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Main barriers to accessing general practice:

- Telephony systems that can't keep up with patient demand – patients find they are either hanging on the phone for long periods before their call is answered, or when they do get through, they are told that there are no appointments.
- A lack of bookable appointments, resulting in large numbers of patients being seen each day as 'emergency' appointments. This is unsustainable in the long term, as GPs become exhausted and unable to function safely seeing large numbers of patients each day
    - Appointments are only bookable on the day, or by the GP, resulting in large volumes of phone calls into the surgery in order to be seen F2F.
    - A reduced number of GPs as they are leaving the profession faster than coming into the profession (currently exacerbated by Covid 19 infections or quarantining) to see patients
- GP numbers reducing over time, rather than increasing, despite increasing numbers of trainees.
    - Workload and work pressures including QOF and CQC inspections, appraisal etc add to pressures of work
    - Pension issues result in doctors (all doctors) finding it easier to retire in their late 50s rather than pay punishing tax bills. Some continue to work 'bit-piece', but many just stop.
    - Negative pressure of the media and press result in GPs losing the desire to continue working, as the public also pick up the negative vibes.
- A lack of 'joined up' working together, to use other healthcare workers to reduce the load on GPs – physiotherapists, mental health workers, social workers, advanced nurse practitioners, paramedics, physician associates, HCWs etc etc. While many practices have some of these professions alongside, most don't have them all, and those they do have are not being used to their full potential.

How can these barriers be tackled?

- Resource to pump prime telephony so that patients can access Primary Care quicker and easier, and of IT systems (a unified patient record) so that workload is reduced
    - Primary Care spends a lot of time checking on Secondary Care work, results of tests, clinic letters etc, which are all found in different places.
- Govt needs to develop a much better approach to workforce planning.
- Using examples of best practice to ensure the most potential is gained out of appointment systems, and none are wasted.
- Reduced pressure on GPs to keep them in the workplace longer:
    - Less emphasis on CQC inspections that are less punitive and more supportive
    - QoF and appraisal made easier, less target driven care that ignores personal care and what the patient really wants.
    - More strategies to increase continuity of care, which has better patient outcomes as well as greater GP satisfaction.
    - Govt to be more supportive of GPs and general practice, so that the media can't get away with its current negative press that often has no basis – GPs need to feel valued!
    - Look at the pensions situation, to make it more attractive to remain in work rather than retire in your mid to late 50s.
- Use of best practice examples to ensure a full complement of healthcare workers is based at each practice and each practice is enabled to use them appropriately.

- Leadership and teamworking skills for GPs to enable grassroots leadership to be maximised.

To what extent does the Govt and NHS England's plans for improving access for patients and supporting general practice address these barriers?

- DoH and NHSE's plans will not address the barriers above
- ICS are a worrying development as the GP voice will be lost
- Setting access targets and threatening to 'name and shame' the bottom 20% is foolish, as there will always be a 'bottom 20%' even if all practices are exemplary. Better to help those practices that are struggling rather than punish them.
- Allocating extra funds will only help if it is continuous and not fixed term, to pay for the additional healthcare workers needed. There are so few locums around that it won't go far paying for GP locums.

What are the impacts when patients are unable to access general practice using their preferred method?

- Anger and frustration
- Patients' symptoms going unseen and potentially losing valuable time in diagnosing serious illness
- Overuse of out-of-hours services and A&E
- Patients seeing a number of GPs and not having continuity of care, as they try to see anyone that they can get an appointment with
- Loss of trust in a very entrustable profession

What role does having a named GP – and being able to see that GP – play in providing patieints with the continuity of care they need:

- There is now a great deal of evidence, both from the UK and from Scandinavia, that continuity of care reduces hospital admissions, saves lives and increases satisfaction with the services. This has been shown recently for dementia care as well (BJGP Jan 2022).
- Increased job satisfaction for the GP – it is much better seeing patients you already know than every patient being someone you haven't met before and need to catch up with.
- Relationship care is a vital aspect of general practice, and the relation between patient and doctor is know to be therapeutic in itself.

What are the main challenges facing general practice in the next 5 years?

- Workforce continuing to shrink if none of the barriers are tackled in the ways I've described above.
- Workload continuing to increase
- More practices going to the wall, and having to be 'managed'
- Privatisation taking over practices that have folded
- A loss of the ethos of general practice so beloved by the public
- A loss of the standards of care we currently offer patients
- Loss of morale amongst GPs – many describe feeling exhausted, overwhelmed and suffering from moral distress.
- The joy of general practice continuing to evaporate
- Without a well organised primary care system, the whole NHS will suffer.

How does regional variation shape the challenges facing general practice in different parts of England, including rural areas?

- Some places are very desirable – affluent, middle class suburbs and small towns etc. Income is steady and because the area is desirable, it is easier to find GP replacements when GPs leave or retire.
- Some places – including rural and coastal areas, are less affluent, and often don't want to work there. A lack of housing, schooling, access to the comforts of a town or city mean many GPs don't want to work there. In the Welsh Valleys for example, there are a large number of older GPs, and International Medical Graduate GPs who are about to retire, with no-one wishing to take over.
- Inner city areas have similar problems – GPs earn less, the practice premises tend to be in less well-maintained condition, and it is difficult to attract new GPs to the area to work.

What part should general practice play in the prevention agenda?

- GPs should have a large part to play in the prevention agenda at a community level. This could be on an ICS basis, but in conjunction with other community services
- GPs are well thought of by their communities and can play a pivotal role in mobilising new services alongside Third Sector and voluntary agencies.
- GPs should be working with schools, the police and community centres/ places of worship to empower the public to take more healthy lifestyle action. By the time someone comes to the GP with Type 2 Diabetes, overweight, high blood pressure, heart disease and depression, it is too late to do any more than apply sticking plasters. It could be prevented by earlier interventions and GPs would be brilliant at this – but THEY MUST HAVE THE TIME TO DO IT!

What can be done to reduce bureaucracy and burnout, and improve morale, in general practice?

- Work with GPs to find out exactly what are the main causes and then find solutions to stop them. For example, CQC could be more supportive and less punitive, QoF pushes GPs into often little -evidenced large-scale work, a unified patient record would save huge amounts of time currently spent chasing information that is difficult to find.
- Institute the role of Medical Personal Assistants in general practice to help with administrative duties that are very time consuming and take GPs away from frontline patient care.
- Devolve responsibility for 'Fit Notes' away from GPs to other members of the healthcare team.
- Clearer Govt support for general practice – both public support and financial support for better premises, better telephony, properly staffed multi-disciplinary teams, leadership training and support etc.

How can the current model of general practice be improved to make it more sustainable in the long term, in particular:
Is the traditional partnership model in general practice sustainable given recruitment challenges, the prioritisation of integrated care and the shift towards salaried GP posts?

- One size will not fit all – there are some places where the traditional partnership model, if it is properly resourced, will work much better than a salaried model. In salaried 'managed' practices, GPs do not have a say in how the practice is run, and there are few economies or solutions to long-winded ways of doing things. They are less likely to stay on when there are still patients to see, if they are salaried with fixed working hours. In general, the current model of general practice, if it is allowed to work well, is the most economical and efficient way of providing services to patients in Primary Care.
- There are many GPs who do not wish to be partners – they wish to be able to leave the responsibility of running a practice to others, just come in to see patients and then leave. That is fine, and many of these GPs are at the beginning or end of their careers, and there must be provision for this type of GP as well as the partnership model.

- Dept of Health and NHSE needs to work in partnership with general practice leadership groups, such as the RCGP, GPC to find solutions and bring general practitioners along with them, rather than imposing unacceptable and inefficient new targets on them.

Do the current contracting and payment systems in general practice encourage proactive, personalised co-ordinated and integrated care?

- The QoF system is now outdated, and promotes target setting that is not personalised to the patient.
- GMS payment, by head of population is better because it allows the GPs on the ground to decide what services their communities need and how to supply these. It gives GPs more scope to be innovative and serve their patients' needs, as the professionals who best know their communities.
- Enhanced services can help GPs to provide additional services that are needed, but need to be locally enhanced rather than 'across country' services.
- GPs should also be given resources to allow them to set up proactive preventive services in their communities.

Has the development of Primary Care Networks improved the delivery of proactive, personalised, co-ordinated and integrated care and reduced the administrative burden on GPs?

- It has not done so to any appreciable extent. If anything, it has increased the administrative burden and GPs take on more and more activities.
- In some respects in individual cases, the PCN has enabled a range of work that would not otherwise have been funded, to the benefit of patients.

To what extent has general practice been able to work in effective partnerships with other professions within primary care and beyond to free more GP time for patient care?

- It's been patchy, and very dependent on what resource has been available. What is really needed is a comprehensive package of healthcare professionals, in effect the 'New Primary Healthcare Team', that can come into all practices to help with the workload, under the leadership of the GPs.

Feb 2022