**Submission by Dr Gillian Farmer LMC Secretary for Worcestershire Local Medical Committee.**

* **What are the main barriers to accessing general practice and how can these be tackled?**

The diminishing workforce ( seen across all practice staff ),lack of capacity and rocketing demand are the main barriers to accessing general practice. Demand has far outstripped capacity. Efforts need to be concentrated on retention of the current workforce by not tolerating abuse of GPs and practice staff and clear messages of public support from government and NHSE. 15 minute appointments with patients will improve patient satisfaction and make the job rewarding again for GPs but will also require a shift of work that GPs do not need to be doing away from practices allowing us to focus on patients who will most benefit from what we can offer. Investment in practice premises is needed for additional staff recruited through the PCN DES. We need a commitment within the Health and Care bill to monitor and build up the GP workforce. It needs to be recognised that the variety of consultation models including remote access all have pros and cons and none should be seen as being better or worse than another. Any data used should reflect the full range of “ access “for patients not purely face to face appointments . Often a face to face appointment is not clinically indicated and GPs must be trusted to make that decision. Full waiting rooms are not safe or necessary and public messaging around patient expectations this Winter are desperately needed in order to work against a negative and misleading media narrative that general practice is shut. To ensure that all those seeking a consultation can access care from general practice this Winter, all models of access need to be available. It is unlikely that we will meet the demand otherwise and this will then impact on other NHS services.

* + **To what extent does the Government and NHS England’s plan for improving access for patients and supporting general practice address these barriers?**

Unfortunately, it does little to address the issues and GPs have felt angered and disillusioned by the skewed NHS data which will single them out as needing support and intervention. There is not a workforce waiting in the wings to come to the rescue and money will not solve this issue alone. It is positive that the impact of transfer of work from secondary care on GP time is recognised but more action needs to be taken to address this contractually. What would have been helpful is redeployment of staff from other organisations to work in hubs triaging calls and redirecting patients to the most appropriate service or indeed overspill hubs for practices to use when they have reached capacity.

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

Currently practices face anger and abuse from patients but I think this question misses the point. We are not in a position as we head into Winter to allow access based on want rather than need. We need to be trusting our GPs to work with patients to offer the most appropriate form of access in discussion with the patient. We can certainly aspire to ensuring a preferred method of access when we recover from the effects of the pandemic and the backlog of demand but it will require significant investment into core GMS and support for the independent contractor model along with a clearly defined workload and freeing up of capacity and additional workforce.

* + **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?**

Clearly for those patients who have chronic conditions, continuity is desirable. However, the workload pressures are so high that many GPs cannot work fulltime as they would now risk burnout. The named GP may therefore not be available every day of the week due to current pressures. A focus on making the working day manageable again would encourage GPs to work more days in general practice and for more to take on partnerships. It should be recognised that for many people they value quick access when it suits them over continuity of care and it is more important to identify who needs that continuity and aim to provide it than to have a named GP for all. Having continuity of care relies on having enough GPs.

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

We cannot continue to be all things to all people. The population is increasing and our elderly population live longer but with multiple conditions and complex needs. Our workforce is decreasing. We will struggle to retain GPs even if we can recruit them with the current workforce pressure. We need to find a way to ensure that we can focus our attention on those most likely to benefit from an appointment with a GP rather than trying to do everything. Integrated care systems are likely to encourage more work out of hospitals and whilst this may well be the right approach, we will struggle to cope with the workload unless we have significant investment into practices and resource to do this work is transferred from secondary care budgets. The independent contractor model allows for innovation and flexibility and investment into core GMS should be the focus now with a drive to recruit GPs to the partnership model. We are spending too much time supervising other roles and working as managers.

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

Working across PCNs has helped in this regard and practices need to work with PPGs and make use of population health data to drive transformation and reduce inequalities. The partnership model is ideally positioned to provide innovative solutions.

* **What part should general practice play in the prevention agenda?**

We should be advising on prevention opportunistically but we need much better public health messaging around diet, exercise, mental health, smoking etc and education in schools.

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

Keep appraisals in their current format ( ie that adopted during the pandemic ). CQC inspections need to be less arduous for practices as they create a great deal of stress and additional workload. Only a very small minority of practices should require this level of intrusion/scrutiny. Public messages supporting general practice, addressing abuse with patients and calling out misleading media articles would help at the moment as would an honest conversation with the public about the level of demand that we are facing. Manage patient expectations. Push back against work transferred from hospital ( requests for re-referrals, follow up blood tests, Fit notes etc ). Make the workload manageable again by encouraging self-care and prevention. Increase the numbers of school nurses and health visitors. Allow GPs adequate time to consult with patients. Build on recruitment and retention drives to allow us to share the workload and make the job enjoyable again. Support the independent contractor model and incentives for those joining as partners.

* **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?**

There are considerable risks and liabilities which affect partners alone and these now need to be addressed in order to recruit more partners. Liabilities such as “the last man standing” need to be removed. The partnership model has allowed for innovation and flexibility throughout the pandemic and a solely salaried service would not have been as effective. For example, the roll out of the GP vaccination programme and development of hubs during covid only worked because of the flexibility afforded by the partnership model. It is absolutely sustainable but funding needs to go into core GMS to meet the needs and wants of patients and too much is being focused on integrated care and other initiatives that impact far less on patients and detract attention away from what patients are asking for which is time with their GP. We are spending too much time supervising ARRS roles and attending meetings for the ICS.

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

We need to consider a different contract through negotiation with GPC. Money needs to go into core GMS to allow practices and PCNs to focus on delivering the right services for their patients understanding local needs and priorities. There are too many separate pots of funding and general practices enhanced service money is not ringfenced within the integrated care systems which means that that money can be used by secondary care resulting in less proactive and personalised care in the community. The PCN DES has afforded some funding for general practices to collaborate across the ICS but it does not cover the supervision of ARRS and all of the meeting which take us away from direct patient care.

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

No. It has improved collaboration with other organisations and encouraged closer working on service pathways across the ICS but the administrative burden on GPs has greatly increased as explained earlier. We support practices working together as this provides efficiencies and encourages shared learning / support networks but practices still need to retain their autonomy.

* **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?**

Time has not been freed up in general practice from working with other organisations as often GPs are asked to work on pathways for secondary care / to reduce A&E attendance etc. Time has been taken away from direct patient care on the whole. There are local forums for working with other professions within primary care and relationships are growing and developing but this does not directly correlate with freeing up GP time.