Cogora

WHITE PAPER

ACCESS ALL AREAS

What general practice staff think about the focus on access in primary care policy

Commercial partner for this white paper

GPS GENERAL PRACTICE SOLUTIONS
EXPERTLY NAVIGATING SUCCESS

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Commercial partner of this White Paper

GPS GENERAL PRACTICE SOLUTIONS
EXPERTLY NAVIGATING SUCCESS

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WHY ACCESS?

'As first steps to deliver the neighbourhood health service, we will restore GP access and ensure a far better experience of arranging care', reads the Government's *10 Year Health Plan for England: Fit for the Future* (10-year plan), published in July 2025.[1]

Patient access to general practice remains one of the hottest political topics. A Health Foundation and Ipsos MORI poll from May 2025 found it is the public's number one NHS priority.[2]

Yet 'access' is a nebulous term and the definition of 'good access' is even less clear. What makes this difficult is that there are two significant strands to GP access: availability of appointments; and ease of access – actually contacting the practice.

Much of the discourse and policy initiatives around patient access prioritises ease of access – how long patients need to wait on the phone, how early they need to call in order to secure an appointment, whether everything needs to be booked online, and so on. Ending the '8am scramble' is mentioned five times in the 10-year plan, and has become a political mantra. The attention is understandable since it is not only highly frustrating for patients, but the phone is traditionally their main connection with their GP practice and, by extension, the NHS as a whole.

Yet questions around ease of access are often conflated with availability of appointments – how and when patients receive care. But how do we define 'good' availability? Is it short waiting times, or longer appointment lengths? Seeing a GP rather than another healthcare professional? Or a face-to-face consultation?

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Continuity of care

Then there is the close cousin of access, continuity of care. This is commonly considered to mean relational continuity, whereby the same healthcare professional – usually a GP – sees a patient most of the time (longitudinal), for a specific health condition (conditional) or for an episode of time or care (episodic).[3]

All of the above have been cited as examples of good access, and while all are now political imperatives, quality of access is often overlooked. This report will highlight that distinction.

That said, everyone – politicians, patients and practice staff – can agree that current access is not optimal. Patients feel it is not good enough and this demoralises general practice staff, who are working harder than ever to give patients what they need.

Finding solutions

This report will consider the various issues around access. The first part will look at data on appointments and patient satisfaction. The second part will look at the often competing priorities of patients, practice staff, politicians, commissioners and the media. The third part will assess 'good' access, how its different elements relate to one another and the effect of systemic issues, such as funding, deprivation and demographics. It will also analyse the effect on practices of recruitment and other capacity issues.

Then we will consider solutions. The fourth part of the report will evaluate the success of attempts to improve the situation from the viewpoint of practice staff. We will offer some more systemic solutions, looking at successful practices and laying out ground rules in the proposed reconfiguration of general practice.

Much has been written about GP access, understandably mostly from the patient view. Cogora is the leading publisher of primary care titles in the UK and we will use our reach and expertise to discuss the perspective of those working in primary care. We will draw on our surveys of 2,000 UK primary care professionals and more than 100 interviews, alongside analysis of NHS Digital data and patient survey satisfaction scores. The report will build on our work on the general practice workforce, set out in the White Paper published earlier this year.[4]

This is not a peer-reviewed paper. Its figures are not statistically robust – they are included to provide an overview of access, how it has changed and any associations between factors. Some areas addressed here also need further development. We will follow up this work by examining the use of AI to improve access, the impact of self-referral schemes and, arguably most importantly, access for minority and disenfranchised groups.

The report focuses on England. We have spoken to staff across the UK and all report similar issues. However, new GP contracts are being negotiated by the BMA GP Committee England and NHS England, which will be heavily informed by the 10-year plan.

Our aim is to provide clarity and inform the debate around patient access before the most important GP contract in England since 2004.

EXECUTIVE SUMMARY

PART ONE
What is the truth about the access figures?

CHAPTER 1
The number of appointments is increasing...

Despite public perceptions, official NHS data seem to point towards increased appointments overall and an uptick in those conducted face to face and with GPs. The average number of appointments a patient has in a year is increasing. This is all despite a fall in the number of full-time-equivalent GPs. The average number of appointments per GP per year is increasing.

At the same time, waiting times for routine appointments – those conducted more than 24 hours after booking – seem to be steady, while the percentage conducted within 24 hours is increasing.

These efforts have been lauded by politicians and the major GP organisations. There is, however, caution around the accuracy of NHS Digital data.

CHAPTER 2
...But this isn't helping patient satisfaction

Patient satisfaction with GP services has been getting worse for at least the past eight years. This is in terms of availability of appointments, waiting times and issues with contacting the practice. However, there has been a slight uptick in patient satisfaction with GP services across the board over the past year, but it remains a long way short of pre-pandemic levels.

PART TWO
What does everyone want from access?

CHAPTER 3
Differing priorities

Access is not a single concept. It has a variety of elements, including routine waiting times, availability of urgent or on-the-day appointments, the choice of face-to-face or remote appointments, and continuity of care or seeing the preferred healthcare professional. Studies suggest appointment availability with a GP has the greatest single effect on patient satisfaction.

General practice healthcare staff believe patients tend to prioritise waiting times and urgent appointments, whereas healthcare professionals most value continuity of care. However, they say there is nuance – the priorities of patient groups differ, with younger patients favouring waiting times, while those who are older or who have long-term conditions favour continuity.

CHAPTER 4
GP practices feeling pressure from commissioners

Numerous initiatives from successive governments have sought to improve access. These have often focused on increasing the workforce, with the most impactful attempts involving the appointment of non-GP direct patient care staff. Other initiatives have involved weekend and evening appointments, support to improve practices' communications infrastructure, training staff on care navigation and improving remote consultations.

Although all these are important, GP partners and practice managers say the contractual requirements – either mandatory or with essential money attached – have left practices unable to focus on the areas of care they feel most benefit their patients. The changes due in October 2025 mandating online access throughout core hours are seen as a good example of this.

Many practices also face pressure from local commissioners around access, again sometimes at the expense of good patient care. But local commissioners can be a support if they build relationships with practices instead of imposing targets.

CHAPTER 5
The practice-patient relationship is being affected

Since the start of the pandemic, general practice staff have felt increasingly disillusioned with media reporting of access. Coverage did become more negative from 2020, and general practice professionals felt much of this was undeserved, focusing on a lack of face-to-face appointments at a time when they had been instructed to move to total triage and offer more remote consultations. This adverse coverage continues today and many feel it is fuelling negative perceptions among patients.

Patient complaints have increased in that period, and practice staff are facing increased abuse. While respondents to Cogora's surveys of more than 2,000 primary care professionals made the point that abuse is never deserved, they do share patients' frustrations with access. Many staff have seen a fall in complaints when access – especially contact over the phone – has improved.

PART THREE
What leads to 'good access'?

CHAPTER 6
How the different forms of access are related

An Institute for Government (IfG) report revealed that overall patient satisfaction increases with practices offering more face-to-face appointments and more appointments with GPs. More appointments with other healthcare staff has no effect on patient satisfaction, which calls into question government policies to use other direct patient care staff to deliver more appointments.

Our own analysis shows practices don't necessarily need to concentrate on one form of access over another. Although a previous *Pulse* study suggested practices offering a higher proportion of GP appointments tended to have a lower proportion

face to face, absolute figures show practices can offer a higher number of all the preferred forms of access per patient. This remains true when we add patient survey scores to the equation. In other words, there are practices that perform well on every facet of access, and practices that perform poorly.

CHAPTER 7
The systemic issues around access

Practices' levels of access are based in part on systemic factors. Older populations and more disease prevalence bring greater funding due to the Carr Hill formula. Funding is closely associated with the standard of access and these practices have a bigger workforce able to provide better access. However, this isn't the only factor. Smaller practices traditionally have higher patient satisfaction and this carries over to the access they provide.

Deprivation levels have an effect too. Unlike age and disease prevalence, deprivation level is not fully recognised by the Carr Hill formula, meaning practices in more deprived areas lack the funding to meet the extra challenges they face. In terms of appointment numbers, deprivation doesn't have much effect, but satisfaction scores are particularly affected by deprivation levels.

The ethnicity of a practice's patient population is strongly linked to poor access levels. In part, this may be due to practices with more non-white patients tending to have younger populations, but there may be other factors.

One is the 'candidacy model', whereby people's eligibility for healthcare is determined between themselves and health services, with patients from more vulnerable communities potentially making less use of GP services – the 'unworried unwell'.

CHAPTER 8
Why practices are unable to provide the access they would like

It is not just the increase in appointments that is creating pressure in general practice. The patients seen by GPs have more complex health needs, in part due to population changes: people are getting older, and developing more long-term conditions and multimorbidity. But practices are also left to deal with patients who would previously have been referred to secondary care, and GPs are also seeing simpler cases passed on to other healthcare staff in the practice or in pharmacies, for example.

The overall increase in demand means that, in order to provide the level of access they would like, some practices are having to consider cutting their lists or closing them to new patients, which has a knock-on effect on funding.

PART FOUR
What have governments done – and have they been successful?

CHAPTER 9
The ARRS

The additional roles reimbursement scheme (ARRS) was introduced in 2019 to increase the number of appointments overall in England. It has undoubtedly achieved this. But, at the same time, we have seen a reduction in patient satisfaction.

There are a number of issues around the ARRS, and why it might not have improved all aspects of access. The IfG report found that an increase in GP numbers was associated with increases in overall patient satisfaction, but that didn't apply to non-GP staff. There is a belief that the ARRS – while increasing overall appointments – can reduce access to GPs.

General practice staff say some ARRS roles are useful, especially physiotherapists and mental health workers. But their usefulness – especially in the case of pharmacists – doesn't necessarily lead to better access, but may lead to better safety or more satisfied patients in certain specific groups.

The structure of the scheme is also an issue – ARRS staff are often shared across practices, which might affect any improvement in access – while the salary bands cause a problem, being too high or too low based on the role.

There is a strong feeling among general practice staff that the ARRS funding should be given to practices, rather than PCNs.

CHAPTER 10
Increasing appointment numbers through extended access

Outside recruitment, extended access has been the principal way in which ministers in England have tried to increase the number of evening and weekend appointments. Broadly speaking, respondents to our surveys said this had been quite successful in improving access.

That said, there are significant caveats to this success. Studies suggest extended access hasn't done much to improve patient satisfaction and has had a negative effect on continuity of care.

These criticisms were echoed by general practice staff. As well as the problems around continuity, they pointed to problems with a lack of take-up of extended access – including a perceived increase in DNA rates – which is in part due to patients not wishing to travel further or consult with unfamiliar clinicians. Conversely, there are also problems with appointments being disproportionately taken up by the lead practices within primary care networks. There are similar criticisms around hub working.

CHAPTER 11
Reducing demand through Pharmacy First

There is lukewarm support among general practice and community pharmacy staff for Pharmacy First, the community pharmacy-run minor illness service. The option for patients to have minor illnesses seen to in community pharmacy is, in theory, useful. But despite some support, there are a number of criticisms about the scheme. GPs and their staff point to the number of referrals that are bounced back to them. Some also have concerns around the quality of care being provided, especially in terms of antibiotics prescribing.

As seen with the expansion of the workforce within general practice, there is some reluctance from patients to be seen by anyone other than their own GP, which has led to a reluctance

to use Pharmacy First services. Meanwhile, general practice workload remains high and appointment numbers continue to rise. GPs even say that the shifting of minor problems to pharmacies is not entirely positive – such consultations can only relieve the daily intensity amid non-stop complex cases.

Community pharmacy is also facing a funding squeeze and increasing workload, affecting its ability to make full use of the scheme. There might be potential for it to work, but it would still require increases in capacity across the whole of primary care.

CHAPTER 12
Improving ease of access: total triage and digital telephony

Improvements in processes are making it easier for patients to contact practices. Although satisfaction with contact is still low, there has been a slight uptick in the past year.

Total triage is being implemented rapidly across the country, in part due to contractual changes due in October 2025. Practices on the whole find it useful in managing demand and helping them respond to patients efficiently and direct them to the appropriate service. Some patients are struggling with these radical changes, and GPs and their staff report workload issues. But total triage systems do seem to have improved since their rapid introduction in 2020 during the first Covid lockdown.

Telephone systems also seem to be improving, with patients reporting increased satisfaction with contacting their practice.

CHAPTER 13
The 10-year plan

The Government's *10 Year Health Plan for England: Fit for the Future* focuses on shifting care from hospitals to the community, moving from analogue to digital and focusing on prevention over sickness. In terms of general practice access, there are two major policies – neighbourhood health centres and the My NHS GP tool.

Neighbourhood centres follow a recent trend to upscale general practice and while details are still sparse, they do seem to open the door to trusts taking over general practice services. They are also a potential threat to the GP partnership model.

The My NHS App promises patients access to health advice using AI, although the algorithms haven't yet been tested.

It is too early to evaluate these policies but the BMA has raised concerns over a potential negative effect on continuity of care.

PART FIVE
How can we improve patient care?

CHAPTER 14
An emphasis on continuity

There is a consensus that continuity of care is of major benefit to patients. It has been shown to improve clinical outcomes, especially for the most vulnerable groups, and to reduce demand, mortality and avoidable hospital admissions.

It has proved difficult to incentivise continuity, partly due to the difficulty in measuring it – but also due to the political imperatives around access. Although health secretaries have paid lip service to the need for continuity, it has been 'sacrificed at the alter of access', as one GP puts it. Often, attempts to increase appointment availability – for example, the increased non-GP workforce and extended hours – come at the expense of continuity. To keep up with patient demand – and with policy initiatives – practices are having to sacrifice continuity.

It has also been made harder due to a shift to less-than-full-time working for many GPs – although this itself is in part due to the pressures of the job.

Despite all this – and the lack of financial incentives – many practices have been able to sustain continuity, and they benefit through better patient care and increased job satisfaction – especially relevant at a time when the system needs more GPs.

CHAPTER 15
Conclusion: A reconfiguration of our approach to general practice

General practice in England faces significant challenges, with increasing demand, deteriorating patient satisfaction and fewer GPs working full-time. Appointment numbers are rising, while factors like population growth and funding disparities contribute to access issues. This needs a new approach. We need to:

- **Strengthen the GP partnership model** GP partners correlate with higher patient satisfaction and appointment availability. However, fewer GPs choose partnership due to personal risk and liability. Revisiting proposals to reduce these risks and introduce new legal models is recommended.
- **Keep general practice GP-led** Shifting care to community settings is supported, but hospital trusts should be prevented from running general practice services to preserve the efficiency and quality linked to GP management.
- **Retain the positives of small practices** Smaller practices provide greater patient satisfaction and continuity of care. Practices should have the choice to hold contracts individually or to join larger neighbourhood organisations, without essential funding being affected. Funding to modernise small surgery premises is also necessary.
- **Simplify and reform funding** Fragmented funding with multiple targeted payments leads to a transactional approach. Combining funding into capitation payments without restrictive strings, reforming the weighting formula and ringfencing staff costs to enable funding increases without political backlash will lead to positive changes.
- **Shift focus from access to quality of care** While good access is essential, quality of care, including continuity and longer appointments, reduces demand and improves outcomes. Future contracts should prioritise quality over appointment quantity.
- **Trust general practice professionals** High-performing practices tailor access models to their patients without financial incentives, emphasising continuity and patient-centred care. Greater trust in general practice professionals will ultimately benefit patient care.

RECOMMENDATIONS

CENTRAL FUNDING OF STAFF

Funding is key to access. The next GP contract should see staff costs ringfenced, with the money given directly to practices. This could remove government reluctance to invest the required funding into general practice for fear of negative headlines. Larger groups of practices could still hire staff to work over a larger population, through PCNs or neighbourhoods.

IMPLEMENT PARTNERSHIP RECOMMENDATIONS

GP partners lead to better access, but fewer GPs are taking up partnership. The Government should commission a follow-up to the 2019 review into the GP partnership model, which should include proposals to mitigate the personal risk associated with taking on responsibility for premises, and introduce different legal models for partnerships.

POOLED FUNDING

GP practices need the financial freedom to provide the access their patients need. Government and the BMA should remove the fragmentation of funding, with strings attached to pots of money, in their negotiations over a new contract. All funding – bar staff costs – should be provided through capitation payments to practices.

FUNDING REFORM

The Carr Hill funding formula needs to take into account the greater challenges faced by practices in deprived areas and those with a higher proportion of non-white patients. It currently uses data from 2000 on the health of the local population, and this should be rectified immediately. This will be a key part of the negotiations for the next major GP contract in England, and it is essential that deprived practices get the funding they need to improve access.

PRACTICES MUST RETAIN RIGHT TO CONTRACT

Patients say smaller practices provide better access. While there are benefits to larger-scale working, the benefits of small practices should not be lost. The Government and the BMA must give GPs the right to hold a nationally agreed contract to provide routine care. Practices may decide locally to hold larger contracts that include services currently provided in secondary care.

GPs TO RUN GENERAL PRACTICE

General practice staff know their practice populations best, and are able to tailor access when given the resources to do so. The Government should instruct integrated care boards to prevent multi-neighbourhood contracts that include general practice services from being awarded to hospital trusts and ensure primary care staff are at the helm.

PREMISES UPGRADES

GP surgeries are in need of upgrades, with the lack of capacity providing a barrier to access. All surgeries – including small ones – must be provided with funding to ensure premises are fit for purpose.

EXPLORE ETHNIC DIFFERENCES

The UK Government should explore why the ethnicity of a practice's population has such an effect on access levels. Although we haven't looked at the data in the devolved countries, it would be worth the respective governments undertaking similar work.

PART ONE

What is the truth about the access figures?

CHAPTER 1
The number of appointments is increasing...

Despite the negative picture around access, raw data in England show that appointment numbers are rising and, on the whole, surpassing pre-Covid figures (Chart 1[5]).

During the Covid lockdowns, the NHS mandated general practice to move to total triage, meaning all patient requests were screened remotely before being directed to an appropriate pathway or consultation type (see Chapter 12). Often, this involved telephone or video first, followed up by a face-to-face appointment if required.[6]

This led to a major decrease in the number of appointments. There are explanations for this, not least that in 2020 during the first lockdowns patients simply weren't using GP services as much, as has been widely reported. From 2021, a lot of activity switched to Covid vaccinations – we have not included those data here.

During Covid especially, much of the debate around GP access revolved around availability of face-to-face appointments. Provision of these took a sharp dip at the height of the pandemic, as patients and practices were encouraged to use remote consultations (Chart 2[7]). The number of face-to-face

CHART 1 Total appointments per day per 10,000 patients[5]

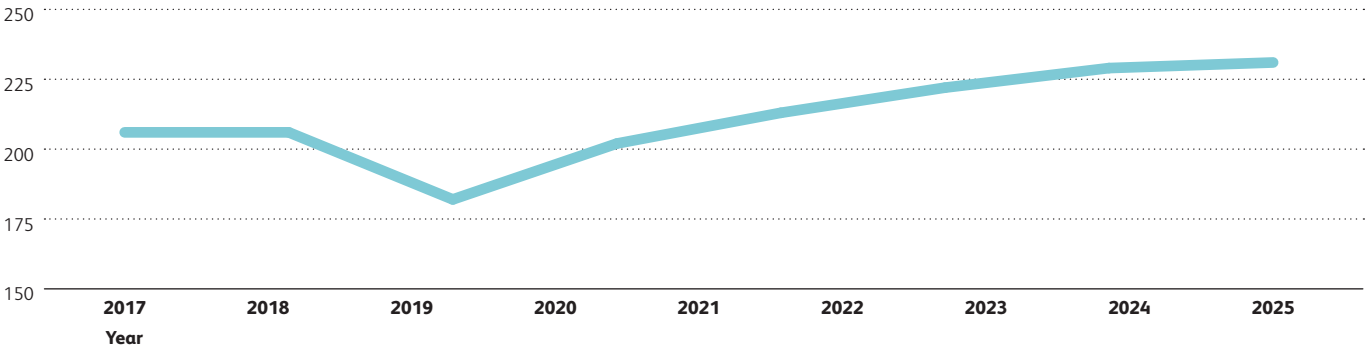
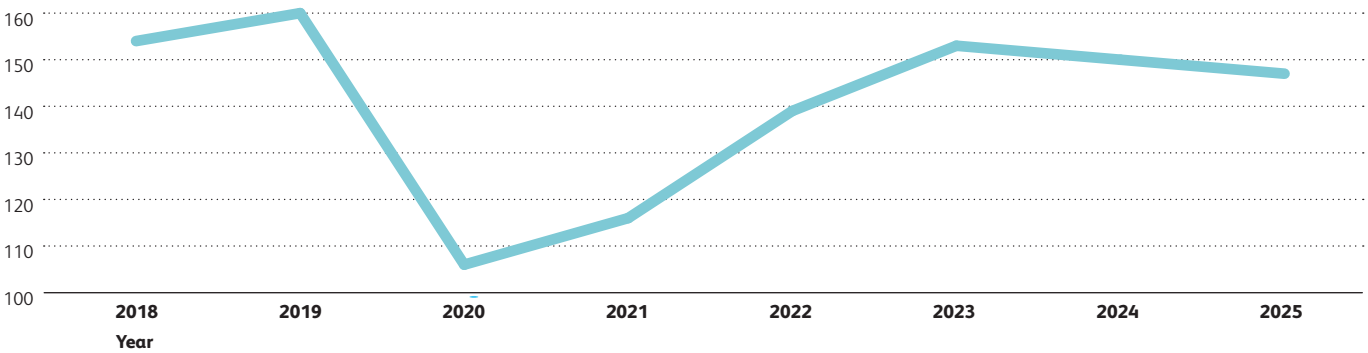


CHART 2 Face-to-face appointments per day per 10,000 patients[7]



AJ_WATT / E+ / VIA GETTY IMAGES

consultations hasn't quite returned to pre-pandemic levels, but this doesn't tell the full story.

Even before the pandemic, then health secretary Matt Hancock had been a strong advocate of providing more appointments remotely, citing patient convenience. In July 2020, he said the feedback from this move was 'hugely positive, especially in rural areas', adding: 'So from now on, all consultations should be teleconsultations unless there's a compelling clinical reason not to.'[8] Before Covid, face-to-face appointments per patient had been increasing. We can't know whether this trend would have continued, but that was by no means inevitable.

Equally, we are not seeing a decrease in the total number of appointments provided by GPs. Successive governments have increased the number of non-GP healthcare staff in general practice, predominantly through the additional roles reimbursement scheme (ARRS). This scheme funds primary care networks (PCNs) to hire a variety of staff and now incorporates 24 roles, including pharmacists, paramedics, physiotherapists, occupational therapists, link workers and podiatrists.[9] Funding to recruit newly qualified GPs was added to the ARRS in October 2024,[10] and a range of nursing roles was added for 2025/26.[11]

As of June 2025, there were 42,401 'direct patient care staff' working in general practice across GP practices and PCNs – up from 21,946 in September 2021 (Chart 3[12]). This basically includes any general practice clinical staff other than GPs and nurses. While this is not a perfect comparison, in September 2015 the total stood at 9,373 (counting direct patient care staff in GP practices, as PCNs had yet to be established). This does highlight the pace of change. At the same time, full-time-equivalent (FTE) fully qualified GP numbers have been decreasing.

Despite this decrease in the number of FTE GPs, they are able to maintain the number of appointments with a GP – and are even providing more than in 2018 (Chart 4[13]).

This is because GPs are individually providing more appointments per year (Chart 5[14]) – up from 5,069 a year in 2019 to 5,900 this year (extrapolated) for a full-time GP. Based on 25 days' annual leave, this is an increase from 22.2 appointments a day in 2019 to 25.8 a day in 2025 – and of course non-clinical work is on top of this.

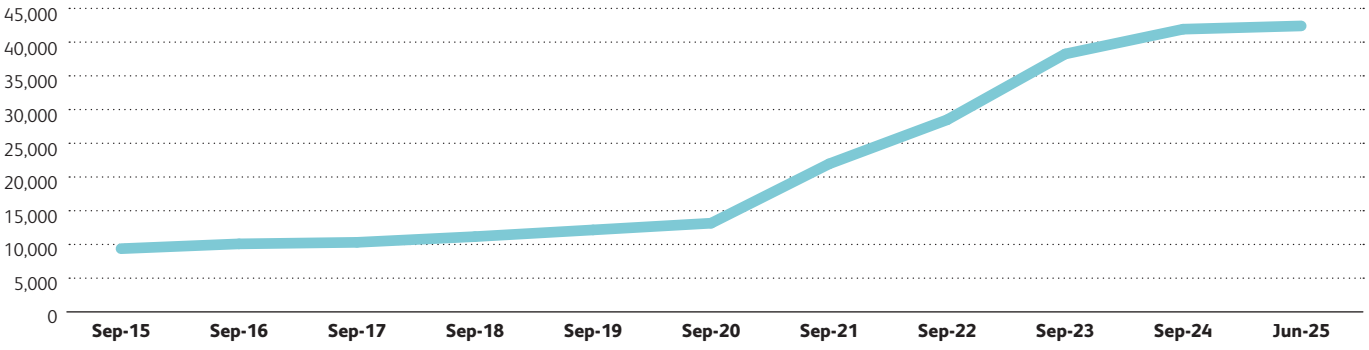
According to the NHS Digital data sets, individual patients are having more appointments at their GP practice every year – up from 5.22 in 2018 to 5.88 in 2025 (Chart 6[15]).

Waiting times

At the same time – despite the prevailing narrative – the time between booking an appointment and having the consultation has remained fairly stable, however you look at it.

Applying a midpoint analysis, including urgent appointments (those on the day or within 24 hours) waiting times remain at just under a week, according to the NHS Digital data set (Chart 7[16]). It is pretty a similar story if we omit the urgent appointments (Chart 8[17]). Meanwhile, the percentage of appointments that are either on the day or within 24 hours is going up, notwithstanding the anomaly that is 2020 (Chart 9[18]).

CHART 3 Full-time-equivalent direct patient care staff[12]



Fully qualified full-time-equivalent GPs

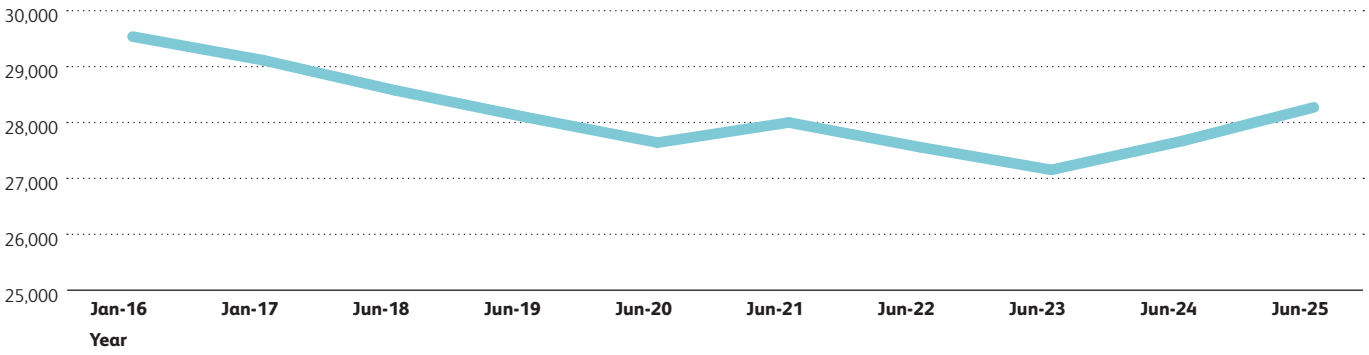


CHART 4 Appointments with a GP per day per 10,000 patients[13]

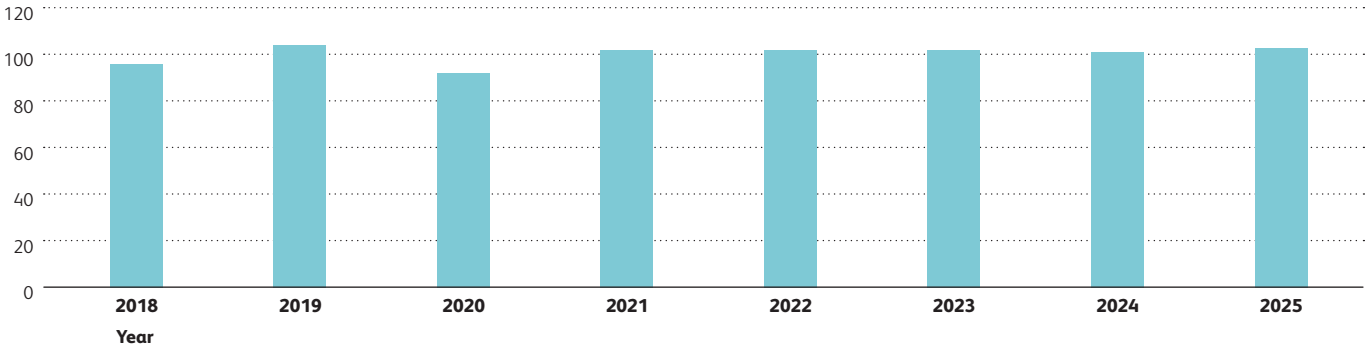


CHART 5 Annual appointments per full-time equivalent GP[14]

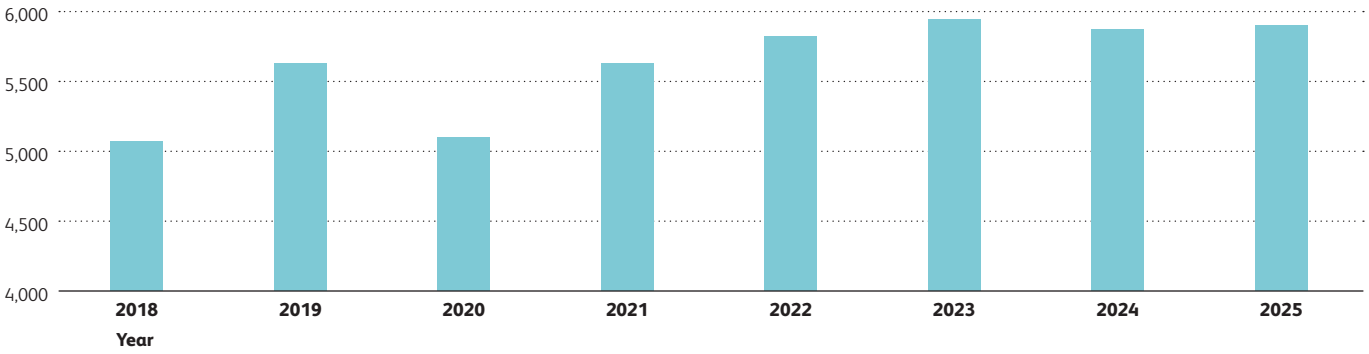


CHART 6 Appointments per average individual patient per year[15]

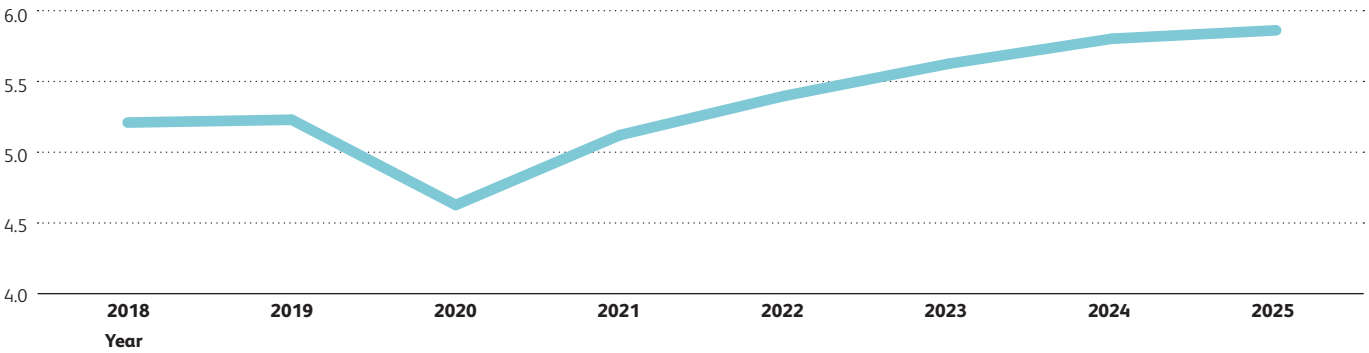


CHART 7 Average waiting times from booking to appointment in days – including appointments within 24 hours[16]

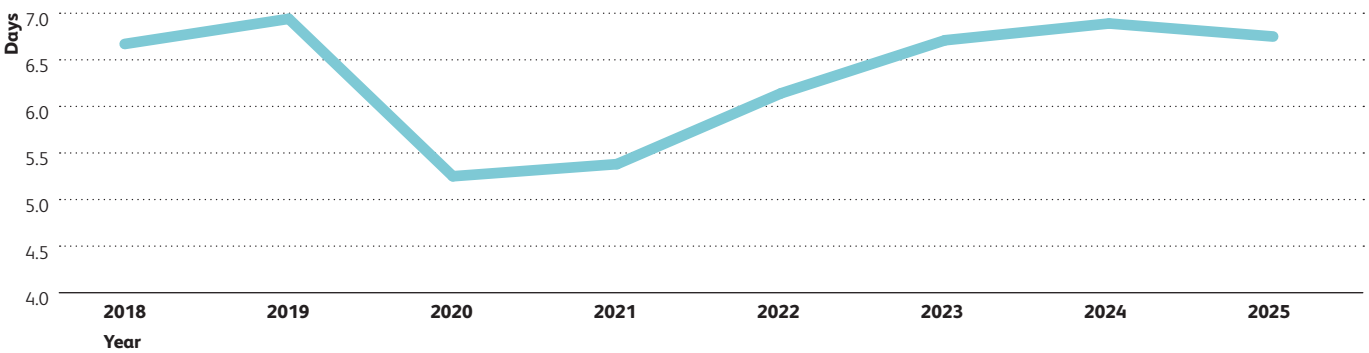
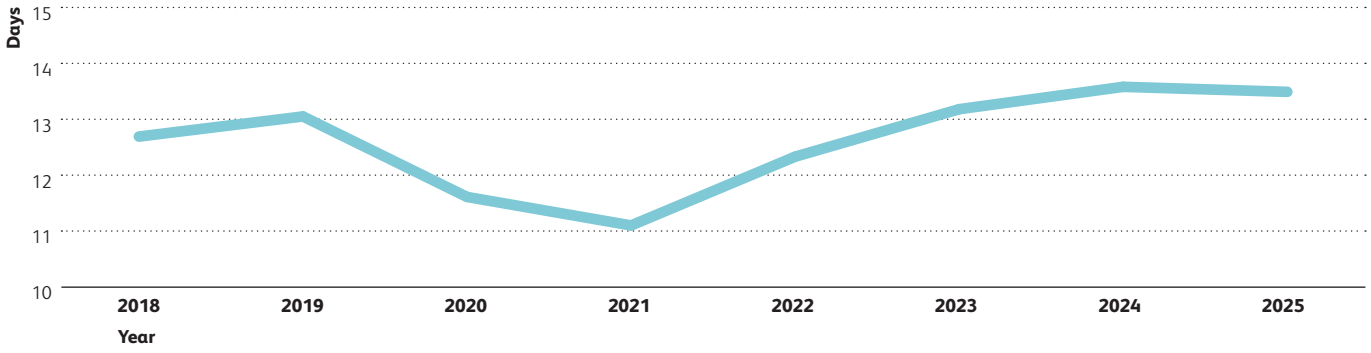


CHART 8 Average waiting times from booking to appointment – not including appointments within 24 hours[17]



Meanwhile, experimental data from NHS Digital suggest appointment lengths are increasing (Chart 10[19]). This should be taken with caution though, since figures have only been collected since early 2022. Furthermore, the data are collected in segments of five minutes, meaning that a midpoint analysis is unlikely to give the true average appointment length. That said, this does offer an indication of the trends in appointment rates.

All this paints a rosier picture than the one often portrayed. Per patient, there are more appointments, more appointments with GPs, more face-to-face appointments and more urgent appointments, while waiting times are relatively stable.

For varying – and understandable – reasons, policymakers and medical organisations hail these figures - albeit with acknowledgments that more needs to be done. In July 2025, GP practices delivered the record number of appointments for a single month.

In August 2025, health secretary Wes Streeting wrote to GPs thanking them for 'the contribution you are making to improve access to, and experience of, general practice for the public', referencing the 'extra 12,000 GP appointments' practices are providing every working day above 2024 levels. This followed NHS England primary care director Dr Amanda Doyle thanking GP teams for 'working exceptionally hard to boost access and turn our services around'.[20]

RCGP chair Professor Kamila Hawthorne says 'the number of appointments being delivered in general practice has been

CHART 9 Percentage of appointments that are within 24 hours[18]

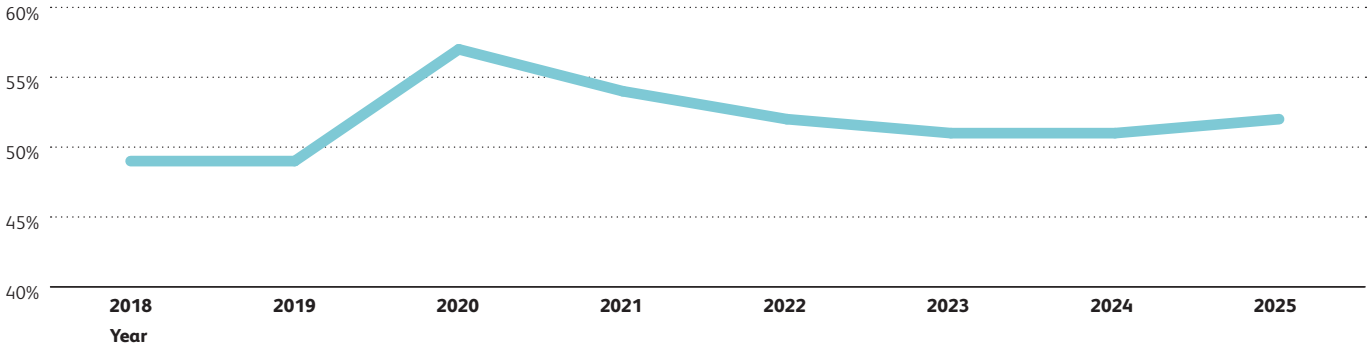


CHART 10 Average appointment length[19]

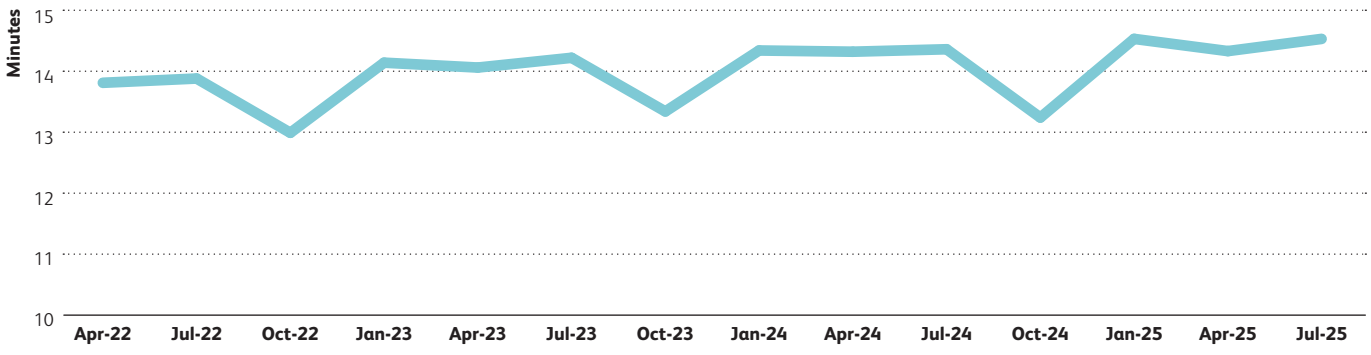
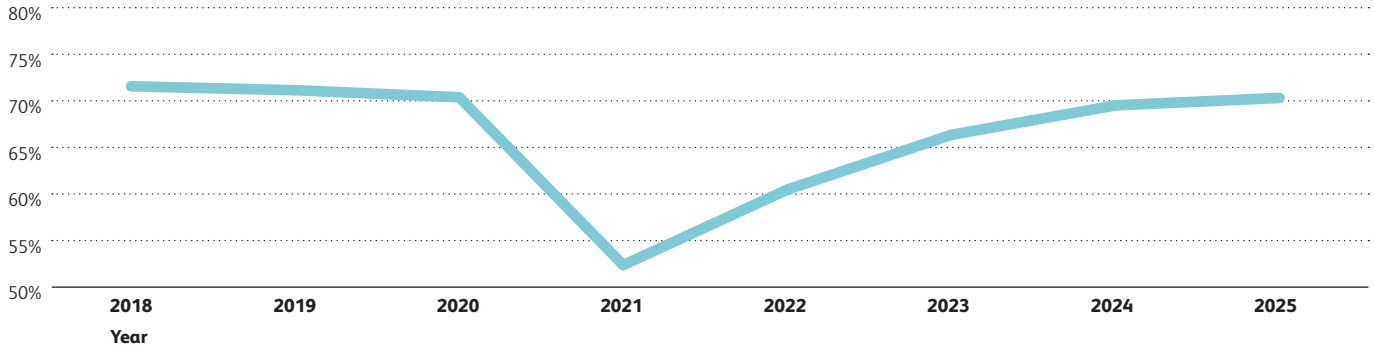


CHART 11 Patients who had reported having a GP practice appointment in the past six months[25]



steadily climbing and we are now delivering millions more a month than we were even six years ago', but adds 'we are still struggling to keep up with growing need for our care'.

Caution

There should be caution over the NHS Digital figures, however. NHS Digital says the GP systems are not designed specifically for data analysis,[21] and while there is guidance on data input for practices, there are still variations in data.[22] The Health Foundation says there is variability in the way different suppliers of GP IT systems store and structure the data they hold.[23]

These figures also run contrary to other data sets. A paper from the The Strategy Unit points out that the uptick in access suggested by NHS Digital is contradicted by the CRPD GOLD data set, which collects data from practices that use the Vision clinical IT system, as well as referral and prescribing data.[24] Most importantly, however, NHS Digital figures contradict patients' own experiences – which we shall examine in the next chapter.

SUMMARY

Despite the public's perception, official NHS data seem to point to increased appointments overall and an uptick in face-to-face appointments and appointments with GPs. The average number of appointments a patient has in a year is increasing and the average number of appointments per GP per year is also increasing. This is all despite the number of FTE GPs continuing to fall.

At the same time, waiting times for routine appointments – those conducted longer than 24 hours after the booking – seem to be steady, while the percentage of appointments taking place within 24 hours of being booked is increasing.

These efforts have been lauded by politicians and the major GP organisations.

There is, however, caution around the accuracy of the NHS Digital data.

CHAPTER 2
...But this isn't helping patient satisfaction

Despite the sustained increase in appointments suggested by NHS Digital data, the GP Patient Survey tells another story. According to the survey, which includes 700,000 respondents, the number of people saying they'd had a GP appointment in the past six months hasn't yet returned to pre-pandemic levels (Chart 11[25]) – contrary to NHS Digital's data (Chart 1, previous chapter).

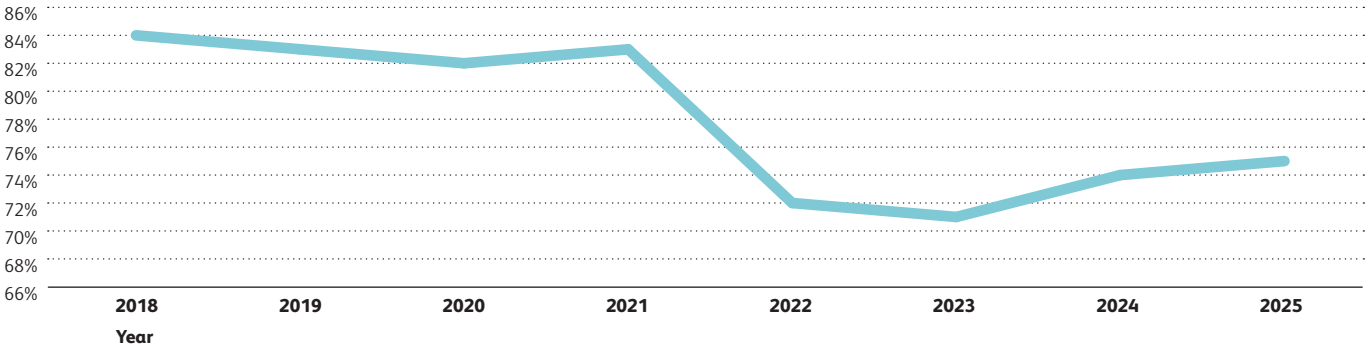
The Strategy Unit concluded this discrepancy was unlikely to be due to unreliability in the patient survey. It found the increases in appointments reported by NHS Digital 'appear to be at odds with trends in patient-reported GP practice appointment rates and with rates of other patient-facing GP practice activities, prescriptions, and referrals'.[26]

One explanation could be a concentration of appointments in a smaller number of patients. The Strategy Unit says: 'The use of GP practice consultations increases with age and with levels of morbidity. Since 2008, the population has aged and age-specific morbidity levels have increased. This suggests that need for GP practice consultations has grown, whilst the average number of consultations per person has reduced.'[27]

Professor Azeem Majeed, a GP and professor of public health and primary care at Imperial College London, echoes this sentiment: 'One reason for the apparent discrepancy may be due to the way demand is distributed across the population. A relatively small proportion of patients – often those with long-term conditions, frailty or higher care needs – accounts for a large proportion of appointments. If activity is increasingly concentrated in these groups, then the overall number of appointments will rise, but many patients may experience fewer or no appointments in a given period.'

However, there is contrary evidence – the Strategy Unit found that 'even patients who are likely to fall into these high-need subsets such as those aged over 85 years or with a long-term illness or disability, report reductions in appointments'. This is a vital question that doesn't seem to have an obvious answer – why appointments are going up while all patient groups are reporting fewer appointments.

CHART 12 Patients describing overall GP experience as 'very good' or 'good'[28]



Patients reporting fewer appointments does at least fit in with the general malaise in patients' attitude towards general practice reflected throughout the patient survey (Chart 12[28]).

This has been well documented. Patients are reporting issues around booking appointments and waiting times. Fewer patients report receiving a booking on the same day or the day after, while the number of people waiting more than a week from booking an appointment is increasing (Chart 13[29]). In the past two years, patient survey respondents have also been asked whether the waiting time after booking was 'about right'. Around two-thirds of patients said it was, with the satisfaction level slightly up in 2025 (Chart 14[30]).

But the real problems in patient satisfaction come when looking at ease of access – contacting the practice. Until 2023, the patient survey asked respondents about their overall experience of booking an appointment, and this had been decreasing from 2018 to 2023, with a blip in 2021 due to Covid (Chart 15[31]). It stopped asking this question in 2024, without a particularly close analogue. In terms of contacting the practice by phone, there has been a sharp dip from 80% saying it was easy to contact their practice by phone in 2013 to less than 50% in 2024.

Patients Association chief executive Rachel Power says: 'Our research found that many patients struggle to access GP appointments when they need them. Those who still need to speak to their practice to book an appointment often find that when they do get through to someone, there are no

CHART 13 Patients reporting waiting times longer for appointment after booking[29]

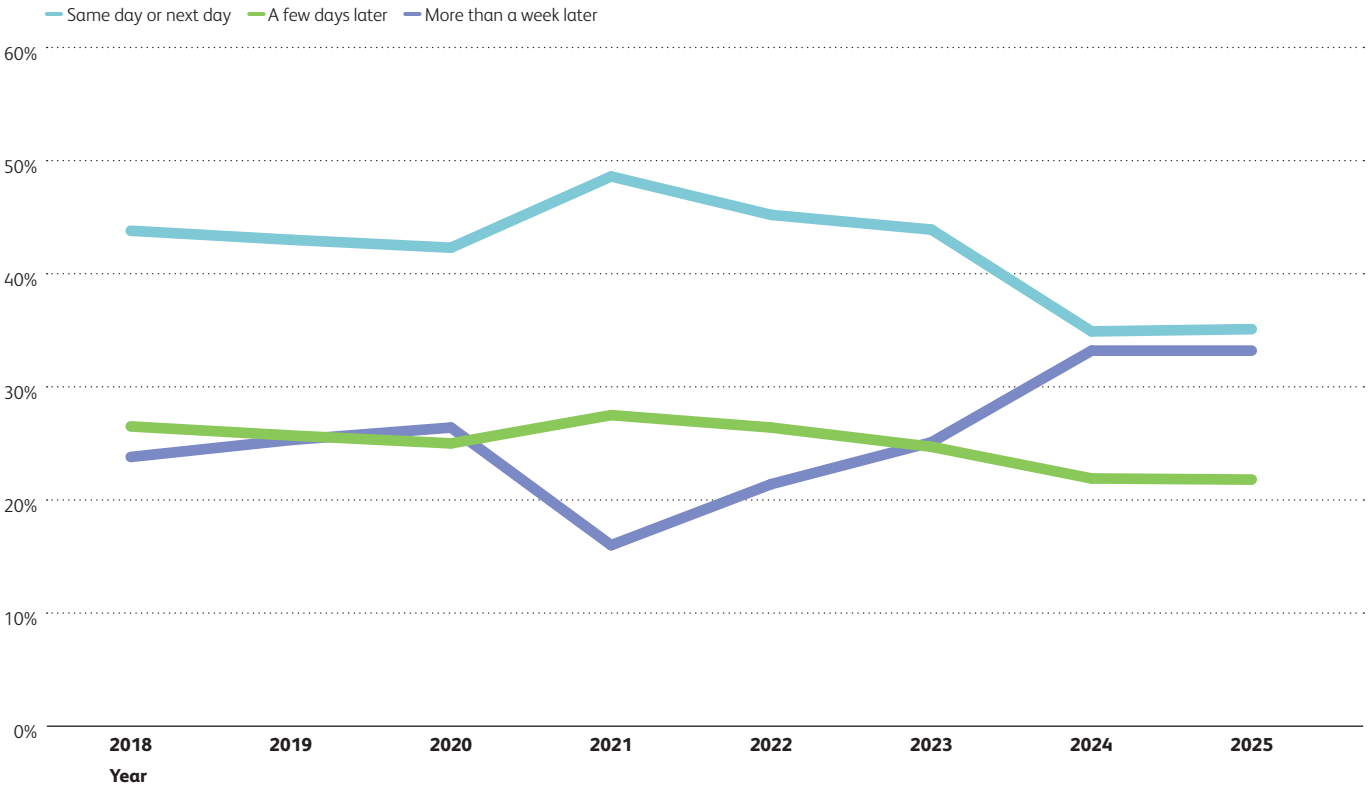


CHART 14 **Patients who felt waiting time for appointment was 'about right'[30]**

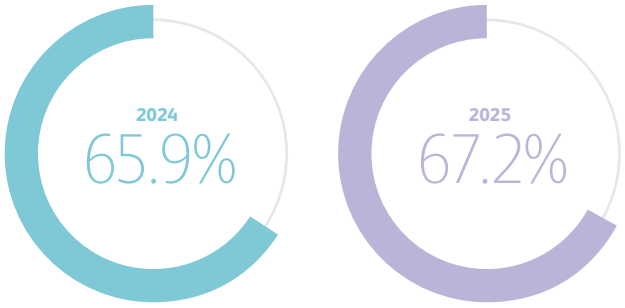
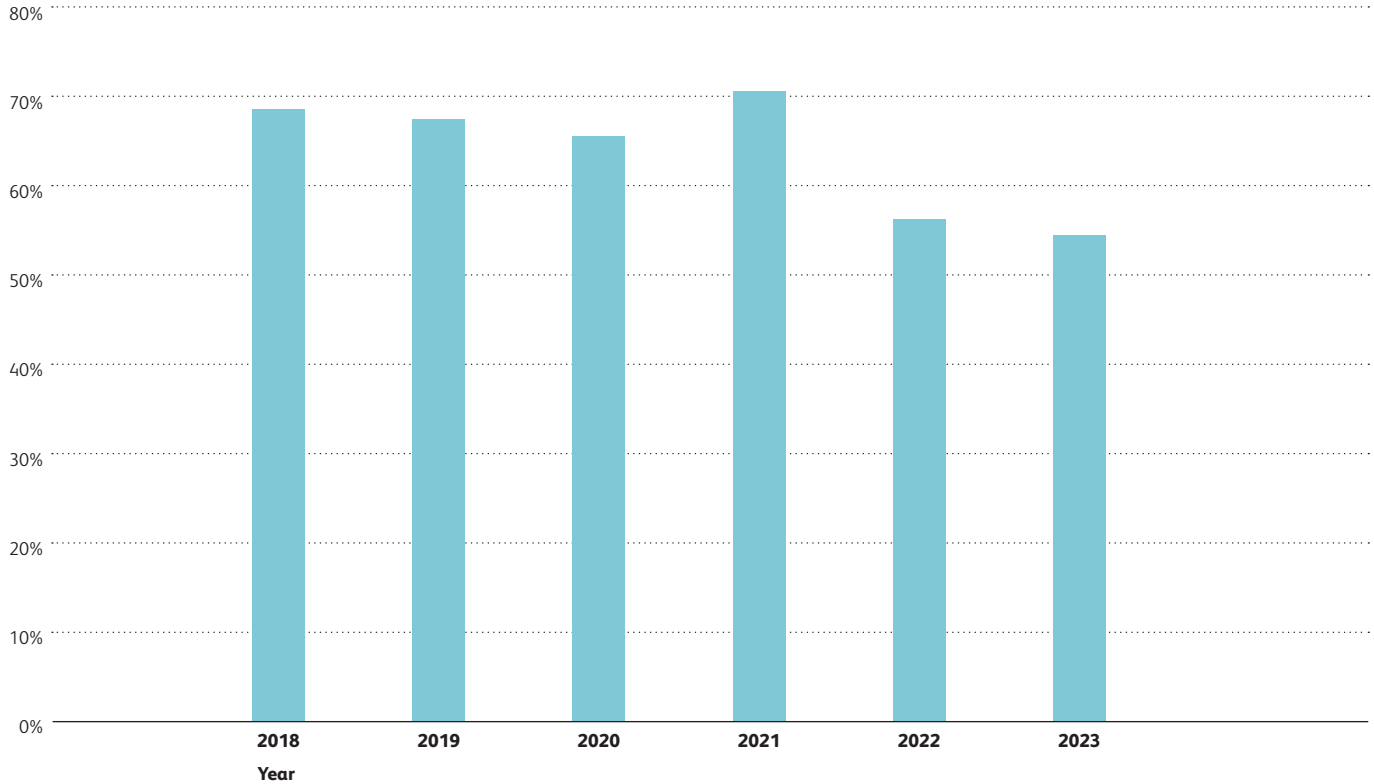
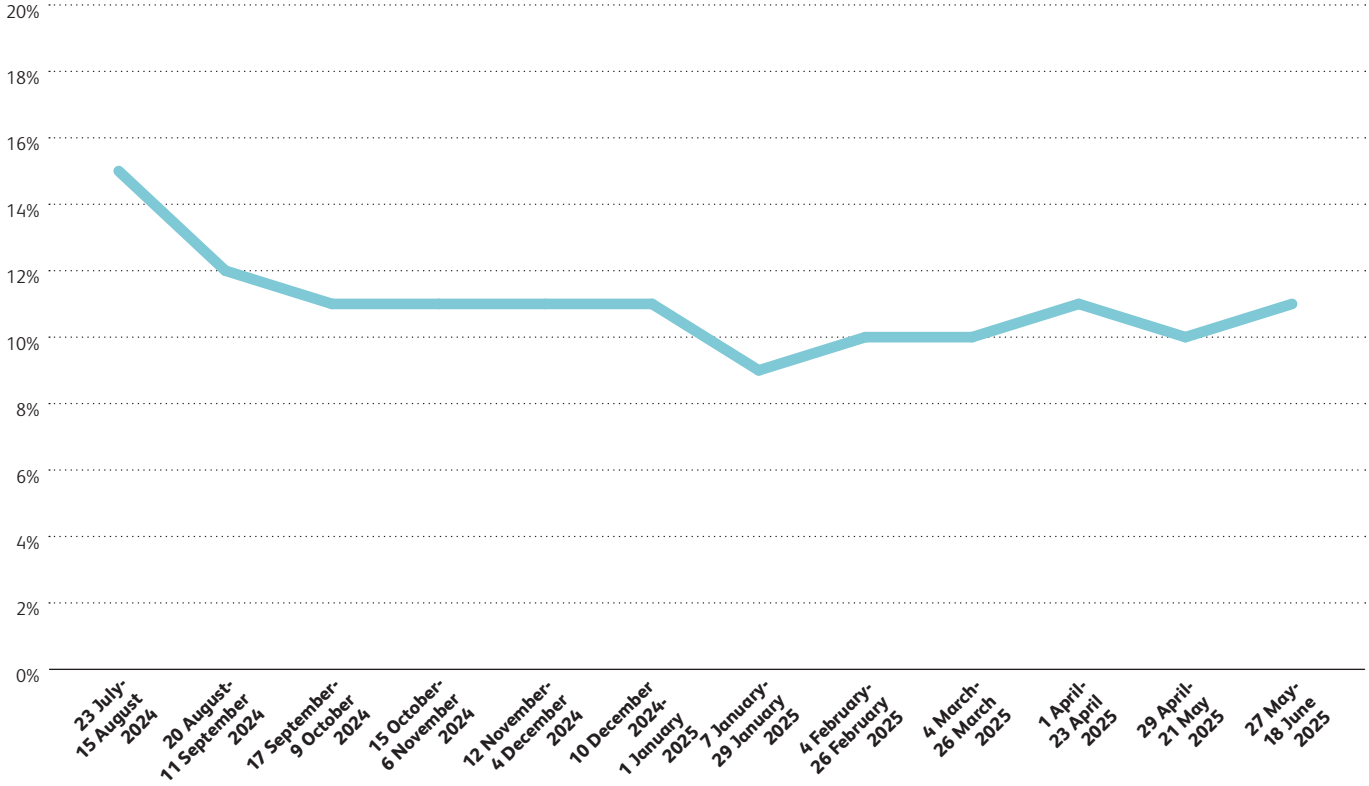


CHART 15 **Patients who had a 'good' experience of booking an appointment[31]**



JULIAN CLAXTON

CHART 16 Monthly data on patients' 'poor' overall experience of GP practice[32]



appointments in the needed time frame. We regularly hear from patients who miss out during the 8am rush for same-day appointments or even must travel to the practice to secure a slot, which is especially difficult for people with mobility challenges.'

However, there has been a slight uptick in this metric in 2025 (see Chapter 12). This is backed up by other results from the patient survey, and by the Office for National Statistics (ONS), which has been commissioned by NHS England to start collecting responses on a monthly basis since July 2024 (Chart 16[32]). We will explore the reasons why in Chapter 12.

Just like the NHS Digital data, however, the patient survey is not an infallible marker of the quality of care provided by a GP practice. As The Strategy Unit pointed out, the survey relies on patient recall. Perhaps more fundamentally, however, what satisfies patients isn't always the right course of action (for example, being given antibiotics often satisfies patients, but is not always the right course of action clinically).

The Institute for Government says: 'Patient satisfaction is not necessarily related to clinical outcomes, and is also a function of patients' expectations, meaning it is possible that patient health could improve while satisfaction with general practice declines, or vice versa.' But, it adds: 'Despite these limitations, there are valuable lessons to draw from variation in patient satisfaction.'[33]

The decline in patient satisfaction with access is well established, but a small part of the explanation might be a difference between patients' priorities for access and those of general practice teams, as we shall see in the next part.

SUMMARY

Patient satisfaction with GP services has been declining for at least the past eight years. This is in terms of availability of appointments, waiting times and issues with contacting the practice. However, there does appear to have been a slight uptick in satisfaction with GP services across the board over the past year, but there is still some way to go if we are to return to pre-pandemic levels.

PART TWO

What does everyone want from access?

CHAPTER 3
Differing priorities

The fact that the concept of good patient access is open to interpretation means there are often differing priorities for general practice staff, patients, commissioners and policymakers. The GP Patient Survey doesn't collect data around patients' priorities when it comes to GP access, but a lot has been written on this topic.

A meta-analysis of 33 studies by researchers from the universities of Southampton, Warwick and Birmingham, and Yeovil District Hospital concluded: 'Patients wanted information about how to access the general practice, choice of clinician, choice of healthcare professional type, and choice of consultation mode. Patients wanted a nearby practice, with clean waiting rooms, easy appointment booking using simple systems and with short waiting times, and to be kept informed about the process.'[34]

The article divided access into several strands: connection, choice, timely access and physical access. Connection was described as a relationship with the practice that included respect, good communication and information about access options and the different healthcare professionals. Choice referred to appropriate prioritisation of aspects such as seeing the preferred clinician, continuity of care and consultation type. Timely access was ease of booking, good organisation of access systems and shorter waiting times, while physical access referred to practices being near patients' homes.

The IfG report into general practice in England provided greater detail on patients' requirements. It stated: 'The number of GP appointments delivered in a practice has a strongly statistically significant relationship with patient satisfaction. An additional 1,000 GP appointments in a practice is associated with patient satisfaction increasing by 0.14 percentage points. For context, the average number of GP appointments delivered per practice was 25,439 in 2023/24.'[35]

This increase in patient satisfaction did not apply to appointments with non-GPs.

The IfG report also found that patients' overall experience of general practice was most closely linked to a higher ratio of

JULIAN CLAXTON

OUR GP-LED, FACE-TO-FACE SYSTEM IS WORKING WELL

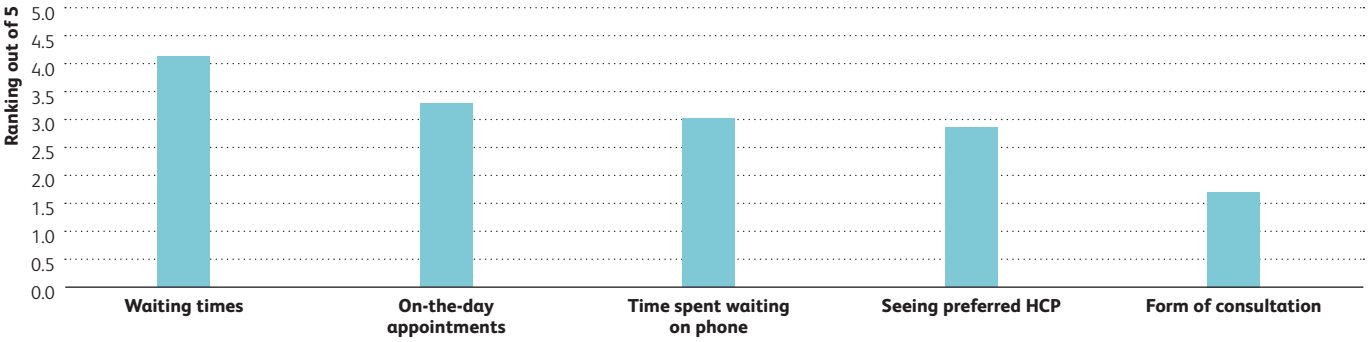
We are lucky enough not to have experienced the recruitment problems faced by others, allowing us to provide a GP-led model. We unblock GP appointments two weeks ahead, one week ahead and on the day (a mixture with each GP). Once those appointments are booked, we have a duty doctor system operating all day – shared between our GPs – which prevents the 'race' for an appointment at 8am. Patients will never be told that we are full and to ring back tomorrow, which also reduces frustration at the reception team.

Last September, we moved all of our GP appointments (15 minutes duration) back to face to face by default. During Covid, we found that telephone appointments created too much duplication. Patients also put lower value on a telephone call – often not picking up or forgetting why they had booked it. By asking them to come into the surgery they get a better assessment of their problem in one go, and attending the surgery makes them think about whether they really need to see someone.

This system works for us – patients are happy, GPs are happy and receptionists find the system very easy to navigate. We've stuck with our GP-led model and it works well for us. I realise that not all practices could work this way and they will have very different challenges to tackle – especially with finances and recruitment – but I guess each practice should be given the ability to find a model that suits them rather than being forced to work in a particular way, which seems to be the way things are going.

Practice manager, Northumberland

CHART 17 What GPs and staff think are patients' top priorities[36]



GPs – particularly partners – to patients, a higher proportion of in-person appointments and smaller list sizes (see case study, p18). It pointed out that the direction of travel for each of these factors was the opposite of what patients wanted, with more GPs taking salaried roles, more appointments provided remotely and a move away from smaller practices.

The Patients Association's Rachel Power says ease of access and continuity are both important for patients. She adds: 'For the millions of people currently stuck on waiting lists, the priority is simply to see progress in their care and an end to the anxiety of waiting. We hear from patients who say long waits have taken a serious toll on both their physical and mental health.'

General practice staff view

Cogora's survey of around 2,000 general practice staff asked them to rank five access/continuity priorities in order of importance: routine waiting times; access to on-the-day appointments; time spent waiting on the phone; consultation type (ie, face to face or remote); and seeing a preferred healthcare professional/continuity of care.

Although there were similarities between their own rankings and what they believed patients would prioritise, there was a difference around continuity/seeing their preferred HCP (Chart 17[36]), which they thought patients would rank fourth while practices placed it overwhelmingly top (Chart 18[37]).

Many survey respondents rightly pointed out that the choice was too simplistic, saying all these priorities mattered and were entirely dependent on circumstance. Despite this, a few broad themes emerged.

Patient demand for on-the-day appointments

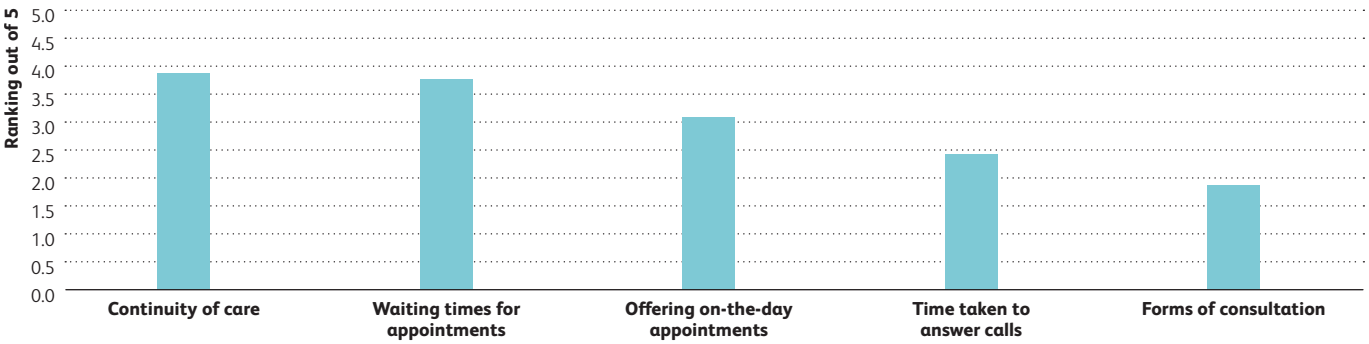
Although we counted on-the-day appointments and routine waiting times as two separate priorities, many of the responses were very much interlinked. For many respondents, patients' desire for an immediate appointment was seen as a negative. A few cited the 'Amazon' or 'Tesco' culture, with comments including: 'They want instant Tesco style, open all hours care'; 'Amazon Prime mentality means the patients just want everything now'; and 'Patients today are increasingly influenced by the immediacy of modern services – such as on-demand streaming, next-day deliveries from Amazon and instant online customer support'.

The main concerns around these issues tended to be either about abuse of practice staff or taking on-the-day slots away from patients in greater need.

A GP partner in Ayrshire says: 'Patients "want" to have same day access to GPs, but, when they do, most of them demonstrably have no need to do so, and their actions are delaying the care of those who need it. I don't mind speaking to them – I'm very fond of my patients and want the best for them – but I do mind when it degrades the care that I can offer the people who need it.'

There is a clinical issue with seeing people too early, too. One GP in Southampton says: 'When things present too early, there

CHART 18 GPs' and staff's top access priorities[37]



is too wide a differential (using time as a tool is valid) and one can understandably miss things as the clues are not there.' He adds that the demand for on-the-day appointments can lead to inappropriate urgent consultations, with online triage 'particularly used by the younger tech-savvy, meaning those more vulnerable and elderly people lose out somewhat in access'.

There was sympathy for patients wanting on-the-day care. One GP in the north-east of England says 'people have a way of knowing when something can wait and when it can't', with another adding that 'most on the day appointments turn out to be urgent/semi-urgent/important like suspected cancer etc'.

A lot of the demand for on-the-day access and quicker routine care was born from anxiety, especially among younger patient groups. 'A large proportion of patients I see are young students, Gen-Z and Millennials, and there appears to be a high level of health anxiety among these groups, possibly due to the influence of social media. As a result, there can be a higher degree of impatience and unwillingness to wait for an appointment,' says one GP. Another, who works in a university practice, says: 'Students are very immediate, often presenting with acute illness, looking for on-the-day access, fewer safety nets/care in place.'

Respondents also saw benefits for general practice staff in reducing waiting times. One GP partner says: 'If our waiting time for a routine appointment goes above ten days all our systems start to fall over and it gets inefficient. People won't wait, get seen in the acute hub, get duplicate appointments, or the problem has resolved, or our DNA rates rocket.' And, in case it gets forgotten, one practice nurse in Cheshire and Merseyside points out: 'Getting appointments is the greatest bugbear of all patients and, as clinicians, we are also patients who are unable to get appointments at times.'

Problems with contacting the practice

A lot of general practice health professionals cited time spent waiting on the phone as the major priority for patients. One GP says: 'People generally happy to wait 7-10 days for an appointment but get sorely pissed off on the phone in a queue.'

Ceri Gardener, a practice manager in Gloucestershire, points out a difference in attitude between practices and patients when it comes to ease of contacting the practice. 'I think for patients, time taken to answer a call is important to them whereas it's not such a priority for us. We all want to be able to give patients an appointment (where appropriate) within a reasonable timescale.'

As we will see in the Chapter 12, upgrades to phone systems seem to be having an effect – many respondents said they were seeing fewer complaints since the introduction of cloud-based telephony systems. This could help to explain the recent uptick in patient satisfaction rates.

Alongside this is the implementation of online triage, with patients being asked to submit forms electronically that are reviewed by a healthcare professional, normally a GP. But this route doesn't appeal to all patient groups. As Heather Wilson, a practice manager in Blackpool, puts it: 'Our patients are VERY resistant to change, they don't want to use the online form even if they can, even though we find patients put more useful information on the form than they do when speaking to a receptionist. I think our "wants" are the same as the patients apart from the form.' However, many practices report real improvements from the use of total triage (see Chapter 12).

Continuity

General practice staff themselves prioritise continuity of care above all else, ranking it number one by a good margin. Most of the comments referred to the health outcome benefits of continuity. For example, one says: 'Continuity reduces poor outcomes – saves time at appointments and gives patients more satisfaction.' Another says that 'seeing the GP saves time and resources and we often get to a diagnosis or plan much faster', while another called continuity 'a vital tool in supporting good quality health care'.

The benefits of continuity of care and the ways in which practices have been implementing it will be discussed at greater length in Chapter 15. But practices see it as a priority, partly because of the benefits it brings for healthcare professionals themselves. Leeds GP Dr Naweed Bukhari says: 'The benefits of this are well documented for patients (satisfaction, clinical outcomes, confidence/ease in their GP). But there are also benefits for GPs in terms of job satisfaction, time management and maybe fewer complaints.'

But although continuity was perceived as being of less importance to patients, primary care professionals did acknowledge its value for many. One GP says: 'For anything other than minor issues patients prefer continuity with clinicians they trust who know their history and their family. We have regular feedback that patients value face-to-face

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consultations and would rather wait a couple of days to get such an appointment with their preferred clinician.'

Beyond improved clinical outcomes, respondents cited practical reasons. 'Patients seeing multiple healthcare professionals and retelling history is a negative,' says one. 'Continuity is highly valued – patients actively request to not have to repeat their histories to someone new,' adds another.

Different patient groups

Perhaps the main theme to come through respondents' answers was that patients' priorities depended on their needs. Dr Sarah Dixon, a GP partner in Hertfordshire, says: 'In terms of continuity there are those patients with ongoing/ long term conditions or an episode of illness that needs more than one appointment and they generally want to see the same doctor, they don't want to keep explaining everything. This is the benefit of a long-term relationship with the same GP. There are others with one off issues who don't mind who they see, they just want to be seen quickly and at a convenient time. It can be challenging juggling the needs of both of these groups of patients.'

As one GP in Essex puts it, many patients are 'young and healthy, with a one off issue who don't often see a doctor and probably don't have a strong relationship with their named GP'. They won't want to wait for their named GP if another GP can see them sooner. Then there are the people with regular health needs or complex problems who, as the GP says, '*do* recognise the advantages of seeing the doctor who knows them well. Often but not always older people, but including most older people'.

There is another reason patients were perceived to rate shorter waiting times and waits on the telephone more highly. A number of respondents pointed out that patients value continuity of care only when waiting times and ability to contact the practice are relatively good – something we will see in Chapter 6.

SUMMARY

Access is not a single concept. It has a variety of elements, including routine waiting times, the availability of urgent or on-the-day appointments, the choice of face-to-face or remote appointments, and continuity of care or seeing a preferred healthcare professional. According to research, appointment availability with a GP has the greatest single effect on patient satisfaction.

General practice healthcare staff believe patients tend to prioritise waiting times and urgent appointments, whereas practices themselves list continuity of care above all else. However, there is nuance to this – different patient groups have different priorities, with younger patients favouring shorter waiting times and older patients or those with long-term conditions preferring continuity.

CHAPTER 4
GP practices feeling pressure from commissioners

There are varying forms of access, and different patient groups have different access priorities. But practices across the UK are feeling pressure from local and national commissioners to focus on different priorities at different times, and this pressure often proves counterproductive.

How various requirements affect practices

The Healthcare Improvement Studies Institute, Nuffield Trust and the Health Foundation have been tracking initiatives and have found more than 400 ideas and efforts to improve access to general practice in the UK in the past 40 years,[38] which they grouped into six major areas (Table 1[39]):

- Appointment innovations
- Giving patients direct access to services that remove the need to access general practice
- Increasing the number and range of professionals available to see patients within general practice
- Offering contacts beyond core hours, core settings and core services
- Supporting patient engagement, empowerment and education
- Supporting the internal and wider structures of general practice.

In Part 3, we will take a look at how successful these measures have been. However, these often conflicting demands around waiting times, extended access, improving ease of access, mode of consultation (remote or face to face) and all the other initiatives have an effect on how GP practices can deliver the standards of care they would like, practice staff say. They point out that they are often diverted from addressing their patients' needs by having to prioritise other areas – including those unrelated to access.

Peter Woodward, a practice manager in Cheadle, says patient feedback 'consistently highlights two recurring frustrations: "you sit forever on the phone" and "you can't see your GP"'. But his award-winning practice struggles to spend enough time on these important issues: 'Rather than adopting a patient-centred strategy to address these areas, which directly affect the majority of our patients, practices are frequently drawn into a wide range of other important but competing priorities: neighbourhood integration, screening uptake, vaccination drives, outbreak response, locally commissioned services, ICB initiatives and public health campaigns. Each has merit, but the absence of an overarching framework to align these with core patient expectations risks leaving patients dissatisfied and staff demoralised.'

The problem ultimately comes down to supply and demand, some respondents say. One practice manager in the north-east of England, says: 'The 8am rush persists and will as long as demand outstrips supply. What practices struggle with is the various methods used, from econsultations, to direct emails, to phone calls including callbacks instigated by NHS England, to call-ins and queues outside the practice from 7am.

TABLE 1 Grouping the attempts to improve access

Category of approach	Examples
Appointment innovations	• Using triage to optimise appointment allocation • Using telehealth to expand the types of appointments on offer
Giving patients direct access to services that remove the need to access general practice	• Self-referral to physiotherapy, psychological services and some types of specialist care (eg, sexual health) • Expanding services offered by community pharmacists (eg, blood pressure checks, oral contraceptive reviews)
Increasing the number and range of professionals available to see patients within general practice	• ARRS • Programmes to enhance recruitment to GP training
Offering contacts beyond core hours, core settings and core services	• Practices providing appointments on weekday evenings or at weekends • Walk-in centres and urgent care clinics
Supporting patient engagement, empowerment and education	• Online advice tools and AI-supported symptom checkers • Improving local transport links to practices • Making practice registration processes easier
Supporting the internal and wider structures of general practice	• Larger-scale general practice • Integration of general practices with hospital trusts and secondary care • Allowing commercial for-profit providers to bid for primary care contracts • Reduction of bureaucracy in general practice

HOW GOVERNMENT POLICY CAN HAVE UNWANTED CONSEQUENCES

We're a single-site practice in the centre of Cambridge with a mixed population of around 15,000 (slightly student weighted). We are six partners and one (soon to be two) salaried GPs, all with personal lists (with salaried GPs' list capped in size) and minor illness cover most days via the advanced nurse practitioner and paramedic.

At present, we manage access completely through Accurx triage, which is on from 8am to 11.30am and 1.30pm to 5pm. Our patients can phone us and can be helped to fill in the Accurx form, but all inputs are streamlined through Accurx so there is one source through which we can prioritise. If a patient walks in, they are given a paper form which is triaged in the same way.

We aim for most routine patients to see their named or requested GP or the doctor they're consulting about that problem, within two to four weeks, as appropriate. Each GP has 'continuity slots' in their rota. Duty doctor shifts last half a day to guard against decision fatigue, hence the need to pause Accurx between 11.30 and 13.30 to enable the morning influx to be completed prior to changeover and allow for visits, paperwork, meetings etc.

Patients are 'trained' to contact us when Accurx is 'on' and know that, in an 'emergency', they can phone when Accurx is 'off'. Our concern is that the high continuity, high proportion of face-to-face appointments and rapid (same-day) response we achieve, along with online access for seven hours daily and phone and walk-in access, will actually deteriorate if online access is open all day.

This could have a number of consequences. It may further disadvantage patients without online access, risking discrimination. Also, when we have trialled 24/7 access to Accurx, it led to increased demand, making it harder to prioritise clinical need – it's easier to contact your GP than search nhs.net, especially for the 3am self-limiting minor illness. Finally, it takes away from continuity.

We'll have to decide between faster processing and potentially poorer decisions, or safeguard against decision fatigue/system overwhelm and reduce appointments. It is potentially a patient safety issue – decisions none of us want to be forced into with limited funding. Our triage is purposefully 'doctor heavy', as GPs are often the most experienced clinicians to make these decisions at speed.

Dr Liz Woodroffe, GP partner, Cambridgeshire

'Commissioners seem ignorant of the fact that allowing patients to contact practices in more ways does not help them as the supply of appointments is finite and just gives patients cause to complain, saying "you never answer the phone, you never answer my emails, you are disadvantaging those with no IT knowledge", etc. More methods means more complaints not more appointments.'

This leads to practices changing their policies. As one GP in north-west London puts it: 'Patients just want phones answered and patches to be open all day. So we have hired an extra receptionist to achieve this metric.'

A good example of these national demands is the contractual requirement set to be introduced in October 2025 that will oblige practices to keep their online access portals open from 8am to 6:30pm every day. While this is something all practices would ideally want to offer, it will have implications for provision of care while their capacity remains as it is (see case study, p21).

A GP in the Buckinghamshire, Berkshire and Oxfordshire ICB says: 'The 8am to 6:30pm online access is unsafe. We will have to block appointments to cover this safely, as people always put in clinically time-critical requests despite red flags warnings and pop-ups. A recent example was a mother asking about a 15-day-old baby with a sticky eye – buried in this was a comment that her baby was making grunting sounds with her breathing.'

This is not to say that these various requirements are unimportant. As we have seen, patients understandably value ease of contacting the practice, and being able to get timely appointments with the right healthcare professional. But, as practice manager Peter Woodward puts it: 'Fundamentally, we can either do a few things well, or a lot of things averagely.'

The local pressure

It is not only national policy that creates pressure for practices – there is local commissioner pressure too. This slightly differs in that it tends to be less contractual – the GP contract in England is negotiated between the BMA and NHS England, ultimately with sign-off from the Department of Health and Social Care (DHSC) and the Treasury. But local commissioners are responsible for implementing the contract, and approaches to this differ. As they have this responsibility, even an informal complaint from ICBs in England around a practice's level of access has implications.

OUR LOCAL COMMISSIONERS SUPPORT US

As a practice we put a high value on proactive care to help balance the reactive on-the-day care. For example, optimising all the patients with a respiratory issue in the summer has meant we've not had to nebulise in the winter.

Another example would be we aim to get 90% of the QOF work finished before flu season starts, which allows us to have cleared things by the traditional winter pressures and then in the spring we can proactively look for new diagnoses rather than scrambling to get QOF finished.

Alongside the proactive work, we analyse all our data sources, telephony, NHS app, EMIS, Ardens, Connected Care and we look for pinch points or areas of improvement. Then through knowing the problems we can change process or buy in products/skills that match the actual, not perceived, needs of the patients.

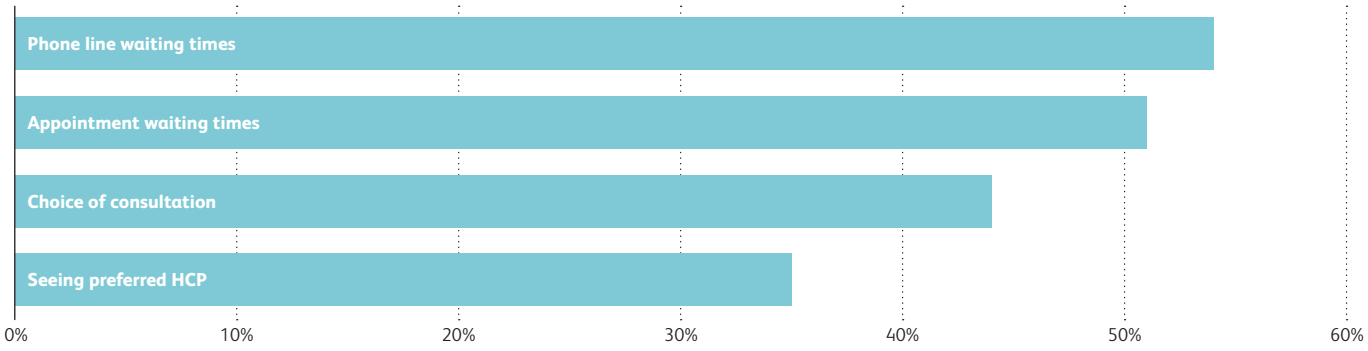
We do this in collaboration with the Frimley ICB transformation team and our colleagues in secondary care to ensure it doesn't just move work to another part of the system.

Practice manager, Frimley, Surrey

Cogora's survey of GP partners and practice managers – with duplicate practices removed (which we are labelling 'distinct practices' – see Methodology) reveals that they do feel pressured by commissioners (Chart 19[40]). The most common causes are telephone waiting times and appointment waiting times, with more than half of practices saying they had felt pressure on each of these. Pressure around the modality of appointment (face to face, remote) and seeing the preferred healthcare professional is slightly lower.

Sometimes this pressure comes through local enhanced

CHART 19 Practices who say they have faced pressure over forms of access from commissioners[40]



services – locally determined contracts to provide additional services, which many practices rely on for funding.

As one GP from Cornwall puts it: 'We have felt clear pressure from local commissioners to improve several key areas of patient access and experience. This includes reducing overall wait times, shortening the time patients spend waiting on the phone, and increasing opportunities for patients to see their preferred clinician to support continuity of care.

'There has also been a strong push to offer greater patient choice in the type of appointment – whether face to face, telephone or online – to better meet individual needs and preferences. While these aims are understandable and align with improving patient care, they add to the operational demands on already stretched services.'

Dr Rebecca Lewis, a GP in the Black Country, says the local framework asks for a certain number of appointments per 1,000 patients per week, and this number has recently increased. 'These can be appointments with anyone in the practice – not just doctors – so the targets are easy to hit, but one has to ask why we need them? If we were free to decide who would benefit from our time the most, within reason, I am sure primary care would offer enough access (of the right kind) to the patients who need it most.

'The issue with all this is there has to be targets and that way they can be measured. But you cannot make the medicine fit the money, and trying to do so leads to moral distress and burnout, and makes people walk away from the jobs they trained long and hard for. This ultimately punishes the patients when practices close, cannot recruit or have very high list sizes with poor continuity and high staff turnover.'

In the north-west of England, one GP working in an APMS practice says their contract – which is negotiated outside of the standard national contract – places requirements that affect the quality of care. He says: 'We have to provide certain things, including urgent access by making a proportion of appointments available each day, correlated with how many of our registered patients access local emergency departments.

'Our clinics currently consist of about one quarter pre-bookable and one quarter to give results/plans. The other half is urgent on the day, which will become total triage dependant by October. It's hard for us to meet the wishes of patients, who often say they want a particular clinician, while balancing the need to prioritise urgent access. They would be prepared to wait, but we only have so many appointments to offer and so we can't convert future urgent slots into follow-up without consequences. People end up just seeing whoever is free and it's just unsatisfactory.'

Not all experiences of local commissioners are negative. When they are supportive, it can benefit GP practices and ultimately improve access.

One practice manager in Frimley, Surrey says his practice has had 'absolutely heaps' of support from the ICB (see case study, p22). 'The ICB in Frimley are colleagues and not dictators. This has led to a very symbiotic way of working,'

SUMMARY

There have been numerous initiatives from successive governments around improving access. In many cases, there has been a focus on increasing the workforce, with the most successful attempts involving the appointment of non-GP direct patient care staff. Other initiatives have involved weekend and evening appointments, support with improving practices' communications infrastructure, training staff on care navigation and improved remote consultations.

Although all these are important, GP partners and practices managers say the contractual requirements – either the mandatory ones or those with essential funding attached – have reduced practices' ability to prioritise the areas of care they feel most benefit their patients. The change due in October 2025 to mandate online access provision throughout core hours is seen as an example of this.

Alongside this, many practices are facing pressure from local commissioners around access, again sometimes at the expense of good patient care. But local commissioners can be a support if they build relationships with practices instead of simply imposing targets.

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CHAPTER 5
The practice-patient relationship is being affected

Practices do not only experience pressure from governments and commissioners, however. The past decade has seen a much sharper media focus on GP access, leading to some to ask whether the media is reporting on issues, or contributing to them.

There is no doubt that consistent media pressure is affecting practice staff morale. More importantly, the media-driven perception around a reduction in access – as well as any actual reduction – is impacting the patient-practice relationship.

The media landscape

In February 2021, a *Pulse* study looked at media coverage involving GPs. It found reporting within news, features, opinions and editorials was still broadly supportive in 2020, the first year of the pandemic. However, at a time when the NHS was being lauded across the media and society in general, coverage of general practice was becoming harsher. In 2018, around 23% of articles had a negative perception of GPs; in 2019, this fell to 19% but by 2020, almost half of articles (45%) had a negative slant.[41] In 2018 and 2019 around 11% and 12% of articles blamed GPs for access problems, in 2020 this rose to 20%.

These included headlines such as: 'Why are GPs STILL refusing to see people face-to-face?' (*Daily Mail*)[42]; 'Warning of extra cancer deaths after more than 25m GP appointments lost during pandemic' (*Telegraph*)[43]; and 'Woman refused GP appointment for cough in lockdown told she has just six months to live' (*Mirror*).[44] This conclusion was supported by a paper by researchers at the University of Oxford.[45]

It is true face-to-face appointments had dramatically reduced in 2020 during lockdowns. But these headlines missed the fact that GP practices had been mandated by NHS England to move to total triage, with only exceptional cases to be seen face to face.[46] And as we saw in Chapter 1, health secretary Matt Hancock had said 'all consultations should be teleconsultations unless there's a compelling clinical reason not to'.

This came to a head in May 2021, when NHS England wrote to practices telling them to ensure patients could book face-to-face appointments.[47] In the context of the pandemic, the letter caused fury among the GP profession. The BMA branded it 'tone deaf' and 'badly judged', and demanded a meeting over the letter with the health secretary, while a number of GP leaders referenced the media narrative at this time.[48]

Reporting around GP access took a turn for the worse during that period, and has remained fairly consistent since. The *Mail* and *Telegraph* have launched tools using appointment data and patient satisfaction scores allowing readers to see how their practice compares. The *Mail's* article was headlined: 'The ultimate guide to all of England's 6,000 GP practices – so is YOURS one of the worst? From how jammed their phone lines are to the competition for appointments, our search tool reveals all...'[49] Meanwhile, the *Telegraph* asked: 'Are you waiting too long for a GP appointment? Use our tool to find out.'[50] This came amid numerous articles questioning the number of face-to-face appointments being offered by GP practices.

A number of respondents to Cogora's recent surveys referenced media coverage, and its effect on their morale. One practice manager in Norwich put the blame on the media for the perception of general practice: 'The media are the main issue, telling patients stuff that is only half true, or is indeed entirely false.' This was echoed by a GP respondent: 'People do not wish to wait, they are fuelled by the media that GPs do nothing all day.' One GP questioned the wording of our survey, asking: 'When you say "online abuse" do you mean from patients, or the constant low level abuse from the *Daily Mail*, the *Telegraph*, the BBC, etc? That's pretty demoralising too.'

One GP in south Wales says the coverage is worse than individual complaints: 'Personally, I think the abuse I take to heart is about primary care/GPs in general in the news/social media, not directly at me.'

It is also common to see local news sites ranking the 'best' and 'worst' GP practices in their region based on appointment data and patient satisfaction. A practice manager in Blackpool says: 'We're not supposed to be booking more than two weeks ahead or we are negatively highlighted by the local press.'

31%
of complaints relate to access

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CHART 20 Practice staff say complaints about access have increased since the start of Covid[53]

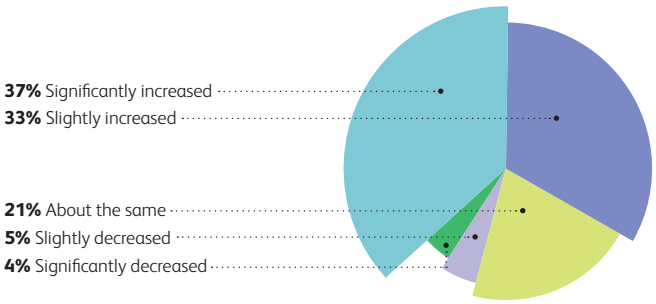
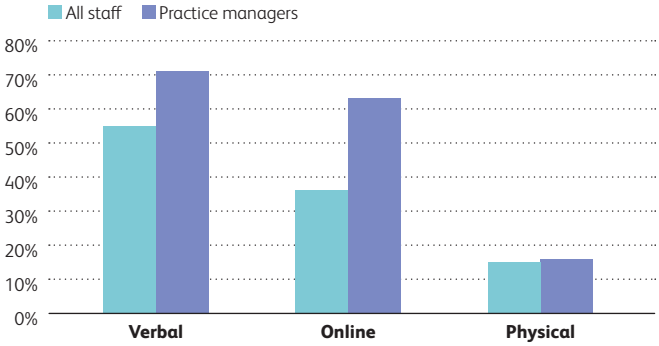


CHART 21 Staff who face abuse 'often' or 'occasionally'[51]



The patient-practice relationship

Regardless of the media's role, the patient-practice relationship has been deteriorating since the start of the pandemic.

Our survey results found complaints around access had risen since the start of Covid, with respondents saying they had increased significantly (37%) or slightly(33%) (Chart 20[51]). In total, respondents said 31% of complaints related to access.[52]

Meanwhile, more than half of general practice staff say they receive verbal abuse around access 'often' or 'occasionally'. For practice managers, the figure is significantly higher (Chart 21[53]).

One locum GP in Cornwall says: 'In my experience, since the post-pandemic era, patients have been increasingly abusive, demanding and entitled towards GPs and other practice staff. Language and attitudes which would have been a rarity before 2020 are now almost a daily occurrence... I suspect I will leave the NHS entirely in the near future as a result of the workload pressures, under-resourcing and patient attitudes.'

Practice managers and non-clinical staff bear the brunt of complaints and abuse. Wendy Foster, a practice manager in Surrey, says: 'We still get abuse from some patients, verbal to punching the reception desk, albeit not daily occurrence. This is usually I want to be seen NOW and we tell them we're not an emergency service.' Mike Neville, a managing partner in Greater Manchester, says: 'The abuse is over the phone, on social media/ google reviews and in person with many patients taking their frustrations out on non-clinical teams from swearing through to approaching staff members and shouting in an intimidating way'. However, he says abuse towards clinical staff is becoming more prevalent with a social shift away from traditional respect towards them. He adds: 'I have created a form for staff to fill in called the "Patient abuse incident reporting form" which formalises the abuse and an investigation arises. In the last three months, I have issued zero tolerance letters to patients as first and last warnings, as well as removing two patients for their behaviour.'

These complaints can even carry a legal threat. As one GP puts it: 'It is common for lawyers to slip an access criticism in there in addition, especially for weaker claims!'

But there is sympathy for patients from general practice staff. One GP in Kent says: 'Almost every patient rants. I tell them the system is broken and I share their frustration.' But staff shouldn't have to deal with abuse, a GP in Cornwall says: 'We have faced occasional incidents of physical abuse, multiple instances of verbal abuse, and increasing levels of online abuse of staff. We understand frustration around access, but such behaviour has a significant impact on team wellbeing and morale.'

But many respondents said improved access – mainly from modernising phone lines (see Chapter 12) – did reduce complaints and abuse. A Staffordshire practice pharmacist says: 'We've had total triage for four years, it has dramatically reduced complaints about wait times. All requests are reviewed by a clinician so it is easier for reception and admin staff to address complaints and explain it has been reviewed. On-the-day availability for truly urgent matters has increased through screening.'

Practice staff acknowledge that patients are within their rights to be frustrated on the whole. But is it possible to provide the kind of access that will ease the frustration? Or do some forms of access need to be sacrificed in favour of others, depending on patient populations? We will examine this in the next chapter.

SUMMARY

Since the beginning of the pandemic, general practice staff have felt increasingly disillusioned around the media's reporting of access. Media coverage did become more negative from 2020, and primary care professionals felt much of this negative coverage was undeserved, focusing on a lack of face-to-face appointments at a time when they had been instructed to move to total triage and offer more remote consultations. This adverse coverage continues today, and many feel that it is fuelling a poor perception of practices among patients.

The number of complaints from patients has been increasing in that period, and practice staff – especially non-clinical – are facing increased abuse. While our survey respondents said the abuse was never deserved, they share patients' frustrations. Many practice staff have seen a fall in complaints when access – especially via telephone contact – has improved.

PART THREE

What leads to 'good access'?

CHAPTER 6
How the different forms of access are related

Practices face pressure across the board regarding the availability of appointments, whether that is consultations per patient, waiting times for routine appointments, on-the-day care, seeing a GP or the mode of consultation (face to face or remote). There is also interest in how much this affects patient satisfaction beyond the logistical aspect of how easy it is for them to contact the practice.

The IfG report illuminated many of these issues, especially on patient satisfaction.[54] To glean what types of access had the most effect on overall patient satisfaction, it examined data from the GP Patient Survey, which asked patients: 'Overall, how would you describe your experience of your GP practice?'

The IfG identified two elements of access that had a real effect on the numbers of patients answering 'good' or 'very good' to that question. It found that patient satisfaction increased with more GP appointments but not significantly so with non-GP appointments, and that patient satisfaction was higher in practices that provide more appointments face to face, especially those where a large proportion of patients are aged over 65.

This suggests that successive governments' ambitions to offer more appointments – either on the day or routine – are misguided. The IfG found a trade-off between the total number of appointments offered by a GP practice and the proportion of these that are face to face – in other words, they can offer more appointments remotely in the same time as they can face to face. Equally, policy has been to increase the overall workforce in an attempt to offer more appointments overall.

The IfG report concluded: 'Patients care about more than just access to general practice; they also care about how those appointments are delivered. It is difficult to assess the quality

TABLE 2 Upper limits for each decile on different appointment metrics

Decile	Total appointments	Face-to-face appointments	Appointments with a GP	Appointments within a day	Routine waiting times
1	3,150	1,872	1,306	1,311	17.51 days
2	3,558	2,188	1,542	1,572	15.90 days
3	3,853	2,427	1,729	1,789	14.78 days
4	4,162	2,652	1,885	2,001	13.77 days
5	4,449	2,874	2,045	2,208	12.88 days
6	4,773	3,128	2,213	2,432	12.02 days
7	5,147	3,400	2,406	2,713	11.05 days
8	5,631	3,758	2,653	3,100	10.08 days
9	6,454	4,359	3,117	3,744	8.84 days
10	6,455+	4,360+	3,118+	3,745+	Less than 8.84 days

Table 2 shows the upper limits for each decile used throughout this part, based on appointments per 10,000 patients per month. The routine waiting times are an average of the waiting times when appointments on the day or within a day are removed.

CHART 22 How performance on face-to-face appointments correlates with other access metrics[57]

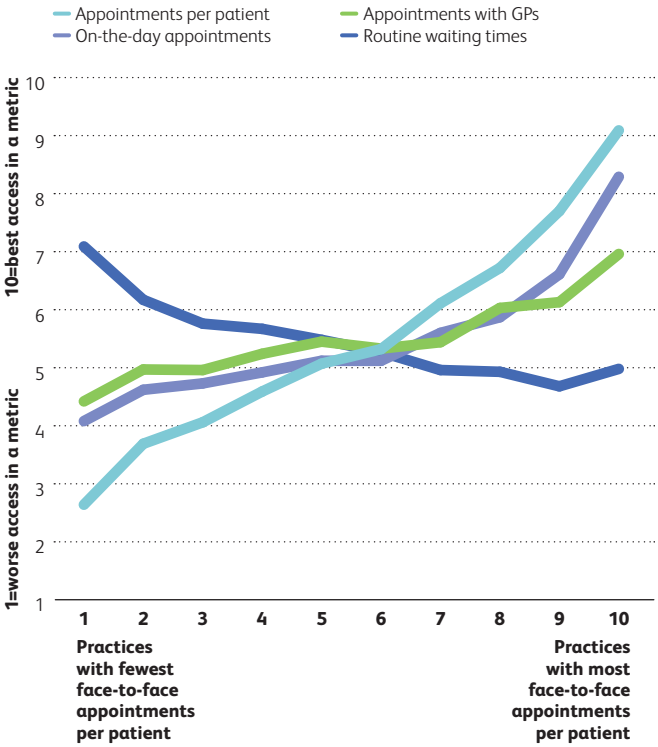
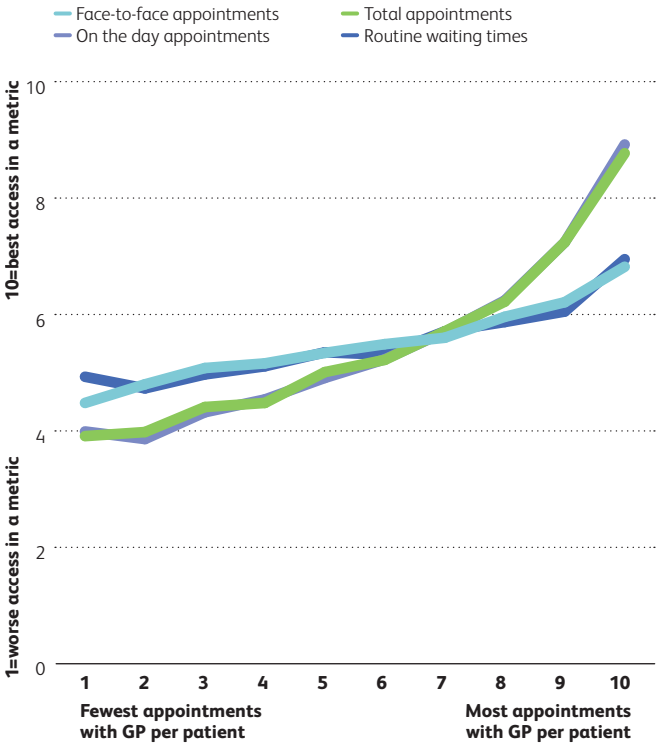


CHART 23 How performance on GP appointments correlates with other access metrics[58]



of appointments, but this report has shown that practices that provide more appointments remotely are associated with lower patient satisfaction.'

Appointment data analysis

Our own analysis of appointment data looked at how each element of access affects the others: overall numbers of appointments delivered; routine waiting times; appointments within 24 hours of booking; the number of face-to-face appointments delivered; the number of appointments provided by GPs; and patient satisfaction scores around continuity.

Based on discussions with primary care staff, it was expected that there would be trade-offs between these elements. A *Pulse* analysis from January 2023 showed practices that delivered a high proportion of their appointments face to face had longer waiting times and also had a lower proportion provided by a GP[55] – -findings backed by Kings College researchers.[56]

However, our analysis of three months' worth of appointment data from May to July 2025 looked at total numbers of appointments, face-to-face appointments and GP appointments per 1,000 patients – as opposed to proportions. We placed each practice in England in a decile based on the number of each type of appointment per 1,000 patients they delivered per month (Table 2). This is a crude methodology, and is not statistically robust. But it does suggest associations.

It seemed to show that practices that provide higher numbers of appointments per 1,000 patients were in fact more likely to provide higher total numbers of face-to-face appointments, more with GPs and more appointments within a day. As *Pulse*'s January 2023 analysis showed, it might be that the *proportion* of face-to-face appointments affects the *proportion* of appointments carried out by a GP, for example, but total numbers still remain high. In other words, a practice performing 'highly' in one access metric tends to perform 'highly' in all of them (Charts 22,[57] 23[58]).

The word 'highly' is used with caution. In terms of appointments with a GP, some consultations are more appropriately done by another member of the practice team. In terms of face-to-face appointments, some patients prefer remote.

This ambiguity over high performance is most true with appointment waiting times. These are calculated from first booking to the appointment taking place. Often, it is not appropriate or even convenient to be given appointments within a day. And in terms of routine waiting times – that is, all appointments excluding those within a day – there is a discrepancy in that those with shorter routine waiting times don't necessarily perform better in other metrics (Chart 24[59]). This is easily explainable – good practice would often dictate that appointments booked well in advance are often the most appropriate – for example, when dealing with long-term conditions.

That said, as the IfG report showed, there are benefits to appointments with GPs and face-to-face appointments. And, as crude as these metrics are, the GP appointment data do reveal that some practices are able to provide it all in terms of access.

CHART 24 How performance on routine waiting times relates to other access metrics[59]

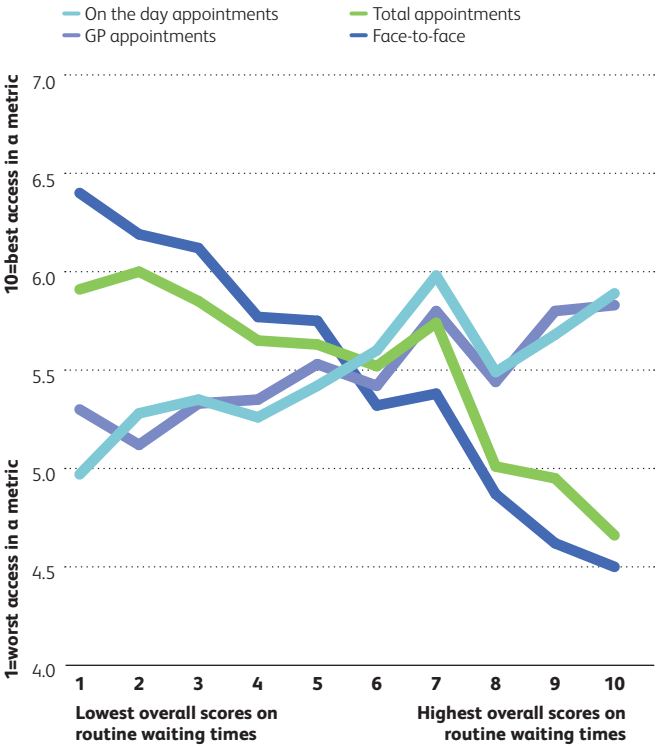
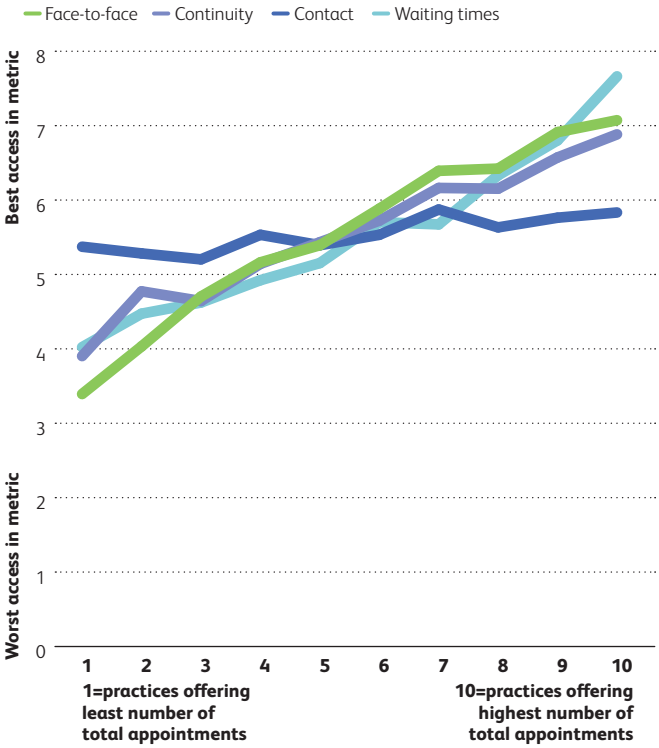


CHART 25 Practices with more appointments score higher on all metrics[60]



Patient satisfaction

This could be seen as a logical product of the NHS Digital statistics – that a greater number of appointments overall would necessarily mean more appointments with GPs and more face to face. We combined NHS Digital data with patient survey data. For face-to-face appointments, we combined rankings on the NHS Digital data with rankings based on how many patient survey respondents said their last appointment was face to face. We added patient scores around continuity – whether they saw their preferred healthcare professional at their last consultation – to data on appointments with GPs. We also added patient scores around ease of contacting the practice (see Methodology).

This seems to show that there are still associations between the availability of appointments per patient and other metrics when taking patient survey data into account, including ease of contacting the practice (Chart 25[60]).

But when we add patients' own views on waiting times, there seems to be a much stronger association with the other forms of access (Chart 26[61]).

This suggests practices that are strong on some forms of access tend to be strong on all forms, with some exceptions of course. But, as we will see in the next chapter, this does not mean some practices are 'better' than others. There are a number of systemic factors involved.

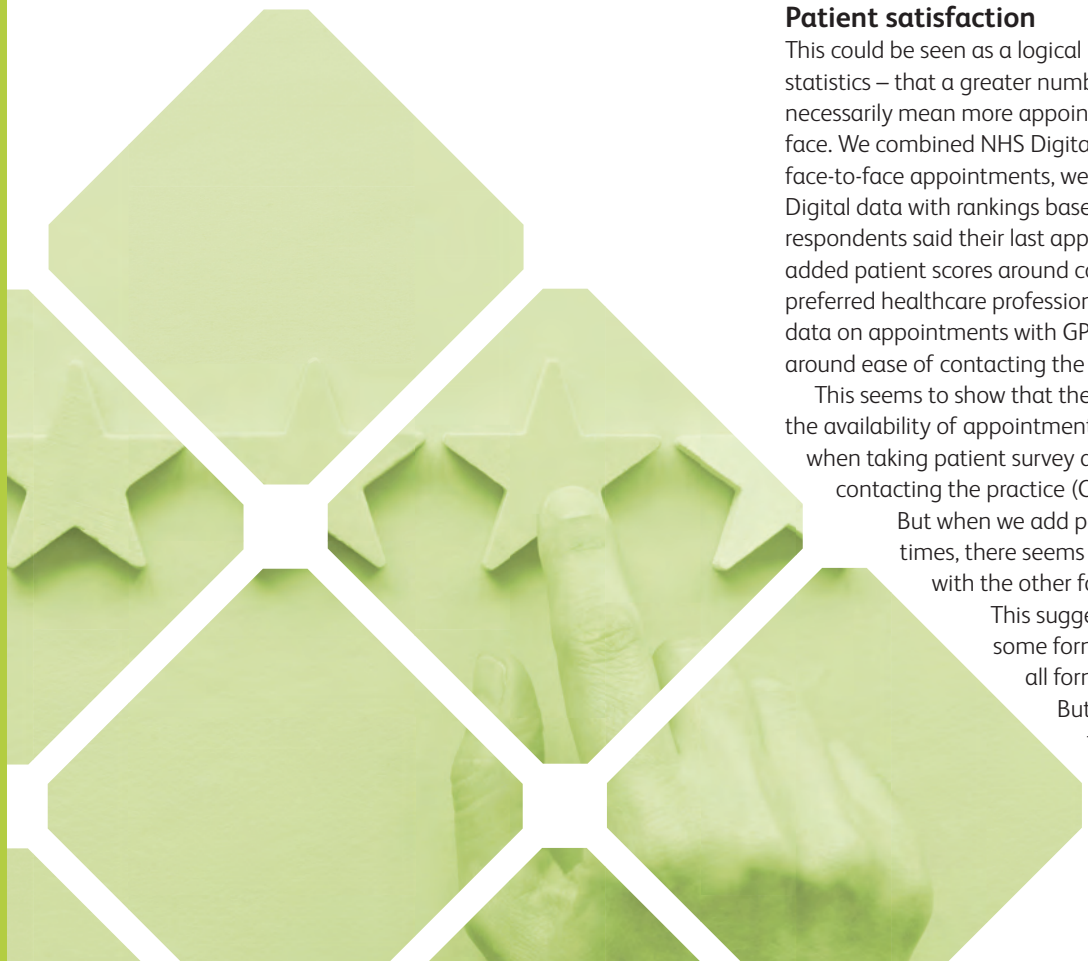


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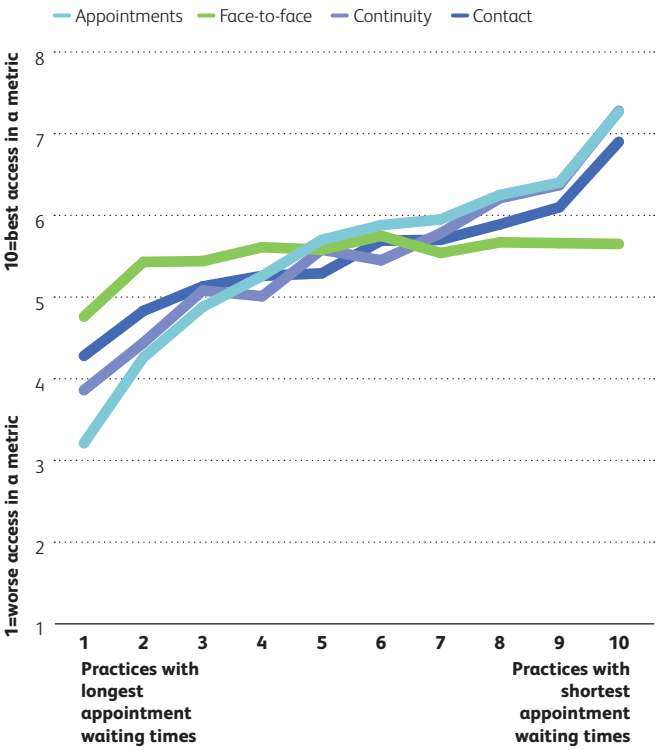
CHART 26 Practices with better waiting times score higher on all metrics when including patient survey data[61]



SUMMARY

An Institute for Government report revealed that overall patient satisfaction increases with practices offering more face-to-face appointments, and more appointments with GPs. More appointments with other healthcare staff has no effect on patient satisfaction, which calls into question government policies to use other direct patient care staff to deliver more appointments.

Our analysis seems to reveal that practices don't necessarily need to concentrate on one form of access over others. While a previous *Pulse* analysis found that those offering a higher proportion of GP appointments tended to offer lower proportions of face-to-face slots, looking at absolute figures seems to show that practices can offer a higher number of all the preferred forms of access based on the number of patients.

This may even be true when we add patient survey scores to the equation. In other words, on the face of it, there are 'high' performing practices and 'low' performing practices in terms of access.

CHAPTER 7
How systemic issues determine good access

It has been tempting for policymakers and the media to hold up examples of good practice when it comes to GP access, and bash practices that they say are not offering good levels of access. Indeed, health secretary Wes Streeting caused anger among GPs with his comment in January 2025 that some GPs were 'coasting'.[62] As we saw in the previous chapter, it is true that there are some practices that are strong on access and others that are less so.

But that doesn't tell the full story. In fact, there look to be several clear and interlinked factors that determine whether a practice will provide strong access.

We ranked practices in England on a variety of factors around access, including their appointments per patient (total appointments, face to face, with a GP, within a day and routine waiting times). We combined this with various patient survey metrics, including: patients seeing their preferred healthcare professional on their last visit; how long they waited on the phone; their recollection of waiting times; and whether they felt waiting times were appropriate, among other factors (see Methodology).

This methodology is fairly crude and has a number of flaws, and a number of caveats that have been discussed elsewhere in this report. But however we tweaked the weighting of these metrics, it seemed that practices providing good access had a number of characteristics in common – most of which are linked.

We looked at seven factors, all of which were linked to the level of access provided by GP practices:

- Age of patient population
- Practice funding
- Disease prevalence
- Workforce
- Size of practice
- Ethnicity of patient population
- Deprivation levels.

Age, funding, disease prevalence and workforce

The reason these are grouped together is they are all directly linked – in England, the Carr-Hill formula that determines practice funding gives the greatest weighting to age and disease prevalence.[63] Our analysis seems to reveal that practices with older patients, higher disease prevalence and higher levels of funding offer better access (Charts 27,[64] 28,[65] 29[66]).

It is unwise to make causal links here, especially with regard to disease prevalence and funding. First, the disease prevalence aspect of the global sum – which is the core funding for practices – continues to be based on data from the Health Survey for England 1998-2000.[67] Second, the disease prevalence recorded here is based on Quality and Outcomes Framework (QOF) reporting. But well-run practices (which, presumably, will offer better access) tend to be more efficient when it comes

CHART 27 High performance is linked to age of patient population[64]

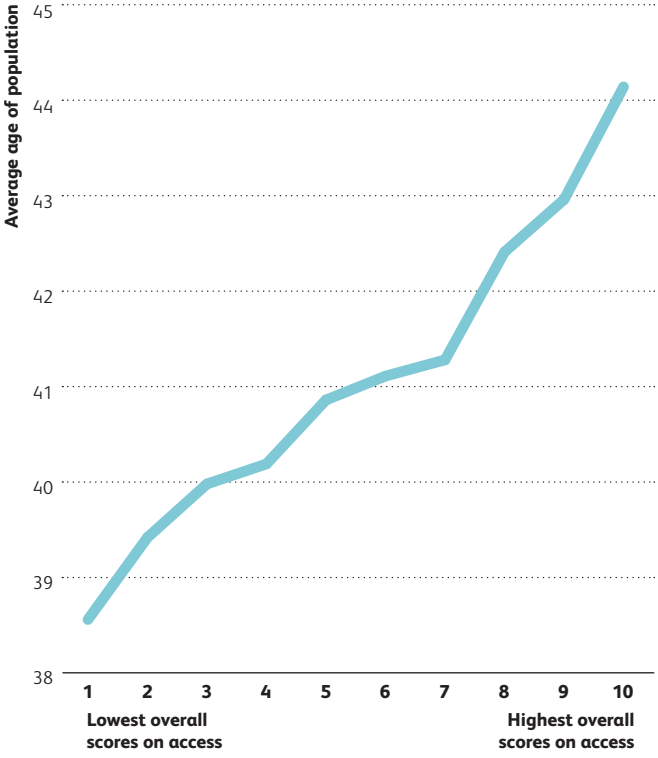


CHART 29 High performance is linked to disease prevalence[66]

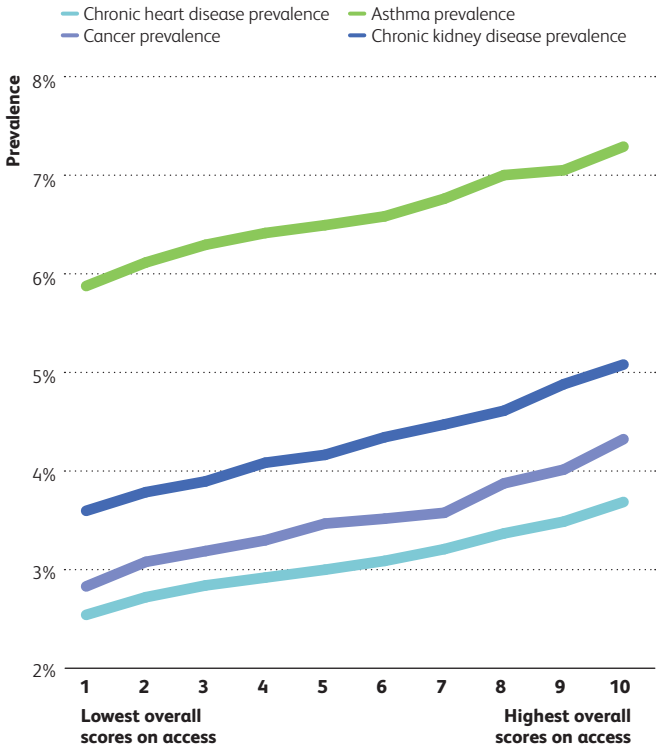
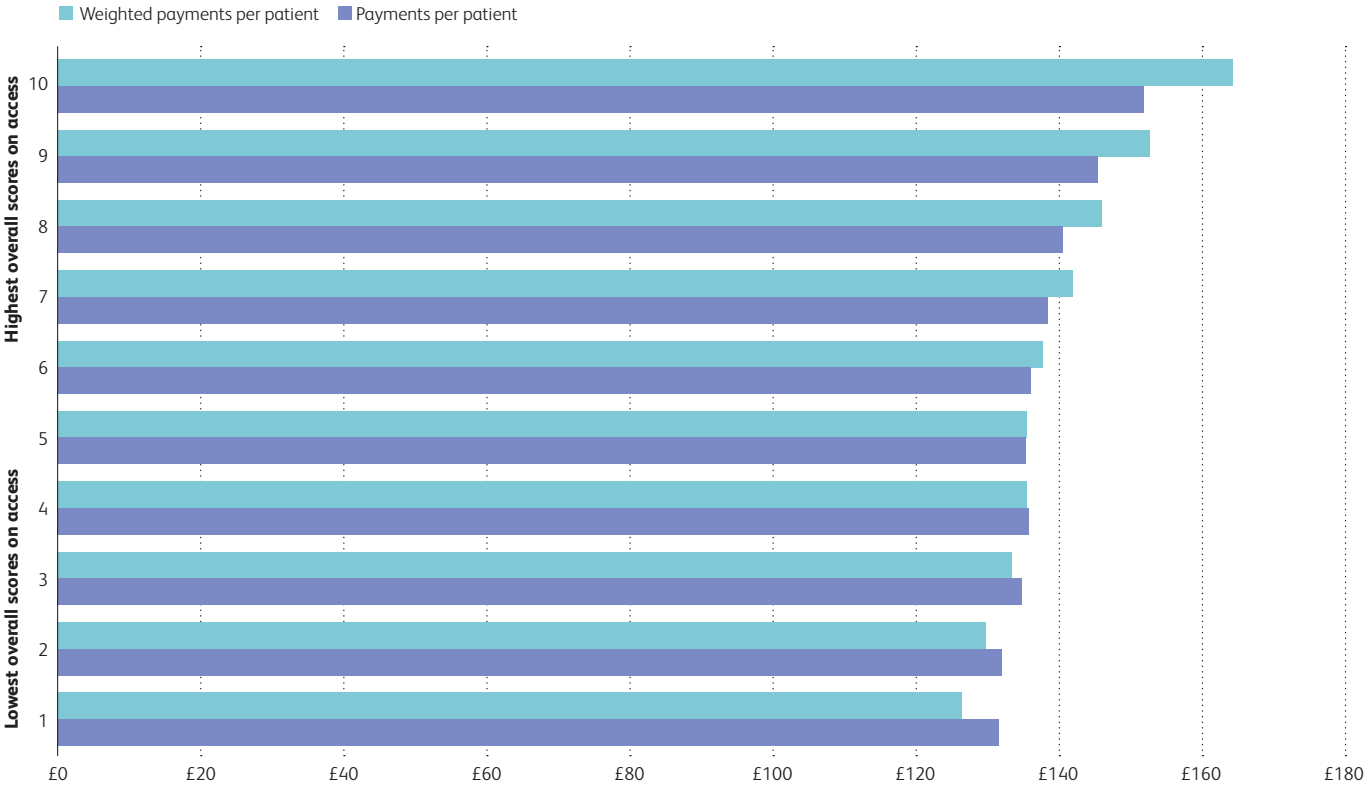


CHART 28 High performance is linked to payments per patient[65]



to recording conditions, as this leads to higher QOF payments. Meanwhile, well-run practices may receive more funding overall due to the QOF, and other enhanced services they provide, leading to more questions around whether more funding is a cause or consequence of being well run.

Those caveats aside, these charts should provide some cheer by showing that those practices whose patients have the highest needs seem to provide the best access.

When we look at funding on its own, there are clear links between a practice's level of funding and the number of appointments it provides across all metrics (Chart 30[68]). Interestingly, routine waiting times are longer, based on the practice's funding levels – but this can be easily explained by the number of patients at the practice who have long-term conditions. These patients are likely to book appointments further in advance (Chart 31[69]).

Age and disease prevalence is linked to higher funding, and the most obvious way this turns into better access is through recruitment (Chart 32[70]). It is therefore unsurprising – but, policy-wise, incredibly important – to see that the best-performing practices have fewer patients per GP and per healthcare staff member than worse performing practices. (Anecdotally, we also know that training practices find it easier to recruit – see case study, p32). There are nuances to this, which will be discussed at length in Chapter 9.

Professor Azeem Majeed, head of the department of primary

CHART 30 Payment per weighted patient is linked to the number of appointments provided[68]

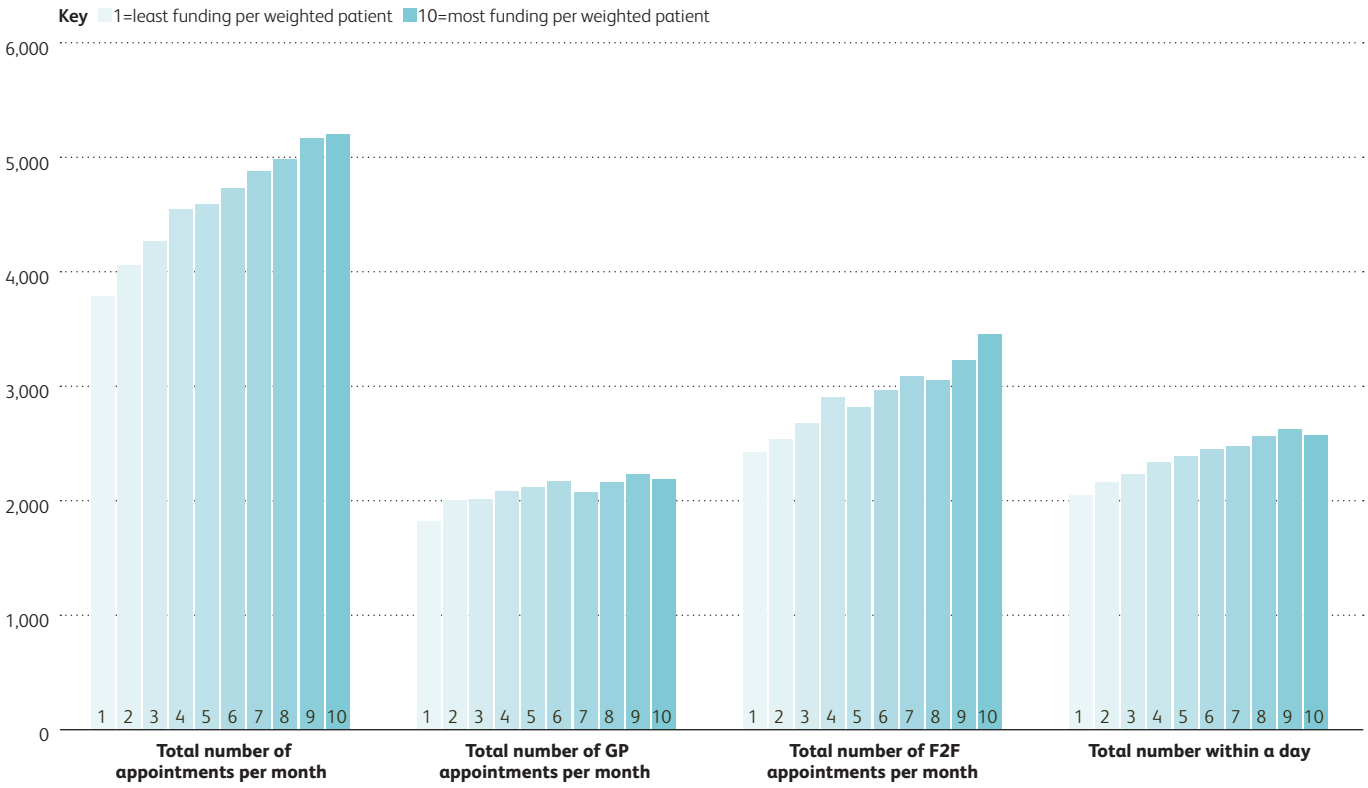
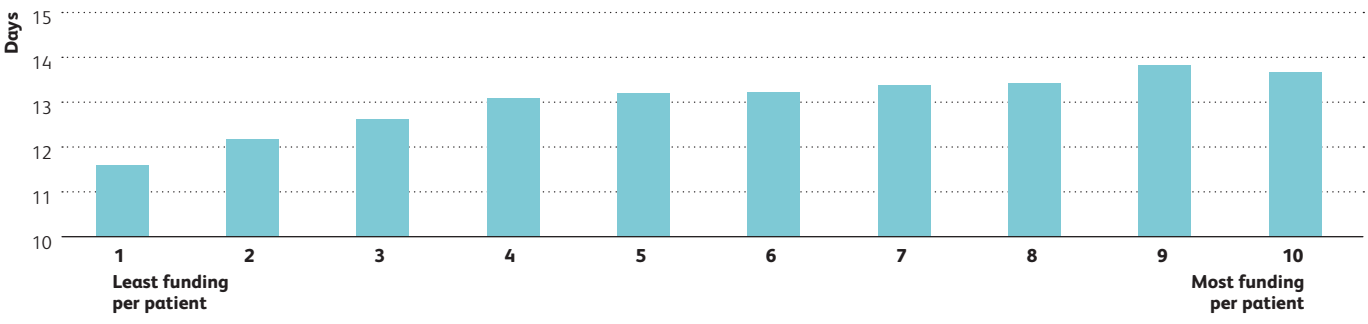


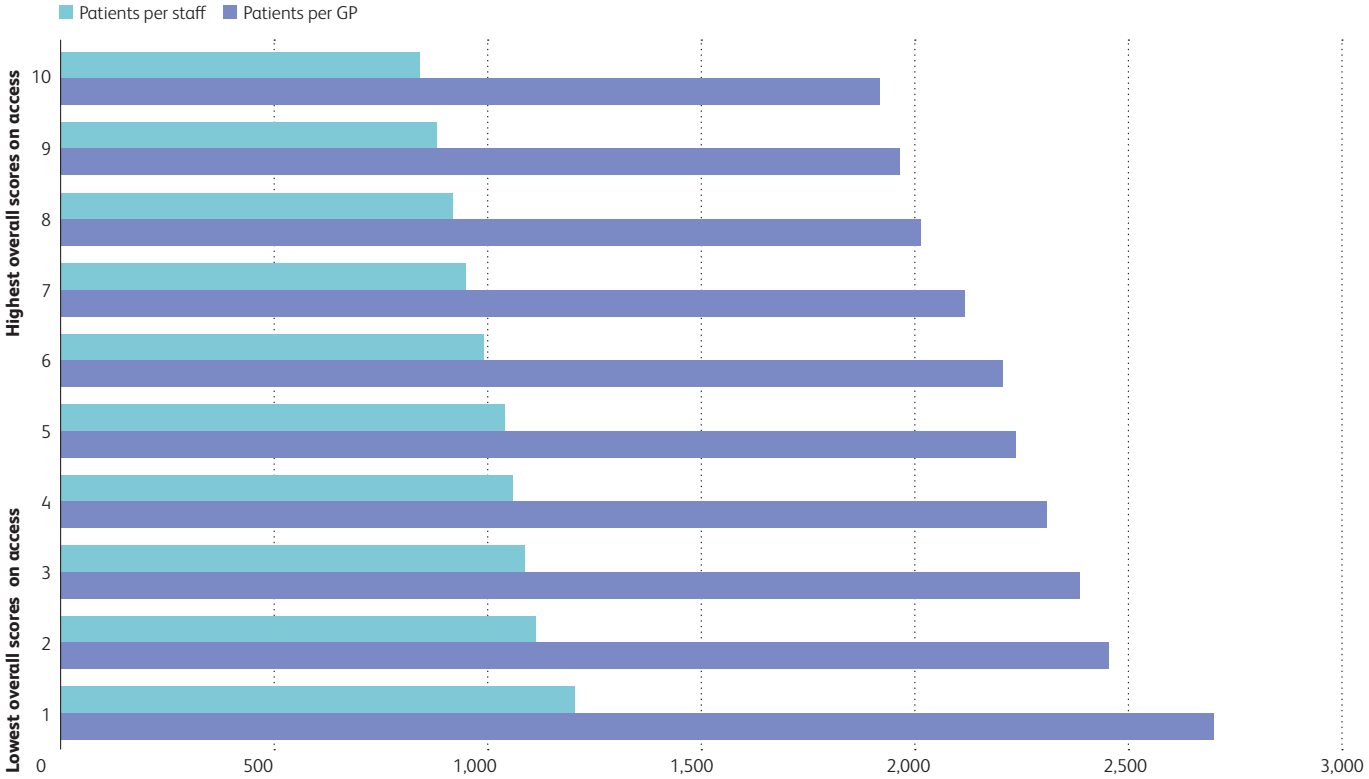
CHART 31 Practices with greater funding have longer waiting times for routine appointments (over two days after booking)[69]



care and public health at Imperial College London, says of the link between high performance and age of patients, funding and workforce: 'This makes intuitive sense and is also supported by the evidence. Practices serving older populations, or those with higher levels of deprivation and disease burden, inevitably need more capacity to meet demand.

'If funding and workforce provision do not adequately adjust for these factors, then patients in these communities will experience poorer access and lower satisfaction. The implication is that equitable access depends on aligning resources to patient need, not just to crude headcounts. This is one of the major challenges facing general practice and the wider NHS.'

CHART 32 High performance is linked to fewer patients per clinical staff[70]



BEING A TRAINING PRACTICE HELPS

We have 8.25 whole-time-equivalent partners, four nurses, three healthcare assistants and 60 other staff – not all full time! We run two practices of 12,400 and 3,870 patients, which gives us just under 2,000 patients each, as nurses and doctors work across both sites.

It is a whole-practice endeavour, and we do celebrate small victories, which creates a positive environment and allows us to develop the way we engage with patients over time/decades (30-plus years for me). Our clinical teams are fully staffed, and we have worked to create a supportive culture . We have achieved this by being a training practice (two registrars) and we teach medical students, nursing students and occasionally apprentices. We have weekly practice meetings with all clinical staff represented, and thrice-weekly huddles with the carenav team before the day begins, all partner led, to iron out problems. Team leader meetings happen at least monthly.

A typical day for a partner has 10% pre-booked, the rest book on the day, with typically 30 patients seen, the majority face to face, some telephone. While we have walk-in and online access, most patients still telephone the practice, and a care navigator will book the appointment or suggest our physio or pharmacist or place with the patient's choice of doctor. Thus we achieve a good level of continuity. Most weeks I suspect we meet demand in 90% of cases (this is an ad hoc feeling). We can easily field 700 calls a day, though it varies of course.

On the whole the nursing team and pharmacist do the chronic (stable) disease management, leaving us partners to do the undifferentiated stuff and follow up as needed. It works well: I hope it survives the 10-Year Plan.

Dr David Garwood, GP, Hull and East Riding

Size of practice

We can also see that there is a correlation between the size of a practice and the levels of access provided, with smaller practices more likely to score higher. This shouldn't be a major surprise to anyone who has studied general practice.[71] It is well known that, despite successive governments' attempts to encourage practices to work in larger groupings, smaller practices tend to do better in patient satisfaction scores (Chart 33[72]).

In its report, the IfG wrote: 'Practices with larger patient list sizes are less satisfied than those in smaller practices. The effect is significant but not large: for every additional 1,000 weighted patients, our central estimate is that satisfaction declines by approximately 1.6 percentage points.'

The IfG report did state that GP access is only one part of the local health economy landscape. It cited a number of studies showing the benefits of larger practices: a Nuffield Trust study found larger practices could operate more efficiently due to standardised ways of working across sites, automating processes and centralising administrative and support staff;[73] a 2006 Deloitte report found a 10% increase in list size was associated with a 3% reduction in cost per patient;[74] and an Institute for Fiscal Studies report found patients of practices with smaller lists were more likely to require admission to hospital.[75]

Dr Steve Taylor, GP spokesperson for Doctors Association UK, says a lot of the benefits of smaller practices come from continuity of care: 'Smaller practices have been shown to increase patient outcomes and satisfaction. It is likely that this is due to greater knowledge of individual patients, continuity being key, but even low-level continuity with previous knowledge of patients can be extremely helpful in managing patient care. This is much more likely in smaller practices, where patients are more likely to have greater continuity of care. It's also more likely that smaller practices have linked knowledge of patients across the whole team, with conversations between admin, reception and clinical staff being more likely to occur.'

Professor Majeed adds: 'There is longstanding evidence that continuity of care and personal relationships with GPs and their teams are stronger in smaller practices. Patients value being able to see the same clinician, and staff in smaller teams may have greater familiarity with their patient population. This tends to translate into higher reported satisfaction, even if the absolute volume of appointments is lower than in larger practices. Smaller practices may also be more flexible in how they offer appointments, though this can vary widely.'

Deprivation

When we look at the deprivation levels in a practice population, the picture becomes somewhat murkier. There is a slight association between levels of deprivation and the access provided (Chart 34[76]).

When we look deeper into the figures, practices in deprived areas are not necessarily offering fewer appointments overall, with GPs or face to face (Chart 35[77]). It is also relevant that deprived practices tend to have younger populations (Chart 36[78]).

CHART 33 High performance is linked to smaller practices[72]

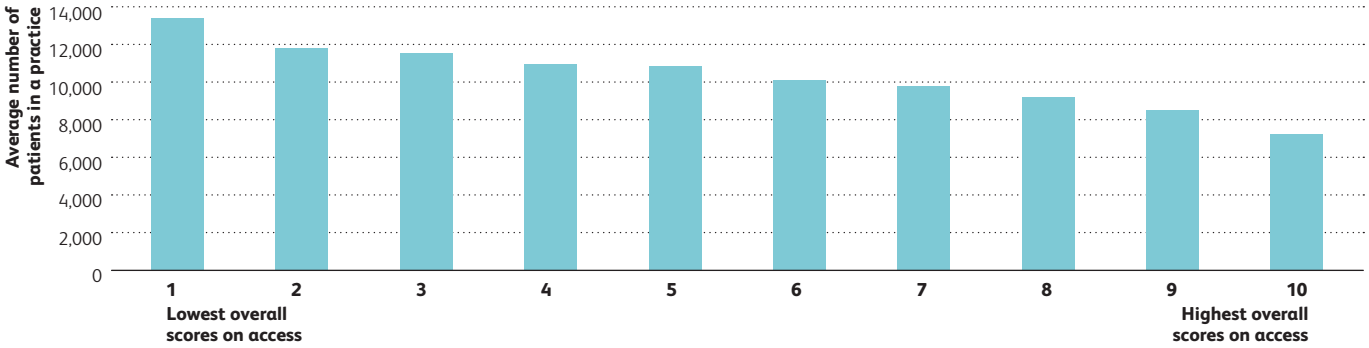


CHART 34 High performance is linked to a practice's index of multiple deprivation (IMD) score[76]

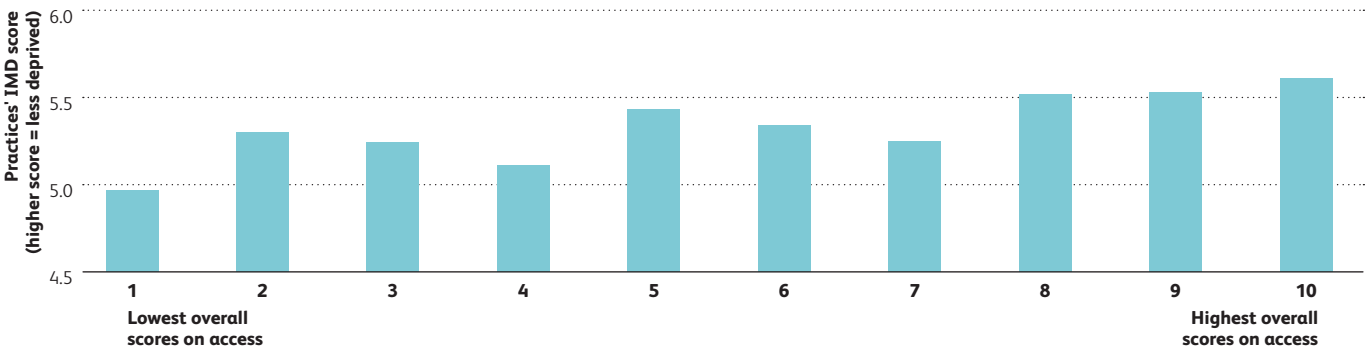
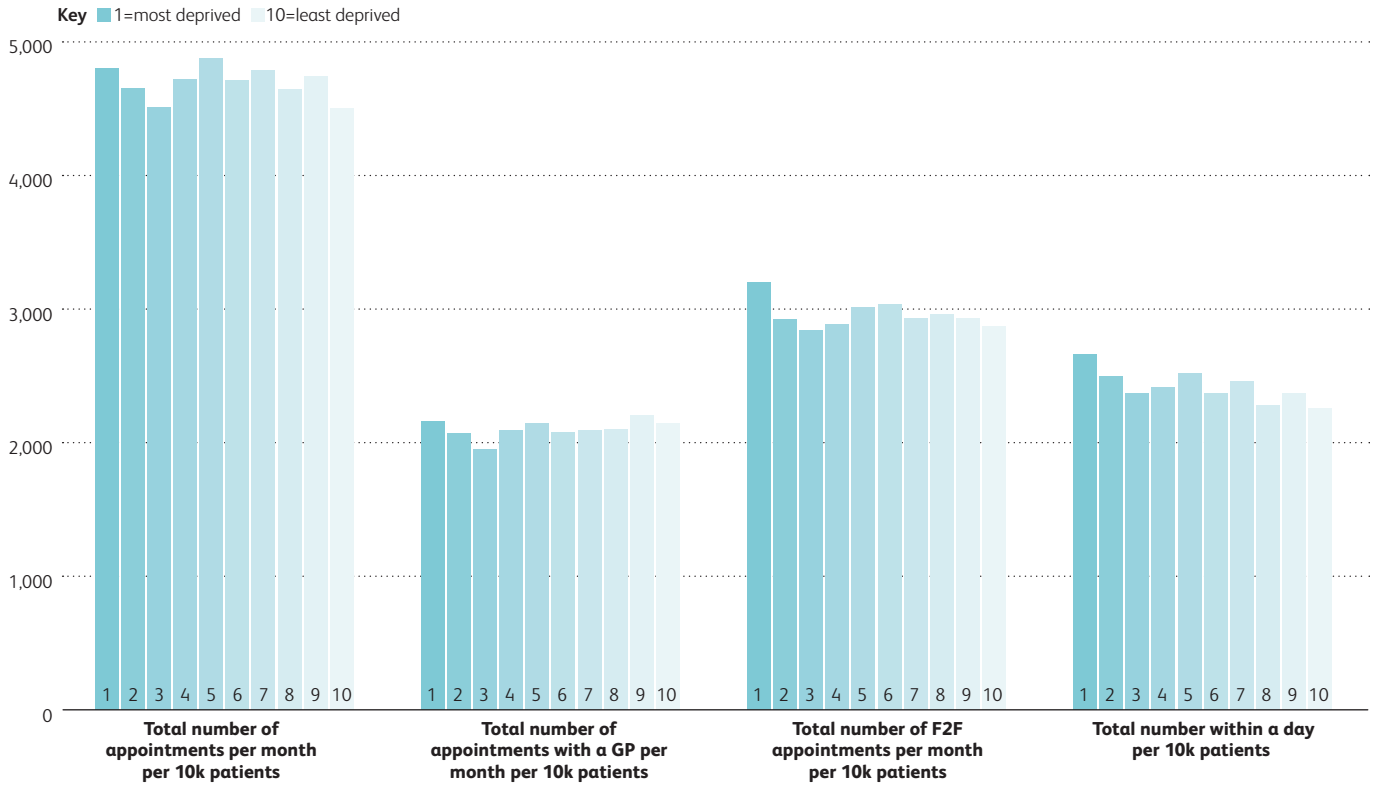


Chart 35 Deprived practices don't necessarily provide fewer appointments[77]



But there is a much stronger link between deprivation and patient survey scores. Patients in practices with higher levels of deprivation in their population report lower overall satisfaction, worse experience contacting the practice and less satisfaction with waiting times (Chart 37[79]). They also report worse continuity of care, based on whether their last appointment was with their preferred healthcare professional (Chart 38[80]).

The Deep End Project is a group covering the 100 most deprived practices in Scotland. Dr Stewart Mercer, who is part of the group, says deprived practices' normal levels of appointments and low patient satisfaction make sense.

Dr Mercer says: 'That's probably due to capacity issues in deprived practices – unmet need is high but the ability of GPs to deliver more consultations to meet this need is limited due to the inverse care law [which states that good care is more readily available to those in least disadvantaged groups]. It may also be that, due to poor access and the 8am phone fiasco, many patients in deprived areas have simply given up trying to get a GP appointment.'

According to GP and practice managers in deprived practices, there are numerous additional challenges involved in improving access. One practice manager in Preston says his practice's patients have needs outside of access, and policies that have been implemented are of little use. He says: 'We serve a population of high immigration, high rates of non-English speakers, low vaccine uptake, low literacy, low take-up of digital

CHART 36 Practices in deprived areas have a younger population[78]

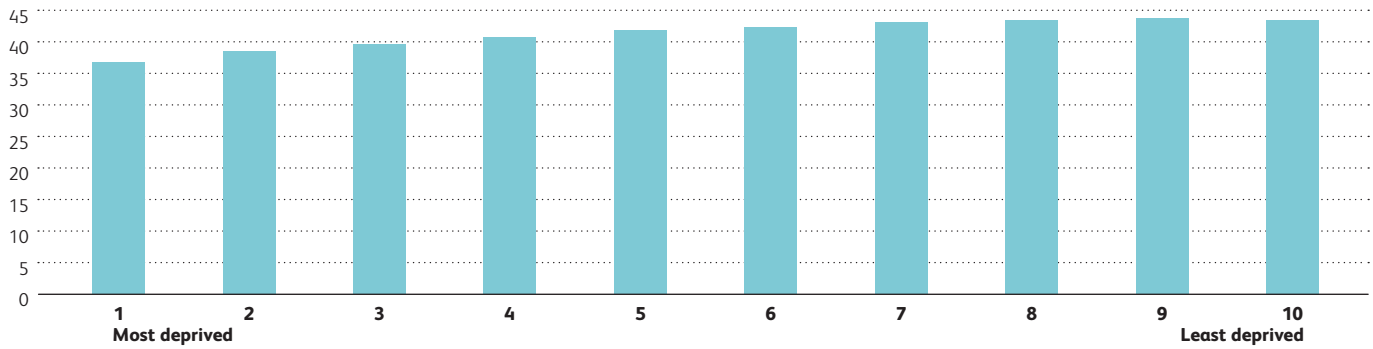


CHART 37 Deprived practices have lower patient satisfaction scores[79]

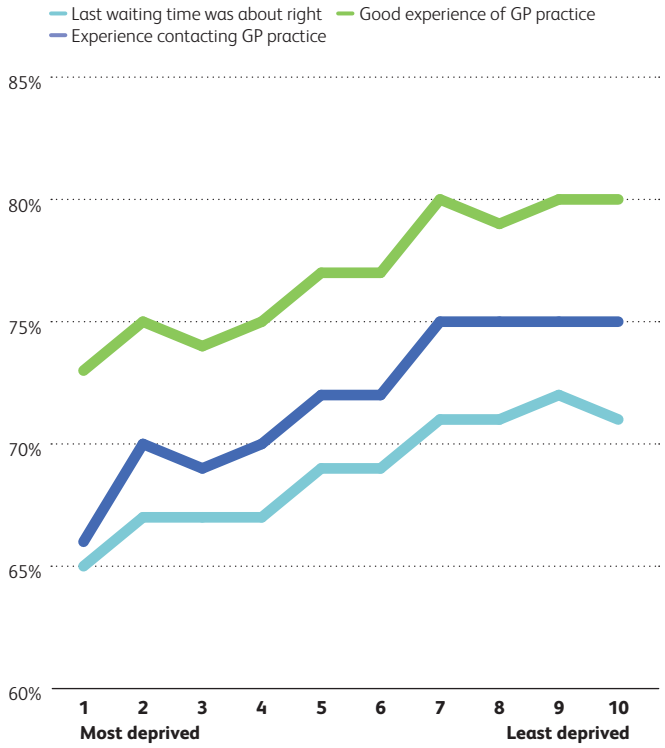
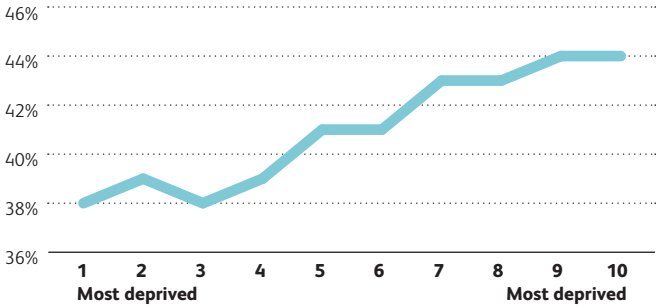


CHART 38 Patients at deprived practices are less likely to see their preferred HCP[80]



tools and low take-up of routine care but high demand for urgent, "walk-in" care. It is a very challenging population to work for and, in my opinion, this is made worse by commissioners not really seeming to have any respect for, nor an idea of how challenging catering to these needs is.

'For example, I don't have any qualms about opening my digital triage tools for the entirety of core hours because we must have had around 20 total submissions in the past 18 months, but "digital first" is a real push from up above and my patients won't engage with this.'

Lothian GP Dr Peter Cairns agrees with these particular challenges. He says: 'I work in a deprived setting – the evidence would suggest our priorities should be implementing interventions known to improve long-term outcomes and population health, especially for those patients who are disengaged from services, rather than endlessly facilitating "access" for those who demand it.

'Much of the demand for "access" is being driven by circumstances outwith primary care's control: sick lines, housing pressures, waiting lists in secondary care, etc. There is no meaningful plan to deal with this in England or Scotland that I can see.'

Patient ethnicity

One interesting area of study is the effect of a practice's non-white population on access levels. Performance in access was linked to the number of patients identifying as 'white' in the GP Patient Survey (Chart 39[81]).

It is the case that practices with more non-white patients tend to have younger populations (Chart 40[82]). However, as with deprivation, patients from ethnic minorities have particular health requirements, but the GP funding model reduces the funding received by practices with these populations.

It is beyond the scope of this study to make any causal links around ethnicity and access. The data in chart 39 do seem to suggest a link that may not be fully explained by the age of the population but the appointments and patient survey data are imperfect, and aggregation into deciles will affect the statistics. That all said, a government review would be worthwhile to assess the relevance of ethnicity, building on researchers' work.[83]

CHART 39 High performance is linked to percentage of patient list who describe themselves as 'white'[81]

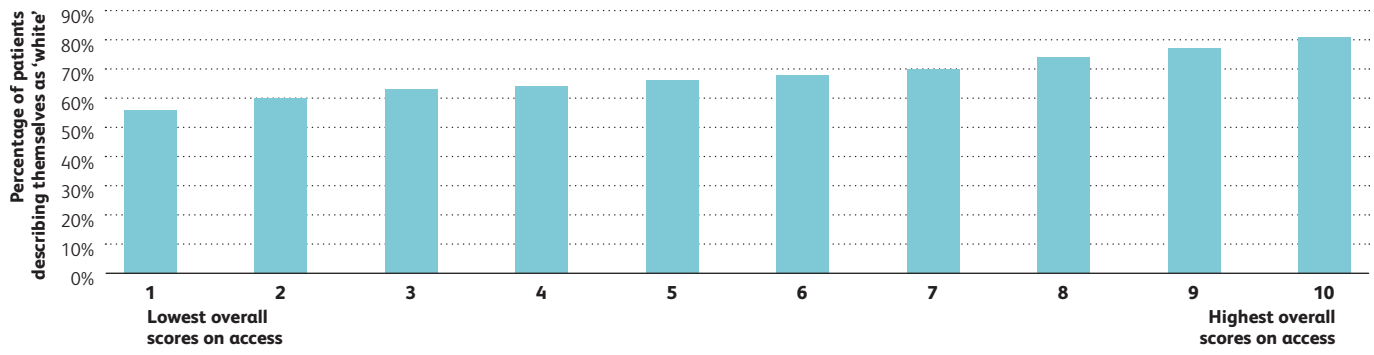


CHART 40 Practices with high percentage of non-white patients have a younger population[82]

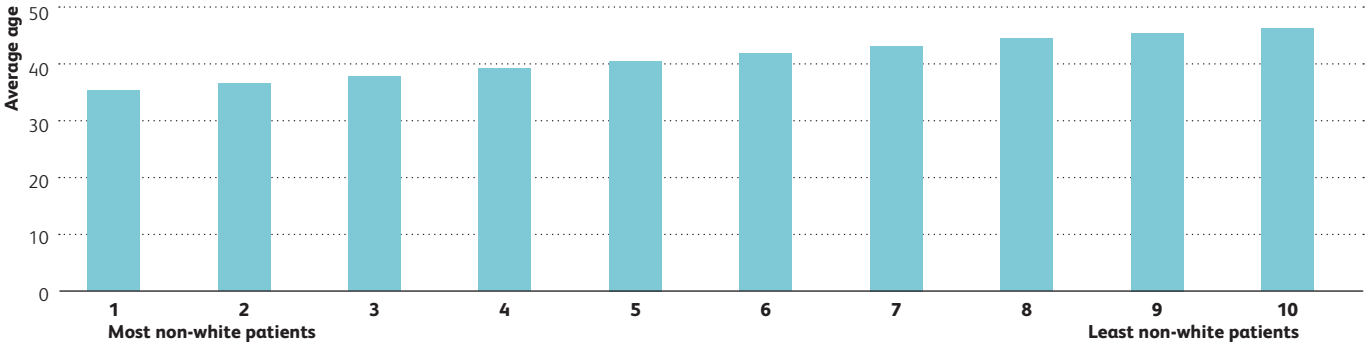


TABLE 3 Health Foundation/THIS Institute: Features of candidacy, with potential applications to general practice

Domain of candidacy	What this means	Example of how this may translate to general practice
Identification	How people recognise their symptoms as needing medical attention or intervention.	People have different thresholds for deciding to seek care from general practice. Some of these are socially patterned (for example, smoking and obesity are more common in deprived areas, and people may delay seeking care because they fear being judged by staff).
Navigation	Using services requires knowledge of what is available, and having the practical resources to use them.	Frequent changes to how people make appointments (online booking, mandatory triage), as well as an increasing range of professionals, might make it harder to know how to get an appointment and which health professional to ask for. Attending appointments requires resources such as transport, a reliable telephone connection or internet access. These resources are not equally distributed throughout the population.
Permeability	How many and what type of criteria people must meet to use services affects how easy they are to use. Permeability also includes cultural alignment between services and individuals.	General practice (the first point of contact for most health problems) has become more closed – less 'permeable' – in recent years. Changes to how appointments are requested and conducted, the criteria patients must meet to get offered the appointment type of their choice, and system pressures have all contributed to this decline in permeability.
Appearances	Appearing at services involves people making a claim to candidacy and requires a set of competencies and comfort with the social and cultural aspects of how services are organised.	Some people may be more able than others to use their 'voice' to present their needs. For example, some people may be more articulate, more confident and more persistent, ensuring their candidacy gets recognised and their related needs are heard.
Adjudications	Once patients have asserted their candidacy by presenting to health services, professional judgements ('adjudications') about candidacy strongly influence people's access to care. These depend on a broad mix of factors, including operating conditions and resource constraints.	Adjudications in general practice can draw on generalist expertise and contextual knowledge of the patient over time, and are significantly influenced by the role of GPs as gatekeepers for secondary healthcare.
Offers and resistance	Individuals may accept or refuse offers of care. Refusals may sometimes occur because people wish to resist the nature of the care offered.	Responses to a patient's claim to candidacy can result in 'offers' for active management, including referrals, prescriptions and investigations. In general practice, these often relate to advice and reassurance in the context of a longstanding professional-patient relationship. Patients may accept or decline offers, so use is not always a good measure of access.
Operating conditions	Perceived or actual availability of services has a major impact on how individuals view their candidacy for services.	When the public are highly aware of pressures in the NHS (eg media reporting of winter pressures), people may alter their thresholds for seeking care.

The candidacy model

One potential factor in lower appointment rates for practices with high numbers of non-white patients can be found in the concept of candidacy developed by Professor Mary Dixon-Woods of The Healthcare Improvement Studies (THIS) Institute, University of Cambridge. This involves 'how people's eligibility for healthcare is determined between themselves and health services'.[84]

One of the drawbacks of appointment data – although it does show rates of 'did not attend' – is it fails to show how many appointments are available. In other words, it might not only be structural issues around a practice that determine how many appointments it offers, it might be that socially vulnerable patients are less likely to access general practice, which would affect the appointment rate itself.

The candidacy model finds that people might have different thresholds for seeking care – for example, smokers or people with obesity-related health issues, which are more common in deprived areas, may fear being judged by staff. Often, and especially with the changes around general practice, patients might need higher levels of health literacy to navigate systems, and there is a potentially self-fulfilling prophecy in areas with system access problems, in that patients may stop even trying to use GP services. This is summarised by THIS and the Health Foundation in Table 3.[85]

Dr Carey Lunan, a GP at the Deep End Project based at the University of Glasgow, believes it is 'important to disentangle about the difference between demand, and need, in driving appointment numbers'. She says: 'Ideally it should be needs-led, but that's not the way the system works.

'[Former Deep End lead] Professor Graham Watt speaks about the importance of GPs in more socio-economically deprived areas needing to be the doctor for the "unworried unwell"; consumption of healthcare can also be driven by higher health literacy, higher levels of agency and "candidacy" and trust, better navigation of systems, higher digital inclusion, better self-advocacy... often meaning that those who don't benefit from these things are less able to proactively seek care and have their needs met, and so health inequalities worsen.'

At the other end of the scale, patients from more affluent communities can – as one practice puts it – have 'a magnified sense of entitlement, stating that they have been taxpayers all their lives and that the NHS is a disgrace'.

It's clear there are systemic issues based on inherent characteristics when it comes to access. Delving into which are the most important factors is beyond the scope of this report – suffice to say that those naming and shaming practices around access should not ignore these systemic issues.

SUMMARY

The levels of access practices provide is based in part on systemic factors. Those with older populations and more disease prevalence receive greater funding due to the Carr Hill formula. Funding is closely associated with the level of access provided. These practices have a bigger workforce, which is able to provide better access. However, this isn't the only factor. Smaller practices have traditionally had higher patient satisfaction and this carries over into the level of access they provide.

Deprivation levels have an effect too. Unlike age and disease prevalence, a practice's deprivation level is not particularly highly rewarded by the Carr Hill formula and, as a result, they lack the funding to meet the extra challenges they face. Although in terms of appointment numbers, deprivation doesn't have much effect, patient satisfaction scores are particularly linked to deprivation levels.

The ethnicity of a practice's patient population seems to have a negative association with access levels, whether that be appointment availability or patient satisfaction metrics.

One explanation is the 'candidacy model', which posits that people's eligibility for healthcare is determined between themselves and health services, with patients from more vulnerable communities potentially making less use of GP services – the 'unworried unwell'.

RECOMMENDATIONS

The Carr Hill funding formula needs to take into account the greater challenges faced by practices in deprived areas, and those with a higher proportion of non-white patients. It currently uses data from 2000 on the health of the local population, and this should be rectified immediately. This will be a major part of the negotiations for the next major GP contract in England, and it is essential that deprived practices are given the funding they need to improve access.

The UK Government should explore why the ethnicity of a practice's population has such an effect on access levels. Although we haven't looked at the data in the devolved countries, it would be worth the respective governments undertaking similar work.

CHAPTER 8
Why practices are unable to provide the access they would like

The systemic issues discussed in Chapter 7 have a strong link with the levels of access practices are able to offer. Prominent among these is workforce – which, as we have seen, is at least in part influenced by funding, which in turn is influenced by a practice's patient demographic.

Practices would like to offer more appointments, cater to patients' preferences and make it easier to contact the practice. But a number of factors impact their ability to do so – and none more so than workload, which is affected by workforce. In other words, many GP practices consider themselves to be working at capacity – or even beyond it.

Complexity of appointments increasing

As we saw in Chapter 1, the number of patients is increasing, as well as the number of appointments each patient has per year. At the same time, the number of FTE GPs has been decreasing for at least a decade. Individual FTE GPs provide an increasing number of consultations in a year.

Meanwhile, long-term conditions and multimorbidity are on the rise and people are living longer.[86] The 10-year plan says: 'More than a quarter of the population have a long-term health condition, and they now account for 65% of NHS spending. The NHS today is no longer just a safety net to help people in crisis – it must provide a continuous service for those who have a chronic illness.'[87] The plan was quoting a 2014 report, but there is little doubt people are living with more health conditions.

£20

The payment for practices per Advice and Guidance referral

Depending on definition, anything from 19%-40% of people are estimated to be living with multimorbidity.[88] And not only are more people living with multimorbidity, but GPs and practices are finding that they are more likely to see these patients due to the deterioration of other health services.

In England, 'Advice and Guidance' is a new scheme that funds GP practices to liaise with specialist services before referring to secondary care. It was introduced as an enhanced service in the 2025/26 GP contract, with practices given £20 per request.[89] Although the practice receives the funding even if a referral is later made, the aim is to reduce referrals, with patients instead managed in primary care. It's a voluntary scheme and there hasn't been major backlash from general practice, but it formalises the management of complex patients in primary care.

More patients managed in primary care

There are other, less appropriate ways that GPs are being left to manage patients who may previously have been seen in secondary care. One GP in the north-west of England says: 'Other health and social care services requesting access or workload dumping has increased. Some local services don't seem to exist or our patients don't meet their recently revised entry criteria. Hospital waiting times are so long that referral is not a realistic option. More and more conditions are being managed in primary care and prevalence of many conditions increasing.'

As the front door of the NHS – and, to many patients, wider public services – general practice is taking on more and more. One practice manager in West Yorkshire says: 'We are no longer just health, we are a resource for other issues that affect health, social issues, and a bridge in the gap of all under resourced health provisions such as mental health, care at home, etc. We are also filling the gap where health related charities have closed.'

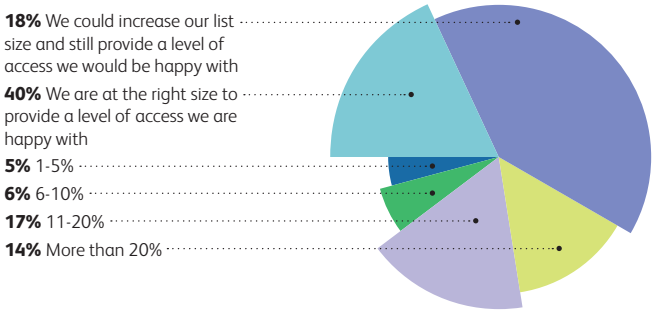
Alongside increasing complexity, GPs are seeing less-demanding work taken away through schemes like ARRS and Pharmacy First. These will be discussed in Chapters 9 and 10 respectively. While the aim is, in part, to take over simpler work, this in itself causes problems.

Stafford GP Dr Lee Sanders-Crook says: 'Pharmacy First has sieved out straightforward cases, leaving a void that has been filled by the remaining more complex caseload. On paper this seems not an issue – 15 x 10 minute appointments with no change, and more patients seeing pharmacists for basic ailments. 'But all GPs would probably agree that not all cases are equal. The undiagnosed dementia patient in denial, the suicidal teacher trapped in her menopause, the elderly growing older and accruing drugs, diagnoses and test results with mixed understanding. These patients bring problems and concerns that can't be managed in 10 minutes. And so their 10 minutes last longer, as clinical necessity dictates.'

Previously, GPs were taught that an essential skill for time management

JUSJUN / E+ / VIA GETTY IMAGES

CHART 41 Many practices say they would need to cut list size to provide appropriate levels of access[91]



was to make up lost time with 'easier' appointments, which could be around a quarter of cases, Dr Sanders-Crook says. 'But as these have been diverted, all that remain are the increasingly complex – except now with less flexibility to juggle time, and claw it back.'

Cutting list sizes and rationing

Due to this increase in appointment numbers and complexity, practices' main avenue to reducing appointments is to cut lists. Under the GP contract, practices are paid on an annual capitation basis, at £121.79 per weighted patient (modified by the global sum based on the patient population).[90] Although they are able to stop new patients joining the practice, this not only reduces capitation payments but also brings other penalties, such as being unable to take on enhanced services, which provide much-needed extra funding. Practices can informally 'cleanse' lists – removing patients who live outside their boundaries, for example.

One South Yorkshire GP says: 'We need more time with patients – both in consultation and greater frequency of consultation. This cannot be accommodated with the current demand. The only ways to reduce the demand and allow the individual time needed is to re-size lists or to take away areas of work – whether this be all acute illness, mental health or benefits.'

Demand in the NHS is effectively limitless, while the service is rationed, says one GP in Greater Manchester. 'Traditionally, rationing has taken the form of long waits on phone lines, or delays in securing appointments. We have already implemented as many technological and process improvements as possible, and primary care is working at full stretch trying to keep pace with ever-increasing demand. That leaves us with three broad options: accept a compromise on access; increase the capacity of already efficient GP surgeries to meet rising demand – something that can only be achieved with appropriate funding and support; or cut list sizes to cap demand in order to maintain or improve access that patients currently receive in primary care.'

The Cogora survey asked distinct practices (see Methodology) whether they would need to cut their lists to provide the required levels of access (Chart 41[91]). Around 40% said they would. As discussed, cutting lists necessarily involves a reduction in funding, so that figure is quite telling, especially as 30% of all responding practices said they would need a cut of more than 10%.

Some practices are having to proactively cut their lists in response to rising demand. One GP partner in Surrey says his practice had to cleanse its list in order to provide the access it deemed necessary. He says: 'It's still an ongoing process. We are writing to patients who are out of area and outside of our designated catchment. It's an issue we've avoided for years because it could be quite emotive for patients and some GPs alike. But our hands have been forced by the demands of managing access for our list size with limited resources.'

While this is helping the practice get on top of access, the GP warns: 'What have we created? Can we sustain this level of access in the long run? Will we be victims of our own success in terms of patients now expecting very quick access and quick responses to their problems? Are we sacrificing continuity of care on the altar of access? Are we still running family practices or small urgent treatment centres? I think these are valid concerns.'

Cutting lists is not something practices take lightly. The knock-on effect on funding impacts their ability to provide care. A practice manager in Blackpool says: 'To provide the access we'd like we would have to cut our list but that would hit income so it's not an option. We do however manage our list closely by deregistering – with notice and explanation – patients moving out of our boundary. We have reviewed this decision recently together with our community nursing team and increased the areas we will keep patients on our list who have moved outside our traditional boundary.'

Cutting list sizes doesn't solve the problem of access, of course. It simply moves it elsewhere. As one practice manager puts it: 'We wouldn't want to cut our list size, where would the patients go?'

Practices are struggling with access, often due to systemic issues rather than through any fault of their own. So what have ministers and NHS managers done to support practices, and how successful have they been?

SUMMARY

It is not just the increase in appointments that is creating pressure in general practice. The patients who are seen by GPs have more complex health needs. This is in part due to population changes: people are getting older, and they are developing more long-term conditions and multimorbidity. On top of that, practices are being left to deal with patients who would previously have been referred to secondary care, and the simpler, less time-consuming cases are being passed on to other healthcare professionals either in the practice or in pharmacies, for example.

Because of the overall increase in demand, in order to provide the levels of access they deem suitable, some practices are having to consider cutting their lists or closing them to new patients altogether, which causes knock-on problems in terms of funding.

PART FOUR

What have governments done – and have they been successful?

CHAPTER 9
Improving access through the ARRS

As researchers at the THIS Institute, Nuffield Trust and the Health Foundation found, there were more than 400 initiatives to improve access from 1984 to 2023.[92] These have involved targets and incentives. In 2000, the New Labour Government introduced a target for patients to see a primary care professional within 24 hours and a GP within 48 hours – yet, as now seems familiar, the Health Foundation found 'People's ability to see their preferred GP declined'.[93]

Over the next few chapters, we will look at the major initiatives designed to improve general practice in the more recent past, predominantly in England. They will focus on efforts to increase the number of appointments available, attempts to reduce demand and initiatives designed to improve ease of access. The final chapter of this part will touch on what has been proposed in the current Government's 10-year plan.

But without doubt, the most consistent policy designed to improve access has – quite reasonably – been around boosting staffing numbers. It's clear that an increase in the number of healthcare professionals in general practice improves access. But this seemingly bland statement has plenty of nuance that we need to explore, and this has implications for government policy.

To understand this fully, it is worthwhile revisiting Cogora's January 2025 report on workforce, which details the various failed attempts made to increase the number of full-time GPs in England.[94] It was partly in response to these failures that the ARRS was introduced as part of the PCN contract in 2019, providing these networks of practices covering roughly 30,000-50,000 with funding to hire certain staffing groups. It has only been since Labour took power in 2024 that PCNs have been funded to appoint GPs, with certain restrictions. But the scheme has already recruited 42,000 full-time equivalent non-GP or nurse direct patient care staff across general practice as of July 2025.[95]

£1.41bn
Annual budget for the additional roles reimbursement scheme

Of all the government policies to improve GP access, the ARRS been the flagship, with a £1.41bn annual budget.[96] There has already been a lot written about whether it has helped improve access, with some claiming success and others saying it has failed. In 2023, a year earlier than planned, the Conservative Government heralded the achievement of meeting its 2019 manifesto ambition to deliver 50 million more appointments a year by the end of that parliament.[97]

As we saw in Chapter 1, appointments with non-GP staff have been responsible for the overall increase in appointments per patient, with GP consultations remaining fairly static (in part, due to the decrease in the number of FTE GPs). This would suggest the scheme has been a success.

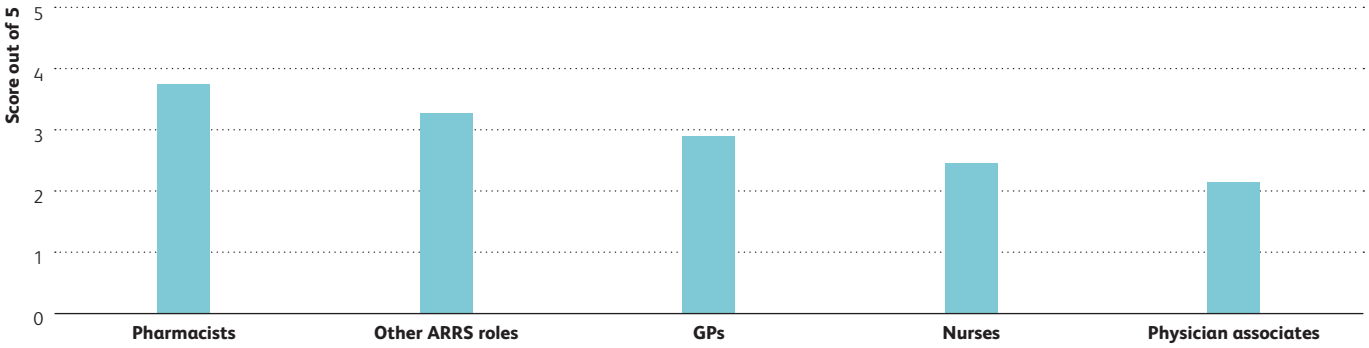
But, as we explored in Chapter 2, that hasn't increased patient satisfaction. The IfG stated: 'Our regressions also showed a negative relationship between the change in DPC staff and the change in satisfaction between 2019 and 2023. In other words, the larger the increase in DPC staff, the more likely it was that patients' satisfaction with a practice would fall.'[98]

These are the two most salient points – yes, the scheme has helped increase appointments, but it hasn't improved patient satisfaction. It's given patients access to something they don't want or don't think they need.

Our workforce report concluded: 'Other healthcare professionals have taken on some more of the work, and this has been valuable in cases such as nurses and pharmacists working at the top of their licences. But GPs have the skill levels and capability for the majority of the work in general practice and, in most areas of activity, are the only professionals who can take on the clinical responsibility. An increase in GPs would also mean less activity overall, because their experience and training mean fewer follow-ups.'[99]

Much of our workforce report was based on whether these staff were clinically appropriate and safe, and whether they alleviated the workload of the established roles in the general practice team – GPs and nurses. Of course, these themes are almost inseparable from the question of whether they improve access. But this chapter will

CHART 42 Pharmacists have helped with improving access



focus on access, and whether those working in general practice feel the ARRS has improved it.

Useful roles

Cogora's survey of around 2,000 primary care staff revealed that, of the most traditional roles included in the ARRS, practice pharmacists were considered most helpful in terms of improving access. However, even for pharmacists, the survey still revealed an average score of less than 3.75 out of 5.

These figures should be treated with caution though. A number of respondents pointed out that it was too early to judge the impact of the ARRS GP and nursing roles. Meanwhile, the other option – physician associates – while not necessarily traditional, has been a source of great controversy over the past few years, with PAs not particularly popular among GPs, practice managers, practice nurses or practice pharmacists. Importantly, the Cogora survey didn't provide a breakdown of 'other' ARRS roles in the answers – a mistake in hindsight. Also, despite the survey question clearly stating it was about impact on access, respondents may have based their answers on overall feelings about the scheme.

Some respondents were pleased with how the ARRS had benefited access. One practice manager says: 'We have a pharmacist who deals with minor illness who frees up

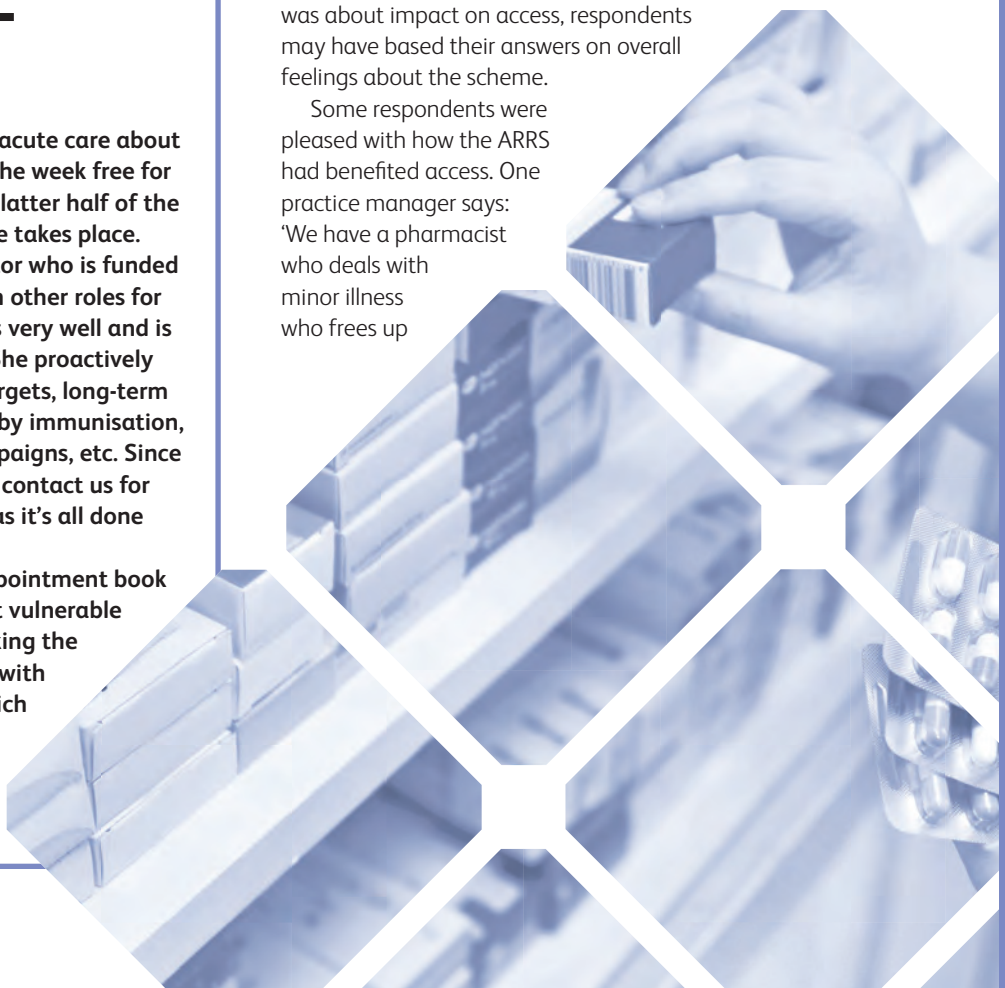
OUR CARE CO-ORDINATOR PROACTIVELY MANAGES PLANNED CARE

We separated our planned care from acute care about four years ago. We keep the start of the week free for acute to meet the demand. Then the latter half of the week is where lots of the planned care takes place.

We have a full-time care coordinator who is funded through ARRS but has been with us in other roles for 10-plus years. She knows the patients very well and is in control of all of the planned care. She proactively manages the chronic disease, QOF targets, long-term conditions local enhanced service, baby immunisation, all screening, carers, vaccination campaigns, etc. Since this change, we rarely have a patient contact us for an 'asthma check' or 'annual bloods' as it's all done proactively.

To us it's about opening up the appointment book so we are ready to deal with the most vulnerable patients when they need it. Not blocking the appointment book weeks in advance with conditions inappropriate for a GP, which is what used to happen.

Sam Metcalf, practice manager, south-west London



GP time. Also, we have a qualified mental health practitioner one day per week plus a MIND worker. This has made great impact in terms of returning patients. We have seen over a 60% reduction for GPs in these types of appointments.'

In the survey question's free text box, around 200 respondents specified the most useful roles. By far the most commonly cited was physiotherapist, or similar musculoskeletal (MSK) roles.

Many people said physiotherapists had been a 'game-changer', pointing out that these professionals allowed patients to bypass what have traditionally been appointments with a GP. As one practice manager pointed out: 'This frees up time for our GPs to undertake work that is more relevant to them.'

Other popular roles included paramedics and mental health workers, although the latter are not particularly common across general practice due to recruitment problems. Broadly, respondents somewhat valued pharmacists, as Chart 42 shows, but it's unclear if they are useful for improving access.

Other comments from GPs included: 'We have used ARRS admin to set up a robust medicine monitoring recall system, this has not improved access but it has significantly improved patient safety and quality of care'; 'Not improved access particularly but they have reduced duty workload'; and 'ARRS pharmacists have been huge help to us, but not necessarily with access'.

ARRS staff can help in areas other than access, say practice managers. One mentions the GP assistants, who lead on managing appointments to secondary care and therefore reduce DNAs to the practice. Another says that social prescribers/care co-ordinators – another popular role among respondents (see case study, p41) – 'have been an absolute asset dealing with social issues like loneliness and support with helping patients accessing funding, especially when they don't have any IT facilities'.

One practice manager in Bristol concludes: 'It feels qualitatively as if the ARRS staff help, but it is virtually impossible to quantitatively measure that. GP appointments are still under huge pressure so have we just created additional work to be done in general practice rather than freed up GPs themselves?'

Need for GPs

Another major theme was that an appointment with a non-GP staff member may not necessarily be of the same quality as one with a GP. Again, it is useful to look at the IfG report for a detailed analysis of how various workforce roles affect patient appointments and satisfaction.

The IfG found GP partners are associated with the largest increase in total appointments across the practice. An additional extra GP partner leads to an annual rise of 5,439 total appointments in a practice, and 4,256 GP appointments. Meanwhile, an additional nurse leads to 4,976 extra annual appointments across a practice, compared with 2,279 for other direct patient care staff – although the report points out that those staff also carry out other unmeasured activity.

There are similar trends with patient satisfaction. The IfG found: 'An additional GP partner in a practice is associated with a 1.4 percentage point increase in patients reporting a "good" service. Additional salaried GPs and nurses are also associated with an increase, but not to the same extent. Yet additional "direct patient care staff" are not associated with any increase.'[100]

The benefits brought by additional GP partners have major implications for future government policy – which we will explore in more detail in Chapter 15.

Respondents to Cogora surveys were clear that an appointment with a GP improved access more than one with another member of staff, unless the presenting complaint was specific to, for example, a physiotherapist or mental health worker. One GP in the north-east of England says: 'Pharmacists need a lot of supervision and training but are not very effective. For example, I do 90-100+ medication reviews each month, whereas our aligned pharmacist can only do 16 max per month. Lots of checks back and forward with GP. One extra GP partner in the practice could do the work of three to four ARRS staff roles themselves.'

A number of respondents referenced the workload implications of supervising ARRS staff, which has an effect on access, notably to GPs. 'With regards to all ARRS except GPs and pharmacists, they are lovely members of our team and I value their contribution, however they increase workload overall,' says one GP in Sussex. 'They cannot hold the complexity that GPs do, tend to over investigate... dilute continuity of care and are overall inefficient compared with GPs.'

'NO ROOM AT THE INN' – AN UNINTENDED CONSEQUENCE OF THE ARRS

We do provide patients with a choice of face-to-face (F2F) or telephone/video appointments. However, the GP partners are only 'in' practice one day a week due to room shortage. They work remotely for the rest of their sessions, thus restricting access F2F with a chosen GP.

Locums are always 'in' practice, apart from a marvellous advanced care practitioner (ACP), who works remotely as she lives far away. We contracted her via an agency during Covid, and we now employ her. Our other ACPs are 'in' practice.

All this is because there is no more room at the inn as we've been inundated with ARRS staff. They are valuable in their own right and take some of the workload from the GPs – especially the physio, mental health practitioner and podiatrist, who are all directly bookable by our reception team. But they all need a room! Apart from ARRS staff, all our ACP and locum GP appointments are F2F or phone depending on what the patient wants – we try to accommodate.

Practice manager, Blackpool

So while some roles are helpful for patient care and access, there are opportunity costs involved too. First, as the Cogora workforce report made clear, PCNs struggle to hire the more popular roles, and sometimes recruit less sought-after staff to ensure they use their budget. Second, and on similar lines, the more useful roles tend to be in greater demand across the NHS – the Cogora paper found recruiting pharmacists to general practice had a negative effect on community pharmacy. As one practice pharmacist in Northampton puts it: 'ARRS roles reduce access to the services they formerly worked in. The ARRS scheme is very useful, but requires clearer defined access and accountability.'

Third, and maybe most important, the workforce paper found the availability of funded staff had led to GPs being out of work. Practices facing a funding squeeze are more likely to hire funded staff even if they may not be as effective. There is often also a lack of premises space to accommodate ARRS staff. This can affect the number of GPs employed, but also the number of face-to-face appointments – which the IfG found was a significant factor in patient satisfaction (see case study, p42).

Structural issues with ARRS

The structure of ARRS also impacts how the scheme can support access, primary care staff say. ARRS staff are employed by PCNs, not practices, and the way this works can differ between PCNs. A staff member might be based full time at one site, such as a hub, or at a single practice that carries out the extra work required under the PCN contract. Indeed, some PCNs comprise just one practice, which makes the process of recruitment simpler.

For most PCNs, though, ARRS staff work sessions for different member practices and practices may not see improved access. One practice manager in Leeds says: 'Those working solely for one practice are invaluable.' But, she adds, for those that work across practices, 'we don't know what they are doing'.

This issue of shared staff was a major theme among survey respondents, who say it has an effect on continuity. 'The problem with the ARRS is that each practice within the PCN has different needs,' says a Luton GP. 'When the PCN needs to be a separate entity, then ARRS staff are shared between five practices and you often get poor continuation of care.' Dr David Coleman, a GP in Sheffield says: 'We have one ARRS GP in our PCN, but they are not based at our practice so no impact on access.'

ARRS salaries

Respondents also spoke of issues related to ARRS salary levels, which could be too high or too low, depending on the role. The salary for GPs under the scheme has been considered inadequate, with one respondent saying it is 'difficult to employ a GP for the provided money'. A practice manager in Cambridgeshire says ARRS GPs are 'not fit for purpose'. They add: 'Funding is not enough to cover a salary and it will not solve the current unemployment crisis for GPs.' Another practice manager in Hertfordshire says: 'The reimbursement doesn't cover the amount of sessions needed across PCN for equity so it is not having the impact it was meant to.'

The amount PCNs can claim for salaried GPs increased to £82,418 in 2025/26 from £73,113, which was the bottom of the salaried GP pay range. Despite this uplift, the salary still falls into the lower quartile of the range.

For other roles, practices find salaries too high. A Devon GP says: 'We use ARRS staff to help provide holistic care, but due to competition with other practices, we have to pay them more than non-ARRS staff.' A practice manager in Cambridgeshire adds: 'Physio is helpful, care coordinators support admin, but I do not agree with the pay range being higher than the practice team.'

As Cogora's workforce report noted, the ARRS has affected practice nurse morale. This time round, one says: 'Nursing associates are great but make me feel insecure in my role', and even more starkly: 'Practice nursing has been left out in the cold.'

The main demand among respondents, however, was for funding to be with practices rather than PCNs, with dozens of comments along these lines. One GP in Gloucestershire says: 'We have one day a week of an ARRS GP. This is helpful but would be better if the funding came directly to practices for this.'

A former PCN clinical director in Derbyshire agrees: 'There are limited benefits to the ARRS, but we are duplicating management costs. This money would be better used and we would see more access if invested directly into the practices.'

There can be a perception among the public that GPs are overpaid, and negotiators on the BMA's GP Committee have

often spoken in private to Pulse about a reluctance from ministers to provide funding to general practice as a result. In a possible bid to counter this perception, GPC England has floated the idea of the Government funding all costs for salaried GPs, as part of the wholesale renegotiation of the GMS contract in England.[101] Negotiations should take place over the next couple of years and this proposal is likely to be a major element of them.

SUMMARY

The ARRS was introduced in 2019 in an attempt to increase overall appointments in England. It has achieved this but, at the same time, we have seen a reduction in patient satisfaction.

There are concerns around the ARRS and why it might not have improved all aspects of access. The Institute for Government study found that an increase in GP numbers was associated with increased patient satisfaction, but that this did not apply to non-GP staff. There is a belief that the scheme – while increasing overall appointments – can reduce access to GPs,

General practice staff say there are a number of useful ARRS roles, especially physiotherapists and mental health workers. But it is partly the case with these two roles – and especially pharmacists – that their presence doesn't necessarily lead to better access, but may lead to better safety, or greater satisfaction for a small but vulnerable group of patients.

The structure of the scheme is also an issue – ARRS staff are often shared across practices, which could dilute any improvement of access – while the scheme's salary bands cause a problem, being too high or too low for some roles.

There is a strong feeling among primary care staff that the ARRS funding would be more effective if given directly to practices, rather than to PCNs.

RECOMMENDATION

The BMA GP Committee (England) and the Government should consider central funding of all staff, with the money given directly to practices as part of the next contract negotiations. This could address the reluctance of government to invest the required funding into general practice for fear of negative media headlines. This should not prevent simultaneous funding of larger groups of practices to hire staff to work over a larger population, either through PCNs or through neighbourhoods.

CHAPTER 10
Increasing appointment numbers through extended access

One of the principal policy goals with regard to access has been to increase the numbers of appointments available in primary care. In England, since 2013, this has been done mainly through extended access covering evenings and weekends. More recently, there has been a move towards on-the-day hubs for patients to access when their practice has no urgent appointments remaining.

Extended hours GP services were introduced in October 2013 by then Prime Minister David Cameron. He established a £50m 'Prime Minister's Challenge Fund' to pilot methods of providing evening and weekend appointments. At the time, he said 'millions of people... find it hard to get an appointment to see their GP at a time that fits in with their work and family life'.[102]

According to the first evaluation of the pilot schemes, the aims were: to provide additional hours of GP appointment time; to improve patient and staff satisfaction with access to general practice; and to increase the range of contact modes. The evaluation also looked at: how the initiative contributed to reducing wider NHS demand; tackling health inequalities; identifying replicable delivery models; delivering value for money; and establishing sustainable and transformational change in the primary care sector.[103]

In October 2018, clinical commissioning groups (CCGs) were mandated to offer extended access to their whole populations[104] – brought forward from the original 2019 deadline.[105] By 2022, this responsibility had shifted to PCNs. The PCN contract (directed enhanced service), mandates the provision of 60 minutes of enhanced-access appointments per 1,000 patients between 6.30pm and 8pm on weekdays and between 9am and 5pm on Saturdays.[106] The requirement for Sunday opening under the CCG schemes was removed.

So, how successful has the concept of extended hours been? According to NHS Digital data, in July 2025, around 367,000 appointments were provided through extended access, making up some 1.1% of all appointments in general practice.[107] Funded at £8.52 per patient per year[108] – based on current general practice populations,[109] this comes out at around £535 million. In other words, around £120 per appointment – or the same as the total global sum practices receive per patient for a year.[110] Again, there needs to be caution with these figures. NHS Digital suggests extended access appointments could be under-reported.[111]

In terms of patient satisfaction, numerous studies have looked at the impact. Analyses conducted by researchers from the University of Manchester and the University of Liverpool 'did not identify significant linear associations between extended access services and patient experience measures'. The researchers also found 'some evidence suggested that the frequency of seeing or speaking to a preferred GP (a measure of continuity of care) was negatively associated with extended access services, although not linearly'.

The study did note that 'a small positive effect was observed on satisfaction with appointment times for patients in full-time employment'. It concluded: 'The provision of extended access services by GPs at scale may provide additional capacity and choice of care for patients, but care continuity could be threatened.'[112]

Another study from the same authors at the University of Manchester found: 'Supra-practice access models can provide effective care for most patients with straightforward issues. When ongoing management of complex problems is required, this model of patient care can be problematic.'[113]

What primary care staff think of extended access

Despite these findings, on the whole, the majority of survey respondents said evening and weekend appointments had been a success where set up – although more people chose 'quite successful' than 'very successful'.

This is reflected in the comments, some of which were very much in favour of the schemes, while others offered a more cautious backing.

The Manchester and Liverpool universities' study found that 'greater cooperation between GPs positively impacted patient experience but might compromise continuity of care',[114] and those who found extended hours to be very successful tended to reference good working within the PCN.

Tanya O'Brien, a practice manager in north-west London, says: 'Extended access has significantly improved service provision for patients registered across our local practices. One contributing factor is the strategic location of our extended access clinic, which sits centrally among the six member practices – making it geographically accessible for a broad patient base. Feedback from our ANP, who delivers sessions at the hub, indicates that member practices are actively booking their patients into the extended access offer. This has been particularly beneficial for patients who work or study during standard hours, as it provides flexible appointment options that better align with their schedules.' Interestingly, she adds: 'Overall, the hub model is helping to reduce barriers and enhance continuity of care across our PCN.'

Other comments described the increased access as an overall help at a time of limited appointments. One practice manager in Bristol says: 'I would say that access is at a premium and while evening or early morning appointments do help, a lot of patients will come at whatever time offered.' Another practice manager, from Leeds, says: 'Saturday appointments for smears and learning disability reviews have been a real success for working people and parents.'

Criticisms of extended hours

But opinions were mixed among other respondents, with criticisms focused around certain themes:

- The effect on continuity and a duplication of work
- Low take-up, and high numbers of 'did not attends'
- A reluctance from patients to travel
- Conversely, low availability of appointments
- A lack of cost effectiveness.

Effect on continuity and duplication of work

Echoing researchers' findings, a number of respondents were concerned about the effect of extended hours on continuity. One GP in Greater Manchester says his PCN provides extra GP appointments and an overflow hub that runs through the winter. 'Both these services have contributed to reduced waiting times but don't really help with continuity – we often end up with referrals to make on their behalf and need to arrange additional tests as they are unable to send routine referrals and don't seem to be able to request bloods/MSUs.' This 'does generate a fair amount of additional work for us', he adds.

A Leicestershire GP says the configuration of the workforce in extended hours has an effect on continuity: 'Extended hours clinicians are mostly not GPs or, if they are, they are external staff. So they offer no continuity of care or access to the GP the patient wants to see – they can at best just help sort out acute issues, like you would get from an urgent care centre or emergency department.'

Other GPs agree. 'Extended hours are good at soaking up acute conditions but less so for the chronic conditions patients tend to rebook with their practices,' says one GP in Luton. Another in north-east England says: 'Patients are often referred back to "own GP" which causes work duplication. Or tests ordered uncovering incidentalomas, causing more work without benefit to the patient.'

CHART 43 Practices with local weekend appointments say they have found them broadly successful

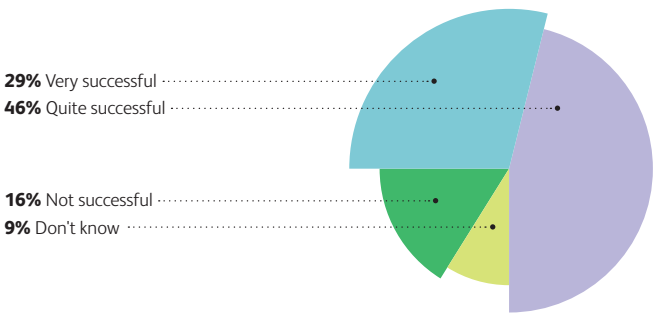
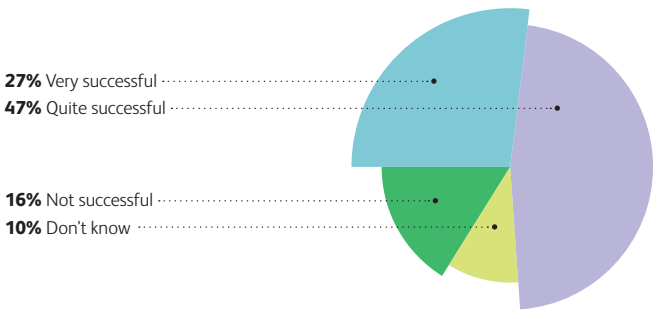


CHART 44 Practices with local evening appointments say they have found them broadly successful



Hertfordshire GP Dr David Turner is scathing: 'Extended hours after 6:30pm and at weekends are in my opinion little more than a gimmick and a soundbite for politicians. If we see a patient out of hours often the pharmacy is closed so they have to go the next day to pick up medications. Samples such as urine are only collected once a day and never at weekends so patients end up having to come back to the surgery in normal working hours in any case. The commissioners just do not understand having GP surgeries open is fairly pointless unless all the allied support services are also working at the same time.'

Lack of take-up

There is little information about the take-up of evening and weekend appointments. A *Pulse* investigation from 2018 – before extended access had been rolled out across the whole of England – suggested that 25% of appointments were unfilled.[115] Anecdotally, practices suggest there are still a high number of appointments unfilled. One GP partner in south-west London says: 'We moved our extended access to within our PCN. We simply struggle to fill the face-to-face appointments on Saturdays for both doctor and nurse appointments, and all telephone calls.'

A number of other respondents agreed, with one saying the most high-use patients 'prefer to see us during working hours – they don't work, buses or lifts are easier, it's daylight, etc'. One GP in Somerset says they 'fill evening appointments with people who don't need evening appointments. It's a farce. Then it looks successful and necessary, but it is neither'.

This lack of take-up can often be seen through increased DNAs, practices say. The GP in Manchester says all extended hours appointments in their area are with GPs and are face to face – which we've seen are drivers of patient satisfaction – but that DNA rates seem to be 'pretty high'. A practice manager in Bristol says: 'Like all PCNs we offer enhanced access appointments in the evenings and at weekends. The majority of people booking them are not working people, and the DNA rates are massively higher.'

Patients unwilling to travel

A potential cause of this – but one that deserves its own analysis – is that patients are unwilling to travel. When appointments are provided at PCN level, patients often have further to travel. Dozens of respondents referenced this, especially in rural areas. One GP in Shropshire says: 'None of our patients have ever used extended access appointments at other surgeries. Our PCN weekend extended-access appointments are at a surgery that is 20 miles away.'

One practice manager in south-east London says: 'Our patients will not go to another practice even within our PCN if they want a GP, even when advised it is a doctor from our surgery.'

Lack of availability

Conversely, appointments in some areas can be hard to come by, many primary care staff say. Some respondents said another problem with the PCN model was that the host surgery would often secure the bulk of available slots. Some practices also game the system, according to a practice manager in south-west London: 'We were finding that some practices were having a monopoly on the appointments and starting with a list of patients ready to book into as soon as the appointments were available. That was very frustrating as lots of the slots would be taken up as soon as they were released, and also the practice often hadn't spoken to the patient yet, which meant lots of DNAs. Frustrating all round.'

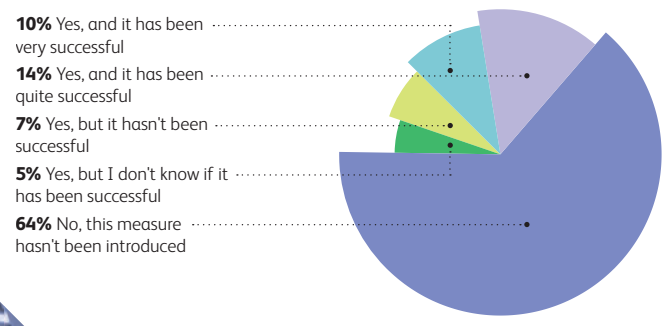
A problem with increasing the number of appointments is that there is no guarantee they will be used by those most in need. One GP in Berkshire says: 'At first it helps, but before long, all the space gets filled, or worse, the gaps are filled with even more trivial nonsense. Our shopping mall walk-in centre recently closed as it led to no reduction in A&E or GP attendance; it just meant more trivial issues were consulted for.'

A lack of cost effectiveness

Many referenced the idea that providing extended-access appointments had not proved a good use of limited NHS resources.

West Yorkshire GP Dr Alex Ross says 'so few appointments and so expensive per appointment – better use of the money would be to do in house'. Another in Cornwall agrees: 'So few hub appointments that it doesn't make an impact – highly paid for the amount seen. It would be money better spent in practice.' Another GP in Herefordshire says: 'These appointments are a faff to organise, probably not cost effective and reduce 8am to 6.30pm Monday to Friday capacity.'

CHART 45 Has a local hub been set up and how successful has it been?



SIMONKR / E+ / VIA GETTY IMAGES

HOW HUB AND EXTENDED HOURS WORKING CAN HELP

One of the places we get support from is the hub our PCN runs for Surrey Heath practices. They provide a mixture of skill sets: GP, paramedics, paediatric nurse, advanced nurse practitioner, and they work quite centrally for the seven practices. It gives options for patients. It's not masses of appointments, but it appears to be working for some.

Saturday working with phlebotomists also working has really supported the Friday 'rush' as people go into the weekends. The Saturday help has meant we have gone from a partner working a Saturday possibly every few weeks, to only having to do one every year or so, which is totally manageable.

The PCN have also been piloting extended hours on a Friday evening for the surgeries. I know this is work that we all did historically (6.30 – 8pm), but we haven't been receiving complaints that patients can't see us at our own place of work on that evening since the pilot has been in place. This in turn has supported health and wellbeing of GPs and staff getting home reasonably early on a Friday.

Wendy Foster, practice manager, Surrey

Hub working

On-the-day hubs are not as common as extended hours. Only around a third of respondents who answered the question said that there was a local on-the-day hub in their area.

Around 363 acute respiratory infection (ARI) hubs were set up across England in the winter of 2022-23, with national funding to relieve pressure on other parts of the system. The hubs were recommended by NICE due to rise of ARIs following the Covid pandemic, including 220,000 people being diagnosed with pneumonia in England and Wales every year, causing significant winter pressures. In a seminar, NHS England said that 83% of providers agreed that ARI hubs 'reduced pressures on primary care' and that without the hubs, about 360,000 patients would have gone to their GP instead. Despite this, NHS England discontinued the funding the following winter.'[116]

Survey respondents in areas with similar on-the-day hubs felt they had been successful, although at slightly lower rates than for extended access – 77% who had hubs in their area said they had been 'very successful' or 'successful' compared with 83% for weekend and 82% for evening appointments.

However, qualitatively, there were more positive comments on the hubs (see case study above). Many came from respondents upset about not having a local hub, or because funding had been pulled. One GP in Lancashire says: 'We did have an ARI hub which was incredibly successful last winter. However, it was temporary and no other on the day hub provision being discussed due to extreme financial difficulties for our ICB.' A practice manager also in Lancashire says: 'The respiratory hub through autumn and winter was fantastic but funding has been stopped.' Meanwhile, a GP in Scotland says: 'Wish we had hubs, nobody does in Scotland, extended hours service is an irritating drag.'

But they weren't the only positive comments. A number of GPs and practice managers referenced how helpful they had been, especially during the winter. As one practice manager in Worcestershire puts it: 'The overflow hub has helped with access and relieved pressure, especially winter, and when a clinician is ill. It helps create capacity.'

Familiar criticisms

That said, many comments offered similar criticisms to those about weekend and evening working. General practice staff referenced issues with travel, lack of continuity and some practices hogging appointments. However, there were no comments around a lack of take-up.

The criticisms were summed up by Richard Langthorp, a practice manager in Humber and North Yorkshire: 'In our experience patients are likely to find an unfamiliar setting, an unfamiliar clinician and the clinician is unlikely to access full patient records. Follow-up action (for example blood tests, referrals or follow-up reviews) are unlikely to be delivered with first class continuity of care. Experience tells us that patients are not reviewed thoroughly and tend to be passed back to their own practice to perhaps review and provide the care they should have been provided with in the first place.'

SUMMARY

Beyond recruitment initiatives, extended access at evenings and weekends has been the principal way in which ministers in England have tried to increase appointment numbers. Broadly speaking, respondents to our surveys said the various models had been quite successful in improving access.

That said, there are significant caveats to the positive responses. Studies have found extended access hasn't improved patient satisfaction to a great extent but had a negative effect on continuity of care.

These criticisms were echoed by GP staff. As well as problems with continuity, they pointed to a lack of take-up – including a reported increase in DNA rates – in part due to patients not wishing to travel further or see unfamiliar clinicians. Conversely, there are also problems with appointments being disproportionately taken up by the lead practices in PCNs. There are similar criticisms around on-the-day hub working.

CHAPTER 11
Reducing demand through Pharmacy First

Governments' main focus has been on boosting general practice capacity, through either recruitment or increasing the number of appointments. But, as the title of a 2024 Health Foundation report said, 'Rethinking access to general practice: it's not all about supply.' It concluded: 'Access to general practice is about more than just the supply of appointments. Broader factors also matter – like how people respond to symptoms, their knowledge of health services and the barriers they face to reach services.'[117]

The report had a major focus on the 'candidacy model' described in Chapter 7. But it acknowledged that there had been attempts by governments to address demand in general practice, and not focus solely on increasing supply.

The supplementary report by THIS Institute and the Health Foundation[118] (see Chapter 4) reviewed all the schemes to improve general practice access. The ones most focused on addressing demand involved diverting patients to other community services.

269,650
The number of self-referrals in June 2025, according to NHS England

NHS England's 2023 *Delivery plan for recovering access to primary care* included a number of initiatives based on using other services. One policy was self-referral to certain services. It said 30,000 people self-referred each month as of September 2023 and estimated that the monthly figure would be 45,000 by March 2024, through expanding services to selected community musculoskeletal services, audiology for older people including hearing aid provision, weight-management services, community podiatry, and wheelchair and community equipment services.[119] It now stands at around 270,000 a month according to NHS England.

In August 2025, NHS England expanded self-referral to maternity services, estimating this could lead to 180,000 fewer calls to GPs and up to 30,000 fewer general practice appointments each year.[120]

There has been little evaluation around the success of self-referral services. But a meta-analysis of almost 3,000 articles found: 'Typically self-referral pathways and direct access pathways tend to widen health inequalities. White, younger, educated women from less deprived backgrounds are more likely to self-refer, exacerbating existing health inequalities.'[121] This is worth further exploration following this report.

Pharmacy First

But the bigger initiative for decreasing general practice demand came through Pharmacy First, designed to use community pharmacy to take pressure off general practice. There are three elements to the scheme: clinical pathway consultations; urgent repeat medicine supply; and NHS referrals for minor illness.[122]

The latter two require referral from the NHS, and were put in place originally as part of the NHS Community Pharmacist Consultation Service (CPCS) from 2019. This was as much designed to relieve pressure on urgent secondary care services and GP out of hours as on GP practices. It allowed other healthcare organisations – including NHS 111, GP practices, 999 and other urgent healthcare providers – to refer patients presenting with low-acuity minor illness conditions or a request for an urgent supply of repeat medicines, to a community pharmacy of the patient's choice.[123]

However, CPCS was replaced by in January 2024 by Pharmacy First, which incorporated these elements but focused on the new clinical pathway consultations. Under the new scheme, community pharmacies are allowed to supply prescription-only medicines for seven common conditions: acute otitis media; impetigo; infected insect bites; shingles; sinusitis; sore throat; and uncomplicated urinary tract infections. As part of this, pharmacists follow a 'robust clinical pathway, which includes self care and safety-netting advice and, only if appropriate, supplying a restricted set of prescription only medicines without the need to visit a GP'.[124]

The aim of the scheme is clear: 'This new service is expected to free up GP appointments for patients who need them most and will give people quicker and more convenient access to safe and high quality healthcare.'[125]

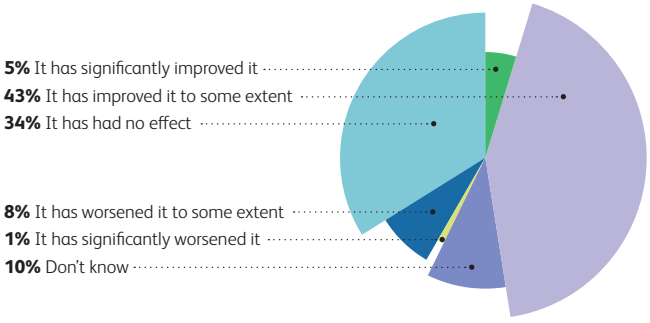
The London School of Hygiene and Tropical Medicine (LSHTM) is currently conducting a major evaluation of the scheme funded by the National Institute of Health Research, which will include a review of its effect on GP access, although there is no current publication date.[126]

Cogora's surveys suggest a lukewarm response to the benefits of the scheme 18 months in: around half of the primary care staff surveyed said Pharmacy First improved access to general practice, while around a third said it had little or no effect.

There were positive comments around its impact. A practice manager in Bristol says: 'We are the highest user of the service and it has significantly improved access for patients who now ASK for a referral to pharmacy.' Many respondents specifically referred to the help around urinary tract infections and sore throats.

A number of respondents said the success of the scheme depended on local services: if there was buy-in from pharmacies

CHART 46 Has Pharmacy First improved access to general practice?



and general practice, then patients seem to like it.
Dr Grant Ingrams, a Leicester GP and chief executive of Leicester, Leicestershire and Rutland LMC, says: 'My own practice remains one of the highest users. But talking to other practices, whether it works clearly depends upon the capacity, capabilities and level of buy-in of the local pharmacies.'
A practice manager in Buckinghamshire, Oxfordshire and Berkshire West ICB agrees that it can be helpful: 'Based on anecdotes it helps individual patients. I think too early to tell if it provides a sustained improvement to access. Key is the quality of the pharmacist handling the referral.'

One practice nurse in Cambridgeshire says she has proactively supported the scheme: 'I developed screening questions for reception to use to support signposting, which really helped.'

Criticisms from general practice staff

The vast majority of the 300 survey respondents who commented on the scheme were critical. This isn't necessarily indicative of the overall scheme, as much of it can be put down to selection bias, but a number of common themes did emerge:

- Patients being sent back to the practice
- Clinical concerns
- Reluctance from patients to use the service
- Limitations of the scheme
- The potential to negatively affect ease of access
- Problems with evaluating how much it is helping.

Patients being sent back to general practice

By far the biggest issue was patients being sent back to general practice. Some respondents put this down to a lack of skills. One GP in Surrey says: 'Patients are still being referred back to us for minor ailments like uncomplicated URTI/UTI and earaches. I wonder if it is a lack of training but we end up with the workload.'

A few GPs specifically referenced insect bites. One, from West Yorkshire, says: 'We direct people there and often they return saying they need to see a doctor. For things like insect bites pharmacists will often say, it looks infected you need to see a doctor. They lack the necessary skills to reduce workload in general practice.' Another, in Cheshire and Merseyside, says: 'The cases seen are so very simple that they don't impact my workload at all. If anything, certain conditions are almost always sent back to us – usually "bites".'

Other respondents – especially practice nurses – said pharmacies were sending patients for a GP practice appointment due to slightly raised blood pressure readings. One practice nurse in North Yorkshire says: 'Pharmacy staff taking blood pressure and sending all slightly raised ones straight to us. Patients come in a panic with no need. Makes more work for us.'

Some respondents said protocols were behind patients being bounced back to general practice. 'Patients do try to access pharmacists for help only to be turned away because of an obscure protocol issue, by which time there are no GP appointments,' says one GP in the north-east of England. 'Patients then directed to 111 by pharmacist which loops the patient to GP where re-looped to 111. Poor patient.'

This is in part because of the criteria for inclusion. There are only seven clinical pathways, and even then there are age-dependent restrictions. One GP in north-west London says: 'Some conditions have silly rules like they won't see children over 5 for otitis media, or they won't deal with sore throats if accompanied by a symptoms of cough, even if that is due to postnasal drip.'

This often ends with an urgent, on-the-day appointment that shouldn't be necessary, because a patient is frustrated at being sent back. A GP in Oxford says: 'Invariably patients are referred back to the GP surgery, often more insistent and angry about the perceived delay. Access is patchy due to inadequate pharmacy cover.' A practice manager in Kent agrees: 'We send patients to Pharmacy First, the pharmacy sends them back to us – we just get the same patients only angry, upset and blaming us.'

The demand for an urgent GP appointment is down to the patient having already had a consultation with a healthcare professional, who told them they needed escalated care. An ANP in Shropshire says: 'Scheme is rubbish. Local pharmacy is not able to accurately assess or treat patients, meaning patients need to be seen urgently as chemist said so.' Another practice nurse team leader in Sheffield says: 'Patients are often bounced up to the GP practice expecting to be seen immediately as the pharmacist has said they need to be seen by a GP/ANP.'

Clinical concerns

A common concern, especially from GPs, was around the clinical advice given by pharmacists.

Dr Kate Hodges, a GP in the north-east of England, says there have been positives around the scheme: 'Our antibiotic prescribing is down, the patients like it because of the perceived walk in status and with increasing usage patients are more likely to seek help there first before coming to us, reducing burdens on phones and care navigation.' However, she adds that concerns exist around the 'clinical acumen' of some of the pharmacy staff: 'For example, misdiagnosing ear wax as otitis media even though the ear drum was not visible, giving antibiotics for a sore throat and documenting centor 4 but, when seen later the same day because the patient was unable to tolerate the antibiotics provided, it was maximum centor 1.' [The Centor sore throat scale guides antimicrobial prescribing].

Many GPs expressed concern around the level of inappropriate antibiotic prescribing – a major theme of the LSHTM evaluation. Typical comments included: 'I'm concerned about the overuse of antibiotics'; 'Only concern is overprescribing antibiotics and the effect on gut microbiomes'; 'Antibiotics given out when I would not have given them'; and 'Has absolutely and irrevocably increased patient demand and expectation for antibiotics'.

There was also a concern around pharmacists not being diagnosticians, best summarised by a practice pharmacist in Cheshire and Merseyside: 'Pharmacy First has had a relatively minor impact, with one of the more common interventions treating patients with uncomplicated UTI. My concern is that the philosophy and direction of travel is the wrong one. Pharmacists are not properly trained in diagnostics, that is what doctors are for.' This 'service-led' approach is pushing pharmacists towards diagnoses 'in a bid to secure much-needed central funding, which is wholly inappropriate and a disservice to both pharmacists' and doctors' skills'.

10.93
Number of Pharmacy First consultations community pharmacists do in a week

Patient reluctance

Another issue comes from patients' reluctance to go to a pharmacist rather than see a GP, which was mainly raised by practice managers. One in Norfolk says: 'It will take further time for Pharmacy First to properly embed and become the first choice for patients suffering from minor complaints. They still feel "fobbed off" currently and carry the "I want to see a doctor" mentality.' Another in South Sefton says: 'Some patients refuse point blank to see a pharmacist and will only see a clinician at the surgery.' A health visitor in Hertfordshire says the scheme 'has helped to take the pressure off minor illness demand', but adds: 'Lots of patients do not "trust" the system, or still want to be seen by a clinician in the practice.'

There might also be a level of inconvenience, especially in rural areas. One practice manager partner in Cambridgeshire says 'it is a 30-40 mile round trip for our patients to visit a pharmacy, it is very difficult to get them to go'. She says this is a common problem with attempts to improve access.

There are issues around awareness. 'The number of conditions covered are limited and it's not well promoted in the media so patients remain largely unaware despite our best endeavours,' says a practice manager in Cheshire and Merseyside.

No noticeable effect

Although all this does give a negative picture of the scheme, a point raised by many general practice respondents was that it is impossible to tell what impact it is having on the ground – and this is likely to be a theme of the LSHTM evaluation. As one GP puts it: 'We cannot count what we do not see.' That said, there seems to have been no drop-off in workload and, as we saw in Chapter 1, there has been no reduction in the total number of appointments either with GPs or other clinical staff.

14.75
Number of extra Pharmacy First consultations community pharmacists say they could do on average in a week in addition to those they currently do

The limitations of the scheme can also limit its utility. South Yorkshire GP Dr David Coleman says: 'We receive around 200 appointment requests daily, perhaps five eligible for Pharmacy First. Once I've triaged them and obtained the information I need to ensure they fit the narrow pathways, I feel I may as well manage the cases myself. I'd rather the funding was invested in GP so we can invest in our own workforce.'

Some have noted that the scheme tends to take away the simpler cases. As we saw in Chapter 8, such cases can often help GPs manage their time, and the slots they free up tend to be taken by more complex patients. As another GP puts it: 'Lots of simple quickies have gone but they were the easy ones anyway.'

Indeed, in some cases, Pharmacy First

reportedly has a negative effect, in terms of ease of access. A practice manager in West Yorkshire says: 'While it has given patients better access for minor ailments, there is little impact on practices as demand still outstrips capacity. However, phone call timings increase with care navigation from an average of two minutes to six minutes and appointments times increase as the more complex patient is being seen.' This idea of duplicated contacts is echoed by a practice pharmacist in North Yorkshire: 'Many patients directed back to us contrary to PGD guidance, thus requiring two calls to the practice – the first where reception signpost to Pharmacy First, the second to make an appointment.'

What community pharmacists think

Community pharmacy is also under significant pressure, with the National Pharmacy Association (NPA) warning that independent pharmacies in England are 'teetering on the brink', with more than six in 10 at risk of closure within the next 12 months.[127] An investigation by *The Pharmacist* in 2024 revealed a net loss of around 1,200 community pharmacies since 2019 – more than 10% of the total of just under 12,000.[128] The latest figures suggest there are now fewer than 10,000 pharmacies.[129]

As with general practice, this creates a dilemma – pharmacies need to take on more work to increase their funding, but simply lack the capacity. As such, some believe general practice should send more referrals their way, while others believe it is using community pharmacy as a 'free triage service', as one puts it.

Taking on more

Community pharmacists are slightly more positive when it comes to the effectiveness of the scheme, with around 16% saying it has significantly improved access to general practice, and a further 40% saying it has somewhat improved it – although this was on a relatively small sample size of 134 respondents. *The Pharmacist* survey also asked how many Pharmacy First consultations they do in a week, and how many more they feel they could do. They say they do an average of 11 a week, but they feel they have capacity to take on a further 15 in a week.

Many respondents said they felt general practice should be doing more to support the scheme. One community pharmacist in Birmingham says we 'need more surgeries on board', adding: 'I firsthand have spoken with some GPs who do not want to send many referrals as they don't want to deal with complex patients. They also don't believe in the competencies of community pharmacists to deal with the Pharmacy First conditions.'

Other community pharmacists say 'practices are not promoting this service'. Hannah Cathrine, a community pharmacist in Nottingham says: 'I still see a significant number of patients visiting their doctor for simple ailments that GPs still don't seem willing to refer to pharmacies.'

General practice over-using Pharmacy First

On the other hand, some community pharmacists feel general practice is sending too many referrals – and this is one of the reasons pharmacies bounce patients back. Typical comments included: 'Doctor's receptionist just wants to refer to pharmacy'; 'Surgeries do not evaluate each patient critically before pressing the button on computer'; and 'Receptionists need more training as they send every patient in our direction first, even if they don't meet the criteria. That makes patients angry and frustrated'.

Community pharmacy doesn't have the capacity to cope with inappropriate referrals, one pharmacist in north London says: 'GPs are not educating themselves on the Pharmacy First service and are automatically referring patients instead of listening to their needs. It has had a negative impact on patients as they are often wrongly referred for an ailment not covered by Pharmacy First.

'Also, in an attempt to reduce the burden on GPs, the burden on pharmacists has significantly increased with zero pay rise. Our workload is constantly increasing but where is the incentive?'

This is exacerbated by the unpredictability of the referrals. One respondent in community pharmacy says: 'Consistent numbers matter as without it difficult to invest in staff.'

Another respondent in Warwickshire agrees: 'The referrals are unpredictable. Hence, in the current economic climate, we can't positively hire staff to increase capacity. If the job were to be done seriously, community pharmacy should be funded one FTE pharmacist salary and allowed to book their own minor illness consultations that don't necessarily lead to clinical pathways.'

Struggles to improve access to general practice and primary care in general during a time of scarce resources is a theme we continue to revisit.

SUMMARY

There is lukewarm support for Pharmacy First among general practice and community pharmacy staff. The option for patients to have minor illnesses seen in community pharmacy is useful in theory but there are a number of criticisms of the scheme. GPs and their staff point to the number of referrals that are bounced back to them. Some have concerns around the quality of care provided, especially in terms of antibiotics prescribing.

As seen with the expansion of the workforce in general practice, there is some reluctance from patients to be seen by anyone other than their own GP, which has led to a reluctance to use Pharmacy First services. Meanwhile, the workload in general practice remains high and appointment numbers continue to rise – any noticeable change comes from minor conditions, and some GPs say even this has a negative effect, closing a pressure valve provided by simpler consultations amid non-stop complex cases.

Community pharmacy is also facing a funding squeeze and increasing workload, affecting its ability to make full use of the scheme. There might be potential for it to work, but it would still require increases in capacity across the whole of primary care.

CHAPTER 12
Improving ease of access: total triage and digital telephony

So far, we have discussed primary care professionals' attitudes towards increasing capacity, through boosting staff numbers and extending hours to enable more appointments to be provided, as well as the attempts to reduce demand through Pharmacy First.

However, successive governments have focused on the '8am rush' to secure an appointment by phoning the practice. Of course, the availability of appointments is crucial here, but the logistics behind the ease of access – how easy it is to actually get through to the practice – have been equally pressing.

NHS England's *Delivery plan for recovering access to primary care*[130] sought to address this through 'Modern General Practice Access'.[131] This is a model encouraged by NHS England, and is based on the following principles:

- Optimised contact channels – offering patient choice of telephone, online and in person through easy-to-use websites, online consultation tools and improved telephony systems
- Structured information gathered when the patient contacts the practice, to understand what is being requested
- Use of a single 'care navigation' across each channel to prioritise patients safely and fairly, instead of 'first come, first served'.

It also refers to making 'full use' of the primary care team and 'self-access' options, as well as improved use of data.[132] GP practices have implemented this through a mandatory move to cloud telephony and through triage systems. As we will see in this chapter, these changes have proved fairly successful in England, according to GP practices. They might even have contributed to the uptick in satisfaction scores on the GP Patient Survey in 2025.

Total triage

NHS England says with total triage, 'every patient that contacts the practice is first triaged before an appointment is arranged. All patient requests are screened and signposted by the practice to the next step of their care journey. Practices use a combination of both digital and traditional pathways to achieve this'.[133]

During the pandemic, NHS produced guidance on how practices could implement a model at a time when patients were discouraged from visiting surgeries unless completely necessary, in a bid to stop the spread of Covid-19. At the same time as moving to this system, practices had to reconfigure their surgeries for social distancing – even setting up 'hot' and 'cold' zones.[134] In difficult circumstances, practices were able to achieve these changes almost overnight, and were rightly lauded at the time[135] – although as we saw in Chapters 4 and 5, the coverage soon turned sour.

In 2021, the RCGP launched a survey of the effects of the move to total triage. It found that only 52% of GPs agreed that 'patients always get where they need to' through total triage system, while 58% said it helps to ensure patients' needs are better met.[136] Meanwhile, the college cited research from 2017 suggesting that while total triage (in this case, telephone) saved workload for some GPs, it had the opposite effect for others.[137]

There is still a lack of research into its effectiveness. A study by the Health Equity Evidence Centre in January 2024 recommended that ICBs and practices take steps to ensure total triage systems do not widen health inequalities, including ensuring they are accessible to patients from diverse cultural backgrounds, forms are easy to use and recommended against a blanket implementation. But it also acknowledged the 'limited evidence on the impact of telephone or digital triage on health and care inequalities' and that 'the evidence that does exist is drawn from out-of-hours services'.[138]

Cogora's surveys revealed that many practices felt total triage had come a long way since the pandemic. Around half say they have introduced total triage in a bid to improve access, and almost 90% of those who did say it has been successful.

Interestingly, many respondents to the survey – which went out in July 2025 – said they had either very recently introduced total triage, or were in the process of introducing it. One GP in Manchester says: 'We are moving to total triage from the end of September this year. All the other practices in our PCN have already done this. It seems to be the only way to control the relentless demand for GP appointments.' Another GP in Essex, writing in August, said: 'Since completing the survey, we have switched to a total triage model.'

A GP in Nottingham says: 'We introduced total triage this week. I am optimistic about it but the triage has to save

CHART 47 How many practices have introduced measures to improve access

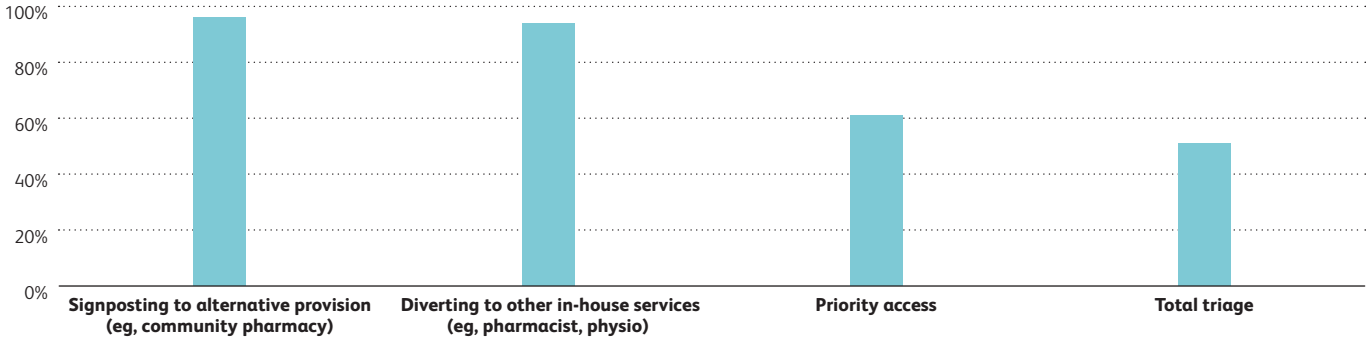
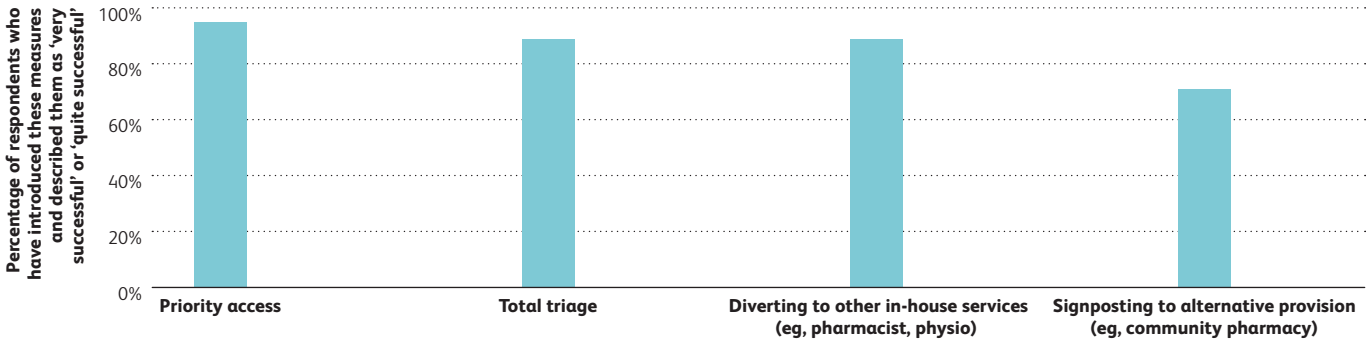


CHART 48 Success of measures introduced by GPs to improve access



a minimum of 30 appointments a day for it to work (as we lose 30 appointments a day for the triage to be able to triage). On two occasions we phoned separate patients within 20 minutes of their triage request and were able to offer them an appointment within 30 minutes but they both decided to go to A&E instead!'

Some who said they had begun setting up total triage in recent months said they were doing so in anticipation of contractual changes from October, which we touched on in Chapter 4. Under the new patient charter, patients can expect to hear what the next stage of their care will be within 24 hours of contacting their practice via telephone, online submission or walk-in.[139] Heather Wilson, a practice manager in Blackpool, says: 'After the recent announcement about online consultations needing to be available during opening hours from October, our partners and I both decided to implement the total triage model.'

The contract changes loom large for some, however. One practice manager in Essex says: 'Triage works for us at present while we have a safe working capacity on it but when this changes from October this will be unsafe and will not be able to deliver the same level as we are. We will not have the capacity for appointments.'

GP triage

In most cases, the process involves the GPs in the practice taking on all the triage. Dr Eithne Macrae, a GP in St Helens, says total triage has worked well since implementation in July 2023. She says: 'With GPs and not admin triaging, we can arrange appropriate investigations, request further history etc, so the patient is seen with the results (if clinically appropriate and can wait) – thus getting the most out of each GP appointment.

'GP triage appropriately diverts patients to the right place first time, so we are physically seeing fewer patients but seeing those who need to see a GP sooner than before. We are managing a much greater number of patients than pre-total triage.'

One GP in Berkshire says his practice dedicates four GP sessions a day to triage, but this has ultimately proved efficient (see case study, right)).

Such a GP-led process isn't used across the board. One practice manager in Bristol says: 'We use trained health navigators rather than clinicians or a machine in order to free up GPs to see the right patients at the right time.'

WE DEDICATE FOUR GP SESSIONS A DAY TO TRIAGE

We have spent years as a practice trying different models and honing various strategies. We moved to a clinical triage system in 2020 and have refined it slightly since then but the principles are the same:

- **GPs triage the clinical reason given by the patient for their appointment request (either using information gathered by eConsult or by our patient services team on the phone).**
- **We dedicate four GP sessions per day to the process.**
- **To justify this investment, we build in efficiencies such as pre-requesting investigations for specific symptoms/presentations, then have a single appointment to review the patient face to face with results, or we use a telephone appointment to answer a medication query or straightforward presentation where F2F is not clinically advantageous.**
- **We rely on being able to prioritise clinical presentations where an on-the-day response is best practice clinically vs convenience to help us plan supply-demand.**
- **If a patient calls up at 4pm or even 6pm with a symptom that merits a same-day GP response, then we have the capacity in our triage GP system to book them in – either for the non-triage GP if a slot remains, or for the triage GP themselves to see.**

GP partner, Berkshire West

Controlling demand

Some practices are using total triage to try to control demand. The Manchester GP whose practice is currently implementing total triage says: 'All requests will now be submitted online or via the receptionists helping the patient to fill out the form. We will be providing no additional appointments but hopefully we can deflect some of the patients who don't need a GP appointment.

'We are planning to offer all appointments as face to face once they have been triaged, 15 minutes duration with the option for telephone at the patient request. Having to have online access open until 6:30pm from October will be a significant challenge. My GP day is now 11 hours long often with no break for lunch – it's not sustainable to do that for years on end.'

Dr Sarah Dixon, a GP in Hertfordshire and West Essex, says online access has made it easier for patients to contact the practice with what are often self-limiting issues. She adds: 'We do need to base access on needs rather than patients' wants and demands.' Some patients might be unhappy with this, she says, but it does ensure patients get the appropriate care.

Workload

Some practices have, however, reported workload issues as a result of triage. Putting GPs on triage means they are taken away from patients. One GP in Gloucestershire, whose practice has GPs triaging all request, says: 'The problem with this is that it is GP intensive and also we struggle to cope with the number of requests in a day. It means the triaging GP is necessarily not doing other things/providing appointments to see people.'

It isn't always the most satisfying role either, says the Essex GP who has recently implemented triage. 'As clinicians we are all struggling with sitting in a hub for 12 hours reading these forms and would all rather see patients and do the job we trained for.'

Patient feedback – health and digital literacy

There have been concerns around how patients will react to total triage, especially with regard to health and digital literacy.

The Essex GP says the number of phone calls has dropped since the introduction of total triage 'so I presume the "I've been waiting on the phone and look at my phone I have called 300 times has changed".' However, the GP adds: 'The abuse continues with patients refusing to complete the form, complaining to receptionists it is a stupid form/system etc. The receptionists have been completing forms for patients of all ages 20-80, the older group at face value managing far better than the younger one.'

Patient feedback has been mixed. Lisa Fall, a practice manager in Dorset, says: 'With regards to online consults we have patients who love completing the forms, as it means the information can be sent, reviewed and an appointment sent back within 24 hours (for us anyway), versus those who absolutely refuse to fill a form in as they want to phone and get an appointment with a GP.'

However, Blackpool practice manager Heather Wilson reports that feedback has been 'angry'. 'Patients don't want to fill in online forms, they want to call the surgery. The main view was that this would mean elderly and vulnerable patients would not be able to use the form and therefore be unable to contact us. When patients do fill in this form, we are finding the information they are giving is much more detailed than what they are giving the receptionist if they use the telephone to call us instead.'

The main takeaway for many general practice staff is summed up by the GP in Essex: 'I think the problem with the one size fits all is it just doesn't. Practices are different, people are different, and their needs are very different, forcing practices to one way of working just doesn't work.' However, as the case study below shows, balanced implementation can bring positive results.

TOTAL TRIAGE HAS HELPED PATIENTS AND STAFF

Our practice transferred to a total triage model a few weeks ago. Our reception team fills in forms for the patients who are unable to complete them online themselves or via the NHS app, and this produces a more equitable approach for all of our patients. This approach allows the triage clinician to identify opportunities for the person to continue to consult with the same clinician about an ongoing problem and this is communicated to our reception team who then book the appointment for the patient.

Many of our online forms result in an outcome within a few minutes of submission, and we are able to decide if it is most appropriate for an online response, or a face-to-face or phone consultation. Most phone or face-to-face consultations offered will be on the same day that the patient contacts us. We encourage patients to declare all their problems on one online consultation form and can offer longer appointments as necessary when they have multiple problems that require examination.

Over the last 12 years we have found that approximately 80% of our patients will accept a same-day appointment if offered one, and we only advance book if there is a good reason to do so, for example to enhance continuity of care or timing a coil fit to a woman's menstrual cycle.

We have had very positive feedback from many of our patients since going on to total triage, and they have particularly valued the combination of speedy access as well as continuity of care. Our staff are also much happier, and our reception team feel supported by the clinical team when offering appropriate appointments. The only disadvantage of our approach of avoiding the concepts of urgent and routine has been massive and rapid list growth as patients transfer to us from other local practices.

Dr Joanne Watt, GP partner, Northamptonshire

Telephony services

Also as part of Modern General Practice Access, NHS England is mandating the improvement of telephone systems. In the imposed 2023 GP contract, NHS England announced that – from the end of 2025 – all analogue telephone systems would be replaced by digital telephony in GP practices.[140] This would allow:

- Routing of calls
- Call-back and call-queuing functionality
- Support for remote working and business continuity
- Enhanced reporting capability to support capacity/demand service planning, including call volumes, time in a queue, calls abandoned and average call length, among other metrics.

To support this move, NHS England made £240m available for practices using older systems as part of its delivery plan. This hasn't been without controversy. Practices have warned of spiralling costs with new systems, with some claiming increased bills of £10,000 a year,[141] and the BMA calling for the project to stop as a result.[142] There have also been fears that the enhanced reporting could be used to performance manage practices.[143]

Issues with contacting the practice can also be seen in attitudes towards reaching a practice by phone, which remains

CHART 49 Patients who said it was 'easy' to contact practice by phone

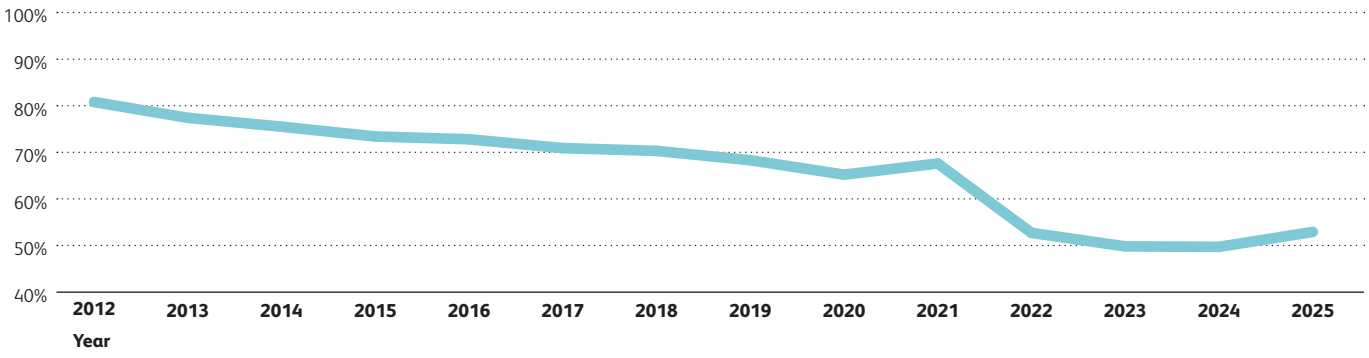
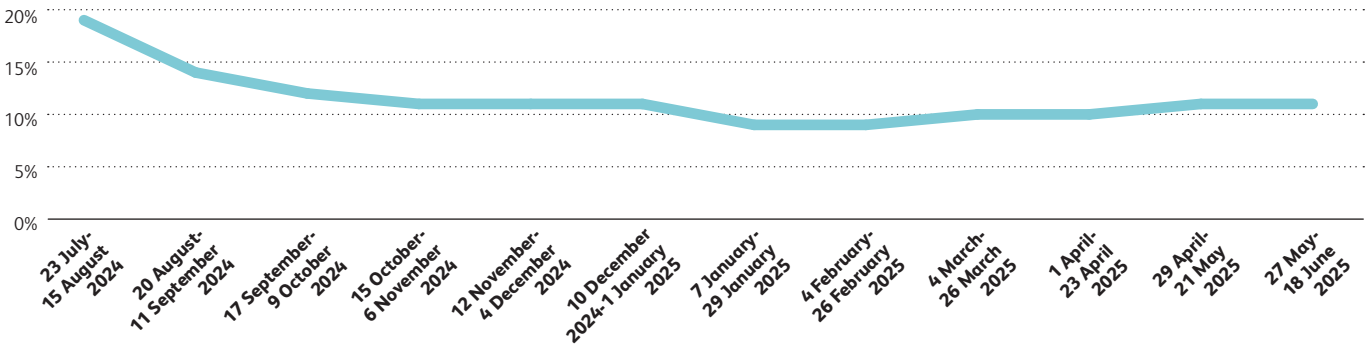


CHART 50 Monthly data on patients describing it as 'difficult' to contact GP practice



the most popular way of doing so – 62% said in 2015 that they had contacted their practice by phone on their last attempt, compared with 14% for both walk-in and online.[144] Yet satisfaction with phone contact has dramatically fallen since 2018, from 80% to just over 50% in 2025. There has been a slight uptick in the past year, however – only the second year to arrest the sharp decline over 13 years, with the other being during Covid (Chart 49[145]). New monthly data from the Office for National Statistics show the percentage of patients reporting difficulty in contacting their practice is decreasing (Chart 50[146]).

Patients Association chief executive Rachel Power says: 'The modest improvements in the 2025 GP Patient Survey reflect some genuine, if incremental, progress from a patient perspective. Overall satisfaction with GP practices has increased, and notably, more patients now find it easy to contact their practice by phone.'

Practices report that digital telephony has helped. One practice manager in Blackpool says she was 'reluctant to move to a new-fangled phone system' a year ago, but adds: 'I have to say I'm impressed. We fully use the system and I didn't have any complaints from patients, or staff, regarding the switch.'

Staffing flexibility

But this still needs staff. One practice manager in Cheshire and Merseyside says getting through to the practice has been a 'longstanding problem' that has been eased by triage. But this has involved a change in staffing: 'We now have all the staff who are in the practice from 8am on the phones – no matter what non-clinical role they have. This simple thing has made a huge difference. We get the call queue down to zero within 30 minutes most days. We flex staff onto the phones if the queue goes into double figures and this has a real positive impact. We have the phone activity visible in the triage hub and the call handlers' office.'

It is a similar case for Stockton practice manager Jane Dalgleish, who said her practice had made many improvements to GP access. She adds: 'The biggest improvement though has been access to the surgery via the telephone. We have an average wait on the phone of around 4.1 minutes and this includes busy Monday mornings. The change we made that has had the most impact on this is to have a "spare" member of staff who is able to jump on the call queue if it is starting to rise.'

But the problem is that, without the staff, even new systems won't necessarily lead to improved access. The GP in Manchester says: 'It is currently very difficult to get through to our practice on the phone – we have invested in a new telephone queueing and ring-back service but the number of calls on a busy day means there is always a delay. Practice finances are under huge pressure. The partners haven't had a pay rise for several years and we are not prepared to take a pay cut to improve access any further by employing more GPs/ANPs or reception staff.'

South Yorkshire GP Dr Mohammed Sharif says his practice uses AI to try to improve ease of access without needing to increase the practice team. 'We are currently trialling an AI receptionist, who has the capacity to answer multiple phone calls at the same time and transcribe this onto Accurx for the on call doctor to review. This has eliminated any waiting times on the phone which means more patients are getting through.'

However, as is often the case with improved access in one form, there is often a trade-off elsewhere. Dr Sharif adds: 'It is early days but this ease of access has increased the workload of the on call GP and we are going to have to review this as a partnership as it does not feel sustainable.'

SUMMARY

Process improvements are making it easier for patients to contact practices. Although patient satisfaction with the experience of getting in touch with their practice remains low, there has been a slight uptick in the past year.

Total triage is being implemented rapidly across the country, in part due to contractual changes due to come in October 2025. Practices are, on the whole, happy with total triage, finding it a useful tool in managing demand and helping ensure they respond to patients efficiently, and direct them to the appropriate service. There are teething problems, with some patients struggling with the radical changes and GPs and their staff reporting workload issues. But it does seem that the systems have improved since the rapid introduction of total triage in 2020 during the first Covid lockdown.

Telephone systems also seem to be improving, with patients reporting increased satisfaction in contacting their practice.

CHAPTER 13
The Government's 10-year plan

These attempts to improve access – the ARRS, extended hours, Pharmacy First and Modern General Practice – are all embedded in the healthcare system now, even if we haven't yet seen formal evaluations of them all yet. But they were all introduced under the Conservatives.

The Labour Party entered government in July 2024 with three priorities for the NHS: moving care from hospitals to the community; moving from analogue to digital; and moving from sickness to prevention. It laid out how it would do this through the 10-year plan, published in July 2025.[147] Although it has yet to enact these plans, it is worthwhile considering what the Government is planning for GP access, and what the initial response has been from the profession.

GP access is front and centre of the plan. 'Many cannot get a GP or dental appointment' was the first bullet point of the executive summary. There were five mentions of the '8am scramble'. It said that 'GP access has become so poor that A&E has become some people's de-facto primary care, particularly in more disadvantaged areas, where there are far fewer GPs per head.' And it vowed to 'restore GP access'.

The solutions it offers for GP access include:

- The introduction of two new contracts, which will see GPs working across larger geographies
- Use of the 'My NHS App' to allow patients to find the most appropriate service and incorporate AI-powered online advice
- An increased proportion of staff trained for community and primary care roles
- A cut in bureaucracy to free up GP time.

The plan offers little detail on any of these. On recruitment, there will be a 10 Year Workforce Plan later in 2025, which will supersede NHS England's 2023 plan.

Around bureaucracy, the 10-year plan says it will 'support providers to roll out technology to cut unnecessary administrative and clerical work'. It highlights the use of ambient voice technology' – or AI scribes – which it says can save 90 seconds for every consultation. Anecdotally, GPs have said they have found these tools very useful. But, in a reflection of how the NHS sometimes works, many practices have ditched the technology after NHS England guidance seemed to restrict its use.[148]

Neighbourhood health service

The major proposed change to general practice came in the form of neighbourhood health centres. The 10-year plan says, in full: 'Truly revitalised general practice will depend on more fundamental reform. Having served us well for decades, the status quo of small, independent practices is struggling to deal with 21st century levels of population ageing and rising need.

'Without economies of scale, many dedicated GPs are finding it difficult to cope with rising workloads. Far too often, that means work is causing chronic stress and mental illness among hardworking professionals. Many GPs are voting with their feet: 74% of fully qualified GPs were partners in 2015, compared to just 55% today. Where the traditional GP partnership model is working well it should continue, but we will also create an alternative for GPs. We will encourage GPs to work over larger geographies by leading new neighbourhood providers. These providers will convene teams of skilled professionals, to provide truly personalised care for groups of people with similar needs.'[149]

To achieve this, it proposes the introduction of two new contracts, to be rolled out in 2026. The first will provide enhanced care for a single 'neighbourhood', covering around 50,000 people – a similar size to PCNs. The second contract will create 'multi-neighbourhood providers', covering around 250,000 people. These larger providers will 'deliver care that requires working across several different neighbourhoods (eg, for end-of-life care). They will involve shared back-office functions, oversee digital transformation and estate strategy, and provide data analytics and a quality improvement function. They will also be able to take over individual practices that struggle with either performance or finances.

These could signal significant change in the profession. But there is so far little information around crucial aspects. First, whether either contract will replace GMS contracts in the areas they are implemented, or whether the constituent member practices of these neighbourhood centres will retain the nationally agreed contract. Second, there is ambiguity over who will negotiate the contracts – whether they will be entirely locally agreed or whether the national BMA GP Committee will be involved.

To further complicate matters, the 10-year plan introduces 'year of care' payments – a capitated budget that covers all a patient's primary care, community health, mental

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health, specialist outpatient care, emergency department attendances and admissions care in a year. This would seemingly invite non-GP providers to take on all general practice services.

The Government has said all the contracts or models being discussed will be open to GPs. However, South West London ICB has already appointed five hospital trusts to 'hold funding' for its neighbourhood centres, with the sixth and final area – Greenwich – yet to confirm at the time of publication. Meanwhile, LMCs in Staffordshire have advised local GPs 'not to apply for it – until we have complete confidence that GMS contracts will be protected'.

The Government has provided little evidence of how this will benefit access. The 10-year plan refers to helping retention by giving GPs the chance to work in larger organisations, and flags more opportunities to develop special interests.

Health secretary Wes Streeting spoke at an extraordinary special representatives meeting (SRM) held by the BMA on 14 September 2025 to 'debate the risk of the 10-year plan to the medical profession at large'. While not unprecedented, such SRMs are rare.

Mr Streeting told the meeting the planned neighbourhood health centres were going to be 'exciting' for general practice. 'I'm looking for partners in primary care who are willing to sort of step up and show everyone else what that future could look like if we had primary care-led health services.'

But GP and other medical profession leaders aren't convinced. The SRM delegates – which included doctors from across the NHS – voted in support of GPs re-entering formal dispute unless 'sufficient legislative safeguards' were introduced to protect the GMS contract and partnership model, and demanded trusts should not be allowed to hold the neighbourhood contracts.

My NHS GP Tool

The other major route to improving GP access proposed by the 10-year plan is the NHS App and AI. Patients will be able to 'access all they need from their neighbourhood team, including booking appointments.'[150]

The app will also provide advice for non-urgent care through 'AI-algorithms to take a patient's descriptions of their worries or symptoms, ask the right follow-up questions and provide personalised guidance'. It will advise on self-care, including recommending 'well-evidenced consumer healthcare products'.

The BMA's SRM passed a motion to 'support the responsible use in the NHS of digital technologies, artificial intelligence and research-led innovation'. However, another motion, which was also passed, expressed 'grave concerns about the Government's ill thought out, extensive digital and technological aspirations in The 10 Year Plan'.

The motion said that when introducing 'AI algorithms which have no concurrent clinical input such as My NHS GP', the Government must ensure it accepts responsibility for 'underwriting all penalties related to missed diagnoses, misleading advice etc'. It also said 'that a future NHS reliant on digital and AI programmes for access will worsen the existing digital inequity divide'. The topic of AI to support GP access is likely to become dominant over the next couple of years, and we will explore it further following this report.

SUMMARY

The Government's 10-year plan focuses on shifting care from hospitals to the community, on moving from analogue to digital and on prioritising prevention over sickness. In terms of general practice access, there are two major policies – neighbourhood health centres and the My NHS GP tool.

The neighbourhood health centres follow a recent trend to upscale general practice. There was little detail available at of time of publication, but this does seem to open the door to trusts taking over general practice services. It also poses a potential threat to the partnership model.

The My NHS App promises to allow patients to access health advice through AI, although the algorithms haven't yet been tested.

It is too early to say whether these policies will improve general practice access, but the BMA has already raised concerns about a potential negative effect on continuity of care.

PART FIVE

How we can improve patient care

CHAPTER 14
An emphasis on continuity

Attempts to improve access have had mixed success. But it could be that asking how we improve access is the wrong question. Instead, it would be beneficial to look at how to improve the care of patients in general practice. One way of doing this is through a focus to continuity of care.

As with access, there is no obvious definition of continuity. However, in general practice it is commonly thought to mean a patient seeing the same healthcare professional – usually a GP – for most of their general practice care so they 'know each other well'. This is normally referred to as 'relational continuity'.[151]

There are numerous studies around the benefits of continuity of care. It is beyond the scope of this report to summarise them all, but it is useful to look at one analysis of evidence and a major study from 2024. Nuffield Trust conducted a rapid review of literature from 2000-2018 for its NHS England-commissioned *Improving access and continuity in general practice* report. It found that relational continuity is 'associated with a significant number of benefits to individuals and wider health systems',[152] including better clinical outcomes, reduced mortality, better uptake of preventive services, reduced avoidable hospital admissions and better overall experience of care. This is especially true for children, the elderly and those with long-term conditions, while vulnerable groups tend to value continuity more.

However, it added that an analysis of the GP Patient Survey suggested some marginalised groups who would benefit from continuity have more trouble finding it: 'For example, those from Indian, Pakistani and Bangladeshi ethnic groups are more likely to have a preferred GP compared with British and Northern Irish respondents (54–55% versus 51%), but are less likely to see a preferred GP (17–25% versus 38%)'.[153]

A major 2024 study of more than 10 million GP patient consultations in 381 English primary care practices over a period of 11 years by researchers from the University of Cambridge and the INSEAD Business School found that the 'time to a patient's next visit is on average 18.1%... longer when the patient sees the doctor they have seen most frequently over the past two years, while there is no operationally meaningful difference in consultation duration'. This benefit is 'larger for older patients with multiple chronic conditions, and patients with mental health conditions'. It estimated that consultation numbers 'could have fallen by up to 5.2% had all practices offered continuity of care at the level of the top decile of practices while prioritising patients expected to yield the largest productivity benefits'.[154]

GPs and their staff have seen these benefits themselves. A GP from the Isle of Wight says that while waits can be long for patients to see their preferred GP, this tends to pay off: 'What we have found is that patients value having a doctor that knows them and they have a relationship with. They tell us that they like knowing that one person has main responsibility for their medical conditions. We find it has meant that the complex patients are not shoved from pillar to post and can be evenly distributed between GPs.'

5.2%

The potential drop in consultation numbers if all practices offered the highest level of continuity

Governments' approach to continuity

No one seriously disputes the benefit of continuity of care, and that includes ministers and policymakers. All government and NHS plans around access mention continuity. But this tends to be paying lip service. In the 10-year plan, there are four mentions: two as part of case studies and the other two as a benefit of the time saved by using ambient voice technologies. The NHS England delivery plan did have a paragraph on continuity, with a nod that 'relational continuity yields significant benefits for patients', and an encouragement for practices to use the RCGP Continuity Toolkit.[155] But even advocacy of continuity was in the context of the benefits that care navigators can have for a practice.[156]

In Sajid Javid's short-lived stint as health secretary, he oversaw a plan for improving access in the winter of 2021/22.[157] This contained few new elements, and barely mentioned continuity of care. The 2016 GP Forward

View was a similar story, simply emphasising that the partnership model provides 'leadership and continuity' – it is not even clear this refers to continuity of care.[158]

The exception was Jeremy Hunt's imposition of a contractual requirement to give every patient a named GP from April 2015. The requirement is still in place but, in reality, is little more than a bureaucratic process. As one study puts it: 'The introduction of the named GP scheme was not associated with improvements in either continuity of care or rates of unplanned hospitalisation.'[159]

Contractual measures

University of Manchester researchers found continuity did often take a back seat to access: 'In the UK, policies addressing access have favoured a simplified view of access, which focuses on the timeliness of appointments, rather than taking a broader view of the concept. The focus on speed of access has undermined other important aspects of care, such as continuity.'

As extensively covered in this report, there are numerous, often justifiable, political imperatives around access. Yet another reason why access takes precedence over continuity is that it is hard to quantify continuity on a practice basis – unlike access, where there are metrics around appointment availability and ease of contacting practices. Continuity, however, tends to have benefits 'further down the line', says Dr Edward Schwarz, a GP in Cornwall: 'No antibiotics for a viral illness is a tough sell from a random practitioner but if you have that relationship over years, treated their family etc then they are more likely to trust you.'

This is often on a patient-by-patient basis according to Stafford GP Dr Lee Sanders-Crook. For all the evidence in favour of continuity, he says, 'personal anecdote strikes harder'.

'Cases where after patient has left you reflect how easy it would have been to miss/dismiss certain findings unless the patient had sat before you and stayed relevant in your memory.'

But he said such relational continuity was hard to measure and a tougher sell than the 'shinier goals' of quicker access.

This makes it harder to implement continuity of care into the GP contract, which is the main method of incentivising good practice. Before the 2024 election the Labour Party had been trailing plans to include continuity of care in the GP contract.[160] This was delivered through the PCN Capacity and Access Improvement (CAIP) scheme, which 'incentivises PCNs to risk stratify their patients in accordance with need – including to identify those that would benefit most from continuity of care'.[161]

But the payment structure demonstrates where the priorities lie: the £1.37 per weighted patient a PCN gets for the continuity element of the CAIP is half that for the access element.

£1.37

The funding per patient PCNs receive to improve continuity of care

What is happening with continuity of care?

Despite its value, continuity of care is on the decline. The GP Patient Survey reveals that the number of patients who get a consultation with their preferred GP or healthcare professional 'at least some of the time' among those who have one has been decreasing since 2018 (Chart 51[162]).

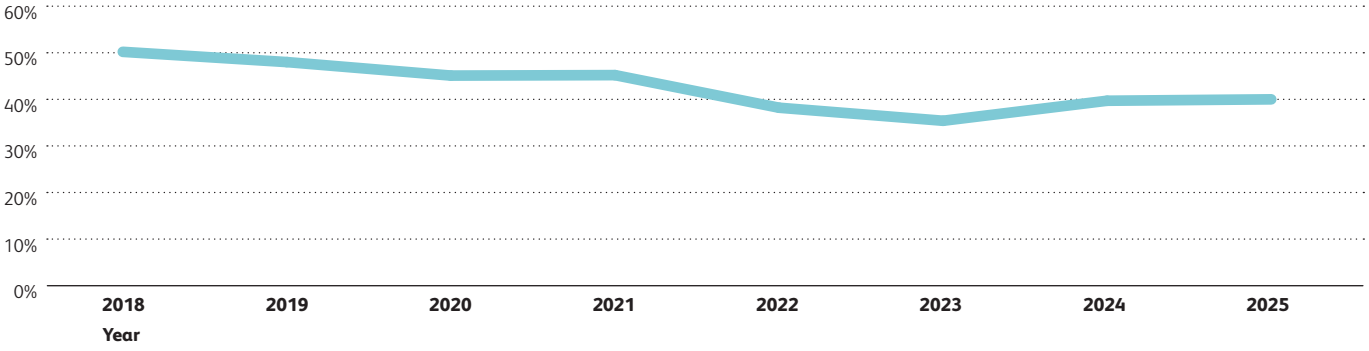
Other studies support this trend, with one finding an increase in continuity during Covid lockdowns, which declined rapidly when restrictions were removed.[163]

Researchers from the universities of Birmingham, Cambridge, Manchester and York – and from health think-tanks – found reasons for this 'downward pressure' – societal changes, including increased part-time working, a growth in practice size and fragmentation of primary care. But these changes are themselves responses to other pressures, they said: 'Part-time working is partly individual GPs' responses to workload pressures. Fragmentation of primary care between multiple professionals and organisations is a policy response to workload pressures. Both undermine continuity, contributing to a vicious cycle.'[164] The effect of less-than-full-time working was a major theme in Cogora's workforce report.[165]

The same researchers found a number of schemes to improve access affected workload: 'Increasing demand for appointments, itself due to demographic change, an ageing population, and increasing multimorbidity... growing use of non-GPs in primary care... and use of pharmacies for first-contact care.'

While the need for increased access continues, schemes such as risk stratification often take a back seat. One practice manager in Formby, Merseyside, says appointment demands have made

CHART 51 Patients who have consultation with preferred GP/HCP at least 'a lot of the time'



continuity harder: 'The GPs' lists have grown to the point that personal knowledge of your regulars and "old chestnuts" has gone. The triage system does help with this to some degree.' Although, she adds that 'each GP has a slightly different take on this'.

Greater demand has an effect on practice nursing continuity too. Helen Anderson, a research fellow at the University of York and a former practice nurse, says nurses are reporting 'declining continuity of care and therapeutic relationships with patients'. Care is becoming more fragmented: 'The concurrent ongoing "taskification" of nursing, with care becoming split into a series of tasks often carried out by less-qualified and experienced workers, has reduced patient access to expert nursing care. This means the beneficial effects of continuity of care may be diminished.' The increased specialism of nursing has a similar effect, says Jennifer Aston, an advanced nurse practitioner in Cambridgeshire: 'Continuity is something patients really value, but many GPNs have narrowed their skill set to a specific area such as asthma or diabetes, which can make this challenging.'

That is not to say that access and continuity – however they are defined – are necessarily inversely proportional to one another. Although the push for access might negatively affect continuity, a certain level of poor access will prevent continuity. Researchers from the University of Manchester found: 'Long waiting times for appointments, poor physical access and lack of available care providers are commonly identified barriers to continuity of care. In addition, appointment booking policies that prevented patients from booking advance appointments with a chosen GP undermined continuity of care.'[166]

Practices implementing continuity policies

Despite these pressures around demand, many practices have managed to implement continuity policies.

Dr Alasdair Wallace, a GP in the north-east of England, says his practice has moved to a named GP system in the past year, with all patients allocated a GP and encouraged to consult with them for routine appointments. He says: 'So far, it's working well and has been easier than anticipated. Patient feedback has been positive. As GPs we are getting our own patients' letters, script queries, etc as often as possible. I have really enjoyed the experience and it has improved my job satisfaction.'

One GP in south-west London says her practice has managed to combine total triage with continuity by indentifying the patient groups most in need: 'Continuity is most important with the frail elderly and end-of-life-care patients, safeguarded patients and those with severe mental health problems. We have several sessions dedicated these patients. This investment in time reduces our workload and admissions to hospital.'

Dozens of respondents referenced efforts to improve continuity, and they named it their number one priority. Yet, there is little financial benefit in focusing on continuity. This should prove a valuable lesson, as we will see in the final chapter.

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SUMMARY

There is universal agreement that continuity of care is of major benefit to patients. It has been shown that patients seeing the same GP (or appropriate healthcare professional) improves clinical outcomes, especially for the most vulnerable groups, and reduces demand, mortality and avoidable hospital admissions.

It has proved difficult to incentivise continuity, partly due to the difficulty in measuring it – but also because of understandable political imperatives around access. Although health secretaries have paid lip service to the need for continuity, it has been 'sacrificed at the alter of access', as one GP puts it. Often, attempts to increase appointment availability come at the expense of continuity – for example, the increased non-GP workforce and extended hours. To keep up with demand – either patient-generated, or as a result of government initiatives – practices are having to sacrifice continuity.

Continuity has also been made harder by the shift to less-than-full-time working for many GPs – although this itself is in part a response to the increasing pressures of the job.

Despite all this – and the lack of financial incentives – many practices have been able to implement continuity of care, and they are benefiting from it in terms of better patient care and increased job satisfaction – especially relevant at a time when the system needs more GPs.

CHAPTER 15
Conclusion: A reconfiguration of our approach to general practice

General practice staff are under pressure as a result of the demand for access. It is tempting to blame the media and politicians for scapegoating GPs, as many of our survey respondents did. Quotes about 'coasting' GPs from the health secretary and media tools to see 'how bad your practice is', or ranking practices in the local area are not helpful.

This is at a time when, concerns around data accuracy notwithstanding, appointment numbers are seemingly picking up across the board when calculated per patient. Increases are apparent in total numbers of appointments and those that are urgent, on the day, face to face and with GPs. Waiting times remain pretty stable.

But ultimately, patient satisfaction is deteriorating, and this isn't just due to external noise from the media and politicians. Access is rightly a major issue for patients. Being unable to get through to the practice and difficulties securing an in-person appointment or seeing a preferred professional are all genuine problems, and general practice staff do acknowledge this.

Yet one reason staff are upset by accusations of 'coasting' is that the deterioration in satisfaction is almost entirely due to systemic factors. The population is growing, and the average patient is having more consultations every year, at a time when there are fewer full-time-equivalent GPs. Individual FTE GPs are, on average, providing more consultations per year – a feat that really should be commended.

Moreover, however access is defined, it is clear which practices offer the 'best' access. They are the ones with the highest number of elderly patients and those with the highest disease prevalence. The way general practice is funded means these practices receive the most money and therefore can afford the most staff. While these are generally the ones with the most patient-related needs, that's not true in all cases. For a vulnerable patient in a lower-funded practice, there won't necessarily be the staffing to provide the desired level of access. This is particularly true of practices in deprived areas, or with a high percentage of ethnic minority patients; these practices are likely to have particular health needs but tend to have younger patients and therefore lower funding.

Nobody understands access problems better than general practice staff themselves. They want to offer better access and they chose the profession to help patients. Yet the practice-patient relationship is being eroded, negating their reasons for being in the job. It should also not be forgotten that people working in general practice (and their families) are patients themselves. Poor access is not something anyone wants.

Recent initiatives to improve access have all had benefits, but the efforts and resources to implement them could have been better spent. Some – like extended access and the ARRS – have reduced continuity of care. The one factor proved time and again to improve access is an increase in GP FTE numbers. But medical graduates are less likely to enter the profession with morale so low.

So what can be done? We need a new approach to the debate. This must take into account political realities – the Government will not diverge from its neighbourhood health service plans, and simply asking for increased funding within the current structure will never work with ministers scared of headlines around increasing GPs' pay. But there is a better way.

We shall look at contractual issues and then at how attitudes towards general practice need to change.

1.4

Percentage point increase associated with every additional GP partner in patients answering 'practice offers a good service' in the patient survey

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1 Strengthen the partnership model

The Institute for Government found: 'More GPs are most closely associated with both higher patient satisfaction and QOF scores. The effect is strongest for GP partners... one additional GP partner in a practice is associated with a 1.4 percentage point increase in the proportion of patients reporting that their GP practice provides a good service. An additional salaried GP and GP trainee are associated with a 0.9 and 0.3 percentage point increase respectively.'

As well as this, GP partners are associated with the largest increase in GP

appointments. 'Alongside their clinical work, partners also have responsibility for managing their practices, which might suggest they would have less time to carry out appointments. But it is also possible that their responsibility for their practices is the cause of this, too: GP partners often carry out much of their administrative work outside of usual working hours, likely because they are either personally liable for the practice or are at least strongly incentivised to make sure that the practice is performing well.'[167]

Yet the trend has been towards salaried general practice. This is in part down to a shift in GPs' attitudes. Many don't want the responsibilities involved with partnership, and there have been societal shifts that mean they are less willing to commit to what can be a lifelong posting. Yet the previous Government commissioned a review of the partnership model, which was well received. While some of the recommendations were taken on, the first and most important was not: reducing the personal risk and unlimited liability currently associated with GP partnerships. This included developing proposals to mitigate the risk associated with being a leaseholder or property owner and introducing different legal models, such as limited liability partnerships and mutuals.[168]

It is time to revisit this recommendation and reinvestigate why GPs are less willing to take on partnerships.

RECOMMENDATION

The Government to commission a follow-up to the 2019 review into the partnership model, which will include proposals to mitigate the personal risk associated with taking on responsibility for premises and introduce different legal models for partnerships.

2 Ensure general practice is run by GP professionals

There is a case for moving care away from hospitals and into the community. Successive governments have all talked about this, and it was one of the three pillars of the 10-year plan.

Yet any attempts to allow hospital trusts to run primary care through multi-neighbourhood health centres covering 250,000 patients must be strongly opposed. It remains unclear how the funding of these health centres will work, but the plan's proposal of 'year of care' payments where organisations will receive capitation payments for providing all primary care and other traditionally secondary care services is of concern.

There have been examples of hospital trusts running GP practices, but these tend to be exceptional cases, and with the blessing of the incumbent GP practices.

General practice is efficient because it is run by GPs and staff, and much of this comes from their links to the patients, as we will see in the following recommendations. There is no thriving secondary care sector that will troubleshoot the problems in primary care. This is not to denigrate trusts – they face the same systemic problems as GP practices. But there is no evidence that trusts can run general practice better than general practice staff. There is, however, evidence that having more GP partners leads to higher patient satisfaction. The best-case scenario of trusts running general practice services is they will run them as efficiently as GPs. The worst-case scenario is the loss of all the positive elements of general practice, of which there are still many, as we shall see in the next few recommendations.

RECOMMENDATION

The Government to instruct ICBs to prevent trusts being awarded multi-neighbourhood contracts that include the running of general practice services.

3 Emphasise the benefits of small practices

There are benefits to be derived from integration. In the context of the 10-year plan, this means practices joining together as neighbourhood providers. There is even a case to be made for actively encouraging GP practices to join up to form these larger organisations.

However, these benefits don't necessarily outweigh those of a smaller practice. It is an inconvenient truth for policymakers over the past decade that smaller practices continue to be associated with greater patient satisfaction at a time when the trend is towards larger practices and integration. Greater satisfaction doesn't always mean better care but a surgery closer to a patient's home has obvious benefits. The continuity of care delivered by practices with smaller list sizes is overwhelmingly beneficial. The benefits of smaller surgeries run by GPs and staff who are mostly permanently based there must be retained, with financial support to modernise the buildings.

Their contract arrangements should be their own decision, however. In practice, this means that any encouragement of practices to join neighbourhood health organisations must not entail essential funding, as has happened with PCNs. It might be that some neighbourhood contracts involve the provision of routine general practice – ie, incorporate what is the current GMS contract. But this must be with the complete consent of all the GP partners involved. The next negotiations for the wholesale revamp of the GP contract in England must ensure GPs retain the right to hold whatever the successor of the GMS contract will be (nGMS).

There should also be options for GP practices to bind together voluntarily – as they did in federations before the implementation of the PCN contract – to bid for neighbourhood services above routine general practice, while the individual practice units retain their own nGMS contracts.

This could be criticised as giving practices too much power. But this will ultimately benefit patient care, provided there is a change in our attitude to general practice, as we will see in the final recommendation.

RECOMMENDATION

The Government and the BMA must ensure GPs have the right to hold a nationally agreed contract to provide routine care. Practices may decide locally to hold larger contracts that also include traditionally secondary care services.

Surgeries – especially small ones – must also be provided with funding to modernise their premises.

4 A new approach to funding

In 2023, as the Cogora workforce report showed, GPs reported being unable to find work.[169] This was mainly due to a funding squeeze, but also to problems around premises.

There are three funding-related issues that have obvious solutions. The first is its fragmentation. The main funding is the global sum, which is a capitation payment (ie, based on the number of patients in a practice). But there are several other strands of national funding: the Quality and Outcomes Framework, which is a set of targets around clinical care; directed enhanced services, whereby practices elect to deliver nationally agreed services; and the various funding around PCNs, predominantly the ARRS. This approach to funding could be considered analogous to decorating a house with a load of tester paint pots.

Not only do the various associated requirements potentially shift priorities away from care that could be more beneficial to patients, but the model leads to more a transactional approach, with care tasks assessed on monetary rather than clinical value.

The solution is to combine all the various forms of funding. Remove the attached strings and allow practices to prioritise as they see fit.

The second issue is the way the global sum itself is calculated. The funding is predominantly weighted towards practices with older populations. Other factors include disease prevalence, although this is based on data from 2000. The emphasis on age is understandable, but it disadvantages deprived practices, which tend to have younger patients, but with their own various health needs. There have been many commitments by ministers to review the global sum, but it has never happened. One reason may be that some practices will lose out, making it politically sensitive, especially to the BMA. But the time has come to reassess what is now an unfair formula.

The third issue relates to political concerns about increasing funding for general practice. While everyone agrees that strong general practice leads to better overall care, and greater efficiency, ministers have been reluctant to increase funding due to potential headlines around pay increases for GPs themselves.

There is a solution to this. It is not without its problems, but ringfencing staffing costs would allow the Government to provide general practice with more of the funding it needs. Staffing costs are the major expense so this would allow desperately needed funds while removing the political concerns.

Furthermore, unlike the ARRS, this funding should be given at a practice level, with no restrictions around what staff can be hired. Practices could pool their money, but it will ultimately be spent on staffing as they see fit.

5 Move the debate away from access and onto good care

The recommendations so far have been practical. These final two recommendations involve a change of attitude about general practice, but they are essential elements of real change.

We haven't mentioned access much in these recommendations, and this is deliberate. Because the debate should shift away from access and onto good care. As we have seen, access is the predominant issue in general practice. But it shouldn't be – the quality of care must take precedence.

Of course, there is no such thing as good-quality care without access. Patients need to be able to get through to their practice and have their issues considered in order to receive good care. Furthermore, patients' frustration at the lack of access is justified. But equally, access cannot be good if the quality of care is not, and this is something often overlooked. Moreover, it is the case that practices that concentrate on their quality of care will naturally see access improve.

This is most obvious when we consider continuity of care, as we saw in the previous chapter. Continuity leads to patients needing fewer appointments. This means that not only is their issue resolved, but they have less need to book an appointment or even to call the phone lines or submit an online request.

Although we haven't considered

this in depth, a number of GPs point to the benefits of longer appointments, and how this negates the need for follow-ups.

What continuity and longer appointments have in common is that attempts to increase the volume of appointments, or the direct patient care workforce, directly contradict them.

Quality is more difficult to measure. But any future contracts or plans must place the emphasis on quality over appointment availability.

RECOMMENDATION

The Government and the BMA to remove the fragmentation of funding, whereby strings are attached to pots of money, in their negotiations over a new contract. All funding – bar staff costs – should be provided through capitation payments to practices.

The mechanism for calculating these capitation payments based on patient demographics needs to be reformed and updated.

Staff costs should be ringfenced and provided separately, enabling ministers to increase funding to general practice while removing the fear that this will be interpreted as a pay rise for individual GP partners.

6 Start trusting general practice professionals

All of the above might seem to be a case of putting the needs of GPs and their staff above those of patients. This is where the final – and, arguably, most important - conclusion comes in. More trust needs to put in general practice professionals.

We interviewed dozens of practices that scored highly on patient satisfaction scores, and had plenty of availability of appointments, with appropriate waiting times. The one thing they all had in common was they implemented their own model of access that worked for their patients. Of course, there were crossovers. But some had total triage, others had bookable appointments. Some relied heavily on other staff to carry out appropriate consultations, others were completely GP led. Some prioritised on-the-day appointments for most patients, others encouraged longer waits for routine care.

They did things that weren't financially incentivised but provided good patient care – for example, having care navigators who ensured vulnerable patients were not missing hospital appointments. Such an initiative brought no obvious financial incentive, but it was best for their patients and benefited the wider NHS. Attaching funding to something like this just makes the task more transactional. Furthermore, their emphasis on continuity isn't due to a financial incentive. It is due to a wish to provide a better quality of care.

The NHS has been able to function due to the goodwill of the staff – to try to prevent hospital admissions, to check in with a patient of concern, to refrain from unnecessary antibiotics. These aren't financially incentivised and, in the case of the latter, may have negative personal consequences in the form of poor patient feedback. This goodwill is being lost, however, as government and NHS policies have focused on micromanaging practices.

There will be greedy GP partners, as is the case in every profession. But attaching strings to every penny, or micromanaging structures, for example, is like using a sledgehammer to crack a nut and ultimately affects patient care.

There are more efficient ways of preventing substandard service while allowing GPs and their teams the freedom to do what is best for their patients – for example, ringfencing staffing costs, or relying on the local knowledge of practices and hospital trusts to help identify those who are prioritising making money at the expense of good patient care. This will be another focus of future work by Cogora.

By acknowledging this need for a fresh approach, we may pave the way for quality – and access – to improve.

METHODOLOGY

Data Dashboard

The Cogora Data Dashboard was built using official data from 22 different official sources for general practice. The dashboard contains around 250 pieces of data for each practice in England. This covers patient demographics, appointments, funding, deprivation levels, QOF scores, disease prevalence, and CQC ratings, among many other measures.

These data sources are:

- General Practice Workforce – NHS England Digital[170]
- Care Quality Commission data[171]
- GP and GP practice related data – NHS England Digital[172]
- Appointments in General Practice – NHS England Digital[173]
- GP Patient Survey[174]
- Patients Registered at a GP Practice – NHS England Digital[175]
- NHS Payments to General Practice, England 2022/23 – NHS England Digital[176]
- Primary Care Network Workforce – NHS England Digital[177]
- Quality and Outcomes Framework – NHS England Digital[178]

The dashboard is updated monthly, and for this report, we pulled out the data on 12 September 2025, all fully up to date at that point.

For the purposes of this report, we excluded all practices that had a blank value for number of patients, and blank value for numbers of GPs/nurses/direct patient care staff at a practice level.

We treated much of the data to provide more accuracy when discussing practice characteristics, as below.

Deprivation decile

We gave every practice an average deprivation score using Patients Registered at a GP Practice,[179] which assigns all patients in a GP practice to 'Lower layer Super Output Areas (LSOAs)'. We then matched LSOA codes to the English indices of deprivation index of multi deprivation.[180]

We calculated average score by multiplying the number patients in LSOA by each LSOA's 'index of multiple deprivation' score, then totalling practices' overall score and dividing by total number of patients. Based on their average scores, we assigned each practice to ten equal deciles.

Payments per patient decile

We worked out total payments per weighted patient based on adding together all funding pots, except for: premises; total locum allowances; and reimbursement of drugs. We counted these as reimbursable costs, so they did not factor in the calculations. We divided this payment by 'average patients', then placed each practice into ten equal deciles.

Ethnicity decile

We placed practices in ten equal deciles based on what percentage of patients described themselves as '% White - English, Welsh, Scottish, Northern Irish or British' in the GP Patient Survey.

Survey

Our survey for this report was open between 2 July and 21 July 2025, collating responses using the SurveyMonkey tool. The survey was advertised to our readers via our website and email newsletter, with a prize draw for a £1,000 voucher as an incentive to complete the survey, alongside our sister publications. The survey was unweighted, and we do not claim it to be scientific – only a snapshot of the general practice staff population.

Distinct practices

GP partners and practice manager respondents were asked to input their practice code, their practice name and their postcode. Where this wasn't clear, we correlated this information with data from official government sources.[181,182,183,184] Where it still wasn't clear, we searched practice websites. All those without the required information after this research were removed.

For duplicate practice codes – more than one respondent from a single practice – we remove duplicates in the following order:

- Those who provided fuller information (ie, fewer blank answers and 'don't knows') were prioritised
- After this, GP partners were prioritised over practice managers
- After this, those who answered first were prioritised.

This left 797 distinct practices, represented by 471 GP partners and 326 practice managers.

We applied the same method to removing duplicate PCNs as for practices, based on PCNs codes.[185] This left 425 distinct PCNs.

NHS Digital appointment rankings

We used the GP Appointment Data[186] from April 2025, May 2025 and June 2025 and averaged out the number of appointments for each metric, total appointments, face to face, with a GP, on the day and waiting times. We then placed each practice in equal deciles for each metric.

Ranking 'high' and 'poor' performing practices

We used the 2025 GP Patient Data[187] for patient satisfaction scores. We identified six 'domains': waiting times; number of appointments; face to face; continuity; ease of contact; and overall experience. Within each 'domain', there were a series of metrics (eg, 'How you felt about waiting times: % About right' from the GP Patient Survey, and 'Average F2F per 10,000 patients' from NHS Digital data).

For each metric, we ranked them out of the 6,115 practices in England that had full data for each metric, from 1 to 6,115. We them averaged out this ranking to work out the overall 'domain' ranking, and then placed them into deciles based on this ranking (1='worst' performing practices, 10='best' performing practices).

We then averaged out their rankings across the six domains to give their overall ranking, and we placed them into deciles based on these scores around overall performance.

There are severe limitations on this methodology, but it is helpful in showing general trends without speculating on causes and correlations.

Waiting times domain
To work out 'waiting times' for the GP appointment data, we applied a midpoint analysis based on the timings of bookings to actual appointment: Same Day=0.5 days; 1 Day=1 day; 2-7 Days=4.5 days; 8-14 Days=11 days; 15 to 21 Days=18 days; 22-28 Days=25 days; More Than 28 Days=31 days. Shorter wait times were considered high performing.

For the patient survey data on waiting times, this was: On the same day=0.5; On the next day=1; A few days later =3.5; A week or more later=10. Shorter wait times were considered high performing.

The metrics were:

- Average waiting times (GP Appointment Data)
- On the day (GP Appointment Data – same day or within one day per patient)
- Average waiting time (GP Patient survey)
- 'How you felt about waiting times': % who answered 'About right' (GP Patient survey)

Number of appointments domain
The only metric was total appointments per patient (GP Appointments Data).

Face to face domain
More face-to-face appointments were considered high performing.

Metrics used were:

- Face-to-face appointments per patient (GP Appointments Data)
- Percentage of appointments that were face to face (GP Patient survey)

Continuity domain
The NHS Appointment data on GP appointments were not a direct analogy for continuity, but belonged in this domain. More appointments with a GP was seen as high performing. Metrics used were:

- Appointments with a GP per patient (GP Appointments Data)
- Percentage of patients who had a preferred healthcare professional who say they saw that HCP at last visit (GP Patient survey)

Ease of contact domain
This was all based on the GP patient survey. The metrics used were:

- Percentage saying it was easy to contact practice on the phone
- Percentage saying they had a good experience of contacting practice
- If their call was answered, with this order used to determine their ranking:

1. Percentage saying last call was answered straight away + Percentage saying last call held in a queue and someone answered
2. Percentage saying call was answered straight away
3. Last call was held in queue with call-back through automated system

REFERENCES

1 UK Department of Health and Social Care. 10 Year Health Plan for England: Fit for the Future, July 2025. https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf#page=29

2 IPSOS Mori poll commissioned by Health Foundation, Easier access to GP appointments remains the public's top priority for the NHS, September 2025. https://www.ipsos.com/en-uk/easier-access-gp-appointments-remains-publics-top-priority-nhs

3 Health Foundation. Measuring continuity of care in general practice, November 2023. https://www.health.org.uk/reports-and-analysis/briefings/measuring-continuity-of-care-in-general-practice

4 Cogora. General Practice Workforce White Paper, January 2025. https://www.cogora.com/cogora-general-practice-workforce-white-paper/

5 NHS Digital, Appointments in General Practice series; June 2025, December 2022, June 2021, December 2018; Table 1, Estimated England total count of appointments), https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

6 NHS England, Digitally enabled triage, last updated 7 April 2025, https://www.england.nhs.uk/long-read/digitally-enabled-triage/,

7 NHS Digital, Appointments in General Practice series; June 2025, December 2022, June 2021, December 2018; Table 1 Appointment Mode: Face-to-Face, https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice.

8 PulseToday, GPs should do 'all' consultations remotely going forward, says health secretary. July 2020. https://www.pulsetoday.co.uk/news/politics/gps-should-do-all-consultations-remotely-going-forward-says-health-secretary/

9 BMA, Primary care network funding, updated 14 April 2025. https://www.bma.org.uk/advice-and-support/gp-practices/primary-care-networks/primary-care-network-funding

10 NHS England, GP contract changes: government response to Doctors and Dentists Remuneration (DDRB) and the Additional Roles Reimbursement Scheme (ARRS), August 2024. https://www.england.nhs.uk/long-read/gp-contract-changes-government-response-to-ddrb-and-arrs/

11 NHS England, Primary Care Networks: Network Contract Directed Enhanced Service from April 2025, March, 2025. https://www.england.nhs.uk/wp-content/uploads/2025/03/letter-primary-care-networks-network-contract.pdf

12 GPs working in general practice: General Practice Workforce, England Bulletin Tables, September 2015 - June 2025, sheet 1a, All Fully Qualified GPs, https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-june-2025, 24 July, 2025

Direct patient care staff, September 2015-September 2021: GPs working in general practice: General Practice Workforce, England Bulletin Tables, September 2015 - June 2025, sheet 1a, Direct patient care staff, https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-june-2025, 24 July, 2025

September 2021-June 2025: NHS Digital, Primary Care Workforce Quarterly Update, https://digital.nhs.uk/data-and-information/publications/statistical/

primary-care-workforce-quarterly-update/30-june-2025, 30 June 2025,

13 NHS Digital, Appointments in General Practice series; June 2025, December 2022, June 2021, December 2018; (Table 1 SDS Role: GP), https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

14 Appointments with a GP per 10,000 patients per day. NHS Digital, Appointments in General Practice series; June 2025, December 2022, June 2021, December 2018; (Table 1 SDS Role: GP), https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

GPs working in general practice: NHS Digital, General Practice Workforce, England Bulletin Tables, September 2015 - June 2025, sheet 1a, All Fully Qualified GPs, https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-june-2025

15 NHS Digital, Appointments in General Practice series; June 2025, December 2022, June 2021, December 2018; (Registered patients at open active practices, and Estimated England total count of appointments), https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

16 NHS Digital, Appointments in General Practice series; June 2025, December 2022, June 2021, December 2018; (Table 2d: Total count of appointments by date and time between booking date and appointment date), https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice. Applied a midpoint analysis on the various fields (Same Day=0.5 days; 1 Day=1 day; 2-7 Days=4.5 days; 8-14 Days=11 days; 15 to 21 Days=18 days; 22-28 Days=25 days; More Than 28 Days=31 days).

17 NHS Digital, Appointments in General Practice series; June 2025, December 2022, June 2021, December 2018; (Table 2d: Total count of appointments by date and time between booking date and appointment date), https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice. Applied a midpoint analysis on the various fields, but discounted same day and 1 day appointments (2-7 Days=4.5 days; 8-14 Days=11 days; 15 to 21 Days=18 days; 22-28 Days=25 days; More Than 28 Days=31 days).

18 NHS Digital, Appointments in General Practice series; June 2025, December 2022, June 2021, December 2018; (Table 2d: Total count of appointments by date and time between booking date and appointment date), https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice. Calculated figures in columns E (Same Day) and F (1 Day) as percentages of total numbers of appointments.

19 NHS Digital, Appointments in General Practice series - NHS England Digital, April 2022 – June 2025: Summary (Table 3h), https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice . Applied a midpoint analysis (1 - 5 Minutes = 3 minutes; 6-10 Minutes = 8 minutes; 11-15 Minutes=13 minutes; 16-20 Minutes=18 minutes; 21-30 Minutes =24.5 minutes; 31-60 Minutes=45 minutes)

20 NHS England, Millions more GP appointments delivered in record year, July 2025. https://www.england.nhs.uk/2025/07/millions-more-gp-appointments-delivered-in-record-year/

21 NHS Digital, Improving GP appointment data, https://www.england.nhs.uk/gp/gpad/

22 NHS Digital, Appointments in General Practice, June 2025 - NHS England Digital, Appointments in General Practice – June 2025: Summary, data quality. https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

23 Health Foundation, Understanding activity in general practice: what can the data tell us?, https://www.health.org.uk/reports-and-analysis/analysis/understanding-activity-in-general-practice-what-can-the-data-tell-us, February 2022

24 The Strategy Unit, Long-term trends in GP practice consultation rates, February 2024, p4. https://www.strategyunitwm.nhs.uk/publications/mdsn-long-term-trends-gp-practice-consultation-rates

25 Ipsos Mori on behalf of NHS England, GP Patient Survey, National results and trends, 2024-25: https://www.gp-patient.co.uk/latest-survey/results, 2012-2023: https://www.gp-patient.co.uk/past-survey-results-materials. Respondents were asked: 'When was your last general practice appointment?' The percentages relate to those who answered 'In the past 3 months' and 'Between 3 and 6 months ago'.

26 The Strategy Unit, MDSN: The gap between need and supply of GP practice consultations, February 2024. https://www.strategyunitwm.nhs.uk/publications/mdsn-long-term-trends-gp-practice-consultation-rates

27 The Strategy Unit, MDSN: The gap between need and supply of GP practice consultations, February 2024. https://www.strategyunitwm.nhs.uk/publications/mdsn-long-term-trends-gp-practice-consultation-rates

28 Ipsos Mori on behalf of NHS England, GP Patient Survey, National results and trends, 2024-25: https://www.gp-patient.co.uk/latest-survey/results, 2012-2023: https://www.gp-patient.co.uk/past-survey-results-materials. Respondents were asked: 'Overall, how would you describe your experience of your GP practice?' Percentage refers to respondents answering 'very good' or 'good'.

29 Ipsos Mori on behalf of NHS England, GP Patient Survey, National results and trends, 2024-25: https://www.gp-patient.co.uk/latest-survey/results, 2012-2023: https://www.gp-patient.co.uk/past-survey-results-materials. Respondents were asked: 'How long after initially trying to book the appointment did the appointment take place?'

30 Ipsos Mori on behalf of NHS England, GP Patient Survey, National results and trends, https://www.gp-patient.co.uk/latest-survey/results. Respondents were asked: 'How do you feel about how long you waited for your appointment?' The percentages represent those who answered 'about right'.

31 Ipsos Mori on behalf of NHS England, GP Patient Survey, National results and trends, https://www.gp-patient.co.uk/latest-survey/results. Respondents who had said they made an attempt to contact their practice were asked: 'Overall, how would you describe your experience of contacting your GP practice on this occasion?' The percentages represent those saying 'very good' or 'good'

32 Office for National Statistics, Experiences of NHS healthcare services in England, 17 July 2025. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/experiencesofnhshealthcareservicesinengland/july2025

33 Institute for Government, General practice across England: The number and type of appointments are related to patient satisfaction, April 2025, p9. https://www.instituteforgovernment.org.uk/publication/performance-tracker-local/general-practice-england/appointments-satisfaction

34 British Journal of General Practice, What patients want from access to UK general practice: systematic review, August 2025, p526. https://bjgp.org/content/75/757/e526

35 Institute for Government, General practice across England: The number and type of appointments are related to patient satisfaction, April 2025. https://www.instituteforgovernment.org.uk/publication/performance-tracker-

local/general-practice-england/appointments-satisfaction

36 A survey of 1,898 general practice staff across the UK (1,029 GPs, 330 practice managers, 476 practice nurses, and 63 practice pharmacists.) Respondents were asked: 'Please rank how important you think the following are for your patients. If you don't want to answer this, please put "Ignore my answers" top: Waiting times for appointments; Time spent waiting on the phone for the practice to answer; On-the-day appointments; Seeing their usual/preferred healthcare professional; Being able to choose form of consultation (ie, face-to-face, remote, home visit); Ignore my answers.' When analysing the answers, those who put 'Ignore my answers' top were removed, leaving 1,898 respondents. We assigned a mark of 5 to the top ranked answers, going down to 1 for the lowest. Where 'Ignore my answers' were in second to fifth place, this answer was deleted, with those answers ranked lower bumped up. We then calculated the average.

37 A survey of distinct practices (see methodology). Respondents were asked: 'Please rank the following in terms of how important they are for you as a GP practice. If you don't want to answer this, please put "Ignore my answers" top.' The options were: Waiting times for appointments; Time taken to answer calls; Offering on-the-day appointments; Continuity of care; Offering different forms of consultation (ie, face-to-face, remote, home visit); Ignore my answers. When analysing the answers, those who put 'Ignore my answers' top were removed, leaving 756 distinct practices. We assigned a mark of 5 to the top ranked answers, going down to 1 for the lowest. Where 'Ignore my answers' were in second to fifth place, this answer was deleted, with those answers ranked lower bumped up. We then calculated the average.

38 The Healthcare Improvement Studies Institute, Nuffield Trust and Health Foundation, What's been tried: a curated catalogue of efforts to improve access to general practice, June 2025. https://bjgpopen.org/content/bjgpoa/early/2025/06/15/BJGPO.2024.0184.full.pdf,

39 Health Foundation, Rethinking access to general practice: it's not all about supply, March 2024. https://www.health.org.uk/reports-and-analysis/briefings/rethinking-access-to-general-practice-it-s-not-all-about-supply, Produced with the approval of the Health Foundation and adapted for reasons of space

40 Survey of 789 distinct practices across the UK (see methodology). Respondents were asked; 'Have you felt pressure from local commissioners (ie, ICBs, health boards or trusts) to improve the following: Time patients spend waiting on the phone for the practice to answer; Waiting times for appointments; Patients being able to choose form of consultation (ie, face-to-face, remote, home visit); Patients seeing their usual/preferred healthcare professional.' Percentages represent those who answered 'yes'.

41 PulseToday, The media's anti-GP agenda, February 2021. https://www.pulsetoday.co.uk/analysis/cover-feature/the-medias-anti-gp-agenda/

42 Mail Online, Why are GPs STILL refusing to see patients face-to-face?. November 2022. https://www.dailymail.co.uk/health/article-8996249/Why-GPs-refusing-patients-face-face.html,

43 Telegraph, Warning of extra cancer deaths after more than 25m GP appointments lost during pandemic, October 2020. https://www.telegraph.co.uk/news/2020/10/15/warning-extra-cancer-deaths-morethan-25m-gp-appointments-lost/

44 Mirror, Woman refused GP appointment for cough in lockdown told she has just six months to live, October 2020. https://www.mirror.co.uk/news/uk-news/woman-refused-gp-appointment-cough-22826277,

45 British Journal of General Practice, UK newspapers 'on the warpath': media analysis of general practice remote consulting in 2021, December 2022. https://bjgp.org/content/72/725/e907

46 PulseToday, NHS advises 'total triage' as GP groups look to limit patient demand, March 2020. https://www.pulsetoday.co.uk/news/uncategorised/nhs-advises-total-triage-as-gp-groups-look-to-limit-patient-demand/

47 NHS England, Updated standard operating procedure to support restoration of general practice services, May 2021. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/B0497-GP-access-letter-May-2021-FINAL.pdf

48 PulseToday, GPs respond to 'tone deaf' and 'badly judged' NHSE face-to-face order, May 2021. https://www.pulsetoday.co.uk/news/coronavirus/gps-respond-to-tone-deaf-and-badly-judged-nhse-face-to-face-order/

49 Mail Online, The ultimate guide to all of England's 6,000 GP practices - so is YOURS one of the worst? August 2025. https://www.dailymail.co.uk/health/article-14897749/Ultimate-GP-guide-practices-search-tool-postcode.html

50 Telegraph, Are you waiting too long for a GP appointment? Use our tool to find out, July 2025. https://www.telegraph.co.uk/health-fitness/wellbeing/stress/are-you-waiting-too-long-for-a-gp-appointment-use-our-tool/

51 Survey of 1,417 general practice staff across the UK (790 GP partners, 311 practice managers, 281 practice nurses and 35 practice pharmacists), after 'Don't knows' were removed. Respondents were asked: 'Roughly what percentage of in-house complaints relate to access issues? 0%; 10%; 20%; 30%; 40%; 50%; 60%; 70%; 80%; 90%; 100%; Don't know.' They were then asked: 'Has this percentage increased or decreased since before the Covid pandemic in 2020?' Significantly increased; Slightly increased; About the same; Slightly decreased; Significantly decreased; I wasn't working pre-2020; Don't know.' Again, 'Don't knows' and 'I wasn't working pre-2020' were removed from the analysis.

52 Survey of 1,417 general practice staff across the UK (790 GP partners, 311 practice managers, 281 practice nurses and 35 practice pharmacists), after 'Don't knows' were removed. Respondents were asked: 'Roughly what percentage of in-house complaints relate to access issues? 0%; 10%; 20%; 30%; 40%; 50%; 60%; 70%; 80%; 90%; 100%; Don't know.' We calculated the average.

53 Survey of 1,947 general practice across the UK (1,054 GPs, 350 practice managers, 475 practice nurses and 68 practice pharmacists). We asked: 'Have you ever faced abuse from patients due to access issues? Physical abuse; Verbal abuse; Online/social media abuse.' The answers were: 'Yes, often; Yes, occasionally; Once or twice; No; Don't know.' The percentages represent those who said 'Yes, often' or 'Yes, occasionally'.

54 Institute for Government, General practice across England: Performance Tracker Local, April 2025, p9. https://www.instituteforgovernment.org.uk/publication/performance-tracker-local/general-practice-england

55 PulseToday, The truth about GP access, January 2023. https://www.pulsetoday.co.uk/analysis/practice-personal-finance/the-truth-about-gp-access/

56 British Journal of General Practice, Patterns in GP appointment systems: a cluster analysis of 3480 English practices, August 2025. https://bjgp.org/content/75/757/e541

57 See Methodology – NHS Digital appointment rankings

58 See Methodology – NHS Digital appointment rankings

59 See Methodology — NHS Digital appointment rankings

60 See Methodology – Ranking 'high' and 'poor' performing practices

61 See Methodology – Ranking 'high' and 'poor' performing practices

62 Health Service Journal, ICBs must target 'coasting' GPs, says Streeting, January 2025. https://www.hsj.co.uk/primary-care/icbs-must-target-coasting-gps-says-streeting/7038598.article

63 BMA, Global sum allocation formula, August 2024. https://www.bma.org.uk/advice-and-support/gp-practices/funding-and-contracts/global-sum-allocation-formula

64 See Methodology – Ranking 'high' and 'poor' performing practices

65 See Methodology – Ranking 'high' and 'poor' performing practices

66 See Methodology – Ranking 'high' and 'poor' performing practices

67 National Centre for Social Research, University College London, Department of Epidemiology and Public Health, Health Survey for England, 2000,May 2024. https://beta.ukdataservice.ac.uk/datacatalogue/studies/study?id=4487#!/documentation

68 See Methodology – Ranking 'high' and 'poor' performing practices

69 See Methodology – Ranking 'high' and 'poor' performing practices

70 See Methodology – Ranking 'high' and 'poor' performing practices

71 BMC Primary Care, Practice list size, workforce composition and performance in English general practice: a latent profile analysis, June 2024. https://pubmed.ncbi.nlm.nih.gov/38862906/

72 See Methodology – Data Dashboard/Ranking 'high' and 'poor' performing practices

73 Nuffield Trust, Is bigger better? Lessons for large-scale general practice, July 2016, p75. https://www.nuffieldtrust.org.uk/research/is-bigger-better-lessons-for-large-scale-general-practice

74 Deloitte, Adjusting the General Medical Services Allocation Formula for the unavoidable effects of geographically-dispersed populations on practice sizes and locations, March 2006 [no link available]

75 Institute for Fiscal Studies, Does GP Practice Size Matter? The relationship between GP practice size and the quality of health care, November 2014. https://ifs.org.uk/articles/ does-gp-practice-size-matter-relationship-between-gp-practice-size-and-quality-health-care

76 See Methodology – Data Dashboard/Ranking 'high' and 'poor' performing practices

77 See Methodology – Data Dashboard/Ranking 'high' and 'poor' performing practices

78 See Methodology – Data Dashboard

79 See Methodology – Data Dashboard/Ranking 'high' and 'poor' performing practices

80 See Methodology – Data Dashboard/Ranking 'high' and 'poor' performing practices

81 See Methodology – Data Dashboard/Ranking 'high' and 'poor' performing practices

82 See Methodology – Data Dashboard

83 Public Health, Ethnic inequalities in primary care experiences for people with multiple long-term conditions: Evidence from the general practice patient survey, December 2024. https://www.sciencedirect.com/science/article/pii/S0033350624004293

84 BMC Medical Research Methodology, Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups, , July 2006. https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-6-35

85 Health Foundation, Rethinking access to general practice: it's not all about supply, March 2024, p10. https://www.health.org.uk/reports-and-analysis/briefings/rethinking-access-to-general-practice-it-s-not-all-about-supply, Reproduced with the approval of the Health Foundation

86 Department of Health and Social Care, Chief Medical Officer's annual report 2023: health in an ageing society, November 2023. https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society/executive-summary-and-recommendations

87 Department of Health and Social Care, 10 Year Health Plan for England: Fit for the future, July 2025. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-accessible-version

88 British Journal of General Practice, Age, sex, and socioeconomic differences in multimorbidity measured in four ways: UK primary care cross-sectional analysis, April 2023. https://bjgp.org/content/73/729/e249

89 NHS England, Enhanced Service Specification – General Practice Requests for Advice and Guidance 2025/26, March 2025. https://www.england.nhs.uk/wp-content/uploads/2025/03/prn01903-advice-and-guidance-enhanced-service-2025-26-v1.2.pdf

90 BMA, GP contract changes England 2025/26, August 2025. https://www.bma.org.uk/pay-and-contracts/contracts/gp-contract/gp-contract-changes-england-202526,

91 Survey of 716 distinct practices across the UK (see methodology). We asked: 'By how much would you need to cut your list size to provide the level of access you would like with the resources you currently have?: We could increase our list size and still provide a level of access we would be happy with; We are at the right size to provide a level of access we are happy with; We would need to cut list size by 1-500; 501-1,000; 1,001-2,000; 2,001-3,000; 3,001-4,000; 4,001-5,000; 5,001-7,500; 7,501-10,000; 10,001 or more; Don't know. We applied a midpoint to each answer.

92 The Healthcare Improvement Studies Institute, Nuffield Trust and Health Foundation, What's been tried: a curated catalogue of efforts to improve access to general practice, June 2025. https://bjgpopen.org/content/bjgpoa/early/2025/06/15/BJGPO.2024.0184.full.pdf

93 Health Foundation, Rethinking access to general practice: it's not all about supply, March 2024. https://www.health.org.uk/reports-and-analysis/briefings/rethinking-access-to-general-practice-it-s-not-all-about-supply

94 Cogora, General Practice Workforce White Paper, January 2025. https://www.cogora.com/cogora-primary-care-workforce-white-paper

95 NHS Digital, Primary Care Workforce Quarterly Update, August 2025. https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-workforce-quarterly-update/30-june-2025,

96 PulseToday, GP networks underspent on ARRS by £88m, new data shows, May 2025. https://www.pulsetoday.co.uk/news/breaking-news/gp-networks-underspent-on-arrs-by-88m-new-data-shows/

97 Department of Health and Social Care, 50 million more GP appointments delivered by the NHS, November 2023. https://www.gov.uk/government/news/fifty-million-more-gp-appointments-delivered-by-the-nhs,

98 Institute for Government, General practice across England: Performance Tracker Local, April 2025, p44. https://www.instituteforgovernment.org.uk/publication/performance-tracker-local/general-practice-england

99 Cogora, General Practice Workforce White Paper, January 2025, p47. https://www.cogora.com/cogora-primary-care-workforce-white-paper

100 Institute for Government, General practice across England: Performance Tracker Local, April 2025, p6. https://www.instituteforgovernment.org.uk/publication/performance-tracker-local/general-practice-england

101 PulseToday, BMA pushing for return of Red Book ringfence of GP staff costs in new contract, February 2025. https://www.pulsetoday.co.uk/news/politics/bma-pushing-for-return-of-red-book-ringfence-of-gp-staff-costs-in-new-contract/]

102 PulseToday, Analysis: PM pushes GP access to its limits, April 2014. https://www.pulsetoday.co.uk/analysis/nhs-structures/analysis-pm-pushes-gp-access-to-its-limits/

103 Mott MacDonland, Prime Minister's Challenge Fund: Improving Access to General Practice First Evaluation Report: October 2015. https://www.england.nhs.uk/wp-content/uploads/2015/10/pmcf-wv-one-eval-report.pdf

104 NHS England, Extended access to general practice: A guide to completing the extended access survey, August 2018. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/08/Extended-Access-Bi-Annual-Collection-Guidance-Updated-July-2018-v4.pdf

105 PulseToday, Every CCG to get £6 per patient to extend GP access from 2019, September 2016. https://www.pulsetoday.co.uk/news/contract/every-ccg-to-get-6-per-patient-to-extend-gp-access-from-2019/

106 NHS England, Network Contract DES - Contract specification 2025/26 – PCN requirements, July 2025. https://www.england.nhs.uk/wp-content/uploads/2025/03/PRN02067v-network-contract-des-contract-specification-2526-pcn-requirements-and-entitlements.pdf

107 NHS Digital, Appointments in General Practice, July 2025. https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/july-2025

108 NHS England, Network Contract DES - Contract specification 2025/26 – PCN requirements, July 2025. https://www.england.nhs.uk/wp-content/uploads/2025/03/PRN02067v-network-contract-des-contract-specification-2526-pcn-requirements-and-entitlements.pdf

109 NHS Digital, Patients Registered at a GP Practice, August 2025. https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/august-2025

110 NHS England, Implementing the 2025/26 GP Contract, July, 2025. https://www.england.nhs.uk/long-read/implementing-the-2025-26-gp-contract/

111 NHS Digital, Appointments in general practice: supporting information, July, 2025. https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/appointments-in-general-practice-supporting-information#extended-access

112 BMC Health Services Research, Did a national extended access scheme translate to improvements in patient experience to GP services in England? A retrospective observational study using patient-level data from the English GP patient survey, March 2025. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-025-12447-9

113 Journal of Health Services Research & Policy, Has the NHS national extended access scheme delivered its policy aims? A case study of two large scale extended access providers, November 2023. https://journals.sagepub.com/doi/10.1177/13558196231216657

114 BMC Health Services Research, Did a national extended access scheme translate to improvements in patient experience to GP services in England? A retrospective observational study using patient-level data from the English GP patient survey, March 2025. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-025-12447-9

115 PulseToday, Revealed: 'Shocking' 25% of evening and weekend GP appointments empty, September, 2018. https://www.pulsetoday.co.uk/news/politics/revealed-shocking-25-of-evening-and-weekend-gp-appointments-empty/

116 Pulse Today, Government defunding of respiratory hubs 'will put pressure on general practice, November 2023. https://www.pulsetoday.co.uk/news/clinical-areas/respiratory/government-defunding-of-respiratory-hubs-will-put-pressure-on-general-practice/

117 Health Foundation, Rethinking access to general practice: it's not all about supply , March 2024. https://www.health.org.uk/reports-and-analysis/briefings/rethinking-access-to-general-practice-it-s-not-all-about-supply

118 THIS Institute/Health Foundation, What's been tried? A catalogue of efforts to improve access to general practice, 1984 to 2023, March 2024. https://www.health.org.uk/sites/default/files/2024-03/Primary%20care%20access%20options%20list%20final.pdf

119 NHS England, Delivery plan for recovering access to primary care, May 2023. https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023.pdf

120 PulseToday, Pregnant women asked to self-refer to maternity services without seeing GP first, August 2025. https://www.pulsetoday.co.uk/news/clinical-areas/womens-health-gynaecology-obstetrics/pregnant-women-asked-to-self-refer-to-maternity-services-without-seeing-gp-first/

121 Health Policy, What impact do self-referral and direct access pathways for patients have on health inequalities? January 2024. https://www.sciencedirect.com/science/article/pii/S0168851023002361

122 Community Pharmacy England, Pharmacy First service – FAQs, August 2025. https://cpe.org.uk/national-pharmacy-services/advanced-services/pharmacy-first-service/pharmacy-first-service-faqs/

123 NHS England, Community Pharmacy advanced service specification; NHS Community Pharmacist Consultation Service, May 2023. https://www.england.nhs.uk/wp-content/uploads/2019/10/PRN00361-community-pharmacy-advanced-service-spec-nhs-community-pharmacist-consultation-service.pdf

124 NHS England, Pharmacy First. https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/pharmacy-first/

125 NHS England, Pharmacy First, https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/pharmacy-first/

126 London School of Hygiene and Tropical Medicine, Pharmacy First Evaluation, ongoing. https://www.lshtm.ac.uk/research/centres-projects-groups/pharmacy-first-evaluation

127 The Pharmacist, Six in 10 pharmacies in England on the brink of closure, finds NPA, August 2025. https://www.thepharmacist.co.uk/news/six-in-10-pharmacies-in-england-on-the-brink-of-closure-finds-npa/

128 The Pharmacist, Revealed: Map of community pharmacy closures over last five years, June 2025. https://www.thepharmacist.co.uk/investigations/pharmacy-closures/revealed-map-of-community-pharmacy-closures-over-last-five-years/

129 The Pharmacist, Under 10,000 NHS bricks-and-mortar pharmacies in England, April, 2025. https://www.thepharmacist.co.uk/investigations/pharmacy-closures/under-10000-nhs-bricks-and-mortar-pharmacies-in-england/

130 NHS England, Delivery plan for recovering access to primary care, May 2023. https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023.pdf

131 NHS England, Modern general practice model, May 2024 (update). https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/

132 NHS England, Modern general practice model, May 2024 (update). https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/

133 NHS England, Digitally enabled triage, March 2025. https://www.england.nhs.uk/long-read/digitally-enabled-triage/

134 PulseToday, GPs lacking 'hot hub' access advised to set up Covid-19 zones in their practices, April 2020. https://www.pulsetoday.co.uk/news/uncategorised/gps-lacking-hot-hub-access-advised-to-set-up-covid-19-zones-in-their-practices/

135 Pulse Today, GP hard work 'out of public eye' says Hancock while pledging bureaucracy cut, October 2020. https://www.pulsetoday.co.uk/news/politics/gp-hard-work-out-of-public-eye-says-hancock-while-pledging-bureaucracy-cut/

136 RCGP, The future role of remote consultations & patient 'triage', May 2021, p9. https://www.rcgp.org.uk/getmedia/72f052b6-3227-48b4-87c9-b05ff90517c4/future-role-of-remote-consultations-patient-triage.pdf

137 BMJ, Telephone first consultations in primary care, September 2017. https://www.bmj.com/content/358/bmj.j4345

138 Health Equity Evidence Centre, What works: Mitigating inequalities in telephone and digital triage for primary health care, January 2024 https://www.heec.co.uk/resource/what-works-mitigating-inequalities-in-telephone-and-digital-triage/

139 NHS England, You and your general practice, August 2025. https://www.england.nhs.uk/long-read/you-and-your-general-practice-english/

140 NHS England, Changes to the GP Contract in 2023/24, March 2023. https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2023-24/

141 PulseToday, Cloud telephony to cost practices up to £10K extra annually, GPs warn, January 2024. https://www.pulsetoday.co.uk/news/technology/cloud-telephony-to-cost-practices-up-to-10k-extra-annually-gps-warn/

142 PulseToday, BMA demands 'immediate pause' of contractual GP telephony requirements, February 2024. https://www.pulsetoday.co.uk/news/technology/bma-demands-immediate-pause-of-contractual-gp-telephony-requirements/

143 PulseToday, ICBs told to mine new GP practice dataset for 'unwarranted variation', April 2025. https://www.pulsetoday.co.uk/news/nhs-structures/icbs-told-to-mine-new-gp-practice-dataset-for-unwarranted-variation/

144 GP Patient Survey results 2025, July 2025. https://digital.nhs.uk/data-and-information/publications/statistical/nhse-gp-patient-survey-results/2025

145 Ipsos Mori on behalf of NHS England, GP Patient Survey, National results and trends, 2024-25: https://www.gp-patient.co.uk/latest-survey/results, 2012-2023: https://www.gp-patient.co.uk/past-survey-results-materials. Respondents were asked: 'Generally, how easy or difficult is it to contact your GP practice on the phone?' The percentages relate to those who answered 'very easy' or 'easy'.

146 Office for National Statistics, Experiences of NHS healthcare services in England - https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/experiencesofnhshealthcareservicesinengland/july2025, 17 July 2025. Respondents were asked: 'How easy or difficult was it to make contact with your GP practice?', with the answers:'Very easy; Easy; Neither easy nor difficult; Difficult; Very difficult'. The percentages represent those answering 'difficult' or 'very difficult'.

147 UK Department for Health and Social Care, 10 Year Health Plan for England: fit for the future, July 2025. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future,

148 PulseToday, GP practices advised to appoint trained officer before using AI transcription tools, 20 June 2025. https://www.pulsetoday.co.uk/news/technology/gp-practices-told-to-appoint-trained-officer-before-using-ai-transcription-tools/

149 UK Department for Health and Social Care, 10 Year Health Plan for England: fit for the future, July 2025, p30. https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf#page=30

150 UK Government. Fit for the Future. 10 Year Health Plan for England, July 2025, p34. https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf#page=34

151 Nuffield Trust, Improving access and continuity in general practice evidence review, November 2018, p8. https://www.nuffieldtrust.org.uk/research/improving-access-and-continuity-in-general-practice

152 Nuffield Trust, Improving access and continuity in general practice: Practical and policy lessons, November 2018, p6. https://www.nuffieldtrust.org.uk/sites/default/files/2019-01/continuing-care-summary-final-.pdf

153 Nuffield Trust, Improving access and continuity in general practice: Practical and policy lessons, November 2018, p9-10. https://www.nuffieldtrust.org.uk/sites/default/files/2019-01/continuing-care-summary-final-.pdf

154 Management Science, Continuity of Care Increases Physician Productivity in Primary, November 2024. https://pubsonline.informs.org/doi/10.1287/mnsc.2021.02015

155 RCGP Learning, Continuity of care: About the toolkit. https://elearning.rcgp.org.uk/mod/book/view.php?id=12895

156 NHS England, Delivery plan for recovering access to primary care, May 2023. https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023.pdf

157 NHS England, Our plan for improving access for patients and supporting

general practice, October 2021. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/10/BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf

158 NHS England, General Practice Forward View, April 2016, p23. https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

159 BMJ Open, The impact of a named GP scheme on continuity of care and emergency hospital admission: a cohort study among older patients in England, 2012–2016, September 2019. https://bmjopen.bmj.com/content/9/9/e029103,

160 PulseToday, Labour will pay GPs more for providing continuity of care, August 2023. https://www.pulsetoday.co.uk/news/politics/labour-will-pay-gps-more-for-providing-continuity-of-care

161 NHS England, Changes to the GP Contract in 2025/26, March 2025. https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/

162 Ipsos Mori on behalf of NHS England, GP Patient Survey, National results and trends, 2024-25: https://www.gp-patient.co.uk/latest-survey/results, 2012-2023: https://www.gp-patient.co.uk/past-survey-results-materials. Respondents were asked: 'How often do you get to see or speak to your preferred healthcare professional (GP for 2018-2023) when you ask to?' This was asked of all patients who have a healthcare professional they prefer to see or speak to, and the percentage represents those who answered 'Always or almost always/A lot of the time'

163 Annals of Family Medicine, Ongoing Decline in Continuity With GPs in English General Practices: A Longitudinal Study Across the COVID-19 Pandemic, July 2024. https://www.annfammed.org/content/22/4/301

164 British Journal of General Practice, What makes general practice work: the role of continuity in efficient and sustainable primary care, August 2025. https://bjgp.org/content/75/757/373.full

165 Cogora, General Practice workforce White Paper, January 2025. https://www.cogora.com/cogora-primary-care-workforce-white-paper

166 BMC Primary Care, Access or continuity: a zero sum game? A systematic review of the literature examining the relationship between access and continuity in primary healthcare | July 2025. https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-025-02860-8#author-information

167 Institute for Government, General practice across England: Performance Tracker Local, April 2025, p40. https://www.instituteforgovernment.org.uk/publication/performance-tracker-local/general-practice-england

168 Department of Health and Social Care, GP Partnership Review Final Report, January 2019. https://assets.publishing.service.gov.uk/media/5c3ca241ed915d50b4b47223/gp-partnership-review-final-report.pdf

169 Cogora, General Practice Workforce White Paper, January 2025, p47. https://www.cogora.com/cogora-primary-care-workforce-white-paper

170 NHS England Digital, General Practice Workforce, (General Practice – Practice Level - Detailed.csv) https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services

171 Care Quality Commission, Using CQC data, (CQC_Latest_ratings.xlsx), https://www.cqc.org.uk/about-us/transparency/using-cqc-data#directory

172 NHS England Digital, GP and GP practice related data, (ePCN; epraccur.csv), https://digital.nhs.uk/services/organisation-data-service/data-search-and-export/csv-downloads/gp-and-gp-practice-related-data

173 NHS England Digital, Appointments in General Practice, (GPAD_Annex1_Practice_Level_Breakdown_Summary.xlsx), https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

174 GP Patient Survey, Survey and Reports, (GPPS_Practice_results_(weighted).xlsx), https://gp-patient.co.uk/surveysandreports

175 NHS England Digital, Patients Registered at a GP Practice, (gp-reg-pat-prac-all.csv; gp-reg-pat-prac-quin-age.csv; gp-reg-pat-prac-sing-age-female.csv; gp-reg-pat-prac-sing-age-male.csv), https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice

176 NHS England Digital, NHS Payments to General Practice, England 2022/23, (nhspaymentsgp.csv), https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice/england-2022-23

177 NHS England Digital, Primary Care Network Workforce, (Primary Care Networks - Individual Level.csv), https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-network-workforce

178 NHS England Digital, Quality and Outcomes Framework, (includes overall domain achievements, and all the disease areas: qof-prac-dom-ach.xlsx; qof-prev-ach-pca-cv-prac.xlsx; qof-prev-ach-pca-hd-prac.xlsx; qof-prev-ach-pca-ls-prac.xlsx; qof-prev-ach-pca-ms-prac.xlsx; qof-prev-ach-pca-neu-prac.xlsx; qof-prev-ach-pca-resp-prac.xlsx; qof-prev-ach-pca-vi-prac.xlsx), https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data

179 NHS England Digital, Patients Registered at a GP Practice, (Patients Registered at a GP Practice – September 2025: LSOA 2021 (all-persons-male-female)), https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice

180 GOV.UK, English indices of deprivation 2019 , (File 1: index of multiple deprivation, IMD2019 tab, Index of Multiple Deprivation (IMD) Decile (column F)), https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

181 NHS England, GP and GP practice related data (epraccur document; epcn for PCNs), May 2025, https://digital.nhs.uk/services/organisation-data-service/data-search-and-export/csv-downloads/gp-and-gp-practice-related-data

182 OpenData Scotland, GP Practices and List sizes, July 2025, https://opendata.scot/datasets/public+health+scotland-gp+practice+contact+details+and+list+sizes/

183 NHS Information Centre for Health and Social Care, Information from the General Medical Services Census Statistics in Wales, https://statswales.gov.wales/catalogue/health-and-social-care

184 HSC Business Services Organisation, Northern Ireland practice list, https://hscweb.hscni.net/pmp/rptMedicalPracticeList.xlsx

185 NHS Digital, GP and GP practice related data, Primary Care Networks, (epcn file). https://digital.nhs.uk/services/organisation-data-service/data-search-and-export/csv-downloads/gp-and-gp-practice-related-data

186 NHS England Digital, Appointments in General Practice, (GPAD_Annex1_Practice_Level_Breakdown_Summary.xlsx), https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

187 Ipsos Mori on behalf of NHS England, GP Patient Survey, National results and trends, 2024-25: https://www.gp-patient.co.uk/latest-survey/results

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Rethinking access in general practice: Beyond more appointments

Access to general practice is one of the most scrutinised aspects of NHS delivery. Despite year-on-year increases in the number of appointments offered, patient satisfaction remains stubbornly low. The most recent GP Patient Survey reveals that although more consultations are being delivered than at any time in the service's history, many patients continue to report difficulties contacting their surgery, securing a timely appointment and navigating the overall system. This paradox suggests that access is not merely a matter of numbers – it is about structure, process and strategy.

Lessons from the pandemic

The Covid-19 pandemic showed that general practice can adapt at speed. Remote consultations, digital triage and flexible workforce deployment became the norm almost overnight. These innovations were not just temporary crisis responses; they were lessons in resilience, efficiency and lateral thinking. To improve access sustainably, practices must now apply those lessons in a deliberate, long-term way.

Access is best understood as a holistic journey. It starts with the first point of contact – usually the telephone – and extends through the booking of appointments, the clinical interaction itself and the follow-up administration. Bottlenecks can occur at any stage. A patient who cannot get through on the phone, who waits weeks to see a GP or who experiences delays in record-keeping will inevitably report dissatisfaction – regardless of how many appointments the practice has technically provided.

Outsourced telephony: Removing a key bottleneck

Traditional reception models expect onsite staff to manage face-to-face interactions and high call volumes simultaneously. This divided attention leads to long waits, unanswered calls and staff stress. Patients interpret these delays as poor access, even if appointment capacity exists.

General Practice Solutions (GPS) addresses this by providing dedicated outsourced telephonists. Unlike practice-based receptionists, GPS call handlers are not distracted by the competing demands of the front desk. Their sole focus is answering calls quickly, professionally

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and consistently. This ensures patients reach the practice promptly, reducing frustration and improving the perception – and the reality – of access. Reception staff, in turn, are freed to concentrate on in-practice duties, improving efficiency at every touchpoint.

Outsourced clinical coding: Freeing GP time

Another major barrier to access is the hidden workload carried by GPs. Clinical coding and workflow is essential for accurate patient records, QOF achievement, and data quality, but it consumes valuable clinician time. Every hour a GP spends reading and coding is an hour not spent with patients.

By outsourcing document management to trained GPS coders, practices release GP capacity back into patient-facing care. This translates directly into more consultation time, reduced backlogs, and enhanced clinical safety. For patients, the benefit is not abstract – they see their GP more quickly, with the assurance that records are accurate and up to date.

Repurposing estate for clinical space

Physical capacity also plays a part in the access debate. Many practices operate in constrained premises where additional consulting rooms are not easily attainable. However, by outsourcing back-office functions such as finance, HR and administration, some providers working with GPS have rendered significant office space redundant. That space has then been converted into new clinical rooms, directly increasing the number of patient appointments without the expense or disruption of relocating or extending premises.

Financial and operational advantages

Outsourcing brings immediate financial and operational benefits. With GPS, providers pay only for the hours worked, with no associated costs for National Insurance, pensions or holiday cover. There is no need to recruit, train or arrange temporary staff to cover absence – GPS manages this on behalf of the provider. This not only stabilises operational delivery but also improves profitability, enabling practices to invest resources where they matter most: frontline patient care.

In a climate where practice finances are under pressure and recruitment challenges are acute, the ability to scale support flexibly is a significant advantage. Outsourcing removes the risk of staffing gaps and ensures consistency of service, both of which underpin patient access.

Strategic access for the future

The central lesson is that access is not solved simply by offering more appointments. True access requires practices to think laterally about every component of the patient journey. Telephony must be reliable, clinical time must be protected, and estates must be used intelligently. Each element is interlinked; weaknesses at one point can undermine the entire system.

GPS works with practices, primary care networks and wider NHS organisations to address these interdependencies. By absorbing administrative and operational burdens, GPS enables clinicians and in-house teams to focus where they add most value. Patients benefit from quicker responses, shorter waits and a smoother journey through care.

Conclusion

General practice stands at a crossroads. Appointment volumes are at record levels, yet patient satisfaction continues to fall. To bridge this gap, practices must move beyond a narrow focus on numbers and adopt a strategic, whole-system approach to access. Outsourcing functions such as telephony, clinical coding and back-office administration offers a proven pathway: one that not only enhances patient experience but also improves operational resilience and financial sustainability.

By partnering with General Practice Solutions, providers can transform access in ways that go far beyond appointment count. The outcome is better use of workforce, estate and resources, ensuring patients experience the timely, responsive and high-quality care they deserve.

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