BMA

England

Saving general practice

November 2017

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British Medical Association
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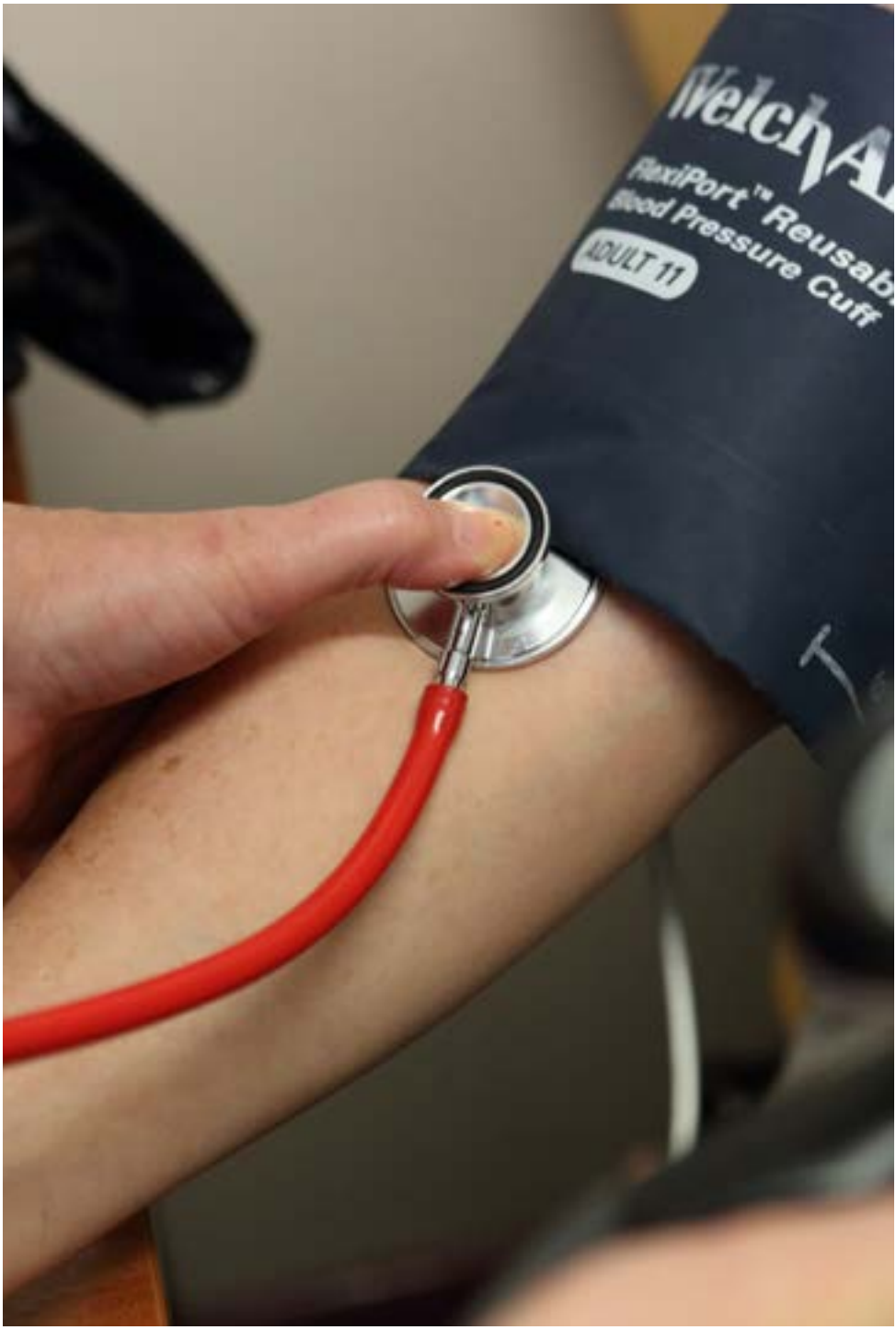
General practice is often referred to as the cornerstone of the NHS; the foundation on which a world-renowned health service is built enabling the delivery of high quality care, free at the point of access, to the whole population. It is inherently flexible and adaptable and has always risen to meet new challenges including increasing demand, and keeping up with a steady stream of ever evolving regulatory arrangements and management system changes. However, it has had to do this against the backdrop of an acknowledged decade of underfunding[1] and a failure by Government to address the urgent challenges facing primary and community care services. As a result, the foundation on which the NHS sits today is cracking and can no longer withstand the weight it is expected to bear.

In response to rising pressure and growing concern over patient safety, GPs across England participated in a survey about their willingness to close patient registration lists to maintain safe workload levels.The BMA found that 54% of practices said they would be willing to temporarily suspend patient registration, whilst 44% said they would be prepared to close their list altogether.

With an insufficient workforce, a funding plan that is no longer sustainable, a growth in population and a sea-change in the level of complex cases being presented, urgent steps need to be taken to save general practice. The health and wellbeing of our nation depends upon it.

1 NHS England General Practice Forward View 2016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The BMA's case to save general practice

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

- **Recurrent and sustainable funding and resources** to secure a minimum spend of 11% of the total NHS budget invested in general practice; a funding deficit that is currently estimated at £3.7bn

- **A workforce strategy that is recurrently funded to enable an expansion** of a collaborative multi-disciplinary general practice and community workforce working both in practices and within localities

- **A sustainable, long-term indemnity package for general practice** that covers all GPs on the national performers list and all staff providing NHS general practice services both in and out of hours (OOH)

- **Enabling practices to manage their workload in order to deliver safe services and empower patients and carers as partners in care**

- **The retention of a national core contract for general practice that provides a high-quality service for patients**

- **Premises, IT infrastructure and administrative support to enable the delivery of quality care**

1

Recurrent and sustainable funding and resources

'General practice, with its registered list and everyone having access to a family doctor, is one of the strengths of the NHS, but it is under severe strain'
Five Year Forward View

Problem: It is widely accepted, including by NHS England and other bodies, that general practice has had to cope with a decade of underinvestment at a time when patient consultations are increasing, the population continues to grow, and patients are living longer with more complex health needs. Problems such as these not only affect general practice, but also extend across the health service leading to an overall pressure that doctors in primary care and secondary care alike are struggling to cope with. To address this issue, the BMA has been clear in calling for an increase in funding for the NHS overall to match health spending in equivalent European countries[2]. In 2005/06, the proportion of the NHS budget devoted to general practice (excluding drugs reimbursement) was 9.6%, however, that figure is now shown to have dropped to a mere 7.9% in 2016/17[3]. This decline in funding has been compounded by an increase in the total number of patient registrations of more than two million since 2013[4], inevitably leading to an increase in workload and further cost implications on practices.

Whilst commitments set out in the General Practice Forward View (GPFV) to invest in general practice over the coming four years by at least £2.4bn[5] are welcome, they remain wholly insufficient to either restore the share of NHS funding allocated to general practice to 2005/06 levels, or reach the BMA's 11% target, which this year leaves a funding gap of £3.7bn[6]. Although this gap will improve slightly by 2020/21, an additional investment of £3.4bn on top of the £2.4bn promised in the GPFV will still be needed to reach the BMA's recommended target[7].

2 British Medical Association (2017) Position on health spend
3 BMA Investment in General Practice September 2017
4 NHS Digital: Patients registered at a GP practice October 2017
5 NHS England General Practice Forward View 2016
6 BMA Investment in General Practice September 2017
7 The BMA has used the Department of Health Total Departmental Expenditure Limit (TDEL) to determine NHS funding. This differs from the approach used by NHS England in the GPFV, where the NHS England budget is used. Both approaches are valid, but we have used TDEL as this provides, in our view, a more consistent picture over time.

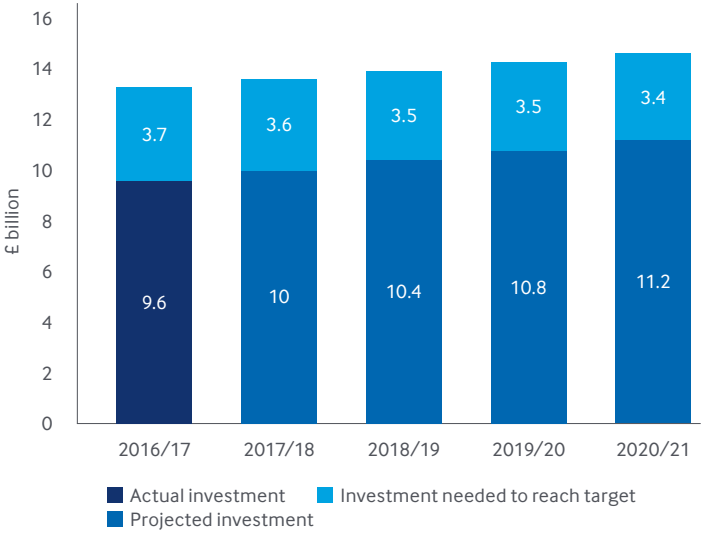
Impact: General practice is facing an unprecedented crisis with inadequate resources to fund an expanded workforce, manage workload levels safely, and meet growing public demand. The proportion of patients waiting more than two weeks for an appointment has risen to a record high of 20% – up from 12% five years ago[8]. Despite GPs consulting more, the needs and expectations of patients are increasingly being unmet, largely due to the failure to address increasing staff shortages and insufficient funding. With nine out of ten GPs reporting that their workload is unmanageable, future services are currently at risk[9]. Increasing numbers of practices are applying to close their lists as they simply cannot deliver a safe service to a growing population with the limited resources provided to them.

Actions:

- A firm commitment from Government to increase the overall proportion of NHS spend in general practice to at least 11% in response to the rising workload in general practice, reaching a total funding target of £14.6bn by 2020/21. This must be from new investment and not as a result of diverting funding away from other NHS and public health services
- A change from multiple, short-term, non-recurrent funding schemes, to sustainable, recurrently funded schemes that enable long-term planning
- Recurrent funding for working at scale arrangements to recognise the management costs associated with these structures
- A general increase in funding for health and social care services in line with equivalent European countries[10]. The BMA has estimated that health funding in England is £7.3bn behind the average spent by comparable European countries and this could rise to over £11.6bn by 2020/21[11]
- Publication and transparency of information on what money CCGs are investing in general practice on an annual basis
- Clearly tracked and documented investment in general practice to ensure resource delivery adequately matches resource planning

8 *Briti*sh Medical Association (2017) Analysis of GP patient survey 2017
9 *Briti*sh M*edical Association (2016)* Patient safety under threat from pressures in General Practice
10 British Medical Association (2017) Position on health spend
11 BMA: What does the future hold for NHS funding?

Figure 1: Investment in general practice excluding drug reimbursement (cash terms) 2016/17 – 2020/21.



Source: BMA Investment in General Practice report, September 2017.
Note: Projections for the total cost of drugs reimbursements is based on figures from 2011 – 2016

Outcome for patients: With more funding, general practice could invest in premises, expand services, increase the workforce, lengthen consultation times and reverse the current trend towards increasing numbers of patients having to wait more than two weeks for an appointment. A general practice supported by 11% of the NHS budget could offer greater continuity of care to patients, and would be able to help deliver a more sustainable future for the NHS as a whole.

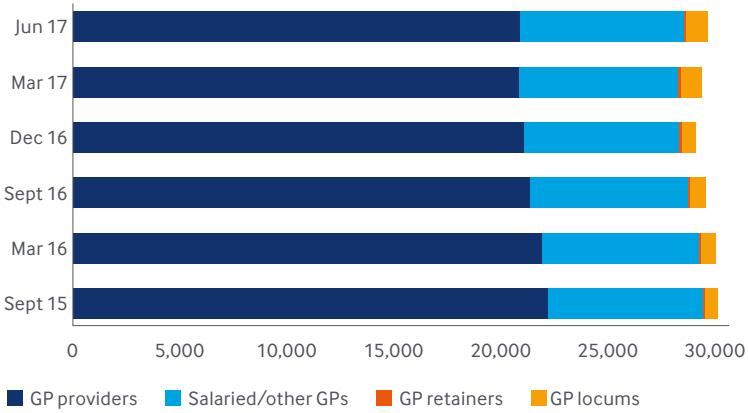
With recurrent and sufficient funding, general practice could meet the needs of our growing and increasingly ageing population and provide the continuity of care that patients deserve. GPs could work alongside an expanded workforce and develop more community based services delivered from practice premises fit for the 21st century. Sufficient funding would enable practices to ensure quality and safety levels are maintained and that they have the capacity to be open to all those patients who wish to register with them.

2

A workforce strategy that is recurrently funded and based on genuine expansion

Problem: From March 2016 to March 2017, the total number of FTE (full time equivalent) GPs fell by 678 (-2.3%)[12]. Not enough doctors are choosing general practice as a career and many GPs are reducing their time commitment or leaving altogether. This is in response to rising workloads and the NHS pay cap since 2011 that has compounded a real terms decrease of more than £31,000[13] (23%) in GP's pay in England since 2005/06. General practice is consequently experiencing one of the most severe recruitment and retention crises in decades. In addition, many of the workforce schemes in England are based on role substitution rather than an expansion of the general practice workforce. Time-limited funding for these schemes provides little or no long-term sustainability.

Figure 2: Number of full time equivalent GPs in England since the introduction of the (primary care) Workforce Minimum Dataset (2015)



Source: NHS Digital General and Personal Medical Services, England as at 30 June 2017, Provisional Experimental statistics (August 2017)

12 General and Personal Medical Services, England As at 30 June 2017, provisional Experimental Statistics

13 GP Earnings and Expenses 2002/03 to 2015/16 Real Terms UK/England/Scotland/Wales/Northern Ireland

Impact: Patients are waiting longer for appointments to see a GP while practices are unable to recruit GPs or nurses with many carrying long term vacancies. Growing numbers of practices are either closing their lists to new registrations, in order to manage their existing population safely, or closing altogether resulting in the loss of a local GP service for some communities.

Actions:

- Government must establish a workforce strategy based on a genuine expansion of a multi-disciplinary workforce that is recurrently funded
- Establish a retention scheme for GP partners that encourages them to remain in the profession
- Utilise existing CCG recurrent resourcing, both financial and human, to support workforce expansion within practices and localities, shifting management resource to support direct patient care as CCGs merge and focus primarily on commissioning
- Provide a national definition for multi-disciplinary locality teams working to support general practice, with built-in flexibility for different localities, so that patients in all areas of the country can consistently access a fully staffed community based healthcare team
- Remove the differential for maternity and sickness reimbursement between GPs and practice staff
- Provide direct access to community physiotherapy schemes for every practice
- Secure full recurrent funding for pharmacists for every practice
- Commission an expansion of the Improving Access to Psychological Therapies (IAPT) service with mental health therapists linked to every practice
- Establish Child and Adolescent Mental Health services (CAMHs) linked to every practice
- Fund an expansion of community nursing services aimed to directly support general practice
- Provide training grants to support the training of nurses and allied healthcare professionals in general practice settings
- Increase funding and decrease bureaucracy for the GP returners scheme, and ensure accessibility for GP partners
- Further support for funded training programmes for doctors from disadvantaged areas
- Improve opportunities for flexible working and promote portfolio career options
- Ensure that increasing demand for flexibility is factored into future workforce planning.

- Design a holistic strategy to utilise and engage with salaried and locum GPs as a key element of the GP workforce
- Establish comprehensive occupational health services freely accessible for all primary care staff
- Secure full recurrent funding for practice manager training, and to support practice manager networks
- Establish an ongoing commitment to the international recruitment of GPs that includes a structured induction and mentoring scheme
- Create stability in the workforce by granting permanent residence to all existing EEA doctors currently working in the UK
- Establish clear employment policy that ensures all existing EEA doctors working in the UK will be given indefinite right to remain
- Add General Practice to the Migration Advisory Committee's Shortage Occupation List
- Work with the profession to promote careers in general practice

Outcome for patients: A clear, recurrently funded workforce strategy based on a genuine expansion of multi-disciplinary teams, could provide significant benefits for patient experience. With the potential for easier, more appropriate access to the care they need when they need it, this would significantly reduce the number of visits patients would have to make to see their GP.

Evidence suggests that clinical pharmacists can improve access to healthcare, improve patient safety through a reduction in hospital admissions and consequent adverse effect of medicines, and reduce medicines wastage and overuse[14].

Recurrent funding (whether from CCGs or national streams) is needed for practices, either singly or working with others in a locality, to enable patients to benefit from better access to other clinicians, such as physiotherapists and mental health therapists. This has potential to reduce the need for patients to make multiple visits to different care sites, a reduction in the number of overall GP appointments, and enable working adults to avoid unnecessarily prolonged sick leave. In addition, proper investment in the workforce, dealing with workload pressures that risk making clinicians themselves unwell and putting in place strategies that make them feel valued and supported, is likely to lead to greater retention of staff resulting in more continuity of care for patients.

14 General Practice Forward View, Clinical Pharmacists in General Practice Phase 2

3

A sustainable, long-term indemnity package for general practice

Problem: Figures show that indemnity fees for scheduled care have risen to approximately £8000 per GP per annum, an increase of more than 50% over the last 6 years15. However, this means that for many GPs working full-time, indemnity bills are significantly more – and for GPs providing out-of-hours sessions the amount they pay is even higher. The sharp fall in the personal injury discount rate announced by the Lord Chancellor in February 201716, will mean that settlements for personal injury compensation claims will significantly increase. Without direct government intervention, indemnity premiums could potentially double to protect against these increases, and have catastrophic consequences for the workforce in general practice.

Impact: A decade of underfunding and a repeated government failure to prioritise general practice has resulted in a workforce crisis. With financial pressure across primary care already at an all-time high, the unsustainable rise in indemnity costs are forcing GPs to restrict their working hours, limiting their ability to work in urgent care and out of hours settings, and in many cases drive experienced GPs into early retirement. It is also restricting practices' ability to recruit new GPs, or other healthcare professionals within localities, and is impacting on the expansion of the multidisciplinary workforce as the financial burden of providing indemnity cover for other healthcare professionals often falls on the practice or individual GP partners. In addition, the significant differential between primary and secondary care indemnity fees is pushing much needed potential future GPs away from a career in general practice.

15 Department of Health GP Indemnity Review July 2016
16 New Discount Rate for Personal injury claims, Elizabeth Truss MP February 2017

Actions:

- Government must ensure a swift roll out of a sustainable long-term, state backed indemnity package for general practice that provides coverage for all GPs and practice staff providing NHS and state commissioned services, including NHS urgent care and out of hours services
- Ensure parity of indemnity fees between doctors in general practice and secondary care
- Government must commit to providing a winter indemnity package for 2018/19, whilst negotiations for the state backed indemnity scheme are being finalised

Outcome for patients: It is clear that the quality and safety of patient care in general practice in England is under threat from rising workload pressures. A new indemnity system for primary care that is comparable and equitable with secondary care, and removes this huge cost burden from GPs would help reduce these pressures by enticing more GPs to stay in the workforce, thereby making the profession more attractive to future doctors, and in doing so directly impact on and improve patient care.

4

Enabling practices to manage their workload in order to deliver safe services and empower patients as partners in care

Problem: Workload for GPs and practice staff in primary care, both in and out of hours settings, has rapidly grown over the last decade and is reaching a level that is unmanageable and unsafe for patients. With a rise in underfunded workload shifting from hospital trusts to general practices, the over burdensome and unnecessary bureaucracy of regulatory reporting, inadequate prescribing and record keeping systems, and the inability of practices to individually determine their own safe working limits, GPs are struggling to cope with the demand being placed on them to deliver a service in a system that is ill-equipped to meet rising patient demand.

Impact: Unmanageable and unsafe workload is the primary reason behind doctors leaving general practice[17] and is leading to a series of serious issues including practices closing to new patient registrations, practices closing altogether, GP burnout and patients being put at risk of receiving unsafe care.

Actions:

- Empower practices to define capacity limits for safe working
- Develop warning systems for practices to use to alert others in the local area when they have reached safe working limits
- Create locality hubs managed by practices, to provide alternative mechanisms to meet the urgent needs of patients when local practices have reached capacity
- Enable and support practices to limit registration on the grounds of patient safety when necessary
- Deliver a reduction in bureaucracy and duplication caused by CQC, GMC, NHS England and other national regulators, which take precious time away from direct clinical care
- Create community locality teams that include GPs, community nurses, pharmacists, geriatricians and other secondary care specialists, to provide coordinated care for vulnerable housebound patients and those in residential and care homes

17 BMA Survey of GPs in England October 2016

- Establish direct access for patients to self-refer to services such as physiotherapy, mental health, podiatry, ophthalmology and maternity services
- Consolidate and ensure the universal delivery of changes to the hospital standard contract intended to improve the primary-secondary care interface
- An extension of electronic prescribing systems to enable specialists in secondary and tertiary care to prescribe and be responsible for drugs they initiate
- Ensure that all DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) forms are completed in secondary care settings prior to patient discharge
- Establish a common and accessible electronic record with built in safeguards within local healthcare systems.
- Deliver an increase in GP and nursing clinical support for NHS 111 to ensure that patients get the care they need without the need for onward referral
- Introduce universal provision of social prescribing schemes
- Provide greater access to Citizens Advice within each locality to enable patients to get support with benefit claims
- Remove the GP's role in assessing eligibility for bus passes, parking badges, housing, gym membership and sports activities, and other non-NHS work and ensure that responsibility for this is taken on by the appropriate requesting organisation (e.g. local authorities and CCGs)
- Establish a clear definition for collaborative service payments that is adequately funded and enforced
- Establish sustained patient empowerment and educational programmes to increase confidence in self-care

Outcome for patients: Reducing the workload burden on general practice is essential if GPs are to continue to provide safe, high quality care to their patients. Working with patients as partners in this task is imperative, giving people greater confidence to manage their care without the need to see a GP, whether for self-limiting illnesses or longer term conditions. In the face of growing patient demand, practices must be empowered to protect both their GPs and patients from unsafe levels of workload.

The national policy drive to provide effective preventative care in community settings is vital. In parallel, it is crucial for patients to have access to generalist and specialist care, and non-clinical services close to their homes to help them to manage complex conditions and multiple co-morbidities better. Combined with improved outcomes for patients, it is anticipated that resilient community locality teams could reduce workload in secondary and urgent care settings and cut the number of emergency care episodes in hospitals. Similarly, increased expert clinical input into NHS 111 would deliver more appropriate and timely advice for patients.

5

The retention of a national core contract for general practice that provides a high-quality service for patients

Problem: A decade of underfunding has contributed to the destabilisation of practices, leading some to believe that there is a national strategy to encourage GPs into alternative contractual models. Some practices have had to take this step to guarantee future sustainability. This has led to doctors being unwilling to commit to becoming partners due to uncertainty, and has significantly impacted on the recruitment and retention of GPs. It also leaves practices reluctant to invest for the future, particularly in premises developments.

Impact: The national GMS contract underpins fair, consistent and high quality health service delivery for patients across England. The stability of a national contract and an independent contractor arrangement has resulted in general practice being rated higher than other organisations in the NHS and social care system. The partnership model encourages doctors to commit to working with communities long-term, with business owners on the shop floor meeting patients every day and responding to their needs. It's a system that leads to continuity of care, with GPs fully understanding their patients' needs and when necessary, acting as an advocate on their behalf in an increasingly complex system. Breaking this personal relationship between local communities and GPs risks a costlier service that loses the support of the public.

Actions:

- An ongoing commitment to the national GMS contract and the independent contractor status
- The development of future working at scale models to be built on the foundation of registered lists and the GMS contract
- The enabling of collaborative working across local healthcare systems that removes barriers between organisations and contributes to the creation of primary healthcare teams, rather than attempting to establish a single employing body
- New regulations to enable practices to provide non-NHS services to their own patients

- Use of the GMS contract rather than an APMS contract when new GP practices are established
- A fully funded and integrated urgent care service that provides consistent and safe care to patients both in and out of hours
- A commitment to support integrated service development for unscheduled care, and close engagement with OOH service leads
- An established set of national terms and conditions for all doctors working in accountable care organisations and systems
- A contract that provides time for GPs to continue to develop professionally and to use and enhance their skills in management, teaching and research

Outcome for patients: The retention of a national core contract for general practice will provide patients with a guaranteed high standard of care. It will also provide continuity and certainty that the needs of patients can be met regardless of postcode, provided by GPs that they know and trust. Integrated urgent care services should work in partnership with local GP out of hours services to ensure patients benefit from the years of experience these services have in delivering high quality care, despite workforce and funding pressures.


Storsafe

6 Premises, IT infrastructure and administrative support to enable the delivery of quality care

Problem: Primary care has experienced a decade of stagnating investment in vital capital assets including premises, IT and NHS administrative support. This has led to a severe deterioration in the fabric of general practice that now impairs the delivery of care to patients. Premises that are increasingly out of date or too small for the growing demands of clinical care prevent the development of newer systems for improved care. Ancient IT systems running on slow networks are increasingly unable to cope with the demands for data transfer required for modern information sharing. This impacts daily on the delivery of care to patients. Administration is a vital part of the fabric of general practice, and the catastrophic decision to outsource NHS backroom functions has led to serious problems in maintaining safe, reliable and up to date lists of doctors satisfying the requirements to perform in general practice. Frequent administrative errors in payments systems for surgeries threaten to destabilise an already fragile structure leading to problems in the delivery of care.

Impact: Restricted investment in GP premises leaves many unable to accommodate the latest innovations in care for patients. Slow and outdated IT systems cause delays in consultations and difficulties with data sharing, while old and unsupported hardware and software are vulnerable to attack, as with the recent "Wannacry" cyber incident episode, putting patient care and confidentiality at risk. Administrative support for GPs during the last two years has been a fiasco, putting patients at potential risk, destabilising practice finances and exacerbating the workforce crisis.

Actions:

- An immediate hardware and software refresh for all GP practices to address system failures arising from a decade of neglect, based on a guaranteed national minimum standard specification for hardware, software and support arrangements, that is jointly agreed with the profession and protected from local interference
- A commitment to prioritise the replacement of all obsolete and unsupported systems that risk patient security

- A commitment to extend the provision of electronic prescribing systems (EPS) for all practices, including dispensing practices, and to enable its use for all prescribed medication, including controlled drugs (CDs)
- Recurrent and fully funded systems through GP Systems of Choice (GPSOC), such as front access modules like askmyGP etc. that expand the availability of new IT initiatives and provide all practices with opportunities to access digital platforms, where there is clear evidence of their benefit
- A firm commitment to end the transfer of paper records and transition to the universal use of GP2GP electronic transfer of records system
- A commitment to ensure that IT systems seamlessly integrate with existing GP platforms
- Increase common access to patient records and data between those doctors involved in the direct clinical care of patients, both in and out of hours
- Enhanced access to clinical information, advice and resources using the NHS portal, to encourage self-help and improve signposting for patients
- Improved electronic advice, guidance and other clinical messaging systems between primary and secondary care clinicians, with data that integrates directly into GP records
- Delivery to all primary care sites of the fully supported networks, connections, routers, hardware and software required to ensure superfast data connections at all times
- The development and implementation of fully functioning back office support systems to support consistent and reliable services for patients and the profession
- A commitment to prioritise a fully resourced digitisation program of all previous paper records (Lloyd George records) being held at practices, which will free up both practice premise space and time
- A fundamental review of premises arrangements to remove "last partner standing" scenarios, reduce the risk of practices seeking alternative contractual models owing to premises problems, and remove any barriers discouraging doctors from becoming GP partners
- Fully funded rental and maintenance costs for all practices
- Increased and ongoing capital investment in GP premises and associated revenue costs

Outcome for patients: There is considerable potential to make efficiencies through the use of technology that would ease GP and practice workload and directly impact patients by increasing the amount of time available for appointments. Patients would benefit from more accessible and joined-up services, where increased expert clinical input and shared patient records would ensure a more seamless experience. Networks must be robust and quick enough to manage the data flows necessary. Similarly, electronic prescribing would provide patients with easier and more convenient access to medications. Better premises funding structures would ensure the necessary general practice building stock to house extended primary care teams and deliver state of the art care within communities.

Conclusion

The problems outlined within this document provide a clear picture of the significant pressures currently undermining general practice. It has been widely acknowledged by Government and other bodies, whether explicitly or through documents such as the GPFV, that if these pressure points continue to escalate and worsen, general practice could risk serious system failure that could compromise patient safety. Underpinned by a decade of underinvestment, unmanageable workload, deteriorating and unfit for purpose premises, out of date IT systems, disorganised referral and prescribing systems, and a threat to the national GMS contract that protects high quality care for patients, these problems are threatening fundamental elements of primary care that if compromised, could create a negative knock on effect throughout the rest of the NHS.

And whilst these problems grow in severity, GPs are being forced to test their resilience beyond reasonable limits and confront issues from not just one, but multiple directions. This has led to a consideration by practices to either temporarily suspend new patient registration, or close their lists altogether due an increase in unsafe workload.

NHS England's acceptance of the BMA's 2015 Urgent Prescription for General Practice, led to many initiatives that have the potential to address some of the issues we highlighted at that time. However, there is much more that needs to be done and, as we stated in 2015, GPC nationally and LMCs locally stand ready to work with the Government and NHS England on the implementation of these actions put forward by GPC, which will go a significant way to rebuild the vital foundation primary care provides for the NHS. These issues cannot and must not be left unresolved if we are to save general practice and provide a service that is sustainable, safe and delivers the best possible care to patients.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