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ACUTE PERSPECTIVE

David Oliver: How hospital doctors' own pressures affect GPs

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Even before covid hit in early 2020, the NHS faced growing pressures from capacity, performance, and demand. GPs in particular had repeatedly sounded the alarm about workforce and workload. A recurrent concern is the transfer of responsibility of complex outpatients and post-acute inpatients back to primary care.¹ This is often accompanied by requests for GPs to chase or arrange investigations, referrals, or follow-up, monitoring patients and issuing prescriptions. Much of this work is a contractual responsibility for hospitals, and GPs aren't remunerated or staffed to take it all on.^{2 3}

Demand for GPs' services has risen steadily in the pandemic, with a growing crisis of morale and unfair attacks in the media over access, waiting times, and remote consultations. Some hospital doctors have fanned the flames by blaming GPs for rising hospital attendances. I deplore and condemn this. Primary care data show that monthly consultations in July, August, and September have been back above pre-pandemic levels, higher than ever, with about half face to face.⁴ And a *GPO* online survey found that 83% of GPs cited transfers of unfunded secondary care work as their main concern.⁵

But two wrongs don't make a right. I've also seen too many instances of GPs blaming hospital doctor colleagues. We've been accused of transferring unfunded work that should be part of secondary care to overstretched general practices, treating GPs like community house officers, and failing to respect GPs as equals with specialist experience and expertise in primary care.⁶⁻⁸

I'm very supportive of GPs' concerns over workload, morale, funding, and workforce, backed by compelling headline data. But I'd like GPs who comment and campaign to show reciprocal understanding of the pressures on acute hospital teams and stop accusing us of acting in bad faith and thoughtlessly overwhelming general practice.

In acute care we also face pressures of recruitment, retention, morale, demand, capacity, workload, and burnout. For many of us, remote working during the pandemic was impossible because of the building based nature of acute care. Like GPs, we're motivated by a concern to do the right thing for patients, our organisations, and the wider health system. England has about the smallest per capita bed base and the lowest ratio of available hospital beds in Europe and other developed nations. We've lost around 15% of our adult general and acute beds since 2010 and now have only 104 000 for the whole population.⁹

Emergency department attendances have risen rapidly in that time, reaching new records yearly.¹⁰ Delayed care transfers from hospital "exit block" due

to under-resourced community health and care services also hit a record high before covid, putting more acute beds out of action.¹¹ Most adult admissions come not from GP referrals but from emergency numbers or concerns from patients, families, or care workers.¹²

Necessary covid infection control measures affected bed availability in the pandemic peaks, but even now, with fewer hospital cases, midnight bed occupancy is back above 90%—well beyond what we'd want for flexible capacity and to prevent endless "black alerts."¹³

NHS England is pushing for more acute ambulatory and same day emergency care so that fewer people arrive on hospital wards.¹⁴ Its discharge guidance urges hospitals to ensure that patients are home as soon as medically stable enough and sets out very tight "criteria to reside" in a bed, even though the step-down community services needed to support patients after discharge are also depleted.¹⁵ Every day in acute care starts with a struggle for beds. And hospitals are often debilitating or distressing places for patients, many of whom would prefer to be back home.

Commissioners of outpatient clinics measure and aim to reduce "new to follow-up" ratios so that fewer patients are repeatedly brought back for routine appointments.¹⁶ Many localities have "demand management" schemes to reduce first appointments.¹⁷ Patient charities such as National Voices and the Richmond Group have highlighted the chaos, lost time or earnings, and inconvenience of patients with multiple conditions coming repeatedly to multiple single specialty clinics on a hospital site.¹⁸

Primary care advocates would argue that it's GPs and practice nurses who provide lifelong continuity and coordination of care for patients with long term conditions. They know the patients best and see them in their own environment. A short, episodic contact with an unfamiliar acute care team or one-stop outpatient visit doesn't change that.

I'd love to see more acknowledgment that doctors in acute care, just like GPs, are trying to do the right thing in the context and constraints of our work. We need unity, not division.

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