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All-Party Parliamentary Health Group

First Point of Care

A Plan for a Better NHS Front Door through Connected Primary Care

September 2026

Health

September 2026

This report was written by Jasmin Adebisi.

The views in this report are those of the author and Policy Connect. Whilst these were informed by the contributors to our inquiry, they do not necessarily reflect the opinions of those individuals and organisations.

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Foreword

Primary care is the front door of the NHS – it is where most people encounter the health service, where long-term conditions are managed, and where problems can be caught early. When primary care works well, the whole health service works better.

Each of us came to this inquiry from different backgrounds. One of us has spent thirty years as a GP and knows what a four-to-six-week wait means for the patient on the other side of it. One has spent nearly two decades as a community pharmacist, working alongside colleagues across the health service. One served as a Minister with responsibility for technology at the Department of Health and Social Care and has long argued that patients should not have to ring at eight in the morning and hope to be seen that day. And one came to this inquiry through constituents raising, week after week, the same fundamental problem: they simply could not get seen by a GP.

Whilst different experiences brought us to the table, the evidence we heard as part of this inquiry brought us to the same conclusion: too many people are struggling to access primary care when they need it, and that must change.

Over the past year, we have heard from patients, professionals, researchers and NHS providers across all four primary care sectors. We heard about pressures on services, workforce challenges, fragmented systems and opportunities for reform. But the evidence that stayed with us most came from patients.

We heard from people turned away when they tried to register and people forced to explain their medical history again and again because information had not followed them through the system. Patients told us about their struggles to navigate services when they most needed help. Perhaps most concerning of all, we heard from people who had stopped trying altogether because experience had taught them there was little point in asking.

Those experiences should concern all of us. Access is not simply a question of convenience – delayed or difficult access can mean conditions identified later, opportunities for prevention missed, greater pressure elsewhere in the NHS and, ultimately, worse outcomes for patients.

These experiences shaped the thirteen recommendations we set out in this report. They are grounded in a simple principle: primary care should be easier for patients to access and

navigate, while enabling the professionals who care for them to use their time and expertise effectively.

The challenges facing primary care have developed over many years and will require sustained attention that cross party lines. Our joint leadership for this inquiry is rooted in the need for cross-party consensus to tip the scales and build the consensus required to tackle the system and build an NHS fit for England tomorrow and beyond.

We are grateful to everyone who contributed to this inquiry: to those who provided evidence; to our steering group for their expertise and challenge; and to our sponsors, without whose support this work would not have been possible.

Above all, we thank the patients who trusted us with their experiences. Their experiences run through this report and have kept our focus where it belongs: on making primary care work better for the people who depend upon it.

Dr Simon Opher MP
Inquiry Co-chair

Jess Brown-Fuller MP
Inquiry Co-chair

Lord Kamall of Edmonton
Inquiry Co-chair

Sadik Al-Hassan MP
Inquiry Co-chair

Signatories

The following parliamentarians have offered their support for the report and its recommendations as signatories.

Cat Eccles MP
Labour

Clive Jones MP
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Dr Alison Gardner MP
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Paul Davies MP
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Liberal Democrats

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Liberal Democrats
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Executive Summary

The All-Party Parliamentary Health Group has spent the past year examining why people in England struggle to get primary care, and what would change it. This report is the result.

It is the first Inquiry of its kind to examine all four primary care sectors together: general practice, community pharmacy, NHS dentistry and optometry. Almost every previous Inquiry has looked at general practice alone. Patients do not experience these as four separate services, and the Inquiry found the same failures repeating across all four.

Access is not only about speed. Being seen quickly matters, but so does whether the person seeing you knows your history, whether anyone follows up, and whether the problem you came with is dealt with. This report treats access as covering all of that.

Chapter 1 sets out the policy landscape and the case for change. Chapter 2 sets out what patients told the Inquiry. Chapter 3 develops the three structural patterns that form the analytical framework the rest of the report builds on: how funding is distributed, whether trained staff are commissioned to do NHS work, and what commissioning arrangements permit.

Chapters 4 to 7 examine the report's four themes in turn: reducing health inequalities and access barriers; digital transformation and system integration; building a sustainable primary care system; and integration, collaboration and the wider system. The final chapter draws the findings together and identifies the questions the Inquiry has not settled.

What the Inquiry found

Funding is distributed in ways that do not follow need. Acute hospital care received around 43 per cent of NHS spending in 2024/25; primary care received around 8 per cent, a share that has fallen even as total spending has risen. Four independent studies find that the general practice funding formula under-weights deprivation. The same problem appears in the other three sectors through a different mechanism in each.

The sectors outside general practice have the weakest foundations. Community pharmacy delivers services costing £5.06 billion against funding of £2.76 billion, with 99 per cent of pharmacies paid less than the cost of what they provide. Dental contract reform

carries an acknowledged shortfall of around £1.5 billion. Enhanced optometry services are commissioned in only about 75 per cent of the country.

Clinicians are trained and then not commissioned to work. A third of pharmacists on the register hold an independent prescriber qualification, and around a quarter of community pharmacist prescribers have never prescribed. Around 46,000 dentists are registered across the UK, while NHS activity in England amounts to the equivalent of about 11,000 full-time dentists. General practice is the exception: there the constraint is supply, and it is tightest where need is greatest.

Organisations outside the NHS are already reaching people primary care does not. Universities, hospices and community organisations are providing services additional to NHS provision, each having acted without a standing route through which the NHS could commission the work.

The analysis matches patients experiences. Patients told the Inquiry they were turned away at registration, that they had to repeat their history at every service, and that they had given up trying. The analysis finds registration guidance that is not consistently followed, records that cannot move between the four sectors, and national measures that count only the people who were seen.

What the recommendations cost

The report sets out thirteen recommendations which emerged from the findings and evidence collated.

Seven recommendations can be implemented within existing resources and redeployment of funds. Three recommendations can be primarily funded within existing resources. Three recommendations require additional funding and investment to tackle the issues they seek to address. Whilst the majority of our recommendations can be implemented within the current funding structures, the Inquiry also clearly shows the need for additional funding to support primary care in England.

Cost type	Recommendations
Within existing resources	1; 2; 3; 5; 6; 12; 13
Within existing resources for the main element, with additional investment for a defined part	7; 8; 9
With targeted additional investment	4
Substantial additional investment	10; 11

Recommendations

Further reform of primary care services in England must be underpinned by a fundamental shift in how NHS resources are allocated. Government should consider how best to deliver on its commitments to rebalance funding towards primary care and care closer to home, through the redeployment of existing NHS spending and away from acute hospital care. As highlighted above, Primary care currently accounts for around 8 per cent of NHS funding, compared with around 43 per cent for acute hospital care. The following recommendations set out the practical steps government can take to deliver this shift and strengthen primary care.

1. The Department of Health and Social Care should establish a primary care access standard covering all four sectors, drawing on existing survey infrastructure to capture the populations currently missing from the measurement system.

a. Establish a primary care access standard covering all four sectors, using the Ipsos MORI GP Patient Survey, the Health Insight Survey, and the Health Survey for England as the core measurement infrastructure.

b. Extend the survey infrastructure to capture populations currently missing from measurement, including people not registered with services, people who have stopped trying to access care, and populations who face the greatest barriers to access.

c. Automate access data collection through primary care record systems where the data can be extracted at source, to reduce the reporting burden on practices.

d. Publish an annual primary care access report against the access standard, disaggregated by sector and by the populations who face the greatest barriers to access.

2. The Department of Health and Social Care should improve primary care access for underserved populations through digital and non-digital solutions, including making inclusive registration standard practice across the GP contract framework.

a. Ensure the Carr-Hill funding formula reflects the additional cost of registering and caring for populations who face the greatest barriers to access. This redistributes the existing general practice budget rather than adding to it.

b. Consider how inclusive registration practice could be incentivised so that the existing contractual requirement is supported by a financial incentive.

c. Permit technology-enabled registration through the NHS App and NHS website, including the use of mobile phone numbers as a proxy for a fixed address for people without one. Evaluate digital registration and navigation tools that have demonstrated success in reaching populations previously unregistered with primary care, drawing on the examples set out in this report.

d. Where systemic patterns of registration refusal are identified, involve the Care Quality Commission as a regulatory response, targeted at those patterns rather than imposing additional documentation requirements of compliant practices.

e. Require Integrated Care Boards to publish annual reports on registration inequalities in their area, so that patterns of exclusion are visible to policymakers, providers, and communities.

3. The Department of Health and Social Care should ensure the local patient voice function is preserved, whether by retaining the existing Healthwatch and VCSE Health and Wellbeing Alliance arrangements or by designing a purpose-built successor architecture.

a. Either preserve the existing Healthwatch and VCSE Health and Wellbeing Alliance arrangements, or design a purpose-built successor with an equivalent function.

b. Ensure the successor has expertise across all four primary care sectors and covers both physical and mental health.

c. Empower patients from populations who face the greatest barriers to access to raise concerns about primary care through the successor.

d. Provide a clear route from the local patient voice into strategic commissioning decisions at Integrated Care Board level.

4. The Department of Health and Social Care and the Departments for Digital, Culture, Media and Sport should mandate open data standards across all four primary care sectors and the wider health and social care systems.

a. Mandate open data standards across all four primary care sectors and the wider health and social care system, with implementation timetables that reflect the different starting points across sectors.

b. Before introducing contractual requirements that rely on Single Patient Record access, ensure that reliable access is in place. Practices should not be expected to meet obligations built on infrastructure that does not yet work reliably.

c. If and when additional funding becomes available, direct investment towards the practice-level system changes are needed to meet the standards, with particular attention to optometry, dentistry, and community pharmacy where the practice-side investment gap is the widest.

d. Set out clear public reporting mechanisms and provide for independent scrutiny of delivery progress against the data standards.

5. The Department of Health and Social Care and the Cabinet Office should establish a safe adoption framework for new technologies in primary care.

a. Establish a safe adoption framework for new technologies in primary care, covering the four sectors, with the following properties any technology should meet: safety, efficacy, consistency of performance across populations, transparency, data protection, and sustainability over the technology's lifespan.

b. Apply the framework to new deployments from the outset, with phased implementation for technologies already in deployment.

c. Include mechanisms for reporting and resolution of concerns about potential bias or other risks in specific technologies.

d. Design the framework as iterative and updated regularly, given the pace at which the technology landscape is changing.

e. Invest in the primary care workforce alongside the framework, through comprehensive training and education programmes in medical education and postgraduate NHS training, in line with the 10 Year Health Plan's commitment to workforce development. If and when additional funding becomes available, support practice-level and primary care network-level training that reflects local implementation contexts, so that the workforce is equipped to adopt new technologies safely rather than left to follow only what developers offer.

6. The Department of Health and Social Care should expand the NHS App and NHS website functionality across the four primary care sectors, alongside a guaranteed non-digital access route and support for people who are digitally excluded.

a. Expand NHS App and NHS website functionality across all four primary care sectors, so that users have one integrated route to primary care digital services.

b. Guarantee a non-digital access route to all primary care services, running in parallel with digital expansion.

c. Fund support for people who face digital exclusion, including community-based digital confidence work and resolution of the NHS number gap that currently excludes some populations from full NHS App functionality.

d. Run a national campaign to build public confidence in using NHS digital services safely, aligned with existing online safety messaging.

7. The Department of Health and Social Care and HM Treasury should establish a Primary Care Investment Standard and reform the funding distribution mechanisms for general practice and community pharmacy.

a. Establish a Primary Care Investment Standard as the formal mechanism through which that redeployment is enacted. The Standard should require year-on-year growth in the primary care share of NHS expenditure, against a published baseline, with progress reported annually to Parliament and Integrated Care Boards.

b. Ensure Carr-Hill reform reflects deprivation, complexity, and the additional workforce cost of caring for populations who face the greatest barriers to access.

c. Alongside formula reform, review the other income streams through which general practice is funded, including the Quality and Outcomes Framework, dispensing payments and enhanced services, so that reform of the formula is not offset by distributional effects elsewhere in practice income.

d. If and when additional funding becomes available, address the community pharmacy funding gaps identified by the independent economic analysis, so that pharmacy provision is sustained particularly in the most deprived areas.

8. The Department of Health and Social Care and Integrated Care Boards should establish an integrated commissioning framework across all four primary care sectors, addressing unmet need in general practice, community pharmacy, dentistry, and optometry.

a. Establish an integrated commissioning framework across all four primary care sectors, addressing unmet need in general practice as well as in dentistry, community pharmacy, and optometry, with Integrated Care Boards jointly commissioning against common outcomes that include reductions in unmet need, improvements in continuity of care, reductions in emergency admissions, reductions in inequalities of access, and patient-reported outcomes.

b. Ensure primary care contracts are held by appropriate provider bodies, so that entities such as Local Optical Committees, which cannot legally hold contracts, are supported to advise on service design while provider companies deliver.

c. Reform the dental contract to include universal urgent access and prevention incentives, and to allow scope for further services to be added over time where the dental workforce and setting could support them.

d. If and when additional funding becomes available, address the identified funding gaps in dentistry (approximately £1.5 billion for contract reform) and optometry (approximately an additional £350 million to reduce the existing funding gap and commission services where currently none are provided), alongside the pharmacy funding gap set out in Recommendation 7.

9. The Department of Health and Social Care and HM Treasury should reform the primary care estates architecture and, if and when additional funding becomes available, establish a capital investment programme for primary care premises.

a. Reform the primary care estates architecture within existing resources, including delegating capital decisions to a more local level, enabling capital and revenue flexibility in NHS accounting, and reforming District Valuer Service methodology to publish valuations methodology, publish appraisals, and provide a dispute resolution mechanism.

b. If and when additional funding becomes available, establish a capital investment programme for primary care premises, prioritising the least-suitable premises across the four sectors.

c. Ensure developer contributions to healthcare infrastructure, including Section 106 obligations and the Community Infrastructure Levy, translate into guaranteed GP contracts and primary care capacity where new residential development takes place.

d. Address the storage of paper records, often held by GP surgeries in shipping containers outside their premises, through accelerated digitisation and, in parallel, shared physical storage facilities at Integrated Care Board level for records that must remain on paper.

10. The Department of Health and Social Care should train, employ and retain the primary care workforce across all four sectors.

a. Set out clear steps to train, employ, and retain the primary care workforce needed across all four sectors.

b. Include targeted incentives for coastal, rural, and deprived areas where workforce shortages are most acute, extending to primary care mental health provision, and ensure workforce planning across all four sectors addresses geographic, socioeconomic, and ethnic inequalities in recruitment, retention, leadership, and career progression.

c. Ensure workforce planning is done at the four-sector level, integrating general practice, community pharmacy, dentistry, and optometry workforce planning.

d. Address sector-specific workforce challenges, including retention of the dental workforce within NHS practice, active deployment of the qualified independent prescriber workforce in community pharmacy, and fuller utilisation of optometry capacity across care pathways.

11. The Department of Health and Social Care should pair the neighbourhood health implementation with a workforce plan and a matching capital plan for the premises that workforce will need.

a. Ensure the capital plan works with existing premises ownership models across the four sectors, including GP cost rent schemes and independently owned pharmacy and dental premises.

b. Include neighbourhood mental health centres in the capital plan, recognising that current operational coverage is limited and that scaling is needed for the model to deliver on its mental health integration ambition.

c. Examine international examples of financing primary care premises, including the Italian and Irish models, to consider whether best practice elsewhere could inform and improve the neighbourhood health implementation.

d. Build evaluation of workforce, estates, and patient outcomes into the neighbourhood health programme from inception, so that the model's impact can be assessed against its integration ambitions rather than only against implementation milestones.

12. The Department of Health and Social Care should enable community anchor institutions to complement existing primary care provision.

a. Enable community anchor institutions to complement existing primary care provision, focussed on capacity-adding functions such as workforce training, research coordination, service integration, and use of anchor institution facilities for primary care delivery where appropriate.

b. Examine examples of community-anchored primary care infrastructure, including the University of East London and University of Essex health hubs, the Whitehaven neighbourhood mental health centre, and Waltham Forest's voluntary and community sector lettings policy, as models that other localities could look further into.

c. Ensure new commissioning routes complement rather than destabilise existing NHS primary care providers, particularly in fragile sectors such as community pharmacy.

d. Examine current procurement rules that limit community anchor institution involvement, identifying which reforms would enable helpful models to scale and which existing rules serve important protective functions.

13. The Department of Health and Social Care should establish a primary care partnership architecture with continuity of care as a founding principle and a guaranteed primary care voice on every Integrated Care Board.

a. Establish a primary care partnership architecture with continuity of care as a founding principle across all four primary care sectors.

b. Guarantee a primary care voice on every Integrated Care Board and strengthen the duty on Integrated Care Boards to consult with and work alongside primary care providers.

c. Enable devolution of power and funding to neighbourhood health centres so they can employ multidisciplinary staff directly, drawing on integrated funding across primary care, community nursing, and mental health.

d. Use strategic commissioning as an active lever for addressing mental health inequalities, ensuring the partnership architecture supports mental health integration into primary care.

e. Require Integrated Care Boards to report annually on continuity of care metrics, on primary care representation in decision-making, on integrated commissioning activity, and on progress against inequalities of access, so the partnership architecture's performance is visible year on year.

Introduction

Primary care is the front door of the NHS. For most people in England it is where contact with the health service begins, where routine needs are met, and where prevention and continuity take shape. This report sets out how well that front door is working, and what it would take to improve it.

Getting an appointment is only the beginning. Whether the person you see knows your history, whether anyone follows up afterwards, and whether the problem you came with is resolved all determine whether the care worked. This report therefore treats access as five connected things: getting in, being seen, finding your way through, having your care continue, and having your need met.

> *"Of all the issues facing the health service, access to primary care is probably the primary one. That is the one you get on the doorstep. People find it very, very upsetting that they cannot get quick access to medical care."*
>
> ***Dr Simon Opher MP, Inquiry Co-Chair and practising GP, Evidence Session 1, 29 October 2025***

Healthwatch England hears from service users every month, and for several years running the same two concerns have come top: people cannot get a GP appointment, and people cannot find an NHS dentist.[1]

Those are the two sectors where care is rationed by appointment. In pharmacy and optometry people walk in, and what they cannot get there they often do not know they were entitled to, so the failure is quieter and generates fewer complaints. That is part of why this Inquiry looked at all four together.

1 William Pett, Head of Policy, Public Affairs and Research, Healthwatch England, Oral Evidence Session 1, 29 October 2025.

About this Inquiry

The All-Party Parliamentary Health Group (APHG) is a cross-party group of parliamentarians with an interest in health and care policy. This is the first substantive Inquiry report the APHG has produced.

It is also, so far as the APHG is aware, the first parliamentary Inquiry to examine all four primary care sectors together: general practice, community pharmacy, NHS dentistry, and optometry. Previous inquiries into primary care access have examined general practice alone, which is where the evidence is strongest and the political attention greatest. That choice is defensible, and it has produced a great deal of useful work. But it does not accurately map how people use these services.

A patient with a painful tooth, a worsening prescription problem, and deteriorating vision does not experience four systems. They experience one front door that may or may not open. When it does not open in one sector, they arrive in another, or in an emergency department, or nowhere at all. Examining the four together turned out to matter more than the Group anticipated when the Inquiry began, because the same failures appear in all four, produced by arrangements the four have in common.

What good access means

It is easy to measure access narrowly – the most familiar measures count how quickly someone is seen and how many appointments are delivered. Evidence to the Inquiry was consistent that these capture only part of what patients need, and that a report about improving access has to be clear about what it is trying to improve.

Four propositions emerged, and together they form the working definition this report uses.

Good access is timely rather than fast. For many patients the ability to book ahead, arrange transport and childcare, and be seen at a convenient time matters more than same-day availability. The goal is the right person, in the right place, at the right time, rather than the shortest possible wait.

Good access is continuous. Being seen once is not the same as being cared for. Patients with a named, consistent point of contact report satisfaction of around 90 per cent, against around 70 per cent for those without, and continuity carries measurable clinical benefit as well as a better experience.[2]

2 National Voices and Ipsos, research submitted to the Inquiry, 2026; and Workforce and Learning Research Group, Nuffield Department of Primary Care Health Sciences, University of Oxford, written evidence to the Inquiry, 2026.

Good access is measured by what happens to patients, not by how many are seen. The Inquiry heard the case for measures such as avoidable hospital admissions, and the time between a patient first noticing a symptom and receiving a diagnosis, rather than counts of people coming through the door.

Good access accounts for the people who do not get in at all. Any honest measure has to include what happens when someone cannot be seen. Research submitted to the Inquiry finds that one in seven people who cannot get an NHS dental appointment carry out dental procedures on themselves.[3] Those people appear in no measure built from the people who were seen.

No single indicator captures all of this, and the Inquiry was cautioned that choosing one distorts behaviour towards it. Recommendation 1 gives that argument its operational form.

Read together, these propositions describe five dimensions along which access can succeed or fail: whether a person can get in at all, whether there is capacity when they do, whether they can find their way through, whether anyone holds the thread of their care afterwards, and whether their need is met and recorded. Each dimension fails for identifiable reasons, falls hardest on identifiable people, and has an identifiable lever.

Dimension	What fails	Who it falls on	The lever
Entry	People cannot register	People without a fixed address, migrants, Gypsy, Roma and Traveller communities	Inclusive registration (Rec 2)
Availability	Waits, and too few clinicians relative to need	Deprived communities, coastal and rural areas	Funding and workforce (Recs 7 and 10)
Navigation	Services are fragmented and hard to move through	Digitally excluded groups, people with limited English	NHS App, website, and with guaranteed non-digital route (Rec 6)
Continuity	Care is episodic and nobody holds the thread	Older people, people with several long-term conditions	Partnership architecture (Rec 13)
Outcomes	Need goes unmet and unrecorded	Minority ethnic groups, deprived populations	Measurement and integrated commissioning (Recs 1 and 8)

3 Pett, Oral Evidence Session 1.

A note on terms

Primary care in this report means the four sectors named above. Where a finding applies to one sector only, the report says so.

Acute hospital care means hospital services taken as a whole, covering both secondary and tertiary care. The report uses the term because the spending figures it draws on are published on that basis.

Inclusion health describes groups who experience severe social exclusion and consistently poor health outcomes, including people experiencing homelessness, Gypsy, Roma and Traveller communities, people in contact with the justice system, people who sell sex, and people with substance dependence. The report also refers throughout to populations who face the greatest barriers to access, which is broader and includes people who are not socially excluded but who nonetheless struggle to get care.

Continuity of care refers to the ongoing relationship with a clinician or team who knows a patient and their history. It is distinct from being seen quickly, and the report treats it as a founding principle that applies across all four sectors.

The evidence base

The Inquiry draws on just over fifty written submissions from professional bodies, patient organisations, academic institutions, NHS providers, regulators, technology providers, and voluntary and community sector organisations. It held three oral evidence sessions in Parliament, covering patient voice and health inequalities; funding, commissioning and workforce across the four sectors; and technology and innovation. It conducted six supplementary interviews to explore specific operational questions in depth, and reviewed the academic and policy literature to provide research context for the analytical chapters.

A steering group drawn from parliamentarians, professional bodies, academics, patient organisations, and NHS and voluntary sector representatives advised the Inquiry throughout and agreed the final recommendations. The full methodology for the Inquiry is set out at the end of the report alongside a complete list of contributors.

Where the report cites oral evidence it names the individual and the session where permission to do so was given. Where it cites written evidence it names the organisation.

What the Inquiry found

Five key findings emerged from the collated evidence – they are stated here in summary; the chapters that follow set out the evidence for each.

Distribution, not only the overall level of funding, drives primary care access failures. Primary care has too little money, and the report says so. But the sharper problem is that what exists is distributed in ways that do not follow the direction of national policy, through a different mechanism in each of the four sectors. Acute hospital care received around 43 per cent of NHS spending in 2024/25; primary care received around 8 per cent, a share that has fallen even as the total NHS spending has risen.[4]

The most accessible parts of the system carry the weakest foundations. Community pharmacy, dentistry, and optometry are the parts of primary care people reach most easily, without appointment or referral. They also hold the weakest contracts, the least secure funding, and the fewest connections to the rest of the NHS.

Clinicians are trained and then not deployed against NHS work. In three of the four sectors the constraint is not how many people have qualified but whether anyone has commissioned them to work: dentists registered but not working in NHS practice, pharmacists qualified to prescribe and not prescribing, optometrists with equipment and capacity beyond what is commissioned. In general practice the constraint is different, and supply is short where need is greatest.

The capability to reach underserved populations already exists outside the NHS contracting perimeter. Universities, hospices, community trusts, and voluntary organisations are providing services to people primary care struggles to reach. What they lack is a standing route through which the NHS can commission them to add services alongside NHS provision.

System analysis and patient experiences align. Registration failures, unmet need, digital exclusion, and care that nobody holds together. The patient experiences and the analytical evidence point at one problem from two directions.

Beneath these findings sit three structural patterns that recur across all four sectors and explain why the failures take the form they do: how funding is distributed, why trained staff are not deployed against NHS work, and how commissioning arrangements decide who can deliver what. Chapter 3 sets out all three, and they are developed through the thematic chapters that follow.

4 Department of Health and Social Care, response to parliamentary question 117398, 25 March 2026, as reported in House of Lords Library, "Acute, Primary and Community Healthcare," 2026; and The King's Fund, "Primary Care in a Nutshell," 2024.

Scope and positioning

No single report can resolve every question about the future of primary care in England, and a good deal is in motion at the time of publication. The funding formula for general practice is under review, the dental contract is being reformed, and the Health Bill will restructure how NHS services are commissioned.

This report sets out the structural patterns that produce the access failures patients experience, and the direction of travel that would address them. Some questions the Inquiry encountered need more detailed work than a four-sector overview can carry, including operational and procurement matters and sectoral specifics. Chapter 8 sets those out.

The report is led by what patients told the Inquiry. Chapter 2 draws on evidence from patient organisations, individual testimony, and the voluntary and community sector organisations that work alongside them, and it frames the analytical chapters that follow.

The report structure

The chapters that follow set out the evidence behind these findings, and each recommendation appears in the chapter where the case for it is made. A guide to the report's structure follows the introduction.

Chapters 4 to 7 examine the report's four themes in turn: reducing health inequalities and access barriers; digital transformation and system integration; building a sustainable primary care system; and integration, collaboration and the wider system. The recommendations appear in callout boxes within each thematic chapter, alongside the evidence that supports them, and in full in the executive summary at the start of the report. Chapter 8 offers a closing synthesis.

Each recommendation is marked with a cost type. Most of what this report asks for is not new spending but new arrangements.

Chapter 1: Background

1.1 The policy landscape

Primary care policy in England has been the subject of sustained public and political attention throughout the period covered by this Inquiry. Three overlapping policy developments frame the environment in which the Inquiry's recommendations sit.

1.1.1 Lord Darzi's Review

Lord Darzi's Independent Investigation of the National Health Service (NHS) in England was published on 12 September 2024.[5] The Investigation found the NHS in critical condition and identified four connected causes: austerity in funding and capital starvation; the pandemic and its aftermath; the lack of patient voice and staff engagement; and management structures and systems. Two of its findings shaped part of this Inquiry. The first finding concerns where the money goes – Lord Darzi found that too great a share of the NHS budget is spent in hospitals, while too little is spent in the community. Between 2006 and 2022 the hospital share of the NHS budget rose from 47 per cent to 58 per cent. He also noted that general practices, as independent businesses, have the best financial discipline in the health service family, because they cannot run up large deficits in the expectation of being bailed out.[6] Governments have promised to move care out of hospitals and into the community since at least 2006.[7] In practice the opposite has happened. Lord Darzi also found that England has almost 16 per cent fewer fully qualified GPs for its population than 19 comparable high-income countries. The variation in how many patients each GP carries is wide, unwarranted, and worst in deprived communities. The second finding concerns a major capital investment gap. The Investigation identified a shortfall of £37 billion in NHS capital investment, meaning the sum that would have been invested had the NHS matched what comparable countries spent on buildings and equipment during the 2010s. Alongside it sits a backlog maintenance bill of more than £11.6 billion, and £4.3 billion drawn out of capital budgets between 2014-15 and 2018-19 to cover day-to-day deficits. Lord Darzi observed that the missing capital could have rebuilt or refurbished every GP practice in the country, and that 20 per cent of the primary care estate predates the founding of the health service in 1948.[8]

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5 Lord Darzi, "Independent Investigation of the National Health Service in England," Department of Health and Social Care, September 2024, summary letter to the Secretary of State, paras. 6 and 13 (online: https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england).

6 Darzi, "Independent Investigation," summary letter, para. 13.

7 Department of Health, "Our Health, Our Care, Our Say: A New Direction for Community Services," January 2006.

8 Darzi, "Independent Investigation," summary letter, paras. 16 and 17.

1.1.2 The 10 Year Health Plan

The NHS 10 Year Health Plan for England: Fit for the Future was published on 3 July 2025.[9] The Plan sets out three shifts that between them define the strategic direction of NHS reform over the next decade: from hospital to community; from analogue to digital; and from sickness to prevention. It also commits to workforce development, including for technology adoption, to support them. The community shift is being delivered in part through neighbourhood health services, which bring primary, community and mental health services together around a defined local population. The first wave followed separately: on 9 September 2025 the Government announced 43 areas as the first phase of the National Neighbourhood Health Implementation Programme, backed by £10 million and prioritising areas with the lowest healthy life expectancy and the longest waits for care.[10]

All three shifts depend on primary care. Moving care from hospital to community means more of it happens in general practice, pharmacies, dental practices, and optometry. Moving from analogue to digital depends on primary care too, because it changes how patients reach these services, and requires the systems those services use, which currently cannot exchange information, to be able to do so. Moving from sickness to prevention relies on primary care, because that is where prevention, early diagnosis and continuity of care mostly happen. Whether the funding, workforce and commissioning arrangements are in place to carry these three shifts is the question this report examines.

1.1.3 The NHS Modernisation Bill

The NHS Modernisation Bill 2026 introduced the path through which government is restructuring the NHS's national and regional architecture.[11] The Bill absorbs NHS England into the Department of Health and Social Care (DHSC), alters the arrangements for Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs), and reforms Healthwatch and the wider patient voice architecture. Its implications for primary care are substantial: it changes who commissions primary care services, how patient voice is heard in that commissioning, and how integration with the wider system is enabled or constrained. The Bill would also remove the statutory requirement for an Integrated Care Board to include a member nominated by primary medical care providers, alongside the equivalent requirements for local authorities and NHS

9 Department of Health and Social Care, "Fit for the Future: The 10 Year Health Plan for England," July 2025 (online: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future).

10 Department of Health and Social Care, "Millions of People to Benefit from Healthcare on Their Doorstep," press release, 9 September 2025.

11 NHS Modernisation Bill 2026, as introduced.

trusts.[12] Chapter 7 returns to what that would mean for primary care's place in commissioning. The Neighbourhood Health Framework of March 2026 sets out the delivery approach for the neighbourhood health commitments and forms part of the same architecture.[13] It places general practice at the centre of neighbourhood health and states that the contribution of community pharmacy, dentistry, and optometry will be considered over the coming years, while their separate reform programmes continue.

Alongside these policy developments, the departmental and cabinet changes announced on 21 July 2026 have implications for several of the report's recommendations. The Department for Science, Innovation and Technology (DSIT) has been dissolved, with its business, innovation, science and trade functions absorbed into the new Department for Business, Innovation, Science and Trade (DBIST). A Department for Digital, Culture, Media and Sport (DCMS), has been strengthened and restyled to restore the digital brief it held before 2023. It now holds responsibility for digital foundations, digital transformation, digital inclusion and skills, information resilience, and online harms, including the data infrastructure that underpins this report's recommendations on open data standards. Responsibility for artificial intelligence (AI) strategy and public sector AI adoption has moved to the Cabinet Office, with a new AI Taskforce established within the newly created Office for the Prime Minister and the Cabinet.[14] These changes followed the change of Prime Minister on 20 July 2026 and the accompanying ministerial appointments, which produced a new Secretary of State for Health and Social Care and a new ministerial team. The programme this report addresses will now be taken forward by this new ministerial team. The recommendations are designed to remain relevant through that transition, focussing on the structural challenges facing primary care and the longer-term direction of reform rather than on the specific institutional arrangements in place at the time of publication.

1.2 What the research tells us about primary care access

This Inquiry reviewed the existing academic and policy literature alongside its own evidence gathering. This section sets out the findings that bear most directly on the report's arguments.

The key principle underpinning research on primary care and inequality is Julian Tudor Hart's 1971 'inverse care law'. It describes a simple pattern: the people and communities with the greatest healthcare needs often have the poorest access to good medical care.[15] This idea has

12 Health Bill 2026–27, as introduced, provisions amending Integrated Care Board membership requirements. The Bill was before Parliament at the time of writing.

13 NHS England and Department of Health and Social Care, "Neighbourhood Health Framework," March 2026.

14 "Machinery of Government Changes," Written Ministerial Statement HLWS298, 21 July 2026.

15 Julian Tudor Hart, "The Inverse Care Law," The Lancet 297, no. 7696 (1971): 405–12.

influenced research on health inequalities for more than fifty years. Reassessments published in The Lancet on the paper's fiftieth anniversary concluded the law to be as relevant now as in 1971, with Cookson and colleagues proposing a refinement of the concept to apply to wealthy countries with universal healthcare coverage. In those systems, disadvantaged people may receive more care in total, but of lower quality, and still far less than their much greater needs require.[16]

That refinement matters for how access statistics are interpreted throughout this report. Similar or higher levels of service use among disadvantaged groups should not be taken as evidence of equal access, because these groups may have greater healthcare needs. Utilisation figures cannot count the people who never made it into the system in the first place. The British Dental Association's (BDA) recent analysis identifies 5.4 million adults who did not attempt to secure NHS dental care because they believed the attempt would fail.[17]

The candidacy framework, developed by Dixon-Woods and colleagues, describes the barriers that may affect an individual patient's ability to access care.[18] It treats access not as a door that is simply open or closed, but as something continually negotiated between the patient and the system. This includes whether a person sees themselves, and is seen by others, as having a legitimate claim to care. It also depends on how difficult the system is to navigate, how easy services are to enter, how eligibility is judged at the point of contact, and whether previous experiences make someone more or less likely to seek care again. The framework recurs throughout this report because it names experiences that the Inquiry heard about repeatedly. Total triage changes how hard general practice is to get into. Digital 'front doors', such as online booking systems, consultation forms and the NHS App, can increase the effort required to navigate services. Being turned away at registration is a decision made by a person, that someone does not qualify.

And for inclusion health populations, meaning groups who are socially excluded and experience much worse health as a result, these failures compound at every stage.

Inclusion health is a broad category, covering people experiencing homelessness, Gypsy, Roma and Traveller communities, people in contact with the justice system, people with substance dependence, and people whose immigration status is uncertain, among others. What they have in common is encountering several of these barriers, if not all of them, at once.

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16 Richard Cookson and others, "Health Equity, Universal Coverage, and the Inverse Care Law: A Global Reassessment," The Lancet 397, no. 10276 (2021).

17 British Dental Association, written evidence to the Inquiry, 2026.

18 Mary Dixon-Woods and others, "Conducting a Critical Interpretive Synthesis of the Literature on Access to Healthcare by Vulnerable Groups," BMC Medical Research Methodology 6, no. 35 (2006).

A substantial body of recent work locates one driver of the inverse care law in how general practice is funded. The Health Foundation's analysis 'Level or Not?' found that practices receive broadly similar funding per registered patient, regardless of the level of deprivation in the population they serve.[19] However, when funding is adjusted for the greater healthcare needs of more deprived populations, the pattern reverses. Practices serving the most deprived communities receive around 7 per cent less funding per patient relative to need. A later analysis, looking across all practice income streams rather than core funding alone, put the gap at 9.8 per cent in 2022/23.[20] Later analysis for the Nuffield Trust set out why the problem has proved so hard to fix, attributing it principally to the Carr-Hill allocation formula, which relies on decades-old data to weight funding according to how GPs spend their time rather than how much care a population needs.[21]

The strength of the finding is demonstrated in the fact that four studies, using different methods and different datasets, all reached the same conclusion. Levene and colleagues found that a 10 per cent increase in deprivation produced a funding increase of only 0.06 per cent.[22] Currie and colleagues, working with Welsh data over time, found that funding fell by approximately 1 per cent for every 10 per cent increase in the proportion of most-deprived patients.[23] Boomla, Hull and Robson showed how borough-wide averages in east London made high-need populations look adequately funded when they were not.[24] Harper and colleagues, examining every small area in England, found that adjusting for age and deprivation improved the accuracy with which both the Carr-Hill Index and total funding predicted clinical need, across every model they tested.[25]

Community pharmacy, NHS dentistry, and optometry each have their own literatures on access and workforce, developed largely separately from the general practice literature. The cost of that separation shows in one of the review's most striking findings. Community pharmacy has historically worked against the inverse care law rather than with it, with better provision in more deprived areas than in less deprived ones, a pattern known as the positive pharmacy care law.[26] Evidence to the Inquiry showed that this protection is now eroding, with a 12 per cent reduction in pharmacies in the most deprived areas of England over the past decade against 3 per cent in

19 Fisher, R., and others, "Level or Not? Comparing General Practice in Areas of High and Low Socioeconomic Deprivation in England," Health Foundation, 2020.

20 Department of Health and Social Care, announcement of the review of the Carr-Hill formula, October 2025.

21 Fisher, R., Loftus, L., Holdroyd, I. and Ford, J., "Fairer Funding for General Practice in England: What's the Problem, Why Is It So Hard to Fix, and What Should the Government Do?" Nuffield Trust and Health Equity Evidence Centre, December 2024.

22 Levene, L. S., and others, "Socioeconomic Deprivation Scores as Predictors of Variations in NHS Practice Payments: A Longitudinal Study of English General Practices 2013–17," British Journal of General Practice 69, no. 685 (2019): e546–e554.

23 Currie, J., and others, "Exploring the Equity of Distribution of General Medical Services Funding Allocations in Wales: A Time-Series Analysis," BJGP Open 9, no. 1 (2025).

24 Boomla, K., Hull, S. and Robson, J., "GP Funding Formula Masks Major Inequalities for Practices in Deprived Areas," BMJ 349 (2014): g7648.

25 Harper, R. A., and others, "Deprivation and NHS General Ophthalmic Service Sight Testing Activity in England in 2022–23," Ophthalmic and Physiological Optics 45, no. 1 (2025): 294–300.

26 Todd, A., and others, "The Positive Pharmacy Care Law: An Area-Level Analysis of the Relationship between Community Pharmacy Distribution, Urbanity and Social Deprivation in England," BMJ Open 4 (2014): e005764.

the least deprived.[27] Literature that examines general practice alone cannot see this, because it cannot see one sector compensating for another, or that compensation is withdrawn. The argument that primary care access has to be understood as a four-sector question, rather than as a general practice question with sectoral appendices, is one of this report's distinctive contributions.

Finally, the evidence on who is being reached and who is being missed draws on both research and lived experience. The NHS Race and Health Observatory's research programme on access equity, and academic work on Gypsy, Roma and Traveller communities, coastal deprivation, and populations without a fixed address supports what the Inquiry heard directly from participants.[28] Evidence to the Inquiry presented findings that young people in deprived coastal communities report worse mental health than similarly deprived peers inland, and are 2.5 times less likely to receive a diagnosis when distressed, with an average wait of 22 months for a mental health referral in Clacton.[29] One patient described being refused registration by GP practices because they live on a boat and cannot give a fixed address, despite NHS guidance that this should not be required.[30] The patient also spoke to the difficulty of maintaining a consistent treatment pathway while living a mobile life. Further evidence to the Inquiry added that some boaters who have secured registration fear losing it if their circumstances become known, and that health data for this population is so sparse that need cannot be assessed.[31]

1.3 The case for change

Government policy has committed repeatedly to shifting care from hospitals into community-based settings. The 10 Year Health Plan places this shift at the heart of NHS reform. The NHS Long Term Plan of January 2019 and the 2022 integration White Paper set out the same direction, while Lord Darzi identified it as necessary.[32]

The funding architecture has not followed – in 2024/25, NHS spending on acute hospital care in England was £74.7 billion, approximately 43 per cent of the total, against £14.5 billion on primary care and £13.8 billion on community services.[33] The gap is also getting wider – since

27 William Pett, Head of Policy, Public Affairs and Research, Healthwatch England, Oral Evidence Session 1, 29 October 2025.

28 NHS Race and Health Observatory, written evidence to the Inquiry, 2026; Friends, Families and Travellers, "Locked Out: A Snapshot of Access to General Practice for Nomadic Communities during the COVID-19 Pandemic," 2021; oral evidence to the Inquiry from the Centre for Coastal Communities, University of Essex, and the Accessible Waterways Association, Oral Evidence Session 1, 29 October 2025.

29 Dr Emily T. Murray, Director, Centre for Coastal Communities, Institute for Public Health and Wellbeing, University of Essex, Oral Evidence Session 1, 29 October 2025.

30 Tim Clarke, Director, Accessible Waterways Association CIC, Oral Evidence Session 1, 29 October 2025.

31 Dr Jane Jervis, Keele University, Oral Evidence Session 1, 29 October 2025.

32 NHS England, "The NHS Long Term Plan," January 2019; Department of Health and Social Care, "Health and Social Care Integration: Joining Up Care for People, Places and Populations," February 2022.

33 Department of Health and Social Care, response to parliamentary question 117398, 25 March 2026, as reported in House of Lords Library, "Acute, Primary and Community Healthcare," 2026.

2018/19, overall NHS funding has risen by 39 per cent and secondary care funding by 43 per cent.[34] By comparison primary care funding has risen by 23 per cent, although its overall share of NHS funding has dropped. Meanwhile community pharmacy funding has fallen by around 30 per cent in real terms.[35] That fall in share can be tracked directly. The King's Fund records primary care as 9.5 per cent of the Department of Health and Social Care budget in 2022/23.[36] An answer to a parliamentary question covering the following year puts it at around 8.4 per cent, and the 2024/25 figures above give around 8 per cent.[37] The direction is consistent, and it runs against the stated policy of shifting care into the community. In other words, the sector the Government says it wants to expand has grown at roughly half the rate of the sector it wants to shift care away from.

> *"If they want to move workload into the community close to people's homes, they cannot keep giving disproportionately larger increases to where they do not want the activity to happen and starve where they do want it to happen. We cannot provide access on a shoestring."*
>
> ***Malcolm Harrison, Chief Executive, Company Chemists' Association, Evidence Session 2, 19 November 2025***

The access failures documented in this report are produced by how funding is distributed. A larger overall budget, distributed on the current pattern, would not resolve them. The issue lies in the distribution of funding between primary and secondary care, the distribution of workforce across the four sectors and across geographies and the distribution of commissioning arrangements including who is eligible to hold an NHS contract.

That is also why the report asks government to consider rebalancing NHS funding between primary care and acute hospital care through redeployment of existing NHS spending rather than through new money. Any future government, of any party, faces significant fiscal pressure from an ageing population supported by relatively fewer working-age taxpayers. The answer to this problem cannot always be new money – creative reallocation of existing resources has to be part of the solution. In order to assess where investment should be prioritised, stakeholders feeding our inquiry were asked to distinguish between what is desirable in the long term and what a government can demonstrate to an electorate within two or three years. The

34 Malcolm Harrison, Chief Executive, Company Chemists' Association, Oral Evidence Session 2, 19 November 2025.

35 Harrison, Oral Evidence Session 2.

36 The King's Fund, "Primary Care in a Nutshell," 2024.

37 House of Commons written answer UIN 2419, 17 November 2023; and Department of Health and Social Care, response to parliamentary question 117398, 25 March 2026.

recommendations in this report are organised by cost type for that reason. Where a recommendation would require additional investment, that element is written as something to do if funding becomes available, rather than as a condition of acting on at all. The rest of the recommendation can be implemented either way, so a government facing a difficult spending round can still act on most of what this report asks for.

Work by the Health Foundation and The Healthcare Improvement Studies Institute catalogued more than 400 efforts to improve access to general practice in the UK between 1984 and 2023, drawn from 449 sources.[38] Over the same four decades public satisfaction with access has continued to fall. The catalogue does not assess which efforts succeeded, and its authors do not claim that none did. What it establishes is that the shortage has not been a shortage of initiatives. This forms an argument for addressing the structures that keep producing the problem, rather than adding another intervention to the list aimed at its symptoms. This report does exactly that. The same body of work classified those interventions using the framework set out earlier in this chapter and found that most were about making services easier to get into: more appointments, new booking systems, different ways of contacting a practice. Far fewer addressed whether patients saw someone who knew them, whether they were believed, or whether anyone was holding their care together over time.

38 Health Foundation, "Rethinking Access to General Practice: It's Not All about Supply," 2024, appendix 1; and "What's Been Tried: A Curated Catalogue of Efforts to Improve Access to General Practice," BJGP Open, 2025, a Health Foundation and Healthcare Improvement Studies Institute study.

Chapter 2: What patients told the Inquiry

This chapter focusses on what patients told the Inquiry about their experiences of trying to access primary care. The analysis of why these things happen, and the figures that measure them are outlined in the chapters that follow. What is outlined here is the experience itself, because the structural argument this report makes is only worth making if it is anchored in patients' reality of trying to access primary care in England and failing.

The accounts are arranged around the journey a person makes when they need care. Some people never begin it; some are turned away at the door; some cannot get through in the time they have; some get in and then lose the thread of their care; and some, having failed everywhere, treat themselves.

2.1 Trying to get through: the 8am scramble

Healthwatch England hears from service users about their experiences every month. The top two concerns have remained the same for several years: difficulty getting a GP appointment, and difficulty accessing an NHS dentist.[39] Healthwatch England illustrated the first with an account shared through local Healthwatch in Lincolnshire.

> *"I absolutely dread the 8am call, where I call on the dot at 8am. I am 37th in the queue. I then have to go to work. I am still on hold for 20 to 30 minutes, not able to leave my phone, which as a teacher is impractical. I then get through to be told no appointments left, or someone will ring me but no idea when. So I have to be able to answer my phone when it rings when I ought to be teaching. I would love to be able to book an appointment myself."*
>
> ***A patient in Lincolnshire, shared through local Healthwatch and submitted in evidence by Healthwatch England, Evidence Session 1***

No clinician appears in the account. The failure happens entirely before care begins, in the gap between a person with a job and a system that expects them to be free at eight in the morning. Two things are worth drawing out. Firstly, this patient is not from any group that appears in inclusion health policy: a working teacher, with a phone, registered with a practice. Secondly,

39 William Pett, Head of Policy, Public Affairs and Research, Healthwatch England, Oral Evidence Session 1, 29 October 2025.

they know exactly what would fix it. Most of the evidence in this chapter contains similar features. People describe the barrier precisely, and they describe the remedy precisely, and neither is complicated.

2.2 Joy's experience

The most detailed account the Inquiry received came from Joy, who is co-author of a written submission to the Inquiry.[40] She has lived aboard a narrowboat for over twenty years, for most of that time as a continuous cruiser, which means she is required to move every fourteen days and therefore has no fixed address. NHS guidance is clear that this should not prevent someone from registering with a GP. However, Joy's account suggests otherwise.

"In March 2022, I intended to register as a temporary patient at a local surgery due to worrying breast pain. Here, I was told to register permanently as I would require an urgent hospital visit. My lack of address meant I was treated as if I were homeless using the practice address.

In September 2022, the practice then informed me that I could no longer use their address for registration. They offered two options: provide an alternative address, or be removed. Being in the position of receiving ongoing care from the hospital, and treatment for a lung infection, I felt pressured and anxious to rectify my situation. The only other address that I could give at the time was my Mother's house in Wiltshire. I offered this, explaining that it was postal only and that I did not live there. Following a brief face to face meeting with the practice manager, they informed me that they would not accept this and would therefore remove me from the practice. Despite writing several letters, emails, and contacting my local MP, nothing changed.

In November 2022 I made a formal complaint to NHS England after I was officially removed from the practice, whilst still receiving hospital treatment. Unfounded claims about my behaviour were then cited by the practice manager in response to this complaint. This caused me immense distress, and I felt stripped of my agency.

It took six months before I could face the prospect of registering at another practice despite needing medication for hypertension previously diagnosed at the last practice. I did this, only to be removed a few months later, again, due to the address issue. On 24th April 2024, one year and five months after my complaint, NHS England ruled against me."

Joy, co-author of the written submission from Dr Fred Barker.
Used with her consent.

40 Dr Fred Barker MBBS MPH, GP Registrar and Academic Clinical Fellow linked to Queen Mary University of London, written evidence to the Inquiry, 2026. Joy is a co-author of the submission and her account is reproduced with her consent.

Several aspects of Joy's experience are relevant to this report's argument. The removal happened while she was under hospital investigation for breast pain and receiving treatment for a lung infection. In other words, it happened at a critical point in her care. The removal of care also happened twice – costing her six months of hypertension medication in between. She did everything the system asks of a patient who has experienced a failure of care: writing letters, complaining formally, contacting her MP. Yet, it took seventeen months to be told she was wrong. And nothing about it required a policy change to prevent. The rules already said she should have been registered.

2.3 Tim Clarke's experience

Joy's experience is not isolated. Tim Clarke lives aboard a boat with his wife who is registered blind and has fibromyalgia. He described similar difficulties in trying to register for a GP.

> *"On my journey I did approach several surgeries. Some of them were very good and they used their surgery address in lieu of my address, which is quite acceptable and it is in the guidance. But there was one in London on the canal side, which said, no address, no way."*
>
> ***Tim Clarke, Director, Accessible Waterways Association CIC, Evidence Session 1, 29 October 2025***

Tim eventually registered with a London practice, but only after invoking discrimination law. He was then placed on a waiting list, faced four cancellations, and found that when he moved his boat on to Birmingham, his appointments could not travel with him. Tim also raised a further issue that the current system has no obvious way to address: people living nomadically have no fixed MP, and therefore no constituency route for escalation. When he raised his concerns, Healthwatch directed him to a local office he did not have, and NHS England told him to contact his local health authority about what is, as he put it, a national problem.

Research presented to the Inquiry by Keele University, highlighted findings from an engagement project across the canal network, identified the wider consequence of experiences like those of Joy and Tim Clarke.[41] Some boaters who have managed to register are now afraid they will lose access if their living arrangements become known. Once a system has shown that registration can be withdrawn, concealment is the rational response. In turn, this makes the nomadic population less visible to those responsible for planning and delivering services. The project participants summarised the problem in four words: no postcode, no doctor.

41 Jervis, Oral Evidence Session 1. The engagement project was funded through the National Institute for Health and Care Research School for Primary Care Research.

2.4 Getting in, but not being believed

For many patients, the barrier is not gaining access to primary care, but the experience they encounter once inside the system. Evidence to this Inquiry from the NHS Race and Health Observatory draws on a survey of more than 2,680 people, published in its 2025 report on patient experience and trust in NHS primary care.[42] Almost half of respondents from ethnic minority communities reported experiencing discrimination from their primary care providers. More than half of Asian and Black participants felt they were treated differently because of their ethnicity, or another personal characteristic. A third of South Asian participants said they rarely or never trust primary care to meet their health needs, against 16 per cent of White British participants.[43] Respondents from ethnic minority groups also reported poorer communication with their practices than White British respondents and were more likely to feel that their concerns were not taken seriously.

The submission identifies a pattern that was particularly pronounced among women. Women from minoritised ethnic groups frequently described that their reports of pain were ignored or minimised by care providers because of both their gender and ethnicity.

Evidence to the Inquiry set out why these experiences matter not only for how patients feel about their care, but for whether they seek it at all.[44] Mistrust does not reduce need; it changes what people do with it. A patient who expects to be dismissed may wait longer before seeking help, go somewhere else, or not go at all. The need is unchanged. What the system sees is one less patient asking for an appointment, which it records as lower demand. The same relationship between experience, trust, and access is particularly pronounced in mental health care. Evidence to the Inquiry from the Centre for Mental Health noted that around a quarter of GP consultations are about mental health, yet it is still often treated as though it were separate from primary care.[45] The consequences of getting this wrong are significant: the same evidence highlighted how people with a mental illness die fifteen to twenty years earlier, largely due to poor physical health.

Written evidence to the Inquiry describes how these shortcomings in primary care access are experienced by people seeking mental health support. Of approximately twelve thousand respondents to the Big Mental Health Survey 2025 who had tried to get support through a GP, 37 per cent had avoided contacting their GP because of negative past experiences.[46] One third

42 NHS Race and Health Observatory, written evidence to the Inquiry, 2026, drawing on "Patient Experience and Trust in NHS Primary Care," 2025. The underlying survey was issued in 2022 and analysed by researchers at the University of Oxford.

43 NHS Race and Health Observatory, written evidence.

44 Dr Veline L'Esperance, NHS Race and Health Observatory, Oral Evidence Sessions 1 and 2, 29 October and 19 November 2025.

45 Andy Bell, Chief Executive, Centre for Mental Health, supplementary interview with the Inquiry, 2026.

46 Mind, written evidence to the Inquiry, 2026, drawing on the Big Mental Health Survey 2025.

of those in need of support had decided not to seek it because they felt their problem was not serious enough. Over a third reported that their mental health had deteriorated while they were waiting, and over half said they would have benefited from a longer appointment. The same evidence identified some of the factors behind these experiences: a ten-minute appointment does not provide enough time to explore why someone is struggling, and the pathways available afterwards are often limited to medication or a talking therapy with a long wait.

2.5 Never counted: the people who stop trying

The largest patient group in this chapter is the one that never appears in measures of access, because those measures count only the people who made contact.

Dentistry is one sector where this gap has been quantified most clearly. British Dental Association (BDA) analysis identifies millions of adults who did not attempt to secure NHS dental care because they already believed they would be unable to get an appointment, alongside a further group who were eligible for care but deterred by the cost (chapter 4 sets out the figures in more detail).[47] What matters for this chapter is the scale of unmet need among people who miss out on care because they do not attempt to access it in the first place. Among them are those who concluded in advance that attempting access was pointless, and as our report suggests, they may have been right.

Similar reports pertaining to missed access opportunities for those with primary care needs are prevalent across other sectors. Evidence to the Inquiry described people who are unaware that they are entitled to free NHS sight tests, and therefore never make use of that entitlement. People with learning disabilities are considerably less likely to receive eye tests than the general population, despite being significantly more likely to have undiagnosed and uncorrected sight problems.[48] The people least able to report a visual problem are therefore the least likely to be tested for one.

Research presented to the Inquiry shows reports of worse mental health among young adults in deprived coastal communities than similarly deprived peers inland.[49] When distressed, young adults in deprived coastal communities are two and a half times more likely to go undiagnosed.[50] The research team tested whether this was about distance from services, transport or the built environment, and found it was not: the prevalence tracks concentrated poverty, low incomes, insecure private renting and limited access to education. On why distressed young people in

47 British Dental Association, written evidence to the Inquiry, 2026.

48 SeeAbility, written evidence to the Inquiry, 2026.

49 Ibid.

50 Dr Emily T. Murray, Director, Centre for Coastal Communities, Institute for Public Health and Wellbeing, University of Essex, Oral Evidence Session 1, 29 October 2025.

these communities are not diagnosed, the researchers told the Inquiry that there was no research at all. These are not people avoiding services – they are people the system is in contact with and does not see. In Clacton, local services told the research team that the average wait for a mental health referral is 22 months, long enough for a young person to move from child to adult services without ever being seen.

2.6 Losing the thread: the care nobody holds together

For those who manage to access care, the Inquiry evidence shows that the problem does not end there: continuity, coordination, and the ability to navigate between services become critical to the quality of care they receive.

Research submitted by National Voices, conducted with Ipsos, tested a common assumption: that accessing services is the problem, but that the quality of care is fine once you are seen.[51] However, for people with multiple long-term conditions, who are among the heaviest users of the health service, that assumption does not hold. Instead, the more services they interact with, the worse their experience of quality becomes. However, the same research found that patients with a named, consistent point of contact report satisfaction of around 90 per cent, against around 70 per cent for those without.[52]

The King's Fund, National Voices, and Healthwatch England research 'Lost in the System' documents what fills the gap when no one takes responsibility for coordinating a patient's care throughout services. In these cases, patients are left chasing up on information, repeating conversations with multiple practitioners, re-explaining their symptoms, and consistently following up. All at the point of need when they are least able to do so.[53] Further evidence to the Inquiry built upon this observation: people experiencing financial disadvantage and poor mental health are less able to advocate for themselves and chase appointments, tests, and medication, and are correspondingly more likely to fall off the radar of services until they present in crisis somewhere more expensive.[54]

One submission to the Inquiry follows one condition through this architecture and shows what happens when nobody is routinely checking in. Chronic kidney disease was removed from the Quality and Outcomes Framework in 2015, which meant practices were no longer paid for the checks that monitored it. The proportion of patients on the disease register whose notes

51 National Voices and Ipsos, research submitted to the Inquiry, 2026.

52 Ibid.

53 The King's Fund, National Voices and Healthwatch England, "Lost in the System: The Need for Better Admin in the NHS," February 2025.

54 Mind, written evidence to the Inquiry, 2026.

recorded the relevant urine test fell from 75.4 per cent in 2014-15 to 40.2 per cent the following year and has not recovered since.[55] What was lost was not only the test but the routine occasion for someone in primary care to review the patient at all. Deterioration that would once have been picked up in a scheduled check now goes unnoticed until the patient becomes unwell enough to present in an emergency. The submission's own phrase for this is that patients 'crash land into accident and emergency'.

The same submission records what happens at the other end of that gap. Some kidney patients now learn of their diagnosis by reading a result in the NHS App, before anyone has spoken to them about what it means. A test result can now reach a patient faster than any clinician takes responsibility for explaining it, which is the coordination problem in its most immediate form.

2.7 Going without: treating yourself

The consequences of failed access are visible in the alternative routes people use when primary care is unavailable or inaccessible.

One in seven people who cannot get an NHS dental appointment carry out dental procedures on themselves, and one in ten present at accident and emergency or call NHS 111.[56] This leads to patients with dental problems arriving at GP surgeries and accident and emergency departments, particularly on Friday afternoons, despite neither setting being equipped to provide dental treatment.[57] In some places this happens because there is nowhere else to go. A Healthwatch Cornwall survey of eighty dental practices found not one accepting new adult NHS patients.[58]

Re-engage's 2026 report 'Care on Hold' found older people delaying care, resorting to NHS 111, or treating themselves when the booking routes they had always used were withdrawn.[59] Age UK's analysis shows how many people may be affected by this shift towards digital access: around 2.4 million people aged 65 and over use the internet less than once a month or not at all, while 69 per cent of those aged 75 and over cannot complete the basic tasks required to use the internet safely.[60] As more primary care access moves online, these patients risk being excluded not because they are unwilling to seek care, but because the routes available to them are no longer accessible.

55 Kidney Research UK, written evidence to the Inquiry, 2026.

56 Pett, Oral Evidence Session 1.

57 Shawn Charlwood, British Dental Association, Oral Evidence Session 1, 29 October 2025.

58 Healthwatch Cornwall, survey of eighty dental practices, cited in evidence to the Inquiry, 2026.

59 Re-engage, "Care on Hold," 2026.

60 National Voices and Ipsos, research submitted to the Inquiry.

2.8 What patients asked for

The evidence in this chapter is not a list of complaints. In almost every case the people sharing insights also described the remedy, and the remedies are strikingly consistent, modest, and cheap.

They asked to be able to book an appointment themselves, at a time they choose. They asked for a named person who knows them. They asked for the choice of a phone, a counter or a screen, rather than one route for everyone. They asked to be registered when the rules already say they must be. They asked not to explain themselves from the beginning every time. They asked to be believed. And they asked for support when it comes to coordinating care across services. Evidence to the Inquiry from the Health Equity Evidence Centre reiterated a similar finding from a medical professional perspective: patients often want to feel the receptionist is on their side more than they want app-based access.[61] Each of these asks reappears later in this report as a recommendation: booking and choice of route in Recommendation 6, registration in Recommendation 2, being counted in Recommendation 1, and continuity of care in Recommendation 13.

None of these requests call for more of the existing system – together, they point to a different way of organising access and continuity of care. Chapter 3 identifies the three structural patterns that help explain why achieving that change has proved so difficult.

61 Dr John Ford, Director, Health Equity Evidence Centre, Oral Evidence Session 1, 29 October 2025.

Chapter 3: The three structural patterns

3.1 The analytical framework

The evidence presented in the prior chapters distils down into three structural patterns that surface across all four sectors and explain the access failures this report documents.

The first is how NHS funding is distributed: between primary care and acute hospital care, and within primary care across different sectors and parts of the country.

The second is why trained staff are not being used to meet NHS demand. In each of the four sectors there are qualified clinicians who do no NHS work, or less of it than their training allows. Dentists who see private patients rather than NHS ones. Pharmacists qualified to prescribe who currently have no NHS service to prescribe in. Optometrists whose equipment and skills are not commissioned in their area. The question is what the system does, or fails to do, that leaves that capacity unused. This is a question about how services are organised and paid for, not about the willingness of individual clinicians.

The third is how commissioning arrangements decide what care is available and to whom, including who is eligible to hold an NHS contract in the first place.

This chapter is organised around these three structural patterns that cut across the primary care sectors. Although these patterns take different forms in each sector, each has implications for inequalities in access and outcomes, which are examined in the sections below, and they are interconnected, as Section 3.5 sets out. These three patterns are not intended to be exhaustive, rather they reflect the issues that emerged most consistently throughout the Inquiry and provide the structure for the recommendations that follow.

3.2 Pattern one: how funding is distributed

The way NHS funding is distributed produces primary care access failures more reliably than the overall level of NHS funding does. A larger overall budget shared out on the current pattern would not resolve them.

In 2024/25, NHS spending on acute hospital care in England was £74.7 billion, approximately 43 per cent of the total. Spending on primary care was £14.5 billion and on community services £13.8 billion.[62] The gap is not only wide but widening. Since 2018/19, overall NHS funding has increased by 39 per cent and secondary care funding by 43 per cent, while primary care funding has increased by 23 per cent and community pharmacy funding has fallen by around 30 per cent in real terms. The share has moved with it: primary care accounted for 9.5 per cent of the departmental budget in 2022/23 and around 8 per cent by 2024/25. Funding has risen in cash terms while the proportion going to primary care has fallen, which is the opposite of the shift successive governments have promised.[63] Government policy over the same period has committed repeatedly to shifting care from hospitals into community-based settings. The money has moved in the opposite direction to the policy. Lord Darzi found the same pattern over a longer horizon: between 2006 and 2022 the hospital share of the NHS budget rose from 47 per cent to 58 per cent, across a period in which successive governments promised the opposite.[64]

43% and 23%

The increase in NHS secondary care funding since 2018/19, against the increase in primary care funding over the same period. Overall NHS funding rose by 39 per cent. Community pharmacy funding fell by around 30 per cent in real terms.

Source: Malcolm Harrison, Chief Executive, Company Chemists' Association, Evidence Session 2, 19 November 2025.

The scale at which general practice absorbs this is easily lost. Around 1.7 million people access NHS care in England every day, and approximately 1.5 million of those contacts are in general practice.[65] A practice receives around £130 per weighted patient per year through the global sum, and that sum covers unlimited appointments, prescriptions and investigations for that patient across the year. The weighting is what the Carr-Hill formula determines, so the sum a practice actually receives for each person on its list depends on how the formula scores that population.[66] A single attendance at an emergency department costs the taxpayer more than a year of that patient's general practice care.

62 Department of Health and Social Care, response to parliamentary question 117398, 25 March 2026, as reported in House of Lords Library, "Acute, Primary and Community Healthcare," 2026.

63 Malcolm Harrison, Chief Executive, Company Chemists' Association, Oral Evidence Session 2, 19 November 2025.

64 Lord Darzi, "Independent Investigation of the National Health Service in England," Department of Health and Social Care, September 2024, summary letter, para. 13.

65 Dr Katie Bramall-Stainer, Chair, General Practitioners Committee, British Medical Association, supplementary interview with the Inquiry, 12 June 2026.

66 Ibid.

The funding position differs across primary care sectors, but in each case the evidence points to substantial gaps between the cost of delivering services and the resources available to sustain or expand provision. In community pharmacy, an independent economic analysis by Frontier Economics and IQVIA, commissioned by NHS England and published on 28 March 2025, found that the cost of delivering NHS pharmaceutical services in England in 2023/24 was £5.06 billion against funding of £2.76 billion, a shortfall of £2.3 billion.[67] It found that 99 per cent of pharmacies received less funding than the full cost of delivering those services, and that nearly eight in ten were not financially sustainable in the short term. More than 1,300 pharmacies have closed since March 2017, over ten per cent of the network, and the Company Chemists' Association reports that 51 per cent of pharmacy owners are operating at a loss, with 45 per cent of those using personal savings to stay open.[68] In NHS dentistry, an acknowledged shortfall of around £1.5 billion has been identified for dental contract reform.[69] In optometry, an additional funding requirement of around £350 million is needed to reduce the gap for existing services and to commission wider NHS optometry services in areas that currently do not have provision.[70]

The funding pattern is not evenly distributed geographically or by deprivation, creating further inequalities in access to care. Community pharmacy has historically worked against the inverse care law rather than with it, with better provision in poorer areas than in wealthier ones. That is now reversing. Peer-reviewed analysis of pharmacy availability across England between 2014 and 2023 found an 11.8 per cent reduction in the most deprived fifth of areas, against 3 per cent in the least deprived, and that the most deprived areas were 65 per cent more likely to lose a pharmacy.[71] In dentistry the geographic disparity is starker still: adult access ranges from 23 per cent in Peterborough, the lowest in England, to 68 per cent in Cumbria, the highest. For children the range runs from 38 per cent in Hackney to 78 per cent, again in Cumbria.[72]

Within general practice, the distributional problem is not only about allocation between sectors. One participant in the first evidence session identified that practices working in the most challenging conditions receive lower funding relative to the complexity of their work, not because the total sum is inadequate but because the Carr-Hill formula distributes it in ways that penalise deprivation.[73] However, he also warned that reforming that formula alone would

67 Frontier Economics and IQVIA, "Economic Analysis of NHS Pharmaceutical Services in England," commissioned by NHS England, March 2025.

68 Company Chemists' Association, written and oral evidence to the Inquiry, 2026.

69 Frontier Economics and IQVIA, "Economic Analysis"; Company Chemists' Association, written and oral evidence; and British Dental Association, written and oral evidence. The 51 and 45 per cent figures are from the Community Pharmacy England Pressures Survey.

70 Association of Optometrists, written and oral evidence to the Inquiry, 2026.

71 William Pett, Head of Policy, Public Affairs and Research, Healthwatch England, Oral Evidence Session 1, 29 October 2025.

72 British Dental Association, written evidence, cited by Shawn Charlwood, Oral Evidence Session 1, 29 October 2025.

73 Dr John Ford, Director, Health Equity Evidence Centre, Oral Evidence Session 1, 29 October 2025.

not be sufficient. Roughly half of general practice income is distributed through the formula, which allocates funding for each registered patient adjusted for the characteristics of the population. The remainder comes through a combination of Quality and Outcomes Framework incentive payments, dispensing payments, enhanced service contracts and other funding streams, each of which can produce inequalities of its own. Adjusting Carr-Hill while leaving the rest untouched, he argued, would not produce the intended result. Instead, he described the major long-term challenge as aligning these different incentive structures so that they work together to improve access for underserved groups.

The current Carr-Hill review, led by the National Institute for Health and Care Research, provides an opportunity to begin that wider reform, with a stated aim of implementing a replacement formula from April 2027. However, reform of the formula also carries risk. One interview participant explained that practice funding baselines were set in 2004, while the populations those practices serve have changed considerably since.[74] These baselines pay for the staff and services practices currently employ and provide. If the same total sum is simply shared out differently, some practices gain and others lose, and the losses fall on money already committed to salaries and services. Practices that have been stable for years could become unviable. The same evidence was equally clear that the current formula does not work well and does not adequately account for deprivation or populations with greater health needs. The concern, therefore, is not with reform itself, but with reform carried out without any increase in the total amount being shared.

This is why the report presents two changes together rather than separately: a mechanism to grow the primary care share of NHS funding, and reform of the formula that decides how that funding is shared between practices. Both are set out in Recommendation 7 in Chapter 6. Changing how the money is divided, without increasing how much there is to divide, moves the harm around rather than removing it. Funding must also move from acute hospital care into primary care, which increases the total available to practices. The formula then determines how that larger total reaches them. The Investment Standard and formula reform depend on each other.

74 Bramall-Stainer, supplementary interview.

3.3 Pattern two: trained but not deployed

The workforce failures the Inquiry documented are mainly failures of deployment rather than of workforce numbers. In all four sectors there are clinicians who have completed the necessary training and are doing no NHS work, or far less of it than their qualifications allow. The gap between how many clinicians are trained and how many are working within the NHS is therefore central to understanding this pattern.

General practice illustrates this pattern most visibly. Evidence from the Royal College of General Practitioners identified that retention is a more pressing challenge than the number of training places, and that morale is falling as fragmentation of care, system-generated bureaucracy, and the loss of continuity erode professional satisfaction.[75] The King's Fund analysis of the general practice employment paradox sharpens the point. Newly qualified GPs report difficulty finding posts despite widespread shortages. Core practice funding has not kept pace with the cost of employing GPs. At the same time, the Additional Roles Reimbursement Scheme has funded around 42,500 additional non-GP full-time equivalent staff at no direct cost to practices, making funded non-GP roles more attractive to employers than unfunded GP posts.[76]

Dentistry further illustrates this issue with approximately 46,000 dentists registered with the General Dental Council across the UK, a rise of ten per cent over six years.[77] In England, around 25,000 of them do some NHS work, but most do only a little of it: their combined NHS activity amounts to the equivalent of about 11,000 full-time dentists.[78] England has the lowest NHS commitment of the four UK nations, at 39 per cent against approximately 50 per cent in Scotland, with six in ten dentists considering leaving the NHS. A dental practitioner giving evidence to the Inquiry put this trajectory in simple terms: at Newcastle Dental School, where he lectures, not a single final-year student told him they saw themselves working in the NHS in five years.[79] The supply of dentists has grown, yet the supply of dentists willing to work under current NHS terms has not.

The share of high street dental practices holding an NHS general dental contract fell from 64.6 per cent in 2017 to 55.6 per cent in 2026, a drop of nine percentage points.[80] At least 600 practices gave up a general contract over that period, while the number of practices without one, largely private or specialist, rose by more than 1,000.

75 Dr Victoria Tzortziou-Brown, Royal College of General Practitioners, Oral Evidence Session 2, 19 November 2025.

76 The King's Fund, "Why GP Trainees Are Worried about Finding Jobs (the GP Employment Paradox)," 2026.

77 Shiv Pabary MBE, Chair, General Dental Practice Committee, British Dental Association, Oral Evidence Session 2, 19 November 2025.

78 Ibid.

79 Ibid.

80 Seville, H. and Dayan, M., "The Great Extraction: The Changing State of NHS General Dental Services in England," Nuffield Trust, August 2026; Nuffield Trust analysis of Care Quality Commission Care Directory and NHS Business Services Authority contractor files, March 2017 to March 2026.

The decline was near universal: 41 of the 42 Integrated Care Board areas saw a reduction.[81] Activity remains around 8 per cent below pre-pandemic levels. The contract has not been withdrawn from anyone. Practices have withdrawn from the contract.

46,000 registered. The equivalent of 11,000 full-time.

Dentists registered with the General Dental Council across the UK, against the full-time equivalent delivering NHS activity in England. Around 25,000 do some NHS work, but most do only a little of it.

Source: Shiv Pabary, British Dental Association, Evidence Session 2, 19 November 2025.

The case of community pharmacy describes this same pattern. In 2024, approximately 2,500 independent prescribers were working in community pharmacy, around 9 per cent of that workforce. Of those qualified prescribers, only around 9 per cent were actually using the qualification.[82] From summer 2026 most pharmacists joining the register hold a prescribing qualification from the point of registration, but the model under which that expanded scope operates in community pharmacy is not yet settled.[83] One evidence session participant was clear that without the right funding, premises, training investment and support, the potential will not be realised.[84] The training capacity exists and is growing rapidly.[85] However, the commissioning, funding, and workflow architecture that would let those pharmacists use the qualification at scale is missing.

The same pattern can also be found in optometry. A witness from the optometry sector identified the extent to which eye care pressures are falling elsewhere in the system.[86] Around 2 per cent of all GP appointments relate to eye conditions. The ophthalmology waiting list stands at around 600,000, including 15,000 people who have been waiting for more than a year.[87] Around 70 per cent of patients attending accident and emergency with eye conditions could instead have been seen in an optometry practice, while only 24 per cent of hospital eye departments report having enough consultants to deliver the care required.[88] The infrastructure

81 Ibid.

82 Harrison, Oral Evidence Session 2.

83 Royal Pharmaceutical Society, written evidence to the Inquiry, 2026.

84 Harrison, Oral Evidence Session 2.

85 Ibid.

86 Dr Peter Hampson, Clinical and Policy Director, Association of Optometrists, Oral Evidence Sessions 1 and 2, 29 October and 19 November 2025.

87 Ibid.

88 Association of Optometrists, written evidence.

to relieve this pressure is largely already in place. Optical coherence tomography scanners, which detect early macular degeneration, glaucoma and retinal detachment, are installed in around 3,000 practices.[89] But enhanced optometry services are commissioned in only about 75 per cent of the country, so in the remaining quarter there is no route through which those scanners can be used for NHS work. Where the services are commissioned the results are strong: an evaluation in Manchester found close to a 40 per cent reduction in eye department attendances, and audits in Lambeth and Lewisham found 95 per cent of patients managed appropriately with no serious adverse events.[90] The equipment is already installed and the workforce is trained, but in a quarter of the country the commissioning pathway needed to use that capacity is missing.

The inequality dimension of this pattern is not only about where workforce capacity is deployed, but about which staff are able to progress, remain and develop within the primary care workforce. One contributor identified the structural inequalities minority ethnic staff face in primary care, and how workforce diversity affects patient experience and access.[91] Shortfalls show up in who progresses, who is retained, and who is supported to develop, rather than in the total numbers trained. This is the same pattern operating at the level of individual careers rather than whole sector.

The same deployment problem can be seen across the wider multi-professional primary care workforce. The Royal College of Nursing identified that nursing capacity in general practice has expanded through the Additional Roles Reimbursement Scheme.[92] However, current funding and career progression arrangements do not support the retention and deployment of that workforce in ways that reduce access barriers for patients with complex needs. The Royal College of Occupational Therapists similarly identified that occupational therapists in first-contact primary care roles can significantly reduce demand on GPs for patients with functional impairment, but that referral routes and commissioning do not consistently enable that redirection.[93] Written submissions from the Chartered Society of Physiotherapy, the Royal College of Podiatry, and NHS England Workforce, Training and Education reinforced the same theme: trained staff are not being deployed at scale against NHS primary care activity, and this is a consequence of system design rather than of workforce numbers.[94]

89 Association of Optometrists, written and oral evidence.

90 Association of Optometrists, written evidence.

91 Dr Veline L'Esperance, NHS Race and Health Observatory, Oral Evidence Sessions 1 and 2, 29 October and 19 November 2025.

92 Royal College of Nursing, written evidence to the Inquiry, 2026.

93 Royal College of Occupational Therapists, written evidence to the Inquiry, 2026.

94 Chartered Society of Physiotherapy, Royal College of Podiatry, and NHS England Workforce, Training and Education, written evidence to the Inquiry, 2026.

The recommendations that respond to this pattern are Recommendation 10 (train, employ and retain the primary care workforce across four sectors) and the workforce-facing elements of Recommendation 5 (safe technology adoption, including workforce training) and Recommendation 11 (neighbourhood health workforce and matching capital plan).

3.4 Pattern three: how commissioning arrangements decide who gets what

The third pattern is that commissioning arrangements shape what care is available and to whom, across all four sectors. The problem lies in how commissioning is structured and its fragmentation across the four sectors. The rules governing who may hold a contract, and what a contract pays for, were written for services delivered by one provider at a time. They do not fit models where several professions or organisations work together. And the incentives commissioning creates do not reliably align with what the evidence says is needed.

Dentistry shows how commissioning contracts can work against the outcome they intend to achieve. The Unit of Dental Activity system pays a practice the same amount for a course of treatment regardless of how complex it is, which means a practice is paid the same for a single filling as for a patient needing extensive work. Evidence from a contributor from the dental sector set out the consequences of this directly.[95]

> *"Dentistry is now the clearest example of what happens when a contract is allowed to fail. The system I work in disincentivises prevention, it penalises complexity, and it makes it financially impossible to take on new patients and high needs patients."*
>
> ***Shiv Pabary MBE, Chair, General Dental Practice Committee, British Dental Association, Evidence Session 2, 19 November 2025***

The same witness proposed a specific interim measure while wider contract reform is negotiated: raising the minimum Unit of Dental Activity value to £40 in the most deprived and underserved areas, where the current rate makes it impossible to recruit dentists or sustain practices. The witness stressed that this would involve redistributing funding within the existing envelope rather than providing additional money. Dorset and parts of the North East were used as examples of where targeted increases had helped stabilise access in high-need communities.

95 Pabary, Oral Evidence Session 2.

The chain runs from the contract to the patient and back again. Because the contract pays the same regardless of complexity, practices reduce their NHS commitment, as the workforce evidence in section 3.3 sets out. Fewer NHS appointments are available. Patients who cannot get one eventually stop trying. And because they have stopped trying, they no longer appear in the figures that measure demand, so the commissioning failure that pushed them out also conceals how many people it has affected.

In England, 13.3 million people have unmet need for NHS dentistry, of whom 6.2 million report that they did not think they could get an NHS dentist.[96] This is a modest improvement on the equivalent 2025 figure of 13.8 million, but total unmet need remains above 13 million. Separate BDA analysis identifies 5.4 million adults who did not attempt to get NHS dental care at all because they believed the attempt would fail, and 1.25 million who were put off by the cost.[97]

When people cannot get NHS dental care, the cost does not disappear, instead it moves to other parts of the NHS. A witness representing the dental sector noted that a wisdom tooth extraction costs in excess of £1,000 in a hospital setting and approximately a tenth of that in a general dental practice, and that patients with dental problems are presenting instead at GP surgeries and accident and emergency departments, particularly on Friday afternoons.[98] One in seven people who cannot get an NHS dental appointment carry out dental procedures on themselves, and one in ten present at accident and emergency or call NHS 111.[99]

Fragmentation between the four sectors also has direct consequences for patient safety. A witness from the dental sector identified that NHS dentists have no access to the Summary Care Record, which means a dentist carrying out an extraction may have no way of knowing that the patient is taking blood thinners.[100] The same point was made in later evidence: there is no routine data sharing between dentistry and the rest of primary care, no access to the shared record, and no commissioning framework for joined-up care.[101]

96 British Dental Association, analysis provided to the Inquiry, 2026, based on GP Patient Survey data.

97 British Dental Association, written evidence.

98 Shawn Charlwood, British Dental Association, Oral Evidence Session 1, 29 October 2025.

99 Pett, Oral Evidence Session 1.

100 Charlwood, Oral Evidence Session 1.

101 Pabary, Oral Evidence Session 2.

12% and 3%

Approximate rate of net community pharmacy closures over the past decade in the most deprived areas of England, compared with the least deprived. Community pharmacy has historically been better distributed in poorer areas than in wealthier ones. That pattern is now reversing.

Source: William Pett, Healthwatch England, Evidence Session 1, 29 October 2025.

In optometry, a technical question about who may hold a contract underpins the sector's ability to work at scale. One stakeholder identified that Local Optical Committees cannot legally hold NHS contracts under current arrangements, and that provider companies such as Primary Eyecare Services are the appropriate contract-holders.[102] A further interview participant identified that the lack of digital connectivity between optometry practices and the wider NHS creates unnecessary friction and duplication.[103]

How that connectivity gets funded is itself a commissioning decision. Of the £20 million allocated for optometry electronic referrals, a disproportionate share is routed to the NHS side of the connection rather than to the practices that have to adopt the systems.[104] Practices are therefore expected to meet the cost of connecting themselves. Those that cannot afford to do so stay disconnected, which means their patients continue to be referred on paper, or not referred at all.

Nowhere is the mechanism clearer than in what happened when an incentive was withdrawn. People with a mental illness die fifteen to twenty years too soon because of poor physical health.[105] GPs are incentivised through the Quality and Outcomes Framework to provide physical health checks for that group, and coverage has reached around 60 per cent, built up over many years from a very low base.[106] Some of those incentives have since been reduced. A cohort study using the Clinical Practice Research Datalink found that when Quality and Outcomes Framework incentives for the component checks were removed, delivery of those checks fell.[107] No explicit decision was made to provide fewer physical health checks for people with severe mental illness. Instead, the financial incentive changed and the consequence

102 Dr Peter Hampson, Clinical and Policy Director, Association of Optometrists, Oral Evidence Session 2, 19 November 2025.

103 Age UK, "Digital Exclusion in the UK: Older People's Experiences of Digital Exclusion," 2025.

104 College of Optometrists, written evidence to the Inquiry, 2026.

105 Andy Bell, Chief Executive, Centre for Mental Health, supplementary interview with the Inquiry, 9 June 2026.

106 Ibid.

107 Bell, supplementary interview; and Emsley, E., and others, "Increasing Uptake of Physical Health Checks for People Living with Severe Mental Illness: A Systematic Review," British Journal of General Practice 76, no. 762 (2026): e21–e28.

followed by potentially serious costs for life expectancy.

Commissioning depends on information - an ICB decides what to buy, and how much of it, on the basis of what its data tells it about the population it serves. That makes the quality of that data a commissioning question, and current data is not up to scratch.

Government is increasingly relying on the ONS Health Insight Survey to measure progress on access, and that the ethnic minority response rate to that survey is 4 per cent, against 17 per cent in the population and 22 per cent in the GP Patient Survey.[108] The survey is also online only, which skews responses towards people who have access to and are comfortable with digital services. A measurement instrument that under-represents the populations with the greatest barriers to access can show improvement even when those groups are not experiencing it. Commissioners reading it would conclude that access is improving and buy accordingly. This provides one of the clearest examples in the evidence base behind the rationale for Recommendation 1.

A related mechanism removes people from the count altogether, and from the population a commissioner is planning for. An example brought forward to the Inquiry highlights how 344,000 patients were removed from GP registers in a recent six-month period through list cleansing, the process by which patients who have not attended for a defined period are written to and deregistered if they do not respond in time.[109] The same evidence identified that no impact assessment accompanied the exercise. The people least likely to respond to such a letter are the people this report is most concerned with: those who do not read English as a first language, those who lack access or the digital confidence to follow the instructions, older people who may mistake the letter for a scam, and people living in houses in multiple occupation who may never receive it.

A person deregistered this way is not classed as an access failure: they simply disappear from the patient list, and, with that, from the figures used to fund and plan services in that area. The first point at which the system may feel the impact is when they turn instead to more costly NHS services for their care needs.

Across the four sectors, commissioning operates through separate routes, contracts and eligibility rules, creating fragmentation across primary care.[110] The NHS technology market can reward suppliers for expanding their own systems rather than ensuring they are compatible with

108 National Voices, Oral Evidence Session 1, 29 October 2025.

109 Bramall-Stainer, supplementary interview.

110 George Johnston, Policy Manager, NHS Confederation, now The NHS Alliance, Oral Evidence Session 2, 19 November 2025.

others.[111] Buying at scale at ICB or national level could improve pricing, support better integration, and oblige suppliers to build compatible systems. Evidence to the Inquiry offered the Electronic Prescription Service as an example of what national-scale procurement can achieve. It was commissioned once, for the whole of England, and has run for fourteen years, allowing prescriptions to move electronically between prescriber and pharmacy everywhere in the country. Wales and Scotland, which commission separately and at smaller scale, have not been able to replicate it. The same technology exists in all three nations. What differs is whether anyone was in a position to buy it once, for everyone.[112]

In their submission to the Inquiry, the Royal Pharmaceutical Society got to the heart of this point: professional bodies representing individual sectors cannot resolve fragmentation without a commissioning framework that treats primary care as one system.[113]

Commissioning also shapes whether community and non-NHS organisations can work alongside primary care to extend access and meet needs that mainstream services do not reach. One participant in the first evidence session described a university-community partnership in one of the most health-deprived boroughs in England, where 6 per cent of residents are in temporary housing.[114] The services it runs are not commissioned by the NHS and do not duplicate what primary care provides. They range from counselling and musculoskeletal therapies to a community breastfeeding service and a teaching kitchen, all delivered free at the point of care and largely by students under supervision. The witness emphasised that the model is intended to complement, rather than compete with, NHS provision. The same evidence argued that its further development is constrained by NHS procurement rules and processes, which frequently prevent community organisations from working effectively alongside NHS providers. Chapter 7 sets this example out in full. Additionally, Health and Wellbeing Boards have latent capacity to convene cross-sector primary care commissioning, but their convening power is not backed by commissioning authority.[115] The opportunity the evidence points to is joint working between primary care providers and institutions that can reach people the mainstream route does not. This report's recommendations are intended to support that collaboration.

111 Ibid.

112 Robert Walker, Head of Health and Social Care, techUK, Oral Evidence Session 3, 3 December 2025.

113 Royal Pharmaceutical Society, written evidence.

114 Robert Waterson, Executive Dean of Health, Sport and Bioscience, University of East London, Oral Evidence Session 1, 29 October 2025.

115 Association of Directors of Public Health, supplementary interview with the Inquiry, 2026.

The recommendations that respond to the issues that emerge from this pattern of commissioning arrangements are Recommendation 8 (integrated commissioning framework across four sectors), Recommendation 12 (community anchor institutions), and Recommendation 13 (partnership architecture and continuity of care). Commissioning also shapes the elements of Recommendations 1, 3, 4 and 6 that address measurement, patient voice, data architecture, and digital service delivery.

3.5 How the three patterns connect

The patterns identified in this chapter do not function independently. Funding shapes workforce, workforce shapes commissioning, and commissioning shapes how funding actually reaches patients. Addressing any one of these patterns without the others produces incomplete reform.

The pattern most visible in the aggregate numbers is funding distribution. The pattern that most directly affects patients is commissioning. The pattern that links the two, and that determines whether the other two can produce change, is deployment. Additional funding does not become additional care unless someone is available to deliver it. Commissioning reform does not deliver services if nobody has been trained or contracted to staff them. A trained workforce achieves little if no service has been commissioned for them to work in, or no funding attached to it. And if funding does not rebalance, neither deployment nor commissioning reform would be sufficient to close the access gap.

Continuity of care runs through all three patterns. One stakeholder set out the clinical case for this: continuity reduces patient mortality by between 10 and 15 per cent, hospital admissions by up to 15 per cent, and emergency department visits by up to 20 per cent.[116] She distinguished between relational continuity, meaning seeing the same clinician or team, and informational continuity, meaning the record following the patient, and argued that as multidisciplinary teams expand, both increasingly matter. Funding determines whether practices can afford the staffing that makes relational continuity possible. Deployment determines whether there are enough people in post for a patient to see the same one twice. Commissioning determines whether the record follows the patient between the four sectors, and at present, between dentistry and the rest of primary care, it does not. Recommendation 13 is the report's response to this issue.

The four chapters that follow examine how each of these patterns appear across four themes identified by the Inquiry. Chapter 4 examines how the system measures access, who it fails to

116 Tzortziou-Brown, Oral Evidence Session 2.

register, and the route through which patients raise concerns. Chapter 5 considers how funding and commissioning affect the digital transformation of primary care. Chapter 6 brings all three patterns together through the question of sector sustainability. Chapter 7 focusses on integration, examining how primary care connects with the wider health system and how continuity can be maintained as service structures change.

Chapter 4: Reducing health inequalities and access barriers

Top Lines

- Access is often measured through surveys of people who successfully reach services. Yet those facing the greatest barriers to access are also the least likely to be captured, meaning measurements can improve while their experience does not.
- Registration is the gateway to primary care. The guidance requiring practices to register people without documents or a fixed address is clear, yet repeated audits show that it is not consistently followed.
- Practices are not paid for the extra work of registering and caring for people who face the greatest barriers. Simply requiring them to do so has therefore not been enough.
- A large group of people are registered, entitled, and still not treated, because of cost, because nobody told them what they were entitled to, or because they were not believed.

4.1 What the system cannot see

Chapter 2 set out what patients told the Inquiry about being unable to access primary care. This chapter asks why it happens and what would change it, beginning with a problem that underlies all the others: the system does not reliably know who is missing out.

Most of what government knows about access comes from three national surveys; the GP Patient Survey, the Health Insight Survey, and the Health Survey for England. Each survey provides strong coverage of people who are already registered with or using services. However, they are much less able to capture those who face the greatest barriers to access. Some never make contact with a service, while others try and are turned away. In both cases, their experiences are largely missing from the data.

The limitations of current access measures are particularly clear in the Health Insight Survey, which government is increasingly relying on. The ethnic minority response rate to the ONS Health Insight Survey is 4 per cent, against 17 per cent in the population and 22 per cent in the GP Patient Survey.[117] With the survey being administered online only it skews responses further towards people who are able to access and are comfortable using with digital services.[118] If a measure systematically under-represents the people whose access is worst, it will show access improving while their experience is unchanged, and it will do so with the authority of an official statistic.

4% and 22%

Ethnic minority response rates to the ONS Health Insight Survey and to the GP Patient Survey. Government is increasingly using the first to measure progress on access.

Source: National Voices, Evidence Session 1, 29 October 2025.

The populations missing from measures of access differ across primary care sectors. In dentistry, of the 13.3 million people in England with unmet need, 6.2 million did not believe they could get an NHS dentist, 5.4 million did not attempt to get care at all, and 1.25 million were deterred by cost. None of them made an appointment, so none of them appears in a measure built from appointments. In general practice, registered populations are surveyed extensively and unregistered populations are not surveyed at all. In primary care audiology, the service is commissioned in only around 30 per cent of ICB areas, and even then not across the whole area. This means some populations are excluded from access measures not because it is hard to reach them but, in some cases, because nothing has been commissioned to do so.

Two further factors can cause people to disappear from measures of primary care access. Stakeholders told the Inquiry that health data for liveaboard boaters is so sparse that need cannot be assessed at all. Others identified that 344,000 patients were removed from GP registers in a single six-month period after failing to respond to a deregistration letter. The significance for measurement lies in what happens next. A person removed this way is not recorded as experiencing an access failure. They are not counted as unable to get an appointment, or as having given up. They simply disappear from the registered population, and with them any evidence that their need existed.

117 Jacob Lant, Chief Executive, National Voices, Oral Evidence Session 1, 29 October 2025.

118 Ibid.

Some populations are missing from primary care data altogether, rather than simply being under-represented within it. The Inquiry identifies that Gypsy, Roma and Traveller ethnic categories are absent from the NHS data dictionary, so most clinical systems cannot record these patients as such at all, despite the categories existing in the 2021 Census.[119] A population that cannot be recorded cannot be counted or planned for, making its exclusion more fundamental than simple under-representation in survey data.

The Inquiry identifies the same blindness in the complaints system, which should provide another way for services to identify where access is failing. However, there is no robust demographic data on complaints about health and care provision. This means inequalities in who experiences poor care cannot be identified, even where patients have formally raised concerns.

The same evidence records that only 7.2 per cent of GP practices participated in the national Learn from Patient Safety Events service in the second quarter of 2025-26.[120] This is particularly significant when set against an estimated 20,000 to 30,000 incidents of avoidable significant harm in primary care each year: the great majority of practices are not contributing to the system designed to identify and learn from them.

Recommendation 1 responds to this problem of measurement. The surveys that exist are well designed for the people they reach, so the recommendation does not propose building new ones. The GP Patient Survey, the Health Insight Survey and the Health Survey for England are large, methodologically robust, and repeated over time. Their limitation is not how they ask, but who answers. The recommendation therefore proposes extending existing survey infrastructure to reach the populations currently outside it, and covering all four sectors rather than treating measurement of general practice as a proxy for the whole of primary care.

119 Sally Burrows and Professor Ewen Speed, University of Essex, written evidence to the Inquiry, 2026.

120 Professional Standards Authority, written evidence to the Inquiry, 2026.

Recommendation 1: The Department of Health and Social Care should establish a primary care access standard covering all four sectors, drawing on existing survey infrastructure to capture the populations currently missing from the measurement system.

Cost type: Within existing resources

a. Establish a primary care access standard covering all four sectors, using the Ipsos MORI GP Patient Survey, the Health Insight Survey, and the Health Survey for England as the core measurement infrastructure.

b. Extend the survey infrastructure to capture populations currently missing from measurement, including people not registered with services, people who have stopped trying to access care, and populations who face the greatest barriers to access.

c. Automate access data collection through primary care record systems where the data can be extracted at source, to reduce the reporting burden on practices.

d. Publish an annual primary care access report against the access standard, disaggregated by sector and by the populations who face the greatest barriers to access.

4.2 The gateway

Registration determines patients' access to primary care – an unregistered person has no route to continuity of care, no invitation to screening or immunisation, and no record for any other part of the system to read. NHS England's Patient Registration Standard Operating Principles are unambiguous; there is no requirement to produce identity or residence information, and being unable to provide either is not reasonable grounds to refuse.

Audit evidence is equally clear that the guidance is not followed. Friends, Families and Travellers conducted a mystery shop of 100 GP surgeries in England in spring 2021 and found that 74 refused to register their shopper, citing missing identity documents, the absence of a fixed address, or a requirement to register online. The same exercise found that for someone with no address, no identification and low literacy, only 6 of the 100 surgeries would have registered them at all.[121] A mixed-methods study of people from inclusion health groups attempting to register at practices in east London found that only 31 per cent of visits resulted in registration and the offer of an appointment.[122] Local Healthwatch mystery shopping in Hillingdon and Greenwich found the same pattern persisting after commissioners had been alerted to it.

74 of 100

GP surgeries that refused to register a mystery shopper in breach of NHS England guidance, in a Friends, Families and Travellers study of 100 practices in England.

Source: Friends, Families and Travellers, Locked out: 74% of GPs refused registration to nomadic patients.

A participant in the Inquiry set out a proposal to address this problem - refusing to register someone who is entitled to register should not be treated as an administrative slip.[123] It is a failure with a known cause, a known remedy, and serious consequences for the patient. The health service should therefore treat it as one that must never happen: recorded on every occasion, investigated, and reported. This report does not carry that proposal as a recommendation, because designing such a mechanism would require operational detail

121 Friends, Families and Travellers, "Locked Out: A Snapshot of Access to General Practice for Nomadic Communities during the COVID-19 Pandemic," 2021. The mystery shop of 100 GP surgeries in England was conducted in March and April 2021.

122 Verity, A. and Tzortziou Brown, V., "GP Access for Inclusion Health Groups: Perspectives and Recommendations," BJGP Open 8, no. 3 (2024).

123 Dr Fred Barker MBBS MPH, GP Registrar and Academic Clinical Fellow linked to Queen Mary University of London, written evidence to the Inquiry, 2026.

beyond the scope of a four-sector overview. It is included here because it reflects the scale of the problem identified by the Inquiry and warrants further development in future work. This proposal for tighter regulation was reflected by other evidence submitted to the Inquiry. One of the nine co-produced action plans in the University of Essex research recommends engaging the Care Quality Commission on compliance with registration requirements.[124] Two independent bodies of work, one clinical and one community-based, arrived separately at the same conclusion: that a decade of guidance has not been enough, and that the answer now lies with regulation rather than with further instruction. That is the basis for Recommendation 2(d).

The problem of financial incentive helps explain why guidance alone has not changed practice. Registering and then caring for people from inclusion populations can carry real additional cost: time for identity verification, interpreting, and the ongoing support that follows from complex needs and unstable circumstances. The Carr-Hill formula does not adequately reflect any of it. A practice that registers inclusively therefore takes on additional work without additional resource. That is why Recommendation 2 leads with reforming the funding formula.

The consequences of this funding formula design are particularly significant in areas where inequalities intersect.[125] Our analysis identified that areas of high ethnic diversity frequently overlap with areas of high deprivation, and that practices serving more deprived populations are systematically under-resourced relative to need, compounding the two disadvantages. Further research shows that these funding inequalities have measurable consequences: higher per-patient primary care funding is associated with greater patient satisfaction, capitation funding with better quality outcomes, and investment in primary care with lower use of more costly secondary care.[126] A separate study found that practices serving more deprived or ethnically diverse populations are less likely to provide incentivised additional services. These are services practices can opt to deliver in return for extra payment, over and above their core contract. So, the disadvantage built into the core formula is repeated in the additional funding layered on top of it, and practices in the areas of greatest need lose out twice.

Evidence to the Inquiry also shows what works when the barrier is addressed directly. The NHS Race and Health Observatory submitted several examples of local practice that reduced access failure without new legislation or significant new money.

124 Burrows and Speed, written evidence.

125 NHS Race and Health Observatory, written evidence to the Inquiry, 2026.

126 NHS Race and Health Observatory, written evidence, citing L'Esperance and others (2017, 2019, 2020 and 2021) and Ashworth, L'Esperance and Round (2021).

Case Study: removing language as a barrier

Frimley Integrated Care Board worked with Manor Park Surgery and Mayfield Medical Practice to translate appointment reminder texts into the six most commonly spoken non-English languages locally, identified from patient record data. Translations were machine-generated and then checked by bilingual NHS staff, and reception staff were trained to send the right version to the right patient. It was implemented from November 2023 using existing systems and existing staff time. Practices report fewer missed appointments among patients with limited English proficiency, and increased uptake of immunisation and screening.[127]

Across Hampshire and the Isle of Wight, a 2022-23 review found that only 101 of 1,082 eligible primary care sites were using language support services at all, leaving an estimated 106,000 non-English speakers at risk of delayed care and greater reliance on urgent and emergency services.[128] The Integrated Care Board consolidated to a single provider, introduced usage reporting, and issued practical guidance to practices. Use of translation and interpreting rose from 67,375 minutes in 2022 to 265,668 minutes in 2024, with coverage improving across all boroughs. The Board also reported an overall reduction in what it paid for the service, achieved through more consistent contracting and better management of usage rather than through any reduction in provision.

One stakeholder gave evidence to the Inquiry on automating registration.[129] He told the Inquiry that registering a patient had typically taken around fifteen minutes of practice staff time on systems designed in the 1990s, and that his company had automated approximately 2.5 million GP registrations over three years. The finding most relevant to this chapter came from a three-month pilot of the company's Bookable service across around 144 practices in London and Manchester. Of the people who used it, 24.1 per cent were not registered with a GP at all.[130] These were people outside the system who used an accessible route into it when one was available.

The Inquiry is not recommending the adoption of a particular product. But what this pilot suggests is that a proportion of the unregistered population can be reached, and that for some the obstacle is the route rather than unwillingness.

Doctors of the World UK coordinates the Safe Surgeries programme, through which practices commit to inclusive registration policies, staff training and displaying clear information about

127 NHS Race and Health Observatory, written evidence.

128 Ibid.

129 Matthew Payne, Catalyst, Health Tech 1, Oral Evidence Session 3, 3 December 2025.

130 Ibid.

patients' right to register.[131] Taken together with the case studies above, these examples point to the same conclusion. Each redesigned a process rather than reminding staff of the guidance, and each was achieved within existing resources. Registration barriers are therefore shaped by how the process itself is designed, and not only by whether staff are aware of the guidance. Recommendation 2 asks government to make that approach standard across general practice, rather than placing an obligation on individual practices and ICBs.

Recommendation 2: The Department of Health and Social Care should improve primary care access for underserved populations through digital and non-digital solutions, including making inclusive registration standard practice across the GP contract framework.

Cost type: Within existing resources

a. Ensure the Carr-Hill funding formula reflects the additional cost of registering and caring for populations who face the greatest barriers to access. This redistributes the existing general practice budget rather than adding to it.

b. Consider how inclusive registration practice could be incentivised so that the existing contractual requirement is supported by a financial incentive.

c. Permit technology-enabled registration through the NHS App and NHS website, including the use of mobile phone numbers as a proxy for a fixed address for people without one. Evaluate digital registration and navigation tools that have demonstrated success in reaching populations previously unregistered with primary care, drawing on the examples set out in this report.

d. Where systemic patterns of registration refusal are identified, involve the Care Quality Commission as a regulatory response, targeted at those patterns rather than imposing additional documentation requirements on compliant practices.

e. Require Integrated Care Boards to publish annual reports on registration inequalities in their area, so that patterns of exclusion are visible to policymakers, providers, and communities.

131 Doctors of the World UK, written evidence to the Inquiry, 2026.

4.3 Excluded from inside

Whilst exclusion is common for people who are currently outside the system, it is also a recurring issue for people within it. A substantial patient group may be registered, entitled, yet still not treated. They are harder to identify than people who never got through the door, precisely because in the data they appear as people who already have access.

Through our analysis, we have identified cost as one of the key mechanism through which this exclusion occurs. The 1.25 million adults deterred from NHS dentistry by cost are eligible for care and priced out of it, and Healthwatch England's cost of living tracker documented the same pattern across other services during 2023 and 2024.[132] Practices providing both NHS and private care now account for more than two-thirds of practices in England, with income from private work helping to cross-subsidise NHS treatment delivered at or below cost. A substantial part of NHS dental capacity therefore rests on an arrangement that no contract secures and no plan accounts for, which makes it fragile in ways nobody is currently measuring.

In addition, £392 million of the NHS's ringfenced dental budget went unused in 2023-24 because ICBs could not find practices willing to deliver NHS care.[133] This is an unusual commissioning failure – the money was available, yet nobody would take it.

£392 million

Ringfenced NHS dental budget unspent in 2023-24 because commissioners could not secure practices to deliver NHS care.

Source: written evidence to the Inquiry, citing National Audit Office analysis.

Information is a second mechanism contributing to this problem. Evidence highlighting a population who do not know that NHS sight tests are free suggests that access may fail despite entitlement due to a lack of information, communication, and awareness.[134]

For some populations, the information that is available is simply not designed for them. SeeAbility documents that people with learning disabilities are considerably less likely to receive eye tests than the general population, despite being significantly more likely to have

132 British Dental Association, written evidence.

133 Denplan, written evidence to the Inquiry, 2026, citing National Audit Office analysis.

134 Association of Optometrists, written and oral evidence to the Inquiry, 2026.

undiagnosed sight problems.[135] The Roma Support Group sets out how low literacy, limited English, digital exclusion and prior experience of discrimination combine at every stage of the process.[136] A person who cannot read the letter, cannot complete the online form, and expects to be treated poorly if they get through faces four obstacles where another patient faces none. The service is technically available to them but practically unreachable.

The third mechanism is identified as the gap between making contact and receiving care – entitlement to care does not guarantee treatment.[137] Peer-reviewed analysis of 63,000 primary care records in ethnically diverse South London found differential uptake of NHS Health Checks and of diabetes and hypertension reviews among women from ethnic minority groups.[138] Health Insight Survey data shows that Black and particularly Asian respondents are less likely than White respondents to report being able to contact their GP on the same day. These are registered patients, eligible for the services in question, receiving less of them.

To address the compounded issues, the NHS should rethink how it measures data – instead of counting how many appointments were delivered, it should track what happened to patients: how many ended up in hospital when earlier care could have prevented it, and how long it took from a person first noticing a symptom to getting a diagnosis. Counting appointments alone will not reveal any of the three mechanisms in this section, because in each case the patient is registered and the service exists. That is why Recommendation 1 and Recommendation 2 have to be implemented together.

4.4 The supply of care

The barriers described so far are linked to whether a person can get through the door. However, addressing these barriers cannot be done without considering the supply side. General practices serving more deprived populations employ fewer GPs relative to the size and needs of their lists.[139] They also perform less well on the measures the system uses to judge quality, including Care Quality Commission ratings, patient satisfaction and the Quality and Outcomes Framework. The inequality in provision narrowed during the 2000s and has widened again since.

135 SeeAbility, written evidence to the Inquiry, 2026.

136 Roma Support Group, written evidence to the Inquiry, 2026.

137 L'Esperance, Oral Evidence Sessions 1 and 2. See also NHS Race and Health Observatory, written evidence.

138 Cross-sectional analysis of 63,000 primary care records, eClinicalMedicine, 2022, cited in NHS Race and Health Observatory written evidence.

139 Fisher, R., Loftus, L., Holdroyd, I. and Ford, J., "Fairer Funding for General Practice in England: What's the Problem, Why Is It So Hard to Fix, and What Should the Government Do?" Nuffield Trust and Health Equity Evidence Centre, December 2024.

A study of 9.4 million consultations across 397 English practices found that between 2018/19 and 2021/22 consultation rates rose by 10 per cent in the least deprived fifth of areas and by 5 per cent in the most deprived fifth.[140] Rates remain higher in deprived areas, as the level of illness there would predict. But the gap between the most and least deprived narrowed by half over the period. The authors describe that narrowing as a cause for concern, given the evidence that health needs are greater in more deprived areas, and conclude that the gap between demand and capacity has widened for patients in those places. As such, practices in deprived areas cannot offer more appointments than they already do. Where a practice is short of clinicians relative to its list, demand that cannot be met simply does not appear in the data. It shows up instead as the unmet need described earlier in this chapter, and further along the pathway as emergency attendances and admissions that earlier care could have prevented.

This matters for the recommendations of this report. Reforming the funding formula would put more money into practices serving the populations with the greatest need. But money alone has historically not been enough to change where clinicians choose to work. Evidence from previous reform attempts suggests that the interventions which made a measurable difference were those that combined funding with training places, premises and early-career incentives. The Equitable Access to Primary Medical Care programme, which ran from 2007 to 2011, has published evidence that it reduced inequality in the supply of general practice.[141] Smaller targeted schemes have not been evaluated.

That is why Recommendation 10 on workforce asks for targeted incentives in coastal, rural and deprived areas alongside expanded training, and why Recommendation 9 on premises matters for workforce as well as for buildings. A practice without room to train cannot grow its own clinicians, and a practice that cannot recruit cannot use additional funding to deliver more appointments. The three recommendations work together or not at all.

4.5 What is already underway

Several of the mechanisms this chapter identifies are already the subject of government action, and the recommendations are framed to shape that work.

The most significant is the review of the Carr-Hill formula, announced in October 2025 and led by the National Institute for Health and Care Research. Its purpose is to recommend a replacement for the formula rather than adjustments to the existing model, and the

140 Vestesson, E. M., and others, "Consultation Rate and Mode by Deprivation in English General Practice From 2018 to 2022: Population-Based Study," JMIR Public Health and Surveillance 9 (2023): e44944.

141 Health Foundation, "Tackling the Inverse Care Law," 2022; and evaluation of the Equitable Access to Primary Medical Care programme, BMJ Open 6, no. 1 (2016): e008783.

Government has said it aims to introduce the new formula from April 2027.[142] This is the most important opportunity identified in this chapter, because it determines whether inclusive registration is financially viable. Recommendation 2 is therefore directed specifically toward the review.

Alongside the Carr-Hill review, the Government's supervised toothbrushing scheme for three to five-year-olds in high-need areas represents a separate attempt to strengthen prevention. However, participants in the Inquiry stressed that preventive programmes cannot compensate for inadequate access to dental treatment.[143] One submission makes a complementary point about the reforms to the dental contract taking effect from April 2026.[144] They are welcome, but should be understood as interim measures, because they increase what practices are paid for urgent and unscheduled treatment without doing the same for the routine check-ups and preventive care that would stop problems becoming urgent in the first place.

Two further reforms are relevant to the recommendations in this chapter. The Neighbourhood Health Framework of March 2026 commits to targeting the first wave of neighbourhood health services at areas with the lowest life expectancy and longest waits.[145] NHS England's Patient and Carer Race Equality Framework provides a mandatory framework for mental health trusts and providers that will form part of Care Quality Commission inspection. Recommendation 1 is designed to build on that approach rather than replace it.

While this government action is a welcome step towards improving primary care access, none of these reforms establishes whether access is improving for the people the current surveys do not reach, and none is designed to ensure that people entitled to register with a GP are registered. Those are the gaps the recommendations address.

4.6 The route for raising concerns

The NHS Modernisation Bill 2026 will change the arrangements through which patients raise concerns about their care. This section sets out what the Inquiry's evidence says any new arrangement will need to be able to do.

Almost all the evidence in this chapter and the last reached the Inquiry through a number of organisations whose function is to listen to patients and report on what they hear. Healthwatch England and local Healthwatch supplied the registration audits, the cost of living tracker, the

142 Hansard, House of Commons, 16 March 2026.

143 Shawn Charlwood, British Dental Association, Oral Evidence Session 1, 29 October 2025.

144 Denplan, written evidence to the Inquiry, 2026, citing National Audit Office analysis.

145 NHS England and Department of Health and Social Care, "Neighbourhood Health Framework," March 2026.

referrals research, and the account of the eight o'clock call. The VCSE Health and Wellbeing Alliance gives voluntary sector organisations a route into health policy. Both contribute to research essential for understanding barriers to primary care access, and both face uncertain futures under the Bill.

The Inquiry takes no position on the institutional form. Government can preserve the existing arrangements with strengthened four-sector coverage, or design a purpose-built replacement with an equivalent function. But it should be clear about what would be lost if neither happens. Every audit, every mystery shop, and every account of being turned away in this report came through a route that is currently under review. Without that function, the exclusions documented here remain unobserved, and a system that cannot see a failure has no reason and no remedy to correct it.

The evidence points to four requirements for whatever replaces the current arrangements.

The first is independence. People with mental health problems can face additional barriers to raising concerns, highlighting the power imbalance created by the Mental Health Act 1983, alongside fears that complaints will not be believed because of a person's mental health status or that they could lead to more restrictive care.[146] Moving responsibility for patient voice into ICBs and provider engagement teams requires further consideration as people may not trust a patient voice function that sits inside the organisation they wish to complain about.

The second is national consistency. Other stakeholders raised concerns about the loss of a forum operating at both national and local level, and asked that whatever replaces it comes with national guidance on how local arrangements should work, rather than leaving each area to design its own.[147]

The third is coverage of all four sectors. Our analysis identified that the present arrangements already carry insufficient expertise across community pharmacy, dentistry, and optometry, and that services are repeatedly designed without the people who deliver them in the room. A replacement built around general practice alone would reproduce that gap.

The fourth is that it hears from patients directly. Expert voices around a table are not a substitute for the voices of the people who use the services. This matters most for the people who use the services. This matters most for the people this chapter is about. Professional bodies can report what their members observe, and they do so throughout this report. But a

146 Mind, written evidence to the Inquiry, 2026.

147 NCHA, the Association for Primary Care Audiology Providers, written evidence to the Inquiry, 2026.

professional body cannot report the experience of someone who was turned away at the reception desk and never came back, because that person did not become anyone's patient.

A further submission to the Inquiry highlights what happens if these requirements are not met.[148] If local Healthwatch is removed, learning from complaints becomes more important. However, its evidence suggests the complaints system is not currently equipped to fill that role: patients already face significant barriers to raising concerns, and the demographic data needed to identify who is being failed is not routinely collected.

Recommendation 3: The Department of Health and Social Care should ensure the local patient voice function is preserved, whether by retaining the existing Healthwatch and VCSE Health and Wellbeing Alliance arrangements or by designing a purpose-built successor architecture.

Cost type: Within existing resources

a. Either preserve the existing Healthwatch and VCSE Health and Wellbeing Alliance arrangements, or design a purpose-built successor with an equivalent function.

b. Ensure the successor has expertise across all four primary care sectors and covers both physical and mental health.

c. Empower patients from populations who face the greatest barriers to access to raise concerns about primary care through the successor.

d. Provide a clear route from the local patient voice into strategic commissioning decisions at Integrated Care Board level.

4.7 Where this leads

The three recommendations in this chapter work as a sequence rather than as separate asks. Recommendation 1 makes the problem visible, because a system that cannot see a population cannot be held to account for failing it. Recommendation 2 addresses the gateway itself, and the funding structure that keeps it shut. Recommendation 3 preserves the route through which

148 Professional Standards Authority, written evidence.

the people affected can report whether any of it is working, and that reporting is what tells the system where to look next.

Whilst each of the recommendation stands on its own they should be addressed and implemented together. Without measurement, nobody knows whether registration has improved. Without registration reform, better measurement only records a failure it cannot fix. And without a way for patients to report their experience, the system is judging its own performance using its own data.

Chapter 5: Digital transformation and system integration

Top Lines

- The Government has committed to introducing a single patient record and making the NHS App the main digital front door to the NHS by 2028. Both depend on information being able to move between services, which is currently not possible in three of the four primary care sectors.
- The technology and systems to enable this already exist and work elsewhere in the NHS. What is missing concerns the purchases made, the commissioning structures behind them, and whether suppliers are required to make their systems compatible with anyone else's.
- Where services have been connected, results have been substantial.
- Sensitive results can reach patients through the NHS App before any clinician has explained them. The technology to prevent it already exists but is not required.
- Every digital tool the Inquiry examined helps those who already face fewest barriers to access, while risking leaving the same excluded minority further behind. That is a design decision, not an accident.

5.1 What the Government has committed to, and why it matters for access

Two of the three shifts set out in the 10 Year Health Plan depend on digital infrastructure. The first commits to moving care from hospital into community settings, which requires a patient's information to move with them between services that currently cannot exchange it. The second is a commitment to digitalise the parts of the NHS still running on paper, phone, and fax. Both matter for access, because a patient who has to repeat their history at every door, or who cannot get through the door at all because it is now a screen, has an access problem however many appointments exist.

The commitments those shifts rest on are specific. The first is a single patient record, for which the NHS Modernisation Bill 2026 provides the legal foundation, with phased rollout beginning in 2027.[149] The second, set out in the 10 Year Health Plan itself, is the NHS App as the universal digital front door by 2028.[150] Underlying both is an expectation that services across the NHS will be able to see the same information about the same patient.

This chapter examines four questions: whether patient information can move effectively between services, whether progress against these commitments will be publicly visible, whether the NHS App is accessible to everyone, and how the NHS should assess the safety of new technologies.

5.2 Current government activity

Several programmes relevant to those commitments are already in progress. GP Connect has been extended so that community pharmacies can send Pharmacy First consultation records into GP systems, though its use remains limited to a small number of specified services. Responsibility for digital infrastructure and for public sector technology adoption moved between departments in July 2026.[151]

The National Commission into the Regulation of AI in Healthcare, established by the Medicines and Healthcare products Regulatory Agency, published the findings of its research and call for evidence on 11 June 2026, with its recommendations expected during summer 2026.[152] Its call for evidence drew 760 responses from NHS bodies, industry, academia and patient groups. Half said the existing regulatory framework needs substantial revision and a further fifth called for a complete overhaul. Its findings point in the same direction as the evidence in this chapter: towards regulation across a technology's lifespan rather than one-off approval, stronger post-market surveillance, clearer rules on liability, and a national system for reporting incidents involving these technologies. Recommendation 5 is framed to complement that work rather than duplicate it, since a national assurance framework for primary care is what would put the Commission's conclusions into practice in the four sectors this report covers.

149 NHS Modernisation Bill 2026, as introduced.

150 Department of Health and Social Care, "Fit for the Future: The 10 Year Health Plan for England," July 2025.

151 "Machinery of Government Changes," Written Ministerial Statement HLWS298, 21 July 2026.

152 National Commission into the Regulation of AI in Healthcare, findings of research and call for evidence, 11 June 2026.

5.3 What works when systems are connected

One stakeholder identified the central barrier to these reforms as difficulties in implementation, rather than the lack of technology.[153] The NHS has shown it can implement new technology at scale. An artificial intelligence tool that reads brain scans and flags a stroke is now in 107 sites, covering around 95 per cent of stroke units in England, and is estimated to have helped avoid roughly a thousand long-term disabilities.[154]

Closer to primary care, the gains are in reduced waiting and travel. One participant told the Inquiry his service receives over 42,000 dental referrals a year, and that around 5,500 patients do not attend their appointment.[155] Each missed appointment is clinical time booked and paid for but not used, amounting to roughly £2.2 million a year in lost activity. Where digital routes removed the need to attend at all, the picture changed. A pilot using Advice and Guidance across 250 patients gave 98 per cent of them a management plan within 90 days, 55 days sooner than the usual route, and saved more than 4,000 miles of patient travel.[156] Virtual multidisciplinary clinics for children with missing teeth moved patients through up to seven times faster.

Eye care provides three further examples of digital infrastructure improving patient access and experience. A single point of access at Moorfields, covering North Central London, cut referral processing from 11 days to two or three hours.[157] It safely downgraded 58 per cent of referrals that had arrived marked urgent, sent 40 per cent to a more appropriate service after triage, and returned a further 11 per cent to community optometry with advice.[158] A digital referral platform in West Yorkshire found 72 per cent of advice requests needed no hospital referral. A macular service in Bristol spared three quarters of patients a hospital visit. All three were designed with patients with sight loss in mind, illustrating the effectiveness of inclusive design.

The finding that 40 per cent of referrals were redirected after triage is significant. It puts a figure on something this report otherwise only asserts: how often patients are sent to the wrong part of the system.

153 Professor Hatim Abdulhussein, Chief Executive, Health Innovation Network Kent, Surrey and Sussex, Oral Evidence Session 3, 3 December 2025. See also Health Innovation Network, written evidence to the Inquiry, 2026.

154 Abdulhussein, Oral Evidence Session 3.

155 Dr Jose Rodriguez, Consultant in Restorative Dentistry, Guy's and St Thomas' NHS Foundation Trust, Oral Evidence Session 3, 3 December 2025.

156 Rodriguez, Oral Evidence Session 3.

157 Royal College of Ophthalmologists, written evidence to the Inquiry, 2026.

158 Royal College of Ophthalmologists, written evidence, citing the Moorfields best practice case study, February 2026.

40% redirected, 11% returned

Share of eye care referrals sent to a more appropriate service after triage, and share returned to community optometry with advice, following the introduction of a single point of access at Moorfields.

Source: Royal College of Ophthalmologists, written evidence to the Inquiry, 2026.

The Greater Manchester Care Record shows what a properly designed shared record achieves over time. It works because it puts shared information inside the systems clinicians already use rather than replacing them, and because it was built with communities rather than announced to them. Use of the record by clinicians has risen 83 per cent, there are 6,500 live advance care plans, 84 per cent of patients are dying in their preferred place, and £48.8 million in savings have been documented.[159]

What connects these examples is that a clinician was able to see what they needed to see, and act on it, without the patient having to travel to a hospital appointment to make that possible.

5.4 Why patient information cannot move between services

The problem is clearest when viewed through the experience of a single patient. One contributor described treating an elderly, confused man who needed a tooth removed and could not remember his medication.[160] The dentist could not see the GP record and could not get through on the phone. When he tried to refer the patient to the hospital where he also works, he found that his practice software had no way of sending a referral into the hospital's system, and when he sent a standard dental file separately, the hospital could not open it. Each service involved held a part of the necessary information. But without an established way of sharing it, none were able to meet the patient's need.

That is not just a dentistry problem. One of the Inquiry's participants recalled asking an NHS England colleague for a map showing how the Summary Care Record, the single patient record, the NHS App and GP Connect fit together.[161] He was told that no such map exists. Optometrists have no NHS.net email address and no access to Summary Care Records, and the OCT scanners in around 3,000 practices, which produce hospital-grade images, are not connected

159 Health Innovation Network, written evidence to the Inquiry, 2026. See also Abdulhussein, Oral Evidence Session 3.

160 Shiv Pabary MBE, Chair, General Dental Practice Committee, British Dental Association, Oral Evidence Session 2, 19 November 2025.

161 Dr Peter Hampson, Clinical and Policy Director, Association of Optometrists, Oral Evidence Session 2, 19 November 2025.

to hospital eye departments.[162] An optometrist can take an image good enough for a consultant to act on, but has no way of sending it to one. Another stakeholder described how this problem manifests in pharmacy: multiple proprietary systems that do not talk to each other, so a pharmacist works across one screen for NHS bookings, one for records, and another for stock, multiplying effort and creating room for error.[163]

The scale of the problem has been measured in eye care – a 2024 survey of ophthalmology clinical leads found only 9 per cent had well-functioning electronic patient record systems and 14 per cent had well-functioning interoperable imaging.[164] Suppliers are under no obligation to meet national standards for medical imaging, which is why an optometrist and an ophthalmologist treating the same patient cannot read and update the same record.

9% and 14%

Share of ophthalmology clinical leads reporting well-functioning electronic patient records, and well-functioning interoperable imaging standards, in a Royal College survey of its own leads.

Source: Royal College of Ophthalmologists, written evidence to the Inquiry, 2026.

Given the evidence from this Inquiry, two elements of Recommendation 4 follow directly. The first, sub-recommendation 4(a), concerns the fact that the four sectors are starting from very different places. General practice has well-developed digital systems, but they are largely closed: other services cannot easily connect to them. Dentistry has no access to shared patient records at all. Optometry has neither NHS email nor a route to send images to hospital eye departments. Community pharmacy is furthest ahead of the three, able to both read from and write into the GP record through GP Connect, but only for the three services that functionality covers. General practice would meet a national deadline because its systems already exist and only need opening up. The other three would miss it because they have far less to open. That is why the recommendation asks for implementation timetables that reflect where each sector actually starts.

The second, sub-recommendation 4(c), addresses where the funding should go. In June 2026 the Government announced £20 million to extend the NHS e-Referral service to all optical

162 Daniel Hardiman-McCartney MBE, Clinical Adviser, College of Optometrists, Oral Evidence Session 3, 3 December 2025. The Association of Optometrists confirms around 3,000 practices, approximately half of all practices.

163 Malcolm Harrison, Chief Executive, Company Chemists' Association, Oral Evidence Session 2, 19 November 2025.

164 Royal College of Ophthalmologists, written evidence, citing a 2024 survey of ophthalmology clinical leads.

practices holding NHS contracts, with full access targeted by April 2028.[165] Our stakeholders welcomed the direction but warned that the allocated funding would not be sufficient – without a clear implementation plan, practices would be left to meet the cost and the administrative work of connecting themselves. The funding is also directed mainly at the NHS systems receiving the referrals, rather than at the practices that have to buy and install the software to send them.[166] Around a tenth of the £20 million would go on the secure smartcards and readers that allow staff to log in to NHS systems, at roughly £20 each, before any clinical function is built.[167] Similar investment in the systems that would make electronic referrals from general practice work reliably is needed in community pharmacy.[168] The practice-side investment gap is largest in exactly the three sectors furthest behind.

If contractual requirements are placed on practices that depend on access to the single patient record, and that access does not yet work reliably, practices are being held to obligations that the infrastructure cannot support. The evidence above describes systems that cannot open one another's files, sectors without NHS email addresses, and a national picture that nobody has mapped.

One Inquiry participant identified why this has not been resolved.[169] The modern technology systems are capable of talking to each other – as such, the barriers that stop them are commercial, structural, and organisational.[170] Suppliers have little commercial reason to build open connections, particularly when asked to do it at their own risk. The framework through which GP systems are bought allows other services to read information from a GP record, but writing into it has been enabled only for specific services, one at a time, rather than as a general capability. Community pharmacy can record a Pharmacy First consultation in the GP record and cannot record anything else. That is not enough for a team working across services in real time. Approval processes are also fragmented, with every region asking suppliers for similar but slightly different paperwork. And the NHS continues to buy outdated technology that cannot support modern data exchange.

The same issue can be seen from the buyer side, where we have identified dominant GP software providers with large market shares and little reason to connect to anyone else. The proposed solution by stakeholders was clear: make interoperability a condition of holding an

165 Department of Health and Social Care, announcement on NHS e-Referral Service access for optical practices, June 2026.

166 College of Optometrists, written evidence to the Inquiry, 2026.

167 Amy Glees, Associate Vice President of Product, Mastek, supplementary interview with the Inquiry, 2026.

168 Dr James Davies, Director of Research and Insights, Community Pharmacy England, Oral Evidence Session 2, 19 November 2025.

169 Robert Walker, Head of Health and Social Care, techUK, Oral Evidence Session 3, 3 December 2025.

170 Ibid.

NHS contract.[171] Suppliers make more money selling additional products that work with their own systems than they do making their systems work with anyone else's. Building a connection to a competitor's product creates no new revenue and may lose them a future sale, so it does not get built.[172]

The Electronic Prescription Service offers a useful example of what changes financial incentives. It was commissioned once, for the whole of England, so suppliers had to build to a single national specification in order to sell anything at all. It has run for fourteen years. Wales and Scotland, buying separately and at smaller scale, have not been able to replicate it. Where a buyer is large enough, suppliers build what the buyer requires. Where buying is fragmented, they build what suits them.

It is, however, worth noting that interoperability projects often reach for complex, high-specification solutions when simpler ones would deliver faster. Greater Manchester Care Record worked because it combined a shared data model with integration at the desktop, so clinicians saw more information inside software they already used.

When considering data sharing we must also take patient safety into account, as some may argue that access could be understood as a patient's ability to reach a safe and timely decision about their care, not simply to obtain an appointment.[173] On that definition, a blood test result that sits in one system and never reaches the clinician who ordered it is an access failure, in the same way as an unanswered phone. The patient has made contact with the service. They still have not received the decision they need, and the delay carries clinical risk.

5.5 Reporting on whether commitments are delivered

The evidence also points to a recurring weakness in how national digital programmes are implemented and monitored, which is addressed by Recommendation 4(d).

A national programme to digitise GP paper records was announced and then quietly stopped, leaving practices to pay for the storage of their own paper patient records, as Chapter 6 sets out. The 2028 commitment to make the NHS App the digital front door to the NHS was announced while some practices were not yet on the platform, so patients directed to the App found it could not connect them to their own surgery.[174] Nobody, including a national clinical

171 Dr Gaurav Gupta, England GP Committee Lead for Premises, British Medical Association, Oral Evidence Session 2, 19 November 2025.

172 George Johnston, Policy Manager, NHS Confederation, now The NHS Alliance, Oral Evidence Session 2, 19 November 2025.

173 Institute of Biomedical Science, written evidence to the Inquiry, 2026.

174 Department of Health and Social Care, "Fit for the Future: The 10 Year Health Plan for England," July 2025.

adviser who asked for one, can produce a map showing how the Summary Care Record, the single patient record, the NHS App and GP Connect fit together. Additionally, the £20 million for optometry e-referrals was announced, in FODO (the Association for Eye Care Providers) public assessment, without a delivery plan behind it.[175]

Each case encountered the same issue – there was no published account of what was promised, what was delivered, and by when. Where delivery is not reported, a programme can be announced, quietly reduced and replaced by another announcement without anyone outside the department noticing. That is why Recommendation 4(d) asks for clear public reporting mechanisms and independent scrutiny of delivery progress. The cost of reporting is small relative to the programmes themselves, and it is the difference between a commitment and delivery.

5.6 Protecting patient data and deciding who can see what

Delivering a successful single patient record that allows information to move safely between services raises three key questions: who should be able to access a patient's record, what information different professionals should be able to see, and how patients should be able to control that access. The Inquiry heard evidence relating to all three.

Evidence addressed the first question through the matter of authentication, and this appears to be one aspect that has been overlooked in the costing. One Inquiry participant set out what anyone accessing the patient record would have to have: authentication through NHS identity.[176] This entails a smartcard, a reader, and a nominated person inside each organisation who manages what each user may see. Extending that to community pharmacy, dentistry, and optometry means issuing credentials and setting up access for roughly 100,000 existing staff, at the per-reader cost noted earlier, before the costs of administration, training, and change management.[177] Without this, the patient record will exist and there will be no authenticated way for anyone to reach it.

To address the second question, one participant described the issue clearly: a community pharmacist does not need to know about an unrelated health problem. However, patients cannot always be expected to judge which parts of their record are clinically relevant to different professionals. Someone therefore needs to define, on a clear clinical basis, what information each professional role should be able to access. Those access rules should be built

175 Federation of (Ophthalmic and Dispensing) Opticians, public assessment of the June 2026 announcement, 2026.

176 Venus Simbulan-Fenwick, Associate Vice President for Strategic Business Development, Mastek, supplementary interview with the Inquiry, 2026.

177 Jack Gibson, Partner, Healthcare and Public Sector, Bright Frog, supplementary interview with the Inquiry, 2026.

into the design of the record from the outset, rather than added afterwards. Another contributor described the technical approach as role-based access control, with information exchanged automatically through encrypted systems.[178] They argued that manual steps, such as uploading, printing or emailing records, introduce additional opportunities for error and security risk.

The third question concerns patient consent and control over access. Our stakeholders described the difficulty that arises in guaranteeing consent. Due to a previous experience of trauma, a patient may reasonably decline to have their sexual health history shared through the record. However, access to that same information may later be what saves their life in an emergency department. A system has to respect a patient's autonomy over their information while also ensuring that clinically important information is available when it is critical for life-saving care.

The Inquiry received a range of proposals for how consent and data governance should work, but there was no agreement on a single approach. Kidney Research UK asks for explicit consent and clear explanation of what will be shared, with whom, why, and when, alongside limited data sharing and strong authentication.[179] The General Pharmaceutical Council reports that confidentiality is a theme its patient forum raises directly.[180] FODO asks that data governance be overseen by the Information Commissioner's Office, supported by sector-specific standards. The Royal College of Ophthalmologists asks for governance covering collection, storage, and analysis, with clear rules on sharing between patients, practitioners, regulators, and technology providers.[181] Each addresses part of the problem. Government will need to determine how they fit together.

Two proposals in the evidence would reduce the burden on the people least able to carry it. One participant noted that in parts of England the average reading age is eight, which makes dense legal data protection terms meaningless as a route to informed consent.[182] Another argued that making individual GP practices, which are small businesses, carry legal responsibility for controlling patient data is unreasonable, and that the NHS should act as a single data controller instead.[183] That is a proposal about where legal responsibility for protecting data should sit. Ownership of the data remains the patient's. The same contributor drew on India's national digital health programme to make a related point: requiring patients to approve every individual disclosure can create delays that risk harm. Safeguards therefore need

178 Dr Tom Oakley, Chief Executive, Feedback Medical, Oral Evidence Session 3, 3 December 2025.

179 Kidney Research UK, written evidence to the Inquiry, 2026.

180 General Pharmaceutical Council, written evidence to the Inquiry, 2026.

181 Royal College of Ophthalmologists, written evidence.

182 Matthew Payne, Catalyst, Health Tech 1, Oral Evidence Session 3, 3 December 2025.

183 Oakley, Oral Evidence Session 3.

to be built into the system, rather than placing the burden on patients at the point they need care.

The consequence of not settling these questions is already visible. There are cases today, where patients across England have learned they have cancer by reading a CT scan report released into the NHS App before any clinician had spoken to them about it.[184] Kidney Research UK reports the same in its own field, with patients finding out about a kidney disease diagnosis through the App before anyone has spoken to them.[185] There must be a mechanism through which a clinician reviews sensitive results and speaks to the patient before they appear in the App. The technology needed to do this already exists.

Recommendation 4: The Department of Health and Social Care and the Department for Digital, Culture, Media and Sport should mandate open data standards across all four primary care sectors and the wider health and social care system.

Cost type: With targeted additional investment

a. Mandate open data standards across all four primary care sectors and the wider health and social care system, with implementation timetables that reflect the different starting points across sectors.

b. Before introducing contractual requirements that rely on Single Patient Record access, ensure that reliable access is in place. Practices should not be expected to meet obligations built on infrastructure that does not yet work reliably.

c. If and when additional funding becomes available, direct investment towards the practice-level system changes are needed to meet the standards, with particular attention to optometry, dentistry, and community pharmacy where the practice-side investment gap is largest.

d. Set out clear public reporting mechanisms and provide for independent scrutiny of delivery progress against the data standards.

184 Ibid.

185 Kidney Research UK, written evidence to the Inquiry, 2026.

5.7 Making sure new technology is safe to use

The points raised so far in this chapter concern the infrastructure that already exists and shortfalls within it. The adoption of AI raises a different question within health and care: how do we know whether something new is safe to use?

At present, there is no reliable way to find out. Every practice currently carries out its own governance assessment of a new tool, which produces inconsistency and occasionally unsafe deployment. A practice of five staff is asked to do work that a national body could do once. Stakeholders told our Inquiry that the regulatory framework is underdeveloped, and decisions about risk cannot be an afterthought.[186] Lord Taylor of Warwick, who chaired the Inquiry's third evidence session as Chair of the Parliamentary Artificial Intelligence Group, raised a question none of the witnesses could answer: if a diagnosis assisted by an automated tool is wrong because the data underneath it was wrong, who is liable, the company that built the tool or the organisation that supplied the data? It is a question the National Commission has been asked to address, and how it is resolved will shape whether clinicians and organisations are willing to adopt these tools at all. The regulatory landscape is currently a pick-and-mix, with the United Kingdom taking a sector-by-sector approach while the European Union has opted for centralisation.

A national framework for digital technologies within health and care services would ensure the NHS can safely and efficiently identify which new tools should be adopted, and avoid problems emerging later. The framework should put new tools through thorough tests before adoption. At baseline, this means safety and efficacy: does the tool do what it claims, and does it do so without causing harm.

A national framework should test for consistency of performance across populations. Tools are often trained on small, homogenous groups rather than diverse cases within a broader dataset. Skin analysis tools built without data on darker skin are one example. A tool that performs well for one population and poorly for another will widen the inequalities this report documents rather than narrow them.[187]

The framework should test for transparency, so that a purchaser can see what a tool was trained on and how it reaches its conclusions, rather than being asked to trust a system whose workings are not disclosed. It should also test for data protection, because these tools are trained and operated on patient information, and public willingness to share that information depends on confidence that it is properly handled. And it should test for sustainability over the

186 Professional Standards Authority, written evidence to the Inquiry, 2026.

187 Daniel Hardiman-McCartney MBE, Clinical Adviser, College of Optometrists, Oral Evidence Session 3, 3 December 2025. See also Kidney Research UK, written evidence to the Inquiry, 2026.

tool's lifespan, because a product that cannot be maintained, updated, or supported over time will fail after the NHS has built services around it.

These properties align with the criteria proposed by techUK, the trade body for the technology sector, which describes trustworthy AI in health as fair, universal, traceable, usable, repeatable and explainable. Its argument is that a supplier should be able to demonstrate each of these before deployment rather than after.

Within today's system, a digital product is approved by the NHS once and is not reviewed again until a replacement product or new major release is announced. This process does not work for AI, which by design evolves as the world around it changes. Instead, suppliers should hold a safety mark demonstrating that the tool continues to perform within its agreed limits, including for particular groups of patients, and should be obliged to report when it does not.

The framework should apply to new deployments from the outset but be phased for tools already in use. Withdrawing working services pending reassessment would remove benefit from patients currently receiving it. Several tools are already deployed, including stroke imaging tools, admission risk tools in care settings, and ambient scribes in general practice, all assured under the current arrangement of a single check at the point of purchase. The framework should also be reviewed and updated at regular intervals, aligned with the pace of digital innovation and the evolution of these technologies.

Recommendation 5 also asks that concerns about a tool's performance can be formally reported and acted upon. If a clinician suspects a tool is performing differently for a particular group of patients, there is currently no route and expectation for reporting this.

Underpinning each of these points is the workforce question. The College of Optometrists, alongside around 1,600 NHS professionals, has called for literacy in these tools to be a mandatory part of clinical training, so that a clinician can appraise a product the way they appraise a medicine.[188] But training only works if clinicians have the time to undertake it. The Inquiry heard that the practical constraint is protected time rather than willingness, and that responsibility for creating it sits with employers rather than with individual practitioners.[189]

Where these conditions have been met, the results are substantial. A tool used to identify people at risk of unplanned admission was associated with a 60 per cent reduction in emergency department attendances and a 35 per cent reduction in falls in care settings.[190]

188 College of Optometrists, written evidence.

189 Abdulhussein, Oral Evidence Session 3.

190 Health Innovation Network, written evidence.

Clinical coaching guided by an automated tool was associated with 34 per cent fewer emergency attendances.[191] Neither of these was a technology success on its own. Both had structured governance and evaluation running alongside them from the beginning, which is precisely what a national framework would make standard rather than exceptional.

Recommendation 5: The Department of Health and Social Care and the Cabinet Office should establish a safe adoption framework for new technologies in primary care.

Cost type: Within existing resources

a. Establish a safe adoption framework for new technologies in primary care, covering the four sectors, with the following properties any technology should meet: safety, efficacy, consistency of performance across populations, transparency, data protection and sustainability over the technology's lifespan.

b. Apply the framework to new deployments from the outset, with phased implementation for technologies already in deployment.

c. Include mechanisms for reporting and resolution of concerns about potential bias or other risks in specific technologies.

d. Design the framework as iterative and updated regularly, given the pace at which the technology landscape is changing.

e. Invest in the primary care workforce alongside the framework, through comprehensive training and education programmes in medical education and postgraduate NHS training, in line with the 10 Year Health Plan's commitment to workforce development. If and when additional funding becomes available, support practice-level and primary care network-level training that reflects local implementation contexts, so that the workforce is equipped to adopt new technologies safely rather than left to follow only what developers offer.

191 Health Innovation Network, written evidence, citing the BRAVE AI evaluation and the UCLPartners evaluation of AI-guided clinical coaching.

5.8 The NHS App and the people it leaves out

While the previous section looked at technology being added to primary care, this section asks how patients reach primary care in the first place. The Inquiry's evidence supports the direction of the NHS App, but identifies two essential conditions: it must provide a reliable route to care, and patients must have an alternative way to access services.

Commenting on the first condition, one Inquiry participant explained why the App does not currently provide reliable access to primary care.[192] Most GP practices in England use one of two clinical record systems, and those systems do not communicate consistently with each other or with other services. Because the App has to work through whichever system a patient's own practice uses, what a patient can actually do through it depends on their practice rather than on the App itself. Booking an appointment may be possible at one practice and not at another. The App also only currently functions as a front door for general practice, as it does not grant patients access to the other primary care sectors. A patient cannot use it to reach a pharmacy service, book an eye test, or find an NHS dentist. Three of the four sectors are missing from the place the public is being told to look.

In relation to the second concern of alternative access, evidence submitted highlighted who would be excluded from an entirely digital front door. One practice's data shows 90 per cent of e-consultations coming from patients under 65, concentrated between 25 and 45.[193] Dr Simon Opher MP observed that the online consultation system in his own practice is not popular, particularly with older patients. Age UK puts around 2.4 million people aged 65 and over as using the internet less than monthly or not at all.[194] And the Roma Support Group surveyed the communities it works with and found 2 per cent using the NHS App.[195]

2%

Share of Roma community members surveyed who reported using the NHS App.

Source: Roma Support Group, written evidence to the Inquiry, 2026.

192 Payne, Oral Evidence Session 3.

193 Gupta, Oral Evidence Session 2.

194 Age UK, analysis of digital exclusion among older people, cited in evidence to the Inquiry, 2026.

195 Roma Support Group, written evidence to the Inquiry, 2026.

Full NHS App functionality depends on being registered with a GP practice and holding an NHS number. This creates a specific exclusion that a general commitment to digital inclusion will not resolve. The populations Chapter 4 describes as unregistered are locked out of the digital front door by the same failure that keeps them out of the building. The digital route cannot be the answer for people the registration route has already refused, which is why Recommendation 6 names the NHS number gap specifically rather than folding it into digital inclusion generally.

The National Pharmacy Association, as part of our evidence gathering, outlined digital exclusion through four separate problems. Some patients lack devices, connection, or data. Some have the equipment but not the confidence or skill to register, verify their identity, or manage several logins. Some face age-related barriers including sensory or cognitive impairment and interfaces not built for accessibility. And some face language barriers, where limited English or low health literacy makes a written digital process unusable. Each needs a different response: a programme aimed only at devices addresses the first and none of the others. There is also a more basic constraint. The NHS App runs only on devices using the Apple iOS or Android operating systems, so a patient with a handset outside those two systems cannot use it at all, however confident they are. The NHS website is available to anyone with an internet connection, which is why Recommendation 6 asks for it to be developed alongside the App rather than after it.

Inquiry stakeholders made the same distinction more sharply: having a connection and being able to navigate an NHS system with it are not the same thing.[196] The University of Surrey documents the consequences, with persistent inequalities in the uptake of online services by age, gender, and ethnicity. Their proposed remedy is practical: one supported front door, where reception and care navigation staff can complete a digital process on behalf of someone who cannot, with visible flags in the record for communication and learning disability needs, prompts for longer appointments, and training for the staff who do it.

What policy consistently underestimates is that supporting people to use a new system is itself work, and somebody has to be paid to do it. The Inquiry heard of a service that put an iPad in the waiting room so patients averaging 68 could complete a questionnaire after cataract surgery. Two things went wrong: they had just had an eye operated on, and the iPad kept disappearing.[197] Introducing a new system without proper support or guidance will not free up time. It transfers time to another workstream, usually the work of helping people use it. Without funding through contracts to pay for that support, the work will not be carried out. Today's health and care reception and administrative staff are not 1940s secretaries. They are the

196 Dr John Ford, Director, Health Equity Evidence Centre, Oral Evidence Session 1, 29 October 2025.

197 Hardiman-McCartney, Oral Evidence Session 3.

gatekeepers of the system from a patient's first contact, and registration automation may be welcome for removing mundane tasks and freeing up capacity, but no amount of training compensates for fragmented systems.

The Inquiry also heard clear conditions for online triage from the perspective of people using it in distress – it should always be easy to reach a human. Automated systems should recommend and guide rather than decide who gets in. And someone in crisis, or a family member seeking help for them, should reach a person rather than a form. These conditions matter because the populations facing the worst digital exclusion also have the highest prevalence of mental health problems, and some symptoms make navigating an online system harder even where the device and the connection exist.

Two further proposals would improve the front door for everyone.

A GP triaging a patient should be able to see in real time how many Pharmacy First and eye care appointments are free locally. At present a GP can tell a patient that a pharmacy may be able to help, without knowing whether any pharmacy nearby has capacity that day. The patient is sent to find out for themselves, and if they cannot get seen they return to general practice. Being able to see live availability would allow the GP to book the appointment rather than blindly suggest it. It requires no new clinical system, only that existing booking information is visible across sectors, and it is the difference between signposting a patient and referring them.

The second proposal is that government should treat digital health literacy as a public health matter. Patients who are reluctant to use digital services often do so out of caution rather than inability. Older patients may take an unexpected NHS message for a scam, and communities with reason to be careful about what happens to their information may choose not to engage. One contributor argued that public health campaigns have changed population behaviour before and could do so again.[198] A dedicated campaign on accessing NHS services safely online would give people accurate information about what is genuine and what is not, and build confidence in using digital services.

198 Ibid.

Recommendation 6: The Department of Health and Social Care should expand the NHS App and NHS website functionality across the four primary care sectors, alongside a guaranteed non-digital access route and support for people who are digitally excluded.

Cost type: Within existing resources

a. Expand NHS App and NHS website functionality across all four primary care sectors, so that users have one integrated route to primary care digital services.

b. Guarantee a non-digital access route to all primary care services, running in parallel with digital expansion.

c. Fund support for people who face digital exclusion, including community-based digital confidence work and resolution of the NHS number gap that currently excludes some populations from full NHS App functionality.

d. Run a national campaign to build public confidence in using NHS digital services safely, aligned with existing online safety messaging.

5.9 How these recommendations work together

The three recommendations work in sequence. Recommendation 4 makes patient information move between services and requires progress to be reported publicly. Recommendation 5 sets the conditions under which new technology can be adopted safely. Recommendation 6 makes sure the front door is one everybody can open.

Taken together, they address the questions this chapter has raised and which current programmes do not yet settle. Whether the single patient record includes all four sectors from the start, or adds three of them later. Who pays for the identity infrastructure that makes access across sectors possible. What each professional should be able to see, and how a patient has any say in it. Whether a non-digital route is a guarantee or an aspiration. And how a clinician is meant to tell a well-built tool from a badly built one.

Every tool the Inquiry examined improves access for those who already face fewest barriers, while risking leaving the same excluded minority further behind. This chapter's evidence shows digital primary care works. The argument here is for building it deliberately, because the alternative is a system that works well only for the people who were already being served well.

Chapter 6: Building a sustainable primary care system

Top Lines

- The same funding problem appears in all four primary care sectors, but it works through a different mechanism in each.
- Contracts do not just pay for work but they decide which work happens. When a payment is withdrawn the work stops, without anyone deciding that it should.
- Half of GP practices say their premises are unsuitable for what they do now. Three quarters say they have no room to train new GPs.

6.1 One pattern, four mechanisms

Chapter 3 set out the report's central argument about funding: access fails because of how resources are distributed. This chapter shows what that looks like inside each of the four primary care sectors.

Within general practice, the Carr-Hill formula decides how the core payment for each registered patient is shared. It weights how GPs spend their time rather than how much care a population needs, and it draws on decades-old data. The consequence is that practices in the most deprived areas receive around 7 per cent less funding per patient when taking into account the additional workload a sicker population incurs. Other analysis covering all practice income streams even put the gap at 9.8 per cent in 2022/23.[199] Four independent studies, using different methods and different datasets, reached the same conclusion. One found that a 10 per cent increase in deprivation produced a funding increase of only 0.06 per cent.[200] Another, working with Welsh data, found funding fell by around 1 per cent for every 10 per cent increase in the proportion of most-deprived patients.[201] A third showed how borough-wide averages in east London made high-need populations appear adequately funded when they were not.

199 Fisher, R., and others, "Level or Not? Comparing General Practice in Areas of High and Low Socioeconomic Deprivation in England," Health Foundation, 2020.

200 Levene, L. S., and others, "Socioeconomic Deprivation Scores as Predictors of Variations in NHS Practice Payments," British Journal of General Practice 69, no. 685 (2019): e546–e554.

201 Currie, J., and others, "Exploring the Equity of Distribution of General Medical Services Funding Allocations in Wales," BJGP Open 9, no. 1 (2025).

A fourth, examining every small area in England, found that adjusting for age and deprivation improved the accuracy with which the formula predicted clinical need, across every model tested.[202] Chapter 1 set these out in full.

In community pharmacy, before recent increases, funding remained static in cash terms for almost a decade after funding was cut in 2016. An independent economic analysis by Frontier Economics and IQVIA, commissioned by NHS England and published in March 2025, found that the sector was experiencing a funding gap of £2.3 billion. Ninety-nine per cent of pharmacies received less than the full cost of the services they delivered, and nearly eight in ten were judged not financially sustainable in the short term.[203] Government has acknowledged in an answer to a parliamentary question that funding in 2025/26 was £800 million lower in real terms than in 2015/16.[204]

Community Pharmacy England, as part of our Inquiry, set out what that means in practice, drawing on a representative survey of owners of the sector's 10,400 pharmacies. Fifty-one per cent were operating at a loss. Of those, forty-five per cent were using personal savings to keep the business open. More than a fifth had cut their opening hours in the past year, which reduces access directly. On average 2 pharmacies are closing every week, most of them in the most socioeconomically deprived areas and in rural areas.

51% and 45%

Share of pharmacy owners operating at a loss, and the share of those using personal savings to keep the business open.

Source: Community Pharmacy England Pressures Survey, Evidence Session 2, 19 November 2025.

Pharmacy is also structurally different from the other three sectors. Most community pharmacies rely on the NHS for 90 to 95 per cent of their income.[205] Yet, they cannot pass on increased costs to the NHS and they cannot manage demand through waiting list. Where general practice, dentistry, and optometry each have some private income to absorb a shortfall, pharmacy has almost none. That is why the pharmacy funding gap appears as a specific sub-recommendation rather than being left to a general uplift.

202 Boomla, K., Hull, S. and Robson, J., "GP Funding Formula Masks Major Inequalities for Practices in Deprived Areas," BMJ 349 (2014): g7648.

203 Frontier Economics and IQVIA, "Economic Analysis of NHS Pharmaceutical Services in England," commissioned by NHS England, March 2025.

204 Company Chemists' Association, written evidence to the Inquiry, 2026, citing House of Commons written answer UIN 113242.

205 Company Chemists' Association, written evidence.

In dentistry, the funding mechanism is based on how much activity is bought – this is clearest where the sector is performing well. The Institute of Dentistry at Queen Mary University of London reports that London is delivering all of the dental activity it has been commissioned to deliver, and that in North East London 37.2 per cent of the population saw an NHS dentist in the two years to March 2024, against 40 per cent for England.[206] This shows that providers are doing everything they are paid to do, yet access is still below average. The limit is what was bought. Denplan, a dental payment plan provider working with over 6,600 member dentists, supplies the other half of the picture: £392 million of the ringfenced dental budget went unused in 2023-24 because commissioners could not find practices willing to take NHS contracts.[207]

In optometry, the problem is that in some areas the relevant services have never been commissioned. FODO, the Association for Eye Care Providers, describes a three-tier framework in which sight testing is available everywhere, while the enhanced services that keep patients out of hospital are commissioned locally and therefore inconsistently. Where an ICB has not commissioned them, a patient who could have been treated in an optometry practice has no route to that care and is referred to hospital instead. Primary care audiology, commissioned across a whole Integrated Care Board area in only around 30 per cent of cases, is the same problem in a sharper form.[208]

Four sectors, four mechanisms, one result. The varying and fragmented funding mechanisms explain why reforming one contract at a time has never been effective in reforming primary care. Each sector fails for its own reason, each reason sits inside its own contract, and nobody is required to look at all four together.

6.2 Why a mechanism is needed

Successive UK Governments have committed to moving care out of hospitals and into the community since at least 2006. That January, the Department of Health published 'Our health, our care, our say: a new direction for community services', a White Paper the then Secretary of State described as a fundamental shift towards services provided in local communities.[209] Its justification was that this would be more convenient for patients, avoid costly hospital treatment, and prevent illness before it became expensive. The NHS Long Term Plan committed to the same direction in 2019; the Government's integration white paper, Health and social care integration: joining up care for people, places and populations, committed to it in February 2022;

206 Institute of Dentistry, Queen Mary University of London, written evidence to the Inquiry, 2026.

207 Denplan, written evidence to the Inquiry, 2026, citing National Audit Office analysis.

208 NCHA, written evidence.

209 Department of Health, "Our Health, Our Care, Our Say: A New Direction for Community Services," January 2006.

Lord Darzi identified it as necessary in 2024; and the 10 Year Health Plan committed to it again in 2025.

Over the same period the money moved in the opposite direction of what had been promised. Lord Darzi found the hospital share of the NHS budget rose from 47 per cent to 58 per cent between 2006 and 2022, concluding that the NHS had implemented the inverse of its stated strategy.[210] His explanation is the important part for this chapter: the distribution is perpetually reinforced, because performance standards focus on hospitals rather than on primary care, community services, or mental health. Additionally, single-year budgets reinforce the position they inherit. The conclusion he set out for the 10 Year Health Plan was that financial flows must lock the shift in irreversibly or it will not happen.

That is the case for the Primary Care Investment Standard. Five commitments over twenty years have not shifted the distribution, because a commitment is renegotiated every year while the mechanism remains the same. The Standard adds a published baseline, a requirement that the share grows year on year rather than merely being discussed, and a report to Parliament so that progress can be reviewed and scrutinised. This requires no new money; only that the redeployment already promised is made visible and accountable.

Reform of the Carr-Hill formula belongs alongside the Investment Standard, because the two solve different halves of the same problem. The Standard determines how much money reaches primary care. The formula determines how that money is shared between practices. General practices working in the most challenging conditions receive less relative to the complexity of their work, not because the total sum is inadequate but because Carr-Hill distributes it in ways that penalise deprivation. The Government's review of the formula, announced in October 2025 and led by the National Institute for Health and Care Research, has been asked to recommend the best approach to replacing Carr-Hill, expressly not limited to adjusting the existing model. In March 2026 the minister told the House that the review was under way and that the intention is to implement a new formula from 1 April 2027.[211] Recommendation 7 asks that whatever replaces it reflects deprivation, complexity, and the additional cost of employing staff to care for people who face the greatest barriers to access.

Reforming the formula alone will not be enough, and this is the basis for the third part of the recommendation. Roughly half of general practice income is distributed through Carr-Hill. The other half comes through the Quality and Outcomes Framework, dispensing payments, enhanced service contracts, and other streams, each of which carries distributional effects of its

210 Lord Darzi, "Independent Investigation of the National Health Service in England," Department of Health and Social Care, September 2024, summary letter, para. 13.

211 Hansard, House of Commons, 16 March 2026.

own. A practice in a deprived area could therefore see its core payment corrected and remain no better off overall, because the disadvantage built into the other half of its income would be untouched. The long-term challenge for government is to align these funding streams so that they work together rather than against one another. The same problem takes a different form in community pharmacy, where the distribution mechanism is a national settlement rather than a formula, and where the gap between the cost of services and the funding available is set out earlier in this chapter. Both sectors need their distribution mechanisms reformed.

However, reforming the formula inside a fixed pot moves the problem around rather than solving it. General Practice budgets set since 2004 currently pay for staff who are already employed. That is why the Standard and the formula sit within a joint recommendation. Growing the pot without fixing the share-out leaves the same practices short. Fixing the share-out without growing the pot destabilises practices that are currently stable.

Recommendation 7: The Department of Health and Social Care and HM Treasury should establish a Primary Care Investment Standard and reform the funding distribution mechanisms for general practice and community pharmacy.

Cost type: Within existing resources for the Investment Standard; with targeted additional investment for the pharmacy funding gap

a. Establish a Primary Care Investment Standard as the formal mechanism through which that redeployment is enacted. The Standard should require year-on-year growth in the primary care share of NHS expenditure, against a published baseline, with progress reported annually to Parliament and to Integrated Care Boards.

b. Ensure Carr-Hill reform reflects deprivation, complexity, and the additional workforce cost of caring for populations who face the greatest barriers to access.

c. Alongside formula reform, review the other income streams through which general practice is funded, including the Quality and Outcomes Framework, dispensing payments and enhanced services, so that reform of the formula is not offset by distributional effects elsewhere in practice income.

d. If and when additional funding becomes available, address the community pharmacy funding gap identified by the independent economic analysis, so that pharmacy provision is sustained particularly in the most deprived areas.

6.3 What contracts actually buy

A contract does not simply pay for work that would have happened anyway – it decides what work happens. The Inquiry heard several examples of what this looks like in practice.

Case Study: What happens when a payment is withdrawn

A structured medication review is a scheduled appointment in which a clinical pharmacist goes through everything a patient is taking, looking for medicines that are no longer needed, doses that should have changed, and combinations that may be causing harm. They are aimed at patients on multiple medicines, who are typically older and living with several long-term conditions.

They were introduced into the primary care network contract in 2020/21, with payment attached. In September 2021 the national overprescribing review, commissioned by the Department of Health and Social Care and led by the then Chief Pharmaceutical Officer for England, recommended that NHS England expand them further. That review found that around 10 per cent of items dispensed in primary care were either inappropriate for the patient's circumstances or could be better served by alternative treatments, that 15 per cent of people take five or more medicines a day, and that around one in five hospital admissions among people over 65 are caused by the adverse effects of medicines. Ministers accepted all of its recommendations.

The 2023/24 primary care network contract removed the specific payment for structured medication reviews, replacing it with a requirement that networks describe how they intended to improve medicines use. The Royal Pharmaceutical Society's evidence to this Inquiry is that delivery has since been deprioritised in some networks.

No decision was taken that patients on multiple medicines should receive fewer reviews. No assessment was published of what withdrawing the payment would mean for them. The financial incentive changed, and the activity followed it.

Source: Royal Pharmaceutical Society, written evidence to the Inquiry, 2026; Department of Health and Social Care, "Good for You, Good for Us, Good for Everybody: A Plan to Reduce Overprescribing," 2021.

Chapter 3 set out the same mechanism operating on physical health checks for people with severe mental illness, where the consequence is measured in years of life.

A further pattern is that referral rules decide who gets care, and they vary enormously between areas. The Discharge Medicines Service is the clearest illustration. The most active area,

Cheshire and Merseyside, recorded 168 completed consultations for every 10,000 people. The middle-ranking integrated care system recorded five.[212] The service prevents one hospital readmission for every twenty-three consultations, so the difference between those two figures is measured in admissions. The smoking cessation service tells the same story, reaching fewer than five per cent of pharmacies.

168 versus 5

Completed Discharge Medicines Service consultations per 10,000 population in the most active area, against the median across integrated care systems. The service prevents one hospital readmission for every twenty-three consultations.

Source: Company Chemists' Association, written evidence to the Inquiry, 2026.

However, general practice triage does not routinely refer patients to community pharmacy. It signposts them, which means the pharmacy is not paid for the consultation that follows. A funding boundary produces a clinical inefficiency and neither party is behaving unreasonably. Evidence from community pharmacy set out what the working version looks like: patients referred from the practice reception desk, the work completed in the pharmacy, and the outcome written back into the GP record.[213] Participants suggested that electronic transfer infrastructure would make this reliable, and that places where it already works should be built on rather than rediscovered.

Additionally, bodies that commission pharmacy services do not control where pharmacies may open. Under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, applications to open a new pharmacy are determined against Pharmaceutical Needs Assessments, which are published by 152 Health and Wellbeing Boards, roughly six for every ICB.[214] Those regulations have been amended repeatedly since, but the split remains the same: the body that pays for pharmaceutical services is not the body whose assessment determines where they may be provided.

What connects these examples is that each concerns a single sector, and each was designed without reference to the other three. That is what an integrated commissioning framework would change. For it to be more than an organisational rearrangement, ICBs should commission against outcomes held in common across the four sectors, including reductions in

212 Company Chemists' Association, written evidence to the Inquiry, 2026, citing Thayer, Mackridge and White, Journal of Pharmaceutical Health Services Research, 2023, and NHS England, Liverpool's Discharge Medicines Service, 2022.

213 Dr James Davies, Director of Research and Insights, Community Pharmacy England, Oral Evidence Session 2, 19 November 2025.

214 The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, SI 2013/349.

emergency admissions, reductions in inequalities of access, and patient-reported outcomes. Without shared outcomes, integration produces new structures and no measurable benefit.

Continuity belongs on that list, and the evidence to this Inquiry quantifies why. Continuity of care reduces patient mortality by between 10 and 15 per cent, hospital admissions by up to 15 per cent, and emergency department visits by up to 20 per cent.[215] No single sector can deliver it alone, because a patient's care crosses between all four and between primary care and the rest of the NHS. A GP practice can organise its own appointments so that a patient sees the same clinician.[216] It cannot ensure that the record follows that patient to a pharmacy, a dentist or an optometrist. That is why continuity has to be an outcome the four sectors are commissioned against together, rather than a value each is asked to hold separately.

6.4 Who is allowed to hold a contract, and what it buys

Two specific problems, identified through the evidence to our Inquiry, show why the framework has to reach into contract design rather than stopping at coordination.

The first is a technical question with severe consequences. The Local Optical Committees, which are the representative bodies through which optometry organises locally and which hold the clinical knowledge of what a population needs, cannot legally hold NHS contracts. Provider companies such as Primary Eyecare Services are the appropriate contract-holders. This results in a gap between the body that understands the local need and the body that can be paid to meet it. The remedy is not complicated: support the committees to advise on service design while the provider companies deliver. But it requires somebody to make that arrangement deliberately rather than leaving each area to work it out.

The second is the dental contract, which is the clearest case in the evidence base of a contract working against the outcome it is meant to buy. The Unit of Dental Activity system pays a practice the same for a course of treatment regardless of how complex it is, so a practice receives the same for a single filling as for a patient needing extensive work.

Two things follow. Firstly, urgent access – when patients cannot get a routine dental appointment, problems that would have been caught early instead develop into pain. Those patients then present wherever they can, which as this report sets out means GP surgeries, accident and emergency departments and NHS 111, none of which can treat them. A contract that buys urgent access as a universal entitlement would meet that need in the setting designed for it.

215 Workforce and Learning Research Group, Nuffield Department of Primary Care Health Sciences, University of Oxford, written evidence to the Inquiry, 2026.

216 Dr Victoria Tzortziou-Brown, Royal College of General Practitioners, Oral Evidence Session 2, 19 November 2025.

Secondly, prevention, which under the current payment structure is the activity a practice is least rewarded for providing. Stakeholders in our Inquiry described the contract reforms taking effect from April 2026 as welcome but interim. They noted that the changes continue to favour urgent and unscheduled care while undervaluing the routine care that would reduce the need for it, and that the new complex care pathways do not fully reflect the cost of delivering them. Instead, the system needs a contract structure that buys universal urgent access and rewards prevention, which is what the Inquiry sets out as part of Recommendation 8.

How to address the funding gaps sits within the same recommendation because they are the price of the reform rather than a separate ask. Dental contract reform has an acknowledged shortfall of around £1.5 billion.[217] In optometry, evidence to the Inquiry identifies a requirement of around an additional £350 million to reduce the funding gap for existing services and commission services in areas that currently have none.[218] Both are framed conditionally, on the availability of additional funding, because the architectural changes in this recommendation are worth making either way.

The referral requirements structure within the framework also requires further scrutiny. Throughout the Inquiry we have heard arguments that referral requirements should come down, so that patients can walk in or refer themselves and the list of conditions expands, as it has in Scotland and Wales. However, many patients do not arrive with a defined problem, and commissioning, which bypasses the initial generalist assessment, risks over-investigation and worse outcomes for people least able to navigate a complicated system.

Pharmacy First currently covers seven defined conditions, not undifferentiated presentations, and around 90 per cent of eligible patients complete their care in the pharmacy.[219] From autumn 2026 the service is expected to expand. Under the 2026/27 community pharmacy contract, pharmacist prescribers will be able to prescribe within the existing pathways, and up to five further prescribing-only pathways will be added, with bacterial and allergic conjunctivitis, oral thrush, skin infections and respiratory tract infections among those under consideration.[220]

Some of those are less clearly defined than the current seven. A patient presenting with a skin infection or a respiratory tract infection may have something else, and deciding where such a patient should first be assessed is a judgement about the whole of primary care. NHS England is convening a clinical reference group of pharmacists and GPs, with input from bodies including the National Institute for Health and Care Excellence, to assess the proposed

217 British Dental Association, written and oral evidence to the Inquiry, 2026.

218 Association of Optometrists, written and oral evidence. The Association confirms this figure is additional to the current optometry budget.

219 Company Chemists' Association, written evidence.

220 Community Pharmacy England, "Community Pharmacy Contractual Framework 2026/27," 2026.

pathways. That is the right body to judge whether a pathway is clinically safe. It is not constituted to settle where the boundary between sectors should sit.

This is why the expansion cannot simply be left to run as it is. Each individual decision is reasonable, and the cumulative effect is that the boundary between sectors moves without anyone holding responsibility for where it should sit. Recommendation 8 asks for a commissioning framework covering all four sectors precisely so that decisions of this kind are taken once, deliberately, and with all four sectors present, rather than sector by sector as each service specification is written.

Recommendation 8: The Department of Health and Social Care and Integrated Care Boards should establish an integrated commissioning framework across all four primary care sectors, addressing unmet need in general practice, community pharmacy, dentistry, and optometry.

Cost type: Within existing resources for the framework; with substantial additional investment where funding gaps are addressed

a. Establish an integrated commissioning framework across all four primary care sectors, addressing unmet need in general practice as well as in dentistry, community pharmacy, and optometry, with Integrated Care Boards jointly commissioning against common outcomes that include reductions in unmet need, improvements in continuity of care, reductions in emergency admissions, reductions in inequalities of access, and patient-reported outcomes.

b. Ensure primary care contracts are held by appropriate provider bodies, so that entities such as Local Optical Committees, which cannot legally hold contracts, are supported to advise on service design while provider companies deliver.

c. Reform the dental contract to include universal urgent access and prevention incentives, and to allow scope for further services to be added over time where the dental workforce and setting could support them.

d. If and when additional funding becomes available, address the identified funding gaps in dentistry (approximately £1.5 billion for contract reform) and optometry (approximately an additional £350 million to reduce the existing funding gap and commission services where currently none are provided), alongside the pharmacy funding gap set out in Recommendation 7.

6.5 The state of buildings

The estate is where the funding mechanisms become physical, and the evidence on its deficiencies is consistent across organisations with very different interests.

Survey data from around 2,000 GP practices, roughly one in three in England, shows that half of practices find their premises not to be suitable for what they do now.[221] Eighty-three per cent said they are not suitable for what they will need to do. Seventy-four per cent said they do not have enough space to train new GPs.[222]

74%

Share of GP practices reporting they do not have enough space to train new GPs. Half say their premises are unsuitable for present needs; 83 per cent for future needs.

Source: British Medical Association GP Premises Survey 2025, Evidence Session 2, 19 November 2025.

The lack of space matters most for the rest of this report. GP trainees add no capacity in terms of appointments while they are learning, but they still need a room. A practice with no spare room cannot train new staff. As such, a shortage of rooms today will become a shortage of GPs in five years. This is not a new problem: a Royal College of General Practitioners survey in 2023 found that 66 per cent of responding GPs said limited space made it difficult to train new GPs, and 75 per cent said it restricted how many trainees they could take on.[223] It also reports that 42 per cent of GPs are likely to leave general practice within five years, at a time when governments have committed to increasing training numbers without it being clear where the additional trainees would sit.

Through our analysis, it is however clear that the shortage within primary care is not only about doctors. Overcrowded GP estates and a lack of consultation space pose a direct barrier to integrating occupational therapists and other allied health professionals into primary care teams. To address this, stakeholders have identified investment in consultation rooms, group therapy spaces and community wellbeing hubs as priorities. The same issue presents itself within pharmacy, where delivering more clinical services requires larger premises with more consultation rooms, and where the General Pharmaceutical Council's patient forum has

221 Dr Gaurav Gupta, England GP Committee Lead for Premises, British Medical Association, Oral Evidence Session 2, 19 November 2025.

222 British Medical Association, "GP Premises Survey Results 2025," 2025, presented in oral evidence to the Inquiry and cited in Primary Health Properties written evidence.

223 British Property Federation, written evidence to the Inquiry, 2026, citing a Royal College of General Practitioners survey, 2023.

separately raised confidentiality in pharmacy consultation space as a patient concern.

There is also existing capacity that is not being used – primary care audiology operates from more than 1,500 locations in England, equipped and staffed.[224] In December 2025 the Government told Parliament that 30 of the 42 ICBs in England commission adult community audiology, that in around half of those areas coverage is only partial, and that in 12 areas no service is commissioned at all.[225] Where it is not commissioned, patients concerned about their hearing must see a GP first and then be referred to a hospital service, while the community capacity sits outside the NHS. Commissioning those services would add capacity without capital expenditure. The estate therefore constrains not just how many people can be trained, but which professions can work together, and which existing facilities the NHS is able to use.

Evidence collated from the property sector set out the condition of what exists. Primary Health Properties, which owns and manages more than 1,100 purpose-built healthcare buildings and works with practices serving around nine million patients across every Integrated Care Board in England, told the Inquiry that the wider primary care estate looks very different from the modern facilities it develops.[226] Lord Darzi described the primary care estate as plainly not fit for purpose, and the evidence submitted to this Inquiry bears that out at every level, from the age of the buildings to the refusal of grants small enough to fix them. The same evidence reports practices where more than thirty staff share a single toilet.

224 NCHA, written evidence.

225 Hansard, House of Commons, 18 December 2025.

226 Primary Health Properties, written evidence to the Inquiry, 2026.

THE STATE OF THE PRIMARY CARE ESTATE

20 per cent of the primary care estate predates the founding of the NHS in 1948.[1]

More than half of primary care buildings are over thirty years old. Only around a third have definitely been built since 1995, and the number of new facilities declined steeply between 2015 and 2024.[2]

Around 2,000 general practice buildings were found unfit for purpose in 2022, roughly a quarter of the total at the time.[3]

Half of GP practices say their premises are not suitable for what they do now. 83 per cent say they are not suitable for what they will need to do. 74 per cent say they do not have enough space to train new GPs.[4]

Over 40 per cent of practices that applied for grants to improve their premises were turned down, despite most of those grants being for less than £150,000.[5]

1 Lord Darzi, Independent Investigation of the NHS in England, 2024; 2 Analysis cited in Primary Health Properties, written evidence; 3 Dr Claire Fuller, Next steps for integrating primary care: Fuller Stocktake, 2022; 4 British Medical Association GP Premises Survey, 2025; 5 British Medical Association GP Premises Survey, 2025.

Lord Darzi identified a shortfall of approximately £37 billion in NHS capital investment relative to comparable countries during the 2010s.[227] That was compounded by £4.3 billion transferred out of capital budgets to cover day-to-day spending between 2014/15 and 2018/19. This is a whole-NHS capital finding rather than a general practice one, but the observation he drew from it is specific: the missing capital would have been enough to rebuild or refurbish every GP practice in the country.

Today, practices hold rooms full of paper records they cannot destroy. These are Lloyd George records, the paper files first issued in 1911 and no longer created for new patients since January 2021.[228] Current guidance is that they may only be destroyed once they have been scanned to the national standard and the scanned images have been quality assured, so until a practice has digitised them, the paper has to stay. Retention rules apply on top of this: GP records are generally kept for ten years after a patient's death, and for a hundred years where a patient deregisters and never registers elsewhere. In our Inquiry we heard examples of practices keeping records in shipping containers outside the surgery.

The 2019/20 GP contract committed to digitising all Lloyd George records by March 2023, and

227 Darzi, "Independent Investigation," summary letter, paras. 16 and 17.

228 NHS England Digital, guidance on Lloyd George records.

NHS England began procuring nationally to deliver it.[229] That deadline passed without national delivery, and current guidance leaves digitisation to be funded by the practice, the Primary Care Network or the ICB.

Our analysis points at two routes that should be made available address this issue – shared physical storage and digitisation. Shared physical storage at ICB level would be cheaper in the short term, and would move records out of clinical premises without the cost of scanning them. Digitisation costs more, but it is the only route that permanently frees the space, and that space is precisely what this chapter has established is missing. A room currently holding boxes could be a consulting room, or the room a practice needs before it can take a trainee.

Where records can be digitised, that should be the default and it should be funded and coordinated nationally rather than left to individual practices. Digitisation is work a practice must do now for a benefit it receives later, and the practices with the least space are usually those with the least capacity to organise it. Left to local discretion, it will not happen, which is what happened after the March 2023 deadline passed. Shared physical storage should be available where digitisation is not practical, so that no practice is left storing records in a shipping container because neither route was open to it.

6.6 Barriers to investment

Investment in primary care premises is blocked less by the level of capital available than by a set of requirements, some in regulation, some in accounting standards and some in contract terms, each of which made sense on its own and which now combine to prevent buildings being built, shared or improved. Changing them requires decisions rather than money, which is why they appear in the part of Recommendation 9 that sits within existing resources.

Reimbursement of GP premises costs is governed by the NHS Premises Costs Directions, under which a market rent must be agreed with the NHS, informed by engagement with the District Valuer Service. That Service is meant to assess whether a scheme offers value for money and agree a fair market rent. Evidence to the Inquiry raised concerns that it is focussed on managing costs, meaning the overall level of rent, rather than fully assessing the value of schemes.

Developers reported that in recent years the costs of construction, labour and capital have risen significantly, with inflation of over 20 per cent on some materials such as steel, and that

229 NHS England, "Investment and Evolution: A Five-Year Framework for GP Contract Reform," 2019; and NHS England Digital, guidance on the digitisation of Lloyd George records.

assessments fail to acknowledge either those increased costs or the value of the new buildings.[230] Improvements to a building are excluded from the calculation of value altogether, unless a financial benefit to the wider NHS can be demonstrated. As one submission put it, value for money is not achieved by deterring new developments. The result is that projects are put on hold because a viable rent cannot be agreed, even where the ICB supports the scheme.

What makes this hard to resolve is that the District Valuer Service does not publish the methodology it uses to arrive at a market rent. Neither party to a negotiation can see how the figure was reached, there is no route to challenge it, and the Service occupies a position that is in practice decisive rather than advisory. Recommendation 9(a) therefore asks that the valuation methodology and the appraisals themselves are published, and that a dispute resolution mechanism is introduced.

On the other hand, an ICB can take on a long lease and sub-let space to different providers as local needs change, which is one of the simplest routes to bringing several services under one roof. However, the international accounting standard IFRS 16 requires the whole value of a lease to be recognised in the year it is signed, and the Capital Departmental Expenditure Limit (CDEL) caps how much capital the NHS may commit. Taken together, a Board that signs a lease funded entirely from day-to-day money can breach its capital limit without investing any capital at all. This was mitigated in the first year the standard applied, and no longer is. IFRS 16 is an international standard, and while it is not immutable, changing it is not within the gift of the Department or the NHS and would take years. The practical remedy is therefore on the NHS side: either flexibility in CDEL where the limit is breached only because of a lease, or excluding leases from it altogether, given that the rents are paid from revenue. That is what the capital and revenue flexibility in Recommendation 9(a) refers to.

Evidence to the Inquiry also identified that one of the two routes for private capital into primary care has effectively closed. Public-private partnership through the NHS LIFT model was caught by the 2018 ban on its predecessor financing structure, and nothing has replaced it.[231]

Additionally, our evidence points to the centralisation of strategic estates planning as a barrier in itself, and participants in our inquiry argued for local decision-making within clear national objectives. Capital envelopes should be managed through ICBs at system level, since those Boards already carry out the financial planning and capital prioritisation for their areas. This is what the delegation of capital decisions in Recommendation 9(a) asks for. However, it is worth noting who is asking for it. This is not providers seeking easier access to public money, but the

230 Primary Health Properties, written evidence.

231 British Property Federation, written evidence.

property sector arguing that decisions taken closer to the local system would unlock investment that currently does not happen at all.

Each of these three changes sits within sub-recommendation 9(a), and each requires a decision rather than new money. Together they would remove the obstacles that currently stop schemes proceeding even where the NHS locally wants them and private capital is available to fund them.

The fourth requirement concerns contract length and how premises costs are reimbursed. GPs are independent contractors whose contracts run indefinitely, which is why they can commit to a building for twenty or thirty years. Other community providers may hold contracts for two or three years, which deters anyone from investing in premises for them. Within the current system, GPs are reimbursed for the cost of premises used to deliver their core contract, but not for space used to deliver anything else. A practice that offers a room to a community mental health team or a visiting physiotherapy service therefore carries that cost itself. A rule designed to protect public money from being spent on non-NHS activity now works against the co-location that neighbourhood health depends on.

Stakeholders also voiced concerns that estates are frequently considered as an afterthought, with the system creating primary care networks before considering where the premises would come from. Two changes would help. Linking estate decisions to new contracts from the outset would mean that when a new service or network is commissioned, the question of where it will operate is settled at the same time rather than afterwards. And changing the rule under which half the proceeds of selling an NHS building must be returned nationally would allow local systems to reinvest the full value of a disposal in their own estate, which would give them a reason to dispose of buildings they no longer need.

The relationship between NHS Property Services and its tenants is a recurring problem in its own right. The BMA survey found 54 per cent of NHS Property Services tenants and 35 per cent of Community Health Partnerships tenants reporting that disputes were making them unsustainable, and around a third had considered handing back their contracts.[232] Witnesses differed on the remedy, from settling the disputes and considering alternative ownership models through to abolishing the organisation. The Inquiry does not have the evidence to support a choice between those options, and this report makes no recommendation on the future of NHS Property Services. What the evidence does establish is that the current position is untenable. A third of tenants considering handing back their contracts is a risk to service continuity as well as to the organisations involved, and the Department, which owns

232 British Medical Association, "GP Premises Survey Results 2025," 2025.

NHS Property Services, is the only body able to act on it. This is a question the estates reform set out in this chapter cannot resolve on its own, and one that government will need to address alongside it.

6.7 Using what already exists, and building what does not

Before considering new buildings for primary care services, we need to review the ones already available within the system. Today, the primary care estate is owned by a mixture of GP partners, private landlords, NHS Property Services, and Community Health Partnerships. With ownership being fragmented there is little reliable data on how the space is used. Even where occupancy is recorded, it does not show whether a room sits empty because a GP works part-time or because it is being used for online triage that could happen elsewhere. As a result, Integrated Care Boards and NHS England do not have a clear picture of what could be repurposed or which sites could expand.

There is no published central NHS dataset reporting utilisation for every clinical room across the primary care estate in the way hospital bed occupancy is reported. The Estates Returns Information Collection reports it for trusts, showing under-utilised space at 1.9 per cent and non-clinical space at 33 per cent of the NHS estate in 2022/23, against a trust target of under 30 per cent.[233] It does not cover primary or community care. Evidence to the Inquiry pointed to space that could be converted to clinical use, including oversized waiting areas and retail space within practices, but without national data there is no way to establish how much of it exists or where.

Measuring how space is used has to be done carefully. A room that appears empty may be capacity a building needs in reserve, to absorb fluctuations in demand on its busiest day, or a room kept free for a patient who may be infectious. Measured crudely, necessary capacity looks like waste.[234]

Some stakeholders who monitored bookable rooms at a trust found that some rooms were booked but not used. In some cases this was due to appointments being rearranged, without the room booking being cancelled. In other cases it was found that staff turnover left nobody in charge of room bookings and cancellations. By introducing a data sharing system for room bookings and addressing the identified problems, the number of rooms booked and used went up.

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233 British Property Federation, written evidence, citing the Estates Returns Information Collection, 2022/23.

234 House of Commons Health and Social Care Committee, "Delivering the Neighbourhood Health Service: Estates," oral evidence, 1 July 2026.

The same pattern can be seen across other sectors. Evidence to the Inquiry argued that by making full use of existing primary eye care premises, workforce and equipment, the NHS could shift services towards a neighbourhood model without new capital, noting that community optometric practices hold facilities matching or exceeding those in hospitals. One example given was the use of spare rooms in GP surgeries as a suitable setting for community diagnostic work.[235]

Taken together, this points to something only a four-sector view makes visible. Each part of primary care holds usable space that the rest of primary care cannot reach, because each building belongs to a sector rather than to the system. An optometry practice with a scanner, a spare room in a GP surgery and a room full of paper records are all part of the primary care estate, and none of them appears in any plan for neighbourhood health.

Whilst the NHS should address how estate is being used and review how it can be improved, that does not substitute the need for further investment. There is some movement from the Government on this issue. The 10 Year Health Plan announced a Neighbourhood Health Centres programme delivering 250 centres, supported by a capital commitment of £426 million across the four years of the 2025 Spending Review, with up to half of that supporting 40 to 50 centres this Parliament through refurbishing existing buildings.[236] The NHS Rebuild scheme and the Utilisation and Modernisation Fund sit alongside it. Set against a backlog in which half of practices report unsuitable premises, around 2,000 buildings were found unfit for purpose four years ago, and over 40 per cent of practices applying for improvement grants were refused, that assessment is difficult to argue with. The programme would refurbish forty to fifty centres during this Parliament. Around 2,000 buildings were found unfit for purpose in 2022, so it addresses a small fraction of the premises that need attention. Our Inquiry recommends a capital programme prioritising the least suitable premises across all four primary care sectors.

235 Royal College of Ophthalmologists, written evidence to the Inquiry, 2026.

236 British Property Federation, written evidence, citing the 10 Year Health Plan and the 2025 Spending Review.

Case Study: Birmingham – seven services, one building, no new build

In Birmingham, a community diagnostic centre was integrated into an existing primary care building through a LIFT partnership, one of the public-private arrangements previously used to fund NHS community buildings. Underused space was refurbished to accommodate modern diagnostic equipment, with improvements to ventilation and energy-efficient lighting. The centre now runs seven days a week, bringing together outpatient diagnostics, two GP practices, an urgent treatment centre, a primary care hub, mental health services and community physiotherapy, and serves over 45,000 patients. It increased lettable space and reduced occupancy costs for the Integrated Care Board. No new building was required.

Source: British Property Federation, written evidence to the Inquiry, 2026.

Where new capacity is needed, there is a funding route that does not draw on NHS capital at all. It is the basis for the developer contributions element of the recommendation. When developers build new housing, they contribute to local infrastructure through Section 106 obligations and the Community Infrastructure Levy. Those contributions do not currently translate reliably into primary care capacity in the communities that new housing creates. Two changes would make them more reliable: NHS organisations should take part in preparing and reviewing local plans, so that health infrastructure is written in from the start rather than negotiated afterwards; and Homes England and Integrated Care Boards should work together earlier in the development process. As the government's housing ambitions are realised, the strain new development places on health services will rise with them, so these changes should be prioritised.

Case Study: Community Infrastructure Levy funding a new dental centre

The Institute of Dentistry at Queen Mary University of London is building a new academic dental centre in central Barking, in partnership with the London Borough of Barking and Dagenham. It is funded with £4.1 million from the Council's Strategic Community Infrastructure Levy programme, which is money raised from local development rather than from NHS capital.

The centre will train 130 new dental students each year and provide NHS dental care to over 5,000 patients annually, free at the point of access. It is the fifth clinic in the group, alongside sites in Tower Hamlets, Newham and Hackney. The Hackney site, funded with £3.2 million, trains 300 students a year and provides around 7,000 appointments.

The need is considerable. North East London has a population of two million, a quarter of whom live in the most deprived fifth of areas in England, and 37.2 per cent of the population saw an NHS dentist in the two years to March 2024, against 40 per cent nationally.

Source: Institute of Dentistry, Queen Mary University of London, written evidence to the Inquiry, 2026.

When considering the improvement of existing buildings, one encounters further constraints – premises cost rules exclude a range of building improvements from reimbursement unless a net financial benefit to the wider health system can be demonstrated. GPs are independent contractors with no obvious way of evidencing that, so improvements which would reduce a building's running costs are engineered out on cost grounds. The result is that practices are discouraged from investing in the fabric of buildings the NHS will occupy for decades.

One caution applies to all of it. Specifying buildings too tightly from the centre makes them more expensive. A room that will sometimes be used for non-clinical work does not need a sink, and every sink brings plumbing, maintenance and legionella flushing with it. Local flexibility here is a cost control rather than an administrative preference.

Recommendation 9: The Department of Health and Social Care and HM Treasury should reform the primary care estates architecture and, if and when additional funding becomes available, establish a capital investment programme for primary care premises.

Cost type: Within existing resources for the architectural reforms; with substantial additional investment for the capital programme

a. Reform the primary care estates architecture within existing resources, including delegating capital decisions to a more local level, enabling capital and revenue flexibility in NHS accounting, and reforming District Valuer Service methodology to publish valuations methodology, publish appraisals, and provide a dispute resolution mechanism.

b. If and when additional funding becomes available, establish a capital investment programme for primary care premises, prioritising the least-suitable premises across the four sectors.

c. Ensure developer contributions to healthcare infrastructure, including Section 106 obligations and the Community Infrastructure Levy, translate into guaranteed GP contracts and primary care capacity where new residential development takes place.

d. Address the storage of paper records, often held by GP surgeries in shipping containers outside their premises, through accelerated digitisation and, in parallel, shared physical storage facilities at Integrated Care Board level for records that must remain on paper.

6.8 Trained, and not doing NHS work

Chapter 3 set out the pattern: every primary care sector has qualified clinicians who are doing no NHS work at all, or far less of it than they are trained and licensed to do. This section sets out what would change that.

Dentistry currently experiences the widest gap with around 46,000 dentists registered with the General Dental Council across the UK. Of those, approximately 25,000 do some NHS work in England, and around 11,000 whole-time equivalents deliver NHS activity. England has the lowest NHS commitment of the four nations, at 39 per cent against roughly 50 per cent in Scotland. Almost two thirds of dental professionals report burnout.[237] Recent surveys found

237 British Dental Association, written and oral evidence to the Inquiry, 2026.

74 per cent of NHS dentists and 65 per cent of dental nurses do not enjoy working in the NHS, 61 per cent expect to reduce their NHS work over the next two years, and 81 per cent expect to do more private work. In 2023/24 every NHS region saw more dental nurses leave than join; in the South West, two left for every one who joined.[238]

Inquiry stakeholders describe an arrangement which policy currently does not account for. Practices delivering both NHS and private care now make up over two thirds of practices in England, and income from private work is used to cross-subsidise NHS work delivered at or below cost. The risk is that a substantial part of NHS dental capacity now rests on a cross-subsidy that no contract secures and nobody is measuring.

In community pharmacy, pharmacists are being trained faster than the system creates opportunities for them to use that training. Pharmacists can qualify as independent prescribers, which allows them to assess a patient and prescribe medicines directly, and growing numbers have done so. As at March 2025, 21,804 pharmacists held that qualification, a third of the entire register.[239] In England the figure is 32 per cent, and the numbers are higher still in Wales and Scotland. Yet in 2024 roughly 2,500 independent prescribers worked in community pharmacy, around 9 per cent of that sector's workforce, and only around 9 per cent of those who hold the qualification were using it at all. A quarter of community pharmacist prescribers have never prescribed, and a further 9 per cent prescribe less than once a year.

Of those pharmacists who had never prescribed, 70 per cent cited a lack of opportunity in their current role, 37 per cent a lack of funding, and 30 per cent no access to medical records. Among those who have not qualified, 52 per cent had no access to a supervising prescriber and 48 per cent had no time for the course. In every case the barrier is something the system controls: whether a service has been commissioned, whether it has been funded, and whether the pharmacist can see the record. From summer 2026 most pharmacists entering the register qualify as prescribers, so this workforce will grow every year whether or not anything is commissioned for it to do. That is the largest pool of unused clinical capacity this report identifies, in premises most people can reach easily without needing an appointment.

238 Ibid.

239 General Pharmaceutical Council, register data as at 31 March 2025. Of 65,776 registered pharmacists in Great Britain, 21,804 held an independent prescriber annotation.

A third of pharmacists qualified. 9% of community pharmacists prescribing.

Share of the pharmacist register holding an independent prescriber annotation, against the share of community pharmacist prescribers who use the qualification. A quarter have never prescribed.

Source: General Pharmaceutical Council register data, 31 March 2025; and National Pharmacy Association, written evidence to the Inquiry, 2026.

Optometry is the only primary care sector where supply is not the problem. The sector trains and recruits outside the NHS capped training system and funds the training itself. It has opened six new schools of optometry over 25 years, and it can expand its dispensing optician workforce when needed. When services move out of hospital it can adjust quickly. The constraint sits entirely on whether Integrated Care Boards commission the work. Where they do not, that capacity goes unused: patients who could have been seen in an optometry practice are referred to hospital instead, adding to ophthalmology waiting lists while trained staff and installed equipment sit idle nearby.

General practice needs its own approach. The Oxford group's analysis of over 5,000 practices found that a higher proportion of same-day appointments is associated with lower patient satisfaction, and a separate study found patients willing to wait five days longer to see a doctor of their choice for a non-urgent problem. Having more available appointments does not equate to better care or higher satisfaction rates. Instead, patients value care from professionals who know them and their problems.

Continuity is also the most promising route to releasing capacity that the Inquiry examined, and the evidence for that is strong. A study of more than 10 million consultations across 381 English practices measured how long patients went between one appointment and the next. Patients who saw their regular GP went 18.1 per cent longer without needing another appointment than those who saw a different doctor, and the appointment itself took no longer. GPs who do not know a patient order 19.1 per cent more tests. And if every practice improved continuity to the level of the current top 10 per cent, total consultation demand could fall by up to 5.2 per cent, which would release much of the current GP shortfall without recruiting anyone.[240] Continuity is one of the few available means of improving access.

240 Workforce and Learning Research Group, written evidence, citing Kajaria-Montag, Freeman and Scholtes, Management Science, 2024.

5.2%

Estimated fall in system-wide consultation demand if all practices improved continuity of care to the level of the current top ten per cent. Patients seeing their regular GP go 18.1 per cent longer before their next visit.

Source: Workforce and Learning Research Group, University of Oxford, written evidence to the Inquiry, 2026.

The current system makes it clear that delivering continuity across primary care requires more than designation. Since 2015 every patient in England has been entitled to a named GP, and research measuring consultations and emergency admissions before and after found the entitlement alone did not shift either continuity or unplanned admissions, because in many practices it was implemented as a record-keeping exercise. Continuity has to be built into how a practice organises its list and its appointments. That is a matter of how a practice is funded and staffed.

Two groups are consistently missing from workforce planning; reception and administrative staff, and the wider clinical team. Reception and administrative staff are the first point of contact for every patient. A review of 29 studies on interventions affecting their work found only one aimed directly at receptionists. There is no professional forum, no peer network, and the main obstacle to training is being released to attend it. On the clinical side, as the GP contract changes, funding for occupational therapy posts is being removed, causing loss of staff and service regression. Several stakeholders in our Inquiry describe the same pattern in their own professions, including nursing, physiotherapy and podiatry.

Additionally, expanding clinical capacity without expanding the time available to supervise and teach may lead to reduced capacity at a later stage. Supervisors already report insufficient time to supervise during the working day, and where that continues, practices become less willing to take learners at all. This points to a case for assessing the effect on training capacity when major access initiatives are designed, so that a policy intended to improve access this year does not reduce it in five.

Recommendation 10: The Department of Health and Social Care should train, employ and retain the primary care workforce across all four sectors.

Cost type: Substantial additional investment

a. Set out clear steps to train, employ, and retain the primary care workforce needed across all four sectors.

b. Include targeted incentives for coastal, rural, and deprived areas where workforce shortages are most acute, extending to primary care mental health provision, and ensure workforce planning across all four sectors addresses geographic, socioeconomic, and ethnic inequalities in recruitment, retention, leadership, and career progression.

c. Ensure workforce planning is done at the four-sector level, integrating general practice, community pharmacy, dentistry, and optometry workforce planning.

d. Address sector-specific workforce challenges, including retention of the dental workforce within NHS practice, active deployment of the qualified independent prescriber workforce in community pharmacy, and fuller utilisation of optometry capacity across care pathways.

6.9 Neighbourhood health: where this chapter is tested

Neighbourhood health is the programme through which most of this chapter's arguments will be settled in practice. The 10 Year Health Plan committed to it, the Neighbourhood Health Framework of March 2026 set out how it will be delivered, and 43 first-wave areas were announced in September 2025. The Health and Social Care Committee is examining the primary care estate over the same period, and the evidence collected through our Inquiry points in a consistent direction.

Our analysis identified four conditions through the evidence and each is drawn from something that has already gone wrong.

The first is that the workforce plan and the capital plan are produced together. When primary care networks were created, the question of where they would operate was left until afterwards. The neighbourhood health programme is at risk of repeating that.

The second is that the capital plan works with how premises are actually owned. Around half of GP practice buildings are owned by GP partners, others are leased from companies such as Primary Health Properties under cost rent and similar arrangements, and pharmacy and dental premises are owned outright by the businesses that occupy them with no NHS capital involved. A capital plan written as though the NHS owns the estate will not reach three of the four sectors.

The third is that capital is paired with contract reform – two international comparisons illustrate the point. Ireland took a different route to the same problem. Under Sláintecare, its programme for shifting care into the community, the Health Service Executive uses an operational lease model: a private developer builds and owns the centre, and the health service takes a long lease, typically of 25 years, at a rent reviewed against inflation. Because the revenue commitment is long and certain, developers can raise capital against it. By late 2024 the Health Service Executive had delivered 177 primary care centres, 109 of them through this route. England uses a similar third-party development model, but the commitments behind it are shorter and less certain, and each rent must be agreed scheme by scheme through the process described earlier in this chapter. The Irish model is not without criticism, since the health service pays rent on buildings it will never own, but it has delivered buildings at a pace England has not matched.

Italy took a different approach again. Its National Recovery and Resilience Plan, issued in 2021 and funded through the EU Recovery and Resilience Facility, allocated €15.6 billion to health, of which €7 billion went to community care facilities, home care and telemedicine. Around €2 billion of that funded 1,288 Case della Comunità, community health centres bringing services together in one place.[241] Crucially, the capital was paired with reform of the primary care contract, using the investment as an incentive to work differently while protecting continuity. The programme concluded in June 2026 with more than 1,200 centres reported operational, though implementation has not been without difficulty: national standards prescribed two models for the whole country, which fitted a metropolitan suburb and a small mountain municipality equally badly.

The lesson this Inquiry draws is that capital investment alone does not change how people work. New buildings house the same services in better conditions unless the contracts governing those services change at the same time. That is why Recommendation 11 asks for the capital plan and the workforce plan to be produced together, and why Recommendation 9 sits alongside the commissioning reform in Recommendation 8 rather than standing on its own.

241 Italian Ministry of Health, Piano Nazionale di Ripresa e Resilienza, Missione 6 Salute, 2021.

The fourth condition is that mental health is planned and funded explicitly rather than absorbed by general practice. Around a quarter of GP consultations today concern mental health.[242] Neighbourhood mental health centres exist but their coverage is limited, and scaling them is what would allow the model to deliver on its integration ambition rather than describing it.

Running underneath all four conditions, the programme needs to be able to answer whether it worked. Evaluation designed in from the start, measuring how the benefit is distributed rather than only the average, is what would let a future government tell whether access improved for the people it was meant to reach.

Recommendation 11: The Department of Health and Social Care should pair the neighbourhood health implementation with a workforce plan and a matching capital plan for the premises that workforce will need.

Cost type: Substantial additional investment

a. Ensure the capital plan works with existing premises ownership models across the four sectors, including GP cost rent schemes and independently owned pharmacy and dental premises.

b. Include neighbourhood mental health centres in the capital plan, recognising that current operational coverage is limited and that scaling is needed for the model to deliver on its mental health integration ambition.

c. Examine international examples of financing primary care premises, including the Italian and Irish models, to consider whether best practice elsewhere could inform and improve the neighbourhood health implementation.

d. Build evaluation of workforce, estates, and patient outcomes into the neighbourhood health programme from inception, so that the model's impact can be assessed against its integration ambitions rather than only against implementation milestones.

242 Andy Bell, Chief Executive, Centre for Mental Health, supplementary interview with the Inquiry, 9 June 2026.

6.10 Where this leads

The five recommendations in this chapter work collectively – Recommendation 7 grows the primary care share and fixes how it is distributed; Recommendation 8 changes what that funding buys and who may deliver it; Recommendation 9 removes the rules that stop buildings being built or shared; and Recommendation 11 makes sure the buildings and the people arrive together. Finally, Recommendation 10 puts people in premises who are able to do the work they trained for.

To tackle the issue at hand, all recommendation need to be implemented jointly. Additional funding without commissioning reform buys more of the same activity. Commissioning reform without workforce reform commissions services nobody can staff. Buildings without contract reform produce, as the international evidence shows, buildings. Chapter 7 takes the argument outward, to the organisations beyond the NHS that already reach people primary care does not, and to how any of this holds together for a patient over time.

Chapter 7: Integration, collaboration, and the wider system

Top Lines

- The Neighbourhood Health Framework puts general practice at the centre and defers community pharmacy, dentistry, and optometry to a later phase. Services designed without all four sectors present are how the current gaps were created.
- Universities, hospices, and voluntary organisations already provide some primary care services to populations the NHS struggles to reach, often without a contract and funded from their own resources.
- Continuity of care reduces deaths by between 10 and 15 per cent, hospital admissions by up to 15 per cent, and emergency attendances by up to 20 per cent.
- Every Integrated Care Board should have a guaranteed primary care voice that speaks for all four sectors, not just general practice.

7.1 What integration is asked to solve

The first three chapters of this report set out failures that no single sector can fix. A patient turned away at registration, a record that stops at the edge of a contract, a dentist who cannot see what medication a patient is taking, a person with several long-term conditions whose care nobody is holding together. Each case involves at least two parts of the system and belongs wholly to none.

Integration is often considered the solution. This chapter examines two parts of it: the organisations outside the NHS that already reach the people primary care does not, and the arrangements through which the four sectors work together.

> *"The recent NHS planning guidance shrunk primary care back to mean medical care largely, pushing out dentistry, optometry, and pharmacy. This is a huge step backwards. It reflects what happens when services are designed without everyone at the table."*
>
> ***Dr Peter Hampson, Clinical and Policy Director, Association of Optometrists, Evidence Session 2, 19 November 2025***

The Neighbourhood Health Framework of March 2026 places general practice at the centre of neighbourhood health. It states that the contribution of community pharmacy, dentistry, and optometry will be considered over the coming years, while their separate reform programmes continue. It defers learning disability and neurodiversity in the same way. As a result, the architecture intended to join up services is being designed without three of the four primary care sectors present, and without two of the populations whose access is the worst.

Participants at our evidence sessions offered insight into the operational counterpart. Within today's system, patients increasingly struggle to reach the physiotherapists and other practitioners they need due to delays further along the pathway. Integration that addresses only the first point of contact only pushes the queue further down rather than shortening it. For collaboration to be effective, it requires clear definitions of roles and responsibilities with different professionals contributing distinct expertise, rather than several people doing the same thing. What primarily drives health is the lives people lead and the environments they live in: their housing, their income, their work, their environment. Health services treat people once they are unwell and can catch problems earlier, but they cannot substitute for those conditions. The recommendations here address the access dimension of that wider problem.

7.2 What government is already doing

Several programmes of integration are already in progress in England. The Neighbourhood Health Framework of March 2026 sets out how the neighbourhood health commitments will be delivered, and 43 first-wave areas were announced in September 2025.[243] The NHS Modernisation Bill 2026 concentrates strategic commissioning in ICBs, which are merging from 42 to 26, and closes Healthwatch England and the 153 local Healthwatch organisations. Their national functions transfer to the Department of Health and Social Care, and their local functions to ICBs and local authorities. The Civil Society Covenant, published in July 2025, sets principles for partnership between government and civil society, though it is economy-wide

243 NHS England and Department of Health and Social Care, "Neighbourhood Health Framework," March 2026; and Department of Health and Social Care, "Millions of People to Benefit from Healthcare on Their Doorstep," press release, 9 September 2025.

rather than specific to health and carries no funded insight programme of the kind the VCSE Health and Wellbeing Alliance provided.[244] The Health and Social Care Committee is examining the primary care estate over the same period.

This Inquiry has identified that three of the four primary care sectors sit outside its immediate phase, that two of the mechanisms which supplied community intelligence are closing as it is built and that primary care has no guaranteed representation where its commissioning decisions will be taken. The recommendations in this chapter are addressed to those three gaps.

7.3 Organisation already providing services outside the NHS

As part of this Inquiry, we engaged with organisations that currently provide some primary care services, similarly to what is described in the neighbourhood health model, outside of the arrangement that the model is built on.

Case Study: A University primary care prototype in Newham

Teaching hospitals have trained clinicians by treating patients for over a century. There is no equivalent in primary care. One participant in the first evidence session described to the Inquiry what one looks like.

The University of East London operates in Newham, one of the most health-deprived boroughs in England, where around six per cent of residents live in temporary housing. It provides counselling, musculoskeletal therapies, sports physiotherapy, podiatry and community engagement, free at the point of care and largely delivered by students under supervision. These sit alongside NHS primary care rather than replacing it.

Four things about how it works could be applied elsewhere. It goes out to people rather than waiting for them: a breastfeeding service run by the university attracts more attendees than the equivalent local authority service, because it is designed for the population it serves, in the language and the settings that population already uses. It uses campus space that is otherwise empty in the evenings and at weekends, including a teaching kitchen where residents learn to cook healthily on a limited budget. It builds prevention into activities people are already doing rather than adding it as a separate obligation. And it complements the NHS rather than competing with it.

244 HM Government, "Civil Society Covenant," July 2025.

Case Study continued: A University primary care prototype in Newham

None of it is commissioned. The services exist because the university decided to provide them as part of its charitable mission, not because the NHS asked for them. Whether they continue depends on the university's willingness to absorb the cost rather than on any route the NHS provides. Waterson identified contract and procurement reform as the condition for going further, describing a closed-door culture in NHS procurement rules that frequently prevents community organisations and universities from working effectively with NHS providers.

The capacity to do this exists across the civic university sector. What is missing is a route through which the NHS can commission it.

Source: Robert Waterson, Executive Dean of Health, Sport and Bioscience, University of East London, Oral Evidence Session 1, 29 October 2025.

Participants also described a parallel model with an additional element. The University of Essex Health, Wellbeing and Care Hub combines three functions: workforce development, with every service led by students under supervision; service provision co-produced with NHS partners, ICBs and voluntary sector organisations, covering cancer, ageing, learning disability, special educational needs, oral health and musculoskeletal care across South Essex, Colchester and coastal and rural communities; and clinical research embedded in everyday practice.[245] It has attracted NHS England funding, which shows what becomes possible when the commissioning architecture deliberately supports this kind of institution rather than leaving it to local goodwill.

The model is not confined to universities – the Bedfordshire Palliative Coordination Service offers an example which brings together hospice, community nursing, and primary care as a single 24-hour point of contact for patients and families at the end of life.[246] The hospice and health charity sector is substantial primary care infrastructure that the neighbourhood health architecture does not formally include. The Institute of Dentistry at Queen Mary University of London runs five community dental clinics across north east London, described in Chapter 6, which train students while treating patients in areas of high need.[247]

Two further examples come from evidence to the Health and Social Care Committee's ongoing Inquiry into the primary care estate. In Whitehaven in Cumbria, one of six national pilot sites for neighbourhood mental health centres, the local community trust and mental health trust

245 Professor Victoria Joffe, University of Essex, Oral Evidence Session 2, 19 November 2025.

246 Sue Ryder, written evidence to the Inquiry, 2026.

247 Institute of Dentistry, Queen Mary University of London, written evidence to the Inquiry, 2026.

bought a closed Halifax branch on the high street.[248] They used NHS England pilot funding to buy and refurbish it, then handed it over to Copeland Community Trust, which runs it as a neighbourhood mental health centre. Those leading the programme describe it as an ordinary building on an ordinary street, deliberately designed not to look clinical. Four of the six pilot sites were led by organisations that were neither NHS nor local authority bodies. Independent evaluation of the programme is expected later this year. Separately, the London Borough of Waltham Forest has delivered several new health centres for the NHS through its regeneration and property functions, working with partners ranging from major developers to community interest companies, using the local authority's planning and property capability to create health infrastructure.[249]

The arrangements behind these examples vary. The University of Essex hub has attracted NHS England funding. The Whitehaven centre was established with NHS England pilot funding. The Queen Mary clinics provide NHS dental care. The University of East London services are not commissioned at all. What connects them is not a shared funding model but a shared origin: each exists because a particular institution decided to act, and each was arranged locally rather than through any standing route the NHS offers. This is what makes them difficult to repeat elsewhere.

These models are already working in some areas, and the Government should look at how to support more of them. The Inquiry heard two suggestions for how this could happen.

The first is that these models should add services rather than move them between providers. Each of the examples above introduced something that was not otherwise available: counselling and podiatry in Newham, a mental health centre in Whitehaven, and dental care in Barking. That is different from a new provider taking on work an existing one already does. It matters because, as Chapter 6 sets out, community pharmacy is a sector where 99 per cent of pharmacies receive less than the full cost of the services they deliver.

The second is that specific procurement rules need to be reviewed. The Inquiry heard that NHS procurement is built around the assumption that a provider will be either a commercial primary care operator or an existing NHS body. Three consequences follow. Contract eligibility criteria exclude organisations that are neither, which rules out a university or a charity before the question of what they could deliver is reached. Block contracts assume a single organisation delivering a defined service, which does not fit a model where clinical care sits alongside teaching and research. Additionally, procurement thresholds are designed for a provider bidding

248 House of Commons Health and Social Care Committee, "Delivering the Neighbourhood Health Service: Estates," oral evidence, 1 July 2026.

249 Ibid.

to run a whole service, rather than one adding a part of it alongside what a practice already does.

Each of these rules exists for good reason: eligibility criteria maintain clinical standards, block contracts make spending predictable, and thresholds keep competition fair where a provider is bidding to run a whole service. They were designed for organisations competing to take over a service. A university offering podiatry alongside an NHS practice is doing something different, and applying the same rules to it excludes the organisation before anyone has asked what it could deliver.

These rules should be reformed. Organisations adding capacity alongside existing NHS provision should be assessed on what they can deliver and to what standard, rather than ruled out because of what kind of organisation they are. Recommendation 12 sets out that ask.

Recommendation 12: The Department of Health and Social Care should enable community anchor institutions to complement existing primary care provision.

Cost type: Within existing resources

a. Enable community anchor institutions to complement existing primary care provision, focussed on capacity-adding functions such as workforce training, research coordination, service integration, and use of anchor institution facilities for primary care delivery where appropriate.

b. Examine examples of community-anchored primary care infrastructure, including the University of East London and University of Essex health hubs, the Whitehaven neighbourhood mental health centre, and Waltham Forest's voluntary and community sector lettings policy, as models that other localities could look further into.

c. Ensure new commissioning routes complement rather than destabilise existing NHS primary care providers, particularly in fragile sectors such as community pharmacy.

d. Examine current procurement rules that limit community anchor institution involvement, identifying which reforms would enable helpful models to scale and which existing rules serve important protective functions.

7.4 The organisations that hear from patients

Chapter 4 set out why the patient voice function matters for access. That function will still be needed after the current organisations close. This section sets out what any new arrangements have to be able to do.

Two mechanisms of patient voices in England are closing at once. Healthwatch England and the 153 local Healthwatch organisations are dismantled under the NHS Modernisation Bill 2026, with strategic functions moving to the Department of Health and Social Care and local functions brought in house to ICBs and local authorities. Separately, the VCSE Health and Wellbeing Alliance was discontinued on 31 March 2026 after five years. The Alliance was the funded route through which eighteen voluntary sector members and consortia brought expertise on underserved communities into national health policy, covering carers, palliative and end of life care, learning disability, LGBTQ+ health, faith communities, and Gypsy, Roma and Traveller health.[250] Both are closing just as the neighbourhood health model is being built, with that model depending on the local knowledge they supplied.

The timing is what makes this an integration question – the neighbourhood health model depends on detailed local knowledge of communities, and much of that knowledge reached national policy through the two mechanisms now closing.

The King's Fund examined the Healthwatch transition in March 2026 and set out four tests any successor should meet: that it improves rather than weakens the system's ability to hear and respond to people's experiences; that it is independent enough to speak plainly rather than allowing the system to assess itself; that it can still gather unsolicited insight from communities, including seldom-heard groups; and that it aligns with local government, ICB areas and neighbourhood boundaries.[251] The report is candid about the risks. ICBs are merging from 42 to 26 with reduced staffing, which raises questions about their capacity to engage communities at scale, and a function held in house lacks the independence that trust and disclosure depend on. The public gave the Healthwatch network nearly 400,000 pieces of feedback in its final two years.

Evidence from the mental health charity, Mind, identifies why independence matters most for the people who find the system hardest to challenge.[252] People with mental health problems face greater barriers to raising concerns because of the power imbalance inherent in the Mental Health Act 1983. Patients may fear they will not be believed because of their mental health

250 Department of Health and Social Care, notice of the closure of the VCSE Health and Wellbeing Alliance, March 2026.

251 The King's Fund, analysis of the proposed abolition of Healthwatch England and local Healthwatch, March 2026.

252 Mind, written evidence to the Inquiry, 2026.

status, and fear more restrictive care if they do complain. Moving the patient voice function inside the organisation a patient may wish to complain about is, in that context, a systemic problem rather than an administrative one.

Whatever replaces Healthwatch will need to do what Healthwatch did: gather what people say about their care, including from those who would never approach the NHS directly, and report it with enough independence that the system cannot mark its own work. Without that, failures of the kind documented in this report risk going unrecorded and unaddressed.

7.5 What a primary care partnership architecture would be

This report uses the phrase primary care partnership architecture to describe the standing arrangements through which the four sectors work with each other, with the wider NHS, and with organisations outside it. The word architecture is deliberate. The evidence does not describe a shortage of goodwill between professionals; it describes an absence of the structures through which that goodwill can operate, meaning contracts organisations can hold, decisions they can be present for, and information they can share.

Through this Inquiry, we have identified factors that would need to be true for it to work. First, all four sectors should be present when decisions are made. Today, services are often designed without everyone at the table and the Neighbourhood Health Framework's deferral of three sectors is the most evident case.

Second, it should sit with a body that can act on it. Integration involves several organisations, so it is often assumed that the answer lies with whichever body brings them together locally. But convening a conversation and changing a service are different things. Only the body that holds the contract can change what care is available, and for primary care that is the Integrated Care Board. The NHS Modernisation Bill 2026 concentrates strategic commissioning there. This is what Recommendation 13 addresses.

Witnesses to the Inquiry questioned whether primary care is in the room when decisions about primary care are taken. At present an ICB must include at least one member nominated by primary medical care providers. The Health Bill would remove that requirement, along with the equivalent requirements for local authorities and NHS trusts, while retaining a mental health member and adding representatives nominated by mayors.[253] Even under the current arrangement there is no guarantee that the member speaks for more than general practice. As

253 Health Bill 2026–27, as introduced, provisions amending Integrated Care Board membership requirements. The Bill was before Parliament at the time of writing.

Boards merge, with reduced staffing, the risk is that primary care representation thins at exactly the moment commissioning is being concentrated. A guaranteed primary care voice on Boards would ensure a seat at the table when decisions are made, rather than only being consulted about decisions. Recommendation 13 therefore asks not for a new guarantee but for the existing one to be retained and widened, so that it covers all four sectors rather than general practice alone. Strengthening the duty on Boards to consult and work with primary care providers gives that representation something to do beyond attendance.

Third, these arrangements should allow neighbourhood teams to be employed together. Neighbourhood health centres are intended to bring several professions together in one place, but the professions that would make up such a team are currently funded through separate routes, with separate contracts, and separate timescales. Chapter 6 set out the consequence: co-location produces several services in one building rather than one team. Devolving power and funding so that centres can employ multidisciplinary staff directly, drawing on funding held across primary care, community nursing, and mental health is what will turn a shared address into a shared service.

Fourth, mental health should be treated as part of the work rather than a specialism to be integrated later. Today, around a quarter of GP consultations concern mental health. Chapter 3 set out what happened to physical health checks for people with severe mental illness when the payment for them was withdrawn, and Chapter 6 set out that neighbourhood mental health centres exist but their coverage is limited. Using strategic commissioning actively to address mental health inequalities is what would make integration reach the quarter of primary care that concerns mental health.

7.6 Continuity of care as the organising principle

The lack of continuity within primary care has appeared repeatedly throughout this report. It is what patients ask for most consistently, what connects the three structural patterns and one of the few available routes to releasing capacity.

Continuity reduces patient mortality by between 10 and 15 per cent, hospital admissions by up to 15 per cent, and emergency department visits by up to 20 per cent. Evidence submitted to our Inquiry distinguished relational continuity, meaning seeing the same clinician or team, from informational continuity, meaning the record following the patient. As multidisciplinary teams grow both forms of continuity will play bigger roles.

10 to 15%

Reduction in patient mortality associated with continuity of care. Hospital admissions fall by up to 15 per cent and emergency department visits by up to 20 per cent.

Source: Dr Victoria Tzortziou-Brown, Royal College of General Practitioners, Evidence Session 2, 19 November 2025.

The evidence also shows that continuity also changes how often people need to return for further care. Research submitted to the Inquiry examined more than 10 million consultations across 381 English practices, measuring how long patients went between one appointment and the next.[254] Patients who saw their regular GP went 18.1 per cent longer without needing another appointment than patients who saw a different doctor, and the appointment itself took no longer. GPs who did not know a patient ordered 19.1 per cent more tests. The study estimated that if every practice matched the continuity levels of the best-performing tenth, total consultation demand could fall by up to 5.2 per cent.

The current system makes it clear that continuity of care is not dependent on designation of support alone. Every patient in England has been entitled to a named GP since 2015, following its introduction for patients aged 75 and over the previous year. Research measuring consultations and emergency admissions before and after that introduction found no improvement in either continuity or unplanned admissions, because in many practices the entitlement was implemented as a record-keeping exercise.[255] However, continuity has to be built into how a practice organises its list and its appointments, and into how the four sectors pass patients between one another. Continuity therefore belongs in the partnership architecture rather than in a single contract. A GP practice can organise its own appointments so that patients see the same clinician, but it cannot make sure the record follows a patient to a pharmacy, a dentist or an optometrist, as Chapter 5 demonstrates. Continuity must be a founding principle of the architecture to create accountability.

When tackling the issue of continuity, we must also address the element of accountability which is evidenced through submissions from the NHS Race and Health Observatory made the case that structures without measurement produce reorganisation rather than improvement. Its own research programme demonstrates what becomes visible when access is measured properly by

254 Workforce and Learning Research Group, written evidence, citing Kajaria-Montag, Freeman and Scholtes, Management Science, 2024.

255 Tammes, P., and others, "The Impact of a Named GP Scheme on Continuity of Care and Emergency Hospital Admission: A Cohort Study among Older Patients in England, 2012–2016," BMJ Open 9 (2019): e029103.

ethnicity and deprivation.[256] Four things would need to be reported on for the architecture to be assessable: whether continuity is improving, whether primary care is formally represented in decisions, whether commissioning is done jointly across the four sectors, and whether inequalities in access are narrowing. An annual report to that effect turns a set of arrangements into something Parliament, ICBs, and the public can hold to account.

The Inquiry therefore recommends:

Recommendation 13: The Department of Health and Social Care should establish a primary care partnership architecture with continuity of care as a founding principle and a guaranteed primary care voice on every Integrated Care Board.

Cost type: Within existing resources

a. Establish a primary care partnership architecture with continuity of care as a founding principle across all four primary care sectors.

b. Guarantee a primary care voice on every Integrated Care Board and strengthen the duty on Integrated Care Boards to consult with and work alongside primary care providers.

c. Enable devolution of power and funding to neighbourhood health centres so they can employ multidisciplinary staff directly, drawing on integrated funding across primary care, community nursing, and mental health.

d. Use strategic commissioning as an active lever for addressing mental health inequalities, ensuring the partnership architecture supports mental health integration into primary care.

e. Require Integrated Care Boards to report annually on continuity of care metrics, on primary care representation in decision-making, on integrated commissioning activity, and on progress against inequalities of access, so the partnership architecture's performance is visible year on year.

256 NHS Race and Health Observatory, written evidence to the Inquiry, 2026.

7.7 Where this leads

The two recommendations in this chapter address different halves of the same gap. Recommendation 12 brings in organisations that are already reaching people the NHS struggles to reach, and gives them a route through which the NHS can commission that work rather than relying on institutional goodwill. Recommendation 13 builds the arrangements through which the four sectors work with each other and with everyone else, with continuity of care as the organising principle and annual reporting so that progress can be seen.

Both depend on what was developed earlier in this report. Neither works without the funding rebalance in Recommendation 7, the commissioning framework in Recommendation 8, or the data standards in Recommendation 4. A partnership architecture cannot deliver continuity if the record still stops at the edge of a contract, and a community organisation cannot be commissioned if nobody has decided who is allowed to hold a contract.

Conclusion

This Inquiry asked why people in England struggle to access primary care, and what would change it. It examined general practice, community pharmacy, NHS dentistry, and optometry together, because that is how patients experience them.

Over the past year of rigorous research, five key findings emerged: funding is distributed in ways that do not follow need; the sectors outside general practice have the weakest foundations; clinicians are trained and then not commissioned to work; organisations outside the NHS are already reaching people primary care are not; and perhaps most telling, the analysis aligns with what patients have described about their experiences of the system.

Rooted in these findings, wider patient experiences, and expert accounts, thirteen recommendations have been set out for government to tackle the overarching issue of access to primary care in England. The recommendations are rooted in one key principle: any solution must be a joint effort across all four sectors of primary care. As shown throughout this report, the structural patterns show up in each sector, with inequality underpinning each issue.

We have set out each recommendation weighted against its costing type – with more than half of the recommendations being possible within current funds or with minimal investment. In the first instance, this means Government, HM Treasury and the Department of Health and Social Care delivering on commitments that remain unmet. That means considering rebalancing NHS funding between primary care and acute hospital care, through redeployment of existing NHS spending, with a published target and timetable, and it means saying by when.

The patients who gave evidence to this Inquiry did not ask for a larger health service. They asked to be able to book an appointment themselves, to see someone who knows them, to be registered when the rules.

None of that is out of reach. What it requires is that the arrangements governing primary care are changed to deliver what successive governments have promised for twenty years.

Methodology

The Inquiry gathered evidence through four routes between summer 2025 and summer 2026.

A public written call for evidence ran until 27 February 2026 and drew responses from around fifty organisations, including professional bodies, patient and voluntary sector organisations, academic institutions, NHS bodies, regulators, and commercial providers. The Inquiry also received submissions from individual patients and members of the public. Respondents were asked to answer only the questions within their expertise, which is why some submissions are cited in this report on a single question and others across several chapters.

Three oral evidence sessions were held in Parliament. The first, on 29 October 2025, covered patient voice, inclusion health populations and health inequalities. The second, on 19 November 2025, covered funding, commissioning, the primary care estate and workforce across general practice, community pharmacy, dentistry and optometry. The third, on 3 December 2025, covered technology, artificial intelligence and innovation adoption.

Five supplementary interviews were held with organisations able to speak in depth to specific operational questions.

Alongside this, the Inquiry reviewed the academic and policy literature on primary care access, workforce and commissioning, which provides the research context set out in Chapter 1.

A steering group of parliamentarians, professional bodies, academics, patient organisations and NHS and voluntary sector representatives supported the Inquiry throughout, contributing their expertise and sector knowledge and reviewing drafts as the work developed.

The report also draws on published research beyond the evidence submitted to the Inquiry, and on evidence given in public to parliamentary committees. Both are cited as published sources rather than as evidence to this Inquiry.

Steering Group

- **Dr Simon Opher MP**, Labour, Member of Parliament for Stroud; Chair, All-Party Parliamentary Health Group; Inquiry Co-Chair
- **Lord Kamall of Edmonton**, Conservative, Shadow Minister for Health and Social Care in the House of Lords; Inquiry Co-Chair
- **Jess Brown-Fuller MP**, Liberal Democrat, Member of Parliament for Chichester; Liberal Democrat Spokesperson for Hospitals and Primary Care; Inquiry Co-Chair
- **Sadik Al-Hassan MP**, Labour, Member of Parliament for North Somerset; Inquiry Co-Chair
- **Professor Mariachiara Di Cesare**, Director, Institute of Public Health and Wellbeing, University of Essex
- **Hayley Blackburn**, Director of Public Affairs, Primary Health Properties
- **Sharon Brennan**, Director of Policy, National Voices
- **Shawn Charlwood**, NHS Dentist and Board Member, British Dental Association
- **Dr Peter Hampson**, Clinical and Policy Director, Association of Optometrists
- **Malcolm Harrison**, Chief Executive, Company Chemists' Association
- **Professor Kamila Hawthorne**, President, Royal College of General Practitioners
- **Dr Veline L'Esperance**, Senior Clinical Adviser and GP, NHS Race and Health Observatory
- **William Pett**, Interim Director of Policy and External Affairs, Healthwatch England

Contributors

The Inquiry is grateful to everyone who gave evidence. Contributors are listed by the route through which each contribution was made.

Evidence session one: patient voice, inclusion health and health inequalities

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- **Tim Clarke**, Director, Accessible Waterways Association CIC
- **John Ford**, Director, Health Equity Evidence Centre; Senior Clinical Lecturer, Queen Mary University of London
- **Dr Jane Jervis**, Keele University
- **Jacob Lant**, Chief Executive, National Voices
- **Dr Emily T. Murray**, Director, Centre for Coastal Communities, Institute for Public Health and Wellbeing, University of Essex
- **William Pett**, Head of Policy, Public Affairs and Research, Healthwatch England
- **Robert Waterson**, Executive Dean of Health, Sport and Bioscience, University of East London

Evidence session two: funding, commissioning, estates and workforce across the four sectors

- **Dr James Davies**, Director of Research and Insights, Community Pharmacy England
- **Dr Gaurav Gupta**, England GP Committee Lead for Premises, British Medical Association; GP Partner and Local Medical Committee Chair in Kent
- **Dr Peter Hampson**, Clinical and Policy Director, Association of Optometrists
- **Malcolm Harrison**, Chief Executive, Company Chemists' Association

- **Professor Victoria Joffe**, Professor of Speech and Language Therapy and Dean of Integrated Health and Care Partnerships, University of Essex
- **George Johnston**, Policy Manager, NHS Confederation (NHS alliance)
- **Dr Veline L'Esperance**, Academic GP and Senior Clinical Adviser, NHS Race and Health Observatory
- **Shiv Pabary MBE**, Chair, General Dental Practice Committee, British Dental Association; NHS dentist and lecturer, Newcastle Dental School
- **Dr Victoria Tzortziou-Brown**, Vice Chair and incoming Chair at the time of evidence, now President, Royal College of General Practitioners; GP in Tower Hamlets

Evidence session three: technology, artificial intelligence and innovation

This session was chaired by Lord Taylor of Warwick, Chair of the Parliamentary Artificial Intelligence Group.

- **Professor Hatim Abdulhussein**, Chief Executive, Health Innovation Network Kent, Surrey and Sussex; practising GP in north west London
- **Daniel Hardiman-McCartney MBE**, Clinical Adviser, The College of Optometrists
- **Dr Tom Oakley**, Chief Executive, Feedback Medical
- **Matthew Payne**, Catalyst, Health Tech 1
- **Dr Jose Rodriguez**, Consultant in Restorative Dentistry, Guy's and St Thomas' NHS Foundation Trust
- **Robert Walker**, Head of Health and Social Care, techUK

Supplementary interviews

- Association of Directors of Public Health
- **Andy Bell**, Chief Executive, Centre for Mental Health
- **Dr Katie Bramall-Stainer**, Chair, General Practitioners Committee, British Medical Association
- **Jack Gibson**, Partner, Healthcare and Public Sector, Bright Frog
- **Amy Glees**, Associate Vice President of Product, Mastek
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Written submissions

Accessible Waterways Association

Association for Primary Care Audiology Providers

Association of British Paediatric Nurses

Association of Optometrists

British Dental Association

British Property Federation

British Society of Paediatric Dentistry

Chartered Society of Physiotherapy

College of Optometrists

Company Chemists' Association

Denplan

Doctors of the World UK

FODO, the Association for Eyecare Providers

General Pharmaceutical Council

Health Equity Evidence Centre

Health Foundation

Health Innovation Network

Health Spot

Institute of Biomedical Science

Keele University

Kidney Research UK

Mind

National Kidney Federation

National Pharmacy Association

National Primary Care Deans, NHS England Workforce, Training and Education

NHS Confederation Primary Care Network

NHS Race and Health Observatory

Nuffield Trust

PAGB

Pharmacy2U and Incisive Health

Primary Health Properties

Professional Standards Authority

Queen Mary University of London

Queens Park Group Surgery

Roma Support Group

Royal College of General Practitioners

Royal College of Nursing

Royal College of Occupational Therapists

Royal College of Ophthalmologists

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Individual submissions from patients and members of the public

About this Report

About Policy Connect

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