BMA

What the NHSEI package means for general practice

BMA England

British Medical Association
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England

NHSEI (NHS England and NHS Improvement), supported by the Government, has published a plan it claims will improve access for patients and support general practice in the current crisis. This has not been negotiated or agreed by GPC England but has been developed by NHSEI and the Government in isolation. The BMA has however made several specific demands to support general practice through the current crisis and for the future of general practice. Some have been highlighted through this document, but the main demands to help manage the unprecedented general practice workload burden and stop the abuse directed at the profession have been for more GPs, more staff, better facilities, resources to manage the backlog of care, Government statements of support for general practice, Government's condemnation of, and campaigning against, against abuse of NHS staff, and increase punishments for assault and abuse of NHS staff.

This document provides analysis of the plan, showing exactly what it means for general practice. Each item/initiative is highlighted to show the following:

Not new/re-stating existing initiative	Potential to support but not immediately
No additional support for general practice	Some new support for general practice

NHSEI's introduction: NHSEI begins with positive comments about general practice and what GPs and practices have delivered over the pandemic period. However, kind words must be followed by appropriate supportive actions. It is evident to us throughout this package of measures that the punitive approach of some of the later proposals undermine the positive expressions in this introduction and that the NHS is being used for political purposes rather than the Government and NHSEI doing what is right for patients and for general practice.

The access challenge: What NHSEI hasn't said is that the Government's IPC (infection, protection and control) guidance has not substantially changed so practices have had to operate in this way – total triage, limit numbers in practices, remote consultations etc. The vast majority of practices are working appropriately, and the vast majority of patients are accessing services in an appropriate manner, yet NHSEI and Government's punitive measures will apply to all. This sledgehammer approach and additional bureaucratic burden is completely inappropriate. General Practice staff have been working as hard as they possibly can throughout the pandemic. They are now exhausted, demoralised and burnt out from trying to shore up an already crumbling NHS and soak up additional demand.

Irrespective of the amended IPC guidance, case rates are rising, the country is still in the midst of a pandemic and patients continue to suffer serious illness and are dying with COVID. Prioritising patient and staff safety therefore remains of utmost importance.

Patient preference for appointment type: While this is not a contractual requirement, it has always been a consideration for practices; however clinical need and patient/practice safety means that patient preference cannot always be provided. Whilst unprecedented demand for appointments continues within a volatile working environment, ie staff sickness, COVID isolation rules, infection risk etc, a responsible health care system must intelligently use the resources at its disposal to achieve maximum impact.

A patient facing campaign to raise awareness of other clinicians' roles and responsibilities will be welcome but will take a significant amount of time to become embedded and will not help manage demand in the interim.

We are clear that access (both mode of access and to whom), must continue to be based on clinical decision making and for practices to determine.

Abuse of practice staff: NHSEI has made a statement of support for practices, but it is nowhere near prominent enough in this document; it is hidden in the middle of the access section. Again, kind words of support need to be followed by action – a public facing communication campaign, having long been a key demand of the BMA, will go some way to preventing the problem only if it is robust and prolonged, but there is no indication of the plans or resources supporting this. Senior Government figures, in concert with major media outlets, set the tone in the public consciousness, and they bear a serious responsibility for the safety of our staff and our doctors. This must be highly visible in any Government messaging. Further information on abuse of practice staff is provided later in the document.

NHSEI actions (supported by Government):

Increase and optimise capacity

1. *Amended IPC guidance*: the NHSEI plan refers to IPC guidance that has been released at the same time – the main change in the guidance is to move from 2m social distancing to 1m in line with hospital IPC arrangements, but which will likely have little to no impact on access in small general practice settings. We are concerned that this updated IPC guidance has been rushed and released in tandem because of a Government agenda rather than being a safety-first, evidence based approach. We must also be clear that many practices do not have the facilities or space to manage this without placing staff and patients at risk.
2. *£10m of continued funding for October 2021 and **a new £250m Winter Access Fund (note this is not a GP access scheme) to***:
    a. increasing capacity and GP appointment numbers:
        - *using the existing workforce*: the existing workforce is already overworked and latest figures show that doctors have started to reduce their hours to manage their workload, work-life balance and wellbeing. The Government is now expecting exhausted GPs and practice staff to work more, and the tone of the document reads very much like NHSEI and Government are retaining their command and control approach, rather than requesting GPs to take action and enabling them to do so. Furthermore many GPs will not want to take the risk of working additional hours and earning more, thus being named and shamed in the national and local media should they breach the £150,000 income threshold that would lead to pay declaration.
        - *Using additional locums*: again, these are from the existing workforce and so the Government is simply wanting the same GPs to do more. In addition, setting a maximum rate for reimbursement will not attract locums and, along with the suggestion of directing the way locums engage (via digital locum banks), disrespects the independent nature of their working.
        - *expanding extended hours capacity*: again, this would be from the same people, so making the existing workforce work longer and harder would have the same implications as above should earnings increase beyond the income threshold.
        - *extra administrative staff*: this might help with administration and telephone response times, but what patients say they need are appointments with their GP – this will not help with that. We also doubt that these extra staff will be able to be recruited given the

recent aggression and abuse toward existing staff, due to the recent media and government anti-GP rhetoric.

- *employ other doctors who are not GPs*: while this might reduce the patient-facing demand for GPs a little, it is not what GPs or patients want or need. There is also a serious question about recruiting doctors that are not qualified to deal with undifferentiated care to work in practices, and appropriate safety concerns might be raised. It also leaves practices with increased work to recruit and manage these individuals who may not have experience of working in general practice and potentially leaves them with additional financial and employer responsibilities/liabilities. We are also concerned about regulatory implications for the performers list.

b. increase the resilience of the NHS urgent care system: This is simply restating what NHSEI has already asked CCGs (Clinical Commissioning Groups) to do, adds no tangible benefit, is not about general practice, and is an insult to exhausted staff.

As a whole this funding package, which is not recurrent, will do very little to support a struggling workforce which is already in crisis and as we enter the most challenging winter for a generation. It will also do nothing to improve the general practice estate, which is in dire need of investment both in the short-term to reduce the risk of viral transmission and in the medium to longer term to accommodate additional staff to be able to offer more appointments.

All of this is for local systems to determine with ICSs (Integrated Care Systems) and CCGs able to add their own criteria. We fear they will simply direct funding elsewhere, away from general practice, or remove already planned funding intended for winter resilience. GPs, practices and LMCs (Local Medical Committees) may have little or no say in how these measures are implemented.

Linking the above funding package to practices being part of the CPCS (Community Pharmacy Consultation Service) programme, especially when CPCS adds even more bureaucracy on practice teams (see below), is not acceptable and is just another unnecessary string attached to this package.

3. *Expanding numbers of GPs and other primary care professionals*: NHSEI and Government are simply re-stating what they have already stated for years but have failed to deliver. This is a long term goal, is greatly undermined by the shortage of approx. 50,000 doctors across healthcare services in England, and will take many years to achieve even if the Government were to invest the requisite amount of funding in the medical workforce. We need immediate action and solutions. Over half way through the five year GP framework, the recruitment of the ARRS (Additional Roles Reimbursement Scheme) staff has not even reached 40%; NHSEI says 10,000 ARRS staff have been recruited in the last 2.5 years, yet they anticipate recruitment for another 5,500 in the next 6 months – while there is a significant shortage of all health care workers, which has been worsened by the pandemic. The lack of support for the current pressures in general practice, and the very little regard NHSEI and Government has for general practice does not make for an attractive offer in any recruitment strategy.

4. *Moving to cloud-based practice telephony:* A significant number of practices already have this. While this might seem like useful support for others, there is no additional staff to answer the additional phone lines and no additional clinical staff for the patients to see for their appointment. Across June, July and August, over 75 million appointments were recorded; that's the equivalent of more than one appointment for every person in England – over 43 million of those (equivalent to nearly three quarters of the population) were face to face, with the rest being done through other means. And that is in addition to a further million appointments for COVID vaccinations over the same period! It is not clear what longer term

funding, if any, would be available once such telephony systems are implemented. In addition, NHSEI all but states that they are introducing this to performance manage practices, therefore using it for punitive purposes which is completely unacceptable.

5. *Making best use of community pharmacy (CPCS)*: Again, this is restating what is already available and is not new; in fact NHSEI decommissioned the previous community pharmacy minor ailment scheme so patients who would have sought their free script from the pharmacy now have to go to their GP for it. While CPCS may bring some benefits of referring patients to pharmacies, the impact for patients and practices would be much greater if patients could self-refer, removing the practice from the process entirely. Piloting an expansion of the services pharmacies provide will not benefit enough patients or practices in the immediate term.
6. *Optimising involvement in the COVID vaccination campaign*: This simply means removing practices from the vaccination programme which they have been instrumental in delivering so successfully, leaving their patients having to go to an alternative source. It is not clear that this would create more appointments for the specific practices, as they are doing this activity on top of their usual practice commitments, so the benefits to patients and practices will be negligible.
7. *Reducing administrative burdens of fit notes and DVLA checks*: These are again nothing new and have been announced previously with little progress made in delivery. In addition, they are plans for future change which have no immediate tangible benefit. While the changes will be welcome, in isolation they represent a tiny proportion of the work that practices undertake – others in the practice would still need to produce these so will not free up much practice time to see patients.
8. *Annual GP appraisals*: Another re-statement of what was introduced previously (a less burdensome appraisal process). While this change was previously welcomed, there are no suggestions for further change so this is nothing but Government rhetoric purporting to be something new when it is not.
9. *Reducing secondary care admin burden impact on GPs*: Another re-statement of something that is already the case, but there is a renewed emphasis on holding secondary care providers to account. While this is welcome we have little faith that this will actually happen; this has been possible for many years but has never actually been enacted. There seems little will to address the senior leadership input and technical infrastructure investment necessary to make this possible.
10. *Re-phasing PCN service specifications*: Another re-statement of something NHSEI announced previously but does nothing to address the current crisis. Rather than fully suspending the new service specifications NHSEI refuses to free-up GPs and others from delivering these services to focus on direct patient care, and instead wants them to work longer and harder, focusing on political aims rather than seeing people who are sick.
11. *PCN Access Offer transfer delay to October 2022*: While we welcome the fact that this delays additional workload in terms of planning for this service change that practices would have had to undertake during the winter, it does nothing to ease the existing pressures.
12. *QOF (Quality and Outcomes Framework) and IIF (Investment and Impact Fund)*: Unlike the positive decisions taken elsewhere in the UK, NHSEI refuses to make any changes to QOF or IIF despite our repeated calls to do so. We believe this would have the greatest impact in freeing up GPs and practice staff from box-ticking and undertaking services that are not immediately necessary, given the urgent patient need in communities. The decision not to make any tangible change to existing practice workload and not to trust clinicians to deliver

long term condition management without micromanagement has lost any remaining good will the profession had. It shows a shocking lack of understanding from NHSEI and the Government.

13. *Redirecting capacity from locally commissioned services*: Again, this is nothing new and something that local systems have already been charged with doing, focussing on practices aiming to minimise impact on emergency departments, so it will have little to no new benefit for practices.

Address variation and encourage good practice

1. *Practice-level review of levels of face-to-face care*: This is nothing new and part of what general practice does as standard as part of their duty to keep patients and staff safe – the restrictions on the levels of face to face care come from the Government's IPC guidance, so they are not currently within practices' control.
2. *Developing the evidence base on hybrid access models and providing professional guidance*: Guidance on the balance of different appointment types will be welcome, if drawn from best practice and evidence-based, however each practice must decide what works best for them and their patients; they must allow for deprivation and social demographic related variation. NHSEI and Government cannot use this guidance as a benchmark.
3. *Additional QOF QI module on optimising appointment type*: Any QOF QI module must be agreed by the BMA as part of contract negotiations, but again each practice must decide what works best for them and their patients. This will be additional work for practices.
4. *Incentivising improvements in patient experience*: This has previously been proposed but the BMA raised serious concerns about its implementation. The renewed focus on it is concerning and we fear this will be used as a stick to beat practices who have made decisions in the best interests of their patients. Many patients will also be concerned to receive unsolicited texts following a consultation at their practice. Patient experience is suffering because of years of underfunding – trying to pin blame on general practice is completely unacceptable and looks like a desperate and cowardly attempt to shift the focus.
5. *Publication of appointment activity and patient satisfaction at practice level*: This will almost certainly be used in a punitive way against practices; it will simply worsen practice morale and will likely negatively impact patient experience if practices and GPs are forced to make changes to the services they provide in response to this.
6. *Expanding the Access Improvement Programme*: *When a wholesale rescue package is needed for all practices,* only 200 practices (that's less than 3% of all practices in England) will benefit from the expansion of this existing programme. Again, this will simply be NHSEI and CCGs performance managing practices that they believe are underperforming.
7. *ICS performance management of 'unacceptable variation'*: This ICS review of national and local data, will mean 20% of practices will be performance managed. ICSs will develop plans, without input from the relevant practices or LMCs, and NHSEI will approve performance management processes. There will always be a bottom 20%, so this initiative is just another stick to keep beating practices with. NHSEI has made engagement with this process a requirement to access the Winter Access Fund – again, another unnecessary string attached to this package.
8. *CQC (Care Quality Commission) rapid inspection programme*: NHSEI and Government support unannounced CQC inspections where CQC believe there are concerns, based on a CQC-devised rapid inspection methodology. This punitive approach is not acceptable and, rather

than freeing them up to provide additional direct patient care, will only add to existing practice burden. The practices struggling most to deliver patient access will have their precious clinical time diverted to answering inspection questions, thereby exacerbating the problem. This is in no way supportive of general practice; but to make matters worse NHSEI has threatened contractual action against any practice that does not engage with this process, which is completely unacceptable and shows a lack of empathy for the strain GPs and practice staff are already under.

Zero tolerance of abuse and public communications

1. *Informing patients about access routes to general practice*: While this information campaign is welcome, it is extremely and unacceptably late given it is something we have called for since the start of the pandemic.
2. *£5m to facilitate essential upgrades to practice security*: Funding to improve practice security is something we have called for, however the small amount being provided (equating to around £750 per practice) and the fact that this will be decided by NHSEI regional teams (rather than based on practice need) is utterly inadequate. Practices are facing abuse and aggression on a daily basis and some practices are seeing a clear rise in violent incidents directed against them. In addition to security upgrades we have also called for investment in the wider general practice estate, something that this package is sorely lacking.
3. *Government zero-tolerance campaign*: this is something we have been calling for and is long overdue. We welcome the opportunity to be involved in the design of this campaign but fear that the profession's voice will once again fall on deaf ears. The Government must be voluble and unequivocal about the unacceptability of abuse, aggression or violence directed towards GPs and their staff.
4. *Government legislating for doubling the maximum prison sentence for common assault of an NHS worker*: Again, this is something we have called for and is welcome, but this will take time and has no immediate impact on practices or patients.

The fact that NHSEI has made minor mention of abuse, aggression and violence toward NHS staff, and not fully acknowledged the huge increase of this for general practice, is really concerning. This should have been front and centre of their 'package'.

In summary, of the 29 initiatives included in NHSEI's package, our analysis suggests that 10 are not new or simply re-stating existing provisions, nine will provide no additional support for general practice (which is the main purpose of this package), three have potential to provide support but not immediately, and just seven may provide some new support for general practice, however when taken together the support these seven initiatives provide will be very little compared to the punitive approach that is being pursued.

This also does not take into account the missed opportunity of not reducing existing workload to free up the current workforce to focus on direct and immediate patient facing care.

Taken as a whole package, we do not believe this will provide meaningful additional support for general practice, enable any major impact for patient access, or provide any immediate desperately-needed support against aggression, abuse and violence against practices.

As a result of this missed opportunity the Government has increased the risk of general practice failing across entire localities this winter. Where general practice collapses the NHS collapses with it, and we must now fear for the viability of the entire service this winter.