BMA

Trust GPs to lead: learning from the response to COVID-19 within general practice in England

British Medical Association
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We were trying to go fully digital before the pandemic. This has accelerated through urgent necessity. We've brought around a decade worth of change in a quarter!

Response by a frontline GP to the BMA Tracker Survey

Introduction and background

One of the most consistent messages and observations that the BMA has heard from frontline GPs is that while responding to the COVID-19 pandemic has undoubtedly been an incredibly challenging time, the necessity to adapt has given rise to more innovative ways of working to deliver care that if maintained could provide long-term improvements for general practice and the service patients receive.

Since the outbreak of the pandemic in early 2020 general practice has seen a 'fundamental recalibration' in how it operates. In a few short weeks practices rapidly moved both to protect patients and staff (including those who are vulnerable) and supported social distancing, by introducing total triage arrangements; effectively moving to a 'digital front door' model overnight. A significant number of consultations were delivered by telephone or online (asynchronous or video), with face-to-face consultations either in the practice or at home only when clinically necessary. This dramatic process of innovation and change was undertaken in the absence of much of the regulatory or contractual requirements that were previously placed on GPs.

Similarly, when the need for additional support for patients in care homes was recognised, practices, often working together with others and local community care teams, responded quickly and effectively and without the need for contractual change.

The response from GPs to COVID-19 is compelling evidence of what can be done when practices are afforded the trust, autonomy, flexibility and freedom to act as the leaders of the profession in their local communities, acting in the best interests of their patients.

With the removal of layers of bureaucracy, GPs have been empowered to work in an environment that has actively encouraged problem solving using clinically-led solutions. We know there will be significant clinical and organisational challenges as GP practices restore core services to their patients. This report sets out a range of principles and solutions that will enable GPs and practices to manage the ongoing demands of responding to COVID-19 as well as being supported to continue delivering innovative patient-focused local services for both the short and long term.

The BMA's five key principles for change

The following principles must be addressed as part of learning the lessons of COVID-19:

1. It is essential that we **capitalise on the greater autonomy provided to general practice** during the pandemic and incorporate the positive learning into new ways of working, as we move to a 'new normal' for services. Whilst some form of oversight and regulation is necessary within any health system this should be light-touch and supportive/not constrictive. It is therefore critical that we now see a 'step change' in the level of trust for general practice and GPs are allowed to once again utilise their clinical judgement as health professionals.

2. There must now be a **significant reduction in the level of regulation within the system**. The burden of regulation has previously fallen on all practices rather than focusing on appropriate support for the very small number of practices when this is required. This must now change, with an emphasis on offering support to those practices where it is required. The 2013 health reforms resulted in too many national organisations sharing a fragmented framework for oversight responsibilities and the pandemic has highlighted even more the limited sharing of information between these bodies. With the most significant health crisis for 100 years there can no better time and no better reason to tackle this challenge.

There is a need for 'less micro management. More respect for frontline professionals'

Response by a frontline GP to the BMA Tracker Survey

3. **There must be a significant reduction in the level of bureaucracy and duplication** caused by information requests from Government departments, national regulators, commissioners, local providers of health services and many other organisations. In addition, all too often the default solution to many problems is to encourage members of the public to "get a letter from your GP". Reducing the burden on general practice is essential if GPs are to continue to provide safe, high quality care, to their patients. It is also important to empower patients to self-care rather than disempowering them by expecting a healthcare professional to act on their behalf, particularly with regards to non-medical issues. There have been numerous reviews to address bureaucracy over the last two decades with very limited progress and this has continued to be a source of significant frustration for general practice, which has had an adverse impact on morale. The BMA looks forward to working with health and care ministers and NHS England and Improvement (NHSE/I), as part of the GMS contract 2020/21 agreement, to deliver meaningful and sustainable change with the barriers identified and then addressed.

4. It is essential to **increase the level of digital and technological support for practices** including a rapid rollout of appropriate, safe, reliable, robust and secure digital technology and consultation software (including video where appropriate) for practices to use. There is also a need for increased investment in IT software and hardware, as well as sufficient training and support.[1] This investment is needed **to maintain and expand the provision of remote consultations where this is clinically appropriate** (this must be a practice-based choice working in consultation with patients but enabled by the above). Social distancing measures and protection in waiting rooms and consultation rooms will be a challenge for the foreseeable future.[2] The rapid and responsive manner in which general practice moved to a sustainable and safe way of remote consulting exemplified the benefits of the independent contractor model of general practice. This now needs to be supported with sufficient resources to make this happen.

5. GPs should be **empowered as clinical leaders in their communities**, strengthening and resourcing the development of primary care networks and giving them the necessary flexibility to use available resources, workforce and partnerships within their area. This means being at the heart of decision making, particularly at a time when all NHS and care services review their way of working to deliver care whilst reducing risks of COVID-19 infection to patients and the workforce.

More widely the BMA has recently published a set of principles for how the NHS should approach managing the increase in 'non-COVID care'. It states that recovery of NHS services will be stepwise over an extended time period and this applies as much to general practice as it does to hospital or other NHS services.

1 bma.org.uk/media/2512/bma-easing-lockdown-principles.pdf
2 bma.org.uk/advice-and-support/covid-19/gp-practices/covid-19-toolkit-for-gps-and-gp-practices/service-provision

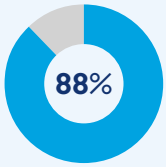
Move away from metrics gathering to allow professionals to be professional

Response by a frontline GP to the BMA Tracker Survey

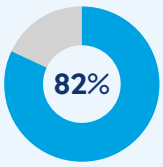
Evidence for the principles supporting greater trust in general practice and addressing unnecessary bureaucracy and regulation

Throughout the pandemic the BMA has conducted regular tracker surveys of the profession. Over 2,500 frontline GPs responded to the fifth and sixth BMA tracker surveys[3] and the vast majority (85%) reported that the changes they had made in the way they were working had been very or somewhat effective at combatting the pandemic.

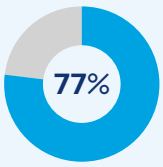
The headlines from the tracker surveys were as follows:



Respondents wanting to **maintain the greater use of remote consultations**

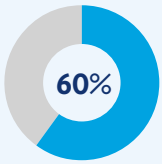


GPs who want to have **less paperwork and bureaucracy** to deal with in future

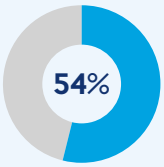


GPs who want to **use video technology to a greater extent for clinical and multi-disciplinary (MDT) meetings** in future

Over half GPs **highlight problems with broadband speed, IT hardware and software not being robust enough, and insufficient training and support available**

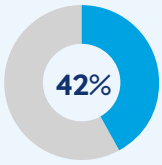


GPs responding who want to **reduce the frequency of appraisal** in the future

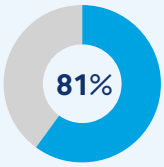


GPs who want **CQC inspections to end or be reduced**

GPs who want **the Quality and Outcomes Framework (QOF) to remain suspended**



GPs responding who planned to **work more flexibly** in the future



GPs who have been **asked to carry out new investigations and manage ongoing care which would normally have been done in hospitals**, contributing to GPs' growing workload during the pandemic as other settings struggle to contain patient demand

3 All of the data is taken from tracker survey results released by the BMA on 4 June 2020 and 22 June 2020

Why are doctors having to work to QOF and not to best practice?

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As part of the 2020/21 GP contract agreement in England, the Government committed to review how it could reduce unnecessary bureaucracy impacting general practice, and NHSE/I said it would take action to reduce the burden on practices and thereby free up valuable time for patient care. The BMA tracker survey has showed what could be possible, how important these reviews will be and how quickly they need to be completed, as despite the challenges they have faced, many GPs have felt more positive about how they have been able to work over the last few months, with 66% experiencing a **greater sense of team working** and 55% feeling **less burdened by bureaucracy**. This is therefore something that should be quickly built upon, not lost, as practices continue to respond to the challenges of the COVID pandemic.

The BMA's *Caring, supportive, collaborative campaign*[4] has highlighted the inordinate and wasteful amount of doctors' time which is taken up by administrative tasks, including filling in forms, dealing with correspondence, and completing mandatory coding and compliance sections on computer systems.

The Kings Fund[5] concluded last year that the NHS (including general practice) as it is currently organised is overly complex, over-regulated and generates substantial transaction costs. The Kings Fund has also highlighted[6] the remarkable innovation seen in general practice since the COVID-19 outbreak, and the need to learn the lessons: keeping what works and is sustainable for staff, providers and technology suppliers; and 'letting go' of what does not work.

Looking to practices in Scotland, where QOF has not been in operation since 2016, practices are trusted to act clinically and professionally in the best interests of their patients, without the burden of box ticking or rigid rules/targets. They are improving their care in striving for clinical excellence and to improve health inequalities for their patients and populations, rather than to secure the funding to deliver those services. The Scottish Government is content to provide the funding practices need to deliver services and trusts them to do this using clinical and professional judgement.

4 bma.org.uk/media/2034/bma-csc-future-vision-nhs-report-sept-19.pdf
5 www.kingsfund.org.uk/publications/articles/big-election-questions-bureaucracy-nhs
6 www.kingsfund.org.uk/blog/2020/04/covid-19-general-practice

The BMA's proposals for change in general practice

There is a need for... 'easier and different communication methods with secondary care colleagues'

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Many national and local bodies have an important role to play in enabling general practice to change, develop and thrive in the future. Above all they must trust GPs and practices to lead and shape services. The following organisations need to act swiftly, in consultation with the BMA's general practice committee England, to learn from the experience of the COVID-19 pandemic and to support general practice in the future.

For all stakeholders in the health and care system

Introduce a new culture within the health and care sector of trusting general practice to deliver high quality care. Before the outbreak many GPs worked late into the evenings within a climate of fear of complaints and regulatory action. A significant theme from the BMA tracker surveys and other feedback from frontline GPs and Local Medical Committees (LMCs) has been the positive impact of the reduction in some levels of 'micromanagement' within general practice including repeated 'improvement' initiatives, performance management targets and oversight meetings. Health ministers and all organisations working with primary care need to acknowledge that delivering change has been part of the fabric of general practice since the inception of the NHS.

Central Government departments

Including Department of Health and Social Care (DHSC), the Home Office, Ministry of Justice (MoJ), the Department of Work and Pensions (DWP), Department of Transport and the Ministry of Housing, Communities & Local Government

- **Urgently address the current requirements on GPs that relate to verification of death and cremation certification.** These responsibilities should be urgently reviewed by the DHSC, the Home Office, the Ministry of Justice, the coronial service and representatives of local Government who oversee and fund the work of the coronial service. Changes must ensure the continuation of the use of remote technology to enable the completion of death certification and cremation forms[7].

- **Review the current system where groups external to general practice set standards that impact on general practice.** Appropriate systems need to be in place to ensure high quality care within general practice. However some expert groups and other bodies have in the past set inappropriate and/or unevidenced standards for general practice settings that have not been fully costed or are unrealistic for implementation within general practice. DHSC ministers should work with key general practice and primary care stakeholders that set clinical standards for general practice. Any new arrangements should allow greater flexibility to remove, relax or not introduce certain standards based on the professional judgment of local clinicians, for example on training expectations for spirometry, smear testing, IUD fitting and other commonly undertaken procedures within general practice.

- **Address the factors that lead employers, schools and universities to request additional confirmation from GPs to confirm the sickness of an individual.** DHSC and ministers from relevant Government departments should work in partnership with key stakeholders to look at the factors that lead to additional requests for confirmation and provide alternative systems for proving assurance.

- **Review the current statutory responsibilities that require GPs to issue MED3 Fit Notes**. DHSC and DWP ministers should work in partnership with key stakeholders to look at alternative arrangements for providing fit notes. These arrangements should consider the value of the self-isolation note system that patients have been able to utilise to

7 bma.org.uk/media/2324/bma-verification-of-death-vod-april-2020.pdf

obtain notes without practice involvement during the pandemic, and whether this can be extended on a more permanent basis up to 14 days. In addition, as a result of government initiatives during the COVID-19 crisis, practices have had to respond to patient requests for letters for a range of issues, including evidence for employers about shielding or the need to work from home, evidence for schools about a child's health condition, and requests for evidence of exemption from wearing a face mask. In many cases patients could provide this information themselves to the respective organisation if they were empowered to do so. DHSC ministers should work in partnership with professional regulators to introduce legislation that supports a range of health professionals (including nurses and clinical pharmacists) being able to complete fit notes and to actively reduce the requests of GPs to write unnecessary letters.

– **Reduce the current requirement for GPs to complete DWP benefit assessments.** DHSC and DWP ministers should work in partnership with key stakeholders to reduce the expectations to seek medical evidence from GPs for benefit appeals.

– **Remove the requirement for GPs to support information requests from local authorities related to housing.** DHSC ministers must work with the Ministry of Housing, Communities & Local Government to direct local government not to seek medical evidence from GPs for housing-related applications. Local council employed medical officers should undertake this assessment independently of practices.

– **Remove the requirement, where it still exists, for GPs to be involved in assessing whether individuals are eligible for a blue disability badge.** DHSC ministers should work with the Department for Transport, Local Government Association and local authorities to introduce changes to the disability parking scheme. GPs are generally not experts in the impact a condition has on an individual's mobility, which is the basis for awarding a blue badge.

Professional and Systems regulation – Care Quality Commission (CQC) and General Medical Council (GMC)

– **Urgently bring forward legislative reform to remove general practice from CQC's remit.** Although general practice is the highest performing sector which CQC currently regulates, its regulatory activities continue to significantly impact practices. CQC inspections, annual regulatory reviews and provider registration management contribute to an already stressful and pressured working environment, divert time and resources away from patient care, and duplicate much of the performance management role of CCGs. However, it has not been demonstrated that CQC's additional regulatory oversight is necessary to ensure the continued delivery of high standards of care in general practice. Additionally, the experience of other national health systems across the UK is that an additional regulator with the role and remit of CQC is not needed to safeguard the delivery of high-quality care. The continued oversight of general practice performance by CCGs must be 'light touch' with a focus on quality improvement and support for practices that are struggling – without the introduction of ratings or a bureaucratic registration system.

– **Simplify the current system of GP appraisal and revalidation.** The current system of appraisal and revalidation, with the need for GPs to gather large amounts of documentary evidence, should be urgently addressed by the GMC and NHSE/I in partnership with the BMA and other stakeholders. This should include an end to CCG or other external demands for various mandatory training, often expected to be done within inappropriately rigid timeframes, and a return to GPs identifying their own training needs as part of their medical appraisal. While COVID-19 challenges remain, and until appraisal and revalidation is reformed, there should be a pragmatic and flexible approach to missed appraisals and a reduction in appraisal bureaucracy and activity. Appraisals, when reintroduced, should be formative, supportive and focused on the wellbeing of the doctor. The demands of responding to the COVID-19 pandemic will also require opportunities for medical practitioners to debrief and have pastoral and supportive conversations.

NHS England and NHS Improvement (NHSE/I), Clinical Commissioning Groups (CCGs) and local primary care organisations

- **Build on the learning within general practice from providing remote access to services including consultations to patients during the initial stage of the COVID-19 pandemic.** NHSE/I should ensure a rapid rollout of appropriate, safe, evidence driven and secure digital technology and video consultation software for practices to allow remote consultations to be offered to patients as part of a range of options (depending on when it is clinically appropriate). All key stakeholders, including the BMA, should be consulted through the process. In order to do this:

  1. There should be a 'step up' in the programme of digital upgrades for practices, including the provision of appropriate IT enablers, allowing more clinical and administrative staff (including locum GPs) to work remotely in flexible ways.
  2. More varied IT software solutions should be explored within general practice, including the use of voice recognition software, digital telephony systems and virtual desktop infrastructure. This should be supported with a much more rapid roll-out of broadband/fibre and IT software upgrades.
  3. More varied hardware solutions should be provided including retaining and increasing the number of laptops that have been distributed during the pandemic and making sure that these are embedded in the system in partnership with general practice staff (including locum staff).
  4. There should be better use of practice websites and digital services to provide more support to patients to self-care or give direction to alternative health and care services with the support of NHSE/I and CCGs.
  5. There should be more flexibility for practices and their local acute and community providers to communicate with each other and their shared patients, for example GPs contacting hospital specialists via email and when appropriate joining them in virtual clinics.

- **Strengthen GP leadership roles in local communities,** including working in primary care networks, building on the greater sense of team working during the COVID-19 pandemic, through support and development for clinical directors and others in leadership roles. It is vital that we offer greater flexibility in the use of additional workforce funding to best meet the needs of local populations, reducing contractual micromanagement through service specifications and enabling PCNs to develop properly funded sustainable community based services that responds to the future challenges rather than having to cope with unfunded or agreed work shifting inappropriately from other service providers to general practice (as shown in the sixth tracker survey results, that 75% have had to refer back to hospital due to the pandemic).

- **Review and significantly reduce the need to process information requests from the acute sector hospitals and other providers**. Many of these requests require complex searches, are time consuming, and need to be completed online through the use of PDF forms or software that practices then need to purchase. There is much duplication, and uncertainty on how they are assessed, with rarely any feedback. Few are automated. NHSE/I must work with NHS Digital, NHSX and key stakeholders to agree a framework that reduces the need for general practice to take information from hospital correspondence and re-input data into GP clinical systems, including medication changes.

- **Allow general practice more flexibility and support innovative approaches in the delivery of extended hours and the provision of access to appointments for patients**. NHSE/I should work with all key stakeholders to ensure that there is maximum flexibility in the system and a reduction in 'top down' arrangements enforced by CCGs.

- **Address the fragmented national and local systems that result in practices being required to report identical information to multiple organisations including regulatory agencies and statutory bodies.** NHSE/I should work with DHSC, CCGs, the BMA, LMCs and other key stakeholders to review and significantly reduce the multiple data gathering exercises that are confusing, contradictory, counter-intuitive and create a sense of 'micromanagement'. These are exacerbated by reminders and pop-up messages that add to the burden on GPs contributing to fatigue that can have a negative impact on patient care.

- **Allow a more localised decision system on drug supply that is informed by national guidance.** CCGs should introduce medication optimisation teams to monitor local drug supply challenges and undertake switches and substitutions (for example HRT and other drug unavailability generates significant amounts of work for GPs with limited improvement in care delivery). This should be undertaken in partnership with general practice, pharmacies and LMCs.

- **Create a patient charter so that patients' autonomy is supported, empowering them to take responsibility for their health, as well as knowledge of what general practice and the wider NHS will deliver.** NHSE/I should work with DHSC, patient organisations, the BMA and other key stakeholders to help create realistic and more honest expectations of services that can be practically delivered as England moves to the next stage of managing the COVID-19 pandemic. This should include removing, where appropriate, barriers for patients to be able to more readily self-refer, including to community nursing services. Patients with hypertension could be provided with blood pressure monitors to enable home testing so reducing the need for attendance in surgeries or the use of waiting room machines. This should also support online access to self-referral services, for example counselling services, managing back pain and podiatry.

- **Create more robust systems that ensure that secondary/acute sector care follow the standard NHS contract**. It is vital that NHSE/I works with CCGs and secondary care providers to ensure greater enforcement of the provisions of the standard contract[8]and reduce the burden on general practice to ensure compliance. This should include addressing the areas of the acute sector that default to sending individuals back to GPs for them to refer to other services (as shown in the sixth tracker survey results, that 75% have had to refer back to hospital due to the pandemic) or even in the same department, and organise prescriptions for ongoing care. Secondary care clinicians should be able to access and use electronic prescribing systems connected to community pharmacies. Referral management centres should be removed, they set arbitrary criteria and pathways usually with no or limited GP consultation, which GPs are required to comply with in order to achieve a referral. Commissioning gaps should also be addressed, by reducing unfunded work shifted to general practice as hospitals and other providers move towards a greater use of remote consulting. Services need to be accessible, adequately planned and fully funded (for example phlebotomy) when investigations, monitoring of diseases and treatment previously done as part of a visit to an outpatient department are moved to primary care. In addition, improved use of digital technology in secondary and tertiary care would enable specialists to continue to care and prescribe for patients without the need to transfer responsibility to GPs.

- **Review, minimise and streamline the multiple systems for reporting, claiming and reconciliation of GP payments**. NHSE/I should work with CCGs, the BMA, LMCs and other key stakeholders to reduce the significant burden on general practice associated with securing payments. The current arrangements, particularly those related to Primary Care Services England, cause financial difficulties for practices in terms of cash flow and resources associated with complying with complex and contradictory systems.

8 bma.org.uk/advice-and-support/gp-practices/managing-workload/pushing-back-on-workload-from-secondary-care

– **Ensure a robust and streamlined complaints process relating to general practice.** It is critical that robust systems are in place so that genuine complaints can be confidently raised and appropriately dealt with. However currently the multiple organisations involved with the overall processes and the systems are confusing for patients and those working in general practice. NHSE/I should work with DHSC, CCGs and other key stakeholders to introduce a more unified system that reduces the opportunities for trivial or malicious, or vexatious complaints.

Next steps

Whilst this pandemic has undoubtedly been an incredibly challenging time for all of us, the necessity to adapt in general practice has given rise to innovative ways of working to deliver care. Practices have risen to the challenge, working closely together in a collegiate and collaborative way. They have been afforded the freedom to use their professional and clinical judgement based on a 'back to basics' principled approach to ensure the way they operate is appropriate for their locality, practice teams and their patients.

It is critical that we now capitalise on this and incorporate these positive developments into our new ways of working as we continue to increase routine services. General practice must be supported to do this.

Many GPs worry that the 'restoration' of services to business as usual mean a return to the pre-COVID ways of working, losing much of the trust and flexibility that have been put in place since the outbreak of the pandemic. **For decades general practice has been 'drowning' in unnecessary paperwork, box ticking, chasing arbitrary targets and unnecessary bureaucracy as well as being micromanaged with ever decreasing levels of autonomy.** This has been a key contributing factor in the workforce crisis experienced by general practice in recent years, as GPs left the profession because of micromanagement and bureaucratic burden impairing their professional satisfaction and enjoyment of caring for patients. We now need to listen to what the profession has been telling us about the need to create a greater sense of trust.

It is critical that Government ministers, NHSE/I and CCGs take notice of what GPs are now saying and make the appropriate changes to ensure that we effectively reduce the burden on general practice to practically cope with the ongoing impact of COVID-19 alongside the growing burden of providing care to patients. There will not be a return to the 'business as usual' capacity seen at the start of 2020 and it is critical that the Government recognises that we are still responding to one of the most significant healthcare emergencies for 100 years.

Without significant action being taken to implement our proposals we will fail to capitalise on the many innovations which have been implemented during this national health crisis, and will simply return to working within a system in crisis which is buckling under the demands of bureaucracy and ever-increasing workload.

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