Bradford District and Craven
Health and Care Partnership
ACTasONE

Proud to be part of the West Yorkshire Health and Care Partnership

Focus on: GP Access

Bradford

Health and Social Care

Overview and Scrutiny Committee

October 2023

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General Practice Access

1. Purpose

1.1 We know through Healthwatch reports and our local 'Listen In' engagement model that being able to book an appointment with a GP is an important concern for our population. Despite more appointments being made available than ever before, General Practice access is an issue both nationally and locally. The expectations of patients are changing as are consumer habits that allow us to access other services in different ways (for example the way we shop or the way we carry out our financial transactions) and yet we have a model of delivery that has changed little over the decades. This is against a backdrop of challenges that leads to GPs in crisis.

1.2 Our current reactive approach to GP access is unsustainable both from the perspective of our patients and our colleagues working hard to support people. This paper discusses how we aim to improve the *quality* of access to general practice, rather than simply working to increase the number of appointments. It is informed by the Fuller Stocktake Report *Next Steps for Primary Care* and local learning in Bradford District and Craven as we continue to work with London South Bank University (LSBU) on Universal Healthcare pilots. While an ever-increasing number of appointments that are available, this is not always meeting the needs and expectations of our population. The recovery of access in primary care needs to go beyond simply offering 'more of the same'.

2. Introduction

2.1 Our GPs, and the wider primary medical care workforce, face challenges in recruitment and retention, increased workload, safe-working practice, and a national contract that continues to focus on driving the volume of appointments to be made available. The current model of access to primary care is not working for our population or those working within general practice.

2.2 This paper describes the need to shift our focus from quantity of access to quality of access. Using the learning from our Universal Healthcare pilot and successful models such as Bradford Central Locality Integrated Care Service (community connectors developing personalised care plans), we know we need an open and ongoing conversation with local people about general practice access and the ongoing perception, and lived experience, that most people cannot get an appointment. We plan to prototype and test models to address the quality of access, while working with our practices to understand and support them where there is unwarranted variation in access. This development, using co-design between patients and primary care teams, is in line with the direction of travel set out in the Fuller Stocktake,

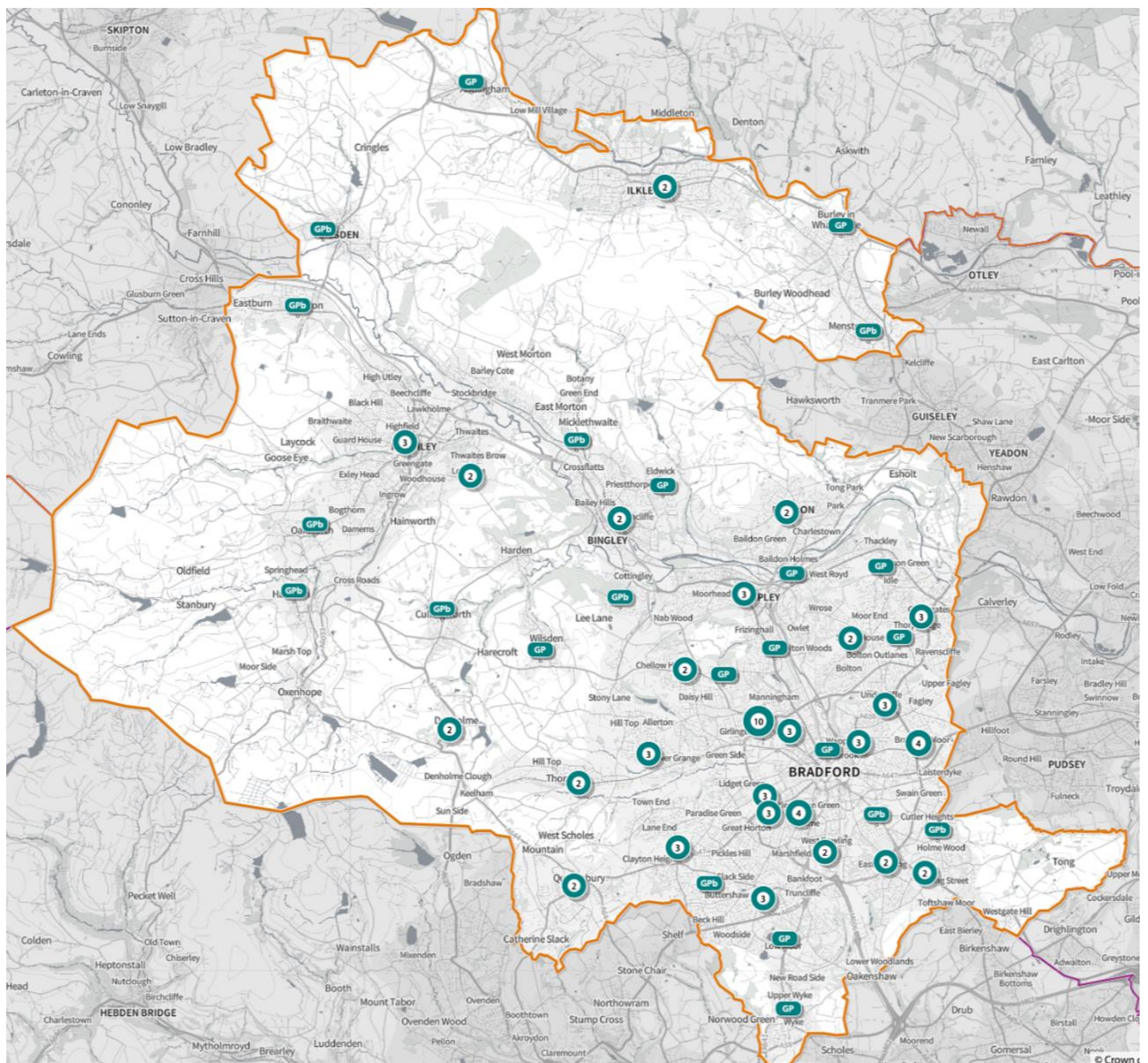
3. Our local operating model

3.1 West Yorkshire Integrated Care Board (ICB) is the delegated responsible commissioner for primary medical services, serving a population of 2,657,293 (August 2023). Legally, NHS England retains the residual liability for the performance of primary medical care commissioning.

3.2 Under delegation, ICBs have responsibility for commissioning and contract monitoring GP services in their localities, with NHS England maintaining overall accountability. Community Pharmacy, Dental and Optometry contracts were also delegated to ICBs on 1 April 2023. The ICB has a statutory duty to improve the quality of services and reduce inequalities, which are critical when referring to access in services. The commissioning and contracting of primary medical care services in West Yorkshire is devolved to the five 'Places' that make up the ICB.

3.3 Of the 269 West Yorkshire GP practices, Bradford District and Craven Health and Care Partnership has 60 practices providing primary medical care services, across 104 sites. This is under a variety of contract models to a GP-registered population of 661,085, 24.85% of the West Yorkshire population (September 2023). Within the City of Bradford Metropolitan District Council (CBMDC) boundary, the GP-registered population is in the region of 610,000 across 98 sites.

Figure 1: SHAPE Atlas – General Practice sites within CBMDC boundary



3.4 Our practices collaborate in an operating model of 12 Primary Care Networks (PCNs). PCNs are based on GP-registered lists and are made up of practices, typically serving 30,000 to 50,000 people. PCNs are small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and other providers in the local health and social care system.

3.5 PCNs build on existing primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and care for people. The model is intended as a change from reactively providing appointments to proactively caring for the people and communities we serve. PCNs are led by clinical directors who may be a GP, practice nurse, clinical pharmacist or other clinical profession working in general practice. PCNs are formed via sign up to the Direct Enhanced Services contract specification.

3.6 It is important to also acknowledge the role our other primary care contractors (Pharmacy, Optometry and Dental) play in providing services to our local populations. Recently, the role of Community Pharmacy in supporting improvements in access has become key through the implementation of schemes such as the Community Pharmacy Consultation Service, which aims to shift lower acuity presentations from General Practice to Community Pharmacy.

4. The GP contract for 2023/24

4.1 2023/24 is the final year of the 5-year framework agreement which was set out in Investment and Evolution. Over the course of 2023/24 NHS England will engage with the profession, patients, ICSs, government and key stakeholders, building further on the Fuller Stocktake from May 2022 which set out the next steps towards integrating primary care.

4.2 The Chancellor in his Autumn Statement set out a commitment to publish a recovery plan for General Practice access, this was published in May 2023. The Delivery plan for recovering access to primary care is considered in section 10.4.

4.3 Changes to the GP contract for 2023/24 can be reviewed here. In summary, they are in relation to:

- Access;
- Changes to Impact and Investment Fund (IIF) and QOF QI modules;
- Increased flexibility of Additional Roles Reimbursement scheme (ARRS); and
- Immunisations and vaccinations.

4.4 In addition to the core GP contract, practices are offered contracts for Directed Enhanced Services (DES) and Local Enhanced Services (LES). DES are nationally agreed and local commissioners can develop LES to offer to local practices to supplement services already offered in the core practice contract. The Enhanced GP services shows examples of this additionality. This list is not exhaustive, but rather an indication of the kinds of services that fall outside of the core GP contract.

5. GP access data

5.1 This section considers the information available that describes 'GP access' for West Yorkshire ICB and Bradford District and Craven (BDC) HCP. The information from NHS Digital uses July 2023. It should be noted that not all appointments are currently flowing through to the national dashboard. For example, the data above does not fully include Enhanced Access activity or several ARRS roles. This data is starting to flow and, as PCNs work on improving their data, this will increase the number of recorded appointments to reflect true activity. That is, more is being provided than recorded. We also know that the way some GP practices upload information does impact on the national data. An example of this has resulted in some practices being flagged as offering fewer face-to-face appointments than they do resulting in inaccurate reporting through the media.

5.2 NHS West Yorkshire ICB routinely offers over 1.3 million appointments per month for our population of 2.66 million. In July 2023, 30% were routine general consultations, 19% were acute consultations, with around 25% used for clinical triage and planned clinics. 44.2% took place on the same day. The mode of consultation has changed in the last 12 months, shifting to more face-to-face work. Most appointments (73%) were face to face, with 21% taking place over the telephone.

5.3 BDC represents 24.85% of the population of the ICB. In July 2023, BDC practices offered 387,160 appointments (Figure 1), 28.5% of the WY total 1,356,606. An increase of 36,593 appointments compared to July 2019 (pre-COVID-19 Pandemic). 70.6% were face-to-face, 22% by telephone (Figure 2). In July 2023, 46.4% were offered for the same day in BDC, 10.5% next day, and a further 16.2% within 2-7 days. That is, 73% of patients had an appointment within 7 days of booking (this is in line with the West Yorkshire wide average of 70%). A further 21.2% within 28 days, 5.6% over 28 days. Around 49% of appointments last 15 minutes or less. On average, 37% of appointments are with a GP.

Figure 2: BDC (36J) Appointments in General Practice February 2021 to July 2023

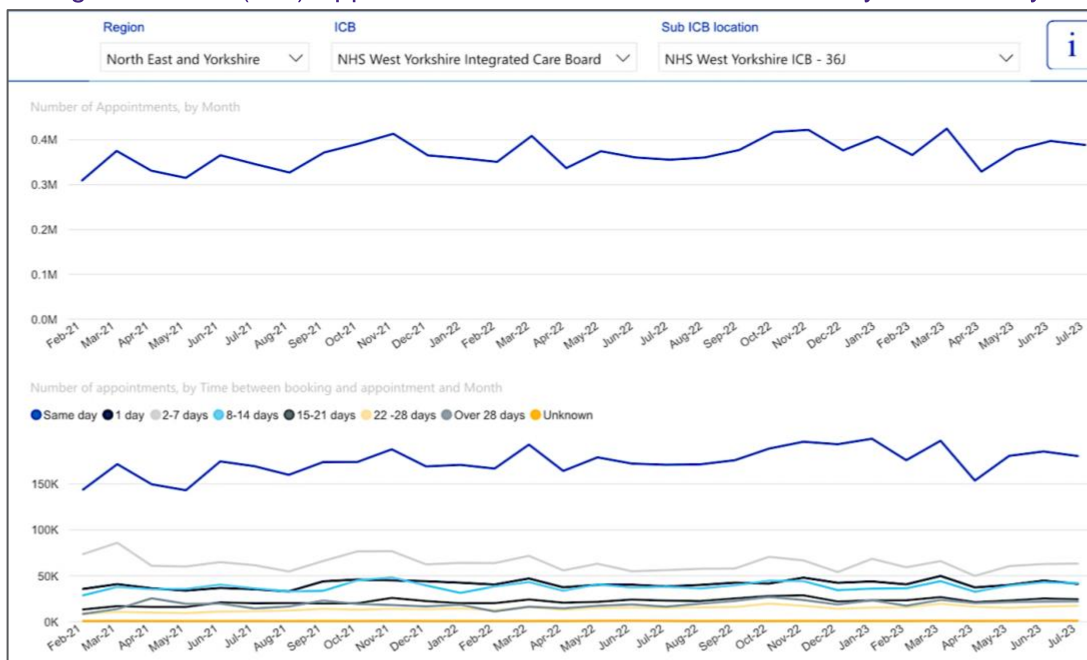
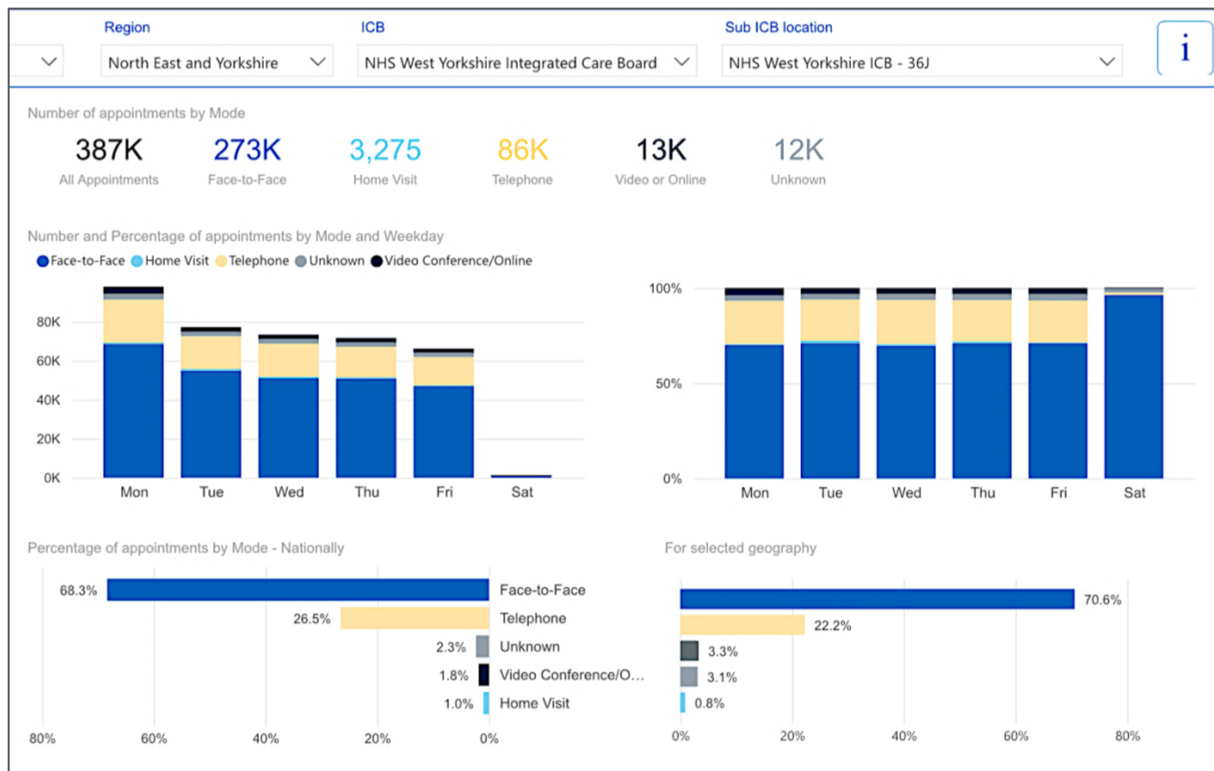


Figure 3: BDC Appointments in General Practice – appointment mode



5.4 Overall, the number of appointments available (Figure 3) and those that are offered on the same day is increasing. **Locally, more appointments take place face-to-face than the national percentage and there has been a 19% increase compared to July 2022 (Figure 4).**

Figure 4: Benchmarking - Total Appointments per 1,000 Registered Population

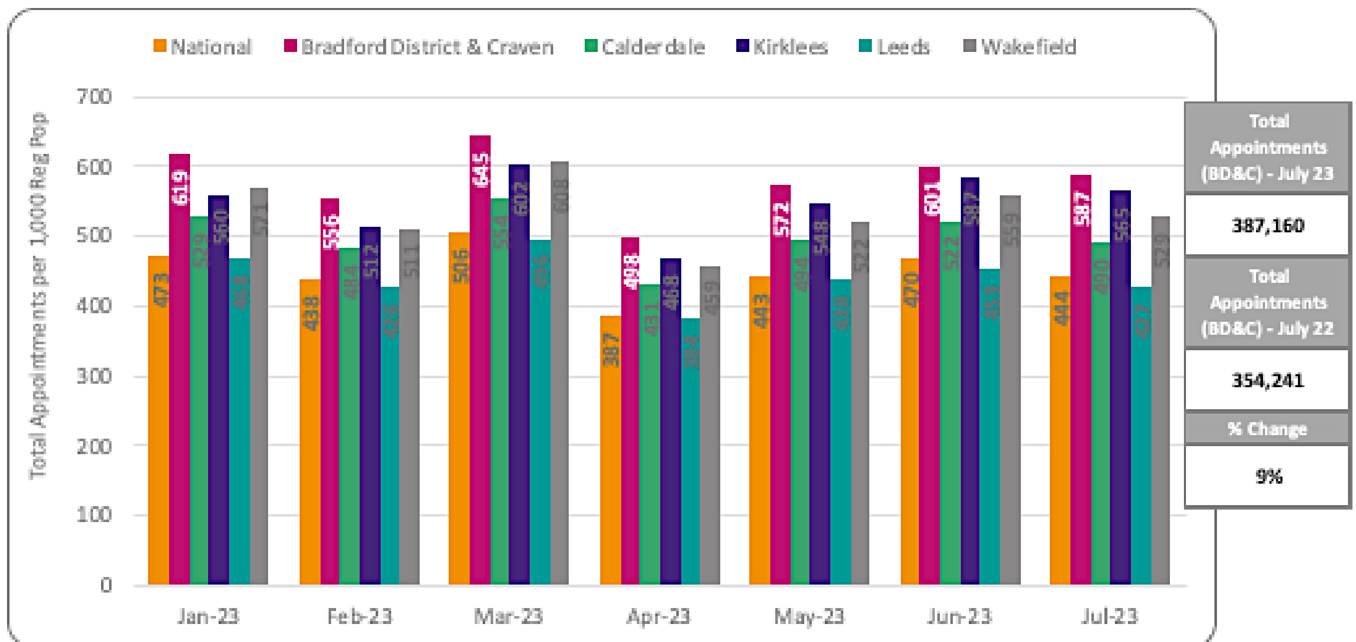
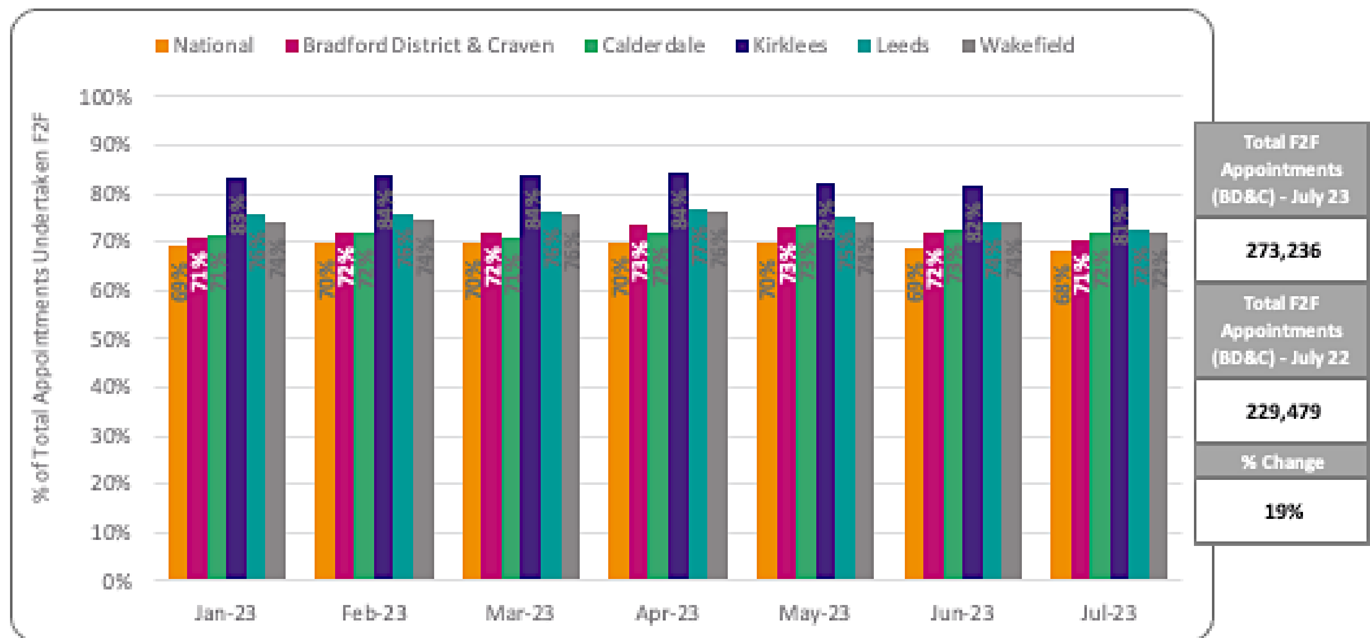


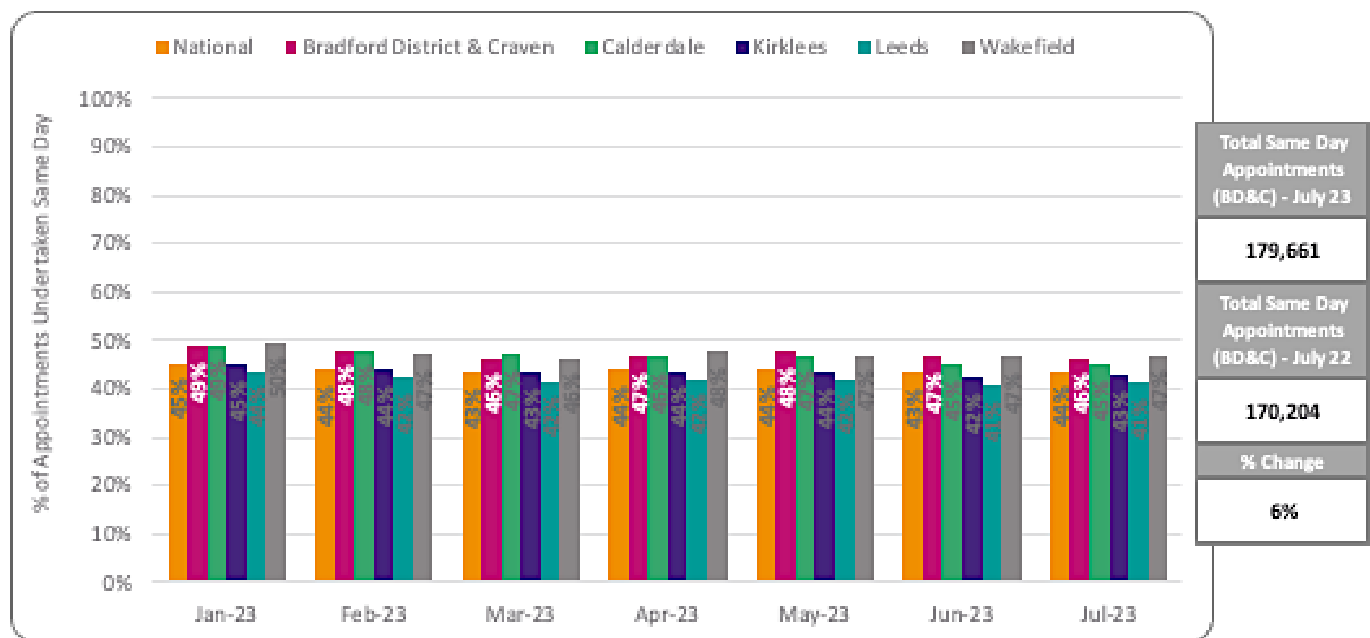
Figure 5: Benchmarking - Proportion of Appointments Undertaken Face to Face (F2F)



5.5 More appointments overall are provided now than pre-pandemic. More appointments are provided on the same day or within one day than the national average.

In July 2023, 51.1% of people in BDC were offered a same day or next day appointment. **Overall, 70.4% of people were offered an appointment within one week. Fewer people wait.**

Figure 6: Benchmarking - Proportion of Appointments Undertaken Same Day



6. What does the data tell us?

6.1 Capacity to meet demand remains a pressure on primary care. A common misconception is that there are fewer appointments available, which is not the case. The number of available appointments has recovered and increased from pre-pandemic levels. In line with the national picture, although we are delivering more appointments there is a higher demand, high expectations of timely access, and significant public dissatisfaction with GP access.

6.2 Bradford District and Craven averaged 386,000 appointments per month over the last twelve months (full year 4.6 million). Most appointments are within 7 days and most take place face-to-face.

6.3 If we consider pre-pandemic access, the number of appointments has increased.

In **July 2019** there were:

- 350,567 appointments

In **July 2023** there were:

- 387,160 appointments

Between July 2019 and July 2023:

- There was **growth** in the number of appointments by 36,593, or **10.4%.**

6.4 While NHS England measures GP workload based on simple appointment data, the work of primary care goes beyond that of patient consultations. Appointment data alone gives an incomplete picture of GP activity and fails to reflect the significant number of non-appointment patient contacts. That is, work undertaken in relation to repeat prescriptions, test results, referrals, targeted clinics, routine vaccinations, and support groups etc is not currently collected, although work on mapping activity is now underway.

6.5 The pandemic brought its own challenges. From February 2021 to January 2022, GP practices in Bradford District and Craven delivered 549,269 appointments for COVID-19 vaccinations. Last year, from January to December 2022, 104,441 vaccination appointments took place in Bradford District and Craven, a significant increase in workload that was over and above our core general practice appointments.

Public View data

6.6 Public View is a performance monitoring, benchmarking, and reporting service for NHS teams. Public View collates information from hundreds of data sources and enables comparison at provider trust and sub-ICB level, i.e. Bradford District and Craven Health and Care Partnership as a ‘Place’ of NHS West Yorkshire Integrated Care Board. It is a licensed product and so not freely available to the general public as the other data sources referenced in this report. The source data is still NHS Digital. The reporting tool is used to allow performance comparison on GP appointments per 1,000 population.

Figure 7: Benchmarking – GP appointments per 1,000 population, sub-ICB ranking

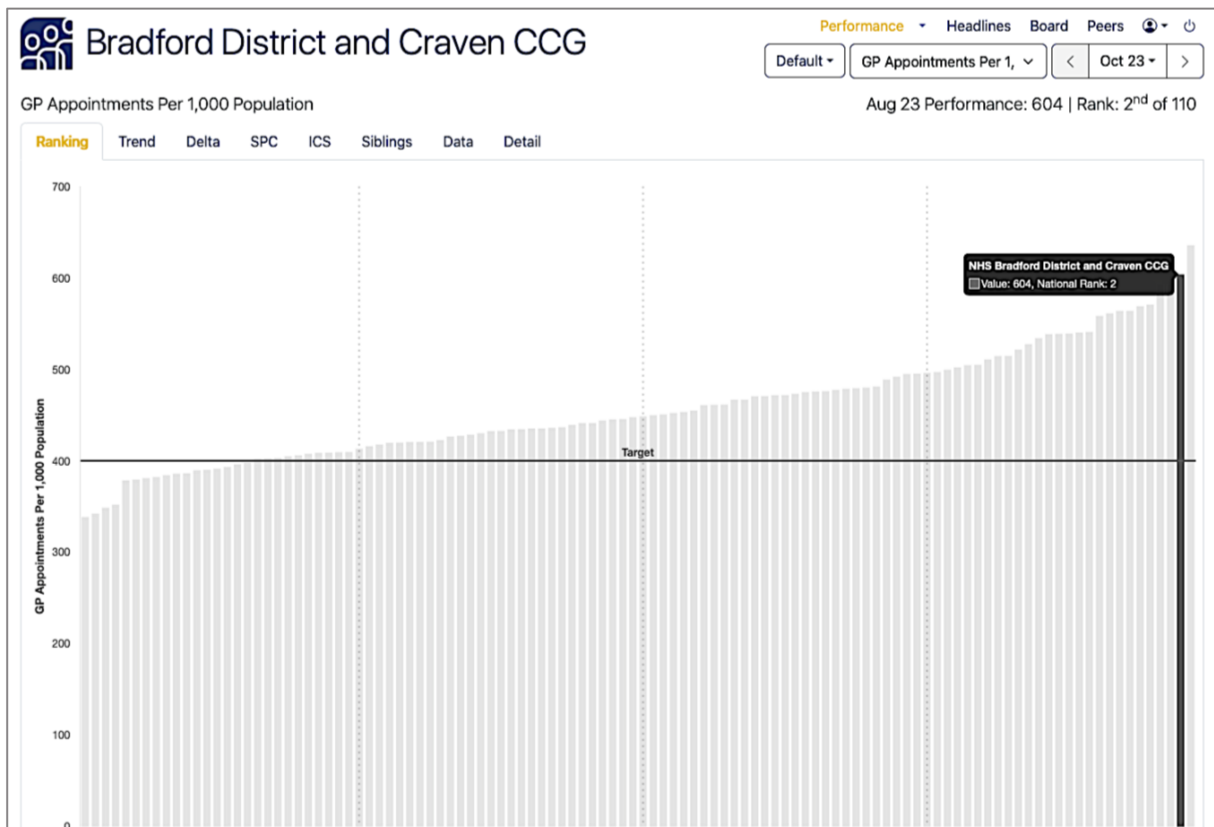
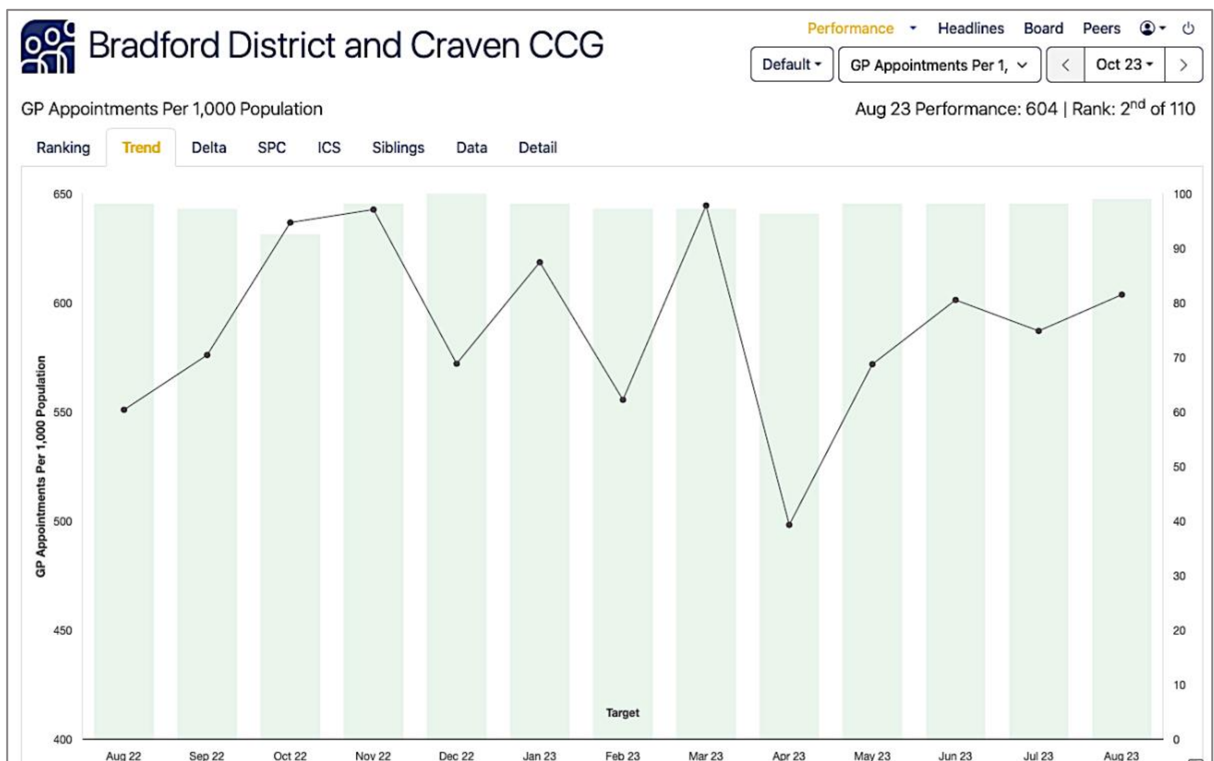


Figure 8: Benchmarking – Sub-ICB performance over 13 months



6.7 As a district, we have ranked in the top five in 12 of the last 13 months for appointments per 1,000 population at sub-ICB level .

7. Our General Practice workforce

7.1 The BDC General Practice workforce has increased over recent years rising from 1,565 Full Time Equivalent (FTE) staff in September 2019 to 1,662 FTE staff in July 2023, a rise of 97 (6.2%). Of these, there are 840 FTE clinicians (50.5% of the total workforce), of which there are 389 FTE GPs (46.3% of the clinical workforce). Bradford District and Craven has 0.59 FTE GPs per 1,000 patients. We average 1,697 patients per FTE GP. 840 FTE clinicians serving a population of 660,237 people (July 2023 population data).

7.2 Core general practice is funded through a national GP contract, with each practice being an independent contractor responsible for the recruitment, training and development, and individual terms and conditions of its staff. There is no specific standard within the contract that determines what workforce a practice should have in place other than that it is sufficient to deliver a safe core service as outlined in the contract.

7.3 The GP contract is funded to provide 2-3 appointments per practice-registered patient per year. For our current population that range is 110,000 to 165,000 appointments per month. In July 2023, there were 387,160 appointments.

7.3 Delivering high quality, patient centred care relies on a large, skilled workforce. With our growing population, living longer with more complexity, our practice teams cannot continue as they are. Since September 2019 our GP-registered population has grown by 2.92%, our GP workforce by 16% and our overall clinical workforce by 15.6%. However, the number of GPs compared to September 2022 has decreased.

7.4 The GP role is one of the most recognised roles within general practice. In 2019, as part of the five-year framework for GP contractual reform, additional investment in general practice was identified to support the expansion of multi-disciplinary teams and create capacity within general practice through the Additional Role Reimbursement Scheme (ARRS). An increase of 60 WTE (42%).

7.5 The scheme sees Primary Care Networks come together to jointly employ and share staff. There are ‘new to primary care roles’ that can be employed under the scheme such as: Social Prescriber, First Contact Physiotherapist, Occupational Therapist, Trainee Nurse Associate, Physician Associate, Practice Pharmacist, Paramedic, Care Co-ordinator, Pharmacy Technician, Dietician, Podiatrist, Mental Health Practitioner, and Health and Wellbeing Coach. Our ‘it’s a GP practice thing’ campaign describes what these different roles do.

7.6 The additional workforce is a welcomed and valuable part of the general practice workforce. It offers not just a significant increase in capacity, but an opportunity for primary care to work differently and collaboratively with a greater skill mix. Still, there are challenges in changing public perceptions of other roles in general practice and continued awareness of these new roles with our patients and wider public is required. We also know that these roles also bring challenges in relation to management and supervision capacity, and the infrastructure needed to accommodate more staff and services.

Prioritising safe working

7.7 The great majority of GP appointments are face-to-face and consultation rates per patient have increased. Fewer GPs providing care for more patients increases the risk of harm and suboptimal care through decision fatigue. This also risks GPs becoming burned out.

7.8 The British Medical Association (BMA) provides guidance for GP practices to make decisions that allow them to best prioritise care through Safe working in general practice. This can be by deprioritising certain aspects of practice daily activities when they fall outside of core requirements, while staying within the constraints of the GMS contract. Overall, it is intended to allow a practice to devote its resources to those patients it is best placed to help.

7.9 'At Your Service', published by the Policy Exchange states that 28 patient contacts per day is ‘safe’. *At Your Service* highlights that GPs are seeing on average 37 patients per day.

7.10 Current BMA standards for a session of GP care is 4 hours 10 minutes. No more than 3 hours of this should be spent in consultation with patients. Practices must provide enough appointments to meet the reasonable need of their patients. This must be done in a way that is safe for both patients and GPs. Remote consulting and triage are safe and effective ways of delivering care that have grown in use and acceptability especially for people who require flexibility due to their busy working lives or other commitments. Utilising these methods allows practices:

- to provide patient appointments more flexibly;
- direct patients to the most appropriate provider of care; and
- prioritise care for those most in need.

7.11 The RCGP tracking survey describes data on GP’s experiences of the effect of workload pressures on the quality of patient care that can be delivered. It notes:

- 68% of GPs say they do not have enough time in appointments to adequately assess and treat patients;
- 64% of GPs say they do not have enough time in appointments to build the patient relationships they need to deliver quality care; and
- 65% of GPs say patient safety is being compromised due to appointments being too short.

7.12 The ongoing, high level of appointments is also impacting GP retention, with GPs leaving the workforce early at ever increasing rates. The 2022 Royal College of General Practitioners members survey found that 39% of the GP workforce across the UK are seriously considering leaving the profession within the next five years. We need to ensure that GPs can work sustainably to ensure our patients receive high-quality care.

8. Our challenges

8.1 Primary care has 15 times more consultations per day than A&E and 5 times more than hospital outpatient appointments for 7% of the NHS budget. To continue to deliver high-quality healthcare, we must start to think in terms of value and sustainability; identifying a balance between cost and outcomes (value) and long-term impacts (sustainability).

Dissatisfaction

8.2 People are less satisfied with the NHS than they were before the pandemic. This is true for different sections of the population, with waiting times rising in prominence as a driver of dissatisfaction. There has been a fall in satisfaction across a range of health and care services, including GPs, NHS dentists, inpatient and outpatient services, Emergency Departments, and social care. This is highlighted by the findings in most recent British Social Attitudes Survey

8.3 In the 2022 National GP Patient Survey, the results for West Yorkshire ICB indicated that 71% (of those surveyed) rated their overall experience of their GP practice as good; this was in line with the national results at 72% but was a decline from 83% in 2021. However, the variation across the West Yorkshire Primary Care Networks ranged between 43% and 92%.

8.4 The Healthwatch Insight Report notes that GP access remains one of the key areas that people are talking to Healthwatch about. People see GPs as the door to wider health and care services, and many feel let down when they cannot access their GP in a way that works for them. The report highlights the variation in terms of communication, access, booking appointments, and access to additional support. These themes were collated from engagement events throughout September and October 2022 with an update presented to a community group in May 2023. Some improvements in satisfaction were noted however it is clear there is still more work to do to reduce the barriers some patients face when accessing services. There are positive experiences, however for many this remains a challenge.

8.5 Feedback from the recent 'Listen in' events across Bradford district and Craven also saw people consistently raise the ability to access a GP as a concern.

Elective Recovery

8.6 There is a growing emphasis on redesigning the way we run outpatient care, not least for people with multiple conditions. There is a move towards using specialist expertise in more innovative, less traditional ways, such as online advice and consulting, or patient-initiated follow-up. We have seen changes to how secondary care specialists can ensure that they meet employers' contractual obligations for ongoing follow-up, prescribing, referral, and investigations, in a way that does not further overburden GPs. If innovation and transformation is championed for secondary care, perhaps it is also possible to do the same for primary care.

9. What are we doing?

GPAS (General Practice Alert State) / OPEL (Operational Pressures Escalation Levels)

Reporting

9.1 GPAS or OPEL reporting allows the pressures in General Practice to be presented in the clearest possible fashion. Information from GPAS/OPEL provides tangible evidence the day-to-day pressures in primary medical care and allows data to be presented in a similar format to that from hospitals, helping to demonstrate that pressures in secondary care are more than matched by challenges faced in general practice. This allows us to proactively consider mutual aid to keep services flowing.

9.2 YOR Local Medical Committee (YORLMC) tracks activity per 1,000 patients. As well as showing demand and capacity, it can be used to make meaningful assessments on whether an increase in GP appointments predicts an increase in Emergency Department (ED) attendances. As more data is gathered, it will inform conversations about when and how to support general practice before the ED numbers rise.

It's a GP Practice Thing

9.3 'It's a GP Practice thing' aims to increase awareness of how GP practices are working, the range of services offered and the specialist team members who are available to help people get the care they need.

9.4 The campaign development, led by Bradford district and Craven, took place in October and November 2022 by working with local patient groups and primary care staff to co-create the most effective messages, design style, community language versions and channels. YouTube

Engaging with West Yorkshire primary care

9.5 Although not yet published, media negativity was given by 25% as a reason for staff considering leaving their role in a survey. However, over half of staff said feeling valued would help them stay in their role. We also heard the message about more support against negative media in 5/10 primary care focus groups held in West Yorkshire.

Resolving long-standing process issues

9.6 Small changes can make a difference. We have examples of partners working together to make simple changes that can reduce the burden on primary care.

Enhanced access and additional capacity

9.7 Enhanced Access means that practices (as part of their PCN) offer appointments up until 8pm in the evening and increased provision at the weekend.

Understanding variance

9.8 There is variance at PCN level in the number of appointments available per 1,000 patients, those done face-to-face, and those undertaken on the same day of booking. Though, this does not necessarily mean that quantity is better than quality. The model of care used by, for example, patients of Bevan medical practice in the city centre is very different to that of patients living in more affluent areas. Bevan supports many patients with complex physical and mental health needs, chaotic lives, and stark health inequalities. Without a 'soon' appointment they are more likely to be unable to access, or to disengage from, care. Patients of other practices may prefer a booked appointment balanced around work or social commitments, or long-term, multiple health conditions.

9.9 When looking at the number of appointments available by practice, there is little correlation between appointments and number of FTE GPs, with practices with high appointment rates having some of the highest patient numbers per GP FTE, and vice versa. It is apparent that there are several variables and that there are multiple factors which impact on appointment numbers. We also know from our local Universal Healthcare work that around 50% of people who make a GP appointment have a social problem rather than a medical need, and that other options may be more beneficial than a GP appointment. Access alone is not a good indicator of quality and in some practices the move is to fewer appointments, done well.

Looking to the future – Universal Healthcare

9.10 Primary care generally waits for people to come to it and then reacts. GP appointments skew to a small portion of the population every year with little left over for proactive work. 40-50% of people registered will not attend primary care in any given year, and a quarter or more have not been heard from for 3-4 years, possibly more. Around 40% of appointments are taken up by just 5-10% of the population, year-on-year. Year on year, 2% of our population take up 9% of appointments, leaving little left for proactive work.

9.11 We know that co-morbidities are not always a good indicator of frequent attenders, which are more likely to be for trauma, opioid use, safeguarding issues, anxiety and depression, complex social issues. When reviewing the top 100 practice list of 'super attenders' over half are known to be in a struggling or chaotic lifestyle. The needs of this group are rarely met through 10-minute appointments and they tend to 'bounce' around services and become increasingly medicalised. One of the key aspects of the Fuller Stocktake is that people with complex health needs should receive continuity as part of a multi-disciplinary team (MDT), proactive care approach.

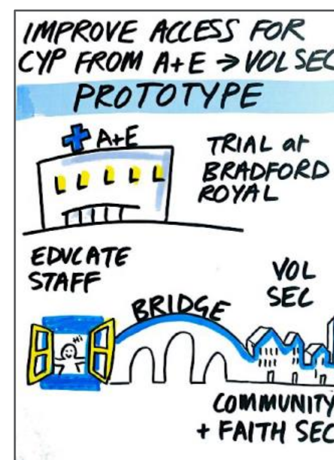
9.12 Our local Universal Healthcare pilot offers an opportunity to look at and understand need, consider continuity, and formulate navigation. We have had some early successes with different MDT approaches for this group of patients. We are also exploring an opportunity to use a VCSE 'front door' to provide continuity (avoiding medicalisation). Our Wellbeing Hubs are having success working with these groups to avoid Emergency Department attendances. This learning could be taken into our future-facing GP model.

10. What next?

Bradford Universal Healthcare proto-typing

10.1 We have found that a flat offer / one size fits all approach in primary care meant that some got 'more' and those that were not getting access ended up getting less. As we investigated appointment systems we found several key things general practice can do to proactively address this inequality. We found that a 'typical' person who is attending frequently will have had 15-20 appointments in the last year and seen 8-10 practice staff. Case notes often reveal multiple repeated tests and looped diagnoses. The exception is when there is a practice-wide strong commitment to continuity. We grouped our proto-typing exploration into access, rationing, medicalising poverty, and motivational and compassionate conversations. Below are a few examples.

Healthy Children and Families

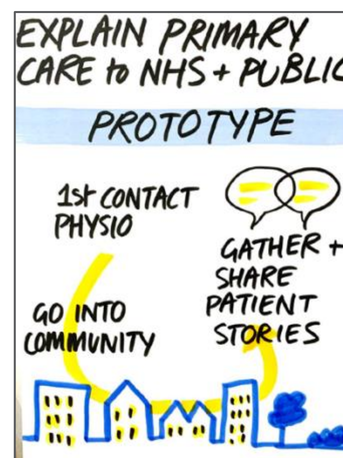


This prototype seeks to connect ED teams to the mental health support available for children and young people through the voluntary sector and help them understand how to promote access to those services. The hope is that all young people experiencing mental health crises will be able to access immediate support within their own community.

Doorstep wellbeing: This prototype seeks to build stronger, healthier communities to relieve the stress on GPs, A&E and provide support where it is needed. We want to develop a filtering/triage service in their neighbourhood using community assets.

Fair funding for Primary Care: Primary Care in poor communities receives less funding from the national formula. This Change Project seeks to ensure that postcode does not affect funding and establish a model of understanding need as the basis for funding distribution.

Rethinking primary care



This prototype aims to ensure that people who need primary care can access it, and that primary care services are proactively designed to meet need. This group is exploring how best to design services for people who turn up frequently, and people who need continuity, to meet need and reduce demand and free capacity to enable the practice to be more proactive in connecting to the whole community. We are also exploring who does and does not get access.

Fuller Stocktake

10.2 The publication *Next steps for integrating primary care: Fuller Stocktake* supports our aspiration for primary care that reorientates the health and care system to a local population health approach. A key aspect of the Fuller Stocktake challenge is in creating the capacity in our workforce, estates, data, and digital. As well as building sustainability through our infrastructure, leadership and representation in key decision-making and delivery forums.

10.3 The Fuller Stocktake proposes that the focus must be on the support to our primary care workforce, and access to care and support for our population. Patients with similar needs could be considered together and offered discrete elements of general practice such as vaccinations and phlebotomy. This assumes patients would be happy going to another practice and we recognise that many practices would not support this model. It also risks missing those who need support because of the nature of a fragmented approach to treatment. Conversely, it risks safeguarding situations where families want to avoid continuity that could lead to scrutiny.

Access Recovery Plan

10.4 In May 2023, NHS England published the Delivery plan for recovering access to primary care, which has two key ambitions:

- Tackle the 8am rush and reduce the number of people struggling to contact their practice; and
- Patients to know on the day they contact their practice how their request will be managed.

10.5 The plan supports recovery by focusing on four key areas, many of which aim to address some of the challenges identified within this report:

- **Empower patients** to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice;
- Implement *Modern General Practice Access* to **tackle the 8am rush**, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment;
- Build capacity to deliver **more appointments from more staff** than ever before and add flexibility to the types of staff recruited and how they are deployed; and
- **Cut bureaucracy and reduce the workload** across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

10.6 Whilst the plan heavily focuses on General Practice access, it is important to note that there continues to be a focus on integration, particularly on integrating primary care through the proposals relating to community pharmacy.

10.7 ICBs are asked to ensure that their actions in relation to the access recovery plan align with the vision described in the Fuller Stocktake. This is with a particular focus on the functionality of digital telephone systems, supporting the future direction of PCNs and places in offering a single system-wide approach to integrated urgent care and integrated neighbourhood teams. As an HCP, we will develop and support plans that incorporate integrated models of care and continuity.

In it together

10.8 Our Health and Care Partnership has an ethos where we ‘Act as One’. The sustainability of primary care is central to our ambitions for the health of our populations. Our problems are shared. GP access is reactive, managing acute and urgent work that cascades through primary medical care. We need to shift the balance back to more proactive care to reduce demand and improve the outcomes and experience of care for local people.

10.9 Working in primary medical care has never been so hard. The negative, anti-GP rhetoric often heard in the media and amplified on social media can fuel patient discontent. Our practices are seeing hundreds of thousands of people each month. A key challenge is putting in place plans that value, recruit and retain GPs and the wider workforce and involve our staff (now and of the future) in designing the model of modern general practice.

10.10 More access is being provided and people are being seen more quickly than ever before, however people feel frustrated when trying to book an appointment. But it’s still not enough. Patient – and staff – satisfaction remains low.

10.11 Our aspiration is to have an open and ongoing conversation with the public about GP access, the resources we have, and how we can make best use of them together. We can take this courageous step to be open to co-designing and prototyping new models that better meet people’s needs. There will be trade-offs, but we can be transparent about these. We have an opportunity to be radical and to think about how we ‘contract’ with the population of Bradford in the delivery of our GP services.

11. Summary

11.1 GP access is an issue nationally and we know from what people tell us that it is a significant concern for local people. An increase in GP appointments should not be our only goal. We can use the opportunity of having a collective focus on GP access to ensure that we co-design new models of care with our staff and patients. We aim to improve our patients' experience and outcomes of care, as well as timely access. We need to consider future changes and expectations from people that matches consumer behaviour in other areas of our lives as we continue to see rapid developments in technology change the way we access other services in our lives.

11.2 Despite offering more appointments than ever, on the same day and face-to-face, it is not working for our patients or our primary care workforce. Our practices face significant challenges in retention, recruitment, increased workload, a national contract focused on numbers rather than quality, and the risks posed by all these factors on safe-working practice.

11.3 To meet the needs of our population and retain and recruit the general practice workforce we need to re-think the models of primary medical care across Bradford district and Craven and West Yorkshire. By using our data and intelligence we can develop a model of care that is sustainable and offers enhanced quality of care. This fits with the direction of travel of the Fuller Stocktake, the next round of the GP contract under consultation, and our learning from the Universal Healthcare pilots.

11.4 We need to shift from *quantity of access* to considering the *quality of access* for:

I. Urgent on the day needs

  a. As part of an integrated primary care same day response service.

II. Continuity of care needs (longer appointments and/or follow up)

  a. GP ongoing medical needs;

  b. With MDT (proactive care) – chronic health needs/frailty etc; and

  c. With non-clinician/VCSE/wellbeing approach – social issue.

12. Recommendations

12.1 The Committee receive this update on GP Access.

12.2 The Committee receive another report in 12 months' time.

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