BMA

England

Safe working guidance: a handbook for general practice in England

bma.org.uk/GPsSafeWorking

British Medical Association
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Safe working guidance: a handbook for general practice in England

Introduction

This handbook has been created to help GP practices make decisions that will allow them to best prioritise care.

We suggest you do this by focusing on the delivery of General Medical Services, in line with the needs of your patients and practice, and deprioritising work and activities that fall outside your core contractual requirements. We offer ways of doing this that still enable you to stay within the terms of your GMS/PMS contract.

The guidance in this handbook reflects the contractual changes imposed by NHS England in April 2024 and incorporates all the relevant changes for 2024/25.

Further guidance and tools can be found at www.bma.org.uk/GPsSafeworking, which has been updated to support and enable practices to prioritise their delivery of safe, high-quality patient care, within the regulatory and professional expectations of the Primary Medical Services contract. The recording from a 'safe working in general practice' webinar is also available online, alongside answers to questions raised during the webinar.

Up-to-date guidance and information

The latest guidance and updated links will be available on the BMA website. We would therefore advise visiting the BMA website in conjunction with the handbook to ensure access to the most up-to-date information.

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Executive summary

- The BMA's safe working guidance aims to ensure patient safety and improve working conditions for GPs. It focuses on managing workload effectively, setting safe limits for patient contacts, and encouraging practices to adopt systems that protect both staff and patients. By implementing these measures, the guidance seeks to reduce burnout and improve job satisfaction among GPs.

- The guidance suggests setting a safe limit on the number of patient contacts per day. It recommends a maximum of 25 patient consultations daily to prevent overload and ensure that each patient receives adequate time and attention. This can be adjusted based on the complexity of cases and individual circumstances within the practice.

- To manage excess demand, the guidance advises practices to implement triage systems, utilise other healthcare professionals within the practice, and consider additional support through locum GPs. It also suggests practices collaborate with local networks to share resources and ensure patients receive timely care without overburdening individual GPs.

- Practices should conduct regular reviews of their workload and working hours to ensure they comply with the recommended limits. Using tools like workload calculators and rota checkers can help practices monitor and manage GP working hours effectively. The guidance also encourages open communication within the practice to identify and address any issues related to excessive workload.

- Team-based care is a crucial element of the guidance, promoting the involvement of multidisciplinary teams to distribute the workload more evenly. By integrating pharmacists, nurses, and other healthcare professionals into the care team, practices can enhance patient care and reduce the pressure on GPs. This approach helps manage workload and ensures comprehensive care for patients.

- Practices should start by assessing their current workload and identifying areas that require immediate attention. Engaging the entire practice team in developing a tailored action plan is essential. Continuous monitoring and adjustment based on feedback and outcomes will help ensure the changes are effective and sustainable. Collaboration with local networks and adherence to the BMA's recommendations will support long-term improvements in practice working conditions.

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Background and context

General practice is in crisis. GPs are faced with increasingly unsafe workloads coupled with a rapidly diminishing and exhausted workforce. Longstanding structural underinvestment in general practice and an ever-reducing share of total NHS spend, coupled with increasing hospital workload transfer and the ongoing impact of the COVID-19 pandemic, has generated a vast backlog of care. This is creating further pressure on a system that is already at breaking point.

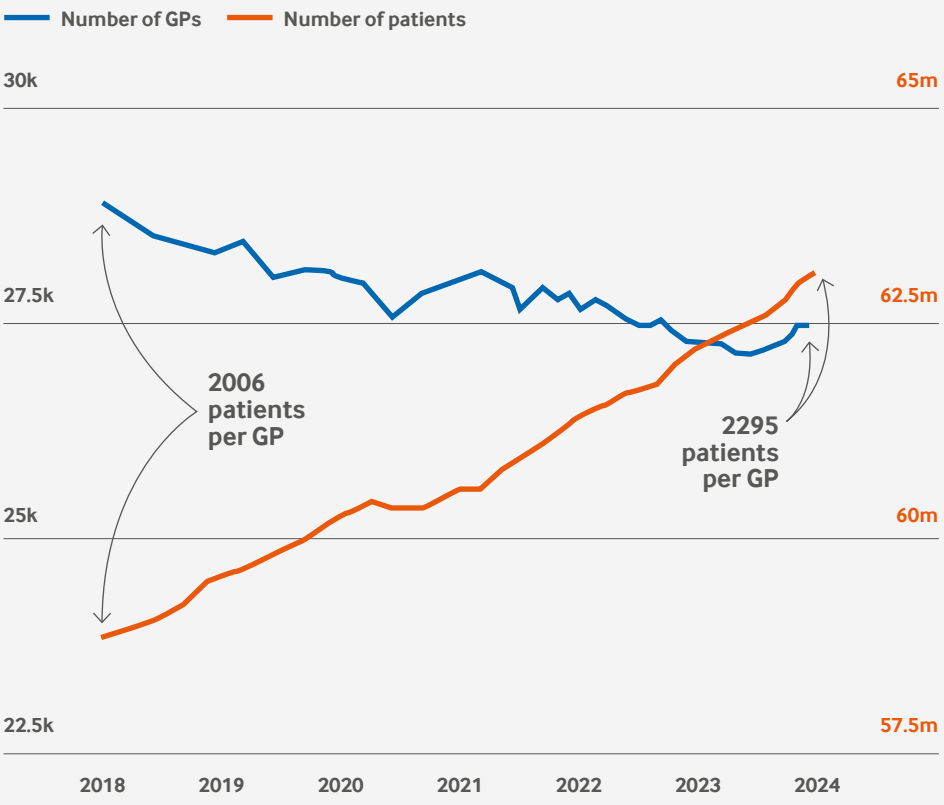
The contractual changes imposed by NHS England over the past three years have done nothing to recognise and address these pressures. Instead, there has been a repeated failure to recognise and act to support the needs of patients, practices, GPs and the wider staff team. The present crisis is so severe that GPC England (the BMA GPs committee England) strongly recommends practices take urgent action to preserve their ability to deliver safe, high quality patient care and to protect the wellbeing of their practice teams.

GPC England encourages all LMCs to promote and support practices in their implementation of the BMA's safe working guidance.

Understanding recent trends

The nation's population and demographics are changing, with more complexity and comorbidity. The number of patients each GP is responsible for has been steadily rising, with the average number of patients each GP takes care of increasing by nearly 17% since 2015 to 2,295 in 2024. The Family Doctor Charter of 1965 and the 1966 GP Contract first introduced a limit of 2,000 patients per GP, recognising the need for effective workload management as a basis for the delivery of safe, high-quality patient care. Patient care is very much more complex than it was in 1965, meaning demand is far higher.

Number of patients registered continues to grow as fully-qualified GPs leave



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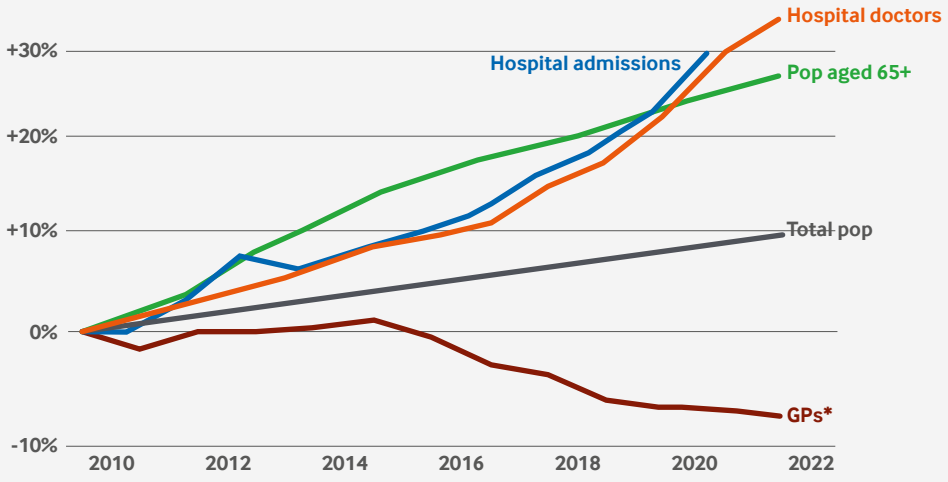
Despite the undeniable need for more GPs, we are seeing GPs increasingly leaving the NHS or reducing their NHS and practice-based commitments. More recent reports show a paradoxical unemployment or under-employment of GPs – especially newly qualified GPs in the face of rising demand for appointments. This is caused by the lack of appropriate investment in general practice to fund the recruitment of additional salaried GP staff or secure appropriate locum cover. There are now only 0.44 fully qualified GPs per 1,000 patients in England – down from 0.52 in 2015.

The number of NHS hospital doctors has grown broadly in line with demand for hospital care, but GP numbers have fallen over the last decade

Change in each indicator since 2009 (log scale)



Sources: Health Foundation, NHS *Fully-qualified, permanent GPs
FT graphic by John Burn-Murdoch / @jburnmuedoch
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GPs and practices are now seeing the numerical equivalent of nearly half of the country's population each month: NHS data shows more than 28.7 million appointments (excluding vaccinations) were delivered by GP practices in June 2024. The majority of GP appointments are face-to-face. Consultation rates per patient have increased. This is unsurprising given changing population demographics, with multiple and complex co-morbidity becoming more common. Patients want and need to see GPs, but the current situation means we have fewer GPs offering continuity of care within the defunded practice setting. At a time when we need to be focusing on prevention and holistic health care, the priority should be to recruit and retain all GPs throughout their careers so that they can deliver the best care for patients, closer to their homes and communities in local practices.

Fewer GPs providing care for more patients is a now-established vicious cycle. It increases the risk of suboptimal care through decision fatigue. It also risks GPs becoming demoralised, unwell and predisposed to moral injury. The NHS then risks hard-working and committed colleagues being lost to the profession altogether.

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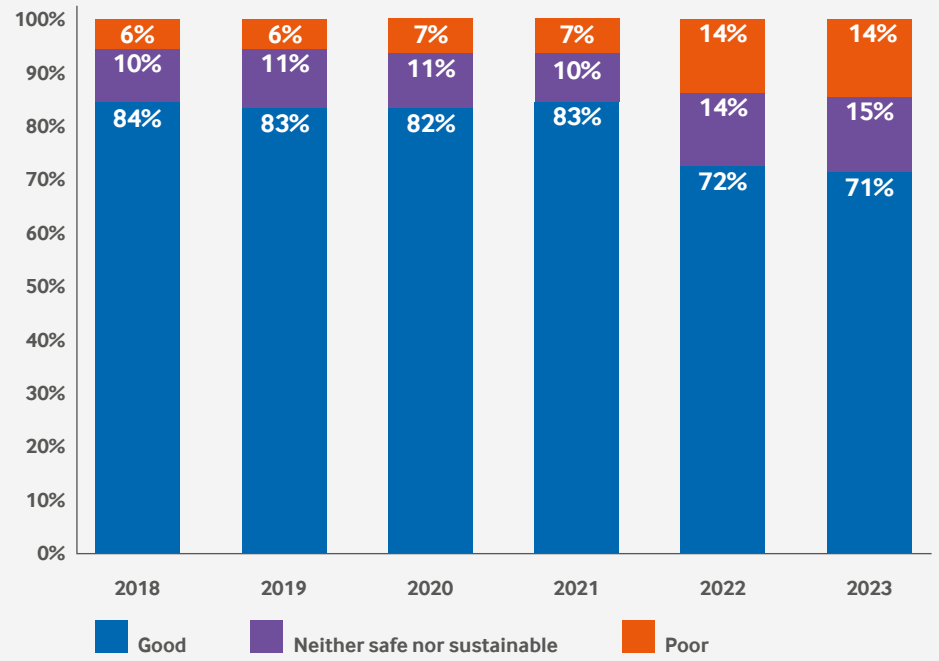
Access vs capacity: record-breaking appointments

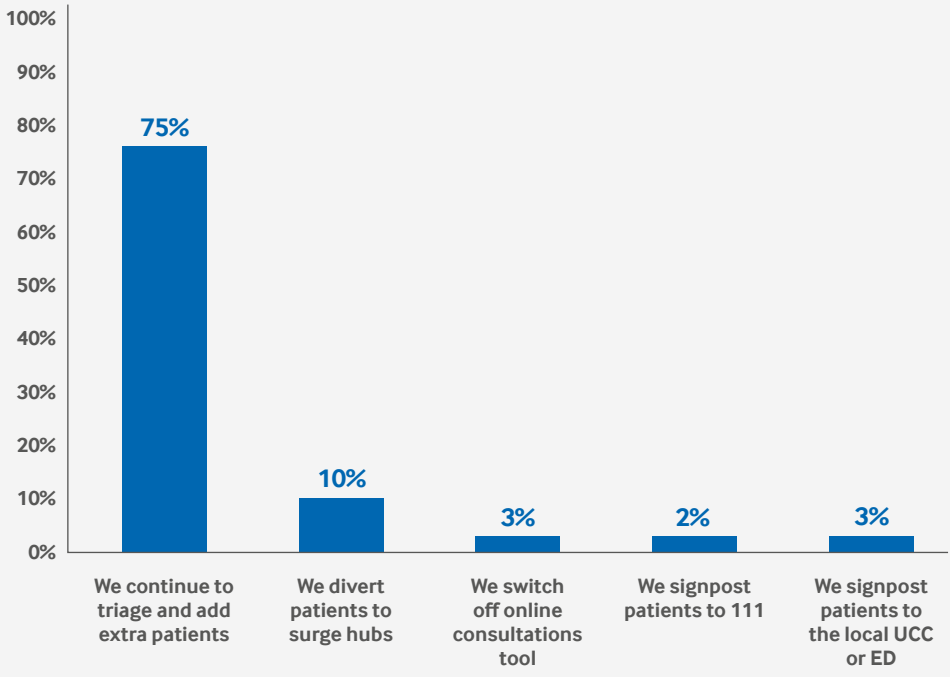
Satisfaction rates continue to fall

Overall, how would you describe your experience of your GP practice?



Practices are offering record breaking numbers of appointments, regularly exceeding their capacity to try and keep up with demand. Cambridgeshire LMC's Demand and Capacity survey published in July 2021, revealed that once capacity was full, local GPs and practices would continue to add extra patients for them to be seen. This is neither safe nor sustainable, and does not enable us to deliver high quality care.

How do you manage same-day urgent need when your capacity is full?



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Inadequate practice resourcing and investment

Despite the massive inflationary increases and financial squeeze, practices were only offered 1.9% in the 2024/25 imposed contract, which in real terms represents a cut in funding. The DDRB recommendation supported by the newly elected Labour Government in August 2024 represented an improved position, but one still lagging far behind the investment practices were receiving in 2018/19. Practices are struggling due to inadequate core funding, which is no longer sufficient to cover workforce and salary costs. Meanwhile, over £1.4 billion per year has been committed for roles within PCNs (primary care networks) as part of the ARRS (Additional Roles Reimbursement Scheme).

The recent addition of one GP per PCN via ARRS does not help individual practices and provides only a fraction of the support needed to allow practices and patients to see the GPs that want to consult with them.

However, despite:
- patients **wanting** to see GPs,
- GPs **wanting** to take up roles within practices,
- and practices **wanting** to employ GPs,

The lack of core practice funding is stopping patients accessing the GPs they want and need to see.

Patient satisfaction has continued to drop, as the number of patients per GP has increased.

The current situation is not tenable.

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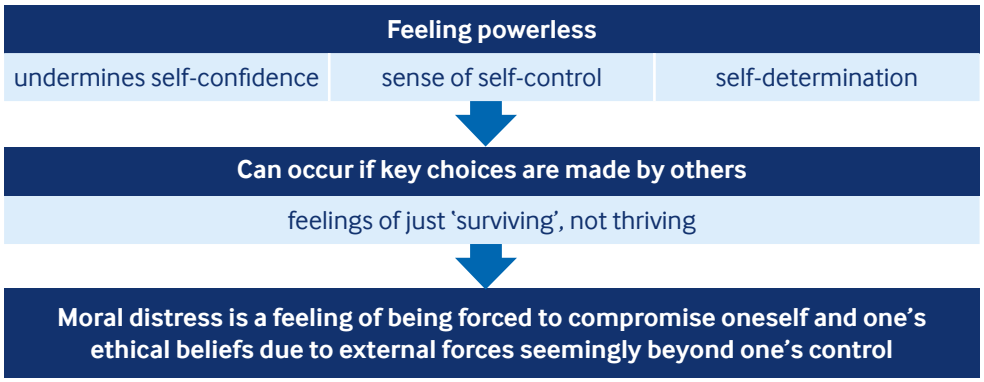
Burnout and wellbeing

The never ending 'hamster wheel' of continually trying to keep up with demand can increase the risk of harm and suboptimal care through decision fatigue. It also risks GPs becoming demoralised, unwell and burnt out, leading to them being lost from the profession altogether: bma-moral-distress-injury-survey-report-june-2021.pdf

Working in overstretched, pressured environments can make people feel powerless, undermining their sense of self-control, self-determination and agency. This is particularly striking when it feels as if key decisions and choices are made by others. Moral distress is the feeling of being forced to compromise one's own professional and ethical beliefs, due to external forces seemingly beyond one's own control. This in turn can lead to moral injury, and harm to the individual. We cannot afford to lose any more GPs, we need to ensure that the working environment enables us to retain GPs within the NHS General Practice workforce.

Powerlessness



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What needs to happen next?

Empowerment

GPs and practices need to regain and retain their sense of agency, self-determination, and autonomy, to create the ability and capacity to deliver safe, high quality patient care. As highly trained and committed members of the practice team, serving the local population, GPs and practices are well placed to work with their patients and communities to design and deliver the services required. This can be guided by the needs of the patients, the community, GPs, staff, and the practice within the framework of the General Medical Services contract.

GPs and practices need to control the speed of their hamster wheel; that is, they need to have control over the rate at which they work to provide safe, high-quality care for their patients.

This can be achieved through using the BMA Safe working and workload control guidance and the recommendations in our GP practice survival toolkit.

Workload control

Reorganise practice services

Collective action

GP practices need to make decisions that will allow them to prioritise their limited capacity to deliver safe, high-quality care. GPC England recommends they do this by reviewing their current services. Decisions will need to be tailored to the needs of both patients and practice. This approach recognises practices are operating within limited resources, but also the need to stay within the requirements of the GMS/PMS contract, as well as the variability of local context.

By introducing the BMA's Safeworking guidance, some practices may see a fall in the number of offered appointments each day. This could mean that patients with non-urgent problems will have to wait longer, but the priority is to ensure that all patients that are seen receive safe high-quality care within your finite capacity to provide this. There will be times when patients will need to be directed to appropriate alternative services. Overall, the steps we outline will allow practices to devote their resources to those patients they are best placed to help.

Appendix 2 has a sample letter that practices can use to explain the implementation of safe working guidance.

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Measurement of workload

NHS England (NHSE) measures GP workload based on appointment data. This gives an incomplete picture of GP activity and can fail to reflect a significant number of non-appointment patient contacts.

GPC England encourages all practices to account for patient contacts in their appointment books as a way of recording this workload. When accounting for workload, indirect patient care and work such as repeat prescriptions, administration and ad hoc patient queries can be counted separately to direct patient contact. This data is not currently collected by NHSE.

Due to the challenges in recording and counting all patient contacts via appointment books, we recommend that practices undertake a period of manual recording over a two- to three-day period.

By doing so, it is possible for practices to better measure and account for all patient contacts. This includes even brief and informal types of contact like discussions with community teams regarding specific patients, calling patients about results, and home visits.

Accurate data allows practices to make informed decisions about how best to care for their patients. It also allows GPCE to demonstrate the impact and changes in workload with stakeholders such as NHSE.

A useful guide to mapping out workload, produced by NHS Lothian, can be accessed here.

Appendix 3 and Appendix 8 outline steps to mapping out workload and assessing capacity.

External un-resourced and under resourced workload

Practices are obliged to deliver on their contractual obligations, and under current funding and resourcing mechanisms this means they do not have capacity to undertake work passed to general practice from outside agencies. This may include non-contractual work coming from secondary care that is not resourced, for example, undertaking blood tests, making referrals for diagnostic investigations, or onward referrals on behalf of secondary care providers. Some of this workload may be contracted separately from your GMS/PMS contract. If the remuneration for those services does not adequately resource the workload, then this work may also be negatively impacting practice capacity. Additional external workload generated comes at an opportunity cost, diverting resource, and reduces the capacity of practices to deliver their core general medical services to their patients.

Please refer to the 'Workload transfer and pushback' section for further information and detail.

Appointments

Under their contract, practices must provide appointments sufficient to meet the reasonable need of their patients. Neither GMS nor PMS contracts specify a fixed number of appointments per practice population. This will be influenced by the practice population but must be done in a way that is safe for patients, GPs and practices.

Signposting and triage are safe and effective ways of delivering care, although not all practices will wish to adopt a 'total triage' model. Using these methods means practices can:

- prioritise care for those most in need
- provide patient appointments more flexibly and utilise other members of the practice team, clinical or administrative
- direct patients to the most appropriate provider of care, which may not be a member of the practice team

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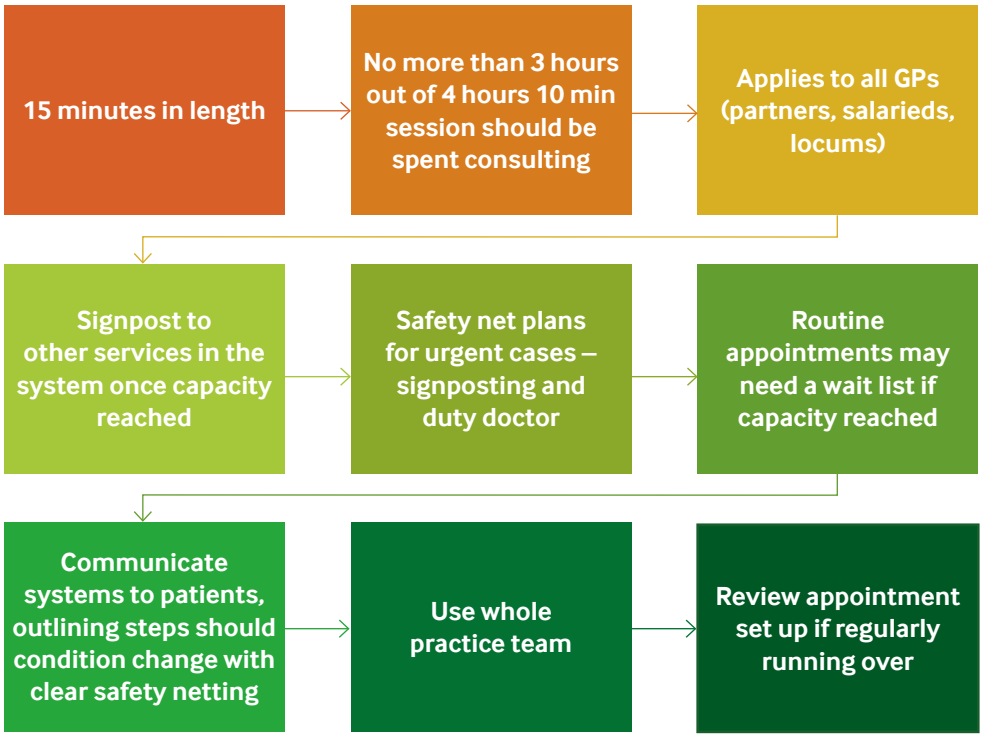
An ageing population, increasing medical complexity and rising multi co-morbidities require longer patient contacts. We strongly recommend practices move to an average of 15-minute appointments. There is no requirement within the GMS/PMS contract that defines the length of a patient contact.

Many practices still provide care at 10-minute intervals which is also supposed to allow time for record keeping, and housekeeping between patients. This differs from many other similar primary healthcare systems. It is also at odds with evidence around quality of care.

By extending appointments to an average of 15 minutes, practices can reduce the need for repeated contacts with patients while still preserving quality of care and patient satisfaction. It can also support continuity of care, which is increasingly recognised as one of the key contributors to better patient outcomes and experiences, as well as helping to reduce overall demand within healthcare systems.

This should be done without increasing the total time GPs spend consulting in their day, meaning, for most practices, a reduction in the absolute number of appointments per session. This is to ensure GPs and other clinicians can practise safely. The focus must be on delivering safe, high-quality care driven by the needs of patients and their practices.



The current BMA standard for a session of GP care is 4 hours 10 minutes. No more than 3 hours of this should be spent in consultation with patients. Within these limits, adequate rest breaks must be taken. Extending sessions beyond this time risks harm to patients and clinicians.

These recommendations apply to all GPs working within practices, including partners, salaried colleagues and engaged locums.

For salaried GPs who are regularly exceeding their contracted hours, a reduction in appointments is one possible intervention, whether these be face-to-face, telephone calls, visits, or online consults.

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Daily working consultations

The European Union of General Practitioners and the BMA have recommended a safe level of patient contacts per day in order for a GP to deliver safe care with a maximum recommendation of 25 consultations per day.

Currently patient contacts per day by GPs in England are significantly in excess of this. GPC England recommends that practices implement an action plan to move towards safe patient consultation numbers per day, by moving away from 'uncapped demand', towards more structured clinical sessions, with recorded and safe working limits. This will help prevent unsafe levels of patient contacts, protecting patients and staff. In some practices, this may lead to a reduction in the number of appointments offered each day. However, through pushing back on unresourced external workload, and offering longer appointments, practices may see that additional capacity will be created. Alternative services and sources of support should be effectively used to provide extra capacity for patient care, and to help safeguard these safe working limits.

Care co-ordinators, care navigators, and appropriately trained reception staff can safely direct patients, signposting them to suitable alternative services, working to protocol and under good clinical governance. This is in addition to current triaging arrangements used by many practices.

See the example Framework for online triage/waiting list in Appendix 4 and the Summary of key learning from online triage at Appendix 6.

NHS111 can directly book GP appointment slots to a maximum of 1 appointment per day, on the day, per 3000 patients, for practice review and triage. It is for the practice to assess these patients anew and decide their appropriate management. NHS111 should not re-refer patients to practices. Unfortunately, many practices and LMCs report difficulties accessing the NHS111 Directory of Services to confirm they are at a daily maximum capacity and should be switched from green to amber for call dispositions by 111. Practices should continue to raise this with their LMC, and LMCs should continue to escalate this to national teams so that we can work towards simpler solutions.

Many GPs now have access to remote working applications and utilise these to manage their working day and current patient demand. Remote access can encourage a working culture that means GPs work longer hours, for example, by logging in on evenings and weekends. This working culture should be avoided as it is unhealthy and such expectations can also disproportionately impact women and part-time GPs.

Sessional GPs are an integral and crucial component of practices. GPC England recommends involving them in discussions at all stages when you are making changes. This is to comply with employment law related to changes in working practices, but also to use their expertise and experience to help shape the provision of patient services.

GPC England recommends discussing any changes being proposed under the BMA's Safe working guidance with your PPG (Patient' participation group). Experience has demonstrated most PPGs are very aware of the unrealistic pressures on all GP practice staff and will support the Safe working guidance and may help in clearly communicating your changes to patients – see the PPG section and appendices for further information.

Appendix 2 for further information and resources on patient engagement and communication, including a case study.

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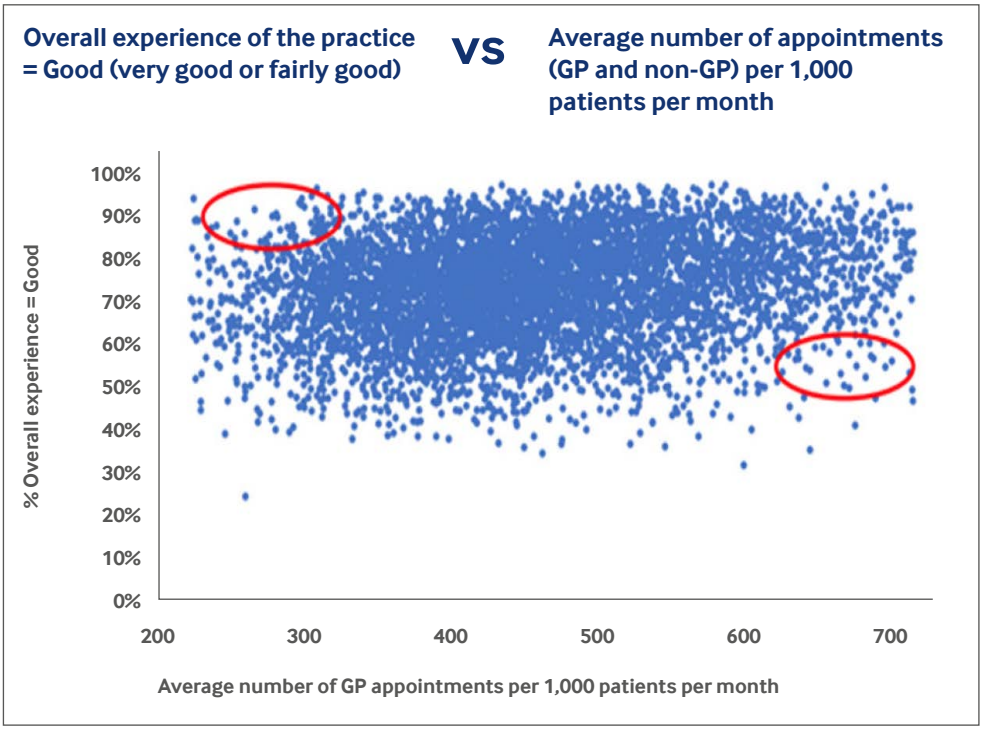
Waiting lists

The COVID-19 pandemic has led to a massive backlog of care. GPC England advises practices to move to a waiting list system for appointments as demand currently greatly outstrips capacity.

There has been pressure on GP practices to offer immediate assessment and management of all patient problems regardless of actual clinical urgency, and appropriateness. This is impossible to maintain, is not required by the GMS/PMS contract, and may be counter-productive in terms of patient expectations, experience and outcomes. Furthermore, there is little evidence this approach correlates with patient satisfaction levels, as demonstrated by Beds and Herts LMC's analysis:



Practices are obliged by their GMS contract to provide for the reasonable needs of their patients and for the assessment of urgent problems arising in their patients in their practice area. Emergency or urgent problems can be directed to emergency departments, 999, or 111. Patients who can wait should, following assessment, be placed on the waiting list if safe capacity for appointments is exceeded for the day.

General practices should have waiting lists that are based on clinical need. This is the approach that exists in secondary care, even if it means that patients with non-urgent problems may wait many months for an appointment. This only formalises the already existing informal waiting lists for patients who cannot get an appointment at a convenient time. This will allow GPs to focus their resources on those with the greatest need, and the most vulnerable to deliver safe high-quality care.

A patient's clinical condition may well change while on the waiting list. It is important to develop and communicate safety netting processes to patients, so they can seek medical attention if needed, should their condition deteriorate. The urgency and clinical need can be reviewed at this point if you have capacity at your practice, or alternatively by signposting to another service if more appropriate.

Appendix 5 for further information on waiting lists and Appendix 7 for the management of urgent cases.

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Vulnerable and disadvantaged groups

Consideration must be given for vulnerable patient groups that for a variety of reasons may not be able to access healthcare as easily, for example children, older people who are housebound or in care homes, end of life care/palliative patients, people with learning disabilities and those with safeguarding concerns. Other groups where English may not be a first language, and those experiencing digital poverty and/or literacy challenges will need reasonable adjustments to ensure they do not experience barriers to care. Other groups such as LGBTQI+ may experience barriers to healthcare, and practices should be mindful of designing and implementing models that support equitable access to healthcare for all patients.

Rural and geographically remote areas

Our safe working guidance is designed to be implemented across a range of settings led by the needs of patients and practices. Rural and geographically remote areas may face challenges in accessing appropriate supportive alternative services, close to and easily accessible by their local populations. Long distances, and a lack of accessible public transport can make it difficult for patients to travel, and infrastructure challenges such as a lack of broadband, and digital poverty mean online access and roll out are limited in their effectiveness.

Appendix 10 for further information and example case studies.

Patient Participation Groups

Practice PPGs are a crucial ally and resource for practices. GPC England encourages practices to engage with their PPGs and to openly discuss the challenges and pressures facing general practice, both in general and locally.

It is important to consult PPGs and seek their support for any changes you are considering. GMS regulations allow practices to provide 'services delivered in the manner determined by the contractor's practice in discussion with the patient'. PPGs are a helpful route for communicating these changes and the reasons for them to the wider patient population.

PPGs may also be able to help practices in their relations with ICBs (Integrated care boards) by directly lobbying them and by demonstrating the practice's patient engagement. They can also give crucial insight into the needs and priorities of the patient population.

Appendix 2 Engaging stakeholders including PPGs (patient resources).

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Workload transfer and pushback

The November 2020 General Practice Workload Capacity Audit from Beds, Herts and Cambs LMCs revealed that 95% of practices reported additional uncontracted requests from acute trusts, with an average practice of 10,000 list size spending the equivalent of a day a week dealing with such requests. Note this preceded outpatient transformation programmes and the roll out of Advice & Guidance initiatives from NHS England.

95%

of practices reported additional requests from acute trusts

Percentage of practices who said the transfer of work was having a detrimental effect upon morale

93%

78% **of practices considered the additional work to be unsafe for patient care**

In order to sustain this level of workload nationally, an additional

7,391

FULL TIME GPs

would be required

8.6 HOURS

The amount of time an average practice with a list size of 10,000 patients spent per week undertaking acute trust work

Practices have no contractual obligation to undertake this work and should pass requests back to the provider. We have produced a pack of template letters for this purpose. Many practices already have protocols in place to do this.

Appendix 12 has useful template letters, which can also be accessed here.

On clinical preview of documents, GPs can highlight inappropriate work for the practice to undertake. Non-clinical staff can then use template letters to pass the work back. It is important that any protocols do not result in the burden of increased workload. These actions will likely help deter local and regional systems from passing on work that is not properly resourced, as well as highlighting commissioning gaps.

Raising instances where this has happened in primary/secondary interface meetings, and LMC liaison meetings with local trust and/or the ICB will also help. If local systems fail to change their practices in relation to work that is not resourced, practices and LMCs should escalate the issue to regional and national teams.

Practices should link with their LMCs to communicate themes and patterns from hospital workload transfer. LMCs should consider the use of Operational Pressures Escalation Levels Framework (OPEL), Situational Reporting (SITREP), or General Practice Alert State (GPAS) systems, as a way of collating workload and workforce pressures, as well as recognising areas and times of distress. This can help outline the case for further investment or deployment of resource in general practice and primary care.

For a salaried GP, external un-resourced workload is work which takes them over their contracted hours. This needs to be measured and then discussed with the employer so that work demands of the salaried GP can be delegated to others, prioritised such that when

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contracted hours are delivered, any remaining demands for work are handed back to the practice to manage.

In the longer term, careful job planning can be used as a tool to identify which of the various demands on a salaried doctor's time are prioritised for delivery within the contracted hours, or a new contract with increased hours and remuneration can be agreed if both parties wish.

Job planning processes are illustrated clearly in our BMA GP retention webinar.

'Core' general practice: essential services

It is crucial that GPs and practices devote their time and energy to providing the essential services and care that are commissioned and resourced.

It is not always clear which services are included within 'core GMS'. There is a risk that practices in different areas can interpret which services are included in different ways. This can result in some practices potentially providing services that are not separately commissioned and resourced.

Generally, if a service is commissioned locally in one area, it cannot be part of core GMS anywhere else. We offer a list of locally commissioned services, which by definition are not core general practice, and which should be commissioned through locally negotiated agreements in conjunction with the LMC.

If these services are not locally commissioned, then a commissioning gap exists. The BMA recommends that practices should give notice and decline to provide unfunded and non-core work to cover such commissioning gaps, lest this work later be labelled as an 'essential service' within the expectations, custom and practice of the core contract. It will be for the local ICS (Integrated Care System) to commission this work from general practice or from elsewhere in the system. This list may not be exhaustive and if there are services commissioned locally in your area and not on this list, please advise us and we shall add them.

By defining what our core offering from general practice is, we are able to provide the best possible care for our patients, and not be diverted into unresourced work that should be provided elsewhere or commissioned separately. A lack of locally commissioned services should not result in GPs being considered the default provider. LMCs should support practices in safely declining this work.

Workload prioritisation

We strongly recommend that practices cease all non-contractual work and divert their resources to core services. This may include giving notice on enhanced services if these are deemed not to be financially viable. Remember income does not equal profit, and refer to the published tools to assist calculating the true cost of providing such services. Your LMC may be able to assist here.

Practices are obliged to provide care for their patients as defined in the core GMS contract. Care outside the core GMS contract is detailed in DES (Directed Enhanced Service), LCS (Locally Commissioned Services), QOF (Quality and Outcomes Framework) and IIF (Investment and Impact Fund) arrangements. Providing patient care within these arrangements is voluntary for practices and attracts payment separate to core GMS.

Appendix 3 is a workload checklist produced by NHS Lothian and Appendix 9 has case studies.

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Practice list closure

General practices should consider closing their practice list if they have reached the limit of their workforce's and practice's capacity to provide safe care to their registered patients.

There is a clear protocol for undertaking this action within the GMS contract and regulations. Practices should initially consult with their PPG and then with their LMC, who can provide support with the process, and finally with their ICB.

Once closure is granted, assignments to the patient list can remain closed for up to a maximum of 12 months.

Primary care network directed enhanced service

NHS England commenced the PCN DES in 2019/20 and has invested further in the DES since then. Although over 95% of practices in England are members of a PCN, the perceived success of PCNs for practices and patients has varied across the country. The PCN DES should not be viewed as an alternative to ensuring appropriate core contract funding that supports the delivery of general medical services.

Many feel the requirements of the DES outweigh the benefit brought by the investment into practices and ARRS staff. Despite repeated requests for the inclusion of practice nurses in the ARRS, this has been rejected.

By signing up to the DES, practices receive a payment of £1.76 per patient (network participation payment) and PCNs receive £1.50 per patient. Further income streams come from the IIF, ARRS reimbursement, and PCN clinical director payments.

NHSE has published its proposals for PCN requirements for 2024/25 following the third annual contract imposition on the profession, without agreement from GPCE.

Practices will need to consider if the PCN DES enables them to offer safe and effective patient care within the context of their wider practice and their present workforce.

There is a mechanism by which practices may express that they no longer choose to continue within the DES between 1 April and 30 April 2025 to their ICS, or at any point at which there is a change to the PCN DES by NHSE. Affected practices should liaise with their LMC.

If practices remain within the DES they are contractually obliged to provide the requirements as set out, though the IIF is paid on activity. Many of the IIF activities probably derive little direct patient benefit, and the incentive associated may not be cost efficient for PCNs to undertake. As such, PCNs may elect not to undertake this work. If you choose to leave the DES, the payments to your practice associated with it would stop.

Your own PCN ARRS staff would no longer be able to provide services to patients on your registered practice list and the PCN itself could be at risk. ICSs are obliged to provide services for patients registered with practices not signed up to the PCN DES. This should mean patients continue to benefit from the services provided by PCNs, without the requirement on their practice.

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Managing workload as a salaried GP

Salaried GPs are on a time-based contract and must be remunerated for every session they are expected to work as iterated within their job plan. This includes direct clinical care, indirect clinical care (referrals, prescriptions, messaged tasks) and other activities like meetings. All time at work counts as work and all work must be paid for (including work done opportunistically). This is in keeping with the SiMAP and Jaeger rulings under the EWTD (European working time directive). Indirect clinical care does not include necessary time spent in team meetings.

Salaried GPs are currently working on average 25% additional hours on top of contracted hours (according to the University of Manchester National GP Work life Survey). Urgent steps must be taken to identify these hours, which can then be paid promptly or where mutually acceptable should be recognised with TOIL (time off in lieu). The use of a diary or the BMA's Dr Diary app may help in identifying these additional hours.

The BMA sessional GPs committee's Workload and overtime guidance for salaried GPs can be found here.

Where demand for additional work arises unexpectedly (for example to cover sickness absence) the salaried doctor should be offered remuneration or TOIL for this time. The hourly rate for this work should be negotiated and may be higher than the standard salaried hourly rate, reflecting its unscheduled nature and lack of accrued benefits for this time (annual leave, CPD, sick leave).

For ongoing predictable demand which exceeds contractual hours, in addition to payment, there needs to be urgent discussion to reach agreement on one of two possible solutions:

1. Prioritisation: identify which areas of work can be dropped from the salaried doctor's workload to enable them to continue to work within their contract

2. Develop a revised job plan, hours and pay: agree a mutually agreeable change to the working hours and the payment rates for those hours. here should reflect a realistic case load for the contracted hours ideally based on 15-minute average appointments with a 3:1 ratio for indirect clinical care, having deducted time required for team meetings.

Increased demands on general practice must not cause salaried GPs to work beyond their contracted hours or terms of employment, and effective planning and discussion must take place at the earliest opportunity.

Managing workload as a locum GP

As locums work in a self-employed capacity, they should define the terms of the service they offer, including a clear description of the caseload (both direct and indirect clinical care where relevant) they will offer within a given time.

This is to ensure they are working safely within their capacity and competencies. It should recognise that a lack of familiarity with patients, processes, referral pathways and teams contribute a level of risk for the clinician which they need to manage through their terms and conditions.

This may be reflected in the clinician choosing to offer different terms of service in different services. Any additional work asked of the locum outside the terms of service they have offered is subject to their agreement, and additional mutually agreed remuneration.

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Advice and guidance (A&G) referral system update

NHS England is increasingly encouraging the use of A&G (advice and guidance) to relieve pressure on secondary care and reduce referrals into secondary care services.

Recently acute trusts and ICBs have started to mandate that in some specialities all referrals must go via A&G, sometimes badged as 'intelligent triage' or 'advice and refer'. This can create further workload for GPs in arranging additional investigations or follow up appointments, and create risk if GPs are managing more complexity than they normally would before referring or are expected to manage investigations they are not familiar with.

A&G cannot be mandated instead of a referral; this is covered in the NHS Standard contract (c6) and eRS referral routes must be kept open.

Also, to deny the ability of a GP to make a referral creates a system that prevents doctors from discharging their responsibility under Good Medical Practice with the GMC, which states you must:

'...refer a patient to another suitably qualified practitioner when this serves their needs.'

This is further underpinned by the NHS Constitution around patient choice.

LMCs should be involved with any implementation plans around A&G, including business rules and payments for processing A&G. Therefore, unless A&G with appropriate funding via an LCS (Locally commissioned service) has been agreed by LMCs, we would recommend that:

- GPs cease taking part in A&G from 1 August 2024. Individual GPs are of course free to utilise A&G where after discussion with a patient this would be better for the patient and their GP, for example, where a simple clarification is sought from a specialist.

- The use of A&G is neither a contractual nor a professional obligation. In some cases, eRS only enables referrals to some trusts via the advice route. If, for these trusts, the GP requires specialist review and not advice, they should provide the full information required for a referral and state that the request is for the specialist to provide the patient with a consultation and is not a request for advice.

- If despite requesting an appointment, the GP is then offered advice from the specialist instead, they should respond stating 'The original request was for a referral to a specialist team, it was not a request for advice. As such, please provide this patient with an out-patient appointment as is their right under section SC6 of the NHS standard contract 2024'.

Further information is available here: Focus on Advice and Guidance.

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Conclusion

Our first duty is to our patients. The profession wants to provide safe, high-quality care for our patients, without risking harm to others or ourselves. At a time of unprecedented pressures, we must make changes to our workload to preserve patient care in the face of a shrinking workforce and rising demand. All this must be done within the constraints of the present GMS/PMS contract.

The changes detailed here are not exhaustive but provide an example for practices. The BMA and LMCs can support and advise practices further on specific proposals.

It is likely to be the case that practices provide fewer appointments to their patients in order to continue to work safely. This may lead to the challenge that practices are providing less care but in fact general practice will be prioritising care based on the limited resources made available to it. Other parts of the NHS may see an appropriate increased demand, based on the principle of prioritisation within limited resourcing, and identifying safe alternatives for care.

We cannot care for our patients if we do not care for ourselves and our colleagues.

Manage workload to protect your patients and protect your practice.

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Appendices

Appendix 1
Safe working guidance/checklist

1. Assessing patient and practice needs: team and PPG
2. Mapping workload
3. Mapping resource streams and staffing
4. Practice discussion
5. Workload prioritisation – core and non-core, use of workload control template letters
6. Engage stakeholders – PPG, councillors, Healthwatch, Commissioners
7. Communication – letters, Accurx
8. Establish triage process – whole practice team
9. Signposting – alternative services
10. Safety net processes
11. Appointment set ups – 25 limits, 15 minutes
12. Monitor and review – experience and numbers (qualitative and quantitative)
13. Review job plans and clinics as appropriate

Summary

- Appointments 15 minutes in length.
- No more than three hours out of four hour 10 min session should be spent consulting.
- Applies to all GPs (partner, salaried, locum), and clinical staff undertaking consultations.
- Signpost to other services in the system once capacity reached.
- Safety net plans for urgent cases – signposting/urgent slots/duty doctor.
- Routine appointments may need a wait list if capacity reached.
- Communicate systems to patients, outlining steps should condition change with clear safety netting.
- Use whole practice team.
- Review appointment setup if regularly running over.

Waiting lists

- Provide for the reasonable needs of your patients.
- Safety netting – clear instructions, website, telephone lines, text message, verbal.
- Communication, education, training.
- Triage, pre-triage and re-triage.
- Use of the wider healthcare system.

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Appendix 2
Patient engagement

- Template letters
- Case study
- Posters and graphics
- PowerPoint for PPGs

Patient engagement suggestions:

- Tik Tok
- Facebook
- Newsletter
- QR Cards for patient feedback
- Communications lead
- Patient experience manager

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Sample template letter to patients (1)

Implementation of the British Medical Association's safe working guidance

We are writing to let you know that we have implemented the BMA (British Medical Association) safe working guidance. This is to protect you as patients and the practice. We are committed to delivering safe, high-quality care: **we are on your side.**

As a result, once maximum capacity has been reached, we may need to signpost people to other supporting NHS services.

We will endeavour to ensure care is prioritised for the most vulnerable. It would be appreciated if patients would consider alternative providers such as the pharmacy service for minor and self-limiting problems.

The changes are designed to create a safer environment for you, our patients, who are our priority, and also for all our clinical teams, to keep this practice open and able to continue to deliver services with the team we have.

Recent surveys have shown GPs across the nation are facing an unmanageable workload, which at times is affecting their ability to provide safe care. GPs are also retiring early, reducing their NHS commitments, or deciding to leave the profession. This is an unsustainable situation which must be addressed, and the BMA's safe working guidance is designed to help both you, as a patient, to receive better care, and your GP to provide it. England has lost over 1,300 GP Practices over the past decade. We are fighting to survive.

Please be reassured that you will continue to receive care from other clinical colleagues working at the practice. You may also be asked, depending on your medical symptoms, to contact NHS 111 or attend other local NHS services which may be more appropriate for your specific needs.

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Sample template letter to patients (2)

Credit: Kingswood Health Centre.

Message for Patients – Incoming!

The NHS is in crisis.
– We're seeing 20% more patients than before the pandemic
– We're seeing more than 1 million patients per day
– Hospital waiting lists are increasing, meaning patients come back to us

Our costs are rising, just as yours are – electricity, estates, supplies, paying our staff – yet we receive no additional funding or grants. We are all struggling to stay afloat. If this continues, your local practice may disappear.

As a patient, you would need to move to a neighbouring practice and join a long list of people waiting for appointments.

At (SURGERY NAME) we are feeling the pressure and are working as hard as we can to provide the right care for our patients.

We are unable to recruit more staff, and cannot fund replacement of new staff which will mean for you:
– wait times for appointments are longer.
– We may not be able to respond as quickly to requests
– Medical reports, assessments or complaints may take longer

Other NHS services can help ease the pressure, so you may be signposted out of the surgery to their local pharmacy or other service. Please do take advantage of these options.

Please help us free up clinical time by trying to self-manage any minor illnesses, visiting the pharmacy first and by attending health checks when invited to which aim to help keep you well at home.

We are worried and distressed about the current situation too and wish we could do more. If you feel strongly about the issue of general practice funding, you may wish to contact your local member of parliament to express your views.

In the meantime, we will continue to do our best to support our patients and we appreciate your support and consideration during these difficult times.

The Partners
<NAME OF SURGERY>
<DATE>

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Sample template letter to MP/Local councillor – Winchcombe Medical Practice

Dear (insert name of your MP)
I am a patient at <INSERT PRACTICE NAME HERE>.

The partners have recently written to the patients informing them that due to government funding cuts they can no longer provide us with the clinical care that they both used to and want to.

The medical centre provides services for almost <X thousand> patients and as there is no hospital in the town, we rely on it for all our health care needs. It provides phlebotomy services as well as acute illness and specialist chronic disease clinics and is a minor injury centre.

Over the last few years, the financial pressures on the medical centre have increased. Staff costs, energy costs and the cost of disposable items used every day have spiralled. The funding from the government however has remained static at approx. 2% compared to inflation that at times has been over 10%.

The medical centre is now working with fewer administrative and clinical staff in an effort to stay financially viable. This means that they are unable to offer the same number of appointments for either acute or chronic care. On top of this the practice are managing more work that is being passed down from the hospitals and patients also require more appointments for drug and disease monitoring. If anything, patients need MORE appointments, not fewer.

As a patient I rely on having a local practice where the GPs know me and my health needs. If the practice closed there is not even an hourly bus service to the next nearest Gloucestershire practice in Bishops Cleeve. In addition, if the practice runs out of urgent on the day appointments and I have to attend Cheltenham hospital, it costs approx. £40 one way in a taxi.

The government needs to urgently invest more money in general practice: In real terms general practice funding has been slashed by over £350million since 2019 despite a backdrop of record patient demand. In addition, the GP share of NHS spend has fallen to an eight year low despite providing 90% of the country's healthcare. As of February 2023, 20% of the county's surgeries are struggling with finances and having to cut services. We do not want to see primary care go the same way as NHS dentistry in England.

Thank you in advance for your time and consideration
(Your name)

See also: https://www.kingswoodhealthcentre.co.uk/files/2024/04/Letter-for-patients-re-2024-contract.pdf and https://winchcombemedical.nhs.uk/wp-content/uploads/2024/04/Letter-to-MP-re.-surgery-Template.pdf

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Case study: Denise Smith, practice manager, Merepark Medical Centre, Alsager, Cheshire

"In 2020, I recognised that the team at Merepark Medical Centre, Alsager, Cheshire, was exhausted because its members were working both at the practice and at local COVID-19 vaccination clinics. I realised that we had to protect the team's health and wellbeing for them to be able to care for patients. Therefore, I introduced a counsellor to support the team every day. This support is ongoing and has been invaluable.

Once the team's health and wellbeing were supported, we looked at the team structure. To combat negative portrayals of receptionists as 'gatekeepers' to GP access, we renamed the reception team 'care navigators'. We also implemented a care-navigation hub/frontline triage desk, and recruited four advanced nurse practitioners, who are now the first port of call in the morning to triage patients.

We then identified that, although our online services (social media sites, practice newsletters, and website) were operational, patients still tended to want to see a member of the team when visiting the practice. Therefore, we introduced a patient experience manager, who speaks to patients in the waiting area and listens to their concerns and compliments. It is so important to receive feedback from patients and staff. We designed a card that all staff can distribute to patients, which includes a QR code that patients can scan to provide feedback about their visit to the practice. I share this feedback with the whole team in my weekly update. In addition, we implemented a meet-and-greet desk at the main entrance, at which a team member answers patients' enquiries. We also established a room for confidential discussions. The patient and staff feedback on these innovations has been extremely positive.

We organised an open day on a Saturday, which the whole team and the proactive patient participation group attended. The patients met the new members of the team, who explained their roles at the practice. There will always be a need to meet patients face-to-face to inform them of any changes and share the services that we provide.

We meet weekly with our management/nursing team and GP partners, which enables us to grow stronger together by participating in important discussions. We assess our organisational culture by reviewing our rules, beliefs and values, behaviours, interactions, and vision. I am proud to say that we have retained and recruited more staff, which has boosted staff morale and, most importantly, enabled us to provide the best care for patients."

Posters and graphics

You can download and print a number of posters from the BMA website. There are also graphics to download and share.

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Appendix 3
Workload mapping steps

The following steps have been developed from material from NHS Lothian

1. Are you ready?

a) Have you made the commitment to review and change the way you work to support a more sustainable delivery of care?
b) Have you, or are you engaged with your practice team, PPGs, etc?

2. What matters to your patients and practice team?

a) Have you sat down as a practice team to discuss the main issues around workload and identified your shared priorities?
b) Have you engaged your PPGs for feedback around patient priorities?
c) Have you taken into consideration the whole practice team (administrative, management, clinical, etc)?
d) How as a practice you will assess, implement and monitor any changes?
e) Consider: **WHY**, **WHAT** and **HOW**? This helps with buy-in and guides next steps.
f) Remember, each practice is different and will be influenced by:
    a. Deprivation
    b. Demographics
    c. Multi-morbidity and frailty

3. Collect your baseline data

a) Select a few days (2-3) or single week during a typical period of work, when staffing, leave and patient demand are within usual levels. For example, avoiding post-bank holidays, Christmas, summer and school holidays.
b) Agree mapping and reporting processes – e.g. paper, electronic etc.
c) Ensure that all sources of practice workload generation are considered and mapped from multiple perspectives, including non-patient contacts and requests.
d) Identify lead(s) for organising data collection communication and collation.
e) Clarify expectations around level of detail roles collecting data and roles participating.

4. Use a Pareto chart to identify what your top workload issue is

A Pareto chart is a type of bar graph used to order categories based on their frequency. It can be a useful way to identify which areas you should target to have the biggest impact. Find out more

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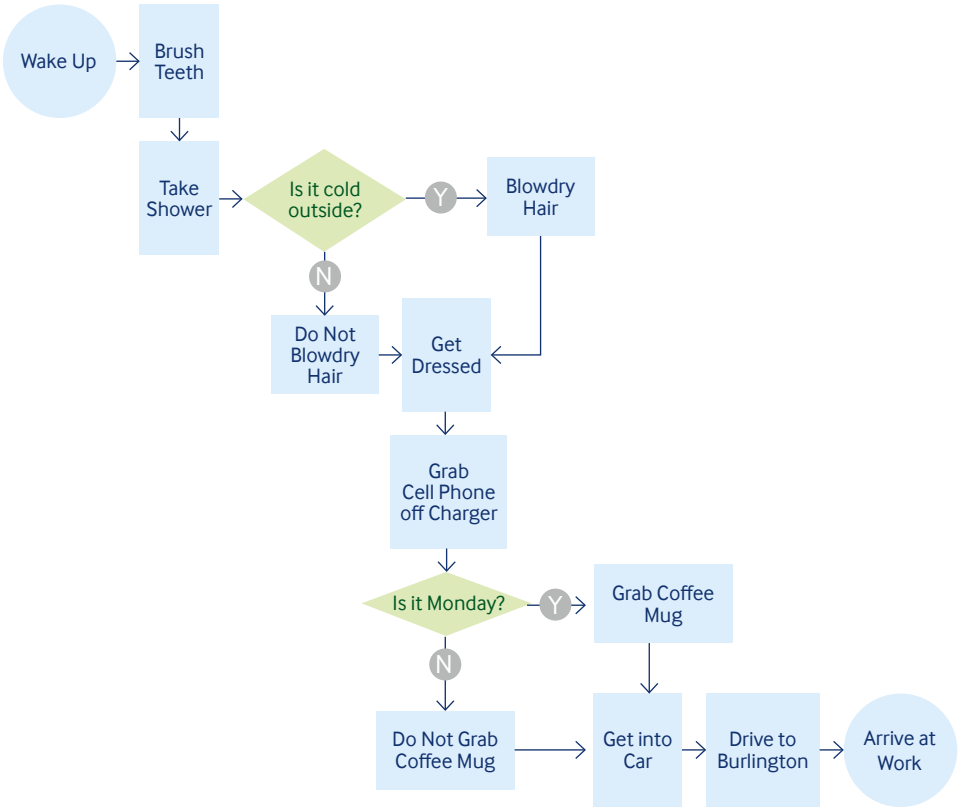
5. Use a process map to look at this issue more closely and identify how you can make changes

A process map is a visualisation of a step-by-step process. Process maps are supposed to indicate how things happen in reality, rather than how things would ideally happen. Whiteboard flowchart

Detailed Process Map: Getting to Work



Nocito, S, & Zeribi, K. (n.d) Building a Swim Lane Flow Chart. Tutorial for ImproveCareNow. (n.p)

6. Consider why this issue is happening and what you can influence

a) Revisit your patient and practice team's priorities.
b) Triangulate with data collection to identify possible areas of impact, factoring in the workload, process and human impact across your patients and practice team.
c) Consider other factors that may be of influence (see section 2 above).

7. Decide what you would like to change and state your aim

a) A written aim statement should be a clear, specific summary that explicitly outlines next steps over defined timeline.

8. Look for ideas or use a change package

a) Brainstorm different approaches, taking into consideration the possible underlying factors.
b) Utilise technology and programmes to support this.

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9. Test and see if it is working – make further changes if it's not

a) Refer back to monitoring processes and agreed measurements of success.
b) Start incrementally – it's a journey, not a destination.
c) Make one change at a time to assess the specific impact.
d) Consider models of improvement.

10. Measure your workload reductions to ensure they are sustainable

a) Outline regular checkpoints for review.
b) Check in with how people are feeling, as well as data points.
c) Agree measurement outputs.
d) Reappraise, considering patient population and staffing changes.
e) Review in light of changes to external services and providers that may have an impact.

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Workload checklist

Suggested possible workload baseline measures (add or remove other measures as relevant to your area of focus). There is an excel version here.

Measure per day/week/month	Source
Direct patient care	
Number of pre-booked routine appointments (phone, F2F, GP, PH, pharmacist, phlebotomy, physio, paramedic, MHP etc)	Vision/ EMIS /TPP
Number of on the day acute consultations (phone, eConsult, walk-ins, home visits)	Vision/ EMIS / eConsult
Multi-morbidity and frailty	
Number of blood tests taken (GP, primary care request, shared care monitoring, community, secondary care request, non-NHS providers)	ICE or labs analyst
Number of/Time spent on Enhanced Services patient contacts (minor surgery, LARC, substance misuse, care homes, safeguarding etc)	Vision/ EMIS/TPP
Number of vaccines given (Flu, COVID, childhood immunisations)	Vision/ EMIS/TPP
Indirect patient care	
Total number of patients contacts to reception/admin (phone, eConsult, walk-ins, third party)	Reception count / telephone system record
Number of prescription requests (acute, repeat)	
Number of prescription reauthorisations	Vision/ EMIS/TPP
Number of results received (haematology, biochemistry, micro, imaging, other etc)	DOCMAN
Number of documents received (discharge letters, clinic letters, info, requests for action	DOCMAN
Times spent/number of Enhanced Services admin (Anticipatory Care Planning)	Individual time and motion
PCN DES (meetings, admin, finances)	
Other work	
Number of report requests (insurance, employment, DVLA, gun licence, child protection)	Practice count / DOCMAN
Time spent in meetings (huddle, clinical, whole team, partnership, cluster and other)	Individual time and motion
Time spent on small business management and finance	Individual time and motion
Time spent on staff management, recruitment and wellbeing	Individual time and motion
Time spent teaching/supervising staff	Individual time and motion
Time spent on Quality Improvement initiatives (SESP, cluster projects, other practice projects)	Individual time and motion
Possible proxy measures	
Log-out time	
Validated perceived stress score	Individual record

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Appendix 4
Example framework for online/ telephone triage

We are mindful that each practice is different, with varying patient demographics, practice teams and commissioning landscapes. You will need to tailor processes as guided by the needs of your patients and practice team, taking into consideration your local context and appropriate adjustments for vulnerable patients. This is an example only.

Digital poverty and literacy may be a barrier for some patients, and lack of access to a telephone (smartphone or landline) for others. Please keep in mind language barriers and adjust approaches to help overcome these.

When outlining the points of contact for patients accessing the practice, please consider appropriate signposting and messaging is in place to help direct patients to other services which may be more appropriate, particularly in the case of emergencies, e.g. 999.

This could be via your website, online triaging system, telephone message and text messages, practice posters, as well as verbally through your reception and care navigation teams.

Patient query submitted – online form/telephone/ walk-in:

- filter/admin
- signpost/clinical triage
- clinical signpost
- texted advice
- investigations
- consultation:
  - telephone
  - video
  - face-to-face
  - home visit.

Stages

Filter, signpost, advice, information, consultation, follow up.

If patient does not have access to online triage or urgent/emergency (unwell, child under five, urgent mental health, etc) – for message board to speak to on-call GP

- consider language requirements
- safeguarding
- vulnerable patients

Reception to clarify via telephone: 'Is this urgent?' If an emergency, need to redirect to more appropriate service.

Document reason and information, then message on-call GP to let them know.

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Form filter by reception/admin team

Reception access form – check patient details and if registered patient:
Address and telephone correct/changed? Out of area?

Depending on how form/query comes in could be via non-registered patient

- Double check NHS number etc
- NHS App – will be registered
- Website – non-registered will have access
- Can also be via email – check patient details

Acknowledge receipt – check text and if not urgent advise will contact within 48 hours. Explicitly explain if urgent query (should be outlined on online triage), need to contact emergency service.

Triaging is according to clinical prioritisation, taking into consideration the particular needs of patients (vulnerability etc), with appropriate adjustments made.

Check query

1. Signpost to other service where appropriate:

a. emergency department
b. urgent care/walk-in centre
c. community services
d. contraception
e. sexual health
f. pharmacist
g. optometrist
h. minor ailments scheme
i. smoking cessation
j. physiotherapy (external to practice)
k. dentist

2. Admin – administrative query

To be dealt with by the admin team

3. Social prescriber

4. External services

a. Self-referral e.g. counselling

5. Reception – booking an appointment

6. Health coach – counselling, support

7. HCA – bloods, BP, weight

8. Nurse – smears, immunisation, chronic disease reviews

9. ANP – acute on the day

10. Paramedic – acute on the day, home visit

11. Pharmacist

a. medication reviews
b. medication reconciliation
c. medication queries

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12. Mental health practitioner – follow ups known to them

13. MSK FPOC (internal practice/PCN)

14. GP

For clinicians/cases – defined list for non-GPs discussed and agreed with them so that these take account of their experience and competencies, as well as regulatory aspects (for example dependent/independent practitioners, undifferentiated/differentiated cases, prescribing, risk management etc).

If not sure – discuss with the on-call duty GP

Signpost – Accurx text sent – templates for above

Book into online triage slots

Can also send Accurx link for self-booking face to face slots on the day

If rash/lesion described reception or clinical triager can text/call patient in advance for photograph request to streamline process. Clinician can then review form and photograph contemporaneously and can telephone sooner – outline timeline for response.

Contraception – send appropriate Florey/template for completion

If expressed preference book in with relevant GP, if issue already being dealt with by clinician – book in with same clinician, preference for gender etc. – online triage slot for relevant staff

Clinical online triage

Each clinician has a specific number of slots:
- Online triage document review
- Telephone slots
- GP bookable – for GP follow up
- Face-to-face
- Urgents
- Administrative time – bloods, prescriptions, Docman
- Supervision slots blocked off– trainees, other clinicians

Online triage outcomes

Redirected to other service – signposted by text

Booked in with other clinician/service at practice for triage
- patient preference
- continuity of care
- gender/other specification
- clinical need – e.g. nursing, chronic disease management

More information required – text sent/telephone call if appropriate

Photograph request – text sent (time limit for response outlined)

Query answered by text – question/clarification

Information sent – link by text

Further investigation planned – text sent to book in for an appointment as appropriate

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Consultation(s) – these can be converted to different modalities during one patient episode

- Telephone consultation
- Video consultation – consider for children, mental health as can view body language and observe – might be quicker than telephone, picking up on non-verbal
- Photo/documentation review
- Face-to-face examination required – booked in with same GP or if needed discussed with colleague and booked into mutually agreed slot (need to take account of need to reduce forms/telephone calls so that workload is managed and controlled as risk that may end up being added to and not accounted for)
- Home visit – GP/visiting service
- Follow ups – booked in GP bookable slot
- or handed back to patient to submit online triage for review at/within defined timeline – for example trial of medication, wait and monitor etc.

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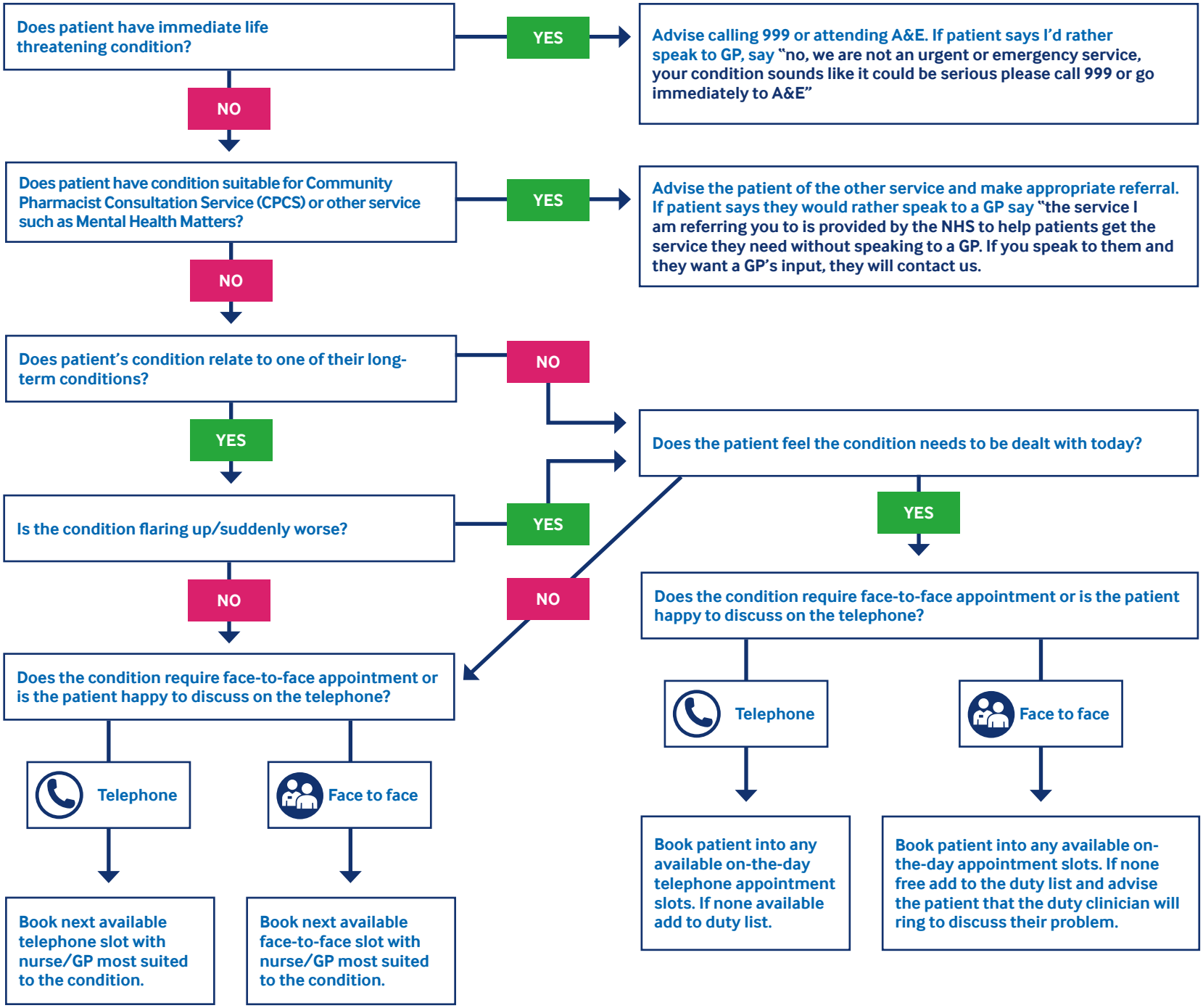

Flowchart Sample 1

Flowchart Sample 1 and 2 are provided as examples only. They may be used as a guide for practices when devising and adopting an approach suitable for the specific needs of the practice.

"Good morning/afternoon,** [XYZ Medical Practice], [name] **speaking, how can I help?"

"Please can I take your date of birth?" – retrieve patient notes and ask for one further identifier

Offer first planned care appointment

Book appointment

(Symptoms >2 weeks with no acute change)

PATIENT STATES MORE URGENT

"Please could you give me a brief reason for the appointment?"

Acute Problem:

- Chest infection
- Breathing problem (follow protocol, if available)
- Chest pain (follow protocol, if available)
- Acute stomach pain
- Skin infection (photo)
- Urine infection (sample)
- Sinusitis >10 days
- Conjunctivitis <2 years old
- Hearing loss <1 week
- Ear pain/infection
- Acute dizziness <1 week
- Acute constipation <2 weeks
- Acute headache
- Acute mental health (follow protocol, if available)
- Limb weakness/slurred speech (follow protocol, if available)
- Another healthcare professional calling regarding patient (please add to list with URGENT at the front and IM CST team) e.g., Paramedic

Please note this is a guide, the list is not exhaustive. If you are unsure, please follow single point of access procedure to your Line Manager who will check with the CST.

Add to same day urgent list

Signposting:

Pharmacy:

- Mild cough/cold
- Conjunctivitis > 2 years old
- Haemorrhoids
- Skin conditions – but well in self, rash, ringworm, eczema
- Threadworm
- Headlice
- Chickenpox/hand, foot and mouth unless acutely unwell
- Hayfever
- Mild – moderate pain
- Mild acute diarrhoea < 5 days

Primary eye care service:

- Red, painful eye/eyelid
- Acute flashes/floaters
- Sudden vision loss
- Foreign body in eye

Signpost to other service

Medication issues:

- Side effects
- Medication queries
- Pharmacy queries
- Urgent queries

Book Pharmacist appointment

Flowchart Sample 2

Flowchart Sample 1 and 2 are provided as examples only. They may be used as a guide for practices when devising and adopting an approach suitable for the specific needs of the practice.

Appendix 5
Waiting list management

Having a waiting list is not obligatory. Urgent cases can be managed through the use of a duty doctor system with protected time, and/or protected urgent slots for GPs and other clinicians on the day within clinics.

Once practices have clinically prioritised and allocated all of their appointments, and have reached capacity, they have the following options:

- signposting to alternative services
- e.g. enhanced access, NHS 111, urgent care, pharmacy, A&E
- informing patients they will be allocated a routine appointment once this becomes available
- safety net if routine that is safe to wait: inform them that should their clinical situation change, they need to get back in touch with the practice, or if it is an emergency the relevant service e.g. emergency department
- meanwhile a list of the unallocated patient cases should be kept and allocated as soon as appointments are booked on
- regular safety netting messages can be sent

Sample telephone answerphone message

'The practice is currently experiencing unmanageable demand for urgent care. Taking account of our practice team's safety and the availability of other options for patient care we are not able to manage any more routine patients today. We are only able to offer urgent appointments at this present time. For routine issues we would suggest contacting alternative services such as NHS 111, your local pharmacy or walk in centre, or urgent treatment centre, which we can signpost you to. We are sorry for this inconvenience, which is beyond our control. If you have an emergency medical problem that you believe cannot wait, then you should seek help from other NHS agencies including NHS 111, urgent care or through accident and emergency.'

ICBs should ensure that there is a formal escalation route for practices that have reached safe capacity. Operational Pressures Escalation Level (OPEL) measurement should be used, and escalation plans should be agreed by practices, LMCs, and ICBs to enable safe onward signposting of patients. Until formal escalation plans are agreed in localities, practices should signpost patients to where they feel clinically appropriate.

Sample text message to send to patients

Thank you for contacting the practice; your request is important to us. It has been reviewed and assessed to be of a routine nature. We are currently at safe working capacity, and therefore unfortunately not in a position to offer you an appointment at this time. Should you require urgent advice please contact NHS111 or if it is an emergency, A&E. Otherwise, should your condition change please get back in touch with us, and we can review matters accordingly. Further information is available on the NHS and our practice website.

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Avoiding/minimising Do Not Attends

Booking appointments very far in advance (beyond 4 weeks), may increase the risk of DNAs (Do Not Attends).

Having a system whereby patients can be reminded of upcoming appointments is helpful to reduce the risk:

- texting date and time of appointments
  - time of allocation
  - reminder 2-3 days beforehand
- telephone calls if texting not appropriate
- ensure that adjustments are in place for particular patients/groups
- requesting patients to actively confirm follow-up or routine appointments following reminders being sent
- alerts and reasonable adjustments of vulnerable groups and patient cohorts
- ensure a shortcut button to cancel appointments is heard early in automated patient messaging on the telephone

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Appendix 6
Learning, feedback and reflections: how to engage and have input from whole practice team

This can be undertaken as a whole practice team or have identified reps from each group:

- Reception
- Admin
- Clinicians
- Management
- Partners

Map out current pathway
- from the perspective of the patient and all of the staff team

Identify
- current/future challenges
- current benefit/future benefits

Other additional needs/wants (not exhaustive)
- Safety
- Protect vulnerable patients – should be accessible for all
- General and specific local population patient needs
- Workload management
- Flexibility – workforce/working week, etc
- Estates

Remote working
- Staff groups
  - Admin/reception
  - Clinical

- Rota
  - Rotational – resilience in case of infection/illness
  - Self-isolation
  - Maximise use of estates

Communication – importance of feeling connected and part of the team
- When and how
- Daily check-in between staff groups offering support
- Daily check-in to support wellbeing
- MT teams
- Create team-specific groups as well as whole practice
- Practice meetings
- Clinical information
- Case discussions
- One-to-one
- Messaging via EMIS
- Tasks
- Telephone

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Map out for current workforce staff group:

- Current baseline skills and experience
- Capacity – hours, etc
- Potential for training up
- Ability to take on extra duties (contractually, regulatory and time wise); 'stretch'
- Think about team resilience – multiple people being able to perform different roles rather than relying on one individual in the pathway

Think about practice population needs

- Common presentations
- Prescribing
- Long-term conditions
- Patient preferences
- Current services

Identify pathways that patients can use to make contact:

- NHS App
- Website
- Accurx
- Footfall
- Email
- Telephone
- Online consultation providers

Decide on non-urgent and urgent

- Clear signposting and redirection if appropriate e.g. A&E
- Telephone message
- Red flag on online triage
- Clear instructions about what to do in URGENT situations:
  - Patients – clear message on answerphone and website
  - Reception staff
  - Clear script and questions
  - Direct to NHS111
  - A&E
  - On-call GP
  - If in any doubt speak to clinician
- Non-urgent
  - Can they be signposted elsewhere? (EXTERNALLY)
  - Decide on list of definitive conditions
  - E.g. travel vaccinations
  - New pregnancy – midwife number/online antenatal self-referral form
  - Sexual health services– online and face-to-face
  - Smoking cessation
  - Outline script and Accurx templates so these can be consistently communicated to patients
  - Links and information communicated via text or other modalities

In practice queries

- Need appointment to be booked directly (e.g. need a blood test)
- Or need to have document request reviewed
- Discuss and agree which clinician is most appropriate
- Communicate and clarify these between reception and clinical team
- E.g. smears with trained nurse
- Have a list for each clinician to minimise confusion
- Any clarification – speak to on-call GP/clinician

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Clinicians

- Review and action triaging, queries
- Important to record activity as it is happening rather than necessarily sticking to template outline
- May need to review workload therefore need to capture it as accurately as possible

Learning – feedback from all team members (admin to clinical staff)

- Agree 'must haves'
  - (for example) Being able to plan working day
  - Defined number of forms/patient contacts
- Benefits
- Not so good bits
- What can be changed?
- What needs to be changed?
- Timelines? Short/medium/long term?
- What training needs identified?
  - Gaps in pathways
  - Gaps in staff skill mix
- Remember cross-team interaction and exchange of information
- Solutions proposed need to be useful but also practical otherwise will not be sustainably embedded
- Mental wellbeing is key
- Flexibility and slack in the system so as to be able to effectively manage illness/staff absence

Review points

- Agree timelines
- Process for feedback
- Agree communication channels/processes
  - Ledger documentation in the session
  - Instant messaging
  - Email
  - Teams chat, etc
  - People can access info and discussions when convenient
- Process for change – date and trial period

Feedback processes (on system as a whole)

- Patient perspective
- Staff
- KPIs – e.g. appts, accessibility, workload etc.

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Appendix 7
Care navigation and triage in general practice: case studies

GP triage case study 1: eConsult/eLite digital triage system

Dr Baldock, a GP Partner at a 10,000 practice in Hertfordshire, uses the eConsult triage system.

How it works

To begin, patients complete an online form detailing their symptoms. If they are unable to complete the form online, they can come into or phone the practice and care navigators complete the eLite form on their behalf. An eLite form is a short eConsult template that the reception team uses to record submissions from patients.

All daily eConsults and eLites are collected in two separate 'duty lists'. A clinician (either a GP or advanced nurse practitioner) triages these forms. There are same day, one-day and two-day appointment slots of conditions that require appropriate and timely triage for GPs and nurses. All GP appointments are 15 minutes long. The eConsult and eLite systems are switched off once those appointment slots are taken.

Creating a 'vulnerable system'

The practice has created its own 'vulnerable system' to ensure that patients do not get turned away when they should be assessed by a GP.

In this system, care navigators inform the patient that they will speak to a GP and that the GP will contact them. The duty doctor continues to have responsibility and has the afternoon available to manage any patients who come in. There is also a pre-bookable system available which allows appointments to be booked three weeks in advance.

The 'vulnerable system' includes:
- any child under 1
- any adult over 65
- anyone on cancer treatment
- anyone on palliative care
- anyone with significant mental illnesses
- anyone with a medical need that results in them being vulnerable
- anyone the practice GPs feel to be vulnerable (shown by a sticker attached to the front page of a patient's notes which allows care navigators to easily identify vulnerable patients for the duty doctor to triage by using the eLite template).

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Care navigation and triage in general practice

GP triage case study 2: Accurx

Wilmslow Health Centre uses a patient triage tool powered by Accurx, which patients can access through the practice website. If patients are unable to complete the online form, they phone the practice and care navigators follow the same process as patients to fill out the form on their behalf.

How it works

RAG (red-amber-green ratings)
The on-call GP triages patients to the appropriate HCP (healthcare provider) in a timely manner by using RAG ratings:

Red: urgent appointments to be seen in the same session
Amber: appointments within one or two weeks
Green: next routine appointment.

Once a rating is assigned, a self-booking link is sent to the patient who can choose to see the GP face-to-face or speak to the GP via telephone (unless the practice defaults all appointments to face-to-face). The practice can switch off access to the triage tool once they have reached full capacity.

Clinical triage by GP

There is usually one duty GP for each morning and afternoon session. There are sometimes two GPs on Monday mornings.

The GP focuses on triage during this session and also completes quick tasks/consultations such as fit notes, uncomplicated UTIs, conditions or requests that only require brief phone calls.

The GP can request further information from the patient (eg a photograph).

The GP can divert patients to other HCPs (practice nurse, first contact practitioner, clinical pharmacists, community pharmacy, acute eye service).

Managing red appointment slots

'Red' patient appointments are meant to be seen by the duty GP in the same session.

Once all the 'red' or urgent appointment slots for all other practitioners have been filled, the GP on clinical triage is responsible for addressing any additional, i.e. 'red excess', appointments for patients whose cases are triaged as red during that session.

As 'red' or urgent appointment slots are limited, patients should only be assigned to these slots in the same session. If practices assign red or urgent appointments to later sessions, this can cause an imbalance of red slots throughout the week, having a knock-on effect on access. The system needs monitoring and tweaking to determine the correct proportion of red/amber/green slots available each day.

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Care navigation and triage in general practice

GP triage case study 3: capped system

A GP practice has introduced a capped system whereby the practice sets aside a specific number of urgent appointments and routine clinics per GP session per day.

The system has been negotiated with the GPs in the practice to meet growing demand and allows GPs to adjust their own clinic time and control administrative workload.

How it works

Routine clinics consist of a specified number of appointments (morning and afternoon):

x number of 15-minute face-to-face appointments
x number of 10-minute telephone appointments
x number of 10-minute usual routine GP appointments, which doctors can use to arrange appropriate follow ups
x number of 5-minute sick note requests slots.

Most GPs provide an equal split between telephone and face-to-face bookable slots and choose how to use their appointments – dependent on patient need/complexity and preference.

The routine availability for each clinic has slots ranging from 3 to 14 days – but no further ahead as this increases the risk of DNAs.

The admin team proactively books patients in for their dedicated 6-week 'mother and baby' appointments and patients with skin conditions are booked in with the GP who has specialist dermatology expertise – maximising GPs' areas of interest and where possible, avoiding the need for referrals and lengthy hospital waiting lists.

Finally, to free up GP time, the pharmacy team supports the practice by dealing with medication reviews and queries.

Urgent on-the-day problems

There are a set number of urgent appointments available per GP per session. Once capacity is reached, additional urgent appointments are added at the GP's discretion. The practice keeps urgent appointments separate from routine GP lists with a dedicated team providing urgent on-the-day care. This consists of doctors and one paramedic, doing a mix of home visits and urgent face-to-face reviews.

Urgent appointments

All appointments are telephone appointments first. Face-to-face reviews are arranged where appropriate.

When capacity is reached, patients are signposted to NHS 111, the local walk-in centre or pharmacy, as appropriate. Care navigators are trained to book a walk-in centre evening appointment for patients themselves, if this is appropriate.

Any home visits, palliative patients or other health professionals are put directly through to the duty doctor, even once capacity is reached. Similarly, care navigators will speak to the duty doctor regarding concerning patients (eg young child, acutely unwell, vulnerable adult), and an additional urgent appointment may be provided.

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Appendix 8
Safe Working: Getting to 25 consultations per day

(credit to Liverpool LMC)

Since COVID times, practices have adopted various methods and processes for determining who should be seen, and how. This can include filtering, signposting and triage (clinical and non-clinical). Some practices operate an almost total telephone triage system for 'on the day' appointments, some expect the majority of patients to have an initial access via online triage, others have a mixture of these, as well as allowing patients to just turn up at the practice. In addition, practices have the facility for patients to book in advance. It is clear that no one system is perfect, and that different populations require different forms of access.

So, what is meant by 25 appointments, and how can it work? The spirit of the guidance is that to work safely, GPs should be seeing, on average, no more than 25 patients per day. If someone is dealing with 40 per day now, they are not going to reduce to 25 tomorrow; they should try and reduce to, say 35, with a view to a further reduction in a couple of months.

But what is actually meant by 25? Let us consider, as an example, a practice that operates a total telephone triage system. If a GP starts a telephone conversation and realises that the patient needs a face-to-face consultation, the conversation usually lasts a matter of minutes; one wouldn't count that as a consultation as the patient is going to be coming in to be seen face-to-face. On the other hand, if there is a full telephone consultation that completes what is necessary, that equals a consultation. The same criteria could be adopted for PATCHS triage consultations.

In this example, patients who need to be seen face to face, will be seen appropriately, rather than be squeezed in as an inconvenience.

However one sorts the appointments, one would always advise a couple of slots reserved for 'urgent' issues that arise; no one should be turning away a sick child; but equally, general practice is not an emergency service and should not be treated as such.

If a practice reaches capacity, it is acceptable to direct patients to alternative services such as 111, walk in centres, the local pharmacy and (if appropriate) A&E.

In changing how the practice handles appointments, it is sensible to discuss the plans with the practice's patient participation group.

Finally, as a GP's work is more than just the consultations undertaken, it is important to ensure that one is recording other contacts and work done during the day.

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Appendix 9
Appointment set up case studies

The BMA safe working guideline of 25 patient consultations per day is designed to ensure the sustainable delivery of high-quality care based on clinical need, taking into consideration vulnerable patient cohorts and those requiring adjustments to access healthcare. It is a whole practice and system approach and should take into account the range of services available within your local setting.

This approach is a journey, not a destination. The speed of change will be set by you as a practice and will be influenced by a host of factors. Changes can be incremental and steady – we are aiming for high-quality, safe care that puts the wellbeing of our patients and practice staff at the heart of what we do: protecting our patients and protecting our practices. You may wish to review and modify your appointment and clinic approach completely overnight, or alternatively, for example, commence by initially reducing appointment and consultations numbers by 5-10%, with regular review and check-in points.

The process will be unique and individual to you.

Next steps:

Following the workload mapping exercise (Appendix 3) and the establishment of key priorities for your patients and team, it is useful to triangulate this with practice workforce capacity. Looking at the different roles and skills that are needed to deliver the service required, coupled with external capacity provided by alternative services, e.g. NHS111, urgent care centres, pharmacy, minor ailments services, etc. It may be helpful to break this down further into acute, routine and chronic disease management, as guided by the needs of your patient population and practice.

The following case studies are from a range of practices and settings.

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Case study 1:

Setting: Urban setting, no nearby urgent care centre

List size:	13,500
Appointment set up:	13 consultations per session
Appointment length:	15 minutes
Appointment mix:	pre-bookable and on the day (latter set by staffing numbers)
Duty doctor:	triage, fewer appointments
Triage:	online triage by duty doctor, am and pm sessions
Triage window:	closed when capacity reached, excluding defined emergencies
Waiting list:	no
Telephone message:	changes when triage closed, so patients aware
Software:	eConsult online triage, Apex Edenbridge to monitor appointment numbers

- Duty doctor calculates number of on-the-day appointments based on workforce capacity.
- This defines the number of on-the-day appointments available.
- A number of pre-bookable appointments are available; these cover a range of timeframes and can be booked by the GP or patients themselves.
- Duty doctor covers triage and 10 quick consultations (e.g. Med3s), rather than complex care.
- Duty doctor covers am and pm sessions, with a cut-off for online triage.
- Duty doctor in morning regularly monitors and comments when need to move to afternoon triage list.
- The afternoon duty list has a comment adding at what point to turn off online.
- The pm duty list has a comment adding at what point to turn off online consulting and another comment added, typically about 10 slots further down, stating 'emergencies only discuss with duty doctor prior to booking'. Typically, we have 10-15 of these slots.
- Separate NHS 111 slots – 2 available
- The 111 list is separate with 2 appointments in the morning and 2 in the afternoon, but the duty doctor will move these to the triage list if they are going to need a consultation so that they are included in the capacity count.
- After the move to emergencies only, the telephone message changes to make the patient aware there are only emergency appointments that day, so they are not on hold for a long time only to be told there are none left for that day.
- There is no waiting list; at the point of emergencies only, if the patient doesn't need an emergency appointment and there are no pre-bookable appointments available, the patient has the option to put in an eConsult the next day, call for an appointment the next day or if they feel it can't wait contact 111, IUC etc.
- They are not added to the list for the next day because a significant proportion never call back, meaning the following day's capacity cannot be filled as the system fails
- Apex Edenbridge is used to monitor appointments, as it would be hard to challenge this approach if the practice can demonstrate it is offering more than the average number of appointments per 1,000 patients per week than the other practices in the ICB.

Comment: The result is clinicians spend longer with patients, but it is based on a realistic rota, which also enables the clinical administrative work to be done, and all tasks completed in the allotted time.

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Case study 2

Setting: Urban

List size:	8,000
Appointment set up:	12 consultations per session
Appointment length:	15 minutes; 30-minute double appointments for complex consultations
Appointment mix:	face-to-face and telephone split between advance and on-the-day
Duty doctor:	fewer appointments, plus NHS 111 slots, actions urgent bloods and scripts
Triage:	patients contact practice by telephone or walk up, filtered and signposted with appointments offered over a number of timeframes
Triage window:	once capacity has been filled
Waiting list:	yes, for routine appointments. Urgent cases like end-of-life, under-5s and 'hot children' will be passed on to duty GP
Software:	EMIS, eConsult mainly used for administrative queries

An example of a standard GP Day:

Morning:

12 x 15-minute consultations (face-to-face/phone) – split between advance and on-the-day
2 x 15-minute consultations for GPs to book into (e.g. telephone consult with district nurse or task necessitating them to initiate call to patient)

Lunch:

1 x visit maximum (unless at care home, where may be 2x)

Afternoon:

12 x 15-minute consultations, as per morning

On-call GP Day:

Morning:

as per standard day
12 x 15-minute consultations (face-to-face/telephone) – split between advance and on-the-day
2 x 15-minute consultations for GPs to book into (e.g. telcon with district nurse or task necessitating them to initiate call to patient)

Lunch:

as per standard day
Visits only if all others have a visit already (duty triages requests)

Afternoon:

6 x 15-minute advance-booked consultations
3 x 15-minute 111-bookable slots

The remainder blocked off for:

administration
answering queries from reception
urgent calls – under-5s, end-of-life, 'hot children', etc
reviews and actions from any abnormal bloods/urgent scripts coming in after 5pm.

Comment:

Opportunistic long-term chronic disease management has improved. For example, vaccination rates have increased, as there is now more time and capacity for additional actions. As a result, it has been noted that repeat patient attendance and practice recalls have reduced. Patient satisfaction has improved

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and is now higher than the national and ICB. There is better long-term chronic disease management, and continuity of care has improved. Patients prefer it as they feel they can see their GP of choice, and staff feel like they have time to undertake interventions and have discussions. Double appointments have supported opportunistic health promotion around lifestyle. Recruitment and retention of staff, in particular GPs, has improved because of safe working guidance and its benefits being communicated through word-of-mouth.

Case study 3

Setting: Deprived, multicultural population

List size:	20,000
Appointment set up:	14 total, mix of 11 telephone and 3 face-to-face, fewer if more face-to-face required
Appointment length:	length of appointment can vary
Appointment mix:	mix of face-to-face and telephone, acute on the day and routine for GPs, ANPs
Duty doctor:	clinical assessment screen (CAS GP), triage and deal with urgents
Triage:	GP-led clinical total triage using CAS (clinical assessment screen), RAG rated (green/amber/red)
Triage access:	patients contact via reception, telephone or Accurx
Triage window:	CAS closes at 3.30pm, or after each CAS GP has each triaged 50 patients in a session (CAS may therefore close earlier than 3.30pm)
Urgent:	if CAS closed, urgent cases first triaged by care navigators and then CAS GP
Waiting list:	if capacity reached, routine (green) and patients informed
Telephone message:	patients informed urgent cases only once CAS closed
Software:	Accurx

- GP-led total clinical triage – called CAS (clinical assessment screen) GPs
- patient access via reception, telephone consultation or Accurx
- GP appointments default to telephone: 11 telcons and 3 face-to-face per session
- if more face-to-face are needed, telcons are blocked
- Triaging uses RAG rating: slot types are either red (same day), amber 1 week, amber 2 weeks, routine (green) according to clinical need
- AHPs such as ANPs/paramedics/MHP used for face-to-face appointments only
- CAS GPs have no booked appointments; they make clinical decisions on RAG rating of clinical triage and use F12 protocol to communicate this, routine patients may go on waiting list if not enough appointments
- CAS screen is capped at either 3.30pm or when each CAS GP has clinically triaged 50 patients per session (which may happen earlier at 2pm). When cap is reached, all online access is closed and patients are told it's urgent only, which are first triaged by care navigators and then CAS GP.

Comments: GPs and clinicians report higher satisfaction levels. GP appointments are remote first – enables better workload management, enabling practice team to meet for coffee and lunch, improving morale. Work is prioritised according to clinical need, with continuity of care much improved. Complaints around wait times have increased from a proportion of patients who do not like to wait for routine appointments.

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Case study 4

Setting: Urban, urgent care nearby

List size:	13,000
Appointment set up:	12 consultations in 4 hours (counts as one session)
Appointment length:	13 minutes
Appointment mix:	mainly face-to-face on the day, some routine prebooked with 1-2 GP follow-up telephone calls
Duty doctor:	am and pm sessions. Fewer patients booked in, deals with urgent clinical queries, prescriptions, bloods and correspondence
Triage:	GP-led clinical total triage using RAG rating (green/amber/red), capacity for on-the-day appointments defined by staffing on the day
Triage access:	total online triage, patients can have forms completed by reception or if vulnerable or require special access, could be booked straight in, or placed for duty doctor review
Triage window:	open from 7.30am, usually for 3–3.5-hour window, may close sooner as per higher demand or lower staffing numbers
Urgent:	telephone calls for urgent cases for review by duty doctor
Waiting list:	if capacity reached, routine (green) and patients signposted to alternative services, or informed they will be contacted once the next appointment becomes available
Telephone message:	online triage platform closed, and patients advised to call practice if urgent
Software:	Accurx, Emis

- Total online triage – GP-led, with a mix of routine and on-the-day appointments.
- Triager has a few empty slots to be used for acute, simple on-the-day consultations, otherwise main role is to triage using RAG (red/amber/green) rating as per clinical prioritisation.
- Clinical triage by GP in the morning. Previously did two sets of triage: am and pm, but this proved difficult to manage in terms of workload and demand, as too open-ended and labour intensive in terms of GP time and resource.
- Triager books acute on-the-day GPs, ANPs, pharmacist and paramedic, depending on case mix and complexity.
- Patients texted and sent self-booking face-to-face slot via Accurx for on-the-day. Alternatively telephoned (if no access to smartphone) by reception and informed.
- Capacity mapped out, and a RAG (red/amber/green) rating approach taken according to clinical prioritisation, patients with specific needs and vulnerabilities have alerts on the system
  - on-the-day urgent: red
  - less urgent, but not routine: amber (48 hours)
  - routine, next available: green (safe to wait, no clinical urgency)
- Once on the day capacity reached, patients redirected to alternative services if appropriate and only urgent queries accepted by telephone, for review by duty doctor.
- Clear communication to patients on timings for online triage window (it used to be open over the weekend and all day, but this carries risks in terms of safety if people ignore the red flags, and demand management).
- Majority of appointments face-to-face, with telephone and GP follow-ups as per patient request. Protected administrative time in clinics.
- GP follow-up slots protected for individual GPs to cover mental health reviews and for continuity of care.
- Duty doctor has fewer appointments booked in. Deals with urgent queries and reviews certain forms as they immediately come in as flagged by reception staff e.g. under-5s, serious mental health, etc.
- Appointments capacity mapped out in terms of
  - Clinicians (e.g. GP/nurse/ANP/pharmacist/PA/HCA/health coach/MHP)
  - Practice; in house
  - Enhanced access; GP federation, on the day, evening and any weekend (routine)
  - PCN; mole clinic, women's health, minor surgery, social prescriber, physio (in addition to the city-wide FPOC physio)

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  - Straight to physio (FPOC city-wide offer)
  - external services e.g. Pharmacy First, minor ailments
- The PCN withdrew from the PCN MHPs, reverting to direct practice employment as the MH trust offer didn't address its needs in managing complex mental health
- Booking of appointments:
  - patients are sent booking links to self-book face-to-face on the day via Accurx (this helps reduce DNAs as patients can pick the most convenient time)
  - appointments can be booked in via telephone for nurse and bloods/smears etc (helps prevent inappropriate booking).
- If patients unable to use online triage, forms completed on their behalf by reception or have direct booking into an appointment.
- In tandem with the above – duty GP. They have a lighter clinic in place, with empty slots for ad hoc queries. Their capacity is used only if the on-the-day capacity has been reached, and for those patients who could not wait.
- They would also deal with urgent Docman (usually mental health or safeguarding cases), third party queries and review urgent bloods that needed to be actioned for those clinicians that were not in.

Comment: The workload of the on-call greatly reduced since the introduction of total triage, releasing capacity to review and see genuine urgent cases on the day. If moderately urgent and routine appointments are all used up, patients are either signposted to other services e.g. urgent care centre, or if routine informed that they will be allocated an appointment once this becomes available. All text messages including failed contacts have safety netting advice included with NHS111 contact information. The clinic outlines enable the completion of clinic and other generated administrative tasks within the allotted timeframe.

Case study 5

Setting: Semi rural, no urgent care centre locally

List size: 23,000
Appointment set up: 25 consultations in one day
Appointment length: 15 minutes
Appointment mix: split between face-to-face and telephone, pre-bookable routine and on-the-day, more blocked off on Mondays
Duty clinician: see urgent on-the-day face-to-face. GPs and ANPs 12/13 patients per session, 15-minute appointments
Triage: 2-3 triage hub with co-located clinicians and receptionists
Triage access: total online triage
Triage window: open until capacity with appointments is reached. Patients then signposted elsewhere
Urgent: if capacity reached – urgent cases telephoned through and seen by duty. If capacity then reached, signposted elsewhere.
Waiting list: no
Software: Accurx, Emis

- The practice recently moved from 28 to 25 consultations a day, for both routine and on-call clinicians (mix of GPs and ANPs).
- Some routine appointments are pre-bookable, some embargoed for on-the-day use (more embargoed on Mondays).
- 12/13 appointments per session (25 total in a day), about half face-to-face, although many telephone/online slots are converted to face-to-face if needed. All 15 minutes.
- 2-3 clinicians per session in a triage hub with receptionists. 2 clinicians 'on call' seeing the urgent face-to-face appointments booked by the hub clinicians. 15-minute appointments.
- The system allows clinicians to be flexed if needed to/from triage/on call.
- Incoming electronic forms are switched off when the hub clinicians judge there are no

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more slots to book into. Usually they go off around 3pm, but it can be earlier or later depending on demand and clinical capacity. Patients can then ring in and will be triaged if emergency/directed to 111 if absolutely no capacity left.
- There has been a recent change so that where a maximum number of clinicians are on leave, more on-the-day appointments are loaded.
- There are separate 20-minute appointments for coils, implants, first menopause appointments and joint injections. There is a GP with an hour blocked for visits (and visiting matrons) and one with an hour blocked to deal with the blood results of any clinician not in that day.

Comments: Clinicians are generally happier than when we had unending duty demand. Initially dropped to 28 but have now reduced it further to 26 consultations with good experience for staff and increased morale. Patients objected at first but now seem to be mostly okay with the system.

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Appendix 10
Rural and geographically remote areas

The BMA safe working guidance is designed to be implemented across a range of settings led by the needs of both patients and practices.

Rural GPs and practices have historically had a broader informal remit in comparison to more urban colleagues, with a greater proportion of activity being led by tradition rather than contract, due to geographical distance and lack of access to alternative supporting health services.

There is a strong connection between GPs, practices and the local community, with a high level of personal accountability as the only healthcare provider within the area. GPs and practices have established relationships with their patients associated with high levels of trust and continuity of care.

However, the absence of alternative services and barriers to accessing secondary care, can create difficulties in the delivery of core essential services. This is compounded by a lack of accessible public transport to local hospitals and emergency departments and in combination with patients' personal preference to engage with their local practice, leads to an increase in the reliance and burden on GPs.

Rural areas can face significant challenges around deprivation, with poor infrastructure spanning transport, digital poverty, literacy and employment. The inverse care law persists, with an aging population facing increasing medical complexity and comorbidity in the context of fewer resources despite greater need.

A significant source of workload in the 10% of rural practices that are dispensing, is generated by medication queries, which has been increasingly exacerbated by stock issues over recent times. Workload transfer from hospitals around prescribing is a particular issue due to long distances and travel times, resulting in patients' preference in having this addressed at their practice. These result in GPs having to call and speak to patients to clarify queries, generating a significant consultation burden, in addition to the usual clinics.

Workload pressures, increasing medical complexity, geographical isolation and challenges in recruiting and retaining staff, make it even more imperative that practices are empowered to take the steps necessary to help protect their patients and practices, through the implementation of safe working guidance.

A key enabler is early and regular engagement with patients, helping them to keep informed about changes that will protect and support their local GP practice in the delivery of high-quality safe care.

We have provided the following case studies as examples of the successful implementation of safe working guidance within the rural setting:

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Rural Case study 1

Setting: Rural, semi-rural

List size:	26,000
Appointment set up:	12 consultations in 4.5 hours (counts as one session) with 15 min coffee break and two 15 min catch up slots/admin slots
Appointment length:	15 minutes
Appointment mix:	pre booked mix of routine telephone calls and face-to-face (4 week wait) with on the day slot for same day urgent care and some slots to book 1 week in advance (telephone and F2F) for those that are not routine but not same day. One slot the clinician alone can book up to 4 weeks in advance for their own follow up.
Duty doctor:	am and pm sessions. Deals with 'same day' problems and urgent clinical queries.
Triage:	GP-led clinical triage, capacity for on-the-day appointments defined by staffing on the day. GPs, ANPs, pharmacist are put on rota to cover the day or parts of the day. Number of slots on duty doctor list for triage correlates with the number of same day slots kept free for booking F2F slots. If 40 same day 'urgent slots' available, then 80 slots on triage list available as half can be dealt with usually by care-navigation or telephone consultation.
Triage access:	via staff care navigators taking details and signposting where appropriate or adding to duty doctor triage list
Triage window:	open from 8am and will close when maximum number of same day triage slots booked. After this cancer/palliative, under 5yo and truly urgent cases dealt with. Otherwise signposted elsewhere – self-care, pharmacy first, NHS 111 etc
Telephone message:	when capacity reached patient signposted elsewhere
Software:	Accurx, Emis

Clinic set up:

08:30	telephone call
08:45	telephone call
09:00	telephone call
09:15	face-to-face
09:30	face-to-face
09:45	face-to-face
10:00	face-to-face
10:15	BREAK/ADMIN
10:30	same day appt for urgent care use
10:45	telephone call
11:00	coffee break
11:20	1 week pre-bookable telephone call
11:35	1 week pre-bookable face-to-face
11:50	CLINICIAN USE ONLY
12:05	face-to-face

Comments:

We used to be on 10-minute appts so moving to 15-minute appointments was a game changer. We had more time for patients who often have more than one problem, and when there is a quicker consultation, it gives some breathing space to catch up on admin or undertake tasks from that consultation.

Having a defined number of slots each day and knowing that 'extras' won't be added is also a big relief and you can map out your session and know what is ahead of you. We built in some time to meet in our staff room for a 10-15 min coffee and chat and work out home visits to divide up too. It is good to see other members of the team then too.

The duty doctor session is a challenge, and we don't have a walk in

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centre or any other help or support day to day from the ICB. This is why we have to cap the numbers to protect ourselves and maintain a semblance of safety. We also work as a team so if the duty doctor session is too heavy others will dip in and help with the odd one or two calls and this makes a big difference, and you realise you are not alone.

Rural Case Study 2

Setting: Semi-Rural (No walk-in centre, A&E > 25 minutes away), Dispensing practice

List Size:	7,000 patients
Appointment set up:	Non-on call: 12 face-to-face appointments with 1 telephone call in a morning session. 11 face-to-face appts and 3 telephone calls in an afternoon session. Our day starts at 08.30am, and we meet for coffee at 12pm.
On Call:	11 telephone triage appointments each session with 4 face-to-face slots to bring these patients in if needed, around 3-6 urgent queries along with medication queries.
Appointment length:	Clinician dependent (10m, 15m, 20m). Work on set number of appointment rather than time, to suit clinicians' personal preference.
Appointment mix:	Triage doctor: Mix of telephone triage (11 appointments) and face-to-face.
Face to face clinic:	Face-to-face with pre-booked telephone calls
Duty Doctor role:	Telephone triage (11 appointments) with around 4 face-to-face slots to review these patients in that session. Handles urgent queries, supports Nurse Practitioners and wider team, allocates visits and deals with medication queries. No pre-booked appointments.
Triage System:	GP-led 100% telephone triage with support using AccuRx and a fantastic reception team! We have been using Telephone triage for around 15 years now, our location is known for having a poor internet connection.
Triage access:	Reception & Telephone
Triage Window:	Until capacity for the day reached. Varies between 10am through till 6pm on some days.
Comments:	In place for 18 months, the system has led to higher satisfaction levels across the wider practice team. We have made many iterative approaches to get to the above position that we are in now. It feels safe. The workload seems manageable – even if individuals are on leave. Regular coffee breaks and script signing have become part of our daily routine, this has opened more collaborative approaches for care! The practice has also reinstated weekly practice meetings with our wider team, which has helped us feel more like a cohesive unit. Additionally, weekly doctor meetings are back which allows us to discuss incoming letters, new diagnosis, end of life patients and inappropriate rejections, this has further improved teamwork and communication. Overall, we can realise the real turbocharge effects of continuity of care. We are supporting both staff wellbeing and the delivery of high-quality care to patients! GPs report feeling less exhausted after work. Given our ethos of working safely we can always accommodate palliative and our vulnerable patients regardless of capacity constraints. I love coming to work now!

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Appendix 11
Safe working guidance scenarios

Below are some common scenarios that practices might encounter, along with developed responses.

Scenario 1: full capacity

Q: What do we do when we are fully booked? Where do we send patients? Will we be in trouble with the ICB if we tell patients we are full?

A: When your practice reaches full capacity, it is crucial to prioritise patient safety and wellbeing. The BMA guidance recommends:

- **Triage and signposting:** implement a robust triage system to assess the urgency of each case. Non-urgent cases can be redirected to other services such as community pharmacies, NHS 111, or walk-in centres
- **Collaboration with other practices:** coordinate with neighbouring practices within your PCN (primary care network) to share the workload and ensure patients receive timely care
- **Communication with ICB:** inform your ICB (integrated care board) about your capacity issues and the steps you are taking to manage patient care. Transparency and proactive communication can help avoid any potential issues with compliance.

Scenario 2: managing patient expectations

Q: How do we manage patient expectations when implementing safe working practices?

A: Effective communication is key to managing patient expectations.

- **Clear information:** provide clear information about appointment availability and the rationale behind setting safe limits. Use posters, websites and patient leaflets to explain the measures being taken to ensure safe and high-quality care
- **Alternative options:** offer patients alternative options for non-urgent care, such as telephone consultations, online consultations, or advice from pharmacists
- **Empathy and understanding:** train staff to communicate empathetically with patients, acknowledging their concerns while explaining the importance of these measures for their safety and the wellbeing of the healthcare team.

Scenario 3: handling high-demand periods

Q: What should we do during high-demand periods, such as flu season or public health emergencies?

A: During periods of high demand, these strategies can help manage the increased workload:

- **Flexible staffing:** increase staff availability through locum GPs or extended hours, if feasible. Consider employing additional administrative staff to handle the influx of calls and appointments
- **Prioritise care:** use triage to prioritise patients with urgent needs and chronic conditions that require timely intervention
- **Utilise technology:** encourage the use of online consultations and telemedicine to reduce the pressure on in-person appointments.

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Scenario 4: burnout and staff wellbeing

Q: How can we support staff wellbeing and prevent burnout in our practice?

A: Supporting staff wellbeing is essential for maintaining a high standard of care.

- **Regular breaks:** ensure that all staff members take regular breaks and have access to a quiet space to rest and recharge
- **Support services:** provide access to mental health and wellbeing support services, such as counselling or employee assistance programmes
- **Team-based approach:** foster a supportive team environment where staff feel comfortable discussing workload issues and seeking help when needed.

Scenario 5: implementing safe limits on patient contacts

Q: How do we implement safe limits on patient contacts without compromising patient care?

A: To implement safe limits effectively:

- **Set clear policies:** develop and communicate clear policies on the maximum number of patient contacts per day. Ensure all staff understand and adhere to these limits
- **Monitor and adjust:** regularly review and adjust the limits based on feedback from staff and patients, and the specific needs of your practice
- **Patient education:** educate patients about the importance of safe working practices for ensuring high-quality care and preventing burnout among healthcare providers.

Scenario 6: compliance with safe working guidelines

Q: How can we ensure compliance with the BMA's safe working guidelines?

A: Ensuring compliance involves several steps:

- **Regular audits:** conduct regular audits of your practice's workload and working hours to ensure they align with the BMA's guidelines
- **Training and development:** provide ongoing training for all staff on safe working practices and the importance of adhering to these guidelines
- **Feedback mechanisms:** implement feedback mechanisms for staff and patients to identify areas of improvement and address any concerns promptly.

Credit to Surrey and Sussex LMCs.

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Appendix 12
Templates for practice use

GMS Contract: NHS Hospital Standard Contract
These template letters have been drawn up to help practices manage workload:
Pushing back on workload from secondary care

Advice for LMCs

LMCs should request for this to form a rolling agenda item at LMC/ICB liaison meetings.

LMCs should feed back examples of significant breaches to their LMC reference group lead, or to their regional GPC representative, so that we can take this up directly with NHS England.

Implementing the above will be a small, but significant step in reducing inappropriate workload for GP practices.

Template letters for clinical systems

Emis Web

Download the ZIP file and copy the files within it to a folder on your computer.
Open EMIS Web and select Configuration -> Template Manager (or Resource Publisher if you are on a newer version of EMIS Web).
Select the "Document Templates" tab and Select "Add -> Folder" and call it "BMA".
Select "Import" and import the Word documents.

We would like to thank QMasters Medical Informatics for creating these templates.

SystmOne

Please note, if you have previously joined this group, you will automatically have access to the new BMA contract letters.

Go to Setup > Users & Policy > Organisation Groups > Wiltshire > BMA NHS Contract letters (Ardens)
Click "Join group" and then turn SystmOne off and back on again
To access the letters, go in to letters as normal and find the contract letters under Ardens > BMA letters

Vision

Download the templates onto your computer. Please save these to a sub-folder within the 'Template' folder.

We would like to thank Dr Michael McKenna and NIGPC for creating these templates.

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Templates letters for practice use

The following twelve template letters have been drawn up to help practices manage workload. Click on the link below to access all the letters online to copy, paste and edit as appropriate.

Amended safe working template letters.docx

Template response to secondary care work transfer

Patient details: Dear X

I refer to your request for this practice to undertake ..... (insert work requested). I enclose a copy of your request (optional).

I am sorry that we are unable undertake this work for the following reason (s):

(Use as appropriate)

The task(s) is not an essential service as per our GMS/PMS contract
This work has not been commissioned by our ICB
This work has not been funded as a national or local enhanced service
This work is more appropriately provided by yourself as a specialist

You will be aware of the current pressures on general practice, and we are unable to undertake unresourced or inappropriate work that is outside our contractual responsibility, and which will as a result adversely affect our core contracted duty of care to patients.

We are aware that your concern will be to do with direct patient care. This letter is written following authoritative legal advice and should you have operational difficulties in arranging care then you should direct your concerns to your trust Medical Director/ Chief Executive Officer

We have informed the patient that this work is not the responsibility of the practice and would be grateful if you would contact them directly to provide the service.

Thank you for your understanding.

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Template response to inappropriate prescribing requests

Patient details:

Dear X

You recently wrote asking us to prescribe the following medication for the above patient. A copy of your request is attached.

We are sorry that in line with our GMC duty of care to patients, we are unable to prescribe this medication because:

(Use as appropriate)

We do not feel competent and skilled to prescribe this specialist drug. This should be prescribed by a specialist who can take clinical responsibility for this prescription.

The initiation of this drug should be done by a specialist, and the patient stabilised on the medication before being considered suitable for a GP to prescribe

The request is for an unlicensed use of this drug, and which should therefore be prescribed by a specialist able to take appropriate clinical responsibility

(For shared care requests)

We are unable to take on this request for shared care, since we do not feel we have the necessary expertise and skills to take clinical responsibility for the prescribing and monitoring of this specialist medication.

We are unable to prescribe this medication under shared care arrangements, since the prescribing of this medication has not been commissioned as a shared care enhanced service from this GP practice

We would be grateful if you would arrange for the patient to receive this medication via the hospital pharmacy or ideally via a hospital FP10HP. The patient could then use the latter to collect this medication from their local community pharmacy.

The practice will be taking no further action with regard to this activity and the transfer of responsibility has not taken place.

Additional comments:

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Template response to requests to follow up investigations performed in other settings

Dear X,

Re: <<Patient Identifier Label>>

We write in response to your letter regarding the above patient requesting that we chase up the ..... investigations undertaken by your department.

A copy of your request is enclosed.

The result of this investigation will automatically be sent to you or your department as the requesting clinician. Please note that as per GMC guidance, and NHS England guidance Standards for the communication of patient diagnostic test results on discharge from hospital, it is the responsibility of the doctor requesting a test to take clinical responsibility to follow up and take appropriate action on the result.

We would therefore respectfully request that you follow up the result and take any action accordingly. You will be aware of the pressure general practice is under, resulting from an ever-increasing workload. We would ask that you review your hospital policy on this issue, to avoid practices incurring inappropriate bureaucratic workload by chasing up results which are already in your possession, and which fall under your responsibility.

We will be proceeding on the assumption that you will be taking responsibility for reviewing and taking any action on the above investigation result(s).

Yours faithfully,

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Template response to requests for post-operative checks

Dear x,

Re: <<Patient Identifier Label>>

We write further to your letter of (insert date) requesting that we undertake a post-operative review on the above patient.

This work falls outside the remit of the General Medical Services contract and has not been commissioned from us as an enhanced service. The best person to undertake such a review is the surgeon who knows what procedure was performed, any difficulties or complications that occurred during surgery, and what post operative complications would be expected, if any. We therefore do not believe it is in the best interests of this patient for us to do this review and are unable to comply with your request.

Pressure on general practice means that we cannot take on inappropriate or unresourced work outside our contract, since this would detract from our core duty of care to patients.

Letter to hospital provider regarding discharge of patients after missed appointment

(a similar adapted letter could be sent to the ICB to change commissioning specifications)

Dear x,

Your department has discharged this patient from your service following missing an appointment.

You have requested that we make a new GP referral for the patient to be seen. We are not making this new referral and instead request that the patient is reinstated on the waiting list, and that it is communicated to them by you.

You will be aware that general practice is under unprecedented workload pressures. It is not appropriate for GPs and staff to incur the additional bureaucracy and workload to re-refer patients after a single missed appointment. Additionally, many GP appointments are wasted due to patients seeing a GP for the sole administrative purpose of a re-referral, and which could instead have been offered to other patients.

We are asking you to review your policy to either routinely send patients a further appointment, or to allow patients to reinstate their missed appointment within a specified time directly with your appointment department, in order to not incur unnecessary additional bureaucracy on hard pressed GP surgeries.

We have copied our ICB to inform them of this. We look forward to hearing from you.

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Template letter to local ICB regarding discharge of patients after missed appointment

Dear ICB Chair/CEO

Request to enable patients to directly rebook missed hospital appointments.

We are currently receiving (a high number of/multiple) requests from our local hospital X to re-refer patients who have missed their hospital appointment with a new referral letter.

Patients miss hospital appointments due to a variety of reasons, some due to human error or due to extenuating circumstances. Patients also report to us that missed appointments can be related to administrative issues on the part of the hospital.

The automatic process of providers discharging a patient from a clinic after missing an outpatient appointment is punitive to patients, results in needless bureaucracy, and is wasting considerable time for both patients and GPs. It raises clinical governance concerns around delays to care or loss of follow up, and can indeed result in critical patient safety issues. Further, those patients who have contacted the hospital directly to reinstate their appointment are still told to see their GP for a new referral.

The NHS England commissioned report from NHS Alliance and the Primary Care Foundation 'Making Time in General Practice' estimates that 4.5% of GP appointments are utilised for this pure bureaucratic purpose, equating to 15m wasted appointments annually which instead could have been available to ill patients.

We therefore request that you amend local commissioning specifications to require that providers put in place an automatic re-referral system to enable patients to directly rebook a missed appointment, provided they do so within an agreed timeframe eg four weeks, from the date of the non-attendance. This is in line with the recommendations in 'Making Time in General Practice', and also with the BMA's guidance on safe working.

At a time when GPs are under overwhelming pressure, which is adversely impacting on access and quality, it is vital that commissioners take action to reduce inappropriate workload in general practice, so that GPs can spend their time attending to the medical needs of their patients.

This step will save money, reducing the unnecessary costs of administration and staff time in hospitals and general practice, by ending the duplication of re-referring and re-processing referrals.

We have written to hospital X separately to request that they review their policy on this matter and have copied this letter to our Local Medical Committee.

We look forward to hearing from you.

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Template letter to ICB regarding inappropriate workload transfer

Dear x,

INAPPROPRIATE TRANSFER OF WORK TO THIS PRACTICE

We are writing to inform you that the following inappropriate work has been requested from our practice.

Source of inappropriate workload request: Details of request (include copy of letter):
This work is not part of our contractual requirement, nor has it been resourced as an enhanced service. Given the extreme pressures that general practices are under, we are not able to take on this additional and inappropriate work, which will detract from and adversely affect our ability to provide core GP services to patients. The requested work will not be carried out at the practice and responsibility for it remains with your service.

We would ask you to review the service specification with the provider for this particular service to ensure that such work is not inappropriately transferred to general practice in the future.

With many thanks

Cc LMC

Template letter for request to complete non-contractual administrative task

Dear x,

We recently received a request from you to carry out (insert description of work, eg questionnaire, or information request requested).

This work is not part of our contractual requirements, The GMS contract sets out that essential services are mandatory for a practice to deliver to registered patients and temporary residents in its practice area. They include the identification and management of illnesses, providing health advice and referral to other services. GPs are required to provide their essential services during core hours.

You will be aware that general practice is under unprecedented pressure, and therefore we are unable to carry out your request, since this would detract from our ability to provide core contracted services to our patients.

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Template response to requests for work absence sick notes for less than seven days

Dear x (employer name) (patient details)

We are writing to remind you that it is the responsibility of employees to self-certificate for any absence from work through illness of less than seven days' duration.

Unfortunately, pressures on general practice mean that we are reviewing our work to ensure that we are able to focus on our key duty of care for patients. We are therefore unable to provide sick notes for absences of less than a week, and to do so is an inappropriate use of the Med 3 system

Template letter to area team regarding delay to information request or payment

Dear x,

We are writing to inform you that we have been attempting to

obtain information regarding (provide details)
chase payments for (provide details)

We have contacted your department since: (details) and have yet to receive a response.

You will be aware that GP practices are under unprecedented workload pressures. It is not acceptable that practices should incur such delays in receiving responses to such requests, and for busy staff to be diverted into the bureaucracy and workload of chasing this up, rather than providing their core services for patients.

Please can we receive a response to our request by...

We have copied the Local Medical Committee to assist us if the information is not forthcoming

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Template letter to hospital provider regarding follow up of diagnostic test results following a patient's discharge from hospital

Dear X

We received a copy of patient X's results on

You will be aware of published NHS England guidance setting out **Standards for the communication of patient diagnostic test results on discharge from hospital**. We therefore assume that this is for information only, and that a relevant clinician in your department has actioned this, in keeping with that guidance.

In future, can we suggest that you refrain from sending copies of results to this practice, unless it is of direct clinical relevance, and clearly marked **'for information only'.**

We have copied our ICB to inform them of this. We thank you for your understanding.

Yours faithfully

Template letter to ICB in response to requests to follow up investigations performed in other settings and diagnostic test results following a patient's discharge from hospital

Dear X,

FOLLOW UP OF DIAGNOSTIC TEST RESULTS FOLLOWING A PATIENT'S DISCHARGE FROM HOSPITAL

We are writing to inform you that we (delete option as appropriate)

have received a copy investigation result from the X Department of Hospital Y, without confirmation of being actioned by the requesting hospital clinician.
have been requested to chase up a result of an investigation requested by a hospital clinician

A copy of the above is attached.

In keeping with published NHS England guidance setting out *Standards for the communication of patient diagnostic test results on discharge from hospital,* **'the clinician who orders the test is responsible for reviewing, acting and communicating the result and actions taken to the General Practitioner and patient even if the patient has been discharged.'** This is also in keeping with BMA joint guidance between the BMA general practitioners committee and consultants committee.

We therefore request that as the commissioner you require that hospitals adhere to this important standard, and to require that hospital initiated investigations are reviewed and acted on by the requesting clinician or relevant hospital department. Additionally, we request that you require hospitals to stop sending copies of test results to local GP practices, unless specifically for clinical information in which case they should be clearly marked **'for information only'**.

With many thanks
cc. Local medical committee

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Template: Shared care agreements

Dear X

We are writing following the request to take on shared care arrangements, as per your enclosed letter. We are unable to take on the requested shared care arrangements. This is for the following reason(s) (delete as appropriate):

- The prescriber does not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care
- The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement
- We are unable to take on this request for shared care, since we do not feel we have the necessary expertise and skills to take clinical responsibility for the prescribing and monitoring of this medication
- We are unable to prescribe this medication under shared care arrangements, since the prescribing of this medication has not been commissioned as a shared care enhanced service from this GP practice
- Other (Complete if there are other reasons why shared care cannot be accepted)

The following excerpt regarding Shared Care is from the BMA's Prescribing in General Practice, published April 2018:

> "Sometimes the care of a patient is shared between the two doctors, usually a GP and a specialist. There should be a formalised written agreement/protocol setting out the position of each, to which both parties have willingly agreed, which is known as a 'shared care agreement'.

It is important that patients are involved in decisions to share care and are clear about what arrangements are in place to ensure safe prescribing. In some cases, a GP may decline to participate in a shared care agreement if they consider it inappropriate. In such circumstances, the consultant would take responsibility for prescribing and any necessary monitoring. Guidance covering these issues (Responsibility for prescribing between primary and secondary/tertiary care) was published in 2018 on the NHS England website.

You will be aware of the current pressures on general practice, and we are unable to undertake unresourced or inappropriate work that is outside our contractual responsibility, and which will as a result jeopardise our core duty of care to patients.

We have informed the patient that this work is not the responsibility of the practice and would be grateful if you would contact them directly to provide the service.

Thank you for your understanding.

Yours sincerely,

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Template letter on issuing fit notes

Dear x

We are writing to remind you that Doctors, nurses, occupational therapists, pharmacists, and physiotherapists can all provide fitness for work advice to patients, using the fit note to help patients return to employment and aid their recovery. This can be based on a written report by another healthcare professional, including those that are not eligible to certify fit notes.

It is important that patients are not signposted to other healthcare professionals when discharged from a hospital setting purely for the purposes of certifying a fit note. Patients who request a repeat fit note should be encouraged to see the healthcare professional responsible for their care to have a work and health conversation.

It is also possible for a fit note to be based on consideration of a written report by another healthcare professional involved with the diagnosis or care planning of the patient. This does not need to be one of the five professions listed in the regulations.

Unfortunately, pressures on general practice mean that we are reviewing our work to ensure that we are able to focus on our key duty of care for patients. We are therefore unable to provide sick notes for absences of less than a week.

Yours sincerely

Further guidance is available at:
https://www.gov.uk/government/publications/fit-note-guidance-for-healthcare-professionals/getting-the-most-out-of-the-fit-note-guidance-for-healthcare-professionals#the-role-of-healthcare-professionals-to-certify-fit-notes

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