Londonwide LMCs

The professional voice of London general practice

Retention in London general practice

April 2023

Why does retention in London general practice matter?

Strong and sustainable general practice is essential to the delivery of high quality, cost effective healthcare.

General practice offers a very wide range of services to people of all ages, provides a gate keeper role for other providers such as hospitals, and navigates uncertainty and risk on behalf of patients and the NHS. From "cradle to grave", general practice services are underpinned by:

- person-centredness with a family and community focus,
- holistic care with patient autonomy,
- ongoing care of a defined local population with GP: patient relationship continuity, and
- multi-disciplinary team working and care co-ordination.

A thriving general practice workforce underpins the success of all key health care deliverables, and yet practices are increasingly under pressure to do more and more with fewer GPs.

People are too complex for their care to be reduced to transactional hurried encounters. Hurried encounters can be unsafe, and transactional care does not enable us to elicit and address our patients' true agendas. But we can no longer provide the type and standard of care that we want to deliver; that took years of study and training to develop; that provides patient satisfaction and professional fulfilment.

- GPs want time to listen to and care for their patients, whilst patients want time with expert GPs in their communities.
- GPs want to support ongoing therapeutic relationships with their patients, understanding how their health and wellbeing needs change over time, treating patients as a whole person rather than a symptom or condition or a set of tick boxes.
- GPs want to advocate for their patients and their families, working collaboratively with other healthcare professionals to co-ordinate care across organisational boundaries.
- GPs want to be a part of the community, understanding the particular needs of, and challenges faced by, people whom they live and work alongside.

The recent Health and Social Care Select Committee report into the Future of General Practice states clearly that: "GP retention needs to be improved" adding "…GPs are facing unsustainable workloads, which increase burnout and make GPs more likely to leave the profession. This creates a vicious circle of workforce and workload pressures for the GPs who remain…".

Essentially:

- We need more doctors and nurses in general practice.
- Each full-time-equivalent GP providing care to fewer patients.
- To be able to provide safe and effective patient care.
- In a sustainable way that retains this valuable workforce.

The untenable workload suffocating the profession, and causing staff to leave in greater numbers every year, leads to even greater work and pressure falling on those who remain. This spiralling attrition in turn reduces morale, increases burnout and leads to even more vacancies. General practice capacity is inextricably linked to Integrated Care Board (ICB) deliverables for primary care and the wider system, and protecting and nurturing this essential part of the health landscape should be a priority. We believe that ICBs can play a vital role in stemming the spiralling attrition if they are able to work and collaborate with general practice.

This report sets out the challenges, and identifies a series of key lines of enquiry for ICB leaders to consider if we are to save general practice and retain its invaluable resource – its highly trained and skilled workforce.

Feel free to share your thoughts with us.

Lisa

Dr Lisa Harrod-Rothwell
Deputy CEO
Londonwide LMCs

We have been hearing about the workforce crisis for years – what has changed?

As GPs and practice staff leave and vacancies cannot be filled, the individual workloads increase further. This is unsustainable for staff and can result in further spiralling attrition, destabilising the practice. A de-stabilised practice, especially if a contract is handed back, increases pressures on neighbouring practices and can destabilise a wide area because all NHS GP practices are working beyond capacity. General practice is inextricably linked to ICB deliverables for primary care and the wider system; the impacts are immense.

General practice should be one of the most rewarding careers; the privilege of being invited into people's lives often at their most vulnerable, the opportunity to touch lives and ease worry and suffering, to develop and maintain enduring relationships with mutual care and regard, to be in a position of authority to advocate for those unable to do so for themselves, to care proactively for an entire community with the associated sense of belonging and meaningfulness.

And yet joy, meaning and fulfillment have been superseded by anxiety, depression and burnout. GPs are leaving the profession, not only to safeguard their own mental and physical health but to safeguard the wellbeing of their families.

There can be no doubt that the role of an NHS GP has become untenable, not for the minority but significant majority. This is not just a problem for GPs and their staff, many studies have shown associations between clinician mental health and the safety and quality of patient care.

In September 2022, Pulse reported that:

- Calls to the BMA's mental health counselling service have sky-rocketed, with GPs making almost two-thirds of calls.
- Last year, the BMA said that calls to its counselling helpline were at an 'all-time high' – with a snapshot of data for July showing more than triple the number of GPs sought support in July 2021, compared to the same month pre-pandemic and double the number in 2020.
- And in April it was revealed that almost one in four GPs know a colleague who has died by suicide, 48% say GPs have left due to mental health issues or 'burnout' and 84% had themselves felt anxiety, stress or depression in the last year.

> ***I love being a GP, I hate working in this NHS environment.***

Why has working as a GP in the NHS become so untenable?

No one can dispute the demand:workforce capacity mismatch in general practice, and the major impact of this mismatch on safe patient care and GP and practice staff retention. Doctors work in a safety-critical sector (on a par with aviation, railway industry etc). The product of the health sector is healthcare of quality - a human product.

Demands have increased across the country...

- Growing population.
- Increase in proportion living with chronic disease.
- Increasing proportion of lives spent in poor health.
- Increasing number of conditions, once managed in secondary care, now managed in primary care.
- Increasing number of consultations per year per person.
- Government promise to deliver 50 million more appointments in general practice.
- The trend of unresourced workload shifts to general practice that began pre-pandemic, such as:
  - referral restrictions,
  - waiting times for onward care,
  - service decommissioning,
  - full capacity of other services, and
  - other provider requests of GPs.

...as workforce capacity has decreased

- Despite promises of thousands of extra GPs, as of September 2022, we have the equivalent of 1,808 fewer fully qualified full-time GPs compared to the baseline of September 2015.
- Over the last year, the NHS has lost 339 individual (headcount) GP partners and 305 salaried, locum and retainer GPs. This has created a net loss of 644 individual GPs since September 2021.
- In full-time equivalent (FTE) terms of 37.5 hours per week, this amounts to an equivalent loss of 364 full-time fully qualified GPs in the last year alone.
- Over one in 10 (16%) of respondents to a BMA survey in late 2021 shared plans to leave the NHS altogether.

38%
of London practices have GPs planning on
retiring
in the next three years

London only has
48.9
FTE GPs per
100,000
patients

59%
of London practices have
vacancies

London's challenge is even greater

The national data is very concerning but London is faring worse than national averages.

NHS Digital data

- The number of FTE GPs per 100k patients is lower in London (48.9 FTE) than England (55.3 FTE) as a whole, with England having a total of 6.4 FTE more GPs per 100k population.
- Participation rates are higher across England as a whole than London, and participation rates are falling.
- In December 2022, the FTE of direct patient care roles for general practice and primary care networks (PCNs) is lower in London than England as a whole.

Londonwide LMCs data

We have been carrying out a workforce survey every six months since 2014 (excluding Summer 2020). This provides us with rich data that includes trends over time. The last survey was in December 2022 and showed that:

Workload

- 93% of practices are concerned about the ability of practice workforce to meet demand compared to 79% in December 2020.

Vacancies

- 59% of London practices surveyed say they have a vacancy. The percentage of practices carrying vacancies is high and increasing - 22% increase from June 2021 to December 2022.
- 75% of practices with vacancies say they have an employed GP vacancy.
- 34% of practices with vacancies say they have a practice nurse vacancy.

Staff:

- The proportion of GPs planning to retire in the next 3 years remains consistent with previous waves at 38%.
- The lack of GPs as a factor preventing or hindering staff recruitment has risen to 61%, increasing from 54% in December 2021.

Patient safety

- 44% of practices are pessimistic about being able to meet patient need safely. This has increased from 33% in December 2020.
- Only 15% of practices were optimistic about safely meeting patient need in 2022, compared to a quarter in December 2020.

Recruitment and retention programmes aimed at individuals are important but:

- There have been many different programmes (such as new to practice offers, retainer schemes, funded programme director posts for post-Certificate of Completion of Training GPs), with cross organisational working, but GP numbers continue to fall.
- There are learning points, for example:
  - increasing recruitment will not have a sustained impact if the working environment remains untenable,
  - expanding the workforce team will only have an impact on the core demand:capacity mismatch if they are employed to support GPs delivering core essential practice services,
  - centrally procured tech platforms, that do not engage the practice nor local community as end users, can increase risks not mitigate them, and
  - individual clinician resilience programmes are ineffective when the problem is not with GPs not being up to the task, but having an impossible task set.

> *Our work is set up in a way that we can't take a break, it's high adrenaline the whole day. There are so many decisions to make in a day, it's very easy to feel quite worried about the care you are giving to your patients.*

We need a more holistic approach that:

Meets basic physiological needs

Physiological needs are often not being met due to the workload pressures. GPs do not get time to eat and take natural breaks, and sleep disturbance due to the stress of the job is common. The working day often extends far beyond mainstream childcare provision.

Ensures physical and psychological safety

Many GPs do not feel safe working in this NHS environment in which there is an increased risk of medical error and patient harm due to unsafe unsustainable workloads and transfer of unreasonable clinical risk to GPs. The NHS culture, behaviours and regulatory systems, recent political and media scapegoating, public attitudes, actions and unrealistic expectation, and our litigation system all compound the lack of psychological safety. This results in fear of repercussions to patients, their dependents and loved ones, the GP and their own families. *See diagram on page 8.*

Meets the need for connection and belonging

Moving up the Maslow hierarchy of human need, meeting the need for connection and belonging has been impacted by unsustainable workloads and pressures. At home, the emotional demands and the intensity result in emotional physical and mental exhaustion that impact on family relationships, and the loss of work:life balance affects wider personal relationships.

At work, excessive work pressures result in no time to debrief/seek advice after emotionally/intellectually difficult cases, and there's no time to build trusted personal relationships and connections with colleagues. GPs, who once valued the sense of belonging in their local communities, are now being abused and face pack-like mentality on community social media groups because they struggle to meet unrealistic patient expectation and demand.

Meets the need for esteem and self-actualisation

Both have been lost. Unsurprisingly, GPs feel the loss of professional esteem and confidence, as a result of denigration and vilification of the profession in the media and by national decision makers and being unable to meet unreasonable patient expectation.

As a GP, it is difficult to feel able to reach your professional potential to serve patients, support colleagues and staff and teach or train in a role where workload pressures, political priorities and the NHS top-down culture hinder creativity and problem solving, and career development opportunities are limited due to need to focus on essential service delivery only.

The focus needs to be on supporting all clinicians and practices:

Individual

- Supporting self-care and professional development.
- Provision of support.

Practice

- Supporting practices to maintain effective team working in the context of unsustainable workloads and pressures.
- Connecting practices to wider system offers.
- Sharing of ideas of how to control workloads.
- Sharing of ideas of how to develop freedom and choice in how, when and where staff work despite the workload pressures.
- Supporting practices with patient engagement, empowerment and setting reasonable expectation.
- Addressing system operational failings.

System partners should commit to addressing the untenable workloads, the underlying aetiology of which is outside the gift of GPs and practices.

Diagram: physical and psychological safety

Many GPs do not feel safe working in an NHS environment in which an increased risk of medical error and patient harm compounds the lack of psychological safety.

Fear of making a mistake because of excessive demands.

Fear of repercussions of a mistake on a patient and their family.

Fear of making a mistake because of excessive clinical risk.

Fear of verbal and physical abuse.

Fear of performance investigation.

Lack of control.

Fear of litigation.

Fear of being unfairly judged.

Repeated moral injury.

Impact of unfair external policies and decisions exacerbating the crisis.

Fear of repercussions of a mistake on the clinician and their family. Loss of: job, career, financial assets and reputation with patient, family and local community.

Each ICB has a vital role in stemming the spiralling attrition through addressing untenable workloads

Despite conflicting priorities and no additional national 'carrots nor sticks', general practice capacity is inextricably linked to ICB deliverables for primary care and the wider system and therefore should be a priority, both strategically and operationally.

Key lines of enquiry to consider:

1. Supporting practices who are struggling to maintain safe services for patients and safe working conditions for staff

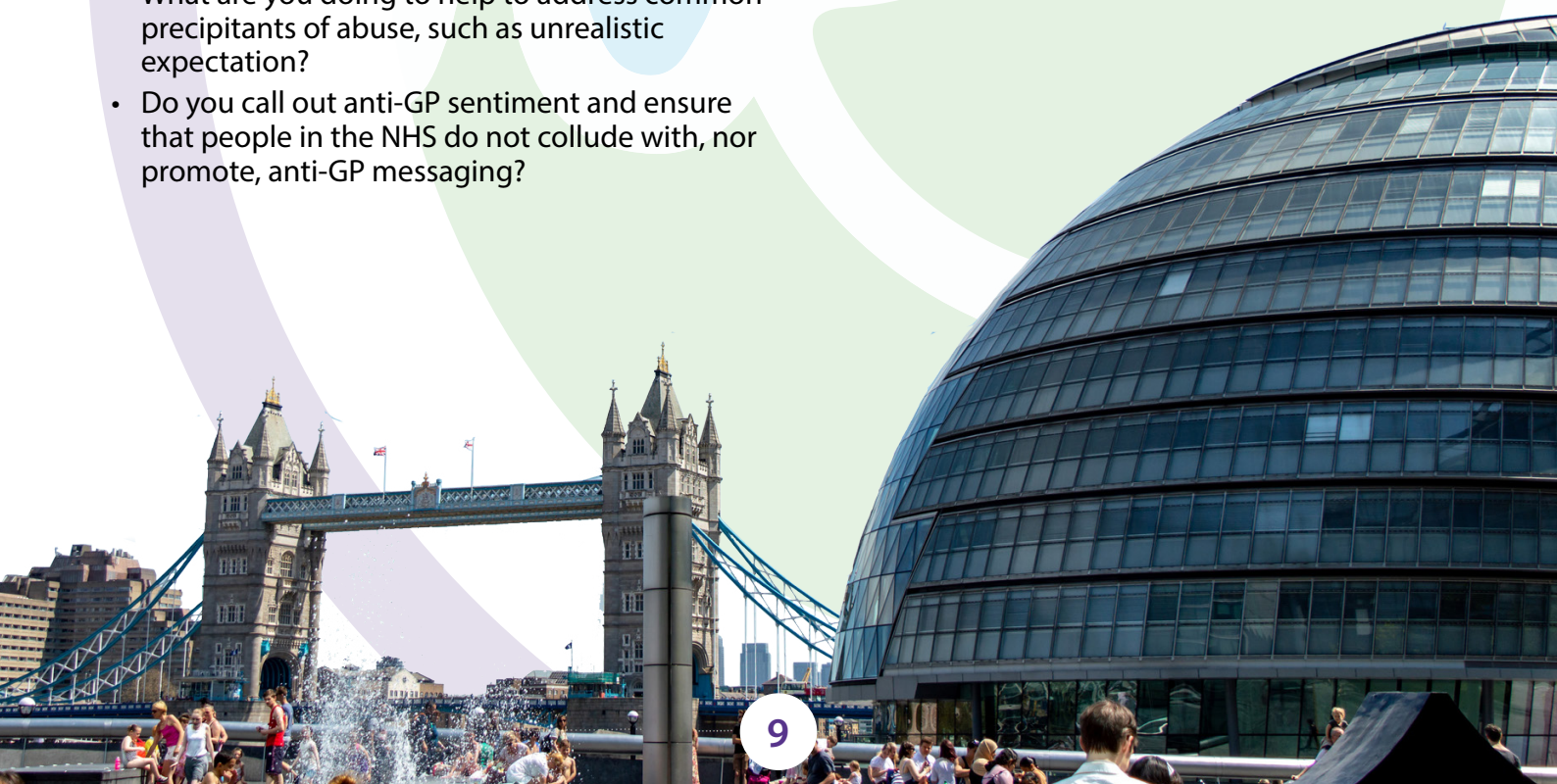
This includes:

- What systems are in place to support practices at risk of further attrition, failing or closing because of workforce shortages?
- How do you ensure safe practice in decisions regarding list closure applications when practices state they would be unable to safeguard patient safety with any increased demand?
- Do you have any arrangements that are de-stabilising for practices with closed lists, such as financial penalties through temporary withdrawal of local enhanced services (LESs)?
- In your liaison with the Care Quality Commission (CQC), do you try to ensure that the demand: capacity mismatch is taken into account in conclusions about practices?
- Do you work with CQC to avoid reputational damage by CQC compounding the underlying aetiology by increasing recruitment and retention challenges?
- What are you doing to help to address common precipitants of abuse, such as unrealistic expectation?
- Do you call out anti-GP sentiment and ensure that people in the NHS do not collude with, nor promote, anti-GP messaging?

2. Assessing the impact of system plans and changes on the general practice demand: workforce mismatch and ability to deliver care safely

This includes:

- How do you assess the impact of system pathways on the demand and workload on general practice?
- How do you ensure appropriate commissioning procedures and governance that protect against exacerbating the demand:capacity mismatch?
- How do you ensure that there are no unintended consequences for GPs and practices in meeting other system priorities?
- When considering system change, do you assess the deliverability by, and impact on, practices?
- Do you ensure that contracts are resourced fairly to enable safe delivery?



3. Addressing system operation failings that result in wasted appointments and inappropriate clinical requests

This includes:

- How do you promote and enable collaborative working between general practice and other sectors/providers to ensure effective and fair interface working?
- Have you established effective collaborative interface working groups across your system?
- How to you promote good practice within your organisation to prevent inappropriate workload shift into general practice?
- Do you seek to gather, collate and address these type of system operational failings?

> *Bureaucratic referral processes, having to re-refer and badly thought out pathways add to patient frustration and add a lot of time to a GP's working day.*

4. Addressing system operational failings that result in needless bureaucracy and diversion of time away from clinical duties

This includes:

- How do you identify and address system operational failings that result in significant wasted time every day?
- How do you ensure that practices are able to very easily navigate referral pathways and processes with any required criteria and forms easily assessable to all GPs?
- How do you ensure that referral processes minimise bureaucracy?
- What are you doing to identify and address IT failings such as EMIS crashes?
- Do you have reasonable expectations of PCN Clinical Directors?
- Do you always contract at the provider level of scale that is appropriate for the service, avoiding needless bureaucracy and layers of governance and complexity?

5. Maintaining the full role of the GP, practice team and the practice and ensuring effective use of clinical time to meet patient need

This includes:

- How are you supporting practices to find an acceptable balance between proactive and same day care?
- Are you supporting practices to be able to prioritise their finite time to effectively meet the greatest need?
- Do colleagues involved in system changes understand the full role of the GP and the types of services offered?
- Do colleagues involved in system changes understand the role of the practice, for example regarding local access and continuity of care, and the role as a community asset?

6. Data

This includes:

- What system data do/could you collect and how do you use it to understand, monitor and mitigate pressures experienced in practices and on GPs (eg measuring burnout scales)?
- How do you ensure credible planning for population numbers and need, for example taking into account levels of co-morbidity and health inequality in different wards and boroughs?
- How do you ensure that contract monitoring processes and data/information collection place minimal bureaucratic burden on practices irrespective of contract type?
- How do you ensure that payment processes place minimal bureaucratic burden on practices?
- How do you account for confounding factors, such as deprivation, mobile population, workforce:patient ratios, practice funding, in interpretation of quality/performance measures?

7. Understanding and overcoming the barriers to successful implementation of the additional roles in general practice

This includes:

- What are you doing to support the successful implementation of the Additional Roles and Reimbursement Scheme (ARRS)?
- Are you supporting the delivery of the Kings Fund recommendations for the integration of additional roles into the PCN?

8. Recruitment and retention programmes

This includes:

- How do you support Health Education England (HEE) in the development and success of recruitment and retention programmes?
- How are you monitoring the funding, development and outputs of the flexible staffing pools?

9. Awareness and understanding from ICB partners

This includes:

- Do you use the integration agenda within ICBs to keep system partners abreast of workforce data?
- Do you use the integration agenda within ICBs to help system partners understand the challenges and constraints faced by general practice in your area?
- Do you use the integration agenda within ICBs to ensure that system partners are aware of the full role of the GP and what general practice can and cannot offer, and to promote realistic expectation and stronger collaborative relationships?

Next steps


What further actions can be taken and by whom?
How can we share successes?
Is the role of ICS in stemming spiralling attrition clear in ICS strategic and operational plans?
Who has/shares accountability for addressing the spiralling GP and practice staff retention crisis?
How can we come together to share and learn, understanding which ICB actions (whether delegated or not) are supporting retention and which are continuing to exacerbate attrition?
How can Londonwide LMCs and borough LMCs work collaboratively with ICBs to address the workforce: demand mismatch crisis?

Appendix 1
The work of Londonwide LMCs in supporting retention

Londonwide LMCs have many different workstreams to help address the GP and practice staff workforce crisis at the individual, practice, borough and ICB levels, regional and national levels. This is a list of some of the work that we are currently doing. However, we are always open to other suggestions and would be delighted to work collaboratively with any system partner in ensuring safe and effective patient care.

Londonwide LMCs' current offer to support GPs and practices

Individual clinician

- Continuing to keep abreast of external wellbeing resources and offers and publicise.
- Publicising and signposting GPs to retention and recruitment offers.
- Continuing to build networks of trainees, first 5, salaried GPs, partners, locums to increase the reach of Londonwide LMCs and system offers of support.
- Supporting career development through continuing to deliver, promote and evaluate our re-designed professional training and development schedule.
- Being agile in responding to what is required by GPs and their practice teams, regarding their ongoing professional clinical and non-clinical training and development needs.
- Helping to identify a clinical and/or educational supervisor when supervision is prescribed by NHS England and/or General Medical Council (GMC)/Medical Practitioners Tribunal (MPT) conditions/undertakings, NHS England procedures/GMC investigation & liaison with Medical Defense Organisation (MDO)
- Supporting a GP to return to work after a period of absence.
- Providing professional and pastoral support to GPs facing performance, health and conduct challenges which may otherwise may have caused them to contemplate leaving the profession.
- Personal support to PCN Clinical Directors (CDs) when struggling with role.
- Supporting doctors with health, mental health, addiction, family problems and signposting as appropriate.

Practice level

- Support quality improvement (QI) within practices to prioritise according to patient need.
- Commission and encourage practices to use General Practice Alert State (GPAS - akin to the OPEL alert system) to monitor alert status.
- Continue to provide support and guidance regarding governance, new requirements and contractual changes.
- Support practices through contract termination, practice closure, list dispersal process.
- Address issues related to caretaking providers, caretaking contracts and managing these processes contractually.
- Advise practices on CQC matters including physical or remote inspections, Emergency Support Framework (ESF), Transitional Monitoring Approach (TMA), enforcement action including warning notices, suspension or cancellation of registration.
- Help practices address registration issues; liaising directly with CQC on practices' behalf to resolve issues.
- Further developing locum matching offer to support workforce challenges on the ground.
- Currently exploring how further practices can be supported in a programme alongside HEE and other partners.

Londonwide LMCs' current offer to help address the underlying aetiology

Borough level

- Provide a representative view of local GPs, evidence-based wherever possible, of the likely workload and workforce impact of proposed policy, contract, service changes, including required clinical time and the impact of diverting this time away from current services.
- Provide a representative view of local GPs regarding clinical safety and risk issues associated with proposed policy, contract, service changes.
- Use representative voice to feedback on workforce challenges, implications and plans.
- Support local, ICB and regional development and implementation of retention and recruitment initiatives.

ICB level

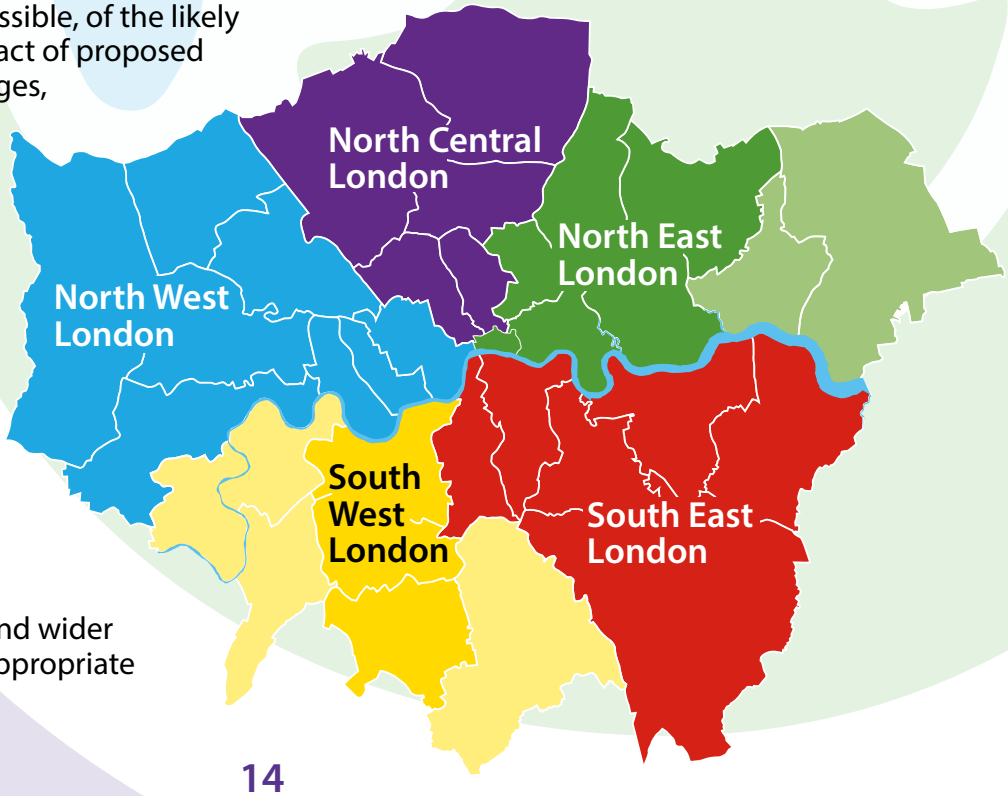
- Work collaboratively with clinicians at local trusts to highlight and address unresourced workload shift and address unsafe and inefficient care processes at the interfaces.
- Continue to review issues wrt inappropriate workload from other stakeholders raised by constituents and work to address collaboratively.
- Feedback IT and pathway operational failings and impact.
- Work with system to find solutions to IT and pathway operational failings.
- Monitor impact of interventions to address IT and pathway operational failings.
- Provide a representative view of local GPs, evidence-based wherever possible, of the likely workload and workforce impact of proposed policy, contract, service changes, including required clinical time and the impact of diverting this time away from current services.
- Provide a representative view of local GPs regarding clinical safety and risk issues associated with proposed policy, contract, service changes.
- Working with local systems and wider stakeholders to minimise moral injury due to unmet patient need.
- Working with local systems and wider stakeholders to minimise inappropriate risk sitting with GPs.
- Use representative voice to feedback on workforce challenges, implications and plans.
- Support local, ICB and regional development and implementation of retention and recruitment initiatives.

Regional

- Regular liaison with London CQC leads on inspections and inspection issues, influencing approach and practice engagement.
- Giving voice to concerns and challenges faced, and identify and source case studies and lived experience examples of workload pressure, patient aggression, etc.
- Provide input into the development and delivery of London Workforce Racial Equality Standard (WRES) plans.
- Use representative voice to feedback on workforce challenges, implications and plans.
- Support local, ICB and regional development and implementation of retention and recruitment initiatives.

National

- Engaging with regulators and medical defence organisations.
- Using representative voice to feedback on workforce challenges, implications and plans
- Raising constraints with the national ARRS with the national team and contribute to setting BMA General Practitioners Committee (GPC) policy.



Appendix 2
The Londonwide LMCs' workforce survey

Londonwide LMCs has been carrying out a workforce survey every six months since December 2014 (excluding Summer 2020). This provides us with rich data that includes trends over time from the first Wave 1 in December 2014 to the latest Wave 14 in December 2022.

Key highlights of the latest Londonwide LMCs workforce survey (December 2022):

Total patient list of responding practices

- Total list size of responding practices 2,861,922.
- Total list size of responding practices with vacancies 1,841,285.
- Total list size of practices with a GP planning to retire in the next three years 1,231,360.
- Total list size of practices with a vacancy and a GP planning to retire 813,296.
- Total list size of practices with 2+ vacancies of the following:
  - GP vacancies – 788,647.
  - Nurse vacancies – 406,250.
  - GP/nurse vacancies – 1,215,809.

Staff

- The number of practices employing additional locum or agency staff to help manage current and future vacancies matches Wave 13, with a peak of 50%, which although is comparable to Wave 12 (49%), is significantly higher compared to Wave 11 (40%) and Wave 1 (37%).
  - The number of practices employing a physician associate has also risen to a peak of 27% in Wave 14, compared to Wave 11 (17%) and Wave 1 (10%).
- The proportion of GPs planning to retire in the next 3 years remains largely consistent with previous waves at 38%.
- The number of practices with a succession plan for retiring GPs stands at 31% in Wave 14 after a peak of 38% in Wave 11.
- The lack of suitable GPs interested in the position as a factor preventing or hindering staff recruitment to the practice has risen from just over half (54%) a year ago in Wave 12 to just under two thirds (61%) in Wave 14.
- The proportion of London GP practices reporting low morale among practice staff is also rising to a peak of 45% in December 2022, compared to 37% six months earlier in Wave 13 and 27% in Wave 1.

Vacancies

- 59% of responding practices have a vacancy.
- 75% of practices with vacancies say they have an employed GP vacancy.
- More practices have an employed GP vacancy of more than 12 months (35% in Wave 14) than one year ago (18% in Wave 12).
- 34% of practices with vacancies say they have a practice nurse (non-prescribing) vacancy.
- The proportion saying there is currently a vacancy in a GP role has increased since one year ago (the last December survey Wave 12) from 70% to 83% vs. 70%, with Wave 14 registering as the highest level of vacancy in a GP role across all waves (previously this was the last survey, summer '22/ Wave 13, when all GP vacancies were at 80%).
- There is a greater number of vacancies for employed GPs (75%) compared to Wave 12 and Wave 1 (63% and 50% respectively), while there are fewer vacancies for health care assistants/ health care support workers in Wave 14 (15%) than in Wave 12 (21%).
- The number of reported partner vacancies stands at 16% in Wave 14, equal to the 16% reported in Wave 13 in June 2022.
- The number of practices with a plan to appoint a new partner to replace GPs who are planning to retire continues to fall after a peak of 39% in Wave 12, now dropping to 26% in Wave 14.
- The proportion of practices considering increasing the hours of existing staff to help manage current and future vacancies has risen to a peak of 36% in Wave 14 from 29% six months earlier, in Wave 13.

Patient safety

- In Wave 10 (December 2020), a quarter of practices were optimistic about safely meeting patient need (23%), however this has dropped to just one in six in Wave 14 (15% - same as in Wave 13), and more than two in five say they are pessimistic (44%, same as in Wave 13) compared to a third saying the same in Wave 10 (33%).

Possible closure

- 12 practices in total with patient lists estimated at 124,914 are considering either, or both of:
  - Terminating their contract within three years.
  - Closure as a way to manage current or future vacancies.
- 11 boroughs have practices that say they are considering closure.

Workload

- More than nine in ten practices are concerned about the ability of practice workforce to meet demand in Wave 14 (93% compared to 90% in Wave 13) compared to four in five in Wave 10 (79%).
- In previous Waves, the greatest concern expressed was about the ability of practice workforce to meet demand. However, Wave 14 saw a three-way split for the most concerning issue between this:
  - General practice being asked to undertake investigations on behalf of secondary care teams – 93% expressed concern in Wave 14 compared to 89% in Wave 13 and;
  - The impact of workload on yourself and your colleagues' mental health – 93% expressed concern in Wave 14 compared to 89% in Wave 13.

Other points included:

- Practices are more concerned about the accessibility of specialists and their support teams for routine enquiries now than they were in Wave 10 (70% Wave 14 vs. 58% Wave 10).
- Only a third of practices remain unconcerned about the availability of diagnostics/ investigations (scans, specialist blood tests) in Wave 14 (34%).
- Fewer practices are unconcerned about accessibility of specialists and their support teams for routine enquiries – 17% are unconcerned in Wave 14 compared to 20% in Wave 13 (20%), decreasing from three in ten in Wave 10 (29%).