PATIENTS FIRST

Why general practice is broken & how we can fix it

BMA

Contents

Foreword **3**

Patients deserve safety stability and hope **5**

What does it mean to patients to 'bring back their family doctor'? **6**

Safety 6

Stability 7

Hope 10

Deliver what patients want, what works and what research tells us the answers are **12**

Patients want access to a GP. Preferably, *their GP* 12

Patients want more time with their clinician of choice 13

Solve the 8am rush 13

Continuity of care is key to prevention 14

Why practices are closing 14

Patients deserve a *new* GP contract 15

NHS productivity – loss of GP hours and exposure to NHS roles matters 15

Harness data as a healthcare asset to drive innovation 16

Premises and estates fit for the 21st century 17

Conclusion **18**

Appendix A – Proposed draft Heads of Terms for a new GMS contract **19**

Appendix B – Letter to SoS from GPCE chair (July 2024) **23**

Appendix C – Sessional GP vision **27**

Appendix D – Joint letter to PM re GP premises (2019) **30**

References **32**

Foreword

Despite its extremely low funding, Professor Lord Ara Darzi's September 2024 report[1] on the productivity of the NHS across England singled out general practice for its unprecedentedly high activity.

The 'front door' to the NHS for an average of nearly **1.5 million appointments every day**, yet collapsing from 15 years of funding erosion, **GP practices across England currently only receive 5.5p out of every pound spent on the NHS for the core (essential) services they are contracted to deliver**. The new Labour Government has begun to invest, but the scale of the challenge is clear: recent uplifts have only contributed a single additional penny per patient per day.

The average GP Practice receives a mere £112.50 each year per patient for essential services – around 31p per patient per day – for unlimited work.

It's no wonder practices are closing; they're no longer financially viable. If one or two practices close, *they* have a problem. But around 2,000 independent GP practices have been lost since 2010 – that's one in five local surgeries. That's a problem for all of us as patients and the NHS in general.

This paper is a vision and a toolkit for how to deliver what patients want from the NHS. In 2023's British social attitudes survey,[2] **91% of the public supported an NHS free at the point of service**. 82% supported this being funded by central taxes and universal for all. To protect these precious principles, the NHS needs a fixed 'front door'.

Fixing the NHS must start with bringing back the family doctor. Patients want the Government to fix the broken general practice it has inherited and deliver them a safe and stable local GP surgery and the family doctor they know and trust.

We need to keep things simple. We need:
- **more GPs** to meet the needs of our patients
- **more GP appointments** to stop the 8am rush
- **more GP Practice Nurses** – familiar faces known and trusted by the patients who need them most
- **more GP Practice Nurse appointments** delivering local joined-up care closer to home in the community
- **better continuity of care** – by seeing the same clinician, patients can build trust in who delivers their care and receive better customer service.

Instead, patients see the problems first hand:
- **More patient need, but fewer GPs**
  - *There has been an increase of 6.5million patients registered with a GP in England since 2015. The average number of patients per full-time equivalent, fully qualified GP is now nearly 2,300 (up from just under 2,000 in 2015)[3]*

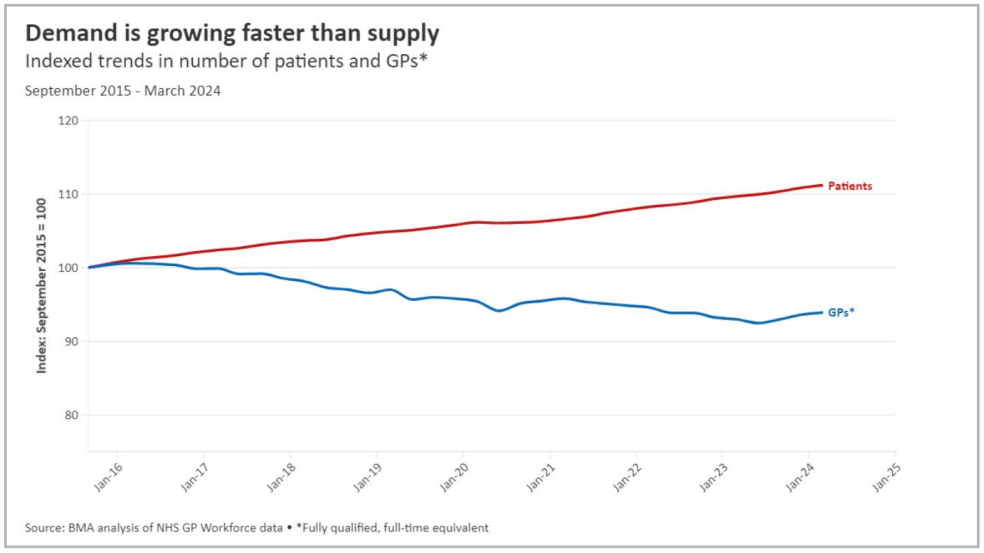
- **Difficulty accessing a GP or GP Practice Nurse appointment**
  - *Despite an average of nearly 1.5 million appointments delivered per working day; 40% same day requests and a clear majority (65%) delivered face-to-face,[4] too often patients cannot get timely appointments with a regular family doctor or nurse. There has been an increase in 50 million appointments with wider team members since 2020 but extraordinarily little research or evaluation into how patient outcomes and satisfaction have changed since.*

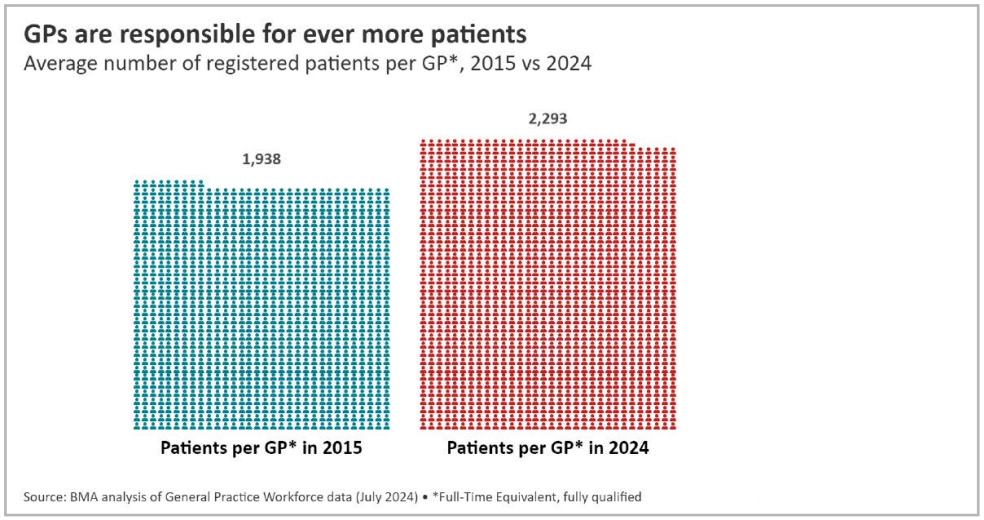
- **More GPs in training but more GPs leaving**
  - *In the last five years, the proportion of GP registrars taking up qualified GP positions within a year of obtaining their CCT (certificate of completion of training) has dropped from 48% to 38%[5] representing an expensive brain drain for the patient as taxpayer*

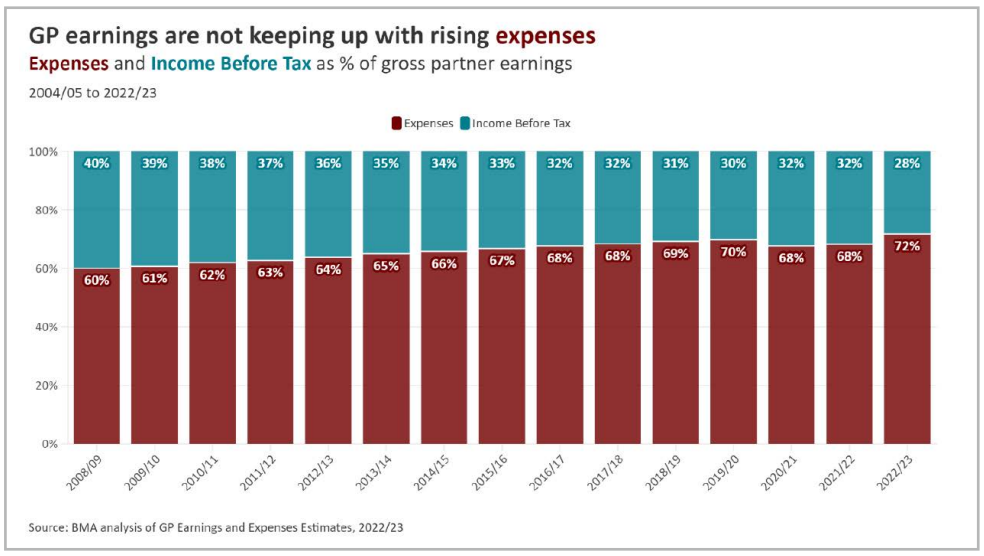
Contents

- **More patient need, but fewer GP Practices**
  - *Over 2,000 GP practices have been lost since September 2010;[6] between 2013 and 2023, the number of independent GP practices fell by 20%.[7]*

Patients are seeing their GPs and practice teams tired of having to fight to survive just so they can provide safe patient care. Patients desperately want a Government on their side to help deliver the general practice they deserve and to bring back their family doctor.







Contents

Patients deserve safety, stability and hope

1. **Safe GP services now**: Immediate action now to embed solutions which have already been accounted for in this financial year, but which will help retain the experienced GPs we have, take on the GPs we need, and mitigate further NHS GP Practice closures.

2. **Stability for next year (2025/26):** with a deal for England's family doctors that will deliver an additional 11p per patient per day, keep practices open and deliver more GP and GP Practice Nurse appointments to stop the 8am rush.

3. **Longer term hope:** in the Government's forthcoming 10-Year NHS Plan with a commitment to a new GP contract that re-ignites patient hope in the future of the NHS.

2024 marks 24 years until the NHS celebrates its centenary. To protect its future, we need to learn from its past. Just like in 1948, when the NHS was first established, the new Labour Government has an opportunity to be bold. Patients must come first. By learning from other European health systems and turning the NHS on its head, we can shift patient focus towards a proactive, preventative, holistic, data-driven, expert-generalist led community-based footing. Shifting away from a reactive and expensive hospital-centred crisis care model will save money for re-investment, as well as lives.

The BMA is the sole trade union and professional association for GPs. GPC England is its elected committee. We are family doctors, elected by other family doctors, and we are feeding back what patients tell our profession every day. We want our patients to feel safe and secure when they access care from their practice, and we want to support them in living longer and healthier lives.

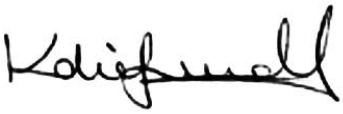
We want collaboration, not conflict.

We want solutions, not problems.

To put patients first, Government and profession, we each have a professional duty to seize the opportunities before us.

We need to commit to transforming the NHS over the next decade into a:

– **digitally led**
– **home-first; community-second; admission-last model**, which
– **prioritises ill-health prevention** and **builds back holistic care** via
– **expert GP-led community practice services**.



Dr Katie Bramall-Stainer
Chair, GPC England

Contents

What does it mean to patients to 'bring back their family doctor'?

It means:
- Protecting and resourcing the GP **expert generalist**
- As gatekeeper to an NHS free at the point of use
- Able to **manage risk and uncertainty**
- Through delivery of relationship-based **continuity of care** across a community
- Driving down unnecessary or unwarranted interventions
- **Focusing on prevention**
- Taking a **holistic, person-centred approach**
- To be the **patient's advocate** – their guide when they need to access the wider NHS.

This is a patient-led vision for a sustainable NHS, as much as it is the sustainable model for general practice.

Safety

Safe GP services now: immediate action to prevent further GP unemployment and emigration, and to stop practice closures.

We must create sustainable NHS GP Practice solutions for family doctors seeking employment

- In a recent BMA survey, **80% of unemployed or underutilised locum GPs stated they want more NHS GP work** but are struggling to find it. Developing a comprehensive substantive longer term solution to embed these GPs in practices beyond the 2024 emergency ARRS measures will be urgently required, lest we risk further increasing the multi-billion-pound brain-drain of the past decade.

- There is evidence that the Targeted Enhanced Recruitment Scheme has been incredibly effective in getting doctors to train in under-doctored areas, so **incentives work to get GPs into rural posts**. Consideration of relocation expenses and 'Golden Hellos' could also alleviate financial barriers to working in remote/rural under-doctored areas, and reinstatement of the **New to GP Partnership Programme**.

- Creating a **two-year fully funded GP fellowship post-CCT practice-level scheme**, part-funded from a review of ARRS budgets and productivity, could enable a rapid means to recruit and retain additional GP roles. Newly qualified GPs and their dependents on Skilled Worker visas could be easily sponsored on such schemes.

- ARRS review could also potentially free up monies to ringfence funding for practice-based **GP nursing fellowships** to help practices employ more of the roles they need, and that patients want. Furthermore, **Training Hubs' budgets** should reallocate ring-fenced monies to help support such roles. GP Nurses also deserve parity of esteem with their Trust-employed colleagues by adding GPN locum reimbursement for parental and sickness absence to the SFE (Statement of Financial Entitlements.

We must urgently resource practices to stem the tide of NHS GP Practice closures

- We need to begin to **reverse contract value erosion over the past five years** by supplementing the DDRB award for 2024/25 with urgent additional investment and **fully correcting CPI erosion to item of service tariffs and locum cover practice reimbursement payments.**

Contents

- We also propose for 2025/26 that Government expand these reimbursement payments to enable recruitment of locums to cover periods of active recruitment to substantive posts, and in dealing with the hospital waiting list care backlog.

- Such uplifts provide Government with financial transparency and are wise preventative steps ahead of what promises to be a highly challenging winter for the NHS.

- Due to the lack of investment into the Global Sum, between 2008/9 and 2022/23, **salaried GPs suffered 32-33% pay erosion** (RPI).[8] Even if a salaried GP received a 6% DDRB uplift in 2023/24 and 2024/25, pay erosion since 2008/09 still stands at 26-27% (RPI).[9] **We need a way to secure dedicated ringfenced funding** to begin to restore practice-employed salaried GP pay[10] and determine a pathway to eradicating the gender pay gap.

- The NHS cannot afford to be overwhelmed this winter. The following public health measures are therefore imperative:
  - All at-risk patients need access to free testing; care homes need testing regimens in place now; and **ICBs (integrated care boards) need to recommission centralised CMDUs** (COVID medicine delivery units) where they have failed to do so, to ensure eligible patients receive Paxlovid/Molnupiravir as soon as possible.[11]
  - The previous Government's response was to reduce the Covid vaccination tariff to £7.54 when co-administered with influenza vaccination, **making this programme financially unviable** for many practices and PCNs. NHSE has stated that the Covid vaccination programme cannot be amended.
  - The Government must therefore find means to provide additional investment into other vaccination schemes to increase the number of eligible practices **to sign up to co-administer Covid vaccinations to provide extensive, effective population coverage**.
  - The current vaccination strategy diminishes the role of general practice in delivering immunisation programmes to the registered list, which presents **a public health risk**.

- Government must take immediate steps to protect the most in-need and vulnerable in our society: remove contractual barriers that disproportionately affect those practices serving deprived and vaccine-hesitant populations, by:
  - **Allowing personalised care adjustments** for childhood vaccinations.
  - **Resourcing child and adult safeguarding nationally via a DES** (directed enhanced service) to resource vital, but complex work for practices serving our most deprived and vulnerable communities.
  - **Improving and streamlining faster cancer diagnosis by standardising and enforcing the use of fast-track proformas for urgent suspected cancer pathways across the country**, allowing fast-track referrals from any setting, e.g. emergency departments or privately, where patients may present with symptoms suspicious for malignancy.

Stability

Ahead of 2025/26, we need the Government to work with GPC England to agree a 2025 Family Doctor Charter and a minimum general practice investment standard

- The state of General Practice in 1964 holds startling parallels to 2024: an NHS in decline following years of austerity; patient demand outstripping capacity; GPs undertaking once-in-a-generation industrial action, and a Labour victory in a general election replacing a Conservative government after 13 years
  - The following year, the Wilson Government heralded the 1965 **Family Doctor Charter** together with the BMA's GP Committee. This charter agreed principles that paved the way for the 1966 Red Book contract and heralded a transformation of general practice

Contents

  - A 2025 Family Doctor Charter would signal a commitment from Government, DHSC and NHS England to:
    - **rebuild a model for England NHS general practice** and
    - **bring back the family doctor** by
    - **valuing continuity** with
    - **a minimum general practice investment standard.**

- We must **restore the core: disinvestment in practice funding** has led to **the loss of one in five independent NHS GP practices** across England since 2013. Patients want a local, familiar family doctor practice. The erosion of the national GP practice contract baseline fund – 'Global Sum' – must be reversed.
  - For 2025/26 specifically, **there must be additional investment in the GP core contract** ringfenced for:
    - Practices – to stabilise vulnerable practices, prevent further surgery closures and avoid rationing of services
    - Patients – to sustain general medical services across the NHS and protect patient services being delivered closer to home
    - The electorate – to signal a commitment to 'bring back the family doctor' and invest greater resource into general medical services as committed in the Government's election manifesto.

- **GP practice core funding for essential patient services should increase by at least £40 per weighted registered patient** – increasing the average daily resource per patient by 11 pence for 2025/26.

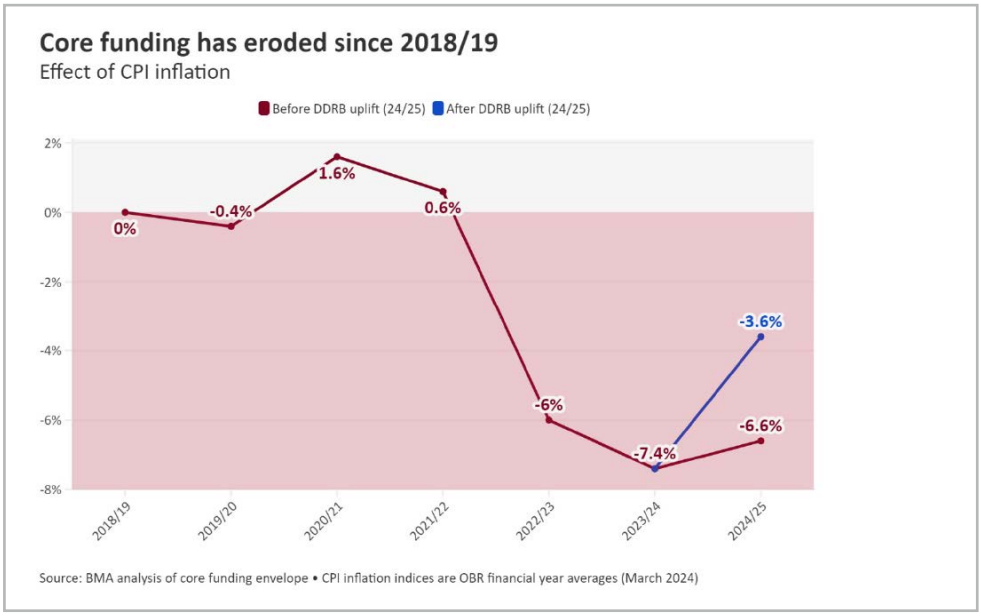
- Longer-term, **there must be a commitment to determining general practice investment plans** in the forthcoming Comprehensive Spending Review (CSR). The 10-Year NHS Plan provides the perfect opportunity to deliver a new GP contract for patients in England, which defines and protects neighbourhood services and the delivery of out-of-hospital care. Led by family doctors who can develop an encyclopaedic knowledge of their patients, their families, and their communities, they will be able to provide continuity of care for years to come.

- A new contract will require a transformative approach: Treasury and DHSC must focus on value for money and productivity within our NHS. The minimum investment standard should be determined **alongside fair annual funding increases to the GP core contract** to recognise population growth, inflation, and provide patients with GPs and practices that have the opportunity to deliver efficient, high quality and safe preventative and long-term expert generalist-led continuity of care.

- **A significant increase in NHS resource will need to be invested in general medical services** in the new national contract to expand its services, and secure the workforce needed to improve patient outcomes, reduce system workload, and reduce the current excessive costs of avoidable care episodes.

- This will provide **cost savings across the NHS** – with patients requiring fewer appointments and referrals, and fewer unplanned urgent or emergency care episodes – offering comfort to the Treasury, and to patients as taxpayers.

Contents



- **"I want to see my usual doctor." Incentivise continuity of care – it saves lives**. Remove the bureaucracy of PCN-level Extended Access for practices so they can prioritise the delivery of care to their own registered patients.

- **A fair deal for GP practice nurse** colleagues with deserved parity of terms with their trust-employed colleagues in parental and sickness leave and pay via a **reimbursement scheme in the SFE.**

- **Joined-up care.** Work with the profession to understand where simple tech could revolutionise pathways and speed acute care flow, e.g. **investing in establishing the Electronic Prescribing Service in Trusts, as well as introducing e-FIT notes.**

- **A greater voice for patients and primary care at the ICB table** to provide fairness and balance in the Government's agenda to reallocate and reinvest NHS resource and prevent spiralling financial losses.

- **Put patients first – ensure solutions to the primary-secondary care interface issues get prioritised by ICBs**, e.g. digital solutions for investigation requests across organisational barriers, and transferring a proportion of outpatient transformation savings into localised contracts to resource practices to proactively assist in waiting list management.

- **Practice data controller liabilities** need to be covered by **adding clinical information governance to the CNSGP** (clinical negligence scheme for General Practice)
  - The GP patient record is integral to patients' trust in their GP, and that integrity and confidence *must* be maintained
  - Government could utilise the richest source of health data in the Western world to raise NHS funds – but maintain integrity, professional standards and public confidence to do so via following the Goldacre Review recommendations with the use of Trusted Research Environments
  - The National Data Guardian has a mantra of "no surprises". That means telling patients how their data is used, for both direct care and secondary uses.

- **Resources for programmes to pilot same-day access should be reallocated into other budgets or designed transparently**: where equitable, populations are given the same funding and KPIs, e.g. patient self-referrals, appropriate usage of secondary urgent care, delayed diagnosis, and preventable morbidity. If such models are to be considered, research them fairly – implementation should be evidence-based rather than ideological.

Contents

Hope

Labour has spoken of no major new investment without major reform – patients and GPs gladly accept this challenge and call for a new substantive GP practice contract to be negotiated in this Parliament

- General practice has been intentionally dismantled by successive recent governments. **Real-terms re-investment must be channelled into General Practice to retain and return family doctors to safe numbers, to guarantee continuity of care for our patients who need it most.**

- Family doctors want to work with the new Government to fix the core GP practice contract, to provide the necessary transparency to invest, to permit GP contractors and partnerships to have the resources to transform, rebuild and reinvigorate general practice at a neighbourhood-level, and to **restore general practice as the bedrock of universal care offered by the NHS to provide greatest value for money to Government and patients as taxpayers alike**.

- The carrot at the end of the stick for us all is the clear evidence from the NHS Confederation and Carnall Farrar[12] showing how **every £1 invested in primary or community care results in up to a £14 return of GDP growth**.

We have an opportunity to be bold and shift NHS focus towards proactive, preventative, data-driven expert generalist medical care in the community, away from a reactive and expensive hospital-focused crisis care model, which will save money for re-investment, as well as lives

- Our nation is now older, and frailer. Many patients live with more than one chronic condition. We need to intervene in pathological processes before they present, through a preventative agenda
  - To do this, we should learn from exemplar nations, **be bold and aim for a gold standard of 1 FTE** (full-time equivalent) **GP per 1,000 patients by 2040.**

- **Practices need GP to patient list size ratios to ensure manageable workloads and patient safety.** List sizes have grown far beyond safe levels across England, and this fuels patients' frustrations
  - The BMA's Safe Working Guidance, based upon UEMO (European Union of General Practitioners) guidance, recommends that GPs deliver no more than 25 patient consultations per day while also safely managing other responsibilities such as pathology results; clinical correspondence; prescribing; patient tasks; home visits; palliative care; clinical training and supervision; associated clinical governance and non-NHS work, e.g. Local Authority, DWP, DVLA, safeguarding.
  - Our 2023/24 survey of general practice across England showed that only 11% of respondents deliver 25 or fewer appointments on a typical day. 89% of GPs told us they deliver 26 or more, with 52% of those delivering between 31 and 50. Improving general practice capacity to facilitate continuity of care through safe patient list sizes will provide the best, as well as the most cost-effective, care for our nation.

- Building neighbourhood and community health transformation around the value for money, productivity, and efficiency of general practice, which guarantees accountability via a named GP and the registered patient list at the core of the NHS, is the natural anchor point.

- **Allow general practice to flourish by wrapping community services around the practice footprint** – make it personalised and GP-led with the resources, modern premises, and diagnostics to match. We believe **this will save Treasury billions.**

Contents

- We need to start conversations around transformative plans and funding for our ageing estates and infrastructure – neighbourhood health centres provide an opportunity, but we also desperately need investment in existing GP practice extensions. We also have resources that could potentially be repurposed from network-level to practice-level.

- We need to go back to the recommendation set out in the Wanless Report (2002) and Marmot Report (2010)
  - improve health literacy in our schools
  - appreciate societal and environmental determinants upon health
  - replace outdated funding formulae, such as Carr-Hill, also reflecting language barriers, deprivation, and multi-morbidity in our communities
  - embed screening programmes that are evidence-based interventions where the cost-effectiveness to the NHS and the safety to the individual are clear
  - initiatives outside national criteria should be part of a validated research project
  - focus additional resources on our most deprived communities to drive up lagging life expectancy across our most deprived Council wards.

Contents

Deliver what patients want, what works and what research tells us the answers are

According to the Commonwealth Fund,[13] four features distinguish top performing countries' healthcare systems:

1. **Remove cost barriers** to ensure **universal coverage**
2. **Invest in general practice** as the **expert generalist gatekeeper** to ensure **equitable outcomes** across all communities with resourced wider primary care
3. **Reduce administrative burdens** that divert time, effort, and spending from health improvement
4. **Invest in social services**, especially for children and working-age adults.

Patients want access to a GP. Preferably, *their* GP

Election promises to 'bring back the family doctor' have clearly chimed with the public. Barriers to accessing a GP have impacted patient outcomes and perpetuated the "inverse care law" across our most deprived communities. Simply put, those most in need of a GP have the poorest access to one. The British Social Attitudes Survey 2023[14] showed 91% of voters want to keep a health service free at the point of use. **If we protect the gatekeeper and rebuild general practice, we have the best chance at fixing the NHS.**

General practice is a people-based service – with exceptional, caring people delivering it. We cannot ignore the very human cost in moral injury to GPs and their practice teams, which has taken place in recent years. Our survey of all GPs and registrars in England, completed by more than 11,000 colleagues in January 2024, confirmed that England's GPs are at breaking point. 22% said it would be unlikely they'd still be working as an NHS GP in three years' time.

As recently as September 2022, the House of Commons HSCC (Health and Social Care Committee) published a report on the future of General Practice,[15] which set out the values of GP-led care, focusing on prioritising both continuity and the gatekeeping role of the GP as the expert generalist as being key to controlling activity and demand on the wider NHS. Considerable academic evidence demonstrates how:

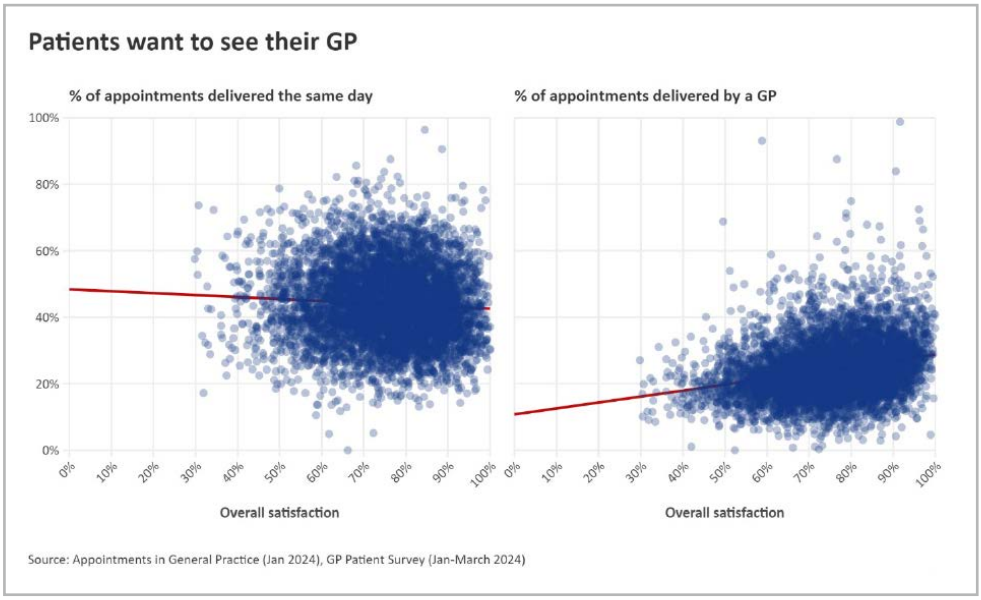
– GP-led continuity of care reduces overall NHS activity and improves patient self-care
– prevents avoidable and costly crisis interventions
– delivers better patient and public health outcomes and
– reduces NHS costs and provides greater job satisfaction.

Unfortunately, recent years have seen successive annual GP practice contract changes in England move further away from this model of delivery. The new Government needs to **enact the recommendations within the HSCC report, which prioritise patient outcomes** and reverse this.

Political priorities in the last government simply focused on *surgery access* rather than *access to a GP*. Patient dissatisfaction doubled over the same period where the value of the GP practice contract was eroded to the tune of c£660 million – compared to five years ago in real-terms – and GP numbers plummeted along with it.

The National GP Patient Survey dataset and the NHSE appointments in general practice national dataset demonstrate that it is being seen by a GP, rather than same-day access, which increases patient satisfaction:

Contents



Patients want more time with their clinician of choice

The opportunity for meaningful change sits with a focus on continuity of care.

PCN workforce reforms to general practice have resulted in less GP access. Some additional roles have been welcomed, but speed of roll-out with a lack of evidence has led to onerous bureaucracy potentially creating delays to diagnosis, greater inefficiency, unknown patient outcomes and patient frustration.

According to the Health Foundation, **the PCN** (primary care networks) **DES is worsening health inequalities**[16] **– but we have an opportunity to achieve the right balance**. The decision to invest in associate roles across primary medical care was undertaken in the USA before England. The evidence did not support the hypothesis, and the findings prompted policymakers to move back to a model of a doctor being the primary provider of family medicine.

Solve the 8am rush

Before millions are allocated to programmes to pilot the aspirations in the Fuller Stocktake, especially around the commissioning of same day urgent presentations, we must pause and reflect on patient safety, cost, and need. A misplaced focus on same-day access in the absence of any increased GP capacity has fuelled the '8 am rush' which frustrates patients, GPs, and their practice teams.

Around 44% of the c.1.5 million daily appointments general practice delivers are **same day requests**. **This reflects firefighting and poorly coordinated overall care**.

Tellingly, **we are now also seeing the lowest proportion of consultations by GPs themselves,** also around 44%, due to **supervising responsibilities for other additional PCN staff**.[17] This imbalance has impacted on practices' ability to offer routine appointments, driven by a relentless focus on 'access' whilst ignoring capacity and fracturing continuity.

Hubs have been suggested for managing "simple" same-day presentations separately from chronic disease management, but **a "simple" diagnosis is one made in retrospect**. Safe **same-day hubs will exclude so many cohorts they will fail to offer value for money**. They will **perpetuate the inverse care law** by **prioritising convenience** for those **patients living in** broadly **good health** at **the expense of those in poorer health** living with multiple complex conditions, or in need of a GP quickly, e.g. paediatric, potentially septic, palliative, or pregnant patients.

Contents

Instead, we should be brave and bold, commit to bringing care closer to the patient and aspire to **one FTE GP per 1,000 patients by 2040, in a new substantive contract protecting the NHS for decades to come**.

Continuity of care is key to prevention

A parent may present with their infant with a same-day acute respiratory illness. Through the examination, history and discussion with the parent, trust is formed and the beginnings of relationship-based care, where opportunities for health promotion and vaccine discussion may better thrive. **This is the essence of family medicine that we have lost in England**.

This is what brings joy back into clinical practice, brings intellectual challenge alongside personal responsibility and makes care safe, as iterated in the excellent HSCC report,[18] where much of the new Parliament's research has already, helpfully, been undertaken.

In a health service free at the point of use, you must embolden and resource the gatekeeper. **If the gatekeeper falls, the health service falls – this is what we are witnessing.**

Resource GPs as the NHS gatekeeper and watch activity, referrals, prescribing, investigations, unnecessary interventions – and costs – fall.

The current state of the NHS was predicted by Derek Wanless in his report. Commissioned by Tony Blair in April 2002 to predict the state of the nation's health and NHS in 2022, he recommended:

- steady, predictable funding uplifts recognising an ageing population, multimorbidity, technological advancement, training costs and sufficient employment of qualified NHS staff
- a focus on health literacy espousing patient-centred care at every level
- public health preventative strategies underpinned by predictable annual rises
- rapid access to expert generalist GPs as gatekeepers within the practice-based model of primary care.

His conclusions were correct; the actions, however, have not been taken. **We need to revisit Wanless**.

Why practices are closing

What can we do to identify those at a higher risk of closure and greater cost to the local NHS system?

Since April 2022 alone, England has lost over 200 independent GP practices.[19]

The restoration of the proportional real terms resource – lost since 2010 – would, we anticipate, cost patients, as taxpayers, and the Treasury billions. The new Government will recognise the paucity of spend, and urgency of need – but must also seek transparency of investment.

A myth has been perpetuated that "*failing practices are due to poor management",* and that *"no one wants to be a GP partner anymore"*. These oft-repeated tropes are not true. **If we compare critical metrics**, such as declining patient satisfaction and CQC ratings, increasing patient population, and declining financial viability, we find that, **nationally, all practices are on the precipice of collapse**. There are very few outliers.

Contents

In other words, **the causes leading to practice closures are systematic, not individual.**

Systemic problems require systemic solutions – practices need fair and proportionate resource, and they need it quickly.[20]

	INDIVIDUAL PRACTICE LEVEL PROBLEM (Occurs in a small minority of practices)	SYSTEM LEVEL PROBLEM (Occurs in a large minority or the majority of practices)
Declining Patient Satisfaction		✓
Declining CQC Ratings (of those re-inspected since April 2022)		✓
Declining FTE GP per 1,000 Patients		✓
Declining Financial Viability		✓
Declining Ability to Keep Pace with Patient Demand for Appointments		✓

Patients deserve a *new* GP contract

The 2004 GMS contract financially penalises GP-led care in favour of lower-quality models of primary medical care. At the same time, the number of GPs choosing to work less than full-time in NHS roles, and develop portfolio careers to supplement this, has been climbing.

GP part-time is everyone else's full-time. In fact, **many full-time GPs are working more than 60 hours a week**. GPs are therefore moving to working patterns that allow better control over hours and NHS workloads to reduce stress, ill-health, and burnout. This also helps them preserve their longevity for an entire career serving their communities.

Most GPs also work additional unpaid hours just to get through the workload. The current NHS definition of full-time now also aligns more with the common average of six sessions compared to the former nine,[21] which indicates longer shifts.

We need to move to hours per week, ensure contractual protections and make sure staff are paid for all the hours they work.

Creating safe patient list to GP ratios will ensure GPs will naturally feel safe to undertake more hours in the NHS, further increasing continuity and professional intellectual satisfaction. GPs who have left the NHS for poorer pay but safer work, will return and patients will feel the benefits.

NHS productivity – loss of GP hours and exposure to NHS roles matters

The hours GPs are choosing to work, across all roles added together, is stable. Government needs to create a safe, stable working environment where GPs will choose to move into NHS practice roles through choice. Aspirations to move to a GP-led model of 1 FTE GP to 1000 patients would achieve this.

Contents

"So many GPs wonder if they're 'doing general practice wrong'. So many consultations not only take longer than the time allotted but also create more work to be done at the end of the day: letters to read, referrals to write, things to look up and pass back to the patient. GPs rarely leave the surgery until the cleaning staff have been and gone. The various alternative models being touted, which promise an efficient service where doctors can concentrate on complex patients while "simple" cases are seen by other healthcare workers, don't look like an improvement. If my patient's problem is straightforward, I can see them quickly, usually building on an existing relationship. If it turns out to be more complicated than the presenting symptoms suggest, I have the training to detect that.

New members of the team (pharmacists, physiotherapists, and specialist nurses) bring their own welcome expertise, but they don't replace the GP colleagues we so clearly need. One of the reasons given for expanding such roles was the shortage of GPs. However, GPs are now out of work because practices can't afford to employ them.

***The down-skilling of general practice is often euphemistically referred to as a "diversification of the workforce," but it's hard not to see it as a deliberate attempt to deprive patients of expert medical care**.*

The motives may relate to cost, despite it being well documented that high quality general practice with built-in continuity saves money overall (as well as lives). The ready availability of resources to pay non-GPs while maintaining that there's no money available to pay actual GPs clearly underscores the intention to down-skill general practice. Many of us believe that it's well past time to push back against the destruction of general practice

Dr Helen Salisbury, BMJ Columnist and Academic GP in Oxford

Harness data as a healthcare asset to drive innovation

The GP patient record is integral to patients' trust in their family doctor, and that integrity must be maintained. Patients will not share their information with their GP if they believe other parties or Government departments may access it.

GPs as Data Controllers need reassurance when legitimately sharing data. Seeking a share in data controllership will only increase liabilities and require a new Act of Parliament. **The most cost-effective way to safeguard liabilities will be to add clinical information governance to the CNSGP**.

Increasingly think tanks and private industry are suggesting the use of the richest source of health data in the western world to raise NHS funds – this is a potentially exciting proposal – but to maintain integrity, professional standards, probity, and public confidence we must enact the recommendations within the Goldacre Review.

Government needs to appreciate that when patients hear or read news stories pertaining to health data security, they come with concerns to their GP as the front door to the NHS. **GPs therefore need to be included and part of the conversation to get this done right. The BMA's and RCGP's Joint GP IT Committee has the support of the profession.**

The National Data Guardian has a mantra of "no surprises" which means telling patients how their data is used, for both direct care and secondary uses – something that GP SystmOnline users can already do. We need to enable this functionality via the NHS app too.

Contents

The "no new emergency"[22] of the Goldacre review remains a chronic unaddressed risk. The BMA and RCGP's JGPITC has been supportive of safe and transparent data use in line with patient wishes. OpenSAFELY is the agreed path forward that keeps all stakeholders at the table throughout, working in patients' interests. None of this needs more expense – just an eye for detail. History will not judge us kindly if we unlock Pandora's box of the GP patient record nationally in ways that only clinical geneticists and actuaries may foresee.

Premises and estates fit for the 21st century

Despite our letter to the then Prime Minister, Boris Johnson, in August 2019 (see Appendix D), General Practice premises continues to need major urgent investment if we are to achieve the aims we all share for our patients.

Professor Lord Ara Darzi's recent review of the NHS[23] stated that 20% of primary care estate predates the founding of the NHS. The shortfall of £37 billion of capital investment "could have rebuilt or refurbished every GP practice in the country."

Were DHSC to allow all premises costs, including management fees, to be reimbursed, this would be significantly cheaper and would remove the inflationary risks from General Practice, stabilising practice finances. We also need a centrally funded programme to digitise and store all paper notes off-site to release precious space in practices that is currently being used to store paper notes. A new contract could also provide the opportunity to determine a plan for estates fit for the future.

Conclusion

We urge the new Government, DHSC and NHSE to listen to patients and work with GPC England in focusing on the short, medium, and longer-term needs to not only create a safe and sustainable general practice, but a safe and sustainable NHS too.

We need to commit to transform the NHS over the next decade into a:
– **digitally led**
– **home-first**
– **community-second**
– **admission-last model**, which
– **prioritises ill-health prevention** and
– **builds back holistic care** via
– **expert GP-led community practice services**.

The evidence from other countries is compelling that **investing additional money in general practice brings greater rewards in terms of health outcomes** than spending much greater sums in hospital models where the pathological pathway is already advanced.

Let us be bold and aim for a world-class health system – free at the point of access, focused on prevention and acknowledging the key role of the GP as gatekeeper.

Use the GP as expert generalist to reduce admissions, investigations, referrals, and prescribing by increasing continuity of care and increasing access to a GP.

Use the productivity and efficiency of general practice to secure innovative initiatives to assist with managing the elective care backlog.

Patients and GPs want solutions, not problems.

To put patients first, Government and profession, we each have a professional duty to seize the opportunities before us.

Contents

Appendix A – Proposed draft Heads of Terms for a new GMS contract

Proposed Heads of Terms Agreement for negotiations on a new GMS (general medical services) contract between the BMA GP Committee England, Department of Health and Social Care and NHS England

This Heads of Terms Agreement ("Agreement") is entered into between GPC England ("GPCE"), the Department of Health and Social Care ("DHSC") and NHS England ("NHSE"), collectively referred to as the "Parties," to establish the broad terms and principles for negotiations regarding the negotiation of a new national contract for general medical services (GMS) in England.

This Agreement does not constitute a legally binding document but serves as a framework for future negotiations. The Parties agree to negotiate in good faith and seek to reach a mutually acceptable contract.

1. Purpose

The purpose of this Agreement is to outline the key areas of negotiation and establish the principles for a new national contract for general medical services ("GMS") in England.

The Parties are in agreement that the overall aim of negotiations is to agree a new GMS contract in line with the Labour Party 2024 Election Manifesto commitments, the findings of the September 2024 Lord Darzi review of the NHS and the GPCE's paper Patients First.

The new contract will enable general practice to return to being a family doctor service, as characterised by the below principles, which reflect the 2025 Family Doctor Charter agreed by the Parties.

To give the best service to their patients, the family doctor must:
- Have adequate time for every patient, and be able to routinely see the same patients on a list limited in size, per full-time equivalent GP, to an agreed safe ratio
- Be able to keep up to date with the latest clinical practice
- Have complete clinical freedom whilst in accordance with the General Medical Council's Good Medical Practice
- Have adequate, well-equipped premises
- Have at their disposal all the diagnostic aids, social services and ancillary services required to serve the needs of their patients within a community setting
- Be encouraged to acquire additional skills and experience in special fields, which enable them to better serve the needs of their local community
- Be adequately paid by a method acceptable to them, which encourages them to do their best for their patients
- Have a work-life balance, which assures doctors with caring responsibilities a career in general practice is feasible.

Both Parties are in agreement that these conditions do not exist at present, but are committed to trying to achieve them through negotiations. If these conditions are met, a harmonious relationship between doctors and patients will be assured, as well as establishing the foundations for securing the best possible patient outcomes.

The above conditions reflect the conditions set out in the 2025 Family Doctor Charter, which shall serve as a guide to the forthcoming negotiations, as both Parties support its aspirations.

Contents

2. Scope

The Parties agree that the scope of the negotiations shall be guided by the below principles. The Parties will work collaboratively to address these aspirations and reach mutually agreeable solutions.

a) A contract that is fully resourced based on the services procured/to be provided and the staffing, equipment, premises and facilities required

Sustained annual investment in general practice is required to enable the delivery of high quality local, long-term, GP-led continuity of care for patients. It also needs to take account of annual cost inflation, using an appropriate measure agreed by the Parties, and uplifted accordingly from year to year.

b) Fair reward for all practice staff and recognition of GPs' responsibilities

The Parties will agree mechanisms for:
– remuneration of GP contractors/partners
– remuneration of sub-contractors (locum GPs) and
– direct reimbursement of all practice-employed staffing costs, including salaried GPs.

The negotiations will also explore the uplift required to provide practice-employed staff with fair remuneration. This will address the erosion of practice staff pay experienced over more than a decade, due to sustained underfunding.

In addition, any outcome will ensure that GPs with any supervisory responsibilities for multi-disciplinary practice teams and their ever-increasing safeguarding responsibilities are fairly recognised.

c) Expansion of the GP and GP nurse workforce

GP and GP nurse workforce expansion is required to ensure there are sufficient family doctors and nurses to serve the population. The new GMS contract will support the recruitment, retention and return of GPs as either contractor/partner, salaried or locum GPs, to reduce the GP to patient list size to a safe ratio, from the current rate of 2,293 patients per full-time equivalent GP, as of 30 July 2024.

The Parties commit to an in-perpetuity policy ambition of reaching the optimal goal of one GP per 1,000 patients. This will therefore mean modelling and projecting how many GPs the population will need to reach this goal, and subsequently resourcing the GMS contract accordingly to ensure GP registrars can be recruited into the NHS as soon as they qualify.

d) Incentivisation of GP-led continuity of patient care

The new GMS contract will incentivise continuity of care for patients, over the achievement of activity metrics, rewarding practices that prioritise holistic continuity of care for their registered patients, whilst recognising the local context within which the care is delivered. This will ensure health inequalities are greatly reduced across the population of England.

The Parties commit to annually monitoring patient healthcare outcomes and both the economic impact for other sectors of the NHS, i.e. via cost savings following reduction of expensive crisis care episodes, and the wider economy, i.e. through reduced sick days, increased productivity, reduced impact following public health crises etc.

Contents

e) Empowerment of GPs and practices

The contract will deliver control to practices, encouraging and enabling them to work collaboratively at scale, particularly for vulnerable and hard to reach patients, while prioritising continuity of care for registered patients. This includes exploring opportunities for practices to have greater autonomy and decision-making authority within the healthcare system, fostering collaboration, and promoting seamless patient care pathways.

In addition, the role of Local Medical Committees, as local leaders and representatives of GPs, will be recognised and maintained in the contract. LMC representation on ICB (integrated care boards)/commissioner boards will be enhanced, and a requirement will be placed on ICBs/commissioning bodies to engage with all relevant LMCs meaningfully and proactively regarding any matters relating to general practice, e.g. especially any local transformation initiatives.

f) Reduction of Unnecessary Bureaucracy

The Parties will explore ways to ensure administrative processes are streamlined, remove redundant requirements, and foster a more supportive environment that enables GPs to focus on delivering high-quality care to patients.

g) Development of safer, modern, green infrastructure

The Parties will agree state-sponsored investment plans for the development of safer, modern and green infrastructure in general practices, ensuring they are equipped with modern premises, facilities and technology that align with 21st-century healthcare standards.

The new contract will also end time consuming and costly disputes between NHS Property Services, other landlord organisations and GP practices over unfair/unregulated service charge hikes, by including a mechanism of direct cost reimbursement for charges, maintenance and improvement.

This will support the delivery of high-quality healthcare within the community, closer to patients, but centred around practices.

h) Protection for practices against legal and financial risks

The Parties recognise that the numerous legal regulations that practices have to comply with and the financial liabilities they hold place a significant burden on them, which can act as a disincentive to GPs becoming independent self-employed contract holders. The Parties will therefore explore how these requirements and risks can be limited and mitigated against, especially in relation to the complexities associated with information governance requirements and staffing and estates liabilities.

These increased protections will help return general practice to a family doctor-led service, where many GPs set down roots in one community for their entire careers. GPs will be allowed to focus more on continuity of patient care rather than organisational risk management, subsequently coming to know and understand their patients well, thus reducing a significant disincentive to younger GPs from becoming contract holders.

Contents

3. Duration and review of agreement

The Parties commit to agreeing a new GMS contract, which will have no fixed end date.

In addition, any future changes to the final contractual agreement can only occur via mutual agreement between the Parties. Each financial year there will be an opportunity for any of the Parties to initiate a negotiation over prospective changes to the GMS contract.

4. Confidentiality

The Parties agree to maintain the confidentiality of all negotiations, documents, and information shared during the process, except where required to seek approval from BMA members, or by law.

5. Timelines

The Parties are committed to aiming to conclude negotiations and finalising the outcome by the end of 2027, for the new contract to be implemented by April 2028 at the lastest. NHS England and Department of Health and Social Care recognise that any negotiation outcome will be subject to approval by the BMA GPCE's GP membership, via one or more referenda of relevant members, as ratified by GPCE, before formal approval.

6. Representation and Engagement

The Parties shall each appoint representatives to participate in the negotiations. The Parties may also engage relevant stakeholders and experts as necessary to inform the discussions and ensure accuracy and a comprehensive understanding of the issues. Prior agreement of attendees will occur, although provision will be included for people outside of that list to attend. Early notification of additional attendees and prior agreement by all Parties will be necessary.

7. Dispute Resolution

In the event of any disputes arising during the negotiation process, the Parties shall endeavour to resolve them amicably through dialogue and good-faith negotiation. If no resolution is reached, the Parties may explore alternative dispute resolution mechanisms, such as mediation, as mutually agreed.

8. Amendments

This Agreement may be amended or modified by the mutual written agreement of the Parties.

By signing below, the Parties acknowledge their commitment to negotiate GMS contract changes in England and agree to abide by the principles outlined in this Heads of Terms Agreement.

GPC England

_____

[Name, Title, Date]

Department of Health and Social Care

_____

[Name, Title, Date]

NHS England

_____

[Name, Title, Date]

Contents

Appendix B – Letter to SoS from GPCE chair (July 2024)

BMA House
Tavistock Square
London WC1H 9JP

E publicaffairs@bma.org.uk

Wes Streeting MP
Secretary of State for Health and Social Care
Department of Health and Social Care

Sent via email

8 July 2024

Dear Wes,

How we can work together to rebuild general practice in England

Many congratulations – not only upon your appointment in Sir Keir Starmer's Government, but also for how the election campaign was fought and won. Also, genuine thanks – for the bravery and honesty in admitting what those of us who work at the coalface have known for some time – the NHS is indeed broken.

Having travelled up and down the country speaking to countless GPs and visiting many practices, you will have felt enormous frustration at the loss of over 2,000 GP practices over the past 14 years and of over 5000 'home-grown' GPs[i] whose training has cost taxpayers in the region of 2-3 billion, number of registered patients in England has increased by 6.4 million in the past 5 years alone, the average number of patients per full-time equivalent fully qualified GP has risen by 18% to over 2,300. General practice activity is at an unprecedented high, whilst erosion to the national practice contract baseline funding value is at a nadir. General practice – the most efficient and productive part of the NHS – is collapsing.

CPI erosion of core GMS contract funding since 2018/19 totals £659 million. A DDRB uplift of almost 11% would be needed this year for real-terms funding to return to where we were in 2018/19, let alone how running costs and staffing expenses are significantly higher now. I do not envy the challenges you will face with the DDRB report on the departmental in-tray. I have heard your call to be creative in looking at how existing resources can be deployed differently to bring better patient outcomes and stability of services. I look forward to this conversation.

I have been heartened by your campaign messages around how the proportion of NHS spend needs to shift from reactive hospital-based care to proactive care in the primary and community setting. In England, general practice receives almost 7p in every NHS pound. At an individual patient level, an average General Medical Services (GMS) core contract payment equates to £107.57 per annum, around 30p per day. It's no wonder practices are closing. This is why GP contractors/partnerships are returning their contracts to commissioners – they're no longer financially viable.

As GPs have become more stretched, the previous Government, DHSC and NHS England have chosen to wrongfully diminish patients' access to their family doctor by focusing on funding staff other than GPs and practice nurses. Fewer appointments in general practice are now directly delivered by GPs themselves, which is leading to a significant drop in patient satisfaction. There has been much talk around 'GP access'. I genuinely see the real issue as *patients' access to their GP*.

Contents

I believe this is where Labour's promise to 'bring back the family doctor' has chimed with the public. Barriers to accessing a GP have impacted patient outcomes and perpetuated the inverse care law across our most deprived communities. This has been compounded by policies seeking to penalise those very practices delivering care among our most vulnerable populations. I have some immediate solutions to recommend.

As you yourself have said, general practice is a people-based service – with exceptional, caring people delivering it. We cannot ignore the very human cost in moral injury to GPs and their practice teams which has taken place in recent years. Our survey of GPs in England, completed by more than 11,000 colleagues in January, confirmed that England's GPs are at breaking point. 22% said it would be unlikely they'd still be working as an NHS GP in three years' time. I'm desperate to change that statistic, and I know you will be too. You'll be aware that April saw a third consecutive imposed contract upon practices in England, which led to our referendum where over 19,000 GPs and GP registrar members voted to reject the contract (99.2%). GP partners are currently being balloted ahead of potential collective action next month, in an act of sheer desperation.

As recently as September 2022, the House of Commons Health and Social Care Committee published a report on the future of General Practice, which set out the values of GP-led care focusing on prioritising both continuity and the gatekeeping role of the GP as the expert generalist as being key to controlling activity and demand on the wider NHS. Considerable academic evidence demonstrates how GP-led continuity of care reduces overall NHS activity and improves patient self-care; prevents avoidable and costly crisis interventions; delivers better patient and public health outcomes; and reduces NHS costs and provides greater job satisfaction. Unfortunately, recent years have seen successive annual GP practice contract changes in England move further away from this model of delivery, and I look forward to working with you to reverse this.

The British Social Attitudes Survey 2024 showed 91% of voters want to keep a health service free at the point of use. To do that, we need to go back to protecting and promoting the GP's role as expert generalist gatekeeper to the wider NHS. Undermining our role or diminishing access to us has led to wider instability across systems and rising demand outstripping capacity. If we protect the gatekeeper and rebuild general practice, we have the best chance at fixing the NHS. Thank you for addressing your understanding around this in the pre-election period, together with signalling the importance of our meeting soon.

In advance of such a conversation, I promise you candour, transparency, and respect. In that spirit, I share our proposed solutions so we can hit the ground running when you have an opportunity to meet me:

1. **Commitment towards a universal GP-led continuity of care model for England NHS general practice with a minimal general practice investment standard**

    - Stop disinvestment in practices which has led to the loss of almost 25% of practices in 14 years. Reverse the decline of the past five years of GP practice contract funding value erosion with a roadmap towards a minimum general practice investment standard. Start a journey to increase the NHS proportion of funding to general practice by 1% year on year, incrementally moving towards a proportional funding floor of 15p per NHS pound for primary medical services including neighbourhood health centres.
    - In the immediate short-term, work with us to develop a practice-level reimbursement scheme whereby we can begin to redistribute network resources transparently into core practice funding to enable recruitment and retention of GPs and practice nurses. Our

Contents

amazing practice nurse colleagues deserve parity of terms with their trust-employed colleagues.

- In our recent survey of unemployed GPs, 80% of respondents stated they want to do more NHS GP work but are struggling to find it. Getting these highly qualified GPs into practice roles must be an absolute priority for everyone, and we have solutions for this.
- Remove harmful red tape preventing practices employing the roles they need, and patients want. Continuity of care saves lives, and patients want to see a GP – if possible, *their* GP. Let's listen to patients and bring back their family doctor.

2. Work with the BMA's GP Committee England to agree a 2025 Family Doctor Charter

- 1964 holds startling parallels to 2024: An NHS in decline following years of austerity; patient demand outstripping capacity; the profession undertaking once-in-a-generation industrial action, not to mention a Labour victory in a general election. The following year, the Wilson Government heralded the 1965 Family Doctor Charter together with the BMA's GP Committee. This charter agreed principles that paved the way for the 1966 Red Book contract and heralded a transformation of general practice. A 2025 Family Doctor Charter would signal much needed hope to patients and the profession alike in agreeing heads of terms for a new substantive contract for England's general practice to be delivered within this Parliament.
- Labour has spoken of no major new investment without major reform – we gladly accept this challenge – let us work together to fix the contract to provide the necessary transparency to invest, to permit GP contractors and partnerships to have the resources to transform, rebuild and reinvigorate general practice at a neighbourhood level, and to restore general practice as the jewel in the NHS crown.
- We have a unique opportunity to be bold and shift NHS focus towards proactive, preventative, public health-data driven primary medical care in the community, away from a reactive and expensive hospital-focused crisis care model, which will save money for re-investment, as well as lives.

3. Practices need GP to patient list size ratios to ensure manageable workloads and patient safety

- Patient list sizes have grown far beyond safe levels across England. The BMA's Safe Working Guidance, based upon UEMO (European Union of General Practitioners) guidance recommends that GPs deliver no more than 25 appointments per day – on top of all other responsibilities to safely manage pathology results; clinical correspondence; prescribing; patient tasks; home visits; palliative care; clinical training and supervision; associated clinical governance and non-NHS (e.g. Local Authority, DWP, DVLA, safeguarding) work. Our survey showed that only 10% of respondents deliver 25 or fewer appointments on a typical day. 88% of respondents deliver 26 or more, with 52% delivering between 31 and 50. Improving general practice capacity to facilitate continuity of care through safe patient list sizes will provide the best, as well as the most cost-effective care for our nation.
- Build neighbourhood and community health transformation around the value for money, productivity and efficiency of general practice, which guarantees accountability via a named GP and the registered patient list at the core of the NHS, and which is the natural anchor point around which social care can be linked in.
- Provide profession and patient confidence in the integrity of the GP patient record via better and wider data-sharing via platforms such as OpenSAFELY. Support GP contractors

Contents

as data controllers by extending the Clinical Negligence Scheme for General Practice (CNSGP) to provide protection for practices when sharing data in good faith for NHS purposes.

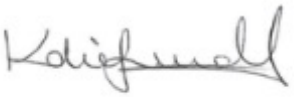
4. **Build real-terms re-investment into General Practice to retain and return our GPs to safe numbers to guarantee continuity of care for the population**

- Despite clear evidence from the NHS Confederation that shows every £1 invested in primary medical care results in up to a £14 return of GDP growth, general practice has been significantly underfunded in England. The equivalent 'full restoration' of real-terms core GMS contract funding in England would be staggering if comparing 2024/25 with 2007/8. The model of general practice is not broken – it has been intentionally dismantled by successive recent governments.
- We need to start conversations around transformative plans and funding for our ageing estates and infrastructure – neighbourhood health centres provide an opportunity. We also have resources which could potentially be repurposed from network level to practice level.
- We need to offer a lifeline to practices on the brink of closure and under-employed GPs by uplifting tariffs eroded in real terms since 2018/19. Likewise, wipe away bureaucracy and red tape that perversely affects those serving our most deprived communities by scrapping the personalised care adjustment to childhood immunisations.

In summary, I believe we need safety, stability and hope.
Safety now to prevent unemployment and practice closures. Stability for the next year, and hope for the future.

As a profession, we are so tired of having to fight to survive – we desperately want a Government on our side – to help us deliver the general practice our patients deserve, to start the journey to bring back their family doctor, and to reset general practice as the jewel in the crown of an NHS we can all be rightly proud of.

I can't wait to get started.



Dr Katie Bramall-Stainer
Chair, General Practitioners Committee England
British Medical Association

Cc: **Preet Kaur Gill MP**
Dr Thomas Gardiner
Dr John Oldham
Mr Cameron Brady-Turner

[i] Between 2015 and 2019, approximately 15,000 doctors accepted ST1 GP trainee places. Assuming the minimum training time of three years, around 8,000 of those ST1 registrars who started GP training between 2015 and 2019 had worked as fully qualified GPs by March 2024. Conversely, up to around 7,000 of those ST1 registrars who started GP training between 2015 and 2019 had not been recorded in NHS England's National Workforce Reporting Service (NWRS) by March 2024, so have not yet been captured as working NHS GP practices. Some could be in non-NHS practice-based settings, have left to work elsewhere / abroad or, indeed, work in private settings.

Contents

Appendix C – Sessional GP vision

Sessional GP: A vision for the future.

BMA

Sessional GPs are invaluable to the NHS and are essential for the delivery of safe, effective and efficient patient care.

A career as a Sessional GP can and should be a positive and rewarding choice for any current or aspiring GP. As expert post-CCT generalist doctors they should be respected, valued and remunerated as such, in accordance with their experience, skill and responsibilities. Sessional GPs should be encouraged and supported to pursue their areas of interest and career aspirations to ensure a personalised, fulfilling and rewarding working life of continuous learning and growth.

However, the Sessional GP Committee is gravely concerned about the underemployment crisis our members face and for our future career prospects.

NHS healthcare providers across the UK are struggling with more than a decade of underinvestment from governments. As a result of inadequate funding and real terms cuts sessional GP work is increasingly difficult to find, while those in work are being stretched thinner with unsustainable workloads. Their pay has been rapidly eroded by 25% since 2008/09. These are our goals and aspirations for sessional GPs. This is a vision of what could be achieved if governments genuinely invested in the profession and truly valued the work of sessional general practitioners.

Safety

The current conditions in general practice for sessional GPs are not sustainable. Those who are able to find work may be subject to unsafe workloads and expected to work well beyond the time they are actually paid and contracted for. On average GPs across the UK are working 25% above their contracted hours per week. The next generation of GPs are justifiably anxious about their future career prospects in the NHS. In a **recent survey** of GP Registrars 73% reported burnout and stress, with less than 20% stating they felt confident about their future as a GP. These are alarming statistics and paint a bleak future for the profession. Our vision for the future is one where we hope GP registrars could once again feel excited and hopeful for their careers.

Over the past few years sessional GPs have seen a dramatic increase in responsibility and bearing the personal liability for supervising an increasing number of allied health professionals including Medical Associate Professions who are increasingly being used as substitutes for GPs.

Where GPs are working outside of practice settings, they are being offered wholly inadequate and derisory terms and conditions which fall far short of what is outlined in the salaried GP model contract.

All of this leads to unsafe working conditions for salaried and locum GPs, which in turn compromises patient safety.

We need to see the following changes:

- Safe workload limits enshrined into all GP contracts, including the model contract, ensuring a minimum of 15 minutes per consultation and a maximum of 25 consultations per day (guidance differs in Wales).
- A mechanism that ensures all employed GPs, regardless of setting, employer or salary, receive the employment benefits outlined in the model contract as an absolute minimum.
- A mechanism that ensures practices are fully funded for annual DDRB uplifts to salaried GP pay and that it is passed on in full to salaried GPs.

Contents

– Safe job plans that can be reasonably achieved within their contracted working hours.
– Agreed overtime worked by a GP is paid in full and in line with the minimum pro-rata rates outlined in the salaried GP rate card.
– A reversal of the pay erosion suffered by salaried GPs since 2008/9 over 3 years.
– An agreed target for patient/FTE GP ratios within practices and nationally.

These changes would see a brighter future for sessional GPs, ensuring sustainable, safe, and fair working conditions. Implementing safe workload limits and the model contract will ensure there is equity and consistency across the profession and go some way to address the GP retention crisis.

Autonomy

The autonomy to define how you work is a core aspect of being a sessional GP, offering the flexibility to tailor professional commitments to personal needs and career aspirations. This not only enhances job satisfaction and work-life balance but also allows GPs to pursue continuous learning and the development of specialist interests.

However, the current lack of opportunities for salaried and locum GPs is leading to increased pressure on existing staff, and ultimately a compromised quality of patient care.

We are asking governments to significantly invest in the sessional GP workforce, including:
– reallocation of ringed-fenced Additional Roles Reimbursement Scheme funding into core general practice contracts and ensure the flexibility to use this funding to employ/engage more sessional GPs (only applicable in England).
– A minimum general practice investment standard should be determined alongside fair annual funding increases to the GP core contract.

Our aspirations for this vision are centred around creating more opportunities for salaried and locum GPs to work in a way that best suits them. This will in turn ensure that patients receive the safe and quality care they expect and deserve.

Opportunities

Sessional GPs need to be afforded the time, opportunity and resource to develop their skills and interests to build a fulfilling and bespoke career.

Opportunities to upskill and further education are being reduced, with essential funding for retention and fellowship schemes being withdrawn.

Despite the value they bring to the NHS, what we are seeing for sessional GPs is a woeful lack of employment opportunities and the unconscionable situation where fully qualified GPs are struggling to find work in the NHS, despite the incontrovertible need for more GPs.

Every GP brings with them their own diverse experience. It is this experience that we bring from working in different settings which fosters the dissemination of best practice and innovation within the NHS, and ultimately contributes to improved patient outcomes and system-wide knowledge sharing.

Having a range of roles positively impacts job satisfaction among sessional GPs in the UK. A study by **BMJ Open** highlighted that nearly two-thirds of GPs who had additional roles outside their NHS clinical responsibilities reported greater job satisfaction. These additional roles can include teaching, research, and management to name a few, all of which help to diversify professional experiences and reduce burnout.

International Medical Graduates (IMGs) form a large and vital proportion of the current and future sessional GP workforce. Those needing a visa to continue to work in the UK on completion of training need to have their visa sponsored by an employer. To ensure their retention within the NHS GP workforce it is essential governments relax visa requirements for such sessional GPs who are struggling to find work and ensure that the opportunities for employment are available to them.

Contents

In addition, we are calling for:
- Reinstatement of funding for the New to Practice Fellowship Scheme and Retention schemes
- IMGs qualifying as GPs to be granted indefinite leave to remain on completion of training.
- The introduction of personal development budgets for GPs to enable them to access training and education to develop their personal interests.
- The costs incurred by GPs for them to be able to work and develop as GPs are fully reimbursed to them directly, including indemnity, appraisal and GMC fees.

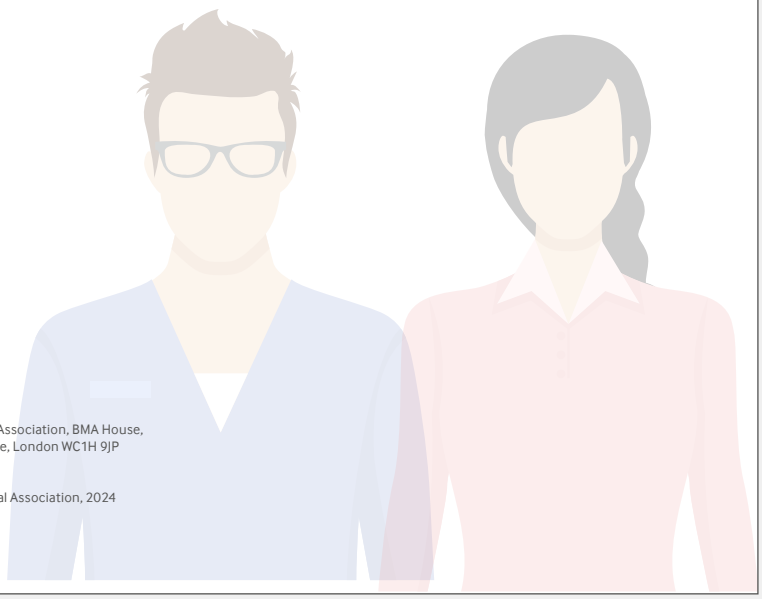
Parity

The sector faces a significant unjust gender pay gap, with female sessional GPs often earning less than their male counterparts, despite the same expertise, for undertaking the same work. In 2023, the overall gender pay gap for all employees in the UK was 14.3%, with a larger gap observed in specific professional sectors, including healthcare. The gender pay gap is far more pronounced amongst sessional GPs. Tackling the gender pay gap is crucial not only for fairness and equality but also for the retention and motivation of our highly skilled profession.

The flexibility of being a sessional GP allows for those with children to take necessary parental leave and retain a balance between work and care responsibilities. Having access to maternity leave and other family-friendly policies can reduce stress and improve job satisfaction by allowing them to balance their professional and personal lives more effectively.

We are asking for:
- A commitment from governments and the NHS to reassess the gender pay gap amongst sessional GPs and agree to implement the measures in the ***Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England***
- Maternity leave entitlements outlined in the model contract to be brought in line with other employed NHS doctors.

By making these changes, we will foster a more supportive and equitable landscape for all Sessional GPs, ensuring the sustainable delivery of safe, holistic and timely GP care our patients want and need.



BMA
British Medical Association, BMA House,
Tavistock Square, London WC1H 9JP
bma.org.uk

BMA 20240402

Contents

Appendix D – Joint letter to PM re GP premises (2019)

Rt Hon Boris Johnson MP
Prime Minister
10 Downing Street
London
SW1A 2AA

05 August 2019

Dear Prime Minister,

Re: Joint letter regarding primary care and premises

We write as the national organisations representing and supporting primary healthcare staff, and those representing patients who regularly use GP services, who are working hard every day to deliver primary care to patients across the country. Following your announcement this weekend on capital funding, your initial comments in Downing Street on taking up office, and your statement to the House of Commons on 25 July, we noted with interest your commitment to ensuring that the NHS receives the funds that were promised by the last Government in June 2018, including urgent funding for 20 hospital upgrades. We agree that premises should be a priority for your Government and ask that, alongside your commitment to hospital modernisation, there must also be an urgent commitment to support investment in general practice and community care premises such as community nursing and mental health services for children and adults, which are fundamental to the success of the NHS Long Term Plan.

GP premises have been underfunded over a number of years leading to a decline in provision available and a situation where safe, timely patient care is being put at risk. This situation is compounded by an overall lack of infrastructure investment, policies of converting health capital budgets into revenue, and delays by NHS England in providing updated Premises Cost Directions (PCDs) which provide the policy framework setting out how premises costs incurred by GP practices are reimbursed and how other funding, such as for premises improvements are delivered.

A survey by the British Medical Association (BMA), showed that only half of practices considered their premises to be fit for present needs, falling to just over 2 in 10 practices when asked if they thought their premises were fit for the future. The recent NHS England GP premises review also concluded that significant additional funding is required for primary care premises and the Patients Association GP Premises Survey 2018 report found serious issues with poor access for disabled patients.

Furthermore, we welcome the commitments made in the contract agreement between NHS England and the BMA's GP committee, which should lead to an expansion of over 20000 additional staff working alongside GPs in their practices. However this and other community based service developments can only take place if practice premises have sufficient capacity to accommodate them. Primary care estates must therefore be prioritised in the upcoming spending review. Such

Contents

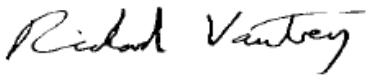
an approach will be crucial in improving patient care and contributing towards reducing GP waiting times.

Finally, we would emphasise that in terms of healthcare spending, the UK remains behind the OECD average, with NHS England requiring capital funding of £9.5bn in 2019/20 to bring us in line with other countries. This would be a £3.5bn increase on top of the current capital budget in 2018/19, rising to £4.1bn by 2023/24. Alongside this, an end to regular transfers from capital to revenue budgets is needed so that NHS trusts can invest and plan for the future. Worryingly, 78% of income from capital sales diverted to revenue spend last year alone.

There is clearly much to be done to stabilise the delivery of primary care (general practice and wider community based services) across the country, however we are hopeful that with the necessary investment and joined up forward planning the NHS and primary care together with hospital and other specialist services will thrive as a world leader in healthcare.

We would welcome the opportunity to discuss these vitally important issues with you and your officials and to work with you to deliver on your commitment to improve access to general practice for all our patients.

Yours sincerely



Dr Richard Vautrey,

Chair, BMA General Practitioners committee

Dr Peter Swinyard,

National Chairman, Family Doctor Association

Dr Minesh Patel,

Chair, National Association of Primary Care

Rachel Power,

Chief Executive, the patients association

Professor Helen Stokes-Lampard,

Chair of Council, Royal College of General Practitioners

Contents

References

1 *Independent investigation of the NHS in England, September 2024*

2 Public satisfaction with the NHS and social care in 2023, March 2024

3 BMA analysis of General Practice Workforce, July 2024

4 Appointments in General Practice, July 2024

5 BMA analysis 'Tracking GPs in training into fully-qualified general practice roles', January 2024

6 Total number of practices in England in September 2010 compared to May 2024

7 The changing shape of English general practice: a retrospective longitudinal study using national datasets describing trends in organisational structure, workforce and recorded appointments, September 2024

8 32% erosion in Income Before Tax, 33% erosion in Employed Earnings. BMA analysis of GP Earnings and Expenses Estimates 2022/23

9 26% erosion in Income Before Tax, 27% erosion in Employed Earnings. BMA analysis of GP Earnings and Expenses Estimates 2022/23

10 Sessional GP: A vision for the future, June 2024

11 At the time of writing, the current circulating Covid FLiRT variant almost completely evades vaccination with anything other than the XBB Monovalent vaccine. This means we have an NHS workforce and millions of patients with no neutralising antibodies against existing variants. Hospitalisations are starting to go up, modelling suggests by autumn and winter 2024/25, we are likely to see many cases in the hospital setting, which will obviously be a barrier to elective recovery.

12 Extra investment in out-of-hospital care can reap billions for the wider economy, August 2023

13 Mirror, Mirror 2021: Reflecting Poorly Health Care in the U.S. Compared to Other High-Income Countries, August 2021

14 Public satisfaction with the NHS and social care in 2023, March 2024

15 The future of General Practice, October 2022

16 'Primary care in poorer areas 'missing out' on vital funding, according to new Health Foundation report', December 2023

17 Appointments in General Practice, July 2024

18 The future of General Practice, October 2022

19 General Practice Workforce, July 2024

20 Bedford and Hertfordshire LMC, May 2024

21 Trends in full-time working in general practice: a repeated cross-sectional study, August 2024

22 Better, broader, safer: using health data for research and analysis, April 2022

23 Independent investigation: Lord Darzi's report on the state of the NHS in England, September 2024

Contents

BMA
British Medical Association, BMA House,
Tavistock Square, London WC1H 9JP
bma.org.uk

BMA 20240659