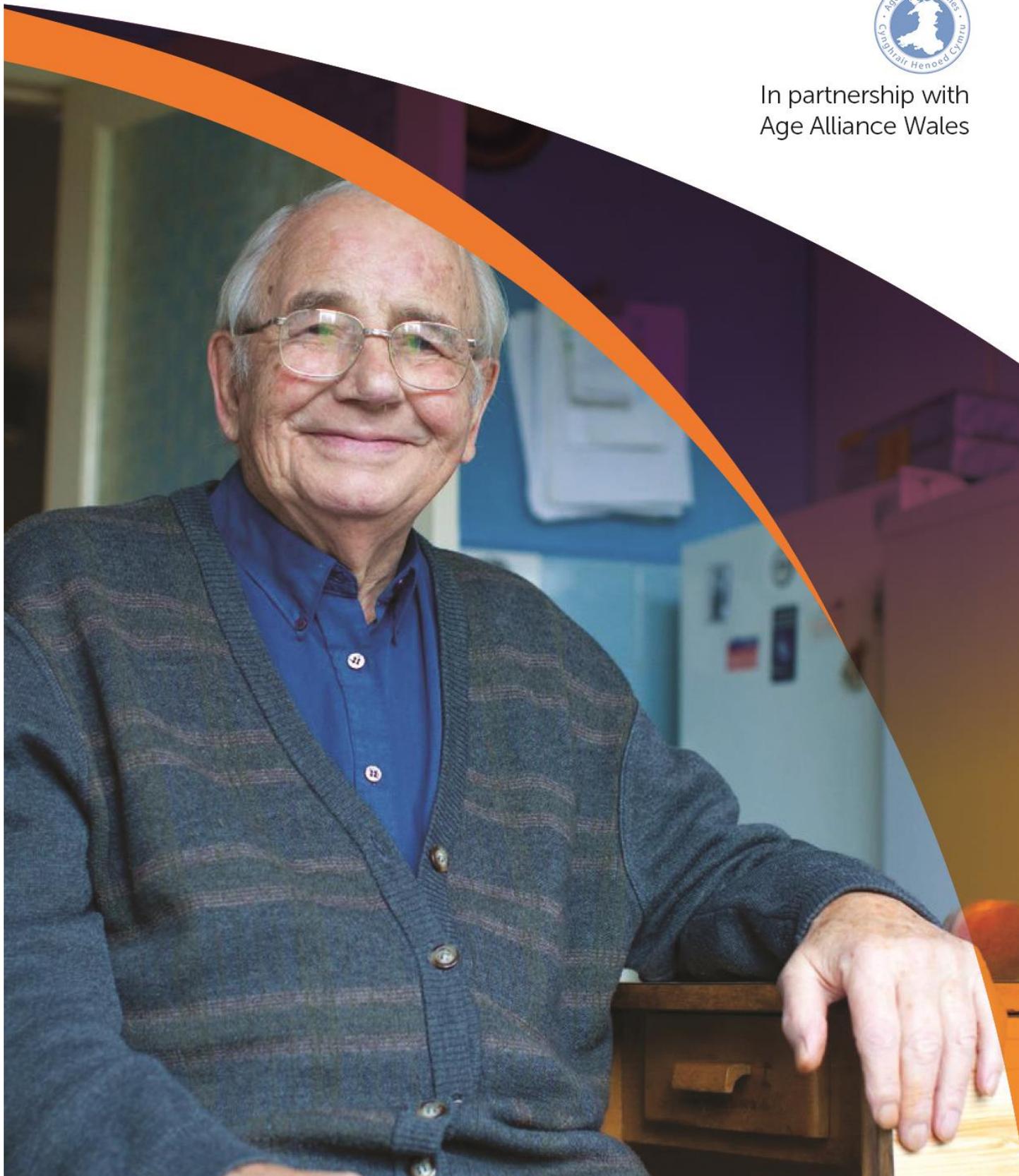


# Access to GP Services by older people

SEFYDLIAD  
**bevan**  
FOUNDATION



In partnership with  
Age Alliance Wales



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General practice is at the heart of good quality healthcare and it is vital that everyone who needs care can access it. The Welsh Government puts primary care at the centre of its new vision for health, with a new primary care model and investment in 'transformation'. Improving access runs through this new vision.

Access is a broad term that covers everything from practice opening times, arrangements for booking appointments, timeliness of an appointment, choice and continuity of care, and arrangements for disabled people. There is a lack of clarity about 'access' in Welsh Government policies.

Good access matters for everyone but is especially important for older people. Older people use GP services more than other age groups, and timely access to a GP of their choice reduces distress, improves health outcomes and helps maintain independence. Older people are less likely to be able to comply with complex appointment booking systems and are more likely to need adjustments because of physical, sensory or cognitive impairments.

There is evidence from several surveys of increasing difficulty accessing GP services. We surveyed more than 300 older people and held six focus groups on older people's experiences. We found a substantial minority of older people had experienced their practice closing or merging, sometimes with little notice and no consultation. The majority reported that making an appointment was difficult, both because of the booking arrangements adopted by practices and because of a shortage of appointments. Some older people opted to see a preferred GP but many felt they had no choice. Many older people disliked signposting, telephone triage and care navigation introduced by some GP practices, citing concerns about the competence of the person asking questions and confidentiality, and others simply struggled to access services.

We were particularly concerned to hear about how some older people were treated by their GP practice, including people being turned away for being late, rigid insistence on telephone booking of appointments for deaf people and those with hearing loss, only one issue being permitted in a consultation, and few adjustments for people with mobility problems, or hearing or visual impairments.

General practice is clearly under pressure. The number of GPs has broadly kept pace with population change but demand for care is growing. The GP workforce is changing rapidly with many more locums and fewer, larger practices. As well as patient demand, GPs experience pressures from bureaucracy, the interface with the rest of the health and social care system, and their own practice organisation.

We recognise the constraints on public funding and the pressures on general practice and on individual GPs. But if the Welsh Government is to achieve its ambitions to transform health and healthcare, it must do so for everyone. We welcome the Welsh Government's recent actions to improve access but feel they could go further to address the specific needs of older and disabled people.

## Increasing capacity

The question of capacity needs to be addressed – we recommend that:

- The Welsh Government's future budgets should allocate real terms increases to primary care.
- The Welsh Government and local health boards should step up their efforts to recruit, retain and train the GP workforce.
- The Welsh Government and health boards reduce the administrative burdens on GPs, using evidence generated from Welsh GP practices as well as that from elsewhere.

## Improving access

**Appointment booking:** We welcome the new access standards; however, they need to be used in conjunction with the All Wales Standards for Communication and Information for People with Sensory Loss. We recommend they be further developed so that:

- GP practices accept appointment requests by several methods e.g. phone, face to face and online.
- Phone systems are introduced with queuing systems so that patients do not need to redial.
- The practice of outdoor queuing be stopped.
- GP practices make adjustments for people's sensory, communication, language and other needs, including making online services compatible with screen-readers.
- Patients including older people themselves are involved in developing the standards and in ensuring practices adhere to them.

**Telephone triage and signposting:** We welcome the Health Minister's recent statements on triage but recommend that standards be further developed to address patient concerns about signposting and triage, including:

- Ensuring call-handlers are appropriately trained, and that patients are aware of and have confidence in their expertise.
- Making arrangements to ensure patient information disclosed to call handlers is confidential and informing patients of those arrangements.
- Ensuring call-handlers can respond sensitively and appropriately to people with difficulties hearing or communicating.
- Increasing patients' understanding of and confidence in the benefits of a multi-disciplinary approach to their healthcare.
- The use of technology.

**Appointments:** We urge the Welsh Government to address some of the concerns about appointments including:

- Asking GP practices to offer appointments of variable length to better reflect patients' needs.
- Ensuring GPs are willing to discuss more than one health issue at a consultation.
- Ending penalties for lateness, particularly for people who have difficulty adhering to tight timescales because of their health or carer responsibilities.

**Continuity and closure:** Changes in the GP workforce are adversely affecting older people. We recommend that:

- Health boards should undertake regular sustainability assessments of practices and intervene early to retain services if possible.
- If a practice merger or closure occurs, Community Health Councils should be actively involved in consideration of alternative arrangements.
- If a practice closure or merger is planned, health boards should ensure patients are informed of the change by letter.

**Disability awareness:** There is much further to go to ensure that GP practices comply with their duties under the Equality Act. We recommend that:

- The new access standards should explicitly address access by disabled people.
- GPs should fully comply with their duties under the Equality Act 2010. This applies to all care services including clinics and all disabilities.
- The new Health and Social Care (Quality and Engagement) (Wales) Bill should be used to underpin accessible health duties.
- GPs should ensure that booking systems for both urgent and routine appointments are available for people with hearing, speech, visual or cognitive disabilities.
- If someone has difficulty communicating, seeing, hearing or understanding staff should respond appropriately and sympathetically.

- Practices should make reasonable adjustments to their systems for patients unable to comply with requirements e.g. re timeliness.

**Patient Voice:** Debate about primary care is dominated by health professionals with limited input by patients in either the design or monitoring of change. We recommend:

- Community Health Councils should always be engaged at the earliest opportunity in changes affecting GP services.
- Community Health Councils (or their successors) should initiate discussion about the changes in the model of primary care.
- Health boards should remind GP practices of the importance of engaging with patients especially when changes are planned and implemented.
- Community Health Councils (or their successors) should have a duty to monitor and report on access to GP services in their area annually.



## 1. INTRODUCTION

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Ensuring fast access to care when it is needed is one of the hallmarks of a high quality system of health care<sup>1</sup>. Evidence clearly supports the significance of primary care on the health of populations, with the supply of GPs being found to improve a wide range of health outcomes.

The question of access is increasingly under the spotlight. There are regular reports of general practices closing their lists to new patients or closing down altogether, and of patients having to ring hundreds of times to get an appointment or wait weeks to be seen.

These challenges have a major impact on people of all ages, but especially affect older people. Older people use GP services more than other age groups, and benefit most from continuity of care because they experience a much higher incidence of long-term conditions. Older people are also more likely than other age groups to have disabilities or impairments that make accessing GP services difficult. They also have established views and expectations, not least as some of them were born before the NHS was introduced.

Recently, Age Alliance Wales has received many accounts from older people of the difficulties they face accessing their GP practice. Older people are still experiencing access problems despite the recommendations made by the Older People's Commission in 2017 about practical steps that should be taken to improve access, and the Welsh Government's commitment to improving access and equity for everyone.

The Bevan Foundation and Age Alliance Wales therefore agreed to work together to understand the challenges in more depth and to develop practical solutions. We have reviewed the evidence on access to GP services in Wales and England, conducted an online and paper survey of older people across Wales, held six focus groups in north and south Wales, and discussed the emerging findings with two groups of stakeholders and at the Age Alliance Wales annual conference.

This report sets out our key findings and recommendations for action. We are grateful to all those people – including GPs, practice nurses, patient representatives and of course older people and their carers themselves – for giving their time to help improve the health of older people. We are also grateful to two professional advisers – both former GPs – who have commented on drafts of this report and shared their expertise.

We hope that their input and that of the Bevan Foundation and Age Alliance Wales will make a difference. The responsibility for the findings and for any errors in the report rests with the Bevan Foundation.

## 2. ACCESS AND OLDER PEOPLE

General practice has been described as the ‘bedrock’ of the NHS in Wales<sup>2</sup>. If access to GPs is so important, it is surely something that everyone should have. That is of course the case. But good access is especially important for older people not only as the group of people most likely to use GP services but also because good access is proven to improve health outcomes. Yet as we shall see, older people are also the group most likely to experience difficulty accessing GP services.

### 2.1 What is access?

Access is a broad term is used to describe several different aspects of a patient’s interaction with their GP. It is important not only in its own right but because of what it enables. As Boyle et al point out: ‘most people would not consider good access to a poor service to constitute “good access”’.<sup>3</sup>

Almost all the different aspects of access are particularly important to older people.

#### Registration with a GP

The first and most fundamental aspect of access is whether a patient can register with a GP. People usually resident in Wales can choose which GP they register with, although the GP does not have to accept a registration. If they refuse they must provide good reasons in writing. GPs can – and sometimes do – close their lists to new registrations on either a temporary or longer-term basis.

#### Contacting the surgery

The second aspect of access concerns the process of contacting a GP practice and requesting an appointment. This covers not only practice opening times but the arrangements adopted by the practice for making an appointment e.g. telephone, face to face or online booking.

#### Timeliness of a consultation

The third aspect of access is timeliness, i.e. whether an appointment can be made within a reasonable time of the request, and the availability of appointments at convenient times of day. The provision of out-of-hours care is also an aspect of timeliness but is not considered here.

#### Choice and continuity

The fourth aspect of access covers patient choice, such as whether a patient has a choice of GP in the practice; whether they can see their preferred GP; or whether they can express a general preference e.g. to see a male or female GP or a GP who speaks Welsh.

## Physical access

Finally, there is physical access, i.e. whether a patient is physically able to attend an appointment at the GP practice. This is affected by the suitability of premises and services for people with physical, sensory and cognitive impairments and the ability of a patient and GP to communicate.

Many of the policy statements about access are not clear which element they refer to. Welsh Government statistics on 'access'<sup>4</sup> cover practice opening times. A statement by the Welsh Health Minister on 'access' mainly addressed arrangements for contacting surgeries.<sup>5</sup> Sometimes access is used to mean being able to see a GP within 24 hours,<sup>6</sup> and sometimes access refers to the additional needs of specific groups of people, including people with physical and learning disabilities.<sup>7</sup> The lack of clarity about the different aspects of 'access' is confusing to policy-makers, health professionals and patients and the public alike, and may well contribute to the challenges of improving 'access'.

### 2.2 Access and older people

General practice is especially important for older people: nearly nine out of ten people aged 75 and over (88 per cent) consulted their GP during 2017-18, as did over eight out of ten people aged 65-74 (83 per cent).<sup>8</sup> In addition, older people consult their GP more often over a year – a study of general practices in England found that people aged over 74 years consulted a GP nearly four more times as often as those aged 5–14 years.<sup>9</sup>

Good access – in terms of timeliness of seeing a GP - matters, both for patients themselves and for the NHS. Prompt diagnosis and treatment or referral help to achieve the best outcomes for a wide range of health problems, while poor access can prolong discomfort or pain and may increase stress at a time when patients are already worried. Timely access also affects the quality of clinical care. Patients who can readily get an appointment with a GP of their choice and who have a say in their care are more likely to comply with treatment and to take responsibility for their care.<sup>10</sup> This is especially important for older people who are much more likely than the population as a whole to have a long-term condition managed by their GP: two-thirds of people aged 65 or older report having at least one long-term condition such as hypertension, diabetes and high cholesterol, while one-third of older people have multiple long-term conditions.<sup>11</sup>

Timely access to a GP can also help older people to maintain their independence. For example routine questions about whether a patient has fallen and if so a referral to a prevention programme can reduce the risk of the distress, pain, injury and loss of confidence associated with falls.<sup>12</sup> Similarly, early diagnosis and treatment of dementia can alleviate symptoms or slow down their progression in some people, enabling them to live in their own homes for longer.

Continuity and choice underpin older people's confidence and trust in GP services. The Older People's Commissioner's survey<sup>13</sup> demonstrated the high value placed by

older people on a good personal relationship with their GP, and a strong preference for being able to see the same GP each time.

Other research shows that older people are more likely than other age groups to trade off the need to be seen against seeing their preferred GP.<sup>14</sup> Not only are older people more likely than other age groups to have a preferred GP,<sup>15</sup> in experiments they were found to be willing to wait longer than any other sub-group of the population to see their choice of GP.<sup>16</sup>

And continuity of primary care has a positive impact on health outcomes,<sup>17</sup> reducing the likelihood of admission to A&E and improving management of long-term conditions such as diabetes. Older people are at increased risk of emergency admissions and are also much more likely to have long-term conditions than other age groups. Hardly surprisingly then, continuity of care has been found to reduce the risk of mortality in older adults.<sup>18</sup>

## **2.3 Conclusion**

Good access to good care is essential for everyone, but it is especially important for older people. They not only use GP services more than others but they benefit from timely and continuous care, with improved health outcomes especially for long-term conditions, fewer hospital admissions, increased ability to live independently and lower mortality. While access is a multi-faceted idea, the case for ensuring that older people, along with everyone else, has good access to primary care is overwhelming. Yet as the rest of this report will show, access for older people is often very difficult.

## 3. POLICY CONTEXT

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The Welsh Government firmly places its approach to general practice within its bigger vision for primary care and the NHS as a whole. There have been no fewer than nine different policy or strategy documents that cover general practice published between 2001 and 2019, all of which have envisaged a significant role for primary care accompanied by a shift in the balance of services away from secondary care.<sup>19</sup>

### 3.1 Current policies on access

Despite the importance of all the different aspects of access to GP services, there have been few statements specifically on it and no strategies or action plans since the target that patients should be able to consult a GP or appropriate healthcare professional within 24 hours was dropped from the General Medical Services contract. The Welsh Government expects GP practices to aim to achieve this target for urgent appointments, and to offer patients the ability to book an appointment up to two weeks in advance for non-urgent appointments.<sup>20</sup>

The Welsh Government's current approach to access dates from the Plan for Primary Care 2015-2018.<sup>21</sup> The plan included a specific commitment to increase 'equity of access', in particular amongst people with physical and learning disabilities, people with sensory loss, people with low health literacy, frail older people and those who do not routinely seek help from the NHS as well as those with language or cultural requirements.

During the life of the Plan, the Welsh Government commissioned a major review of health and social care,<sup>22</sup> and in response published its latest vision document 'A Healthier Wales'.<sup>23</sup> 'A Healthier Wales' sets out a long-term vision of a 'whole system approach' that is focused on health and wellbeing and on preventing illness. The basis of this approach is a new model of health and social care which is intended to be seamless.

As part of this new approach, a new Primary Care Model for Wales has been developed. Details of the model are not easy to find and are sketchily set out in the new 'Strategic Programme for Primary Care'.<sup>24</sup> The model is essentially that care is provided by multi-disciplinary teams rather than a GP alone, with an emphasis on prevention and improving well-being through better lifestyle choices by individuals. Some of the delivery will be by GP practices working in 'clusters', along with other primary care providers.

The Strategic Programme focuses on delivery arrangements and describes a number of work streams. There are no targets, outputs or timelines. The question of improved access cuts across workstreams on 24 hour care, contractor responses to changes in the GMS contract and the role of technology in accessing care.

As part of the delivery of the primary care programme, the Welsh Government announced in March 2019 that it expects all GP practices to meet new access standards within two years.<sup>25</sup> The standards are mainly concerned with the ability to make contact with the GP practice. The aims of the standards are that:

- People receive a prompt response to their contact with a GP practice via telephone.
- Practices have the appropriate telephony systems, avoiding the need to call back multiple times
- People receive bilingual information when contacting a practice.
- People are able to access information on how to get help and advice.
- People can use a range of options to contact their GP practice.
- People are able to email a practice to request a non-urgent consultation or a call back.

In July 2019, the Health Minister announced the allocation of £13 million to help practices to achieve the new standards,<sup>26</sup> of which £9.2 million is for implementation and £3.765 million is for infrastructure needs of practices.

### 3.2 Some challenges

A Healthier Wales and its subsidiary plans and strategies have been generally welcomed by healthcare professions. Despite this, there are some important questions that should be asked about its implications for older people and its delivery on the ground.

First of all, the emphasis on primary care has not been accompanied by a shift in resources. Expenditure on primary healthcare services as a proportion of all Local Health Board gross healthcare service expenditure has remained broadly the same in cash terms but has experienced a real terms cut of around 5 per cent.<sup>27</sup>

It is difficult to see how the development of primary care services can take place without an increase in expenditure. £100m of funding has been allocated to the Transformation Fund over the two financial years 2018-19 and 2019-20, but this is for activities to achieve change rather than investment in core services.

Second, the lack of clarity about what is meant by access already noted is all too evident in the policy documents. Sometimes access appears to mean 'opening hours', while elsewhere it means the ability to contact a practice by phone. Without being clear about what needs to improve it is impossible for the Welsh Government and health boards to drive change.

Third, the new model of general practice is much more than just a change in which health professional a patient consults. It marks a significant change in the relationship between an individual and his or her GP. This is a relationship traditionally based on

trust, confidentiality and continuing, holistic, person-centred and community-based care. In the new model, while patients are registered with a specific GP, the likelihood of seeing him or her is much reduced. Instead care may be directed by a 'care navigator' – often staff who previously had a reception function - and delivered by other healthcare professionals such as practice nurses.

By fragmenting care between health professionals, the new model may well lose what has been described as the 'exceptional potential' of a GP consultation.<sup>28</sup> A consultation offers scope to not only to address the problem the patient presents with and to manage any long-term conditions but also offers opportunities for health promotion and to greater self-care. Much of this potential is lost in a system that lacks continuity of care, with the consultation becoming more transactional. Yet despite the huge change in how GPs engage with patients, there has been very little public or political debate about it.

Last but by no means least, the policies and plans make only very limited reference to patients' views or experiences. It is not clear how patient experiences have informed the proposed changes nor how patients will input into their implementation. As this report was completed, proposals emerged to reform community health councils. Whether or not changes are needed, they will come at a time of considerable reform in primary care – precisely when a strong voice is needed.

### **3.3 Conclusion**

Current Welsh health policies are aimed at the very significant challenge of improving the quality and availability of seamless health and social care services. There is now a clear vision as set out in 'A Healthier Wales'; and ambitious plans for the future.

Access – in all its forms - to primary care is no longer driven by targets but is instead seen as part of the bigger picture of the NHS. However, some vital questions about clarity of purpose, the balance of resources, the wider implications of change for the patient – GP relationship and for patient voice have yet to be considered. Going forward, these questions need to be answered if the vision in 'A Healthier Wales' is to be achieved.

## 4. EXPERIENCES OF OLDER PEOPLE

Older people's experiences of accessing GPs services are varied. In order to find out their views, we conducted an online and paper survey in March and April 2019 for older people and their carers. In total 348 people aged over 60 responded.<sup>29</sup> In addition we held five focus groups with older people in April 2019 – three in south Wales and two in North Wales. We also held a focus group for blind and partially sighted people which included some people under 60 years of age.

This section of the report summarises the results of our survey and focus groups alongside evidence from other sources, in particular the Older People's Commissioner's report of 2017<sup>30</sup> and Welsh Government data from the National Survey for Wales.

It is important to acknowledge the very substantial respect that almost all people who contributed felt for their GP. Many completed the survey because they wanted to explain how much they valued their GP, and some of those who had concerns nevertheless wanted us to know that they appreciated that their GP was under pressure.

However it is also important to understand that some older people are experiencing difficulties accessing GP services, whether for urgent or routine appointments. While the rest of this section considers specific concerns, some older people sensed that these changes were part of a bigger change in their relationship with their GP. A number said they felt they no longer felt they had a GP of their own, while a few said they felt 'abandoned' or 'cut adrift' by the NHS, or that their practice was trying to 'hold back the hordes'.

### 4.1 Registering with a GP

Everyone eligible for NHS care can ask to register with a GP of their choice. GPs can accept or decline the request, and they are also able to close their list of patients to new registrations on either a temporary or permanent basis in certain circumstances,<sup>31</sup> or close their practice completely if they wish. A BBC Wales report estimated that over five years, more than 45,000 patients had been forced to move to a new GP practice as a result of closures.<sup>32</sup>

In our survey, 20 per cent of older people said that their GP practice had changed or moved other than at their request. The change of GP practice brought a change in health care professionals, which many disliked as long-standing relationships were broken.

*I don't know my doctors any longer – I have been seen by several different ones (Female, aged 68)*

*Now a much bigger practice. At the old practice the receptionists knew me. Now it feels quite impersonal (Female, aged 67).*

A number of people said that they felt the change brought a poorer service, such as greater difficulty getting through on the phone and longer waits for appointments.

*Makes it less easy to get an appointment. even when the GP says he wants to see you in 2 weeks. no appointments are available. (Female, aged 69)*

For some, a change in GP practice also increased the distance patients had to travel, creating significant problems for older people travelling to the surgery.

*Access may be a difficulty as I am hemi-plegic post stroke and have no access to private transport (Male, aged 65)*

*Now offered Appointments which require two buses to reach surgery (Female, aged 63, difficulty standing or walking)*

Not all responses were negative – a minority of people said that the change had made no difference and a few welcomed the improved services brought by a change of practice.

*Merger of former [x] Surgery with [y] Health Centre has shown an immediate improvement in services. (Male, aged 71)*

Many older people felt that they had not received enough information about the change, and they felt that advertising the proposed changes in the local newspaper was of limited benefit as older people may not read it. While they understood that GPs retired or moved on, the lack of information was cause for concern particularly if the older person was allocated to a GP that they were unhappy with.

## 4.2 Booking an appointment

The ease – or otherwise – of getting a GP appointment has long attracted headlines and generated public debate. Evidence suggests that it is relatively difficult for a substantial proportion of people to get an appointment and that more people are reporting difficulty than before. According to the National Survey for Wales,<sup>33</sup> 38 per cent of 65-74 year-olds and 37 per cent of people aged 75 and over reported that it was fairly or very difficult to get a GP appointment in 2018/19. This is a slight improvement on the 2017/18, but the overall trend of dissatisfaction remains upwards. While the proportion reporting that booking an appointment is very difficult has increased amongst all age groups, the increase is largest amongst older people.

The Older People's Commission's survey undertaken in 2016 found higher proportions of people reporting difficulty getting an appointment than the National Survey for Wales did in that year, with 24.4 per cent saying it was always hard to get an appointment and 38.6 per cent saying it was sometimes hard. Our survey found a similar proportion

to the Older People's Commission survey saying it was always hard or sometimes hard to get an urgent appointment (39.5 per cent and 25.0 per cent respectively).

People's perception of the ease or otherwise of getting an appointment is very much shaped by the process for contacting the GP practice and whether a convenient appointment was available, either on the same day or within a week.<sup>34</sup>

## Booking systems

Appointment booking systems are a major issue for both patients and health care professionals. There is a plethora of different systems, ranging from online booking, telephone booking or open access surgeries. The BMA noted that:

*No appointment system whether booked, open access or mixed has proven a perfect solution.*<sup>35</sup>

Practices in Wales are free to devise their own appointment systems. This in itself is a source of considerable confusion to patients:

*I don't understand. ... There are four different practices in Mold, and the four of them have different ways of making an appointment.  
(Focus group participant, Connah's Quay)*

There are different views about patients' experience of booking systems. The BMA argues that patients are generally very satisfied with the methods in place.<sup>36</sup> However we found that patients' views are much less positive.

## Telephone booking

In the National Survey of Wales 2018/19, difficulty getting through on the phone was reported by 53 per cent of respondents, with 55 per cent reporting that they needed to make an early morning call to do so.<sup>37</sup> The proportion reporting difficulty with phone bookings has increased markedly since 2012/13 when 36 per cent reported difficulty getting through and 44 per cent said an early morning call was needed. A recent Welsh Government qualitative survey also found that difficulties with telephone appointments were a top concern.<sup>38</sup>

Older people are no less likely to report difficulties contacting GP practices by phone than other age groups although the National Survey of Wales data are not very reliable. The Older People's Commission found that some patients needed to redial their practice some 200 times over a period of 45 minutes, only to find that all appointments had been booked and they needed to call again the next day. Similar experiences were reported by many older people in our survey and in focus groups.

*The problem I have is you have to phone at 8.15 in the morning.  
There are no available pre-bookable appointments at all, so whether*

*you're an emergency or not you're on the quarter past eight phone-in system, and you can be phoning 20, 30 times just to get through, or more, and when you get through ... they've got rid of all their appointments that day, 'cos of the time you've been held. (Focus group participant, Betsi Cadwaladr Health Board)*

*I've seen me phoning the surgery, right, at five to eight, and I haven't got through until about nine o'clock. It's ridiculous. (Focus group participant, Cwm Taf Morgannwg University Health Board)*

*My surgery has no service on Thurs and I have to phone the next morning, listen to the info telling me what services are not available TWICE and then be told there are no appointments available - this is less than five minutes after the place is supposed to be open. (Male, aged 72)*

For patients who are unable to make a telephone appointment when they rang, the majority in our survey simply kept on trying until they were successful. For some people the process was stressful.

*It is a very stressful situation trying to get through on the telephones as they are always engaged. The emergency [appointments] for the day are usually gone and then you repeat the following day and then the following day and the one after and the one after that. Having had cancer it is very stressful not being able to see or speak to a doctor. (Female, aged 62)*

Telephone booking can be very difficult for older people with impairments. The Older People's Commissioner found that older people may lack phones with redial capability, may have difficulty holding the phone for a protracted period or may have difficulty speaking to practice staff e.g. because of hearing or speech impairment. One survey of people with hearing loss found that 29 per cent had to ask someone else to make an appointment by phone on their behalf and 36 per cent had to travel to the GP practice to do so.<sup>39</sup>

Older people in our survey reported a range of problems due to an impairment.

*For urgent [appointment] or nurses' clinic, you have to phone or call in. As a deaf person I consider this to be a second-rate service. (Female, aged 67)*

*I am deaf and have mobility problems. Have to walk to surgery to ask for appointment. Present GP arranged this, however some receptionists refuse and send me home to phone - impossible for me. (Female, aged 82)*

*My 88 year old mother-in-law can't cope with the telephone system,*

*choosing options and waiting ages to speak to someone...and then can't hear them!! (Female, aged 65)*

Requiring people to ring at fixed times can also be problematic for older people. For example, people with Parkinson's disease can find getting ready to ring early in the morning impossible. One focus group participant described access for older people in sheltered housing:

*It's not acceptable for people with chronic pain ... we have people who hardly sleep at night with pain, so when they are asleep they don't want to have to get up at 8 o'clock (Focus group participant, Connah's Quay)*

### *Walk-in appointments*

Some surgeries operate open access or walk-in appointment systems, in which a patient presents in person and then waits. While some patients felt this system at least offered a guarantee of being seen, many others found it extremely difficult. We heard of a number of practices where patients queue from 7.30 am. This is how one survey respondent described the process.

*This is what happens if you need a doctor. You wake up feeling really ill ... it's pouring and blowing a gale, you have to drag yourself up the hill to the bus stop to get to the surgery by 7.30 am to ensure you see a doctor. You queue outside with about 10 in front of you until the receptionist opens the door at 8 am. You queue again, by this time your back and legs [are ] in so much pain you can hardly stand, to be told, your appointment is in hour and half to two hours, do you want to go away and come back or sit and wait. Go out in that weather, no, you opt for the latter. Your backside is numb, there's people coughing and sneezing, you'll probably go home with something different to what you needed to see the doctor about. And so it all begins again. (Female, aged 72)*

*I think the trick is getting there early, innit, and then you've got to get there about half past seven so that you're in the front of the queue. (Focus group participant, Cwm Taf Morgannwg)*

Queuing systems are especially difficult for older people. Being asked to wait, sometimes outside in the rain, is unpleasant for anyone. It is especially problematic for people who may find standing for a long period painful, or be unwell. In addition, we heard of older people who found it difficult to get to a GP's early in the morning, for example if they take time to get ready, rely on carers to get them up and out or need to access early morning public transport. One focus group participant said that she was unable to stand in a queue and instead had to rely on friends or family to queue to make appointments for her, and then bring her to the surgery.

### Online booking

Online booking is an alternative to telephone or personal calls, and a number of older people in our survey and focus groups either used it already or urged that greater use be made of it. However, online booking requires the patient to have online access and digital skills, which older people being the least likely of all age groups to have. Appointments made online do not always allow booking of urgent appointments or a choice of GP.

*Online booking could be brilliant but it's very restricted. You can book a non urgent appointment online (but even that depends on them putting up all the availability regularly). (Female, aged 67)*

People with visual impairments pointed out that many online booking systems used in Wales do not work with screen readers, so cannot be used by blind or partially-sighted people.

### Booking rules

In addition to the sheer difficulty of making an appointment, older people were perplexed and frustrated at the perceived rigidity of appointment systems. Several accepted only one method of booking, such as by phone or in person. We heard about a surgery which would not allow an appointment to be booked in person, requesting that the patient leave the premises and ring instead. We were told about several practices refusing to see patients who were more than a few minutes late for an appointment. Older people with conditions that make compliance with strict deadlines difficult are at particular risk of being turned away from surgeries with these rules. Representatives from the Parkinson's Society and Alzheimer's Cymru both said that they knew of people missing appointments for these reasons. The Alzheimer's Society also found that people with dementia can struggle to remember to attend appointments, so risking non-attendance.<sup>40</sup> One person told us:

*My surgery, if you go for an appointment, if you're five minutes late you don't get the appointment. They won't let you see the doctor. (Focus group respondent, Connah's Quay)*

We also heard of several practices which have automated check-in systems. Not all older people know how to use these and the system is unlikely to be suitable for people with visual or cognitive impairments.

*The practice reception is mostly boarded up with a sign telling you to use a machine to book in. It feels very unfriendly. (Female, aged 61)*

### Convenience

Older people are less likely to report that it is difficult to get a convenient appointment than other age groups – 24 per cent of people aged 65-74 and 18 per cent of people aged 75 and over said this in the National Survey for Wales 2016/17. In focus groups, most people did not raise concerns about the timing of appointments – indeed, most were grateful to have an appointment at all.

Nevertheless, convenience can be a problem for people who are dependent on a carer to take them to the appointment or have an infrequent bus service and so can only attend on a specific day of the week or at a specific time. One man in a focus group found it easiest to attend appointments on Mondays, so had to ring each Monday until he eventually got one – a process which could take several weeks. A survey respondent told us:

*I care for a parent with Alzheimer's. Getting appointments for them is very difficult. Having to call repeatedly at 8.30 and, if successful, there is no flexibility in appointment times so it's a huge rush to get them organised which causes them anxiety and distress. (Female, aged 63)*

### Continuity and choice

Continuity and choice are vitally important to older people. Research by the Welsh Government<sup>41</sup> and by the Older People's Commissioner have found that continuity of care matters. In our focus groups older people reported that they preferred to see the same GP to reduce the time spent summarising their condition, or because they felt that GP had a specific interest in their condition e.g. diabetes or understood their disabilities.

*I have been waiting longer than three weeks to see a specific doctor ... you don't want to go over old ground and explain your situation over and over. (Focus group participant, Colwyn Bay)*

*I can't just go to any doctor. I have one doctor that understands my condition ... but it's really difficult to get an appointment with him. You can wait up to 3 or 4 weeks sometimes (Focus group participant, visually impaired people)*

Many older people were very unsettled by changes in the GP workforce. Some reported that they were surprised to discover that their GP had retired when they a follow-up appointment. Others felt that they no longer had a GP but were instead seen by a succession of locums.

*Well, you get used to one person and all of a sudden they're not there (Focus group respondent, Cwm Taf Morgannwg)*

*All the GPs that worked at the old surgery seem to have left ... you [can] never get to choose which one you [are] seen by so there's no*

*development of a rapport or relationship. (Female, aged 62)*

*My practice changed to locum doctors a few years ago and the lack of continuity I find disturbing as the patient's history is not known. (Female, aged 64)*

### *Timeliness*

A great deal of Welsh Government policy has focused on the timeliness of getting an appointment, not least because it enables prompt diagnosis and treatment, and reduces the length of time a patient may spend worrying or in pain. However, research shows that patients' views and needs are more complex and that same-day access is not necessarily the right option for all people in all circumstances.

In the National Survey for Wales 2018/19, people of all ages said that the length of time waiting for an appointment was one of the main difficulties experienced, reported by 55 per cent of respondents. Older people were slightly more likely to say that a long wait was a problem than other age groups although the data are not very reliable.

The Older People's Commissioner's survey of people's experience of access also found many respondents reporting long delays for non-urgent appointments, with some respondents quoting waiting times of six or even ten` weeks. Our survey showed similar experiences. We also asked what patients did if they were unable to make an appointment. Of those who had been unable to make an appointment, around a third decided to wait until one was available, sometimes several weeks. For some, a protracted waiting time was very worrying.

*I have been asked to wait five and a half weeks to see a particular doctor. It threw me into a panic. I felt, for the first time, adrift from the health service. If you live alone as I do, that can be stressful, creating anxiety out of an already worrying situation. (Female aged 68)*

Some older people chose to wait in order to see the doctor of their choice.

*I always wait to see the same Doctor, unless they are on holiday. (Female, aged 76)*

*I needed to have an appointment with a specific doctor that gave me injections in my knee that enabled me to walk easier, it took me 3 months to get one. (Female, aged 72)*

*Apart from being able to make a fairly quick appointment, I would prefer to see a GP known to me. (Female, aged 64)*

However we found that many older people were resigned to seeing whoever was available on the day. They commented:

*You feel jolly lucky you've got an appointment, never mind your choice  
(Focus group participant, Colwyn Bay)*

*You take it or leave it. Well, they've told us 'you can't choose your GP'  
(Focus group participant, Maerdy)*

Most people in focus groups felt that they had no opportunity to see a GP of a specific sex or who spoke Welsh.

### 4.3 Triage, signposting and care navigation

A growing number of GP practices are introducing some form of signposting or triage service when appointments are booked. There are various different systems, but the aim of all of them is to direct patients to the most appropriate care, which may not be a GP appointment, and in so doing help to reduce demand.<sup>42</sup>

A Welsh Government survey found 'mostly positive' responses to the approach, although it noted that a small number of older people 'instantly disliked the ... model and did not want to deal by phone with an individual they did not know'.<sup>43</sup>

Other research is less positive. In 2017, 35 out of 72 practices in the Abertawe Bro Morgannwg area were found to have some form of signposting or triage in place, but that 55 per cent of respondents were unhappy with providing information to a call handler or receptionist, either as a matter of principle or because too much information was requested.<sup>44</sup> HIW reported that 'patients were generally not happy with signposting systems, particularly when they involved reception staff asking questions during appointment booking conversations'.<sup>45</sup> In our survey, a substantial minority of older people in the survey – 36 per cent - said that they were not usually happy to answer questions when they attempted to book an appointment.

There are two key concerns about triage or sign-posting systems. First is a lack of confidence in the call-handler's ability to understand health conditions and decide who should or should not see a GP.

*I don't feel they have the info to make a decision on my health and only want to talk to the doctor or nurse (Female, aged 84)*

*Sometimes questions can be intrusive. Receptionists do not have the training/knowledge to make judgements on the seriousness / importance of a request. (Male, aged 72)*

*I also feel that some things should be only discussed with a doctor and the reception staff don't know enough to be able to prioritise.  
(Female, aged 68)*

Older people also had significant concerns about privacy and confidentiality:

*I don't want to discuss my health problems or issues in front of other patients who are waiting in a queue (Female, aged 71)*

*Nobody likes to talk to reception on why they need an appointment. Other people can hear what you are saying. (Female, aged 65)*

Some older people were happy to reveal the reason they wanted an appointment because they felt it was the best way to ensure they were seen.

*I am usually happy to answer questions to keep on the staff's good side (Male, 82)*

People were most comfortable if they perceived the questioner to be appropriately experienced or qualified.

*Our receptionists have been there years and years and years, and they do know a lot more than what people give them credit for, you know? They are quite capable of sorting. It's the new ones who come who don't know it, you know? ... The older ones have done it for that long they know what they're doing (Focus group participant, Colwyn Bay)*

*I'm usually happy to answer non-medical / receptionist questions - Trust all employed at GP staff would be treating my request with confidence. (Male, aged 75)*

Others said they were happy to explain their reasons if they were offered privacy to do so – we heard that some practices are arranged to provide privacy, but others were not.

*The receptionist quizzes you, which I don't find right. I usually ask to go into the small room if I want to say what my condition is. (Focus group participant, Cardiff)*

One of the purposes of questioning patients is to route them to the most appropriate health care professional. However sometimes patients who were unable to get a GP appointment ended up in A&E, the GP out of hours service or by requesting a home visit.

*Had to go to the hospital instead (A&E) as could not see a GP on the same day (Male, aged 82)*

*My sudden-onset double vision was not considered by the receptionist to be urgent. I ended up having to go to A&E (Female, aged 72)*

Views about other healthcare professionals such as practice nurses, varied. Some were very positive but others clearly disliked some individuals:

*Nurse practitioners are a blessing (Male, aged 80)*

*Honest to God. I can't stand [the practice nurse]! (Focus group, location withheld)*

We also heard some reports about people who ended up seeing their GP despite being referred to other health care professionals, in particular because nurses or pharmacists could not prescribe, and of a small number of older people who had avoided contacting their GP about a matter of concern because they did not want to reveal their condition to the receptionist.

#### **4.4 Appointment duration and restrictions**

Some older people in the focus groups and online felt that ten-minute consultations were not enough, and many raised concerns that their practice would only permit discussion of one ailment per appointment.

*[I would like] having a little longer to speak to the doctor. Conscious that they only have 10 minutes per patient and don't like you bringing more than one issue to the appointment. (Female, aged 70)*

*A ten minute appointment can be inadequate. Seeing different GPs is a concern and raises doubts in the patient that issues are fully understood. (Male, aged 72)*

We understand that this limitation is no longer permitted within Welsh general practice, but nevertheless many older people either experienced the rule being applied or believed it to be in place.

#### **4.5 Access in premises for people with disabilities**

Access not only means being able to make an appointment but also being able to attend once it has been made. A patient needs to be able to get into a GP's premises, move around and be able to hear what practice staff say and read essential signs.

Despite the importance of accessibility, there is very limited evidence. The evidence that does exist suggests that older people with additional needs can experience significant problems. Healthcare Inspectorate Wales' 2016-17 report of inspections concluded found that 'practices could still do more to accommodate patients with additional needs'.<sup>46</sup>

In terms of mobility, the Older People's Commissioner noted that many older practice buildings have poor accessibility. Seven per cent of people responding to their survey said it was not easy to get in to or move around their GPs premises, typically because

of a lack of ramps or handrails. Almost a quarter (24 per cent) said they found the waiting room uncomfortable, for example because of inappropriate seating, while over 15 per cent found the consultation room environment was uncomfortable.

In our survey, a slightly smaller proportion of people reported that access was difficult for people with mobility impairments (4.6 per cent), and 3.4 per cent reported that the toilet was difficult to use. Even if practices have good physical access, some respondents said that their surgery did not offer nearby parking for people with mobility difficulties. Poor physical access had an impact on people's health, with some respondents reporting that they no longer received care because of access problems.



*[There should be] level access to at least one nurse's room. I have given up going for breathing monitoring tests because the relevant nurse's room is ONLY upstairs. (Female, aged 79)*

People with hearing loss report that it can be very difficult to access their GP. Healthcare Inspectorate Wales' inspection of general practice found that while most – but not all - practices had a hearing loop system, in some the system was either not working, was not portable (so whilst it was available for patients in the reception area, it was not available in consultation rooms) or not all staff were aware of how to use it.<sup>47</sup> Older people interviewed by the Older People's Commission reported similar problems using a hearing loop, and also found that high noise levels or poor acoustics can prevent older people from communicating well with staff, as well as specific problems such as GPs not facing patients or speaking clearly. Action on Hearing Loss found similar problems with the availability of hearing loops with one in five of

respondents to its survey said a hearing loop system was not available at their GP surgery. Only four per cent were asked if they needed support.<sup>48</sup>

In our survey by far the most commonly-reported problem was hearing one's name being called, with just over half (51.4 per cent) saying that this was easy and one in six (16.9 per cent) saying it was difficult. Several respondents mentioned that piped music in the waiting area made hearing what was said even more difficult. A slightly smaller proportion said that they had difficulty hearing or understanding the GP or receptionist (60.9 per cent said it was easy, 7.8 per cent said difficult).

Being unable to hear affects health outcomes. The evidence review by Smith<sup>49</sup> found that more than a third of people with hearing impairments were unclear about their condition because of communications difficulties, while Action on Hearing Loss found that more than half of respondents left the practice unsure of their diagnosis or how to take medication.<sup>50</sup>

For people with visual impairments, research has found that appointment letters are sometimes received in formats they are unable to read, resulting in missed appointments, and nearly three-quarters of visually impaired people could not read the personal health information that was given to them by GPs.<sup>51</sup> Healthcare Inspectorate Wales has noted that some practices have notices in Braille, but found that the majority could do more for visually impaired patients.<sup>52</sup> A minority of respondents to our survey reported difficulty reading signs (3.4 per cent) including visual displays used to call patients.

A number of people reported that practice staff were not very helpful to visually-impaired people, or else over-reacted when they realise that the patient is blind or partially-sighted.

*They don't come out [from behind the desk) and help me, and I've asked. I go through [the door to find the surgery] and it's like a maze. (Focus group respondent, visually impaired group)*

*The amount of people who still get all flappy when they realise you have a cane or something. They just go to bits (Focus group respondent, visually impaired group)*

There is very limited evidence on access to GP services for people with cognitive impairments. The Older People's Commission similarly found that people living with dementia and other cognitive impairments experienced difficulty contacting their general practice, when attending for an appointment and in communicating with their GP and practice staff. People with learning disabilities or memory impairments can have difficulty in expressing their concerns in the short time available with the GP, and in recalling discussions about their care. They also often find that they do not receive information on support available or reviews of their care as needs change.

## 4.6 Conclusions

Older people are experiencing increasing difficulty with practice closures and mergers, with booking convenient appointments with a GP of their choice, and with participating in a consultation. While people of all ages face challenges accessing GP care in a system under pressure, some systems seem designed to be particularly difficult for older people or disabled people. At best, it is frustrating and time-consuming, while at worst health problems are not being addressed in a timely way and possibly not at all. Disabled older people in particular risk their health care needs not being met. And while some demand may be managed by new systems of signposting to other professionals, it is occasionally diverted to emergency services.

## 5. THE CHALLENGES IN GENERAL PRACTICE

At its most basic, having access to GP services depends on having sufficient general practitioners in practices located near patients and with appropriate hours available for consultation. This section looks at the current position in the supply of GPs and their practices, and practice opening times.

### 5.1 Number of GPs

There have been some striking changes in the GP workforce in the last ten years.<sup>53</sup> The number of GPs and registrars has increased slightly in the last ten years, to a total of 1,964 GP practitioners and 230 GP registrars in 2018. However, the number of locums has increased markedly since they were first counted in 2015, up 144 in just three years. Locums now account for nearly three out of ten of the total GP workforce.

The increase in the GP practitioner and registrar workforce has broadly mirrored the increase in the population of Wales between 2009 and 2017-18. On average there are 6.3 GPs per 10,000 population. Powys has a slightly above average number at 7.7 GPs per 10,000 people whilst Hywel Dda health board area has the fewest at 5.8 GPs per 10,000.<sup>54</sup> Unfortunately the headcount of GPs does not indicate their capacity for consultations, not least as the breakdown between full-time and part-time posts is not known. This makes assessing the adequacy of current GP workforce very difficult, as well as affecting future planning.

### 5.2 Number of GP practices

There are also changes occurring in the organisation of general practice which affect patients. The number of GP partnerships has fallen from 483 in 2011 to 410 in 2018.<sup>55</sup> The largest decreases have occurred in Aneurin Bevan and Cwm Taf Health Boards, where more than one in ten practices has disappeared. As independent contractors, GPs are at liberty to retire or return their contracts when they wish.

At the same time there have been changes in the size of practices. The number of multi-practitioner practices has increased sharply: between 2011 and 2018 the number of practices with 6 or more partners grew from 118 to 153. With the rise of multi-partner practices has come a decrease in small practices, down from 303 in 2011 to 215 in 2018, and in singled-handed practices, down by nine to 52 practices in 2018. Nevertheless, one in six practices has only one GP.

The decrease in the number of practices has a mixed impact on patients. On the one hand, the BMA claim that changes to practices have forced more than 46,000 people in Wales to move GP.<sup>56</sup> A practice closure can mean patients lose continuity of care and familiarity with the practice and its staff, at which some older people may have been patients for decades. The process of change may be very unsettling for

those with multiple or complex care needs, or for disabled people or people with a cognitive impairment who have learned how to manage access to a particular environment. In addition, a new practice may be some distance away from their former practice. Getting there may involve a longer journey, taking extra time possibly with accessibility issues, or involve additional expense e.g. a longer taxi ride.

On the other hand, some policy makers are concerned about the quality of small or single-handed practices. There is conflicting evidence on the ability of small practices to deliver high-quality care.<sup>57</sup> Some research evidence shows a relationship between size and quality, with larger practices generally offering higher quality care and a wider range of services. However the relationship is not causal, and small practices do not necessarily offer poorer quality care.<sup>58</sup> Crucially for older people, for whom continuity is extremely important, larger practices are also associated with offering less continuity of care than medium-sized and small practices.<sup>59</sup>

### **5.3 Increasing patient demand**

Demand for GP services is increasing. Although Wales' population growth is relatively modest, the population aged 65 and over has increased rapidly, up by 76,880 between 2011 and 2017.<sup>60</sup> Older people are more likely than younger people to consult their GP in a twelve month period, with 88 per cent of over-85 year olds doing so in 2017/18 compared with 71 per cent of 25-44 year olds. At the same time, long-term conditions are becoming more prevalent and more complex. Two-thirds of people aged 65 and over report having at least one long-term condition such as hypertension, diabetes and high cholesterol, while one-third of older people have multiple conditions.<sup>61</sup>

These population changes are reflected in demand for GP services. There are no figures for Wales but evidence in England shows that the number of times a patient consults a GP has increased and the duration of a consultation has also grown.<sup>62</sup> By 2014/15 the Kings Fund estimated that each registered patient consulted their GP 4.91 times a year and that a typical consultation lasted 11.7 minutes.<sup>63</sup>

The combination of the increased number and duration of consultations has substantially increased the GP clinical workload. There is no data on GP consultations in Wales but it is estimated that in England GPs' clinical workload increased by 16 per cent between 2007-8 and 2013-14.<sup>64</sup> Looking ahead, the Nuffield Trust estimate that the number of GP consultations will increase by 17 per cent in Wales by 2025/26.<sup>65</sup>

On top of the increase in numbers, consultations have increased in complexity, not least as some patients with more straightforward needs are cared for by other health care professionals. GPs therefore see patients with multiple long-term conditions, some of which may be raised in a single consultation. One study cited by the Kings Fund found that an average consultation included discussion of 2.5 different problems across a wide range of disease areas in less than 12 minutes, with each additional

problem being discussed in just two minutes.<sup>66</sup> The result is an intense working day for GPs.

## 5.4 System pressures

As well as patient demand, general practice is under pressure from changes in health care services, pressures from other parts of the NHS such as secondary care, as well as external demands e.g. for fit notes.<sup>67</sup>

A ground-breaking analysis of how GP practices use their time found that 18 per cent of all GP appointments could have been avoided if the practice had been organised differently.<sup>68</sup> By far the main reason was that the patient would have been better served by being directed elsewhere in primary care – often within the practice. Other reasons for avoidable appointments were to inform a patient of normal test results or because no care plan for the patient had been established.<sup>69</sup>

Other parts of the NHS also generate pressure on GPs and take up consultation time. Referrals and re-referrals to secondary care, sending ‘expedite letters’ and chasing test results together account for 4.5 per cent of avoidable appointments.<sup>70</sup> Liaison with mental health and social care services have also been identified as taking valuable GP time.

Additional pressures on general practice include keeping up to date with new medicines or guidelines, and managing external demands such as providing ‘fit notes’ to writing reports for insurance claims.

GPs themselves feel under intense pressure. The Royal College of GPs reports that 31 per cent of its members in Wales say that at least once a week, they are so stressed they feel they cannot cope.<sup>71</sup> The BMA found that 74.8 per cent of Welsh GPs felt that workload pressures had negatively affected the health of their staff<sup>72</sup> and that 81.4 per cent felt that workload pressures had had an adverse impact on the quality of services for patients.<sup>73</sup>

## 5.5 Conclusion

The total number of GPs is static and there are changes within the GP workforce and within practices which will inevitably have an effect on patients: locums are around a third of the GP workforce, the number of practices is falling, and barely half of Wales’ practices are open 08:00 to 18:30 without a lunch break. This, combined with rising demand from patients with long-term and increasingly complex conditions, puts pressure on GPs and patients alike.

However the solutions are not simply to increase GP numbers – even if that could be achieved. Bureaucracy, pressures from other parts of the health and social care system, and the organisation of general practice itself are all factors which contribute to pressure.

## 6. SOLUTIONS

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The challenges facing general practice have been the subject of numerous recommendations over many years, although most are addressed to the NHS in England rather than in Wales. We have drawn on some of these findings, along with suggestions made by stakeholders in two focus groups and older people themselves, to set out recommendations for action by the Welsh Government, health boards and GPs themselves.

The recommendations fall into four broad areas: first, increasing capacity in order to match the growing demand for primary care both from changes in the population and shifts in government policy; second, improving access for older people and specifically addressing issues in the appointment booking system; and third, strengthening patient voice.

### 6.1 Increasing capacity

The question of expenditure on the NHS and on primary care generally, the challenges facing the GP workforce and the role of other pressures on GP time are major issues that many organisations have been struggling with for a number of years. However without some increase in capacity it is hard to see how the needs by older people for health care at their GP practice will be met.

Ironically it is difficult to assess and forecast either current capacity or future requirements. Good quality data on the GP workforce itself<sup>74</sup> and information on the number of consultations held are a prerequisite for forward planning. And while several reports have shown that it is possible to increase capacity through changes to internal and external processes, e.g. reducing bureaucracy and improving the primary and secondary care interface, questions of funding must remain.<sup>75</sup>

### Funding

In 2017-18, Welsh health boards spent £405 million on general medical services, some 6.2 per cent of health board expenditure that year.<sup>76</sup> Expenditure on primary care has fallen by 5 per cent in real terms since 2010-11, at the same time as spending on other parts of the NHS has increased.<sup>77</sup> Funding provided to health boards for general medical services is ring-fenced, with health boards typically spending more than their allocation. This suggests that the solution lies in an uplift in the Welsh Government's annual allocation of funds to general medical services and in health boards utilising that increase for primary care.

Both the BMA and RCGP have recommended that the funding allocated to general medical services increases to between 10.3 per cent and 11.0 per cent of health board expenditure respectively. This is some £268 million extra to be earmarked for primary care. Increasing spending when there are severe pressures on public finances is clearly difficult, and with limited data on requirements it is impossible to assess whether the figures proposed are realistic. Nevertheless, continued real-terms cuts in primary care expenditure at a time of rising demand is clearly not conducive to improving access, and **we therefore recommend that the Welsh Government's 2020-21 budget and future budgets allocate real terms increases to primary care.**

## Workforce

It is clear that the GP workforce is stretched. However, with limited data on the capacity of the GP workforce it is difficult to measure the scale of the problem nor the solutions required. Many different organisations are actively involved in addressing workforce issues. The solutions are generally agreed to involve increasing both the current and future capacity of GPs including:

- Increasing the retention of GPs already in the workforce
- Increasing recruitment to vacant GP positions
- Increasing the number of trainee GPs.

The Welsh Government's latest plan for primary care recognises workforce issues and continues to aim for a sustainable GP workforce, through the measures above. It is clear that improving access to GP services depends partly – but not entirely – on it succeeding. **We therefore recommend that the Welsh Government and local health boards step up their efforts to recruit, retain and train the GP workforce.**

## Reducing bureaucracy

In the discussions about capacity there has been relatively little consideration given to the role of administrative demands on GPs. In England bureaucracy has been identified as an important factor in pressure on practices, and the recommendations for action there<sup>78</sup> could be usefully used as the basis for reducing administrative burdens in Wales. **We therefore recommend that the Welsh Government and health boards reduce the administrative burdens on GPs, using evidence generated from Welsh GP practices as well as that from elsewhere.**

## 6.2 Improving access

Many of the challenges faced by older people accessing the health care they need owe as much to the systems adopted by GP practices as they do to lack of capacity. We welcome the recent Welsh Government initiatives to better understand patients' experiences, the new access standards and the allocation of funding to improve access. However we think there is scope to go further: there is no place in modern primary care for patients with mobility difficulties queueing at the practice door at 7.30 am for an appointment, for older people making 200 early morning calls to speak to a receptionist, or a patient with dementia being turned away for being five minutes late.

### Appointment booking

Making an appointment is a time-consuming and frustrating task. For older people with disabilities, the obstacles can be insurmountable. GP practices have been free to choose their own systems, resulting in many different approaches to appointment booking even within single localities. These variations have little to do with patient need but are driven instead by individual preferences, custom and practice.

We welcome the new standards on access announced by the Welsh Government, but believe they should be used in conjunction with the All Wales Standards for Communication and Information for people with Sensory Loss. Furthermore, we recommend that they go much further. The Welsh Government and health boards should encourage practices to consider their whole approach to booking appointments. This goes much further than investing in new phone systems. Patients have many and varied different needs and their ability to comply with systems varies. There are valuable lessons to be learned from practices adopting 'person-centred' appointment systems:<sup>79</sup> adopting a more flexible and personalised approach, rather than expecting one-size to fit everyone, would ensure that the needs of all patients are met.

**We therefore recommend that the access standards be further developed so that:**

- **GP practices accept appointment requests by several methods e.g. phone, text, face to face, online, and face to face.**
- **Phone systems are introduced with queuing system so that patients do not need to redial.**
- **The practice of outdoor queuing be stopped.**
- **GP practices recognise and respond to people's sensory, communication, language and other needs.**
- **Online access is improved and is compatible with screen-readers for visually impaired people.**
- **Standards are fully compliant with GP practice equality duties.**

- **Patients including older people themselves are involved in developing the standards and in ensuring practices adhere to them.**

### Telephone triage and signposting

We welcome the Health Minister's recent announcement that telephone triage and signposting will be part of the new access standards and look forward to more detail in due course.

**We recommend that practices should develop and deliver a strategy to address patient concerns about signposting and triage, including:**

- **Ensuring call-handlers are appropriately trained and that patients are aware that they have the necessary skills. This may require triage being undertaken by nursing staff rather than receptionists.**
- **Ensuring call-handlers can respond sensitively and appropriately to people with difficulties hearing or communicating.**
- **Making arrangements to ensure patient information disclosed to call handlers is confidential and informing patients of those arrangements.**
- **Increasing patients' understanding of and confidence in the benefits of a multi-disciplinary approach to their healthcare.**
- **The use of technology**

### Appointments

Older people had a number of concerns about arrangements for appointments themselves. **We recommend that:**

- **GP practices offer appointments of variable length to better reflect patients' needs.**
- **GP practices should ensure that more than one health issue can be discussed at a consultation.**
- **Penalties for lateness should stop, particularly for people who have difficulty adhering to tight timescales because of their health or carer responsibilities.**

### Continuity and closure

Even if the Welsh Government succeeds in solving the workforce challenges, there are likely to continue to be GPs who wish to leave primary care whether for retirement or other reasons, and practices are likely to continue to close or merge. The impact on patients, and especially older people who lose all-important continuity of care, can

be significant. There is action that health boards can take to try to minimise the risk of closure. The BMA outlines a number of alternatives to a GP handing back a contract, including list closure, reducing boundaries, and cutting unpaid work. It also suggests seeking help from a local health board who may be able to help struggling practices e.g. with premises.

**We recommend that health boards should seek to minimise practice closures and their impact by undertaking regular sustainability assessments of practices and acting early to retain services if possible.**

When GPs retire or practices close or merge, GPs are recommended to inform patients, but this is not a requirement. Unfortunately not all practices do so effectively, as several Community Health Councils (CHCs) and press reports attest.<sup>80</sup> Many CHCs are already active in discussions about the sustainability of practices in their area. **We recommend that if a practice merger or closure occurs, Community Health Councils should be actively involved in consideration of alternative arrangements.**

Where a practice closure or merger is planned, **we recommend that health boards should ensure patients are informed of the change by letter.**

### Disability awareness

The challenges facing people with disabilities in booking and attending appointments were striking. We recognise that there are challenges in some parts of the GP estate, but not all the barriers were physical. Systems that suit the majority of patients, such as telephone booking, visual displays to call patients or penalties for lateness, can be very difficult if not impossible for disabled people to use. This is simply not acceptable.

There is no shortage of standards, advice and guidance on improving access for people with disabilities, covering everything from the design of buildings to providing a choice of booking systems, providing video and audio call systems, using 14 point font for printed materials, speaking clearly but not shouting and providing seating with a range of different heights, including some with arms. How practice staff – including reception staff, nurses and GPs – respond to disabled people is also important.

**We recommend that:**

- **The Welsh Government’s new access standards should explicitly address access by disabled people.**
- **GPs should fully comply with their duties under the Equality Act 2010. This applies to all care services including clinics and all disabilities.**
- **The new Health and Social Care (Quality and Engagement) (Wales) Bill should be used to underpin accessible health duties.**

- GPs should ensure that booking systems for both urgent and routine appointments are available for people with hearing, speech, visual or cognitive disabilities.
- If someone has difficulty communicating, seeing, hearing or understanding staff should respond appropriately and sympathetically.
- Practices should make reasonable adjustments to their systems for patients unable to comply with requirements re timeliness.



### 6.3 Patient Voice

Running through our findings is the lack of voice for patients and their carers. This is clear at all levels. There has been little if any debate about the new Welsh model of primary care outside health professionals. Yet it marks a major change in the relationship between GPs and their patients, which warrants public consideration before it is made. When changes are made to GP services e.g. if a practice merges or closures, while the Community Health Council may be consulted, patients themselves are rarely involved and so are left feeling voiceless. And in individual GP practices, older people were rarely aware of, let alone involved in, patient groups that could provide valuable feedback on matters such as problems with telephones or disabled access. This has to change if GP services are to improve and the profession is to continue in high public esteem.

We were also struck by the limited oversight of GP practices. As independent contractors, practices can and indeed do adopt their own arrangements, and it was perceived that they did not necessarily comply with all Welsh Government guidance or requirements. There appears to be limited monitoring or evaluation of how many of the changes underway affect patients.

Ensuring that high standards are met and that changes are evaluated is a basic requirement of good primary care. The current independent contractor arrangements for GP services seem to make compliance with standards even more complicated. At a minimum, community health councils (or their successor bodies) could play an important role in regular monitoring of access, without adding to the administrative burden of GPs.

#### **We therefore recommend:**

- **That Community Health Councils are always engaged at the earliest opportunity on changes affecting GP services in their areas.**
- **That Community Health Councils (or their successors) initiate discussion about the changes in the model of primary care, engaging with a wide range of individuals and organisations in doing so.**
- **That health boards remind GP practices of the importance of engaging with patients to secure their views.**
- **That Community Health Councils (or their successors) have a duty to monitor and report on access to GP services in their area annually.**

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## END NOTES

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