**Future of General Practice**

Written by Barry Moyse, Medical Director of Somerset LMC,

This has been submitted as we are the Somerset LMC which represents all GPs and GP practices within Somerset.

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

The main barrier is managing the infinite demand on general practice, when we have a finite capacity and declining workforce.

**Numbers of GPs are falling**

Capacity is dependent on our workforce numbers, and the key to primary care is GPs. There has been a promise and desire to increase their numbers by 1500 by 2024, yet we have had a fall of 1704 fulltime equivalent GPs in comparison to 2015.

**Decline in all primary care staff**

In Somerset, not all ARRS roles can be filled. There are simply not enough to go around. There are only two mental health practitioners that have been recruited under this scheme in Somerset. Recruitment and retention remains an issue. Receptionists are not well paid and overworked and increasingly choose to work in easier positions (including in supermarkets) rather than under the stress, strains and public abuse present in many practices on a daily basis.

**Fewer doctors are looking after a greater number of patients**

Since 2015, the numbers of patient per GP have increased by 15%.

**Changing work patterns.**

It is documented that the number of full-time equivalent GPs (working eight sessions) have fallen. These GPs would on average be working 50 hours per week, yet the definition of full-time work is only 37.5 hours. We need to look again at the definition of full-time work in general practice because, according to this, six sessions would be full time. Certainly, in hospital medicine six clinical sessions is be seen as full-time with four sessions left for other activities such as administration and education. A GP session is classed as four hours and 10 minutes, but no one works an eight-hour 20-minute day. In addition to the clinical work time is spent on things including: clinical administration; Covid vaccinations; business management; supervising of Primary Care Network Direct Enhanced Service Additional Reimbursable Roles Scheme colleagues, medical students and GP registrars; preparing for or reacting to CQC inspections; patient participation groups; continuing professional development; reading emails, new guidance and local protocols and covering colleagues’ absences illness.

We use to see ‘childcare’ given as the main reason for working less than eight sessions. This is no longer the case and certainly four – six clinical sessions would now be the norm for male and female GPs. We have to question how this has happened. GPs that left practice due to work pressure often work full time elsewhere. How do we make the working day more reasonable? Perhaps we should acknowledge that are in fact three sessions in a day? This happens regularly in hospital practice.

**Demand increase**

The number of appointments has increased by 10% since the pandemic, with face-to-face appointments making up around 60% of all appointments. On one Monday in Somerset a practice with a population of 14,000 was faced with 640 contacts. Online consulting is designed to make it easier to contact a surgery but demand is infinite and ease of access encourages unlocks more unmet needs. All other parts of the NHS have capped capacity. For example NHS dentists, secondary care referrals, physio appointments have long waiting lists. In extreme cases Emergency Departments can ask for ambulances to be diverted. General practices often run with only same day access but even then the demand is not stemmed. We need to address the demand and not necessarily encourage ease of access when we do not have the capacity to manage it. Rather than being proud that, in October Somerset offered over 325,000 appointments of all types to its 558,000 people, perhaps we should ask why so many are needed by the population?

In conclusion, reduced GP workforce with unlimited demand is the ultimate barrier to access.

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

Face to face appointments are not necessarily a sign of success or great care, yet the government has failed to understand how Covid enabled a development of the way in which GPs work. The demands of the vocal patients – some utterly justified but nevertheless amplified and coarsened in the popular press - fuelled the impression that ‘naming and shaming’ of practices was policy. There seemed little grasp that there is no extra pool of GPs to ‘fill the gaps. Paradoxically, some practices are now reluctant to document the full extent of administrative workload in case this reduces their proportion of face to face consultations! The impression is that policy decisions are not informed by the real-life experiences of those actually doing the work.

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

These are self-evident and include: not seeking help and so getting sicker before being forced to do so; attending emergency departments (EDs), calling ambulances and Minor Injury Units (MIUs) inappropriately.

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?

In an ideal world a named GP is the “conductor of the orchestra”. The concept can offer true continuity of care when it matters most, for those with chronic pain, frail and elderly, cancer care, dementia and end of life. It can also reduce the number of appointments for complex care patients including ‘high service users’. Such patients value this form of care and will choose this over speed of access. We know that it is a cost effective way of managing complex care.

However, the idea of turning the clock back to pre-Blair reforms of the ‘named GP’ does not consider the changed GP landscape of a reduced and part-time GP workforce and an increase an increase in allied health professionals. To ensure that the concept of having ‘named GP’ means anything we need more GPs.

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

Workforce shortages, unlimited demand from patients and bureaucratic regulatory burdens.

The traditional partnership model involves partners owning or leasing a building to work in. The “last man (sic) standing” fear is a real barrier to continuity as fewer wish to accept the unlimited liability.

In addition, there is a risk that Integrated Care Systems (ICS) will be dominated by hospital trusts despite all the warm words about general practice being “the jewel in the crown” and that “if primary care fails, the NHS fails.”

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

Regional variation changes with time. Perhaps 20-30 years ago rural or market town practices might attract literally hundreds of applicants. Nowadays, applicants are generally much fewer but anecdotally younger GPs seem to prefer the bright lights of the cities to more remote places. We do have young and enthusiastic GPs coming forward and locally have ensured good quality mentoring and training (including through the GP Fellowship Programme introduced by the Watson Review) to allow this to happen. Our new GPs also want to be partners which is reassuring. I strongly believe the NHS cannot afford to have a totally salaried service. The previous partnership review produced in 2019 by Dr Nigel Watson made this clear (gp-partnership-review-final-report.pdf (publishing.service.gov.uk))

Perceptions of policy inflicted on rural areas to solve London’s problems have long caused resentment.

What part should general practice play in the prevention agenda?

We are aiming for a proactive rather than reactive healthcare, but we need to put ‘the fire out’ in this quotidian workload before we start to rebuild the future*.*

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

More trust and more of a light touch from NHSEI and CQC.

A sense that HMG understands that demand cannot be infinitely met and that money is not the only answer would help. Public spending is not all that is needed. Andrew Lansley promised to “take the government out of the day-to-day running of the NHS” but Aneurin Bevan’s “dropped bed pan ringing through the corridors of Whitehall” seems to resound still. Given the vast amount of tax payers’ money involved in this, centralisation, though possibly unavoidable, has its own problems.

How can the current model of general practice be improved to make it more sustainable in the long term?

It remains a mystery why governments, especially a Conservative administration, should appear to feel such animosity to GP partners in small and medium sized businesses that are contractors for the government should make profits. In every other field getting value for tax payers’ money is paramount and if shareholders profit by it through the efficiency of the operation then everyone is content. Why are GPs so different?

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?

Please see my comments about the next 5 years relating to ownership and leasing of premises. I believe that this is the biggest bar to partnership recruitment as our experience of young GPs is that many are keen on partnership as far as clinical care, practice organisation and career progression is concerned.

# A colleague adds, “The sustainability of General Practice is dependent on maintaining traditional partnership models. In Somerset one third of young GPs are already partners and the remaining aspire to be over the next five years. Sustainability rests in how we can maintain these doctors in post. “Train people well enough so they can leave, treat them well enough so they don’t want to” – Sir Richard Branson. Investment in partnership encourages a long term commitment which is aligned to continuity of patient care and underpins the key cultural values of the profession. There may be an initial rise in those that take up salaried posts due to freedom of movement and maternity leave. However neither of these situations last. Partnership provides unique qualities not necessarily attainable as a salaried GP. It can give control, vision of care, job security, own autonomy, leadership skills, and education roles and generally a higher income. Salaried GPs mainly hold purely clinical posts and their income does not necessarily increase with clinical experience as would occur with hospital doctors pay scales. I can only think of a handful of salaried GPs that are GP trainers, as this role often works best in partnership. Salaried GPs freedom of movement often results in short lived posts and practices without partners often have a higher proportion of vacancies. Partnership and salaried roles remind me of the differences of home ownership and rental. Both have their merits, but most efforts go into ‘owned’ homes and the rental option has a tendency to be transitory. One of the advantages of pure salaried positions would be the possibility of an equality of pay for doctors, but this does come near to outweigh the benefits that partners give back to their local populations. I conclude that retention of GPs is the ultimate issue, and the fellowship is working for new GPs, but there’s no support for the experienced ones.”

It should be noted however that this view is universally held and some GPs feel that the traditional model has outlived its usefulness. .

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

We have heard much about “not worrying about contracts” or “about who employs whom” as we move towards ICSs but rather ‘’ it’s what works that counts’’. This is applauded by GPs who see this as real progress. Nevertheless, a disempowered and unimaginative regional NHSEI often blocks such moves in real life. For example, when it was suggested locally that Covid and flu vaccinations might be given efficiently by trained care home staff, NHSEI blocked any payment to fund the scheme via practices because “they would not be your employees.”

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

The PCN DES has given impetus and hope to many, by allowing practices to work together, whilst retaining individual autonomy at the same time as helping working towards mergers where they are preferred. But progress has been patchy and the pandemic has led to the latest services under the DES being delayed albeit for good reason. In time the PCN DES could bring about the good things listed above, although the recent LMC England conference has shown how strongly opinion to the contrary has grown. Much of this is due to the added administrative burden revealed as time has gone on. For example, Health Education England dictating the supervision and training requirements for AHPs has led some to question whether it might be easier just to carry on doing the work themselves thus defeating the entire object of the exercise.

As a colleague adds, “ARRS roles have added to the burden of practices with the requirements for mentorship and supervision of individuals as well as competing for limited clinical spaces in many practices. In my practice for example we have one first contact physiotherapist one day per week for just under 14000 patients who is fully booked one month in advance due to limited physiotherapy services locally (more than a 10-week waiting time for routine appointments). Although a valued member of staff for additional expertise they bring their impact on day to day workload is minimal due to sheer volume of demand.”

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?

Again, this has been patchy and limited by the pandemic so far. Indeed, there have been examples of other professions “pulling up the drawbridge” and retreating to core contract work in the face of demand.

But In Somerset there are signs that, at long last, the Community Pharmacy Consultation Service (CPCS) may make a small difference to the number of consultations for minor conditions in general practice. However, this is only the latest of many such schemes that have sunk without trace and even the most sanguine estimates are that perhaps 1;20 consultations might be so diverted. This is welcome but only a drop in the ocean of unlimited demand.

In conclusion let us examine what ‘free up more time for GP care’ might mean? In a world of unmet demand does this means the aim would be for the GP to see more patients? They are already working 12-14 hour days. A GP would naturally ask for more time with each patient. This is because GPs have seen the “bread and butter” work of general practice being increasingly managed, after triage, by other clinicians leaving them with more of the complicated cases. A positive benefit to come out of the pandemic was that enforced triage gave GPs the opportunity to manage their work more effectively.

For example, if a patient presented suicidal ideation a GP might need more than 30 minutes to manage this properly delaying other patients being seen. But being able to triage cases in advance, means that the same consultation could be booked to allow the patient to see the right person in the right place for the right length of time to the benefit of all. Allowing patients *carte blance* to return to choosing face to face risks undoing such good work.