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1. What are the main barriers to accessing general practice and how can this be tackled?

Simplified this is due to the issue of supply vs demand. There is a clear workforce issue i.e. there are not enough GPs. This is due to a multitude of reasons including the fact that it is now a very difficult job with most GPs seeing more than the recommended number of patients per day to try to manage demand. This then leads to burnout and leaving the profession sooner than they would like. In addition to this, patients have more complex issues and a 10 minute appointment is not enough time to manage the patients needs.

The demand on GPs far outweighs the supply. Reviewing the demand, there is a percentage which is not appropriate for GPs to be dealing with i.e. there are alternatives that people are not choosing e.g. pharmacies, voluntary sector organisations. There is also a general cultural perception to "see your GP" for multiple issues, a cohort of which are not medical in nature.

In terms of solutions to these problems:

- Patient education e.g. making them more aware of the alternatives
- Changing the way GP surgeries are set up i.e. if we are to provide more than medical services, lets set up practices for this e.g. voluntary sector organisations invited into practices to support patients with their non medical issues, clear signposting to other services like pharmacies for minor issues.
- Set up urgent care review i.e. same day urgent problems as a separate but connected service to GPs. Allow GPs to concentrate on long term conditions whilst the urgent same day service is run by ANPs, clinical pharmacists, first contact physios to remove this demand from primary care.
- There is the ongoing pensions issue which affects all doctors.
- Review the primary:secondary care relationship, make the connection stronger e.g. GPs to spend time in secondary care and vice versa. Ensure all secondary care doctors have to spend at least one rotation during their training in primary care to make them more aware of the pressures in primary care but also this will increase the workforce.
- Use of media campaigns to make the public more aware of the additional roles. E.g. "you don't always have to see a GP".. and case studies of the great work the ARRS staff can do
- Improve public perceptions of GPs, currently the derision means newly qualified doctors do not want to become GPs, we need to change that narrative.
- The need to create a method by which GP trainees who don't pass their training are retained within the workforce i.e. a GP version of the trust grade position
- Estates issue needs a resolution. There is not enough space in current primary care buildings. Offer the use of derelict/brownfield sites for PCNs to use a central back office for telephone/admin duties. Allowing more space in GP practices for patients to be seen.

1. To what extent does the Government and NHS England's plan for improving access for patients and supporting general practice address these barriers?

It doesn't do enough. The current plans to improve access are helpful but they fall far short of what is needed. It seems confusing that when we don't have enough staff to provide 8-630 Monday to Friday cover, we are then trying to pursue cover for more than that. GPs try to provide this but there is abuse of this system e.g. getting ANPs to cover these sessions meaning patients aren't getting what they want.

We need to improve the core hours first and once the workforce is solved for this, then we should be looking at improving extended access.

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

Sadly it reduces confidence in primary care and patients are coming to harm from delayed diagnosis, investigations or treatment.
There is the risk this then leads to more patients going elsewhere to be seen and this can be at times being seen in an inappropriate setting for them e.g. going to A&E which then has financial consequences for the patient and the economy.

3. What role does having a named GP—and being able to see that GP—play in providing patients with the continuity of care they need?

Continuity of care is a major reason many GPs continue to be GPs. Its what makes the job so enjoyable when you create long term relationships with patients. Having a named GP I feel is tokenism, it has little real impact for a patient.

Being able to see that same GP is far more important in the quest for continuity of care. The issue though comes back to how feasible this is. There are not enough GPs in the system and those who are still working are unable to provide a 5 day 8-630 service. Continuity of care will be plausible when the job is made doable. Again the use of other technologies e.g. online consultations or emails so GPs can manage these when they are in work, would be a possible solution to this. The issue though comes these extra technologies can't be an add to the current workload or the exodus of GPs will progress further.

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

- Estate
- Workforce
- Morale
- How will PCNs develop in the future
- How to merge all the options of access whilst still making the job doable
- Public perception of GPs
- Future funding

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

This does make primary care far more challenging because we currently have a one size fits all payment mechanism which isn't equitable. Further to this, the challenges in terms of patient needs varies massively between inner city Birmingham and Cornwall due to the variations between areas.

6. What part should general practice play in the prevention agenda?

Prevention is a vital part of the work of primary care. We are still trusted by patients but how we do this can and should be changed. It is again making GPs far more part of the community, allowing

cancer charities, British Heart Foundation, Diabetes UK to host sessions in practices to help patients manage their own conditions or prevent disease. Opportunistic screening is a perfect opportunity to educate patients on how to avoid illness and disease. This again though cannot fall at the feet of the GP, it is up to additional roles within primary care that provide these services.

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

This returns to the initial question, the volume of work that somehow ends at the door of a GP needs to be reviewed. This includes DVLA reports, insurance reports, DWP forms etc. Writing reports is not what made anybody want to become a GP. This barrier to seeing patients needs to be removed as much as possible as soon as possible.
It would also help if we created a feedback system as to how much work a practice can do similar to what happens in A&E. Calculate what demand a practice can take, create RAG rating systems and when a practice is at red status, same day support can be provided via the commissioner for example to help reduce that stress.
Reducing burnout would occur by limiting how many patients a GP can see within a session or day. Once that limit is reached, no more patients are to be seen by that GP that day.
Another option has been mentioned above, make GPs manage chronic conditions only and move urgent care centre staff to PCNs. All urgent cases are then reviewed nearer to a patients home with the ability for the PCN urgent care staff to communicate with the patients GP if needed on the same day.

8. 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?

I would look at the description above to help. We need to reduce the demand in general practice, by doing this it would become a more enjoyable job again and allow us to create more continuity of care. I think the current partnership model is sustainable and my concern is that by moving a 100% salaried model, those who are GP partners are unlikely to move to the new salaried model. Many practices are now making non GPs partners to help with the admin load of being a partner and I think this is the way forward (on a side note, the new to partnership scheme should include Practice managers which it currently doesn't). As per Nigel Watsons review, the partnership model works need to extract the gains from this rather than throwing the successful model away.

10. Do the current contracting and payment systems in general practice encourage proactive, personalised, coordinated and integrated care?

    No it doesn't the current GMS contract needs revision to take into account the new ICS and how important primary care is to it. The PCN DES pushes the need to be part of this but far too much work is placed at the feet of PCN clinical directors which is again not feasible. Most practices who are not active within their PCNs, do pay the PCNs and CDs lip service only. By pushing the onus more onto practices, this would help to encourage personalised, proactive care.

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