BMA response to the Public Accounts Committee inquiry into Access to General Practice

About the BMA
The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

Executive Summary
We welcome the Public Accounts Committee’s timely inquiry into access to general practice. In this response, which has been informed by our General Practitioners Committee (GPC), we seek to address the challenges raised in the National Audit Office (NAO) report improving patient access to general practice. We believe the issues raised in the report are part of a wider picture of concern across an NHS which is struggling with unprecedented patient demand, set against a backdrop of crippling financial restraint. With bed occupancy at record highs, social care on the brink of collapse, and general practice in crisis, we now consider the NHS to be at breaking point. Key points raised in this submission include:

• The funding allocation in general practice needs to be reconsidered, to meet the aims of the GPFV, given that despite the growing demand for services, the proportion of NHS funding spent on general practice has fallen from 10.4% in 2005/6 to 8.1% in 2014/15. The BMA believes that funding spent on general practice must reach a minimum of 11% of NHS spend to ameliorate the crisis general practice is in and to ensure patients are able to access the care they need.
• General practice has an effective funding deficit of at least £2.5bn which is starving GP practices of resources and exacerbating shortages in appointments.
• Unless sufficient resource is made available to general practice, and as it is currently struggling to meet patient demand with existing staff numbers during the week, NHS England and commissioners must reconsider the consequences of their plans to extend opening hours to general practice at the earliest possible opportunity.
• There is a need for flexibility to meet the needs of patients in different areas. Practices should seek to address this by offering extended access through collaborative working. This is more cost-effective model than individual practices trying to do so on their own.
• The BMA is calling on government to deliver on its commitment to help stabilise general practice in England in the face of soaring demand, a critical shortage of GPs and excessive bureaucracy. It must ensure a manageable, safe workload for GPs and enable longer consultations (of 15 minutes or more) to address the increasing needs of patients with multiple and complex conditions.
• The main General Medical Services (GMS) contract, which covers core services, does not preclude service redesign or collaborative working. There are lots of examples of services built around the core contract providing extended access.
• We believe that linking up general practice through steps such as hub working and greater integration with other local services is important. This includes incorporating skill-mix to help free up GP capacity, such as offering direct access to physiotherapy appointments.
• There is also a need to improve the image of general practice as a career option to increase recruitment, alongside supporting the independent contractor status model and flexible career options and working patterns for GPs.
• To support practices taking on trainees it is crucial to ensure that appropriate resource and support is provided to practices taking on these trainees, to allow them to continue to manage existing pressures.
• There should be a comprehensive consultation and evaluation on how best to structure and roll out technological innovations, such as web consultations, to ensure they demonstrate clinical and benefits, and are cost effective when looking at measures to increase access.
1. **NAO report: Overview of the current situation**

1.1. The BMA recognises that the NAO report *Improving Patient Access to General Practice*, raises very timely questions about efforts to fill workforce gaps in general practice, which auditors found were ‘at particular risk from falling retention, shortfalls in recruitment and increases in part-time working’. The BMA’s 2016 survey of over 5,000 GPs, supports the NAO’s concerns that there are serious shortfalls in the number of doctors choosing to train as GPs and that senior GPs are choosing to retire early or leave the NHS due to increasing pressures\(^1\). More broadly, while we support some of the NAO’s findings and recommendations regarding access to general practice, we do have some concerns regarding its criticism over value for money. Per-patient cost of a year of general practice care is less than the cost of just two emergency department visits, based on the average cost of an A&E visit and total average payment to a GP practice per patient per year\(^2\). We believe this represents excellent value for money. However, despite this value for money and a growing demand for GP services, the proportion of NHS funding spent on general practice has actually fallen from 10.4% in 2005/6 to 8.1% in 2014/15\(^3\).

1.2. We believe that this demonstrates that government’s approach to funding allocation (see also below) is contrary to evidence which shows that investment in general practice reduces secondary care costs and is therefore, crucial to NHS sustainability. It also runs counter to the intention of delivering more care in the community, a central theme running through the *Five Year Forward View* (5YFV).

1.3. We agree with the NAO summation that the Department of Health (DH) and NHS England ‘have not fully considered the consequences and cost-effectiveness of their commitment to extend access’\(^4\); specifically recognition that funding in general practice is struggling to meet current patient demand. For this reason we recommend that NHS England and commissioners need to reconsider at the earliest possible opportunity the consequences of their plans to extend hours across seven days, which will significantly impact service delivery by stretching existing services and resource across more days.

2. **Allocation funding**

2.1. Following national policy directives from the DH since the 2012 Health and Social Care Act, and since NHS England and HEE (Health Education England) were established, focus has shifted within the healthcare system to prioritise seeing patients in primary and community care settings. This has the objective of allowing patients to be treated closer to home and for a patient’s care and treatment to be managed long before their health deteriorates to crisis stage. We believe that this approach is without doubt best for patients, but also makes more effective and efficient use of NHS resources. We have always been supportive of the rationale behind moving more care into the community. However, for existing, expanded and new services to deliver strong patient outcomes, resource has to follow the transfer of diagnosis and treatment from secondary to primary care.

2.2. As outlined above, the percentage of NHS funding spent on general practice has fallen, leaving practices receiving an average of only £141 per patient to deliver a year of general practice care. This means general practice has an effective funding deficit of at least £2.5bn\(^4\). This is starving GP practices of resources and exacerbating shortages in appointments. The result is that general

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practice does not have sufficient funds for the workforce, premises or services needed to meet the growing demand of patients and this is undermining the safety of care delivered. Delayed access for patients, intense practice workload and practice recruitment difficulties are now frequent. The BMA has been publically calling for a rebalancing of resources since 2012, most recently in Responsive, Safe and Sustainable: Our urgent prescription for general practice⁵.

2.3. To address these concerns it is the BMA’s view that funding spent on general practice must reach a minimum of 11% of NHS spend to ameliorate the crisis general practice is in and to ensure patients are able to access the care they need. The GPFV announced an additional £2.4 billion recurrent spending will be invested in general practice by 2020/21 in addition to a non-recurrent £508 million funding for additional schemes, including practice transformational support and a new practice resilience programme. This will take us some way towards this goal, by raising general practice’s share of the NHS budget from 9.6% in 2015/16 to 10.1% in 2020/21, with funding up from £9.6 billion to £12 billion. However, this remains lower than the 11%, or £2.5bn, we believe is necessary and it will take longer to deliver than patients and the profession need.

3. **Contractual arrangements and commissioning**

3.1 We are deeply concerned that the NAO’s report into improving access to general practice found that the DH and NHS England are attempting to increasing access whilst not fully being aware of the demand for services or the capacity of the current system. We are particularly concerned that, owing to fragmented data sharing arrangements and protocols, many commissioners may not have robust baselines for understanding practices’ capacity, and what is known is often limited to the agreement in the contract between NHS England, CCGs and individual GP practices. This restricts the ability of commissioners to oversee access to general practice services and impacts their ability to commission appropriate care within their area of responsibility. We believe that to address this, commissioners need to have a better understanding of what doctors can realistically deliver and what patients want and need. This includes a better understanding of both the demands placed upon GPs by patients with the greatest need, as well as ensuring excluded and vulnerable groups, who may face poorer health outcomes, have sufficient and appropriate access to GP services.

3.2 We recognise and agree with the NAO’s comment that new commissioning arrangements offer the opportunity of greater local understanding in the management of services. To achieve this it is crucial that commissioners listen to GPs and patients to get a better understanding of why access remains variable. NHS England’s guidance for commissioners on how to involve patients and the public in designing service care models is helpful in ensuring commissioning is based on need. The guidance also includes some useful best practice case studies. We believe it is important that commissioners reach out to communities to ensure local services reflect what patients want and need. When people are involved in and can influence decisions that directly affect their lives, it empowers them and increases self-confidence.

3.3 The NAO notes that the main GMS (General Medical Services) contract does not set absolute requirements on access to services including practice opening hours, highlighting that shorter opening hours are associated with poorer outcomes. We recognise that while practices are typically contracted to provide services between 8 am and 6.30 pm on Monday to Friday, they can often tailor their opening hours to meet the reasonable needs of their patients. In addition GP practices often hold a number of other locally commissioned contracts for wider services, including schemes related to access both in and out of hours. Because of this variation it is necessary for commissioners to look at the whole picture of local access in order to determine where there are shortfalls, and how resource should be best allocated.

3.4 It should be noted that the GMS contract does not preclude service redesign or collaborative working. The contract only covers core services and there are lots of examples of services built

⁵BMA, Responsive, Safe and Sustainable: Our urgent prescription for general practice
around the core contract providing extended access, proving that increasing access is not just about minimum opening hours.

3.5 We believe that in an environment of tight public funding it is important that lessons from existing schemes are learnt. One example of this is The Prime Minister’s GP Access Fund (originally Challenge Fund), which provided £175m of funding to improve access to general practice, seven days a week, across two waves of pilot sites. Combined, the two waves cover a population of over 18 million across 2,500 practices in 37 pilot sites. The evaluation of the first wave found that ‘collectively the pilots have been successful at providing additional GP appointments as well as providing more hours for patients to access other clinicians’6. However, the evaluation also confirmed that demand is variable across the week: ‘the vast majority of pilots suggest that utilisation of the extended hours appointments is generally high in the week. There is also evident demand on Saturdays (mornings more so than afternoons) but there is typically very low utilisation of Sunday GP appointments’. The GP Forward View recognised that improving access ‘is not about every practice opening 7 days a week’ and that the ‘level of capacity required on different days of the week will be up to individual commissioners and schemes to determine in light of patient demand in their area’. In light of this, it is vital that the ‘minimum requirements’, which are currently being developed, are evidenced-based and give localities the flexibility to improve access in a way which meets local patient needs.

3.6 We believe that in order to provide the highest quality and continuity of care for patients, GPs must continue to lead the delivery of primary healthcare, centred on the registered list model. However, this independent contractor status model does not prevent GPs from working collaboratively or collectively with other practices, or other health and care professionals. In fact many of our members are working at-scale through GP networks, which can give patients timely access to a trusted local practice team, while also offering access to wider community-based health and care services. These types of flexible, and innovative approaches, to managing limited resources, is in our opinion, a better way of managing need than focussing rigidly on opening hours of individual practices. In addition, we would emphasise that common reasons surgeries close to patients is for practice staff to undertake training, routine administration, to have team meetings or carry out appraisals. These types of activities must be undertaken, and placing unrealistic demands on GPs to juggle practice administration and patient care with insufficient resource, coupled with workforce shortages can contribute to falling morale and reduce the level of patient care.

4. Supplying staff

4.1 We echo the NAO’s concerns that there is variability in waiting times to see a GP from one practice to the next, indicating there is an issue with providing a standard level of access to every patient, and significant concerns regarding workforce retention and recruitment. A year after the government promised to recruit 5,000 more GPs, the BMA’s 2016 survey of over 5,000 GPs found that 31% of practices are still unable to fill GP vacancies at all, while 27% are unable to fill vacancies within 6 months7. To address this and help get more GPs into practices, we believe the government should work to promote the uptake of general practice amongst trainees, retain GPs within the workforce and work to attract more GPs back into the workforce.

4.2 There is also a need for continuing cooperation with the BMA to implement the recommendations in the BMA’s report GP Safe working and locality hubs to ensure the current number of GPs are able to deliver safe care to their patients. These include a safe level of appointments per day, appointment times that are sufficient to accommodate patient need, and support for the rollout of ‘locality hubs’, where appropriate, to help combine local resources in areas where demand outstrips capacity. In addition, as outlined in the previous section of this response, practices should also seek to offer extended access through collaborative working. We

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consider that this approach is more cost-effective than individual practices trying to do so on their own.

4.3 Recruiting trainees is a significant aspect of increasing the general practice workforce to better meet patient demand. The NAO highlighted that HEE had only filled 93 per cent of GP training places in 2016/17, although this was an increase from 2015/16, suggesting while some progress is being made, there is still improvement needed. One improvement should be to address the understandable concerns medical students and foundation doctors’ may have regarding the level of pressure that currently exists in general practice.

4.4 We believe that the vicious cycle of intense workload and increasing GP vacancies leading to fewer general practice trainees must be broken if access to general practice is to be genuinely improved. Alongside improving the image of general practice as a career option, it is also important that the independent contractor status model, flexible career options and working patterns for GPs are supported, as these present a range of options for new trainees increasing the likelihood that they’ll find a career into GP that is right for them.

4.5 While it is imperative that sufficient high quality GP trainees are recruited, it is just as crucial to ensure that appropriate support is provided to practices taking on these trainees. There is a need to acknowledge that trainees, while an essential part of ensuring sustainability of general practice, do require a significant amount of time and resource from existing practices who may already be struggling to meet patient demand. One member estimated the cost of taking on a trainee to their practice equated to upwards of £70,000 per year. We therefore believe it is imperative that existing financial support for training continues, otherwise the cost implications may adversely impact the number of practices willing, or even able, to take on trainees.

5. Innovation

5.1 The BMA is supportive of commissioners and practitioners exploring new and innovative models of delivering care. However, we believe that it is imperative that these approaches are evidence based and best meet the needs of patients, while not placing additional burden on GPs themselves.

5.1 Greater use of technology can be an effective way of managing demand, by providing alternatives to face-to-face consultations. However, there are concerns which must be managed if technology is to successfully ease GP’s workload. Setting up and maintaining effective IT infrastructure for phone and web consultations will require extra resources and staff time. Remote consultations also rely on patients having reliable signal or internet connections, which practices cannot control. As part of increasing the use of technology to improve access to general practice, it is important that different people’s communication needs be considered. GP practices are increasingly providing patients with online and phone access to services, including booking of appointments and ordering repeat prescriptions. However, some patients do not have access to the internet and those hard of hearing will not be able to use phone services. Implementation of the new Accessible Information Standard, which all organisations providing NHS care or adult social care are required to follow, will be an important step in ensuring that hard to reach parts of the population are included, especially as these groups often have the lowest health outcomes.

5.2 Our ‘National Survey of GPs, The future of General Practice 2015’ found that 65% of GPs are worried that introducing video or web consultations will increase their workload. There is a particular concern that email consultations will be on top of current workload and harder to manage, as they will not have discrete timed boundaries in the way that traditional consultations do. This was borne out in feedback from members, which suggests that telephone consultations don’t reduce the number of consultations doctors have, as often they just ask the patient to come
in after the consultation for re-assurance. In addition the pressure to carry out many more, shorter consultations in a given time period is likely to add to GP stress, which could in turn impact further on retention and recruitment. Fifty percent of respondents to the BMA’s survey were also concerned about clinical limitations of video or web consultations. We therefore recommend that there must be comprehensive consultation and evaluation with the profession, patients and the community about how best to structure and roll out such opportunities, and ensure they demonstrate clinical benefits. It is also clear that providing more services and communications online will require significant additional funding and training of staff to use them effectively.

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