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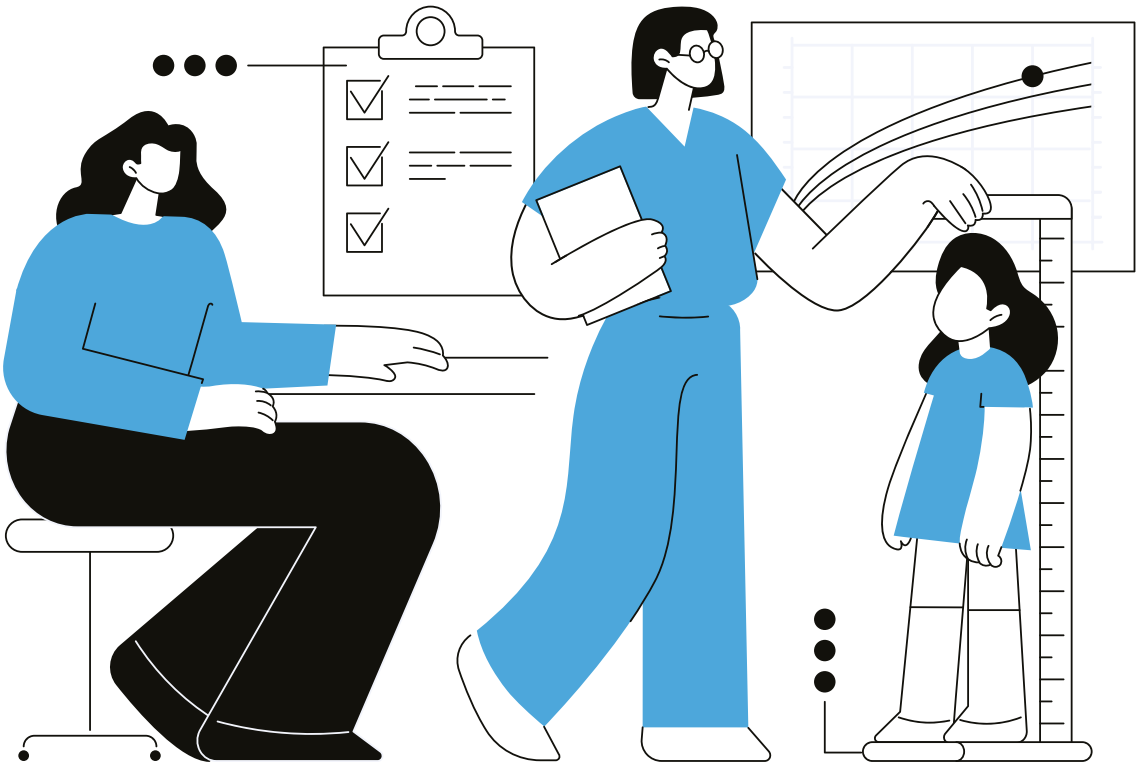


SEPTEMBER 2025

# General Practice — Prioritising effectiveness over volume?

AUTHORS: Nick Downham | Simon Bricknell | Sajid Khan | Max Pardo-Roques | Steve Boam

# Authors

## Nick Downham

Nick Downham is a leading healthcare quality, systems thinking and organisational development specialist and director of consultancy Cressbrook Ltd. He is committed to helping professionals and communities be their most impactful improving healthcare quality, productivity and outcomes.

Nick has shaped, and continues to shape, some of the largest and most enduring quality, organisational development, leadership programmes and improvements in the NHS. He is a member of visiting faculty at the Health Systems Innovation Lab at London South Bank University and is a graduate of the groundbreaking Lean Enterprise Research Centre at the University of Cardiff. Nick supports front-line teams and their leaders at all levels in services across primary and secondary care domestically and internationally.

He is the co-author of Improving Quality in Healthcare – Questioning the Work for Effective Change (2024), published by Sage. More on Nick can be found at www.cressbrookltd.co.uk or www.linkedin.com/in/nickdownham

## Steve Boam

Steve Boam is a highly experienced healthcare improvement leader with a distinguished background at Toyota in both the UK and Japan.

For over 20 years, he has applied Toyota's world-renowned methods to health and care systems in the UK, Australia, Canada, and New Zealand. As CEO of KM&T, and now of Develop Consulting, Steve has led whole-hospital transformation programmes in more than 50 NHS trusts.

He played a pivotal role in creating national improvement initiatives such as the internationally recognised Productive Series. More recently, he has overseen the delivery of NHS England's General Practice Improvement Programme, which has supported over 2,000 GP practices nationwide in the past two years.

Learn more about Steve's work at www.develop-consulting.co.uk

# Contributors

## Max Pardo-Roques

## Simon Bricknell

## Sajid Khan

# 1. Introduction

## Why we care about Primary Care and General Practice

The health and care system faces significant and sustained pressures. Demographic change, rising demand, and an increasing prevalence of long-term and complex conditions continue to challenge capacity and resources. Given the limited scope to expand funding or workforce at scale, providers will be required to adopt new approaches to the organisation and delivery of care.

No health system can meet the demands of population ill-health with a reactive approach. Despite the excellent work carried out in our secondary care system and efforts to expand capacity, this will be little more than a sticking plaster to increasing demands without a robust, revalued, and effective primary care and general practice system. General practice can innovate, hold risk, manage undifferentiated needs, promote wellbeing, and facilitate integration in ways that other parts of the health system cannot. It is, of course, central to the NHS's recently released ten-year plan.

While the plan is currently light on implementation detail, it is clear just how pivotal general practice is to the success of the majority of the shifts in care detailed.

However, despite this positive focus, general practice remains a sector under tremendous pressure, displaying all the symptoms discussed in vast volumes of commentary.

Our view is it would be too simplistic for general practice to externalise all of these challenges, and therefore, we aim to support the vital work of front-line general practice through our focus on developing more effective and robust models of care.

## This paper and why we care about effectiveness rather than volume of appointments in general practice

This paper challenges the current focus on increasing appointment access and volume as a response to the challenges faced by general practice. Instead, through the narrative and data presented, we argue that there are significant opportunities in enhancing effectiveness and quality that will be much more impactful against these challenges faced. We illustrate how doubling down on the effectiveness of model general practice may be more impactful in reducing demand and appointment pressure than solely focusing on access speed and volume. In conclusion, we suggest areas of focus required if practices and the wider system were to pursue these opportunities.

While these insights and conclusions are not an exercise in deep academic research, they are the product of in-depth case studies, observations from thousands of hours spent with practices, and the authors' expert reflections and pattern spotting from many years of supporting general practice at practice, regional, and national levels. They offer a carefully considered, hopeful, and positive view of just how much potential there is, despite a challenging external environment, for well-supported general practice to be much more than just a 'front door to the NHS' and instead be the lead in redefining models of care, putting the patient at the centre with better quality provision and advice to re-establishment of the world-class health system we all desire.

# 2. Context and strategies for improvement

## The changing face of general practice

It is important to acknowledge that general practice is not homogeneous, nor does it have the same levels of hierarchy seen in other parts of the NHS. Innovation in many practices can therefore outpace that of larger organisations and institutions.

General practice has evolved dramatically over the last decade. The model that was once largely single-site, single-channel, non-triage, mono- or duo-professional has become a multi-professional, multi-site, digitally enabled, multi-channel, often triage-based service.

There has also been a significant increase in the level of pathway and task specification, same-day access, signposting, decision support tools, guidelines, and scrutiny of practice. These dramatic changes are summarised below:

| FROM | TO |
|---|---|
| Largely single site | Multi-site |
| Single channel (tele) | Multi-channel (digitally enabled) |
| Non-triage | Triage based |
| Mono / duo disciplinary | Multi-disciplinary team based |
| Contained model | Signposting and partnering with other services |
| High levels of autonomy | Lower levels of autonomy (rise of task focus and pathway specification) |
| Lower expectations on access | High expectations of access |

With these increasingly intricate models, challenges arise such as understanding what is actually happening within a practice, multi-disciplinary team working needs, workflows and plans, and ensuring effective leadership. In short, general practice is much more complex than it was even 10 years ago.

## Strategies to drive improvement

Against this backdrop, GPs in the NHS are implementing strategies to create capacity and enhance care, such as:

1. **Boosting access:** this includes nationally prioritised efforts to improve access to general practice through triage, website enhancements, and appropriate signposting. Some practices receive support with this in the form of the NHS General Practice Improvement Programme (GPIP).

2. **Workforce (capacity) expansion:** recruiting GPs, allied health professionals and other additional roles to help manage the workload.

3. **Work-to-rule actions:** some GPs are capping daily patient numbers to ensure they can dedicate adequate time to each patient.

4. **Efficiency improvements:** investing in better IT systems and administrative support to reduce GP time required for paperwork and non-clinical tasks. Others are using quality improvement techniques to improve key processes.

5. **Expanding team-based care:** delegating routine tasks to nurses and pharmacists, freeing GPs for complex cases.

6. **Asset-based approaches to care:** re-orientating the deficit care model to instead see patients and their communities as assets in health.

7. **Quality and Outcome Framework (QOF) and other incentives:** practices respond to the requirements laid out in QOF and other streams of financial incentives to drive better outcomes.

8. **Pooling / Federating**: combining resources or specialisms to offer services across a defined patient population.

# 3. How to Create Capacity in General Practice

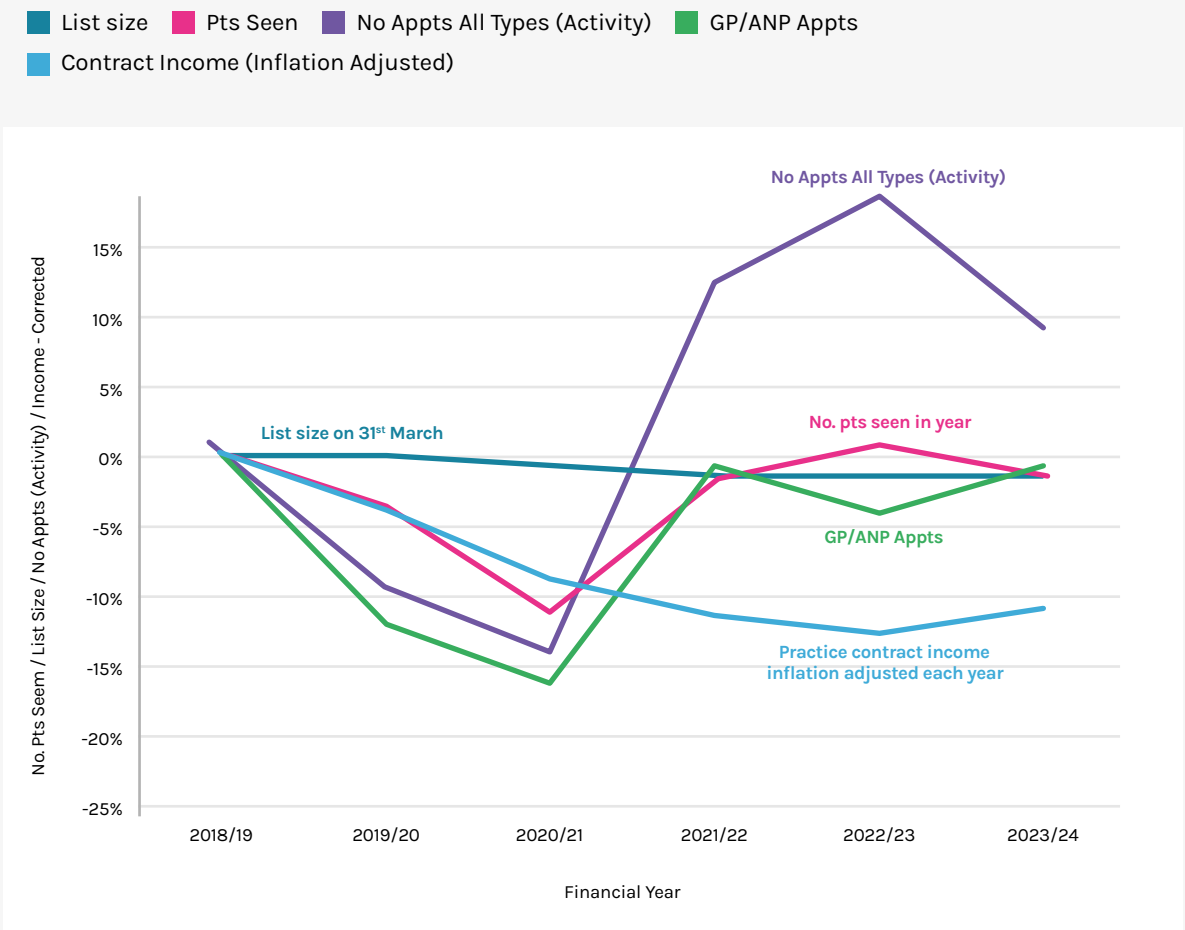
## Section A | 6 years in the life of a general practice – what can this tell us about quality and effectiveness?

The following case study of a large, capable, single PCN practice highlighted challenges with the effectiveness of the model of care - something we have also seen in a number of other practices.

The graph below shows 6 years in the life of this digitally enabled, highly regarded practice. It illustrates changes in the volume of face-to-face appointments across all staff types, the number of GP appointments, list size, the total number of patients seen, and income over this 6-year period[1].

Like many others, the practice excels in its QOF attainment, holds a Good CQC rating, but struggles with population health risk trends (such as BMI), long-term condition outcomes such as the type 2 diabetes three treatment targets, and patient expectations. Furthermore, like many practices, the staff workload pressure is not at all comfortable. The practice has a well-developed access system that aligns strongly with the principles of Modern General Practice[1].

### Are we seeing more people, or are we seeing people more often?



## 4 key observations:

1. **Rising practice productivity**
   - Appointment numbers in aggregate have surged, even with less real-terms funding*.
   - The practice is delivering more - a success overshadowed by press rhetoric around difficulties getting an appointment.

2. **Rising GP productivity**
   - When measured through an appointment volume and income lens, GP productivity is higher.
   - GPs are broadly doing the same number of appointments for less real-terms funding**. Given the national picture of an NHS productivity crisis[2], this is seemingly a huge success.

3. **Increased patient activity**
   - The practice isn't seeing more unique patients, but it is seeing some patients much more frequently.
   - This trend can be a surprise to GPs who report that it feels like they are serving more of the list and seeing more people.

4. **The list size remained static**

Our experience of this practice, and others studies show that list size increase does not match the activity increase.

## 5 factors that might be impacting this GP practice

1. **Health inequalities are widening and some patients are less well**
   The COVID-19 pandemic and cost-of-living pressures have disproportionately impacted some people, in terms of both physical and mental health[3].

   Older people have been impacted by the earlier onset of ill health and reduced life expectancy, and younger people[4] in terms of development, school attainment, and long-term health patterns. In short, the pandemic has led to some people being less well.

   Most research on widening inequalities focuses on national and regional geographical differences. However, since much of the impact on health is driven by poverty[5], it is highly likely that, within the practice's own list, health inequalities have widened, leading to higher practice attendance among some individuals.

2. **Longer waits for secondary care**
   One of the biggest impacts of the COVID-19 pandemic on our secondary care system, which was deliberately run with little capacity headroom, is that elective waits have exploded.

   With 7.5 million people waiting for elective procedures[6], general practices are left to 'hold' patients – managing increasing anxiety, addressing queries, and supporting the knock-on health and social effects of extended delays.

3. **Patient expectations are rising**
   Influenced by a "next-day delivery" culture and negative media narratives, GPs often report that public expectations are rising. Although these figures show that the overall number of people accessing the practice is not rising, the greater expectations of those who do may be fuelling the increase in attendance.

4. **Better, more comprehensive care**
   One of the main reasons for the significant increase in all types of appointments is the roles introduced through the Additional Roles Reimbursement Scheme (ARRS). The introduction of clinical pharmacists and social prescribers has enhanced care quality, with staff improving medicines management and addressing complex social needs respectively.

5. **There is a problem with effectiveness**
   It would be tempting to say that although appointments and productivity have increased, it is the above, largely external factors, that explain the challenges faced by this and many other practices. However, we don't believe it is as simple as that.

   The fact that the practice is not seeing more people, but is seeing some people more often, challenges us to consider what is really going on.

   We believe there are significant opportunities to improve outcomes if the focus shifts from activity volume to quality, and from crude appointment productivity to effectiveness.

*The volume of touchpoints is likely to be higher still, given the increase use of digital communication channels with patients such as SMS messages. **Note this is analysis of one practice, GP funding is variable depending on demographics and other patient profile variables.

# 7 signs we have big opportunities to increase effectiveness

Amid a backdrop of significant and often externally driven changes, there is data and argument to suggest that there are real challenges to the effectiveness of the model of care.

Through our research and support with practices at a National level we have identified 7 key signs or areas in which we are losing capacity and effectiveness within practices and the system:

1. Failure Demand
2. Access Inequalities
3. Access at the expense of planned care
4. Looping patients
5. Variability in post consultation actions
6. First Contact Resolution (RFT – Right First Time)
7. Continuity

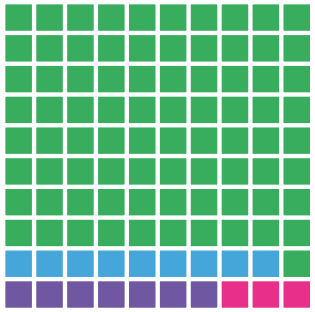
## 1. We are creating our own work - Failure Demand:

Failure demand refers to extra demand caused by system issues or inefficiencies, not by patient needs. These avoidable problems can occur when there has been a poor response to a patient's needs, such as a delay or error, or an issue with effectiveness, safety, experience, efficiency or equity.

Our studies of failure demand[7] reveal significant levels in general practice. A GP-led analysis of 599 GP and ANP consultations in a large practice shows that 19% of all consultations arise from these system failures, stemming from ineffective models of care and processes. Importantly,

### Failure Demand

Work created by failings in our system of work



Source: Develop Consulting Ltd

**81% No** **7% Yes** - Secondary Care
**9% Yes** - Practice **3% Yes** - Wider System

9% of the failure demand originates from the practice itself, while 10% comes from secondary care and the wider system.

For a practice serving 10,000 people, 19% failure demand could account for 5,000 appointments per year — a modest reduction of which would almost instantly solve demand pressures on the practice.

As explored by Anderson-Wallace and Downham[8], failure demand arises from four core issues:

- Fragmented working: with an expanded professional mix in many practices, teams often operate in silos which can create inefficiencies.
- Role confusion: we see generalists performing highly specialised work, specialists doing work that well-supported generalists could do, and both groups handling work that communities could address more effectively.
- Defensive practice: many GPs tell us that they work cautiously due to fears of litigation; a fear intertwined with the growing task, decision and process specification of general practitioner work.
- Misinterpretation of need: under time pressure, GPs may treat symptoms and manage risk rather than uncover and address a health or social root cause[9].

While some of the root causes of failure demand are systemic, we have found that practices can begin to address many of these issues to ease pressures.

## 2. Access inequalities are widening

Fairness is a cornerstone of general practice, with "flat" access systems – such as a digital triage – designed to ensure that everyone has the same opportunity to secure an appointment. However, these systems can inadvertently perpetuate health disparities, with LSBU's Health Service Innovation Labs Universal Healthcare work noting that a flat offer is often not fair[10].

Although access is seemingly improved by digital systems, our 6-year graph above demonstrates that the same number of individuals continue to receive care while others do not. To prevent inequalities, access must be prioritised for those who are disadvantaged in its use and/or already facing health disparities. This is widely recognised as the inverse care law[11].

While many practices are aware of and strive toward initiatives like Core20PLUS5[12], the reality is that in fast-paced digitally enabled triage practices, identifying patterns regarding who is receiving care and who is not can be extremely challenging.

Due to workload pressure, clinicians in triage roles often work without a holistic view of the patient's history, shifting their focus to risk assessment rather than fully addressing needs.

## 3. Access at the expense of planned care

> "For people with type 2 diabetes, there has been a significant [national] decrease [in achieving the three treatment targets]"
>
> 15 months ending March 24
> Office for Health Improvement & Disparities, HM Government

Our work with hundreds of practices shows a clear trend: practice leaders are prioritising access over other concerns including care for chronic conditions.

Despite the intentions of QOF and widespread recognition of the importance of managing long-term conditions (LTC), both practices and patients have heard a clear message: the priority is greater access. This is reinforced by the emphasis on access measurement (such as GPAD[13] data) and the focus of support from national improvement initiatives for practices, such as the National General Practice Improvement Programme[14].

A warning sign that planned LTC care is suffering is the stark **declining achievement of the type 2 diabetes three treatment targets**. Numerous GPs we work with see the three treatment targets not only as a measure of good medical care, but as a litmus test for the health of their LTC systems. Meeting the targets reflects a practice's ability to deliver organised, engaging, supportive, encouraging and effective care.

**In our practices and national data, the decline in meeting the three type 2 diabetes** treatment targets will increase patient complication risks, putting a higher demand on services and increasing avoidable costs.

External pressures – like personal pressures, financial strain and shifting health patterns – contribute to this decline. However, we argue that it is also a result of the significant and sustained emphasis on access over other priorities. With limited time and capacity for change, practice leaders have understandably focused on the most urgent priority: rapid access.

Ironically, less focus on planned LTC care may be making same-day access harder. Many patients needing urgent appointments are the same individuals whose LTCs aren't being proactively managed. When LTC care breaks down, the same patients are cycling through urgent care appointments and unplanned care settings, including A&E.

# 4. Looping Patients

General practice has more control over its demand than many realise. With our studies[15] of busy practices show that up to 33% of patients seen today will be back, at least once, within the month. Of those, up to 50% will return at least once within a second month, and up to 59% of those will be seen again, at least once, within a third month.

This may be due to a direct suggestion from the GP to make a follow-up appointment, or because individuals seek additional help unprompted.

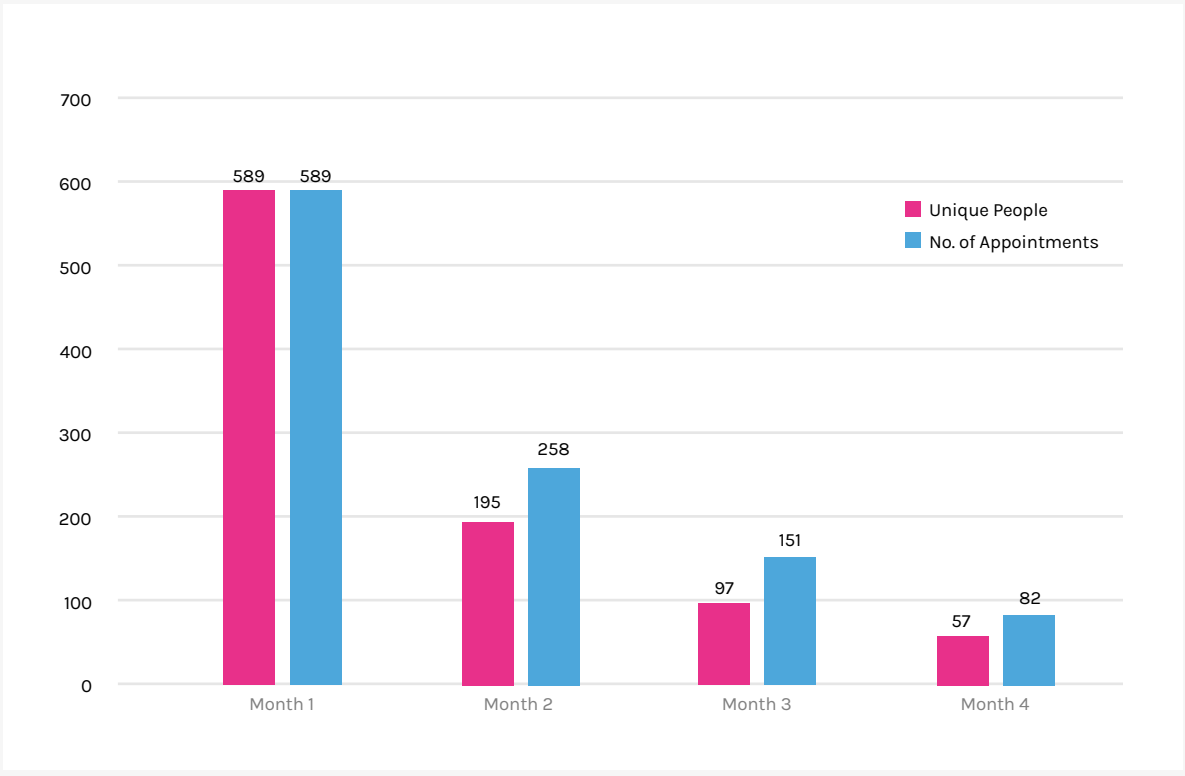
Of course seeing someone again is the bread and butter of general practice, but rather like compound interest on a mortgage, small changes in the 'see again' rate in the early months have a compounding effect in subsequent months. **Being more effective pays off multiple times over.**

When we supported practices to analyse frequent attendance patterns over multiple years, certain assumptions didn't hold.

For example, many long-term frequent attenders are not old and they often don't have any or many classic QOF long-term conditions. When we looked at the attendance patterns of cohorts who were long-term, multi-year frequent attenders with no LTC, 80% were on analgesic drugs[16], possibly for chronic pain. This suggests that a one-size-fits-all, fast-paced relative system of access for this group is of no benefit to either the practice or the individual.

Our GP-led demand studies have shown that up 60%[17] of all same-day requests for appointments were not urgent, yet they were processed through the same-day access system. GPs have shared that when routine appointments are not available for 3 to 4 weeks, patients feel there is effectively no routine care on offer which leads to uncertainty and lack of trust. They therefore learn which words to use to unlock faster care within the same-day access system, even if it means joining the 8am 'rugby scrum'. These appointments are therefore not new work, even if the same-day access systems categorise them as such.

**Follow Up Looping** (within week follow up discounted)

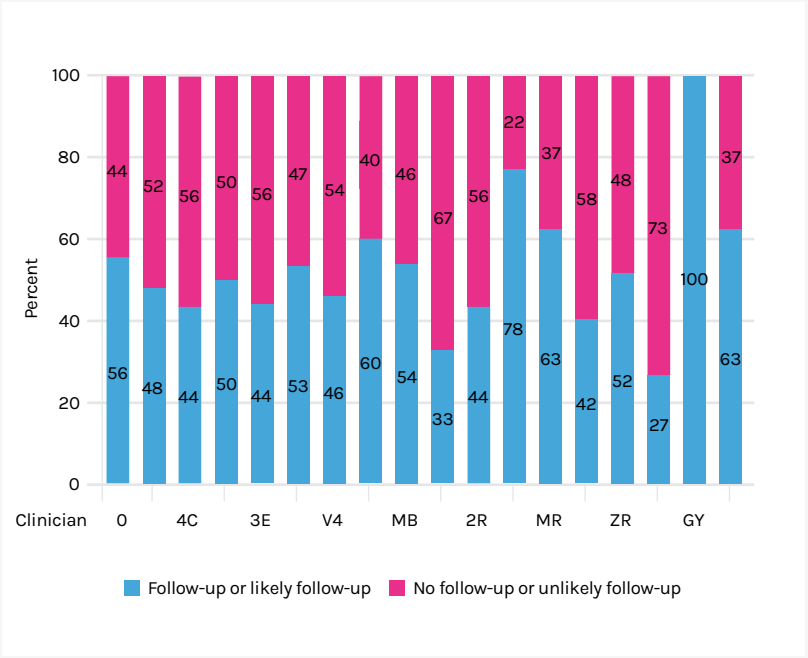


# 5. Variability in post-consultation actions

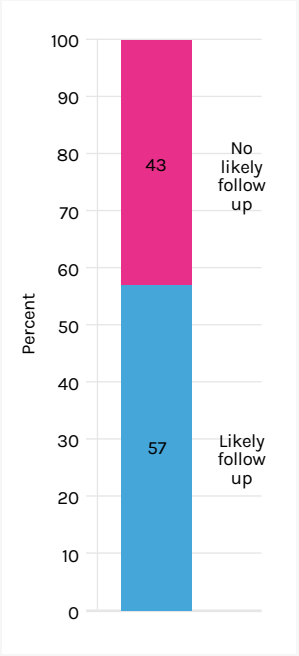
One cause of variation in post-consultation follow-up is hidden in plain sight. Our study of a large, busy practice reveals striking differences in how often individual GPs invite patients back.

The graph below illustrates the variability in GPs triggering follow-up. While this may be somewhat unsurprising, the visualisation is a powerful prompt to start vital dialogue on the subject.

## Concluding actions catagorised by staff reference
(Sample Size: 722)




## Total of concluding actions




Our GP-led studies of practices show that up to 57%* of consultations involve GPs determining a very likely follow-up at some point in the future, triggered either by the GP or then patient. Notably, this follow-up rate can vary considerably across the GPs involved in the analysis[18]. A 2% reduction in this looping could release thousands of appointments per year for an average practice.

The reasons for follow-up variability are multifactorial, including factors such as experience, confidence, case mix, supervision, training, specialism, experiences of complaints or litigation, and the time of day. But in a high-volume environment, this variability matters and must be explored in a generative way. This involves using clinician-generated data – data that GPs trust - and providing GPs with time and support to make sense of it. This allows clinicians to understand patterns, avoiding unwarranted variation[19].

The potential here is immense when you combine trusted data like this with other data sources, such as prescribing, diagnostics, and referral usage together. We believe in and strive to support clinicians in their efforts to reduce unwarranted variability, with the principle being 'not to control doctors but to help them in managing their systems of work'[20].

# 6. First Contact Resolution (RFT – Right First Time)

As part of our data-led work, we provided care navigators, in a Midlands super practice, with diagnostics tools to categorise whether they were able to resolve patient requests at the first contact – an essential measure of effectiveness.

They found that, across 3,500+ categorisations, 17% of the time it was not possible to resolve requests on the first attempt. Further investigation yielded an important insight: a disproportionate percentage of the calls not resolved on the first attempt were attributed to only a few care navigators – a group who hadn't received complete care navigator training and were struggling in their roles.

The importance of contact resolution is a hard lesson the call centre industry has learned over the past 15 years, yet it seems many practices are tripping over the same avoidable problems. With better training, these repeat contacts – and the workload they generate – could be avoided.

Interacting with patients once and correctly is not only a huge benefit to the practice and other providers in terms of capacity, patient management and resolution but also to the patient in terms of time chasing professionals and also elapsed time and anxiety in some cases with no information or conclusion. It is therefore important to listen to the patient, assess their request or needs and then process them correctly, communicating well and ensuring there is a robust handoff to the next process or professional.

This concept has been adopted from industry, in particular Toyota, whose business model centres on the need for RFT (Right First Time) to ensure quality and efficiency within its production processes. In acute care "Right First Time" in refers to initiatives aimed at improving care quality, reducing errors, and enhancing patient outcomes by getting diagnoses, treatments, and processes correct from the outset.

# 7. Continuity

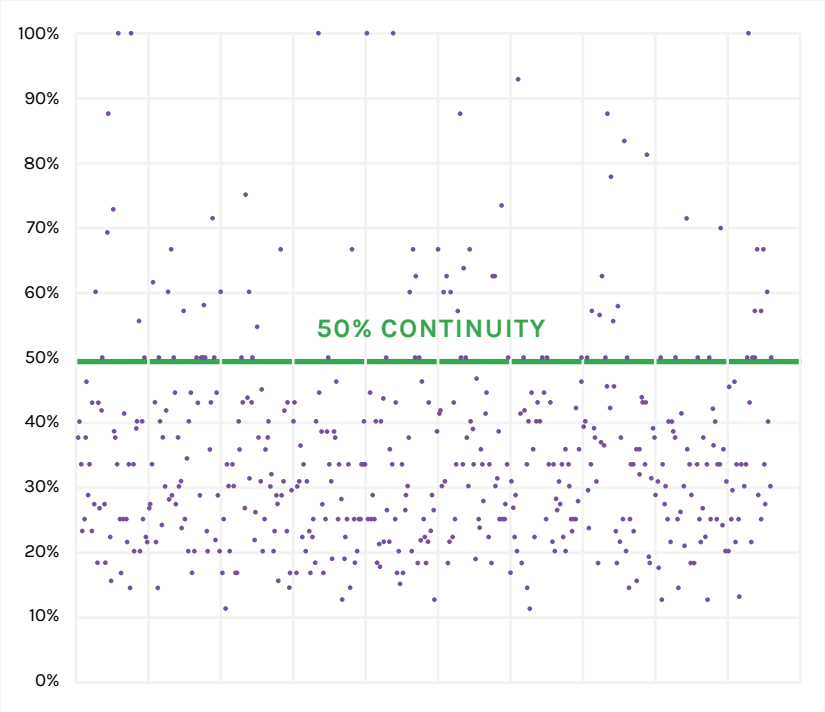
Continuity is a vital component of effective care for high attendees and the overall population, and is directly linked to reducing A&E visits[21]. Upon speaking to GPs about factors impacting how they work, they consistently highlight continuity as a key enabler of quality consultations and relational care.

In our work to support practices, we have observed difficulty measuring and maintaining continuity. Existing continuity metrics, such as the National GP Survey, lack actionable detail and frequency. Real-world challenges – GP working patterns, larger practice structures, extended opening hours – make universal continuity unrealistic.

Thus, **the question must shift from how to give continuity to everyone to how to give continuity to those who need it.**

When we have provided continuity analyses to practices, the extent of the continuity struggles has been enlightening. Even among long-term, high-attending patients, continuity is often lacking. The graph below illustrates the level of continuity for the top 481 long-term high attenders in a large, busy practice over a 10-month period. Each dot represents a patient, and the vertical Y-axis indicates the level of effective continuity for the individual GP that the patient has seen the most. The median level of continuity achieved was 33%.

## Continuity For Long Term Attenders




Sample size 481 patients

Notably, the few patients who exhibit 100% continuity are not only statistical outliers[22], but also all had their highest continuity GP as the on-call Urgent GP – a rotating role designed for a rapid, reactive response rather than long-term care. This is far from ideal for patients attending most frequently.

This lack of continuity, which we have seen over many large practices, is even more stark when we consider the number of GPs seen. The 400+ high attenders in the busy practice above had seen a median of 11 GPs over the 10-month period - highlighting just how fragmented care can be. In other large practices, examining continuity over three-year periods, we have found that high attenders see 20 or more individual GPs / ANPs.

From data like this, we have shown that practices can address this fragmented approach by building systems of continuity that help rebalance the impact of prevailing same-day access systems. Most importantly, greater continuity serves as the foundation for relational care – care that represents the dominant care archetype for at least 21% of consultations[23].

# Section B | Supporting general practice to move towards more effective models of care: 3 core themes

This section explores 3 core themes that can help practices provide more effective care, with positive impacts at practice, local and national levels. They are core to building strong foundations for the key shifts detailed in the NHS 10 Year Plan.

We advocate for a re-orientation of national focus onto effectiveness and quality rather than more narrowly on access and activity volume.

## 1. More activity does not necessarily mean more effective care: instead focus on quality

As discussed, there has been a national push to increase appointment numbers. This has become the focus for much of the improvement support available to practices, as well as a success measure.

While well-intentioned, it risks pushing practices into a supply-driven care trap[23,24], where more appointments don't necessarily translate to better outcomes at a patient or population level.

We advocate for a **re-orientation of policy and practice focusing on effectiveness and quality** rather than more narrowly on access and activity volume.

### This means:

**Practices** should:

- Take steps to understand true demand, as opposed to volume of activity.
- Focus on the effectiveness of appointments and episodes, rather than volume.
- Prioritise systems of continuity for those who need it most.
- Prototype more effective models that seek to see and help people in context (such as asset-based models, longer appointments, group consultations, health coaching and integrated neighbourhood teams).

**The NHS** should (regionally and nationally):

- Re-align support, and focus of policy, on helping practices to improve the effectiveness of their model of care, rather than just parts of it (such as access or appointment volume).
- Invest in helping practices and local systems understand end-to-end costs. Encourage this data to be used over commissioning or budget line data.
- Invest in support for practices to overcome the challenges involved in achieving effective, multi-disciplinary working – both within practices (e.g., with ARRS roles) and with local systems (e.g., with integrated neighbourhood teams).
- Offer flexible, whole-practice improvement support tailored to local practice contexts.

## 2. Fundamentally, clinicians (and patients) control resource use, not managers[25]

Against the national context of a struggling economy, the NHS invests significant time and resources to control costs, implementing cycles of budget review, control and commissioning. Costs have been systematically stripped out in most settings, line by line. Yet, overall system costs continue to creep up.

Part of the problem with this approach to controlling spending is that in healthcare, it is not managers but clinicians who control the lion's share of resource use [23, 25, 27]. This principle and innovative work to support clinicians in the peer-based review of decisions and decision support form the foundation for the phenomenally successful Intermountain Healthcare[27] secondary and primary care cost-effectiveness improvements.

### Supporting primary care clinicians in peer review and scrutiny

In addition to being key for reducing avoidable resource use, peer-to-peer review and scrutiny is the foundation for improving safety and outcomes. Being able to discuss each other's work – moving beyond individual cases to consider patterns in decision-making – is difficult and delicate. It requires not only good data that provokes curiosity and conversation, but also the support and facilitation of skills necessary to engage in these conversations and effectively challenge each other's work generatively.

### This means:

**Practices** should:

- Begin conversations with their clinical teams on the variability of their approach. This goes beyond discussing past and present complex cases to include peer review of patterns of decision-making.
- Protect time for peer review, acknowledging that it will take time and practice to do well.
- Use detailed, relevant data on the variability of decision-making to drive these conversations - for example, carefully curated data combining patterns in post-consultation actions, prescribing, referrals, resource use, long-term attendance patterns and case mix complexity.

**The NHS** should (regionally and nationally):

- Support practices for gathering data to stimulate peer-to-peer discussions on the variability of approaches and resource use.
- Resist the urge to immediately impose externally derived standards. Instead, invest in studying what practices and professions learn from the process.
- Provide coaching support to help practices hold these potentially emotive discussions.

# 3. Understand and revalue the work of general practice, then measure it accordingly

General practice is often referred to as the front door of the NHS, and its value is often reduced to numbers: appointments, completion of tasks and checks, or A&E attendances avoided.

Yet this does general practice an enormous disservice and, combined with systems of coding (labelling needs), provides a distorted view of the needs to be met, as well as the role and purpose of general practice.

### Acknowledging different work archetypes and supporting general practice in more effective models

In the same afternoon, a GP can identify cancer, be confronted with a broken heart, adjust complex drug mixes, support complicated home therapies, be presented with coughs and colds, recognise sepsis, have someone confide in them about domestic violence, plan palliative care, and guide lifestyle changes. Not all of this work fits neat pathways, tight protocols, and standards; rather, it requires relational, flexible, and high-continuity care.

### This means:

**Practices** should:

- Develop a view, across clinicians, of what good relational care looks like.
- Look beyond coded or labelled needs to understand real patient contexts.
- Track continuity using meaningful measures beyond that provided by the GP National Survey.
- Build access systems to achieve high continuity for those who need it.
- Prototype extended consultations, group-based consultations, health coaching techniques, asset-based community care, and comprehensive multi-morbidity long-term condition care.

**The NHS** should (regionally and nationally):

- Re-orientate the use of work specifications, decision support, guidelines, and protocols to support – not fragment – relational care. This may mean reducing task focus to liberate professionals to do what matters for patients.
- Re-calibrate measurement and management focus towards achieving effectiveness rather than volume of activity.
- Measure and act upon systemic sources of failure demand – demand that burdens general practice but is caused by problems in the wider system.

# 4. **Summary and Conclusion:** Prioritising effectiveness over volume – vital for general practice and beyond

This paper highlights several key areas where practice processes either drive patient demand or fail to manage it effectively. Despite increasing the number of clinical appointments, practices are not necessarily seeing more people, but they are seeing people more often. Issues such as poor continuity, a focus on providing same-day access, and existing patterns of inequality often work against the best interests of both patients and practices – potentially increasing avoidable demands.

Through our research and support with practices at a National level we have identified 7 key signs or areas in which we are losing capacity and effectiveness within practices and the system:

1. Failure Demand
2. Access Inequalities
3. Access at the expense of planned care
4. Looping patients
5. Variability in post consultation actions
6. First Contact Resolution (RFT – Right First Time)
7. Continuity

In order for practices to better understand these areas they need to collect and evaluate their own data for their population and provision of services, focussing on demand and capacity.

This simple analysis will help practices to identify ways to improve processes, manage patients and work across the NHS network to improve the coordination of care and losses we currently see in capacity.

The emphasis on volume and access, whether intended or not, has led to more pressured patient touchpoints and thus more time being spent managing risk, with less time for understanding the underlying causes of poor health, providing proactive care, educating patients, and addressing needs. Patients often present with multiple issues during consultations, which are typically addressed by different professionals. Patient looping then begins, with practices seeing the same individuals repeatedly because their problems weren't fully addressed the first time. Longer, more in-depth consultations, with higher continuity and lower unwarranted variation, offer a major opportunity to break this cycle of looping. Clinicians can then better understand and address the root causes of health issues rather than just managing symptoms. With time to build relationships and a foundation for more effective care, the need for repeat visits may ultimately be reduced.

In summary, the focus from system leaders should be on the delivery of high quality, rather than high volume, care. This means re-orientating the measurement and commissioning of general practice to reflect this – otherwise the intention will purely be lip-service. By prioritising effectiveness and addressing the root causes of health issues, practices will improve patient outcomes and reduce the need for repeat visits, ultimately benefiting both patients and clinicians. While this paper focuses on the core need for robust general practice, the narrative provides important prompts for those in other services, including new neighbourhood teams – the learning transfers and, without careful consideration, the same volume traps will repeat.

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