

Call to action for general practice

The BMA's call to action for general practice, created by GPs for GPs, is our strategy for what we need to provide high-quality care for our patients and brings together GPCE's (GPs committee England) existing policy calls.

We want the Government to trust GPs to deliver the care that our patients deserve, and to do this, we need:

- **more investment in general practice** to deliver better local, long-term care for patients
- support with **expanding the GP workforce** so that we have the equivalent of at least 40,000 full-time, qualified GPs in post by 2030/31
- **safer, greener infrastructure** to bring general practices into the 21st century and provide better care
- **more control** to practices so they can work collaboratively at scale, while offering continuity of care
- the necessary **time** to provide better quality care by removing unnecessary bureaucracy and box-ticking.

The profession's demands of Government

- Government must increase funding for general practice to enable practices to deliver the core agreed services and provide the quality care that patients deserve.
- Government must commit to a workforce plan that contains funded recruitment and retention policies that *will* increase GP numbers to the equivalent of at least 40,000 fully qualified full-time GPs within seven years (by 2030/31).
- Government must remove any bureaucratic hurdles, box ticking and targets that are not clinically necessary, and take GPs away from providing quality care.
- Government must agree a contract that trusts GPs to deliver the care they are trained to provide and know their patients need.

Wider context and basis for a new negotiated contract

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Workforce

- Establish a fully resourced and immutable seven-year plan to bring numbers of FTE (full-time equivalent) GPs up to at least 40,000 by 2030/31 to meet projected demands in this period.¹
- End the punitive pensions taxation structure faced by GPs and other doctors and agree a tax unregistered scheme for those impacted by pension taxation in the NHS, along with other mitigatory measures.
- Resolve the restrictions that exist around obtaining Tier 2 visas for prospective GPs.
- ‘What we need for what we do’ based on population demographics, prevalence and safe working limits with adequate and uplifted funding for services ordinarily expected to be delivered in general practice.
- Safer working recommendations to be adopted by all practices and supported by NHSE with capping of contacts universally applied to ensure safe patient care.
- Recognition, measurement and management of all work undertaken by GPs in general practice – not just that recorded as an appointment.
- As GPs provide more complex care, there must be recognition of how that care is provided must change, eg longer appointments to ensure optimal patient care at first time of asking; innovative ways of providing care etc.
- Urgent review of the GP retainer scheme, expanding its scope to include GPs working in all sessional and IC (independent contractor) roles, and a funded ‘off ramp’ that includes re-entering the scheme for longer periods if the external factors that trigger entry to the scheme are unchanged.
- Golden handshake and other recruitment incentive schemes to be extended beyond partners to include sessional GPs.
- A nationally co-ordinated and funded retention scheme for GPs towards the end of their careers to encourage these experienced GPs to stay within the profession, eg supported mentorship roles; support of partial retirement; development of transitional arrangements etc to retain workforce and pass on expertise.
- Fully resourced occupational health service for all practice staff, which is supported by the GP retention scheme through increased flexibility supporting periods of ill health.
- Contract must support equality of pay to eliminate the gender pay gap.
- Pay restoration for salaried GPs when fully funded by NHSE to employing practices

How we provide care

- GP services must be designed and resourced to prioritise continuity of care to their patients as recommended by the [Parliamentary Health and Social Care Committee](#) and the Royal College of General Practitioners.
- GPs should be enabled to use the full depth and breadth of their skill set to provide holistic care to their patients, with all suitable tasks undertaken by others. GPs should be doing what only GPs can do.
- GPs working with patients are best placed to understand their needs and design practice services within their community to provide for their reasonable needs. This principle should be followed at ICB (integrated care board) and place level.
- Government, NHSE (NHS England), and GPCE agree nationally on communication to patients on what they can reasonably expect their practice to provide, and agree that this reasonable expectation be fully resourced.
- Patients have a reasonable expectation of access to timely care, and practices must communicate effectively what services they can provide and what patients can expect.
- Practices provide excellent access to their services and current pressures exist solely around the mismatch between commissioned capacity in general practice and patient demand for GP time.
- Practices and systems agree how to measure workload and capacity and agree escalation plans.

¹ [The GP shortfall in numbers - The Health Foundation](#)

Wider context and basis for a new negotiated contract

Quality

- Remove QOF (Quality and Outcomes Framework), IIF (Investment and Impact Fund) and all other micro targets, and introduce a quality improvement approach with data available to practices.
- Remove general practice from CQC's (Care Quality Commission) remit and replace this with a quality improvement-based GP contract.
- General practice must rapidly evolve into an environment in which GPs can work safely and provide high-quality care to their patients.
- General practice contracts should include provision for a quality improvement approach to all long-term conditions.

Working at scale

- Because it has proven to be a failed project that results in a postcode lottery for patients and patchy staff recruitment for providers, abolish the PCN DES (Primary Care Network Directed Enhanced Service) and move all funding and resources into core GMS (general medical services).
- Encourage practices to work collaboratively to provide general practice at scale, but only those services that need to be provided at scale, and all practice level activity to be contracted and resourced at practice level.
- Contractual arrangements must adequately resource this collaboration, and a national framework contract developed.
- Collaboration to be locally led and designed, with effective OD support and resources.
- ARRS staff to be redeployed to support the provision of core general practice care as their primary function.

GP contract

- A fit-for-purpose and modern core GP contract that is based on agreed ideals between GPs and NHSE; a high trust environment with the support and recognition of the professionalism of GPs and their desire to provide high-quality care for their patients; and low regulation.
- Agreed core offer that all GP practices deliver with regular reviews to identify and resource any additions.
- A unified contract with all funding through one contracting mechanism.
 - All QOF, IIF, and PCN DES funds to be moved into core general practice funding with simplification of all contracting and resourcing streams.
- Sufficient GMS funding to enable practices to deliver the agreed core services.
- GP practices to be the preferred provider for all clinical services commissioned in general practice that would ordinarily be provided by general practice. This scope to be agreed with NHSE.
- Locally negotiated contracts for the provision of locally developed services not in the agreed core offer to be based upon nationally agreed frameworks and principles for contracting and resourcing services.
- Practice expenses to be recognised, regularly updated in scope, separately funded and ringfenced, and subject to annual inflationary uplifts based on RPI. Funding for the GP practice workforce.
 - Workforce expenses to be funded separately and to be uplifted at least annually in line with the DDRB (Doctors' and Dentists' Review Body) and AfC (Agenda for Change) recommendations to include non-contractor GPs to ensure equity of pay for general practice employees
 - Resource and support moving all non-GP employees onto fully funded Agenda for Change contracts, with commitment to covering ongoing costs.
- Quality monitoring and regulation of contracting must be light touch with low levels of bureaucracy. Agreed provisions of quality improvement principles to be the primary mechanism of core GMS contracting.

Wider context and basis for a new negotiated contract

Continuous education

- GPs are on a lifelong learning journey and need time for study and access to resources and appropriate supervision throughout their careers.
- Access to fully resourced CPD (continuing professional development), coordinated by local education hubs, with backfill to practices, to meet the ongoing requirements of revalidation.
- Adequately resourced and backfilled education and supervision of GP trainees and non-GP clinicians working in general practice.
- Time and resources for supervision and training of trainees (GP and other clinical professions) must automatically follow the trainee; be adequate for its intended purpose; include backfill for trainers.
- Protected and funded time in the working week for training, education and CPD – with the introduction of SPA (supporting professional activities) type arrangements into GP job plans.

Infrastructure

- Fully funded long-term premises plan to be prioritised and initiated to bring all premises to standard and future-proofed, with standards set and maintained for practice and population size.
- Fully funded and installed modern and future proofed IT solutions to meet the needs of patients and practices.
- National standards of general practice infrastructure must be agreed, resourced and universally applied across England. This should include but not be limited to premises; IT; medicines and consumable medical products within practices.
- The standards and the resource be regularly reviewed in their scope, remit and value, with agreed changes to be automatically applied.
- A national review of GP premises and an urgent action plan agreed and resourced to bring all GP premises up to standard, and future-proofed.

Ways of Working

- Gaps in commissioned services ordinarily expected to be delivered must be identified and resolved to prevent general practice being the unfunded provider of last resort.
- All unfunded, non-contractual work including from secondary care must be stopped from being passed to general practice, with contractual levers applied to ensure system-wide adherence.
- Transfer of unresourced workload from other providers – who do so because they cannot manage their own high-pressured workload – to become a 'never' event, with systemic measures in place to review, fund and resolve breaches.
- Respect, equity of esteem, and recognition of all forms of general practice working to provide NHS services.
- A nationally agreed, fully funded and universally applied BMA model salaried GP contract adopted by all employers in all environments in which GPs are employed.
- Recognition and support for the independent contractor model as the best and ideal mechanism for the provision of practice-level contracting, while respecting the multitude of ways in which GPs choose to work within the NHS.
- Support and resource a move to 15 minutes as the standard quantum of GP appointments, and organisational development support to encourage systems that have flexible appointment times dependent on the complexity of patient problems.
- Equity of esteem and representation between general practice and other providers at ICB level.

Wellbeing

- Development and provision of a fully funded occupational health service for all GP staff.
- Locally adapted, easily accessed service, which is supportive of staff, GPs and practices.
- No clinician to work beyond safe working levels for them or patients.
- Understanding of the false economy of not providing said services.
- It costs considerably more in staff absence than it does to run the requested service and keep the workforce healthy.
- The public/patients would support this as a common-sense way to ensure the NHS is always adequately staffed.

BMA

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