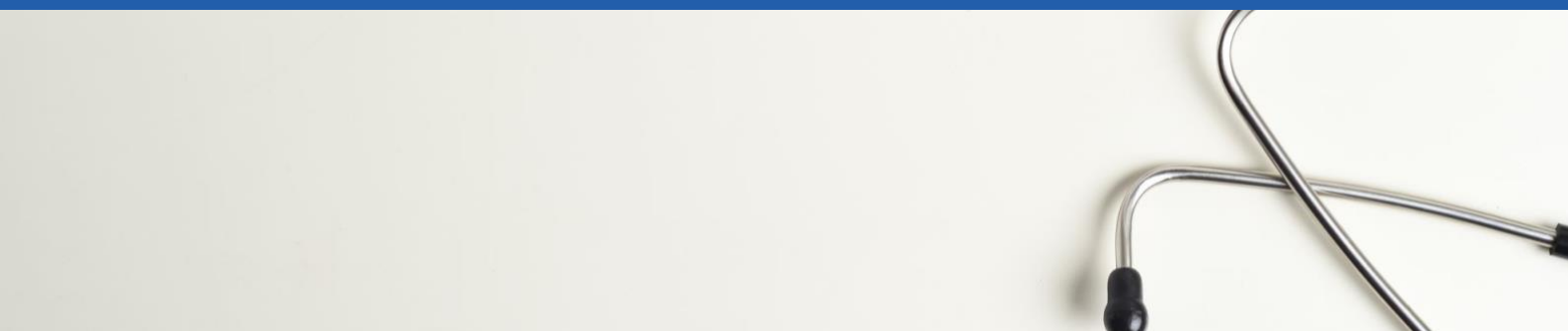
The Big GP Consultation

Final Report:

A summary of our findings and implications for the future of General Practice in the UK

September, 2022



The Team


Devina Maru


Liam Loftus

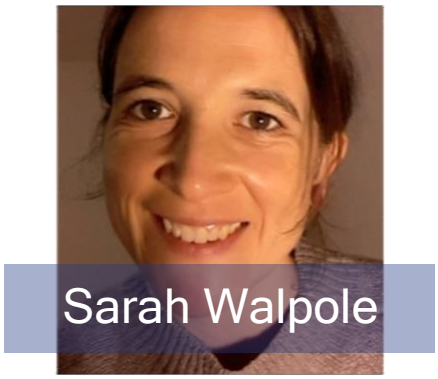

Claire Edwin

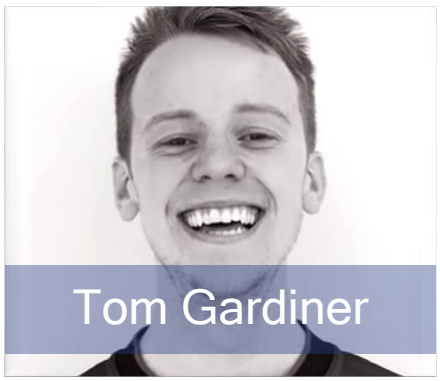

Georgina Neve


Rachel Weaver


Rammina Yassaie


Rob Cullum


Sarah Walpole


Tom Gardiner


Veena Aggarwal


Vijay Patel

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Foreword

"General Practice is in crisis... Patient demand is higher than ever before... Patients are more unhappy than they ever have been... General Practice is a dismal place to be..."

Many of the reports and commentaries I read on the state of General Practice open with disheartening and doom-laden words to this effect. And this is understandable – I hear, and I see for myself in my day-to-day clinical life, how challenged General Practice is at present – both for our workforce, and of course for our patients. At times, this negativity can be overwhelming and the light at the end of the tunnel can feel far away, or even absent.

At times like this, I seek out hope and inspiration. Hope founded in reality that not only will things improve, but that we have the skills, the passion, and the right people to lead us towards a brighter future; the one that we want for our loved ones, and the one that the public and our patients deserve. In this report, I find some hope, and a good measure of inspiration.

Reading this felt different to reading many other reports. The work has been led by Trainees and amplifies the voice of the next generation of the workforce; a voice not often heard clearly in policy-making spheres. Furthermore, it has not been generated by a few select people, in isolation. Instead, The Big GP Consultation has carefully and considerately engaged over 100 GP Trainees and early career GPs from around the country. Those at the start of what we hope will be a lifelong rewarding and invigorating career in General Practice; those who have passion, enthusiasm, and fresh insights in abundance.

This report goes far beyond dwelling on the current challenges. Instead, it takes the bold step of outlining what the future of General Practice could look like, from the perspective of those who will be working within it. It not only lays out a vision that has been co-produced by the next generation, but it also identifies those key next steps required to get us there.

Above all, this work demonstrates the power, and the potential, that is waiting to be unlocked amongst our next generation of GPs. They should, and indeed will, be critical in shaping both the present and the future of General Practice. The sooner we recognise this, and the sooner we ensure they have a seat at the table, the sooner we will all reap the reward from doing so.

On a personal level, it has been an absolute pleasure to support this work; to see first-hand the drive and energy that exists amongst our future GPs, while also hearing the novel and innovative ideas they present within the report. It has reinforced for me that the light at the end of the tunnel certainly does exist, and may even be a little closer and brighter than we think…

Professor Dame Helen Stokes-Lampard
GP Principal and Chair of the Academy of Medical Royal Colleges

Executive Summary and High Level Actions

The Big GP Consultation sought to co-create a 'positive vision for the future of General Practice' by engaging GP Trainees and early career GPs. The focus was on describing what the future should and could be, and laying out the steps to get there. The topics discussed have therefore been wide-ranging, covering almost the entirety of what General Practice offers to the patients that it serves, and also to the doctors who work within it.

Summarising the breadth of discussion into two pages would be impossible, so here we present key high level actions across three key domains which were explored during the consultation: Clinical Care; Recruitment and Retention; and Leadership.

The Clinical Care that we Offer

The clinical care that we offer to patients is ever-evolving. Participants highlighted that the care we offer now, and in future, should focus on two key areas – continuity of care and holistic care. These have always been two of the cornerstones of General Practice, but the changing environment in which we practice means we need to do things differently. In order to evolve we need to:

⇒ Continue to facilitate continuity of care for all patients who need or want it, but do so in a team-based approach in order to ensure this is both sustainable, and makes the best use of the skills the wider MDT in Primary Care has to offer patients.

⇒ Continue to make use of the bio-psycho-social model of illness to provide our patients with holistic care, recognising that social determinants of health play as much of a role in making a person healthy as biological aspects.

⇒ Continue to build on the technology-enabled care journey which started during the pandemic including considering how we use remote consultations, and how we record and share data about patients between Primary and Secondary Care to support delivery of holistic care.

⇒ Make addressing health inequalities part of the core business of practices by embedding them into all workstreams and ensuring our staff are equipped to do this.

⇒ Make environmentally sustainable delivery of healthcare a priority through recognition of the challenges faced by our planet, the impact these will have on our patients and the urgency with which action needs to be taken.

⇒ Revising our training model for current and future GPs to ensure they have the skills to deliver this vision.

Recruiting and Retaining Members of our Profession

The profession is currently facing a workforce crisis. Participants were well aware of pressure the GP workforce is currently facing, feeling the impact of these in their day-to-day practice. In order to address this we need to address recruitment of new workforce, and retention of the existing workforce, by:

- ⇒ Widely publicising the benefits of a career in General Practice, including ensuring there is parity of esteem with Secondary Care careers.
- ⇒ Improving the transition from GP Training to working as a qualified GP to ensure that our newly-qualified workforce do not burnout immediately.
- ⇒ Providing better support for International Medical Graduates progressing through GP training to reduce differential attainment and challenges once qualified.
- ⇒ Continuing to support the flexibility that a career in General Practice offers doctors as a key way to both recruit and retain the workforce.

Leading across the Healthcare Landscape

Leadership by GPs has been a key feature of the organisation of healthcare for a long time. Participants felt that strong GP leadership is vital for offering care that is high quality, cost-effective and patient-centred. In order to maintain and develop this we need to:

- ⇒ Provide specific, relevant and ongoing training to GPs to ensure they have the knowledge and skills required to lead within and beyond their practice.
- ⇒ Ensure that GP training provides the knowledge and skills required to provide clinical supervision of the wider MDT.
- ⇒ Ensure the Primary Care voice is sufficiently represented at all levels of healthcare leadership and management, including in the new ICS structure in England.
- ⇒ Improve the equity with which resources are distributed in practices, PCNs and more widely.

The Big GP Consultation Team, made entirely of Postgraduate Doctors in Training, have been amazed by the clarity with which participants were able to outline this vision, and the relative consistency of voice with which they spoke. Now that this vision has been established, there is a challenge that rests with all of us – participants and readers alike. This challenge is how we can all work together, bringing individual insight and experience from across the General Practice landscape, to make this positive vision a reality, and create a future system that meets the needs of both patients and the workforce.

Introduction to the Consultation

General Practice is often described as the bedrock of the NHS. However, it is becoming increasingly clear that to overcome our current challenges, things need to change. As a team of junior doctors from both Primary and Secondary Care backgrounds, we recognised that in order to conquer these challenges, it is crucial that we harness the passion and ideas that exist amongst the next generation of GPs. Their voice, and their energy, will be vital for success.

As a result, we created The Big GP Consultation – a platform for the next generation of GPs to come together and discuss, "what does a positive vision for the future of General Practice look like for us, and how do we get there?"

The consultation consisted of five 90-minute sessions, each covering a core theme relating to the future of General Practice. These were hosted on Zoom between February 2022 and May 2022. Participants were recruited largely through social media including Twitter and WhatsApp groups. There was broadly an even split between GP Trainees and early career GPs. Participation was voluntary and the mean number of participants per session was 66 (range 38 to 120).

Box 1: The 5 Sessions

- **Session 1** - What is the role of the GP in the Integrated Care System?
- **Session 2** - How do we best prepare the next generation of GPs?
- **Session 3** - How do we most effectively recruit and retain our workforce?
- **Session 4** - GPs in The Big Picture, Part I: Health Inequalities
- **Session 5** - GPs in The Big Picture, Part II: Primary-Secondary Care Interface; Greener Practice; and Holistic Medicine.

Prior to each session, participants were sent a survey to share initial ideas on the topic. Each session began with a keynote talk from a national leader[1], who shared their view on the session's topic, with a Q and A afterwards. This was then followed by a 45-minute breakout room discussion. There were four breakout room topics per session, which were based on sub-topics within the session's overall theme. Participants were able to self-select which room to join, based on their own interest. These breakout rooms were facilitated by members of The Big GP Consultation team. Finally, following each session, participants we invited to share further thoughts via a second survey.

[1] Dr Nikki Kanani, Dr Mayur Lakhani, Professor Dame Helen Stokes-Lampard, Dr Bola Owolabi, and Professor Martin Marshall

Findings from each individual session have already been published on our website[2] in the form of an infographic and brief report. The purpose of this larger report however is to provide additional detail from the sessions. We have deliberately presented this in themes which crosscut the session topics to provide what we feel is a comprehensive summary of the views of participants on what the future of General Practice could and should be.

The insights within this report were directly generated from the consultation sessions, attended by GP Trainees and early career GPs from around the UK. Importantly, this work was led by Postgraduate Doctors in Training, many of whom are GP Trainees by background. In other words, this was a peer-to-peer consultation, independent of any national organisations.

[2] https://thebiggpconsultation.co.uk/?page_id=1815

General Practice in the Wider Healthcare Landscape

GPs in England are encountering the biggest shake-up in health and social care for a decade. The vertical and horizontal collaborative opportunities created by integration could bring significant benefits to Primary Care. Workforce diversification and digital integration may allow us to pivot back to the "core business" of General Practice - complex care in the community, continuity of relationships with patients, and a renewed focus on preventive medicine and population health management. This is both an exciting and uncertain time to be finding your feet in Primary Care and our consultation reflected these mixed sentiments.

Context

This consultation took place prior to the launch of Integrated Care Systems (ICSs) on the 1st July 2022. In recent years, integration has become the watchword of healthcare policy and ICSs are the practical manifestation of this, designed with the purpose[3] of bringing partner organisation together to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Within an ICS, providers will collaborate over geographies referred to as 'places', with teams delivering local services on smaller footprints known as 'neighbourhoods' (Figure 1). Much of this will be familiar to those working within General Practice already, with Primary Care Networks (PCNs) being an established part of the landscape for a number of years now.

Amidst this transformation, it is important to recognise that integration is not a new phenomenon in the United Kingdom; the devolved Scottish and Welsh healthcare systems are reaching a mature phase of integration. So, whilst this chapter focuses on the consultation's reflections on the role of General Practice in the evolving healthcare landscape in England, it would be remiss not to acknowledge that we are not starting from a 'blank slate', and that there is much to learn from the experience of the devolved nations[4].

[3] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/
[4] https://www.good-governance.org.uk/publications/insights/growing-pains-integrated-care-lessons-from-scotland-and-wales

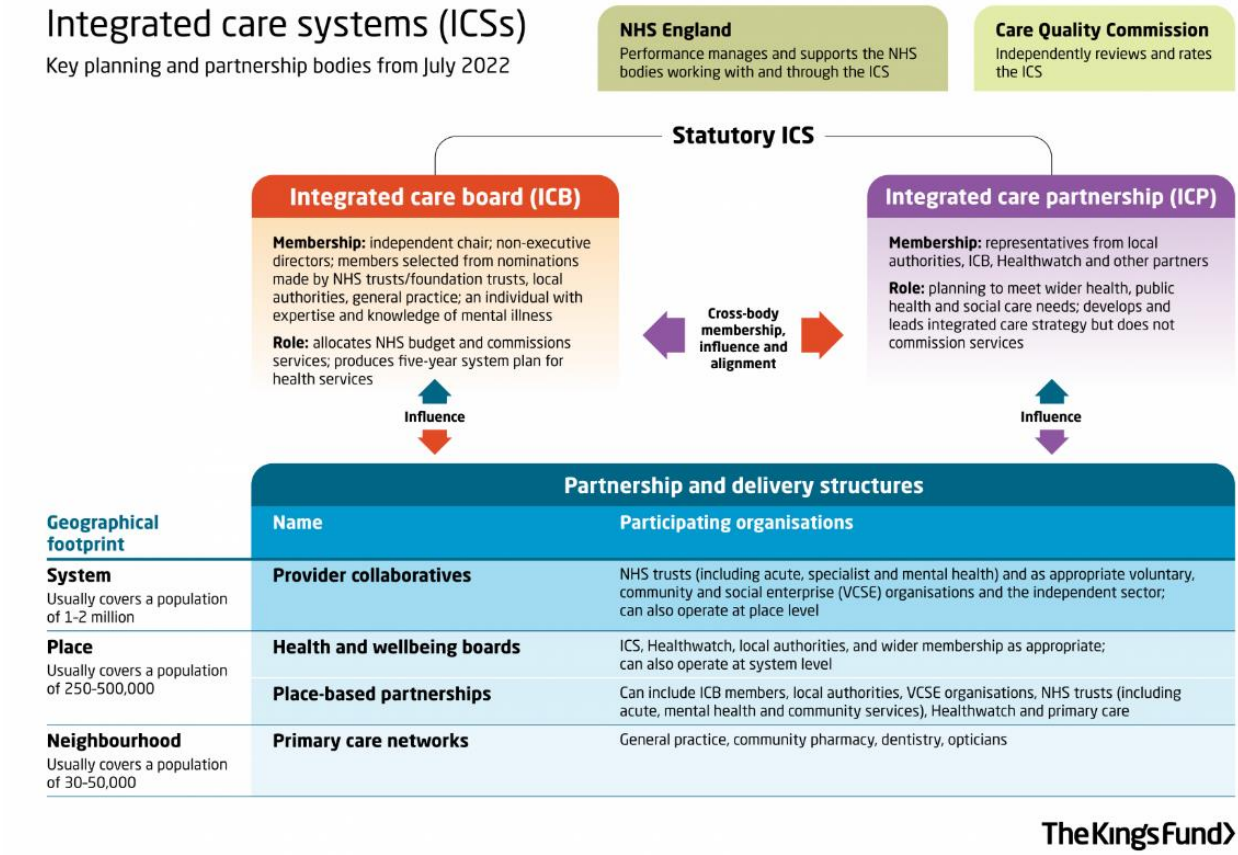

Figure 1- Integrated care systems (ICSs): key planning and partnership bodies from July 2022 [5]

Beyond this backdrop of change, it must be noted that Primary Care across all four nations is under immense pressure, and it would be disingenuous not to acknowledge the growing dissatisfaction of both the public and the workforce with the status quo. This chapter does not attempt to re-hash the invaluable insights and recommendations set out in the recent Fuller Stocktake report[6]. Instead, we reflect the hopes, worries and ideas of those at the start of their General Practice careers who face the simultaneous challenge and excitement of a rapidly evolving wider healthcare landscape.

Integration is not a new phenomenon in the United Kingdom: the devolved Scottish and Welsh healthcare systems are reaching a mature phase of integration.

[5] https://www.kingsfund.org.uk/audio-video/integrated-care-systems-health-and-care-act
[6] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

GPs in Integrated Care Systems

General Practice is no stranger to structural reform - PCNs were introduced just three years ago, and it is apparent from the consultation that there is a strong yearning for a period of stability and consistency. Nevertheless, it is clear that the upheaval and transformation of General Practice during the COVID-19 pandemic and the subsequent establishment of ICSs on a statutory footing have signalled the arrival of a new era for GPs.

There was consensus amongst participants that the concept of an ICS, with multisector collaboration and economies of scale, could bring significant benefits to Primary Care services. However, there were concerns about how ICSs will function in reality, and that significant resource would be needed to ensure success. Similarly, the importance of bringing the whole of the Primary Care workforce on the journey was deemed essential for this to be realised. It is especially important to avoid an “us vs them” scenario between GPs and other organisations, such as hospital trusts.

It was felt the profession needs to capitalise on the momentum for change stimulated by the pandemic, to continue to mould General Practice into a sustainable and enjoyable career, which puts patients' needs at the core. Participants explained that the current independent contractor model of General Practice, whilst preferred over a nationalised model, needed transformational change to ensure sustainability. This was both in terms of the model itself but also was seen as essential in providing a career where GPs can flourish.

The profession needs to capitalise on the momentum for change stimulated by the pandemic, to continue to mould General Practice into a sustainable and enjoyable career, which puts patients' needs at the core.

The autonomy of General Practice to be able to organise care based on local population needs is a key positive attribute of the current model. However, GPs worry that this autonomy is at risk of being eroded by working at scale or in a nationalised system.

Participants raised concerns around how contracted Primary Care clinicians would work within a nationalised system. Could imposed changes to working terms such as working times and ‘Out of Hours’ commitments affect the flexibility that General Practice offers as a career? Would this make it less appealing as a specialty and thus create further workforce challenges?

Early career GPs do not feel adequately trained for system-based healthcare leadership. Participants do not want to enter the new landscape on a back foot. General Practice has always been privileged in having a significant influence in healthcare delivery in the UK, and this is something the profession is worried about losing in the new system in England. It was

felt that GPs, including those in the earlier part of their career, should not be on the periphery of decision-making but rather at the core.

GPs have significant knowledge and skill to achieve some of the key aims of the new ICSs in relation to improving population health.

As well as feeling inadequately prepared to contribute, there was widespread concern amongst participants that both General Practice and Primary Care would not be sufficiently represented in ICS decision-making fora. Participants highlighted how GPs have significant knowledge and skill to achieve some of the key aims of the new ICSs in relation to improving population health in localities. There is apprehension however, that, in the current climate of clinical pressure, GPs not directly employed in ICSs may not be released to share this knowledge. Furthermore, the size and scale of the ICS could mean that a single GP representative may not be able to effectively represent the views of a diverse geography.

Interfaces within Primary Care and with Secondary and Social Care Colleagues

More joined-up working between all health and social care providers was seen as a potential opportunity of the new NHS structure in England. The development of Integrated Care Partnerships (ICPs), alongside ICSs, will allow GPs to work more closely and more effectively with our local authority, and voluntary, community and social enterprise sector partners. This will allow us to look more holistically at the needs of our patients, especially those from underserved communities.

The launch of ICSs also presents opportunities for better interfacing between Primary Care and our Secondary Care colleagues. Sharing of resources including clinical data, workforce, and budgets was seen a key opportunity to ultimately improve the patient experience of care. Furthermore, benefits of scale, particularly with respect to software, data and analytics, were seen as an invaluable opportunity to be innovative in how resources are used.

A good interface between Primary and Secondary Care is crucial for effectively managing patients who have Long Term Conditions (LTCs). These patients are frequently looked after by specialists in hospital as well as by their Primary Care team. Communication is critical for this so that all care providers remain up to date with their care, including results of investigations and current management plan, and can integrate this holistically into the other care they are providing. The opportunities that technology affords to communicate more effectively, particularly through sharing patient information, were enthusiastically embraced by participants. It was however recognised how challenging this is in reality, with different IT providers and computer systems.

Finally, more joined up working across the health and care system offers the potential for better mutual aid in times of acute strain on particular components of the system. A key example of how this might work described in the consultation was that of resilience alert

systems as shown in Box 2[7]. This said, there is concern that further integration could mean that Primary Care may be increasingly asked to reduce referrals and manage the downstream consequences of the increasing challenges seen in Secondary Care without appropriate support being reciprocated.

Box 2: Resilience Alert Systems

It is currently routine practice for hospitals to keep local GP practices updated with regards to their level of pressure with systems such as the 'Operational Pressures Escalation Level' (OPEL) System. GPs across the country are now in the process of looking at implementing similar systems, and with improved joined up working, there is a real opportunity for organisations to support each other at times of need through the ICS infrastructure This might include support through PCN collaboration as well as with colleagues in Secondary Care and Local Authorities as appropriate.

The Role of Primary Care Networks

Against a background of a global economic downturn, a pandemic, and the health impacts of a growing ecological crisis, it is clearer than ever that we need to invest in a healthcare system centred around Primary Care. This service should provide a universal and holistic model of care that is community oriented, preventative, and personalised. Since the NHS was established 74 years ago, the population has grown and Primary Care services have done a remarkable job to enable greater provision of proactive, personalised and coordinated care. Now that most GP Practices are working together with their Community, Mental Health, Social Care, Pharmacy, and Voluntary Sector partners, these opportunities are bigger than ever.

Participants were largely positive about the role PCNs will continue to play in the changing landscape. PCNs are small enough to provide the personal care valued by both patients and GPs, but large enough to reap the benefits afforded by economies of scale through greater collaboration between GP Practices, and other partners in the local health and social care system. This is already realised through provision of shared services such as extended access and through provision of specialist healthcare professionals which can be shared at PCN level.

Not all agreed however that PCNs, as currently operated, offered the best value for money or the best way of providing some services. There was concern that this model may not always provide the most equitable distribution of resources such as 'Additional Roles' and may reduce the overall funding available to smaller practices. They instead felt that it would be better to fund practices directly. As the role of PCNs in England grows over the next few years it is therefore essential that these concerns are taken into account.

[7] https://www.england.nhs.uk/publication/operational-pressures-escalation-levels-framework/

The suggested role for and benefits of 'Neighbourhood Teams' described in the Fuller Stocktake report, 'Next Steps for Integrating Primary Care[8]' also closely aligns with the value seen by early career GPs in neighbourhood working. There is a clear enthusiasm for reorientation of General Practice with greater emphasis on prevention, population health and holistic care in the community. That said, there is understandably some trepidation that, without sufficient resource, this admirable vision will fall short of expectations. The buy-in from system leaders into the vision set out in this report, with all 42 ICS chief executives committing to its principles, is a promising sign of a shift towards a healthcare system that appreciates the integral role Primary Care plays in improving the health of local populations.

Conclusion

General Practice is entering this new healthcare landscape plagued by pre-existing challenges. Yet, the advent of ICSs in England provides Primary Care with the chance to drive change within communities like never before. From improved collaboration, to economies of scale, there are significant opportunities open to the profession. However, the benefits afforded by integration at all levels will only translate to improved access, experience, and outcomes if an "environment of change" is embraced within the profession. There also needs to be recognition that General Practice should play an integral role in this new structure, promoting the health of local communities with our system partners. It remains to be seen whether ICSs will achieve all they set out to, but it is clear, that early career GPs are committed to playing their part in ensuring success.

Recommendations

I. General Practice must be sufficiently represented at all levels of ICS decision making architecture to represent the views of a diverse geography.

II. ICSs should develop a resilience alert system and resilience plans which detail how the wider system will respond in support of General Practice when demand outstrips what practices can safely deliver.

III. GPs and GP Trainees should be sufficiently educated about the systems in which they operate, in order to lead most effectively within a system-based healthcare leadership.

IV. Time spent developing system-based healthcare leadership, supervision and mentoring skills should be protected time and adequately reimbursed.

[8] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

The Evolving Role of the GP: Clinical Care

The role of the GP is changing rapidly. First and foremost, the GP's role is to provide clinical care for their patients at an individual and practice population level. Yet demands on services are increasing as the needs of our populations evolve. With increasing multi-morbidity and an aging population, the skillset required of a GP is shifting. GPs are managing patients with multiple long-term conditions and increasingly complex needs, acting as a conduit between a patient's everyday life and their care. Further, as the wider health landscape evolves into one of greater integration, it is more important than ever that GPs show the clinical leadership required to advocate for their patients.

Context

The 'Fit for the Future' report[9] published in May 2019, lays out the Royal College of General Practitioners' (RCGP) vision for the future of General Practice. This report recognises the differing needs of patients, including those who want to see the same GP or those that wish to see the next available member of a team. This sentiment has been recognised in the recent Fuller Stocktake report: 'Next Steps for integrating Primary Care'[10].

To some patients and practitioners, continuity of care is seen as a vital part of the doctor-patient relationship, but for others a more general continuity is acceptable, particularly as this can enable easy and convenient access to healthcare. To facilitate these ways of working, GPs are increasingly looked upon as leaders of multi-disciplinary teams in clinical practice. This enables practices to provide continuity of care to those that both need and want it, whilst delivering a service that is acceptable, accessible and flexible for those with busy working and personal lives. As such, team-based care is now core to everyday General Practice.

As explored in the previous chapter, GPs have always played a role in local community health and this role will likely grow in the new healthcare landscape in England. As clinical leaders, the Primary Care community must continue to develop skills in population health management and preventative medicine, ensuring that there is equitable access to care for all patients, whilst also delivering personalised care. To do this, GPs must embrace the wider multi-disciplinary team members who can assist in providing holistic care for all patients. Working in PCNs allows GPs to collaborate across a locality, to help shape community services, share learning and integrate health and social care services. This way of working aims to improve the local population health and wellbeing and reduce health inequity; clinical leadership is more important than ever to ensure our patients have good clinical care and better health outcomes.

[9] https://www.rcgp.org.uk/policy/fit-for-the-future/
[10] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

The Role of the GP and 'Additional Roles' in the Management of Clinical Complexity

Participants regularly reflected throughout the consultation that clinical complexity in their day-to-day working was consistently increasing. There is recognition that 'task-shifting' to other healthcare professionals for less complex presentations could free up GP capacity to focus on patients requiring more complex care. It is also clear that more joined up working with Secondary Care colleagues is essential in supporting GPs to undertake this work – something which, at present, is often variable.

'Additional Roles' in Primary Care are particularly welcomed in the current climate of workforce shortages. This is particularly true for the expert roles who can offer improvement in patient experience (for example, social prescribers in supporting the patient's more holistic needs). In order for GPs to best use this highly skilled wider team however, there needs to be familiarity with these roles – understanding of what they can offer to individual patients. Despite the opportunities these roles provide for improving patient experience however, it was also highlighted that sometimes patients are reluctant to see other healthcare professionals and just want to see a GP. This is a challenge which needs to be addressed so that patients share our understanding of the importance of 'right place, right person'.

Despite the clear advantages identified for patients, there was some concern that the use of 'Additional Roles' to manage more 'straightforward' patients might leave GPs with the most complex patients without adequate appointment time or resources to manage these patients. Many early-career GPs are worried about how they can effectively manage complexity in the standard ten-minute appointment, and that the pressure of this can impact how GPs perceive their jobs and negatively impact wellbeing.

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There is also concern that this shift in which patients see a GP may lead to de-skilling of the 'bread-and-butter' GP skillset. An example given was around musculoskeletal presentations, with many patients now seeing a 'first contact physiotherapist' for these types of problems. In some areas this is reducing exposure to musculoskeletal problems for both Trainees and GPs; something once a very common presentation. Participants expressed concern that they may no longer be skilled at managing more complex musculoskeletal presentations if they are seeing only this small subset.

The issues of time and de-skilling also present challenges for effective clinical supervision of those working in 'Additional Roles'. Effective supervision requires time and there is

concern that the amount freed up by patients seeing alternative professionals does not match that required for such supervision. Furthermore, colleagues expressed the challenge they face in being called to support colleagues from other healthcare professions when they rarely see some presentations in their daily clinical work. This was felt to be particularly challenging for early career GPs who do not have the same level of experience to draw on as their more senior colleagues.

Delivering Holistic Care in General Practice

Holistic care is care that recognises a person as a whole, moving beyond purely a disease or diagnosis. It acknowledges how biological, social, psychological, and spiritual needs interact interdependently to impact on the individual needs and circumstances in a patient presentation[11]. It is well recognised that many problems manifesting as physical ones have wider psychosocial elements. Attendees at our consultation recognised this and felt that providing holistic care in the bio-psycho-social model (Figure 2) was a core component of being a GP. This said, they highlighted that in the current model of General Practice we are limited in our resources to provide truly holistic care. This is in part due to time constraints, limiting how much we can explore the wider context and circumstances with a patient.

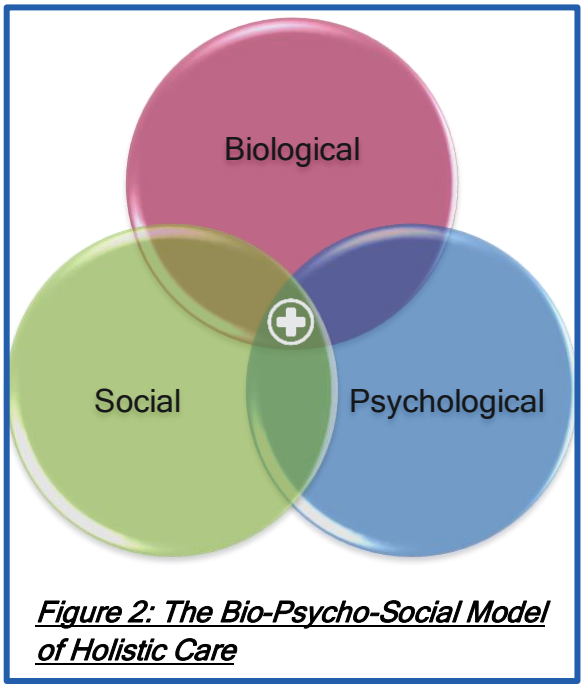

Figure 2: The Bio-Psycho-Social Model of Holistic Care

Notably, participants also highlighted that they felt they were not adequately trained to deliver this form of care. Many struggled to articulate what holistic care truly is in General Practice and were unable to conceptualise how it could be delivered feasibly, whilst balancing patient expectations and the resources available.

> Holistic care is the golden thread of meeting the deeper needs of the population, going beyond the surface clinical level. This thread is an important means to explore the needs of a population and an opportunity to address health inequity.

GPs are frequently reliant on colleagues with specialist skills, such as social prescribers, to provide some of this care. However, this can become a 'dumping ground' of patients with

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4441185/

complex social needs, whilst also reducing the working knowledge of GPs of the organisations available in a locality that can be signposted to as a resource for supporting the delivery of holistic care to patients. Participants felt that GPs require a better understanding of when to signpost, and what the role and boundaries of different organisations are. When performed well, holistic care is an excellent starting point to providing better, more cost-effective and prevention-focussed medicine in the community.

Sustainable Delivery of Continuity of Care

Providing good holistic care is inherently linked to continuity of care. Understanding the complex psychosocial needs of a patient is not possible in a single consultation; it takes time to build relationships, trust and understanding with patients to explore these issues.

Continuity of care was explored multiple times throughout the consultation and was described as one of the cornerstones of General Practice for both patients and GPs. Effective continuity of care improves patient satisfaction, leads to better health outcomes, and reduces overall costs[12]. This was not only recognised by participants, but they went a step further, recognising that the ability to provide continuity of care to patients and families over years and generations is a key draw to becoming a GP. They identified that caring for some of their patients over the course of their lives rather than through a single episode of ill health was one of the best parts of the job.

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However, despite this recognition of the benefits, it was also recognised that providing continuity of care is a challenge, and a balancing act between patient expectations and the realities of a challenged and under-resourced workforce. Many participants described the frustrations they feel with patients who expect their clinician to know their full medical and social history prior to seeing them, assuming that the clinician has had time to review medical records from both Primary and Secondary Care. As the complexity of services continues to grow, being able to assimilate information from multiple sources ahead of seeing a patient is simply unrealistic and further erodes the patient and public perception of GPs. Patients look to their GP and team members to know their story and their circumstances.

With the historic model of General Practice - that of a single doctor providing the continuity of care to a large number of patients - being recognised as increasingly unfeasible, a number of solutions were explored within the sessions. These mainly centred on a multidisciplinary team (MDT)-led approach to continuity of care. This approach appears to be being utilised in pockets across the country. One example team was described which includes 2-3 named

[12] https://www.health.org.uk/journal-article/association-between-continuity-of-care-in-general-practice-and-hospital-admissions

GPs in a wider MDT made up of practice nurse, physiotherapist, and social prescriber. The GPs are often the accountable senior decision makers, much like in Secondary Care. Similarly, micro-GP teams within a practice were proposed which enables the flexibility needed for staff to work in portfolio roles and balance clinical work with non-clinical roles and responsibilities whilst delivering a service across the week that can provide continuity. Whichever method is chosen, patients are still able to be seen by familiar team members, and care can be co-ordinated and discussed where required. Understandably in smaller practices this is the model that is already utilised.

It was also highlighted that certain patient groups tend to benefit from continuity of care. Typically, these tend to be older patients and those with complex health needs. Younger patients tend to prefer flexibility and ease of access to a health care professional. Participants felt that within practices this should be facilitated as much as possible. This approach is backed up by research, with a recent paper in the British Journal of General Practice reporting that patients with dementia who experience high continuity of GP care, experience safer prescribing, and lower rates of major adverse events[13].

The move to using digital platforms through transactional reviews, medication requests and tasks has been seen as a positive change to support this palette of options within continuity. It has provided a more instant access approach for patients who want to receive healthcare in that way, whilst also freeing up appointment times for patients that need face-to-face care and continuity. However, our participants felt that aspects of how we delivered Primary Care during the pandemic have resulted in erosion of public and patient trust in access to their GP, which is reflected in the current media narrative. It was strongly felt that restoration of good continuity of care with the ability to see patients face-to-face is a necessary step in restoring faith in access.

GPs as Clinical Leaders

It was clear that clinical leadership in General Practice was considered an essential role of GPs, with discussions on leadership transcending all the sessions and breakout rooms. As well as the outward facing leadership to external organisations, which was discussed in the previous chapter, inward facing leadership was also a common theme. This was particularly highlighted in the context of leading a practice, which is discussed in the 'Developing the Future Workforce' chapter, and leading the wider MDT in Primary Care, which is discussed here.

Being able to effectively lead and supervise the MDT in practice, especially at times of high workload such as being the 'Duty Team', was an area participants felt deserved greater attention in training.

[13] https://bjgp.org/content/72/715/e91

An area of significant stress in wider MDT working identified by participants is that of clinical supervision. Whilst it is clear that 'Additional Roles' are very welcome, with recognition of how much they add to patient care as well as supporting their GP colleagues, participants felt underprepared in supervising these members of the team and managing the risks associated with this. It was shared how this often leads to increased workload and inefficient working for GPs, with some re-reviewing patients after they have been seen by another member of the MDT.

Being able to effectively lead and supervise the MDT, especially at times of high workload such as being the 'Duty Team', was an area participants felt deserved greater attention in training going forwards, similar to how this is addressed in Emergency Medicine training. It was also felt that development of suggested supervision models (such as each role having a daily debrief or having one GP supervising a number of roles each day) would also be helpful. Relatively small actions in this area could be an opportunity for a significant improvement in the working lives of newly qualified GPs.

Summary

Clinical care is the central role of a GP. Our discussions highlighted that this clinical care is becoming increasingly complex, and in order for us to being able to deliver high quality Primary Care we must do so in a holistic way, with continuity at the heart. Early career GPs recognise that to meet these needs, a multi-disciplinary approach must be taken. If we strip back to these basics, we will be able to continue to provide the high-quality, personalised care that GPs have been renowned for since the creation of the NHS.

Recommendations

I. Health Education England and GP training schemes must ensure that leadership and management are integral parts of training with a focus on the practicalities of the daily running of a GP surgery. Given the emergence of 'Additional Roles' in the wider team, training must include how to supervise and support these colleagues.

II. Continuity of care is a cornerstone of General Practice and should be facilitated for those patients that need or want it. To avoid overburdening an already overstretched workforce, this should be delivered in MDTs within practices.

III. Good communication between Primary and Secondary Care is essential for managing patients with LTCs and reviewing communication channels and harnessing digital technology are potential solutions.

IV. Patients with medical complexity must be managed through an MDT approach which includes focusing on their social determinants of health (SDH).

V. Training on SDH should form a more robust part of the GP Training curriculum.

VI. To provide holistic care requires collaborative working with specialists such as psychological services, social prescribers, and the local health and social care teams in order to improve population health and to design and deliver services that meet the population health needs.

The Evolving Role of the GP: Society and the Environment

There is overwhelming evidence that the social determinants of health (SDH) play an enormous role in determining the needs and outcomes of patients in Primary Care. This goes all the way from the types of problems that people present with, the nature of the consultation, the subsequent actions that the patient may take, and the patient's overall experience of healthcare. Participants recognised how difficult it can be to collate relevant information about the social circumstances of a particular patient during a time-limited consultation.

The NHS in England has committed to reaching 'Net Zero' by 2045. Consequently, General Practice will need to play its part in meeting this target over the next twenty years. Given the quantity of healthcare delivered in Primary Care and the ambitious nature of this target, we rapidly need to adapt how we deliver care in the community to meet not only this target but also the needs of our planet.

Addressing Health Equity in the Consulting Room

Whilst issues such as the quality of local housing or employment opportunities were felt to be beyond the remit and influence of GPs, participants felt that GPs should (and often already do) play a role in tackling SDH at an individual level. This is driven by the recognition that SDHs not only play their part in influencing health outcomes, but also that a patient's wider context is important for a clinician to understand in order to meaningfully personalise their care – a core component of good General Practice. Participants shared that they are undertaking work every day to address SDHs to improve the lives of their patients. This includes actions such as writing in support of housing or benefit applications.

However, despite this recognition there are substantial barriers preventing SDH being front and centre in the consulting room. Two of the most significant challenges for GPs are the limited availability of information about a patient's social circumstances within the clinical record, and limitations of a GPs' capacity and power to address these issues.

Early career GPs felt that having SDHs coded in the record would help to enable both improved personalisation of care, and individualised signposting. Such signposting from a trusted source, accompanied by information on how SDHs impact upon health, could help to empower patients to address the challenges they face. Furthermore, ensuring that this

information is readily accessible would save clinicians time asking about SDH, would better support their consideration during clinical decision making, and would also save the patient time and energy by removing the need to repeat their story in multiple settings. Figure 3 shows some of the potential clinical benefits participants highlighted to having better access to this data.

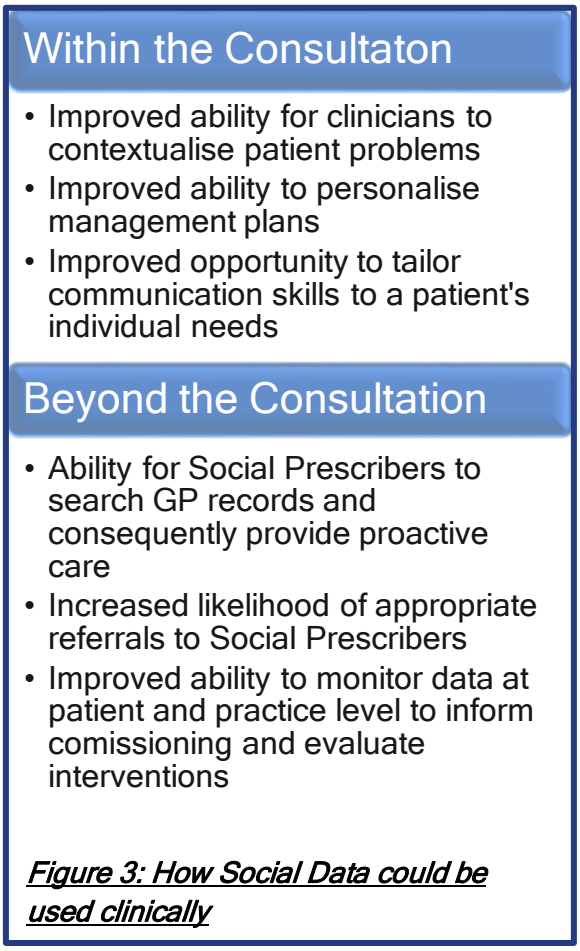


Figure 3: How Social Data could be used clinically

Despite these clear benefits, it was highlighted that current GP IT systems do not allow adequate recording or supply of this kind of data, however. For example, there was broad agreement that the 'Core20PLUS5[14]' approach taken by NHS England to address health inequalities for example would be useful for GPs, but that there will be barriers to its use in everyday consultations. This is because the Index of Multiple Deprivation[15] (IMD) it incorporates is not integrated into clinical record software. Overall, it was felt that changes would need to be made in record keeping in order to make best use of this kind of data. It was also noted that it would be useful for information about SDH to be shared between providers of health and social care in order to give the most rounded view of a patient's circumstances.

Addressing Health Equity at Practice Level

As well as at an individual level, it was recognised that GPs may impact upon SDH at a community level too. The NHS is seen as an anchor institution, and GP practices can similarly act as this within their own locality. Some participants talked with passion about how practices they worked in had taken on the challenge of improving the healthcare received by underserved populations. One individual described how they had a significant number of migrant patients who did not speak English and had a different cultural expectation of healthcare. In order to meet these needs, the practice has recruited in-house translation staff who were also able to work with patients as health coaches outside of appointments with a doctor or nurse to provide culturally competent care. These individuals were drawn from within the communities the practice served directly and therefore also helped build trust between the community and the practice.

It is also important that practices are managed with the needs of the local community and underserved populations in mind. One early career GP talked about how their practice is

[14] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/
[15] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

currently ensuring all non-clinical staff receive training in 'Trauma-informed Care' in order to ensure that everyone understands the challenges some patient groups might face. Another approach is for practices to focus their quality improvement work to improve the experience of patients who are at high risk of health inequalities. For example, it might be helpful to examine care experiences of patients who:

- Repeatedly do not attend appointments
- Access the majority of their care through the urgent and emergency care pathway
- Do not attend preventative care such as long-term condition reviews, screening, or vaccinations
- Are in transient populations such as military personnel, looked after children and the homeless.

As well as consideration of health inequalities and SDH in how they deliver care, practices must be aware of how these issues and those of Equity, Diversity and Inclusion (EDI) impact their own workforce. This must include consideration of the ethnic and cultural diversity of the workforce and how this represents the local population. Active work to recruit staff within a practice who reflect the community in which they are working was felt to be an important way to both support the SDH within the community, but to also ensure the cultural expertise is present to meet the needs of diverse patients.

There remains a significant gender pay gap in GPs of 15%.

It was also identified that issues of gender equity need to be addressed. For the past 25 years, more women than men have entered medical school. Within the NHS as a whole over three quarters of staff are female, and in social care this is even higher at 82%[16]. Whilst the ratio in General Practice has not yet reached this level, since 2014 there have been more female than male GPs[17]. Worryingly, in spite of this, even when corrected for hours and employment status (i.e. partner versus salaried GP), there remains a significant gender pay gap in GPs of 15%[18]. This is an area which needs to be urgently addressed.

Addressing Health Equity at PCN and System Level

It was identified that some work to address SDH and health inequalities lie beyond the level of the practice, but that GPs still have an important role to play. One example given was that health inequalities might be exacerbated by the way PCNs currently function, and that a change in approach might be needed. This was exemplified in how 'Additional Roles Reimbursement Scheme' clinical staff are deployed - they are often based in larger,

[16] https://www.nhsemployers.org/articles/gender-nhs-infographic
[17] https://www.gponline.com/rise-women-general-practice/article/1458988
[18] https://www.pulsetoday.co.uk/analysis/workforce/why-female-gps-are-earning-15-less-than-their-male-counterparts/

wealthier practices within the PCN. Certainly, participants highlighted they are usually deployed on the basis of patient numbers rather than need.

PCNs should also work collaboratively alongside their colleagues in Secondary Care, Public Health services, Local Authorities and Voluntary, Community and Social Enterprises to address health inequalities.

PCNs should also work collaboratively alongside their colleagues in Secondary Care, Public Health services, Local Authorities and the Voluntary, Community and Social Enterprise sector to address health inequalities. This might include examining barriers to accessing care, service opening times, registration difficulties, or a lack of flexibility of appointments. There are also opportunities to work with third-sector organisations to explore how to embed healthcare and health promotion in places that traditionally underserved groups already are engaged with, such as community centres or places of worship. Clearly the new Integrated Care Systems should enable this to happen practically and there is excitement about the opportunities this might present.

The Role of Primary Care in Sustainable Healthcare

The NHS in England has committed to being 'Net Zero' by 2045[19]. Consequently, General Practice will need to do its bit to support meeting this target over the next twenty years. There are many ways in which practices can be more sustainable, from getting the basics right in terms of waste reduction and energy use through to health promotion and prevention. With medicines being identified as the source of up to quarter of NHS carbon emissions in England[20], one area where there is lots of scope for improvement is in prescribing, where addressing both issues of overprescribing as well as considering the impact of medicines we prescribe, such as by ensuring we only prescribe environmentally-friendly inhalers, is vital. Participants felt that in order to be able to achieve this in Primary Care, it is essential that we bring our colleagues on the journey with us. This includes promoting the business case around sustainability, ensuring that colleagues understand that sustainable healthcare not only helps the environment, but also improves health, and often saves money, making it a 'triple win'. When communicating about climate change, it is important to talk about the positive benefits of climate action, with practical ideas for changes everyone can make, as colleagues and patients alike respond better to hope and positive action rather than fear.

[19] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/
[20] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/areas-of-focus/

Positive experiences of joining a local 'Greener Practice' group were highlighted as a method to help people feel inspired, share ideas and receive support from others doing similar work. Resources such as the Green Impact for Health toolkit which give an award to practices who complete certain tasks can help to encourage and motivate staff. More examples of resources to support sustainable healthcare delivery in Primary Care are given in Box 3.

As well as the work which needs to happen within practices to limit our negative impact on the environment, it was felt that GPs should use their trusted voice to advocate about climate change and health issues to both patients and policy makers. Frequently, behaviours that are beneficial for an individual's health are also beneficial for the environment – in other words, there are co-benefits.

Box 3: Resources to Support Sustainable Healthcare Delivery in Primary Care

⇒ **Greener Practice website:** https://www.greenerpractice.co.uk/information-and-resources/

⇒ **Sustainable QI Ideas:** https://sustainablehealthcare.org.uk/susqi-resources

⇒ **Green Impact for Health Toolkit:** https://greenimpact.nus.org.uk/green-impact-for-health/

⇒ **RCGP Curriculum Topic Guide Population and Planetary Health:** https://www.rcgp.org.uk/training-exams/training/gp-curriculum-overview/clinical-topic-guides

⇒ **Building an environmentally accountable medical curriculum through international collaboration:** https://pubmed.ncbi.nlm.nih.gov/28681652/

⇒ **AMEE Consensus Statement: Planetary health and education for sustainable healthcare:** https://pubmed.ncbi.nlm.nih.gov/33602043/

There are a number of areas which GPs could do this such educating those living in urban areas on the impact of air pollution on their health and how they might reduce their contribution to it. Other examples that participants identified discussing in their clinical work included:

- Exercise Advice - Using active transport (i.e. Walking/Cycling) rather than private motorised transport
- Dietary Advice - Avoiding ultra-processed foods which frequently have high salt, fat and sugar content and a high environmental footprint
- Insulating homes so that they are warmer and/or money can be saved on fuel and the home is more energy efficient to heat in winter.

Sustainable healthcare improves health, the environment and often saves money, making it a 'triple win'.

Challenges for GP Training

It was widely recognised that whilst GPs aspire to address both health inequalities and the environment and feel this is an important part of the role of the modern-day GP, they do not feel adequately skilled to deliver on these. Due to the complex nature of these issues and their impact on all areas of healthcare delivery, it was felt there should be education through all three levels of medical education: undergraduate studies, postgraduate training and continuing professional development. This is something participants felt was lacking at present in both areas, despite them being high up on national agendas. These topics should be embedded into clinical teaching across all domains to support healthcare professionals to understand how they can deliver on these important agendas in a practical manner in daily clinical work. Table 1 reflects how participants feel these topics should be delivered.

Health Inequalities	Ensuring approaches being taken within each devolved nation (e.g. CORE20Plus5 in England) is taught at all stages of training from medical school to CPD. Consideration of how practical aspects of addressing health inequalities can be tied into training placements in innovative ways such as spending time working with underserved populations. Further development of fellowships focussing on health inequalities to develop a skilled workforce of GPs with a special interest in this area. Updated curriculum which includes newer considerations in health inequalities such as digital exclusion and a link to healthcare leadership. Inclusion of the patient voice/experience essential to ensure this is done with patients.
Sustainable Healthcare	Expansion of curricular content on sustainable healthcare, linked to clinical topics rather than a separate field. This must be integrated as a vertical theme rather than a stand-alone topic and must be included throughout all stages of training from medical school to CPD. Consideration should be given to using a wide range of approaches to learning the subject which goes beyond didactic teaching. There needs to be a specific area for evidencing within the ePortfolio where Trainees can provide evidence of undertaking work in sustainable healthcare. This might include a requirement to undertake a specific QI project within training with a theme in greener healthcare. Further development of fellowships focussing on sustainable healthcare to develop a skilled workforce of GPs with a special interest in this area. In order to deliver this ambition, significant work needs to be undertaken to upskill educators at all stages of training and education.

Table 1: Training needs on health inequalities and sustainable healthcare

Recommendations

I. GPs need to have access to coded information on an individual patient's SDH in order to be able to better support them.

II. Training for Primary Care professionals on healthcare inequalities is needed so they can actively help to support their patients and their communities.

III. Visible healthcare inequalities leadership is essential at all levels.

IV. Sharing of good practice examples, both within their PCN, and beyond will benefit Primary Care.

V. 'Additional Roles' need to be distributed equitably to ensure that the patients who need care the most can access it.

VI. Active recruitment and community collaboration might be helpful to tackle inequalities within the workforce.

VII. We must ensure the links between climate change and health, and sustainable healthcare practices, are taught at all levels, from medical school, to GP training, through to GP trainers.

VIII. GPs should use their trusted voice to advocate for climate change and health issues and educate the public, for example, on reducing contributions to and avoiding exposure to air pollution.

Developing the Future GP Workforce

In the face of the complex challenges that General Practice currently experiences, the need to develop and nurture the future GP workforce has never been greater. This was a cross-cutting theme throughout discussions. There are two distinct elements that make up effective development of the next generation of the GP workforce. These are ensuring effective:

- Recruitment into the GP profession.
- Training of those who are entering the GP profession.

It is therefore important to not only recruit more GPs, but also important to improve how we train them, so that those entering the workforce feel both competent and comfortable with the challenges that a modern-day GP faces.

Context

Though increasing the number of practicing GPs has now been a stated priority of successive governments, we are yet to see substantial progress in this area. The most recent of these pledges was in 2019, when the Government announced their commitment to recruiting an additional 6,000 GPs by 2024[21]. When questioned about the Government's progress towards this goal in November 2021, the then Health Secretary Sajid Javid replied, "No, I do not think we are on track"[22].

The workforce amendment to the Health and Care Bill would have been a positive step forward and we need to aim towards an oversupply of doctors to help cope with the increasing workload. Participants were disappointed that the Government has removed this amendment; without a long-term workforce plan, patients will likely experience further delays, further cancellations and poorer outcomes.

Once recruited, another key element of developing the workforce of the future is keeping hold of them: GP retention. As recently as June 2022, the RCGP warned of a "mass exodus, with 18,950 GPs and Trainees set to leave the profession over the next five years, putting patient care at risk.[23]" This stark warning highlights the need to both better understand the drivers of GPs leaving the profession, and to take swift action to stem the flow.

A key factor participants felt was contributing to this significant loss of GPs is a lack of preparedness for being a fully-qualified GP post-training. This leads to stress, then to burnout, then ultimately to them reducing their clinical hours, or leaving the profession entirely. The phenomenon that early career GPs described which underpins this is that GP

[21] https://www.conservatives.com/our-plan/conservative-party-manifesto-2019
[22] https://committees.parliament.uk/oralevidence/2942/pdf/
[23] https://www.rcgp.org.uk/News/Mass-exodus

training is not keeping pace with the rapidly developing nature of work in Primary Care – rather we are training GPs for the job which existed ten to twenty years ago. It is therefore imperative that training is more relevant to 2022 clinical practice, ensuring that colleagues are more confident in the skills they need to undertake the role of a modern-day GP.

> We are preparing the next generation of GPs for the job that existed 10 to 20 years ago, rather than the job that exists today.

England is now training a record number of GPs, with HEE confirming to us that there were 13,000 GPs in training in 2020/21. If GP training is done right, and leads to improved retention and clinical effectiveness, imagine the positive impact these GPs will have on improving the care that our patients receive…

Challenges in Recruitment

Why #ChooseGP?

The failure to meet successive ambitions in GP recruitment reflects that recruiting more GPs is a complex issue; one which Government is yet to solve. This complexity is reflected in the views of participants, who described a series of factors which impacted the decisions they had individually made to become a GP. These are a mixture of push and pull factors which moved them towards choosing to be a GP, as well as a need to overcome factors which might have deterred them. It is the balance of these three which ultimately impacts the choice, as illustrated in Figure 4.

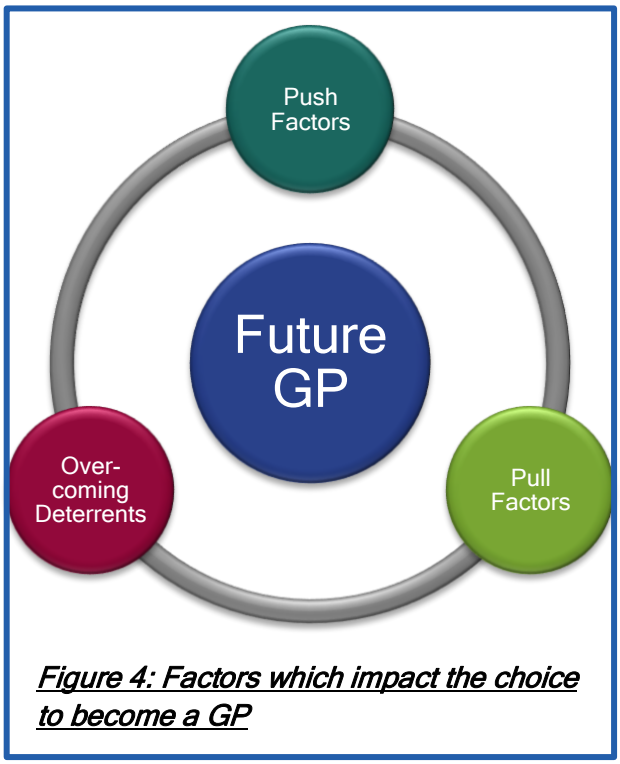


Figure 4: Factors which impact the choice to become a GP

It is clear people choose to be GPs for a wide variety of reasons. For many, it is about a match between their personality and skills, and the nature of work as a GP – the 'Pull Factors'. These people described themselves as wanting to understand the wider context of a patient's presentation, having less desire to know minute details about rare conditions. They also spoke of the desire to care for an entire family (identifying with the term 'Specialist in Family Medicine'), while also enjoying feeling a part of their community. Additional draws were not only the wide variety of work that core General Practice offers, but also the

opportunity to develop a portfolio career and pursue other areas of interest, leading to a varied and, hopefully, fulfilling career.

Participants also spoke of 'Push Factors' in terms of the practical aspects associated with being a GP in comparison to hospital-based specialities. This included factors such as the ability to work more flexible hours, as well as the option to keep weekends free if desired or necessary.

How do we Encourage More Doctors to #ChooseGP?

Participants felt that it would be beneficial to better publicise these Push and Pull Factors – the benefits and opportunities associated with a career in General Practice - to aid recruitment. Particularly focussing on the 'Pull Factors' would also support the recruitment of those doctors who are most suited to General Practice, due to their skillset and personality; where becoming a GP is an active choice, rather than it being something passive that some fall into. That said, doing this alone would not be enough, and further steps should be taken. It was highlighted that that further facilitating flexibility, both in terms of the number of hours worked, and the ability to do a variety of work, might support this. This is explored in more detail in the following chapter.

In terms of the 'how?', medical school General Practice placements were identified as a prime opportunity to publicise these benefits. At present however, it was felt that much of the focus of these placements is as an opportunity for medical students to learn and develop their generic clinical capabilities (such as communication skills), rather than focusing on the specialist knowledge and skills required to be a GP, such as balancing conflicting clinical guidance, long term condition management and holistic care. This is in stark contrast to hospital rotations, where students who are on a respiratory placement will learn specifically about respiratory conditions and how they are managed in hospital, for example.

Medical school General Practice placements were identified as a prime opportunity to publicise the benefits of a career as a GP and hence improve recruitment.

This can lead to a hidden curriculum where students are 'taught' that GPs are less skilled or knowledgeable than our Secondary Care colleagues. Participants spoke of this perception that General Practice is seen as a less prestigious career; one that doctors may resort to if they are not 'good enough' to pursue a specialty. It is well recognised that students receive significant exposure to this narrative during medical school[24]. Despite a rigorous membership exam, a growth in university Primary Care academic departments, and the opportunity to pursue postgraduate qualifications in clinical and non-clinical topics, participants felt that General Practice does not have a parity of esteem with Secondary Care specialities. This forms a significant deterrent for students to overcome as part of deciding

[24] https://www.medschools.ac.uk/media/2881/by-choice-not-by-chance.pdf

that they would like to pursue a career in General Practice. There is clear recognition this is a very complex issue to resolve, but one suggestion identified was to consider replacing the term “General Practitioner” with a title such as “Specialist in Family Medicine,” to highlight the expertise that GPs have.

Participants also recognised the importance of supporting doctors who are part of a non-GP specialty training programme, or even those who are fully qualified in another specialty, to train as a GP if desired. They reported a perception that switching specialities is generally discouraged. Steps that would encourage, rather than discourage, this, such as proper recognition of competencies they have developed as part of their previous training meaning that some training may not need to be repeated, alongside removing the administrative burden associated with switching, would be welcome steps towards increasing recruitment. The diverse range of skills and backgrounds that this would bring to the GP workforce would also be welcomed, and seen as a significant benefit for patients and the profession alike.

Thinking Beyond the Headcount

Though participants recognised that the absolute number of doctors recruited into General Practice was of great importance, they did not want to lose sight of the fact this should not be the only aim of effective recruitment. They also noted that diversity and the equitable distribution of GPs across the country were vitally important for the GP workforce of the future.

Equitable distribution of a diverse workforce of GPs across the country is vitally important.

There is significant passion about the need for the GP workforce to be diverse, and to truly represent the populations that they serve, in order to build trust within communities. For GPs specifically, they felt this starts by examining how university admissions can be adapted to ensure that people from traditionally underserved areas are more sufficiently represented amongst medical students. They also spoke of the need for GPs to lead by example and recognise that they have a social responsibility to ensure that their own workforce is diverse and inclusive. This principle extends to the whole practice team. Beyond a moral impetus, this should also help to address some of the issues discussed in the previous chapter regarding health equity.

Alongside this, participants were well-aware of the emerging evidence that there are areas of the country that are underserved in terms of the number of GPs they have per needs-weighted patient. These are often socioeconomically deprived areas, which may be anywhere from inner city practices, through to those in remote, rural areas. There are significant barriers to working in these areas that early-career GPs discussed, which are shown in Figure 5. Despite these barriers however, it is clear that there is a need to improve recruitment into these localities. They felt that improving training on how to work effectively

in underserved areas would be a significant positive step towards doing so, undertaking the suggestions discussed in the previous chapter.

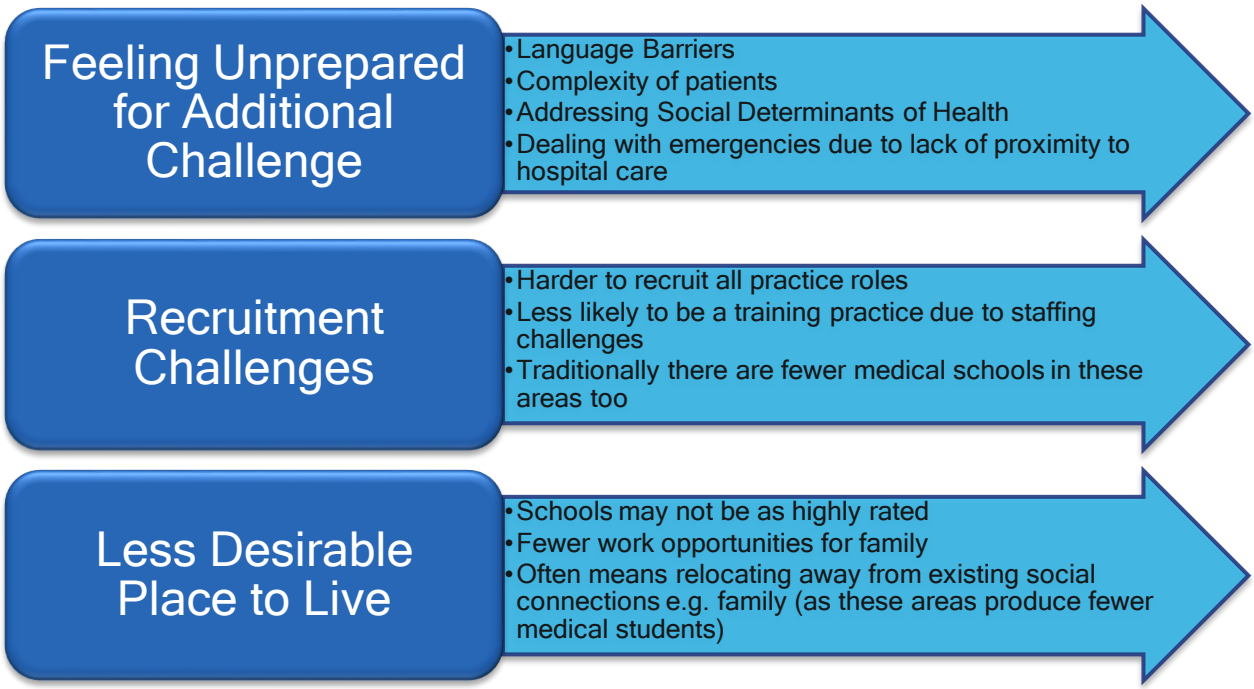


Figure 5: Barriers to GP recruitment into areas of highest need

One of the reasons identified for why practices in underrepresented areas are relatively understaffed is that financial resource allocation is not adjusted to match the increased patient need in these areas, and therefore funding is not distributed equitably[25]. There is a feeling that national steps to improve the equity with which funding is allocated will likely enable underserved practices to recruit more staff, and therefore help to correct this relative understaffing. Once corrected, it is then more likely that GPs will be attracted to these practices.

Noting that doctors are likely to stay where they train, it was highlighted that an increase in the number of training opportunities available in areas where it is harder to recruit at all levels would be useful. This may be anywhere from creating new medical schools, through to supporting practices in these areas to become training practices. On the latter, participants felt it would be right to offer additional support and resources to practices in underserved areas to help them become training practices, whilst also supporting them to develop their estate to take on more Trainees. Introducing supported fellowship posts to further incentivise GPs working in these areas, which include mentoring, networking, and professional development opportunities, were felt to be a positive step. Direct financial incentives, such as the Targeted Enhanced Recruitment Scheme[26], were felt to be another positive way to increase GP recruitment in specifically underserved areas with some participants openly discussing how this had influenced their choices.

[25] https://www.health.org.uk/publications/reports/level-or-not
[26] https://www.hee.nhs.uk/news-blogs-events/news/targeted-enhanced-recruitment-scheme-support-gp-trainees#:~:text=The%20Targeted%20Enhanced%20Recruitment%20Scheme,under%2Ddoctored%20or%20deprived%20areas.

Opportunities for Training

The Recorded Consultation Assessment (RCA)

The previous GP clinical skills exam, the Clinical Skills Assessment (CSA), was thought to have been very helpful in supporting GP Trainees to develop the skills required for independent clinical practice. This examination evolved into the RCA during the pandemic, moving from an Objective Structured Clinical Examination (OSCE) format to one more akin to coursework. Though participants understood the rationale for this, they felt the RCA, in its current form, detracts from meaningful learning and development. Whilst at the time of undertaking The Big GP Consultation the RCGP were already commencing development of a new examination to replace the RCA, details of this had not been announced. The team welcome the work that is going into this development, and many of the points discussed in this segment of the report appear to be being addressed. However, they are still included here due to the strength of feeling on these points which were raised repeatedly in various forms throughout the sessions.

It was highlighted that candidates 'cherry-pick' cases in order to pass the RCA exam, rather than focussing on more broad development. They also report how time-consuming it is to undertake the exam. When combined, these two factors mean that Trainees spend a large portion of their final year in training looking for, and completing, 'RCA compatible' cases; cases that are not necessarily representative of the variety of work they will see once fully qualified. Perhaps even worse is that some report actively avoiding seeing more complex patients, cases which would not fit into the time constraint of the assessment, or scenarios that would be harder to conduct over the phone/video, such as with a translating service, as these cases would not help them to pass the exam. They also felt it was more challenging to demonstrate competency if the patient had already seen you, or another member of the team, about this issue. This leads to candidates actively seeking new presentations, and inadvertently discourages continuity of care.

Some report actively avoiding seeing more complex patients, due to the time constraint of the assessment, or scenarios that would be harder to conduct via telemedicine, as these cases would not help them to pass the exam.

Alongside this, participants felt that the RCA does not examine many of the equally important non-patient care related competencies expected of a modern-day GP, such as the ability to clinically supervise those members of the team that they work alongside. When combined with the overall feeling that this exam does not prepare them well for the variety of cases they will see post-CCT, they called for urgent reform to ensure that the exit exam does not hinder the preparedness of newly qualified GPs.

The Changing Nature of Consulting

The number of methods through which a patient may consult with their GP is now greater than ever, from face-to-face, telephone, video, and online consulting, through to home visits. Though participants spoke favourably about this from both a patient and clinician perspective, they noted that how we train GPs has not kept pace with these developments. Specific, formalised training on how to manage patients remotely is notably absent from GP training. Instead, GP Trainees and those in the early part of their career are having to learn this 'on the job'. Given the significant quantity of patients who are now managed remotely, preparation in these skills is essential, and should therefore be better incorporated into training.

Leadership Development in GP Training

Though training was felt to largely well-prepare newly qualified GPs for the clinical aspects of the job, it is felt that opportunities to develop the wider skillset required to be a GP could be improved. This is, in part, because of the growing importance of aspects of the job not relating to direct patient care, such as leadership and management, tackling health inequalities, and using data effectively. Though these elements may previously have been considered as an "add on" to practice for those with a special interest, participants felt that these skills were now core and essential for all practicing GPs.

> Training largely well-prepares newly qualified GPs for the clinical aspects of the job, but opportunities to develop the wider skillset required to be a GP must be improved.

Leadership and management skills were highlighted as being essential for all modern-day GPs. Though some may acquire a special interest and develop further in this area, it was felt to be sufficiently important for every GP to have a baseline, core competency in leading and managing. In practice, participants reported that this could be split into two broad categories: leading within your practice and leading beyond your practice.

GPs play a critical leadership role within a practice, and whilst there is enthusiasm about undertaking this, the lack of training received in this area leaves early career GPs feeling unprepared to do so. A number of key skills were articulated which must be developed for new GPs to be able to undertake this role. These are shown in Box 4. Given the limited capacity that GPs have, training should focus on the clinical elements of leadership - those best undertaken by a clinician – rather than the non-clinical elements. Participants felt that GPs are well-placed to develop a clinical pathway, for example, but less well-placed to navigate complex Human Resources issues, or seek planning permission for building development. Overall, it was felt that developing these skills both earlier, and more

effectively, would not only impact positively on workforce retention, but would likely encourage recruitment to GP Partner posts.

It is clear, however, that a single GP practice cannot tackle the complex challenges currently faced by the profession alone. Participants welcome the move towards collaboration through PCNs, ICSs and the proposed move to integrated neighbourhood teams, as outlined in the Fuller Stocktake report[27]. However, in order to make the most of these opportunities, GPs must be well-prepared for leading beyond their practice. This will require skills over and above those needed to lead within a practice, as shown in Box 4. It is essential, therefore, that GP training reviews how it develops leadership skills to meet these needs.

Box 4: Key leadership skills required for:

Leading within your practice:

- Evidence and data-led service design and development in practice
- Vision development and leading the team towards it
- Change management
- Understanding of budgets, and how money flows in and out of the practice
- Management of risk, particularly non-clinical risk
- Leading a practice within the wider landscape of PCNs and ICSs
- Co-production with patients/communities

Leading beyond your practice:

- Population health management including tackling health inequalities
- Lead change at scale
- Building relationships between different providers within the system
- Sharing learning across organisations

Working with the Multidisciplinary Team (MDT)

Participants were very positive about the increase in MDT working in General Practice, describing colleagues employed under the ARRS as a "much-needed addition" to the workforce. They spoke particularly favourably of the "expert" roles who can offer expertise beyond what a GP may be able to offer; for example, a social prescriber's ability to support the holistic needs of the patient. That said, participants reported that they are not effectively trained to work as part of MDTs in General Practice and improving GP training in this area would further unlock the potential of MDT working. This goes above and beyond the need to supervise the MDT which was discussed in the Evolving Role of the GP: Clinical Care chapter.

Some spoke of a lack of familiarity with the different skills and expertise that members of the MDT bring. This prevents GPs from knowing when to refer patients to these roles or how to make the most of them in their practice team. Given the direction of travel towards greater MDT working, it was felt that the introduction of Interprofessional Education (IPE) in training would be of value. In short, IPE aims to promote working relationships between healthcare professionals, by providing an opportunity for professionals from different roles to learn with, from and about each other. Participants therefore felt that introducing more IPE (from as

[27] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

early as medical school) would improve familiarity with the roles that they work alongside and would like to see this explored further.

The Structure of GP Training

It is clear that there is an appetite for more to be covered in GP training to effectively prepare those completing training for the job they are about to commence. In the shorter term, the move to increased time in GP placements as part of training is a positive step, and an opportunity to support the development of the additional skills outlined above. However, this was not felt to be enough to meet all needs. That said, views on extending GP training were mixed amongst participants. Some felt that this would be beneficial, but others expressed concern that lengthening GP training may negatively impact recruitment, with the short duration considered a positive factor in career decision making for many. Rather than extending training, participants spoke more favourably of increasing the reach and uptake of the General Practice Fellowship Programme[28]. This programme would be a good vehicle through which to deliver some of this additional training, providing that it was undertaken by 100% of newly qualified GPs.

Rather than extending training, participants spoke more favourably of increasing the reach and uptake of the General Practice Fellowship Programme.

Related to this, many identified that hospital placements could be better utilised in training. There is significant negativity about experiences of hospital posts, with participants feeling that these were entirely designed around service provision, rather than training to be a GP. Early Career GPs had a number of suggestions to improve this. Participants called for an increase in the time spent in outpatient departments, as they felt this experience has a more direct positive impact on their ability to be a safe and effective GP. This could also include time spent with GPs with a Special Interest related to that placement. There is also a feeling that the culture associated with these posts needs to change, ensuring hospitals understand that Trainees are there for development, and not solely service provision. Re-framing hospital posts as an opportunity to improve mutual understanding between Primary and Secondary Care clinicians, whilst also improving the interface between the two, would be of benefit.

Some of this culture change might be achieved by having Trainees from other specialities spending time in General Practice during their training. Participants felt this would bring significant benefits to both sides, by improving mutual understanding. It might also increase the likelihood that Trainees from other specialities would transfer into GP training. That said, participants recognised the challenges associated with this in practice, especially a lack of capacity to accommodate them in General Practice, as well as the challenge of removing them from their specialty workforce for a period of time.

[28] https://www.england.nhs.uk/gp/the-best-place-to-work/gp-fellowship-programme/

Supporting International Medical Graduates (IMGs)

IMGs make up a significant and growing component of the GP workforce. Whilst this work did not specifically ask participants where they trained, anecdotally there were a limited number of IMGs who participated. As such the views of IMGs are therefore relatively underrepresented. With that caveat, participants were clear that GP training probably does not meet the needs of IMGs. A dedicated programme of work is required in this area which works directly with IMGs to co-design support which meets their needs.

There are two main areas where our participants felt improvement should focus. Firstly, IMGs may require additional training on certain elements that are not required by somebody who has grown up or trained in the UK, such as a high-level overview of how the NHS functions. This has recently been addressed in part by a new virtual induction package[29]. Secondly, they may also require support in some areas over and above what is currently offered to all Trainees, such as areas of clinical management where guidance differs substantially from that of an IMG's home country. This is further to any additional personal and pastoral support that they may need, such as navigating visa issues and ensuring they have adequate housing.

[29] https://www.e-lfh.org.uk/programmes/nhs-induction-programme-for-international-medical-graduates/

Recommendations

I. There must be wide publicity of the benefits and opportunities associated with a career in General Practice to everyone from medical students through to doctors in other specialties.

II. The Royal College of General Practitioners (RCGP) should consult on replacing the term "General Practitioner" with a more appropriate title that reflects the specialist skills a GP possesses, and to improve parity of esteem with other medical specialties.

III. Medical schools need to ensure that student placements in General Practice focus on showcasing and developing the skills required to be a GP, rather than generic medical competencies.

IV. Health Education England (HEE) need to reduce the administrative burden, and duplication of training, faced by doctors in other specialties who choose to commence GP training.

V. Practices need to lead by example through ensuring that their entire workforce is diverse, and reflective of the communities that they serve.

VI. A more equitable approach to funding allocation is needed in all four nations to improve GP recruitment in underserved areas.

VII. There must be expansion both of the training opportunities available in underserved areas, and the support that is offered to GPs and practices in these regions.

VIII. The RCGP needs to undertake urgent reform of the RCA, so that it supports the development of Trainees into well-rounded GPs.

IX. HEE must embed training on managing patients remotely, such as via the telephone, or via text-based consultations, into GP training.

X. HEE must rapidly develop a GP-specific leadership and management training offer that is embedded into GP training.

XI. There must be promotion of interprofessional education at all levels of training, to improve MDT working within General Practice.

XII. There needs to be development of suggested supervision models for ARRS staff, as well as training GPs to safely provide this supervision.

XIII. There must be exploration of how hospital-based training posts for GP Trainees can be more effectively utilised, paying particular attention to the development of the non-clinical skills outlined above.

XIV. There needs to be specific engagement with IMGs to improve understanding of the challenges they currently face, with a view to coproducing solutions to overcome them.

Creating a Sustainable Career

It is widely acknowledged that the sustainability of General Practice as a career is crucial in order for the NHS to meaningfully recover from the pandemic, tackle waiting lists and continue to support the remaining workforce. There has been a notable spotlight shone on the challenges facing Primary Care over recent months, with GPs frequently being invited to provide evidence to parliamentary committees on the topic. However, this crisis has been long-standing; the pandemic simply exacerbated and exposed it for all to see.

Despite growing patient demand, the number of fully qualified full-time equivalent GPs has fallen over recent years[30], with the latest data from the 'GP Worklife Survey' highlighting that one in three GPs intend to leave "direct patient care" within five years[31]. It is therefore not surprising that participants spoke with great passion around how it is imperative for General Practice to both be seen as, and become, a sustainable career choice.

Preparedness for Transitioning into 'First5'

There was a general consensus throughout the consultation that GP training, in its current format, leaves Trainees feeling unprepared for independent practice. This degree of unpreparedness and anxiety around post-CCT life was described by one participant as being "dropped into the ocean with the life vest of your trainer being suddenly taken away". There is significant concern that the final year of GP training, in particular, disproportionately focuses on the combination of passing the RCA (as discussed in the previous chapter) and portfolio assessments, rather than undertaking more meaningful activities which would contribute more positively to preparing Trainees for post-training life.

The degree of unpreparedness and anxiety around post-CCT life was described as "being dropped into the ocean with the life vest of your trainer suddenly being taken away"

It was suggested that one solution to this would be to lessen the curriculum requirements in ST3. This could be achieved by reducing the burden and repetition of assessment and increasing focus on grounding oneself in the reality of being a GP through an apprenticeship model. There was also discussion that there was a need for time to transition from the role of a GP Trainee to that of an independent GP. It was felt that a window of at least six months

[30] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services
[31] https://prucomm.ac.uk/eleventh-national-gp-worklife-survey-2021.html

following completion of exams might be appropriate to aid this transition. This should be undertaken in a phased format and might include Trainees taking on their own patient list under supervision.

Familiarity was noted to be a helpful factor in supporting a smooth transition to post-CCT life. Early-career GPs noted that their transition to First5 was much easier if their first post was either in the same practice or a similar practice to where they had completed their training. A number of factors which may be relevant to how prepared a Trainee might feel post-qualification were suggested. These are shown in Figure 6. It was therefore felt that having the chance to experience a variety of practices during training may help Trainees adapt into a new one when qualifying. This may also mitigate for some of the variability of experience found between practices during training. With the recent increase of time spent in General Practice during training, it was felt that this should be feasible.

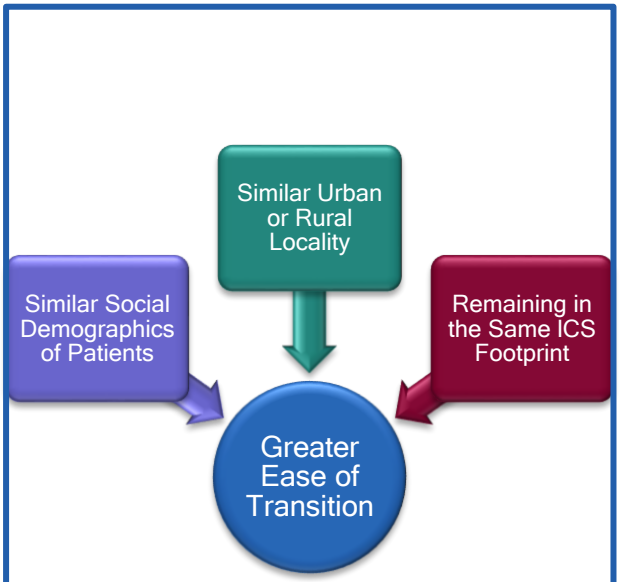


Figure 6: Familiarity factors which impact ease of transition to First5

Post-CCT support

It was acknowledged that there is wide variation in the provision of post-CCT support. A spectrum of support was seen as key in aiding their transition into working life and subsequently sustaining a successful career. Participants highlighted that access to both mentoring and coaching, as well as supporting and instilling strong 'First5' communities, were both essential forms of support required as they embarked as fully qualified GPs. They also identified that these are often underutilised. Providing dedicated, protected time for newly qualified GPs to access post-CCT support was thought to be a sensible move which would help them to navigate the transition more smoothly. This would require provision of ring-fenced funding, however.

It was highlighted that the Post-CCT fellowships discussed in the previous chapter (General Practice Fellowship Programme[32]) were one way of providing some additional support to ease the transition period. There was a general consensus that these could be better promoted to colleagues as many were unfamiliar with what fellowships involved or how to apply. It was also highlighted that these fellowships should have appropriate exit pathways to ensure that those who wish to continue working in areas they have developed interests and skills in during the fellowships have the opportunity to do so.

[32] https://www.england.nhs.uk/gp/the-best-place-to-work/gp-fellowship-programme/

Preventing Burnout

It is well recognised that levels of burnout remain high amongst the Primary Care workforce. The causes and solutions for this were discussed with great passion by participants, reflecting the palpable recognition that for many it was a clear and present danger for themselves, colleagues, and by extension their patients. Participants described these across the six areas of worklife linked to burnout shown in Figure 7[33].

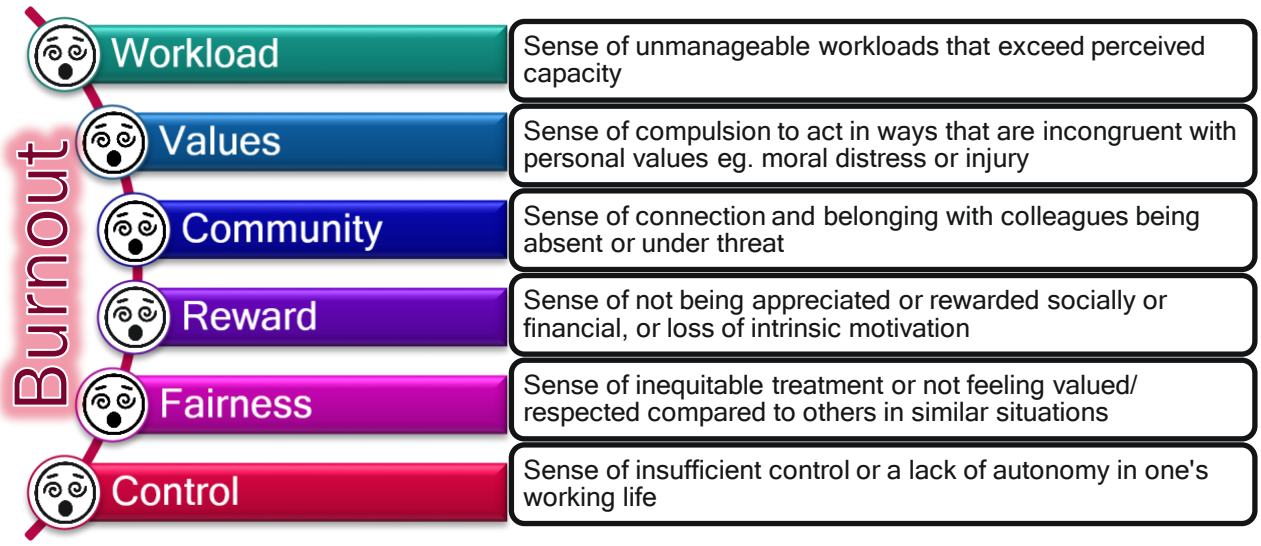


Figure 7: Leiter and Maslach's 'Burnout and Areas of Worklife' theoretical model

Workload and Values

Participants agreed that workloads had become unsustainable, attributing this to three core reasons:

- Underlying workforce deficits;
- Increasing expectations and demand from the public;
- A shift to more complex patients, traditionally managed by Secondary Care, being seen by GPs.

It is widely accepted that GP workforce gaps contribute to the mismatch in demand and capacity, ultimately putting clinicians on a treacherous road towards burnout. Participants felt there was a strong argument to aim towards an oversupply of doctors to help cope with the known mismatch but acknowledged it will take many years for GP numbers to substantially increase. In the meantime, we may need to consider greater cohesive multidisciplinary working and the potential benefits of Secondary Care consultants working within the community.

[33]https://www.researchgate.net/publication/235297409_Areas_of_Worklife_A_Structured_Approach_to_Organizational_Predictors_of_Job_Burnout

Figure 8: The hidden workload of General Practice

Many asserted that 10-minute appointments were no longer practical for some of the most complex patients, and that they were seeing more in succession due to 'straight forward' cases being seen by allied healthcare professionals. Extending appointments to 15-minutes was debated by colleagues as a potential solution. It was discussed that it would impact upon wait times for patients to see a GP but was identified as a key component of changing the tide of unsustainable workloads. It was clear however, that this would not be the silver bullet to save multiple generations of GPs from burnout, but rather one facet of a recovery programme for the profession. Further areas of consideration should include the length of a normal working day, the number of patients seen per session, better acknowledgement of the so-called hidden workload (as shown in Figure 8[34]) and the complexity of the workload. An adaptable appointment system that better reflects these criteria would be beneficial.

These workload pressures described by participants contributed to a feeling of being overstretched in many ways, with some describing feelings of moral distress or injury by being unable to provide the care for their patients that they would ordinarily want to. This is a significant risk factor for burnout, as ultimately it leads to an encroachment into the core duties and values of a doctor.

Some described feelings of moral distress by being unable to provide the care that they would ordinarily want to, ultimately leading to an encroachment onto the core duties and values of a doctor.

[34] https://www.egplearning.co.uk

Sense of Community

Whilst the challenges described above with regards to workforce may not be in the gift of GPs to solve, the need to develop a meaningful sense of belonging and community very much is. Isolated practice (particularly whilst undertaking burgeoning admin tasks) and a lack of peer and senior support was viewed as another key contributor to burnout within General Practice. Participants described a lack of sense of belonging, comradery and teamworking as a growing challenge, and expressed a desire to have peer support across the different generations of GPs, which would help with wellbeing. Newly qualified GPs felt that closer relationships with experienced GPs would also allow access to mentorship and support them through common challenges faced in practising, addressing some of the challenges discussed regarding transition. Having these kinds of informal relationships within the work environment would also allow colleagues to 'keep an eye' on each other and to identify and then offer support to those who may be struggling. Others also suggested that isolation could be reduced by looking at the design of practice buildings, enabling admin tasks to be completed in communal spaces, much like they are in Secondary Care.

Reward and Fairness

Another central theme to the current crisis in morale seen in the profession was identified as the feeling of being devalued by the system, by the media, and by patients. This is compounded by a lack of opportunity to 'set the record straight'. Colleagues noted a deterioration in the doctor-patient relationship, that has so long been held in such high regard. Some highlighted that this break down in relationships had led to verbal or even physical abuse by patients to practice staff. This may lead to a loss of intrinsic motivation to continue in such a complex and challenging vocation. Many felt that a stronger narrative on the pressures and challenges of providing a General Practice service were needed going forward and proactive steps should therefore be taken to repair and maintain a positive doctor-patient relationship.

A central theme to the crisis in morale seen in the profession is that of feeling devalued by the system, by the media, and by patients. This is compounded by a lack of opportunity to set the record straight.

Relaying the message to the public and profession about the true extent of the hours GPs spend in work, and the nature of the hidden workload shown in Figure 8 was felt to be a key role of GP representative bodies such as the British Medical Association. The only way to counter any negative media narrative was to maintain a united, system-wide front, that clearly describes both the pressure the system is under, and that the staff within it are doing their utmost to provide safe, high-quality care. Parity of esteem with Secondary Care colleagues was felt to be much needed in this area. It was highlighted that informative TV

documentaries detailing the daily working life of GPs (such as GPs: Behind Closed Doors[35]) are also likely to be helpful.

Autonomy and Flexible Working

Instilling a sense of autonomy in career trajectory, the pursuit of special interests and overall more flexible working patterns was strongly supported both during training and in the First5 period as a method for preventing burnout. Flexible working options were seen as crucial; both in terms of flexible hours but also flexibility in terms of the variety of work performed by enabling portfolio careers.

This said, participants raised concerns that the reality of modern-day General Practice means that many GPs who are described as working 'less than full time' (LTFT) are still working well in excess of 40-hour weeks. The LTFT label here is therefore misrepresentative and impacts negatively on staff morale. Similarly, there was an agreement that the profession should move away from the term 'sessions' as it is a poorly understood term that does not translate well into the time a GP spends working. Using terms that both the public and the wider profession understand, such as 'shifts', or simply describing hours worked, would be helpful in more fairly and accurately representing the time GPs spend working.

> In order to meet the needs of our patients, our own basic needs must first be met.

When discussing how flexible working can be achieved alongside meeting patient need, participants agreed upon a key underlying principle: in order to meet the needs of our patients, our own basic needs must first be met. An overworked profession not only risks delivering poor care to patients, but will also lead to GPs leaving the profession, further exacerbating this issue. As one participant noted, "a GP that works flexibly is better than no GP at all." Encouraging and supporting portfolio working and special interests may help balance service needs with personal goals and interests as a suitable compromise to sustain a work-life balance.

Education and Learning to Prevent Burnout

As well as addressing the key causes of burnout within the profession, it was also felt that there was an opportunity to provide education for GPs at all career stages on prevention, recognition and management of burnout. It was highlighted that learning from other industries on motivating staff to continue to work in stressful and challenging roles may also support with this. That said, this came with an important caution - acknowledgement that any notion of resilience training was demoralising, incorrectly implying that the issue was within the individual's resilience temperament rather than working in a challenging, and increasingly unworkable, healthcare system.

[35] https://www.channel5.com/show/gps-behind-closed-doors

It was also highlighted that a scheme similar to the Post-CCT fellowships discussed earlier might be useful for mid-career GPs who are at risk of leaving the profession due to burnout. These could act as a useful mechanism for retention by addressing many of the contributing issues that have just been outlined. This may be an effective alternative to the GP Retainer Scheme[36].

Appraisals and Revalidation

Whilst appraisals are often are seen as a negative, participants who had recently qualified saw appraisal as a positive experience and a good opportunity to access mentoring and support from a senior colleague. They described how it provides an open space to discuss the challenges of working as a GP and reflect on past experiences.

However, despite these clear benefits colleagues were unclear as to whether the current system truly meets the aim of satisfying the requirements of Good Medical Practice whilst supporting professional development, with appraisal relying largely on complaints and compliments rather than a review of competence and capabilities. This then leads into a process of revalidation which appears to happen 'automatically' with limited scrutiny. Whilst revalidation was felt to be a necessary measure to ensure accountability, it was felt by some participants that it would be beneficial to analyse and review the work performed by a doctor rather than the current (probably biased) process of 'cherry-picking' patients and colleagues to provide feedback. There was also a concern that appraisal and revalidation has turned into a tick box exercise that did nothing to offer peer support to fellow clinicians.

Colleagues had a number of ideas of additional processes which could form part of the appraisal process to both make it more robust but also to act as a better springboard for professional development. These are shown in Table 2.

Process	Description	Benefits	Risks
Internal Appraisal	A partner in a practice could provide structured feedback on the GP's clinical practice, capabilities and areas for improvement, based on their observations of the work of the GP.	More constructive feedback on areas for development.	Conflicts of interest and bias.
Patient Record Auditing	Review of metrics relating to the performance of the doctor such as referral rates, range of presentations seen or a review of investigations requested.	Provides data to act as a springboard for reflection and subsequent self-development.	Unlikely to be popular with the profession.
Move to FAST Goals.	FAST goals are Frequently-discussed, Ambitious, Specific, and Transparent.	Allows more complex and ambitious goal setting in comparison to the traditional SMART goal model.	Harder to demonstrate completion.

Table 2: Possible additions to appraisal to improve learning outputs

[36] https://www.england.nhs.uk/gp/the-best-place-to-work/retaining-the-current-medical-workforce/retained-doctors/

Continuing Professional Development

Participants highlighted frustration at how time is allocated for continuing professional development (CPD) in General Practice, drawing a stark contrast to the dedicated time for this built into Secondary Care consultant job plans as well as access to study leave and study budgets. This was felt to be much needed in General Practice due to the importance of staying up to date with the rapidly changing evidence base.

One participant talked positively about a peer-review system, where someone locally is sent to experience other ways of working in other locations as a form of both support for colleagues as well as CPD. This person then brings back the learning to help inform and improve local practice. This two-way direction for information transmission helps prevent introspective working and promotes innovation and development. Taking opportunities to be innovative like this may provide new ways of working which will improve the current situation for clinicians and patients alike.

Recommendations

I. Review and reform of the RCA examination, along with other portfolio requirements in the final training year, is urgently needed.

II. A review of what is needed to better support the transition from Trainee to 'First5' with ring-fenced funding to guarantee this support is required.

III. There must be promotion of Post-CCT fellowships more widely and assurance that there are appropriate exit pathways to enable ongoing utilisation of skills developed.

IV. Greater cohesive MDT working is required to help overcome workforce challenges in the medium-term.

V. All healthcare organisations should provide a stronger narrative on the pressures within General Practice, to alert the public to the realities of the challenges it faces.

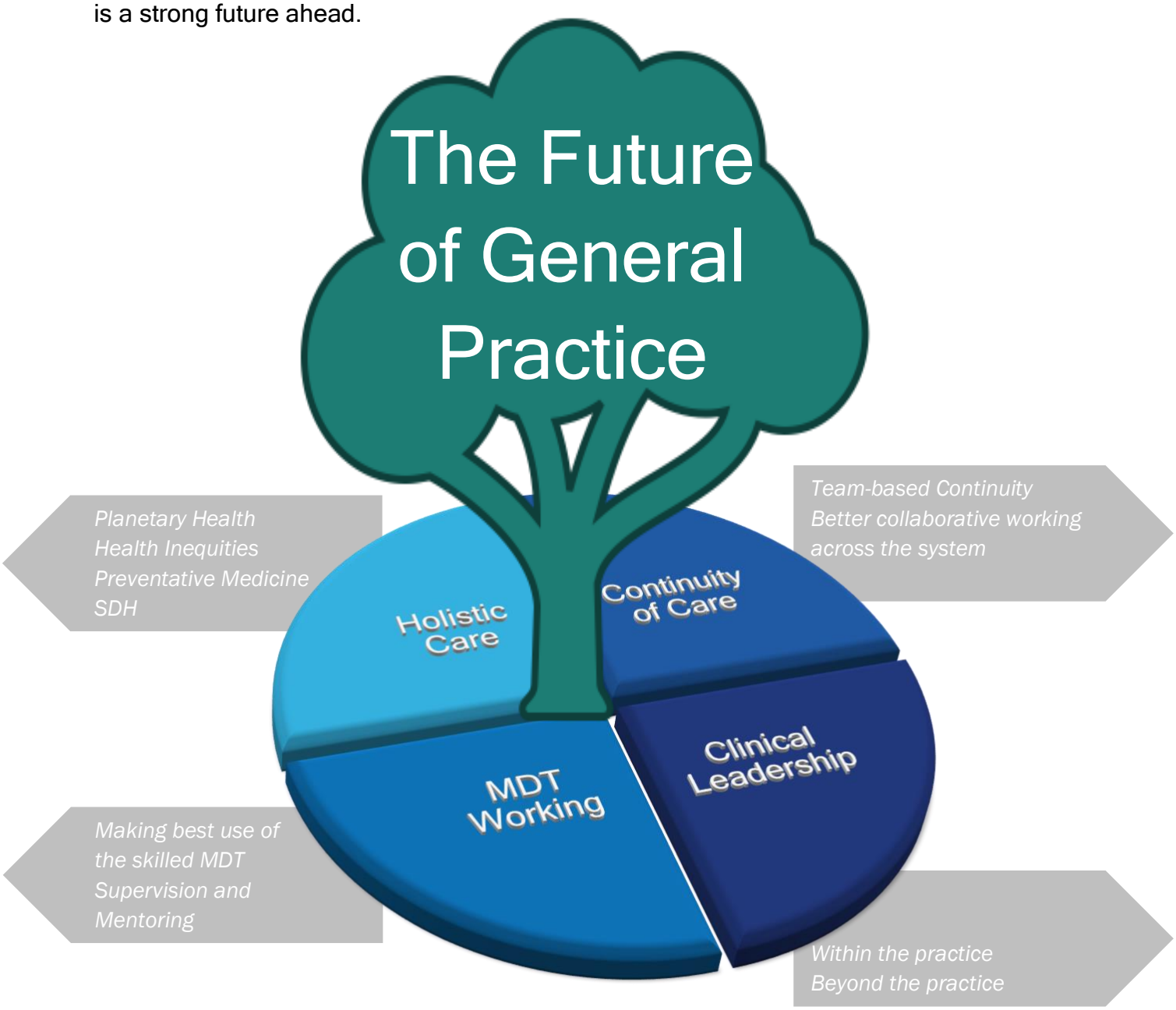
VI. There must be promotion of flexible working and portfolio careers to minimise burnout.

VII. Review of the appraisal process is required in order to ensure it meets the need to keep patients safe as well as being used as a positive and productive tool.

Conclusions

The Four Cornerstones of 21st Century General Practice

Participants in The Big GP Consultation clearly described a future of clinical General Practice built on four key, interconnected cornerstones: Holistic Care, Continuity of Care, Multidisciplinary Working and Effective Clinical Leadership. All of these have been features of General Practice for a long time, to greater or lesser extents. There was optimism that early career GPs could play a meaningful role in refocusing work back to these cornerstones. By moving away from the relentless fire-fighting mode of the last two years and using these as a foundation to rebuild Primary Care our participants are clear that there is a strong future ahead.



Acknowledgements

The Big GP Consultation Team would like to say a massive thank you to all participants for their invaluable contributions to sessions. We know how hard it is to come home from a busy day in practice and then contribute to challenging discussions. This report would not exist without the time and enthusiastic input you gave us.

Similarly, we would like to thank our speakers for giving up their valuable time to support the consultation and their professional insights at each session. Their views no doubt sparked healthy debate in all sessions.

Finally, we'd also like to thank all of the organisations - local, regional and national - who have welcomed the findings of this consultation already, and who are committed to delivering a positive future for General Practice. We know these findings are in safe hands.

The Big GP Consultation Team

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Email: thebiggpconsultation@gmail.com

Website: https://thebiggpconsultation.co.uk/

Twitter: @biggpconsult