communities, the NHS can use public capital to update and refurbish existing, under-used buildings. Moreover, the NHS will "co-develop with the National Infrastructure and Service Transformation Authority (NISTA), building on the successful NHS Local Improvement Finance Trust (LIFT) programme, and will look to drive competition in the market to incentivise others, including third party developers, to improve their offer to deliver better services at lower cost to the taxpayer". It proposes to work across government, on a business case around NHCs that sets out the potential and an assessment of value for money with a decision on the approach by the autumn Budget 2025.[63]

During 2025-26, ICBs can use allocations from a new Primary Care Utilisation & Modernisation fund, from business-as-usual primary care capital and from wider system budgets (an additional £102 million was allocated in 2025-26 to support improvements in the primary care estate). The fund aims to enhance the use of existing infrastructure, create additional capacity for the GP workforce, and increase the number of patient appointments available. Funding is being indicatively allocated to ICBs on a weighted population basis. Schemes have to be deliverable by March 2026 with approval dependent on value for money and measurable patient benefits, including increased clinical appointments.[64]

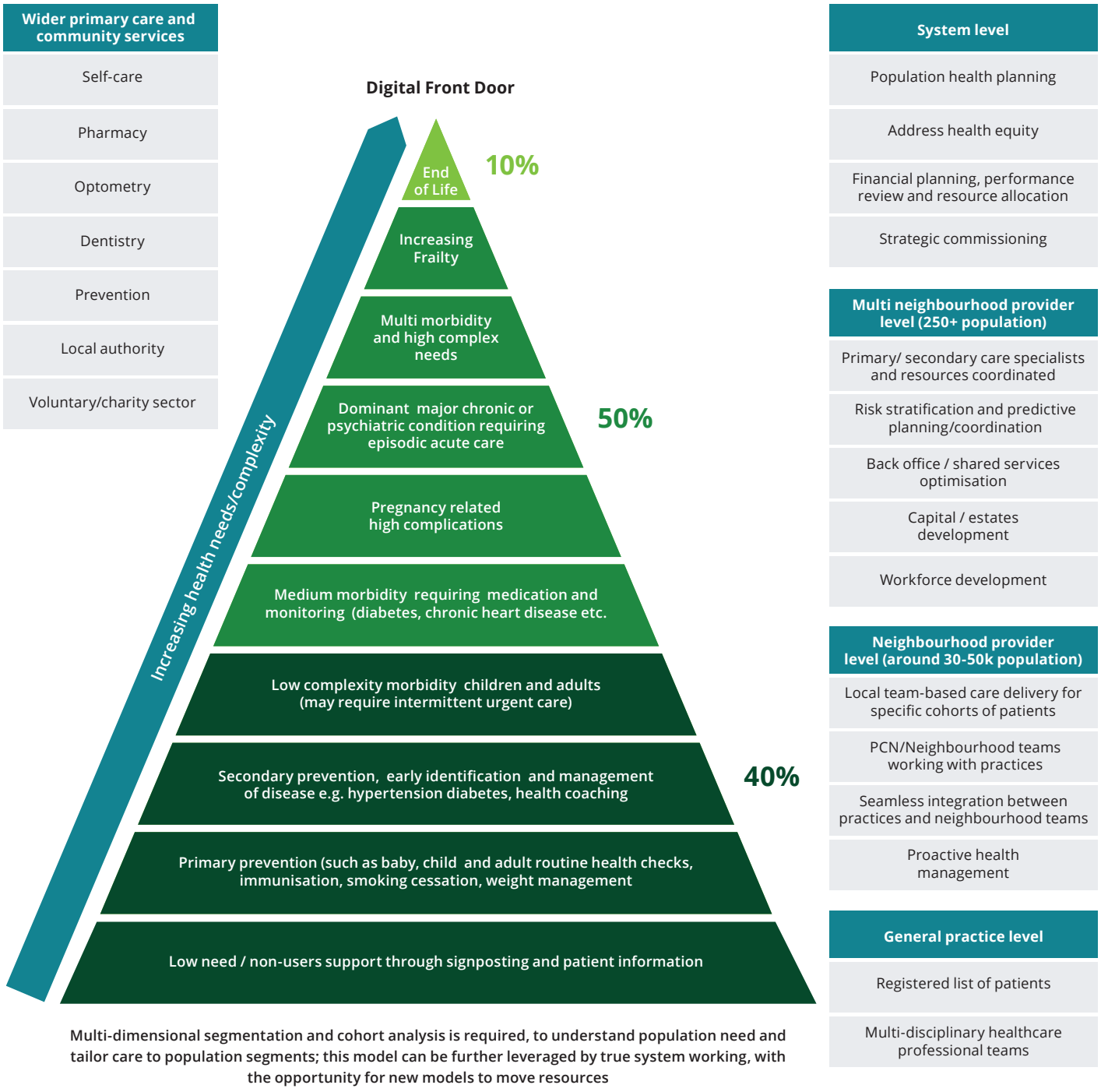
Designing a future-proof primary care system

While the obstacles currently facing general practice appear more severe than ever before there is a profound productivity paradox. Many more appointments are being delivered and GPs and other practice staff are working harder than ever, but staff and patient satisfaction at its lowest ever level. At the same time there is a tangible measure of optimism among GP leaders and a belief that general practices can survive and thrive and once again become the cornerstone of an efficient, and cost-effective healthcare system. The missing ingredient is how to realise this ambition. The final section of this report draws on our interviews, surveys, national and international case examples, and our experience working across health services in the UK and globally, to identify the changes that could make this ambition a reality while meeting the expectations in the Plan.

The Plan provides a pivotal opportunity for general practice and the wider primary care system to shape its own future and adopt alternative operating models aimed at delivering better outcomes for patients and staff. Our research has identified several building blocks that are already in place such as population health management/data analytics systems and the extended use of the NHS App. Indeed, some practices are already working as part of neighbourhood teams and GP federations and other 'at-scale' general practices. There are also numerous digitally mature practices that continue to achieve high patient satisfaction scores. Importantly, as our interviewees emphasised, there is no 'one size fits all' model of care, but there are fundamental changes that are needed to the current contract. These include our suggestions for a future general practice model comprising a population-led, digitally enabled service offer that incorporates core elements of the current system as well as wider community and public services (see Figure 13).

The Plan includes several case studies that have demonstrated improved outcomes such as quicker access, reduced pressure on staff, shorter waiting times, and rising patient satisfaction scores. Alongside this report, we have produced a primary care compendium with examples of evidence-based good practice. Together these examples illustrate the art of the possible and how to deliver better outcomes for patients and staff based on the foundational principles of 'list based general practice and universal access'. The rest of the section considers how to go beyond the art of the possible and accelerate the shift into new models of care.

Figure 13: The future health service model is a population-led, digitally enabled service offer



Multi-dimensional segmentation and cohort analysis is required, to understand population need and tailor care to population segments; this model can be further leveraged by true system working, with the opportunity for new models to move resources

Source: Deloitte analysis

Figure 14: What a future model of primary care could look like

Reform of primary care needs to be proactive, patient-centred, and focused on technologically advanced care delivery that empowers patients and ensures equitable health outcomes and be integrated with community and acute reforms

Patient activation using AI-enabled digital tools

Deploy virtual coaches and care navigators to empower people to manage their own health using data from wearables, at-home diagnostics, environmental and other health data. Co-create care plans, products and services that improve health literacy, reduce health inequities and provide access to personalised insights. Consumers choose who they share their data with and use trusted AI tools to proactively manage their physical and mental wellbeing

Examples

- Use of digital Patient Activation Measures
- NHS App –providing digital front door for patients
- Approved, evidence based, AgeTech and FemTech services and tools provide crucial tools in delivering 5P healthcare
- Omnilingual digital health technology has increase health equity

Integrated data ecosystem using AI

Create a fully integrated, compliant, healthcare data ecosystem that leverages population health management, and uses AI to enhance planning of patient care coordination across primary, secondary, and community care, reducing inefficiencies and predicting patient needs. View the NHS App as a digital front door for patients.

Examples

- Single integrated care record across the system
- NHS App integrating real-time health monitoring, virtual consultations, AI-driven diagnostics, and personalised health management plans.
- AI driven predictive analytics; Adverse event prediction and clinical decision support
- Patient Q&A Chatbots
- AI Friend to combat loneliness

Next-generation workforce models

Establish integrated, multi-disciplinary teams that deliver care both at the practice and outreach in the community to provide care in alternative settings. Leveraging community assets and technology integration to deliver care seamlessly and efficiently across care settings as part of the system MDT.

Develop digital skills across workforce, alongside clinical and leadership development

Examples

- Remote diagnostic teams consisting of specialists who can provide diagnostic services via telehealth tech
- Mobile Healthcare Units, staffed MDT capable of delivering preventive and acute care services in underserved areas

Performance monitoring and aligned incentives

Use real-time performance monitoring to drive a transparent, efficient, and responsive system. Utilising population health data, real-time analytics, predictive modelling, and interactive feedback systems to closely monitor and enhance care quality and safety whilst connecting financial performance with patient outcomes.

Examples

- Real-Time Performance Dashboards utilising cloud-based technologies to monitor clinical outcomes and operational efficiency in real time.

Sustainable healthcare environments

Leverage community assets and the flexible use of estates across the whole system to revolutionise patient access and deliver services more sustainably. This includes using alternative spaces such as retail and pharmacies (health on the high street), and digital technologies to deliver care where patients are. The aim being to provide a frictionless experience and drive a net zero agenda.

Examples

- Neighbourhood health clinics with GP hubs co-located with other community services e.g. job centre, travel clinic
- Investing in renewable energy in primary care estate
- Roving screening and immunisation services in retail spaces e.g. cancer, diabetes, childhood immunisation

Proactive health equity initiatives

Eliminate health disparities through targeted initiatives that ensure all communities, especially the most vulnerable, have access to the resources needed for optimal health.

Utilising big data and AI to target initiatives to close the gap, and shape contracts to incentivise this delivery.

Examples

- Using PHM approach to focus prevention scheme on appropriate communities
- Co-location with mental health services in deprived areas
- Roving digital literacy clinics in supermarkets

Delivering the Plan's vision for revitalising general practice

Considering the proposals in the Plan and the insights gathered from our surveys and interviews, and our wider experience of transforming healthcare systems, we have identified six pillars that we believe are needed to deliver a resilient and sustainable future primary care model (see Figure 14).

Achieving the shift from analogue to digital

The Plan expects that all practices, whatever their size and configuration, will need to embrace digitalisation and make use of validated AI-enabled tools. They will also need to decide what model of 'shared back-office services' will work best for them and routinely measure their progress in achieving outcomes that matter most to patients and staff. In addition, practices need to support their patients to adopt and use the 'My NHS GP tool' and other NHS App innovations together with the SPR as they become available. We have identified six critical design principles for the future of digitalised and sustainable general practices (see Figure 15).

Figure 15: Critical design principles for a resilient general practice model

These principles can serve as the foundation for the future primary care model and provide guidelines that all elements of the future model should consider

	Design principles	How this translates to a new model of care
1	**Patient-centred design:** fosters a holistic care model prioritising patient empowerment through shared decision-making, with a unified patient financial and health record system.	This ensures that the patient remains the focal point of all healthcare strategies and models, which is essential for creating a responsive and effective care model.
2	**Digital-first:** champions interoperability and integration, utilising the NHS App as a cornerstone, while automating processes and ensuring digital –first accessibility for all.	By emphasising the integration of services and accessibility, this principle supports the creation of a seamless patient experience, along with empowering better decision-making.
3	**Proactive population health management:** prioritises preventative measures and early intervention, with special attention to mental and physical health parity to improve lifelong wellbeing.	Focusing on prevention and early intervention can reduce long-term costs and improve patient outcomes, a key goal for any sustainable healthcare system.
4	**Quality and safety:** commits to shared ownership and stringent compliance with regulations, adopt standardised, integrated governance within and between general practice and wider primary care to reduce variability and fragmentation.	This underscores the non-negotiable aspect of safety and quality in healthcare, critical for maintaining trust and achieving clinical excellence.
5	**Financial sustainability:** enables general practices to hold the new contracts envisaged in the Plan and which compensate practices for the complex range of tasks undertaken based on innovative outcomes-based agreements balanced with risk mitigation strategies.	Delivers solutions and designs that are sustainable and achievable within the current and future financial constraints.
6	**Data-informed decision-making:** fosters an insight-driven culture including harnessing genomic data and includes building a robust infrastructure which enables seamless interoperability with other systems like like pharmacists and other relevant health and social care services.	Ensures that the care model is built on evidence-based practices and is continually refined based on actual performance and feedback, leading to more informed and effective care.

Source: Deloitte analysis

The business case for digital transformation is clear.

Many at-scale and other digitally mature general practices are already reaping the benefits of digital transformation, including the following:

- **Improved efficiency and patient care:** digital tools like e-consultations, telehealth and remote monitoring alongside AI-enabled triage and diagnostic aids can improve access to care and enhance patient outcomes. AI (especially ambient AI) can reduce staff workload. GPs who embrace these technologies and see their positive impact experience greater job satisfaction and will also see an increasingly positive return on investment.
- **Seamless access to patient information:** interoperable EPRs and access to patient data from various sources can improve population health management and health equity. It can also empower GPs to make better-informed decisions and provide more personalised care, leading to increased GP and patient satisfaction.
- **Widespread adoption of new models of care, such as digitally enabled super practices and federations:** collaboration, underpinned by an explicit GP to patient ratio and multi-disciplinary approach to care, enabled by evidence-based, trusted, digital technologies and automation of back-office functions, can foster higher levels of staff and patient satisfaction and better health outcomes.
- **Greater focus on preventative care and personalised medicine:** a focus on PHM that embraces preventative care and more personalised treatments, enabled by technologies like digital, genomics and AI can improve productivity and deliver better patient outcomes. GPs who are passionate about these advancements and their potential to improve patient lives believe this will help general practice to survive and thrive.
- **Increased opportunities for flexible working:** electronic rostering and job planning, together with digital consultation platforms offer opportunities for flexible working which can improve flexibility and work-life balance and contribute to greater job satisfaction and retention of some GPs who might otherwise have to give up work.

Source: Deloitte analysis

Moreover, our interviewees identified the following priorities for digitalisation.

1. **Patient communication and triage:** Interviewees identified the need for more efficient triage systems beyond simply managing queues and wanted to see a reduction in the need for excessive patient form filling. Total triage systems need to effectively reduce clinicians' time and improve trust and provide assurance on accuracy of decision, which will also make GP-led triaging more effective.
2. **AI-powered consultation support:** validated, ambient AI scribes that generate consultation summaries and can be seamlessly integrated into patient records.
3. **Developing intermediate services:** digital solutions that can bridge the gap between primary and secondary care to help manage acute demand more effectively and reduce unnecessary patient touchpoints. Also, digital command centres that signpost to the most appropriate HCP and setting, for example Pharmacy First.
4. **Revitalised general practice business models:** streamlined total triage systems to transform access to care, with at-scale general practice sharing automated back-office functions, e-rostering for flexible staffing.
5. **Proactive, preventative and population health approach to support people in a person- centred way across the life stages:** AI embedded into clinical pathways across the life course (expanding initiatives such as children's and women's health hubs and best practice pathways including coronary heart disease, frailty and dementia).

Specific digitalisation initiatives referenced in the Plan that are relevant to primary care, with plans for implementation over the next three to five years, include the upgrades to the NHS App and the new SPR. These should not only give clinicians and patients access to personal health data, but will also enable clinicians to see patient information from different care settings, such as their housing status, level of digital exclusion or caring responsibilities. The wholesale roll-out of ambient AI to release time to care and technology that enables a single click to access patient information, as well as access to other digital solutions provide opportunities to improve productivity.

Enabling the shift from hospital to community

Currently, many general practices lack the capacity or capability to lead the shift from 'hospital to community'. While the Plan does not address how already overstretched primary care or community services staff will be resourced or empowered to take on expanded leadership roles in neighbourhood care and develop the skills they will need to co-create services; GPs recognise that these skills are necessary for general practice to thrive. This is a crucial development that needs to be addressed urgently. It requires local leadership, and a workforce empowered and upskilled to make the most of the Plan's ambitions and the changes to clinical pathways that will be required.

If the shift from hospitals to community is to be realised, managers and clinicians currently working or wanting to work in hospitals will need to be convinced of the merits of working in primary and community care settings. While the commitment in the Plan to expose nursing students to neighbourhood settings is a positive move, there needs to be an equivalent requirement for doctors, managers and allied health professionals to establish a pipeline of future leaders who are trained and motivated to work in community-based care.

In addition, GPs often have or would like to develop a specialist interest – which can be an asset to the health community – for example, frailty care, urgent care, minor surgery or women's health. Renewing this option for GPs to maintain or develop specialist skills could improve recruitment, retention and enable the development of community hubs and neighbourhood health clinics.

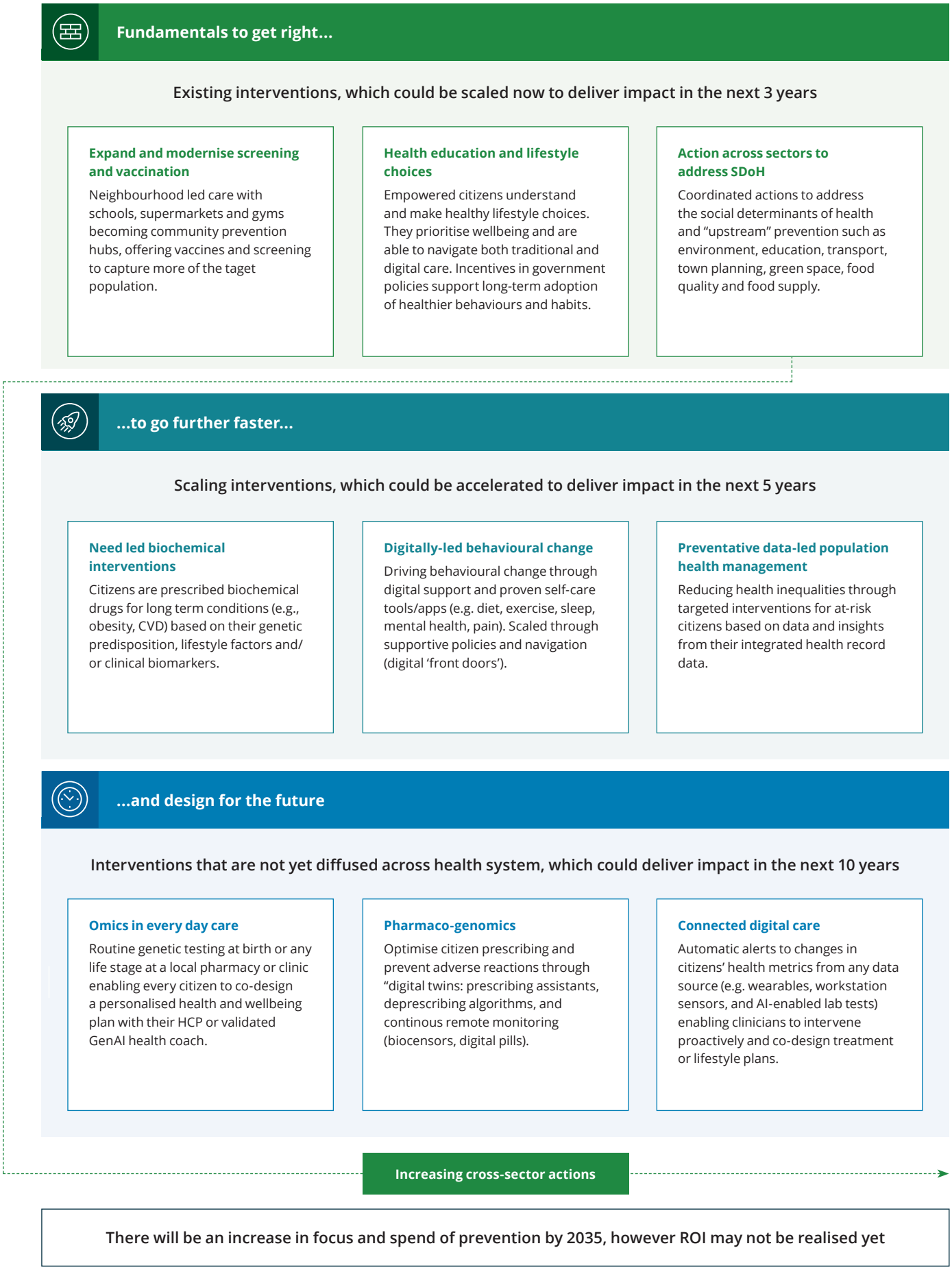
The shift to prevention

Deloitte's July 2025 report, *The shift to prevention: A new ecosystem of health promotion and protection,* envisions a future for the NHS that can help deliver the Plan's proposal to move from a reactive, treatment-focused model to a proactive and preventative approach. Developed in partnership with Google and The Royal Society, the report envisions a future centred on a new prevention ecosystem focused on interventions that extend health lifespan and prevent prolonged periods of illness before they occur. It acknowledges that reducing the disease burden of the UK population will require a paradigm shift in the NHS's health strategy, including improving people's understanding of their own health through enhanced health education, advanced screening, digital technologies and support from digital health navigators.[65]

The human-centred health promotion and protection system envisaged will be driven by advancements in genomics, health education, and an AI-powered digital infrastructure to provide hyper-personalised health insights for everyone, at every life stage. Moreover, the insights created can be used to empower individuals to manage their own health. The report identifies the need for an increased focus and spending on preventative interventions, involving partnerships and collaborations outside of the health system and significant investment in the NHS data and technology infrastructure. This will help increase healthier life expectancy, reduce health inequalities and improve the resilience and productivity of the healthcare workforce, as well as boost economic growth and innovation for a healthier and wealthier economy. To achieve this technology enabled future the report includes several considerations that the system will need to realise a future prevention focused health system (see Figure 16).[66]

There is a unique role for general practice for whom preventative medicine is a fundamental activity that is part of every consultation from screening, diagnosing and identifying the problem early and identifying solutions as quickly as possible, to treating and/or halting the progression of disease. Specific interventions include disease screening, delivering immunisations and providing advice and guidance to encouraging healthy lifestyles. Given that most touch points within the healthcare system happen in general practice there is a crucial role for GPs and the wider team to lead the paradigm shift that is needed to make prevention everyone's business across everyone's life course, from prescribed pre-natal and post-natal check-ups to support at the end of life and all the stages in between.

Figure 16: Considerations that need to be addressed to realise a future prevention focused health system



Source: Deloitte, Google and the Royal Society

The future of general practice

General practice has a critical part to play in leading the system transformation needed for effective integrated working. These new ways of working will not simply happen by bringing teams together but requires leadership, creating a culture of collaboration, organisational development support and a focus on understanding and changing mindsets. It also requires practices to equip staff with new digital, AI and genomic skills, engender trust in the changes and provide tools to support the transition. This includes designing new digitally-enabled clinical pathways, developing population data driven approaches and embracing clinical collaboration across practices and the wider health system to redesign care delivery sustainably. In addition, there is a need to create a safe space to design and test new ways of working and provide the support to embed them sustainably into wider service delivery. Practices need to start by choosing the right model of modern general practice that will best suit their local geography and population demographics. Figure 17 summarises the key features that will be required regardless of which model is adopted.

Figure 17: Building a resilient general practice-led primary care and neighbourhood health system

Reforming the future general practice model will require a blend of innovative thinking, credible challenge and subject matter expertise

Collaboration is key

Collaborations and partnerships need to come together to support new models of general practice which is seen as the lead provider of an integrated primary care focused system, including designing shared target operating models that both exploit the benefits of economy of scale and align best to the geographical and demographic nature of the local population.

Take a population health led approach

Proactive health management can utilise data and technology to identify individuals at risk and intervene early. Patients can be segmented and care tailored to provide treatments and preventative interventions based on genetic and life-style factors. These include changes to how patients are monitored. With better joined up working across the organisations responsible for keeping people well by promoting healthy lifestyles and addressing the social determinants of health.

Value the workforce and enhance leadership

Collaborative and distributed leadership is important in driving better care outcomes. By valuing and enhancing leadership roles, and empowering multi-professional teams by recognising and respecting everyones expertise, primary care can drive increased system resilience, improved care quality and adopt continual improvement initiatives. By addressing the drivers of job satisfaction and dissatisfaction the leaders can ensure they have a committed and sustainable workforce.

Key levers for a resilient general practice led primary healthcare system

Innovation and technology integration, and effective, routine use of data

Widespread adoption of telehealth using technology to bridge gaps in workforce capacity, improve access and enhance the patient journey into and across the health system. AI-driven schemes for triage, diagnostics, patient coding, and clinical decision support will streamline operations and improve care accuracy. AI-enabled triage and patient engagement and monitoring tools ensure care is provided in the right place at the right time by the right members of staff improving access and outcomes. Integrated EPRs enabling seamless data sharing and care coordination between providers; underpinned by robust cybersecurity systems and processes.

Build sustainable healthcare networks

Enhance network capabilities through negotiation of contracts, focusing on quality improvement, staff development, and leveraging digital. Strengthen relationships with cross-sector stakeholders adopting new models of public/private funding to enhance service delivery and modernise the IT and estate infrastructure. Build strong relationships, trust and shared purpose among the teams involved in delivering integrated care. Sustained and longer-term resourcing of new primary care models and the community services working in collaboration with them, rewarding quality and value-based outcomes.

While the partner-based model of general practice has been largely unchanged for 75 years, there has been an evolution of the types of staff involved in providing service, the hierarchical nature of decision-making and changes to the preference for face-to face care. In future there will be a need to remove perverse incentives that focus on and measure activity and not quality of outcomes and to consider how best to deliver care in the way that patients elect to receive it, whether virtual or in person. There will also be a need for an overarching strategic agenda to reflect the policy priorities in the Plan including consolidating the role of general practice in the new neighbourhood health approach, including clarity on roles and responsibilities, who holds the contract(s), and designing services around the various needs of different parts of the population. In addition, there is a need for a clear understanding and agreement with system partners on how best to deliver these services.

The Plan highlights the importance of continuity of care for people with complex long-term care needs, but for others with less complex needs it prioritises convenience and speed over continuity and relationship-based care even though research from the Health Foundation was clear that continuity benefits everyone.[67] Our survey respondents and interviewees were unanimous about their belief in and support for continuity of care highlighting GPs skills and expertise as a generalist, including their strength in risk management, identification of disease and deterioration, and in investigating undifferentiated illness (including referral for diagnosis, and if needed, treating until a specialist is seen). However, they also saw an important role for GPs to orchestrate where patients can, and should, be seen by other teams working within the primary care/neighbourhood networks.

As noted, there is no 'one size fits all' model for general practice but what will be common to all is the need to embrace digitalisation and data-based decision-making including pharmacogenomics, share and automate back-office functions, establish robust long-term workforce plans and new outcome-based contracts that incentivise multi-professional teams and embrace the shift to prevention. Ten years from now, the landscape of general practice in England will likely be vastly different, with adaptable, resilient and forward-thinking leadership and workforce models, high levels of job satisfaction and a restoration of high levels of patient and staff satisfaction.

While these are welcome developments, research indicates the need for specific actions on system redesign, ways of working and new funding approaches that are needed to deliver an economic, efficient and cost-effective general practice care model.

On system redesign:

- shift from top-down mandates to a supportive national framework that enables locally led clinical and digital transformation, prioritises innovation tailored to community needs and classifies care records as a critical national infrastructure
- prioritise basic, practical applications of technology, with a focus on using technology for tasks like documentation, texting, routing results, storage and dictation
- develop clinical pathways and funding flows that, where appropriate, support the shift from hospital to community, including careful design of people processes and technology to deliver high quality effective care in the right place, at the right time by the right people
- improve data and technology interoperability, with seamless integration with other systems, particularly pharmacies, community, mental health and acute settings as a priority
- ensure systems intended to improve access through digital-first triaging are interoperable and embrace AI for tasks such as consultation summaries, pathology automation, automated recall and risk stratification.

On ways of working:

- build sustainable, relationship-based care with modern equitable solutions, based on collaborations and partnerships, while maintaining continuity of care for those that need it, especially people with long-term conditions
- provide education and training to upskill the workforce's data and digital literacy skills to narrow the cultural and technical skills gap and unlock the benefits of digital transformation
- invest in leadership development and workforce redesign, including providing training to optimise the use of multi-professional GP-led teams founded on trusted relationships
- embrace patient activation measures that help boost patients' digital and health literacy, by a primary care compact with realistic access parameters and provide virtual coaches and care navigators to empower people to manage their own health using data from wearables, at-home diagnostics, environmental and other health data
- co-design digital services and care plans with users and actively address both digital and financial exclusion to ensure all communities can benefit from the NHS's shift towards digital-first care and a reduction in health disparities
- real-time remote performance monitoring to drive continuous quality improvement and a transparent, efficient and responsive system utilising population health data, real-time analytics, predictive modelling, and interactive feedback systems to closely monitor and enhance care quality and safety.

On funding:

- compensate general practices adequately and accurately for the complex range of tasks undertaken and replace outdated contracting models
- distribute funding between practices equitably, in line with population need while incentivising desired outcomes, such as improvements in care quality, service integration and/or care coordination
- ensure that the new neighbourhood contracts support the implementation of the new models of modern general practice
- maintain clear provider responsibility and accountability for holding the contract and how funding (including PCN funding) is spent
- provide practices with access to up-to-date evidence on the cost-benefits of investing in approved technology solutions
- provide sufficient capital to ensure that GP premises and equipment are fit for purpose while utilising community assets such as retail and pharmacies and more flexible use of estates across the whole system to provide alternative ways of accessing and delivering general practice services sustainably.

Conclusion

History has shown us that many GPs and practice staff have a proven track record of being able to modernise, are flexible, adaptable and innovative and given the right enablers will be key to enabling all three shifts in the Plan and rising to the challenge ahead.

GPs express a mix of frustration and hope about the current state of primary care, and recognise the crucial challenges relating to funding, workforce, integration, IT, digital transformation and estates. However, they also see opportunities for improvement through population health management technology, and a more integrated, multidisciplinary approach to care. The overarching message from our interviewees and survey respondents is on the need for new models of funding to enable systemic change and support so GPs can deliver high quality patient care while adopting new ways of technology-enabled, collaborative, system-level, working.

The ambitions for general practice and the wider primary care identified in the new 10-Year Plan provide some of the levers while signposting the direction of travel that is expected for general practice. This includes the GPs and other practice leaders taking a leading role in the design and development of neighbourhood teams and the new multi-neighbourhood organisations, expanding the number of GP federations and other models of 'at-scale' general practices. It also recognises that for some practices, the existing partnership model will be the right approach but that whatever model is adopted, embracing the proposals for the SPR and expanded NHS App will be essential.

To help expedite the transformation needed in general practice we have identified several ideas, suggestions, and frameworks, together with a link to a series of national and international good practice examples, compiled as part of an evolving general practice compendium. Specifically, we explore the merits of population-led, digitally enabled, future models of general practice and highlight the critical design principles that will be needed to ensure any future models are resilient, including the business case for digital transformation. We identify several considerations to help the NHS deliver a more preventative primary care and neighbourhood health system. Finally, we suggest several specific actions to effect system redesign, new ways of working and more cost-effective, outcomes-based funding models. As it is for the Plan, the devil is in the detail, especially in the design of the general practice funding and operating models. One thing is clear, GP leadership and trust in the development of wider system collaborative ways of working will be essential in determining how different GP practices might respond and the effectiveness of the choices they make in delivering better outcomes for all.


Johnson

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