

BMA

Responsive, safe and sustainable: our urgent prescription for general practice

April 2016



British Medical Association
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General practice is facing increasing and unprecedented pressures. There is a significant and growing gap between the demand placed upon it and its capacity. These pressures are not limited to one area; general practice is being forced to try and cope with an unsustainable workload, a workforce crisis and inadequate resource. This is in addition to cuts to individual practices through correction factor changes and PMS reviews.

There is no single magic bullet to address the many issues facing general practice. However, it is clear that significant and multifaceted action to resolve this current crisis is needed, primarily by Government, NHS England and Clinical Commissioning Groups (CCGs), but also by practices and GPs, and supported locally by Local Medical Committees (LMCs) and nationally by the BMA GPs Committee (GPC). The actions required are both immediate as part of a 'rescue package', and long term to provide a sustainable, viable and vibrant future for general practice. The list of actions is not exhaustive, but is a good starting point for beginning to address the challenges facing us. This document builds on and summarises the issues and solutions often highlighted by the profession, and outlined in a number of key documents including the following:

- [Developing general practice today: Providing healthcare solutions for the future](#), GPC, December 2013
- [Quality First: Managing workload to deliver safe patient care](#), GPC, January 2015
- [The Future of Primary Care: Creating teams for tomorrow](#), Primary Care Workforce Commission, July 2015
- [Responsive, safe and sustainable: Towards a new future for general practice](#), GPC, September 2015

An urgent prescription for general practice

An urgent prescription for general practice

The following key areas must be addressed to turn around the current crisis facing general practice:

- **Fair and sustainable funding and resources** to reach a minimum of 11% of NHS spend to cover the work of general practice and to resolve the funding deficit of around £2.5bn
- **Reducing workload to ensure delivery of safe and high quality care** with a national standard for a maximum number of patients that GPs, nurses and other primary care professionals can reasonably deal with within a working day and greater clarity about what work is appropriate to be delivered by practices
- **An expanded workforce**, both within and around the practice
- **Reducing the regulatory burden of the Care Quality Commission (CQC)** to prevent time and resource being taken away from service provision
- **Reducing bureaucracy and duplication to empower professionals** and to give more time to meet the needs of patients
- **Empowering patients** to give them confidence to manage their care and to free up GPs' time for those who need it most
- **Infrastructure and technology to deliver practice and system resilience** to ensure practices are able to deliver the services needed

Fair and sustainable funding and resources

Fair and sustainable funding and resources

Problem: The percentage of NHS funding spent on general practice has fallen from 10.4% in 2005/6 to 7.4% in 2014/15, leaving practices receiving an average of only £141 per patient to deliver a year of general practice care.¹ This means general practice has an effective funding deficit of at least £2.5bn.

Impact: General practice does not have sufficient funds for workforce, premises or services to meet the growing needs of patients and this is undermining the safety of care delivered.

Actions:

- Government must commit to incremental recurrent funding in general practice, to reach a minimum of 11% of NHS spend. This would require funding the current deficit of at least £2.5bn in addition to the £8.3bn spent on general practice in England in 2014/15 and £9.8bn spent across the UK. This funding commitment will require a rebalancing of NHS resources to where care is delivered, in the context of care moving out of hospital.
- Provision of an immediate stabilisation fund for general practice to provide emergency support to vulnerable practices at risk of closing, or where safe patient care is significantly compromised.
- Establish a healthcare resilience task force within each CCG or locality area to provide support to vulnerable or at risk practices, which could include the provision of management resources, clinical input, proactive support, eg for unfilled vacancies, project management support or technology support which could be called upon at short notice for a practice in crisis. This should be developed in liaison with LMCs and needs to operate in a non-threatening and non-judgemental culture to support openness.
- Increases in indemnity insurance costs for all primary care practitioners should be fully reimbursed or paid for by NHS England, and steps taken to introduce a sustainable system of indemnity for those working in primary care comparable with clinicians working in secondary care.
- The funding allocation formula for practices should fairly reflect the workload of practices, including activity common to all practices that is not related to the demographics of the patient population.
- Practices serving atypical populations should be supported through dedicated bespoke funding allocations.
- A long term mechanism should be agreed to calculate and fully fund practice expenses including direct reimbursement of expenses incurred specifically to deliver NHS services.

Reducing workload to ensure delivery of safe and high quality care

Reducing workload to ensure delivery of safe and high quality care

Problem: Consultation rates and numbers have dramatically increased. The needs of many patients have become much more complex, with many being less confident to manage self-limiting conditions. Additionally, increasing amounts of work have moved from secondary care to general practice, often inappropriate and unfunded, and the bureaucratic burden on practices and practitioners has increased.

¹ BMA calculations based on NHS budget TDEL, source PESA. GP investment, source HSCIC NHS budget TDEL, source PESA. GP investment, source HSCIC

Impact: Workload pressures are undermining the safety of care to patients, with 93% of GPs reporting that heavy workload has negatively impacted on the quality of patient services. 9 in 10 GPs believe that the 10 minute consultation is inadequate to meet patients' needs. 34% of GPs are considering retiring in the next five years, and 17% of GPs are considering less than full-time working due to workload pressures, hence reducing GP capacity further.²

Actions:

- Set a national standard for a maximum number of patients that GPs, nurses and other primary care professionals can reasonably deal with during a working day to maintain delivery of a safe and high quality service.

- Establish locality hubs to which practices can refer urgent patients when they have reached the capacity threshold for safe care on any given day. These hubs will not be walk-in-centres, but services that practices can refer to when required. Their primary purpose will be to provide the support necessary for a sustainable service at practice level. See [Locality hubs](#) for further information. These hubs can ultimately:
 - › become centres for training, development and recruitment
 - › host much of the wider primary healthcare team
 - › organise care home provision
 - › control and cost care being moved into the community from hospitals and other sources.

- Provide organisational development funding and support to enable collaboration between practices and others within their locality, including the development of practice networks and multispecialty community organisational arrangements, building on current GMS/PMS contracts. Such networks can be used to:
 - › support individual practices with workload, including the development of locality hubs
 - › encourage sharing of back office functions and administrative support
 - › expand services in primary care, with the managed transfer of care out of hospital
 - › develop the general practice and primary care workforce, aligning the diversity of the GP profession with local identity
 - › develop sustainability.

- Ensure GPs and other practice team members are enabled to routinely offer 15 minute consultations or longer where necessary for patients with greater needs such as complex or multiple morbidity. This may result in a waiting list for routine appointments in the interests of patient safety. To mitigate this, NHS England and commissioners can expand capacity by resourcing locality hubs, skill-mix, manage demand, and commission direct access to other providers in order to release GP capacity

- Optimising the care of patients in their own home:
 - › dedicated community nursing teams fully integrated with GP practices, to provide case management of frail elderly patients including being the first point of contact for appropriate home visits.
 - › CCGs to arrange patient transport services for appropriate patients to attend GP surgeries, as is currently the case for similar patients accessing hospital outpatient clinics
 - › expansion of community nursing independent prescribing to avoid contacting a GP for the sole purpose of issuing a prescription
 - › CCGs to commission specialist and multi-professional rapid response teams or similar to support early discharge of patients. This will help to avoid inappropriate demands on GPs, and will serve patients' needs with timely dedicated support
 - › hospitals to directly arrange community nursing, rehabilitation or social support in the community for patients being discharged from hospital.

- Separate contractual arrangements, such as a new Directed Enhanced Service or multi-professional contract, for dedicated care of patients in nursing and residential homes, and frail elderly housebound patients, providing significant new funding to enable the creation of multi-professional teams and appropriate specialist input to better meet the needs of this group of patients.
- Establish a national list of services that are not included in core GMS which practices can choose if they wish to provide, with pricing benchmarks nationally set that can be locally adapted according to any variations.
- Stem inappropriate clinical and bureaucratic workload shift onto GP practices, including the following:
 - › define a specification for appropriate, related internal hospital referrals, eg a rheumatologist to a pain clinic, with the practice to be copied in
 - › ensure that hospital initiated investigations are followed up and actioned by the requesting clinician, including communicating with the patient, in keeping with the recent NHS England guidance³
 - › hospital clinicians to use HFP10s and be enabled to use an electronic prescription service for the initiation and ongoing prescribing of specialist medication – ending the current inappropriate workload and clinical governance risk of GPs prescribing outside their competence and for clinical decisions for which they are not responsible
 - › hospital practitioners prescribing a full course of treatment when initiated in out-patient clinics
 - › enable community nursing teams and other allied health professionals to be trained and accredited to prescribe independently, and to make appropriate direct referrals where appropriate (eg to an incontinence nurse or social services)
 - › end employers of community nurses insisting on patient specific directions for items that have been prescribed
 - › introduce pathways for granting permission for low priority procedures to be streamlined, including appeals procedures that do not necessarily involve the GP
 - › hospital practitioners to issue fit notes for patients at discharge or in out-patient clinics for full duration of recovery
 - › enable patients to contact hospital clinicians directly for queries relating to their clinical management in hospital, rather than being redirected to their GP
 - › enable patients to book all transport to hospital appointments directly with the service without the need to involve the practice
 - › enable hospital doctors to directly book investigations using a commissioned and resourced community phlebotomy service as opposed to asking the GP to do so
 - › information about all patient contacts being sent electronically or added directly to the patient record within 48 hours of a patient being seen
 - › ensure that discharge processes from secondary care are always followed and that community support for the patient has been arranged by the hospital where needed prior to discharge
 - › ensure all shared care protocols are only implemented if the GP is willing and able to take on the additional clinical responsibility and workload and is additionally resourced.
- Ending inappropriate workload shift with effective CCG commissioning, to be taken forward locally with the support of LMCs:
 - › LMCs, practices and CCGs should coordinate local strategies, including electronic service alerts via templates on clinical systems for CCGs to take action
 - › CCGs should put in place troubleshooting staff to address problems of inappropriate workload shift flouting local commissioning agreements, to avoid practices incurring bureaucratic time
 - › all hospitals should provide a dedicated GP helpline to address primary/secondary care interface problems

³ [Standards for the communication of patient diagnostic test results on discharge from hospital](#), NHS England 2016

- Universal access to and promotion of Pharmacy First (or other minor ailment) schemes, including the provision of medications without charge for patients who are exempt from prescription charges.
- Enable patients exempt from NHS prescription charges to directly access products such as gluten-free products, other food supplements, dressings, appliances and stoma products without the need for GPs to prescribe these items, with appropriate regulatory changes made to make this possible.
- End the GP role in assessing the eligibility for bus passes, parking badges, housing, gym membership and other similar non-NHS work and ensure that this work is commissioned from an appropriate source by the requesting organisation, eg the local authority or CCG.
- Clear definition, funding and enforcement of payment of all collaborative services.

An expanded workforce in and around the practice

An expanded workforce in and around the practice

Problem: In the last decade the number of hospital consultants has increased by 48%, while GP numbers have increased by only 14%, and since 2009 the number of GPs per head of population has declined.⁴ GP training posts are not being filled, and increasing numbers of older GPs are planning to retire. There is a similar recruitment and retention crisis in practice nursing, with a fall of community nurses of 38%.⁵ Further, there are increasing numbers of GP partner vacancies, adding often unmanageable workload burden on a smaller pool of partners.

Impact: The reduced capacity of the general practice and community workforce leads to increased workload burdens, increased practitioner burnout, delays in access to appointments, and care that is fragmented or potentially unsafe being provided. All these factors lead to a vicious circle, impacting further on morale, recruitment and retention. Governments' attempts to resolve some of these issues through the use of APMS contracts has often made the situation worse, not better.

Actions: While there are inadequate numbers of GPs currently, there needs to be use of skill-mix built within and around the framework of the GMS/PMS contract, to support GP pressures, ensure retention of the current GP workforce, while creating definitive solutions to improve recruitment to expand the GP workforce.

- A step change in GP recruitment initiatives with a clear and credible plan to recruit more GPs.
- Immediate resources to fund an expanded and comprehensive primary care team to reduce and relieve GPs' workload, including fully funded clinical professionals to work directly with practices, including pharmacists, mental health practitioners, advance nurse practitioners, physiotherapists, medical assistants and physician associates.
- Direct access to services to avoid GP first point of contact, eg:
 - > extended scope practitioner eg direct access physio
 - > specialist nurses for chronic diseases (eg diabetes, epilepsy, rheumatoid)
 - > mental health services
 - > Pharmacy First and minor ailment schemes
 - > health visitors
 - > district nursing services.

⁴ [The Future of Primary Care: Creating teams for tomorrow](#), Primary Care Workforce Commission, July 2015

⁵ [The Future of Primary Care: Creating teams for tomorrow](#), Primary Care Workforce Commission, July 2015

- Establish closer links between community pharmacists and practices where this can support GP workload.
- Commission a comprehensive and nationally defined community nursing team to support and work with each practice in an integrated manner.
- Expand the number of hospital based clinicians delivering care in the community working in partnership with primary care clinicians.
- Dedicated funding to support GPs to develop portfolio careers and specialist skills to improve recruitment and retention, eg an individual professional development budget that a GP could use over the 5 year revalidation cycle
- Establish training hubs for enhanced training for practice managers and other practice staff.
- Further reduce the bureaucratic burdens of the returner scheme.
- Improve the investment in and promote the retainer scheme.
- Encourage permanent GP practice placements with inducement schemes.
- Alongside the model GMS salaried GP contract, develop a nationally defined employed GP contract modelled on the hospital consultant contract for those GPs working for other providers or GP led organisations.
- Investing in the GP out-of-hours service to enable an expanded and sustainable clinical workforce, addressing issues such as additional indemnity costs. This would also support the development of a clinically appropriate integrated seven-day *urgent care* service.

Reducing the regulatory burden of CQC

Reducing the regulatory burden of CQC

Problem: The process of CQC registration and inspection duplicates work already done by other bodies, is disproportionate and costly in time and resource, is not evidence based, is demoralising and therefore is not fit for purpose.

Impact: The 2016 BMA survey showed that 8 out of 10 GP practices report that preparing for a CQC inspection resulted in a reduction in time available to care for patients.⁶ Almost 9 out of 10 GP practices said that on the day of the CQC inspection, staff had to reduce GP services available for patients. Three quarters of practices reported that staff suffered from significantly increased stress in preparing for and undergoing inspections, but only 1 out of 10 (11%) regarded their final CQC rating as a fair assessment.

Actions:

- Replace the current flawed and erroneous content and pattern of CQC visits and ratings, with targeted assessments of essential quality assurance processes where supported by evidence of risk of patient safety.
- End the duplication of the current CQC registration process and NHS England managed national performers list and performance management arrangements, with a single slimmed down cost-effective process funded by NHS England not practices.

⁶ [BMA's CQC Survey 2016](#)

- Separate the regulation of safety and competence from quality improvement. CQC should be concerned that adequate quality assurance systems are in place, rather than conflating 'regulation' with 'quality improvement'. Develop quality improvement as a professionally agreed peer review rather than a regulatory process, using a limited number of clinically relevant and important indicators that can be used by practices to compare their activity with peers. This should be managed and resourced via NHS England and CCGs drawing upon the Health Foundation's report on measuring Quality in General Practice.

Reducing bureaucracy and duplication to empower professionals

Reducing bureaucracy and duplication to empower professionals

Problem: The increased bureaucratic burden created to assess, performance manage and regulate general practice has dramatically increased in the last decade, costing significant amounts both in lost clinical time with patients and financial resource for the NHS and practitioners.

Impact: The burden of unnecessary bureaucracy has disempowered professional clinicians and undermined their morale, added unnecessarily to practice and NHS management workload, resulted in significant duplication, misled patients, and wasted millions of pounds that could have been better spent on direct patient care.

Actions:

- End the Quality and Outcomes Framework and invest the unweighted resource in the core GMS/PMS contract, developing in its place a professionally-led system that encourages and celebrates quality of care delivered and is not linked to financial targets.
- End the Avoiding Unplanned Admission enhanced service and invest the unweighted resource in the core GMS/PMS contract to enable practices to care for vulnerable patients without the added and unnecessary bureaucracy of this scheme.
- Review the bureaucracy and frequency of the appraisal process and reduce so-called 'mandatory' training requirements.
- Provide at least half a day of protected funded time every month for all GPs and practice staff to engage in learning and professional development.
- End the annual cycle of GP contract negotiation and provide stability of contract to practices.
- Reduce the bureaucracy involved in moving between the nations' performers lists, particularly when working in border areas.

Empowering patients to give them confidence to manage their care

Empowering patients to give them confidence to manage their care

Problem: The lack of focus on and support for educating patients to self-manage conditions where appropriate, particularly in the case of long-term conditions. Patients' confidence in managing self-limiting illnesses needs to be encouraged and developed to help to reduce unnecessary visits to their GP, and to ensure patients know which service to access, and when. Empowering patients to self-care when they are able to do so and to visit their GP when they need to is vital to ensure that patients have greater control over their own health, and that GPs' time is used where it is most needed.

Impact: Consultation rates and demands within consultations have dramatically increased leading to increased waits for appointments, and inadequate consultation time to meet the needs of patients, undermining access and quality, and leading to increased stress amongst GPs and staff.

Actions:

- Develop a national programme and publicity to give patients greater confidence to self-care and to help them to make the right decisions about when and where to access NHS services to reduce avoidable pressures on GP appointments. The commitment in the 2016/17 GP contract agreement for NHS England and GPC to discuss a national promotion of self-care and appropriate use of GP services is welcomed and must be built upon. This includes supporting and building on self-care week.
- Greater use of accredited web tools and healthcare apps designed specifically to support patients in self-care, as well as provision of software on GP systems with self-management information and signposting at time of patient online booking.
- Support the development of expert patients to better manage chronic conditions. These patients can also be used to provide support to other patients seeking advice and guidance.

Infrastructure and technology to deliver practice and system resilience

Infrastructure and technology to deliver practice and system resilience

Problem: Primary care has had to cope with historic underinvestment in practice premises, fragmented IT development and limited support for development of people or systems. There is also considerable potential for technology to ease GP and practice workload with efficiencies.

Impact: Practices are unable to respond to increased demands from patients or the service because of limited or no space in their premises, computer hardware that is not kept up to date and IT connections that do not have sufficient bandwidth to cope with demand. Fragmented IT development leads to difficulty achieving interoperability which limits collaboration and undermines the quality of care that can be provided. Lack of investment in people and system support has left some practices isolated and vulnerable.

Actions:

- The introduction of a comprehensive investment plan to ensure all primary care premises are fit for purpose with a rolling programme to ensure all practices that require it have a purpose-built surgery, working with NHS bodies, Local Authorities and third-party developers where necessary.
- Enable current GP partners to seek shared or full ownership of their practice premises, where this is within the CCG's Estates Strategy, and introduce break clauses in the Template lease with NHS Property Services to address the 'last man standing' phenomenon on contract termination.
- Ensure the delivery of fit-for-purpose, fully funded, information technology packages, which incorporate user-identified improvements, including:
 - › improved clinical communications, such as:
 - i. GP2GP record transfers
 - ii. electronic Prescription Service
 - iii. electronic advice and guidance requests and other clinical messaging between primary and secondary care clinicians, with agreed data ready to be saved, or automatically entered, into the GP record
 - iv. ensuring all hospitals make available bookable electronic appointment slots across all services, to avoid patients attending the GP surgery to chase up delays in appointment notifications
 - › national GP data collection systems, allowing reliable automated extracts to minimise practice workload in the manual submission of data, eg for vaccination programmes

- › investment in secure remote access software and hardware to clinical records through mobile technology, to allow flexibility for GPs when working away from the surgery, eg for housebound patients
 - › interoperable systems between GPs and other healthcare providers participating in the patient's care, to facilitate the sharing of information, where there is a legitimate and appropriate need, both in and out of hours
 - › hospitals to be enabled to directly access results and clinical records relating to care provided to patients from other providers, rather than the bureaucracy of asking the GP practice to retrieve and send such information
 - › improved document and workflow management systems to manage information between clinicians and staff within a practice, eg hospital correspondence. Systems should allow staff to route relevant letters to the appropriate clinician, with an audit trail
 - › patient self-booking appointment screens and kiosks for the self-input of data (eg health questionnaires) which can reduce the need for contact with receptionists and reduce staff workload
 - › a rolling programme of regularly updated IT hardware and software to ensure practices can respond to a rapidly changing environment
 - › single logon to multiple systems to enable clinicians to move from one application to another without the need for repeated sign in
 - › ongoing practice choice of clinical systems.
- National guidance on data sharing, including template data sharing agreements, agreed between the BMA, NHS England and the Information Commissioner's Office.

Ensuring the delivery of a responsive, safe and sustainable general practice service

Ensuring the delivery of a responsive, safe and sustainable general practice service

The Government and NHS England have explicitly acknowledged the parlous state of general practice, and the need to address this, including more resources.

GPs, LMCs, GPC and patients expect more than just a commitment to general practice; that both the Department of Health and NHS England should be held to account to deliver on their words with implementation of a significant and sustained rescue package. Above all, urgent steps are needed to address the funding deficit that is at the root of the current crisis facing general practice. A decade of under-investment has to be reversed to provide renewed stability to the general practice service which is the foundation on which the NHS is built. Without this, more practices will close, more patients will be put at risk of exposure to unsafe care or have to travel further to access primary health care, fewer junior doctors will chose general practice as a career and costs to the NHS will increase.

Taken together, the implementation of these actions put forward by GPC will go some way to address the crisis facing general practice.

GPC nationally and LMCs locally now stand ready to work with the Government and NHS England as a matter of urgency to not only rescue general practice but to move instead towards the development of a responsive, safe and sustainable general practice service of which we can all be proud.

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BMA 20160280