Safety, Stability, Hope

A Vision to Rebuild General Practice in England

British Medical Association
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General practice is collapsing.

Across England, general practice is working at an unprecedented level of activity with daily appointments running at almost 1.5 million. Despite this, the value of funding into the national contract is at a nadir with core funding for essential services amounting to 6p in every NHS pound in 2024/25. At an individual patient level, the average core contract payment equates to £107.57 per annum, around 30p per patient per day. It's no wonder practices are closing – they're no longer financially viable.

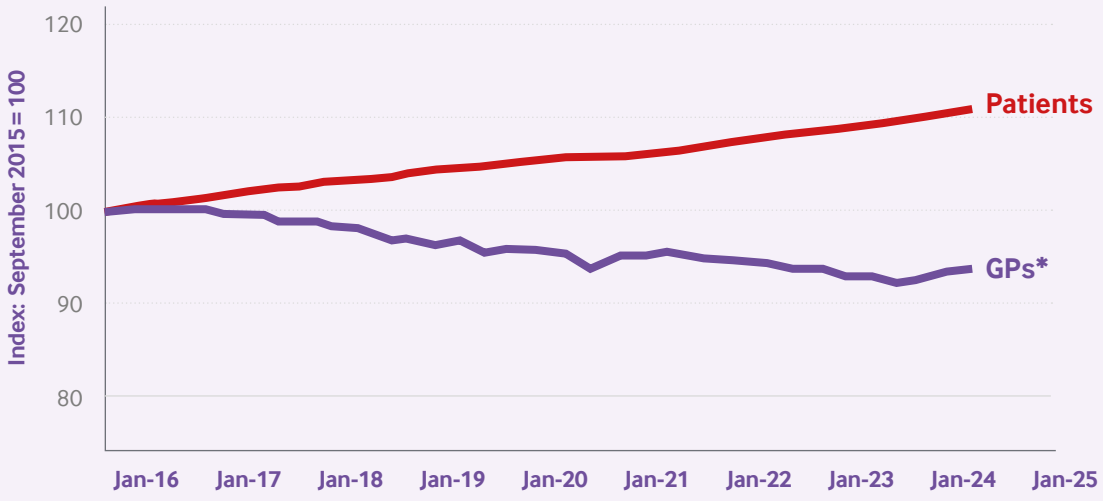
General practice, the most efficient and productive part of the NHS, is being driven to collapse.

Every working day in general practice across England:
- Around 1.5 million appointments are delivered
- 4 in 10 appointments are same-day access
- A clear majority (65%) are delivered face-to-face

In the last five years:
- The average number of patients per full-time fully qualified GP has risen to 2,300, which is unsafe
- The proportion of GPs taking up NHS GP roles within a year of completing their training has dropped from 48% to 38%

Since 2015:
- Over 1,000 NHS GP practices lost
- An increase of 6.4 million patients registered with a GP

Demand is growing faster than supply
Index trends in number of patients and GPs*
September 2015 – March 2024



Source: BMA analysis of NHS Workforce data • * Fully qualified, full-time equivalent

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The workload for GPs and practice staff is unsustainable. GPs are burning out and leaving the NHS. Our 2024 survey of BMA GP members showed a profession at breaking point: 22% of respondent GPs (11,000+ in total) said it was unlikely they would still be working as an NHS GP in the next three years.

As a profession, GPs and their practice teams are tired of having to fight to survive. We desperately want a government on our side, to bring back the family doctor and the general practice our patients deserve. In return we will bring constructive solutions in good faith to rebuild the profession. This will be through protecting and resourcing the GP **expert generalist** as a gatekeeper to an NHS free at the point of service, able to manage risk and uncertainty through the delivery of relationship-based **continuity of care** across a registered population, **focusing on prevention**. Taking a **holistic, person-centred approach** as the **patient's advocate** – their guide to access the wider NHS.

We begin with safety first, then stability in next year's contract, and finally longer term commitments to bring hope.

Safety

As soon as possible within the current financial year, we must create NHS practice roles for GPs and Practice Nurses seeking employment

- Creation of a **two-year funded GP fellowship post-CCT practice-level reimbursement scheme** to enable the recruitment and retention of additional GP roles from the hundreds of unemployed young GPs. Offer relocation expenses and 'Golden Hellos' if moving into under-doctored systems, thus solving Tier 2 Visa requirements which threaten GPs emigrating after training, and **reinstate the New to GP Partnership Programme**. We must secure these roles into NHS general practice lest we risk further increasing the multi-billion-pound brain-drain of the past decade
- Monies could potentially be reallocated to fund this scheme from a review of the Additional Roles Reimbursement Scheme; historic ARRS underspend; and pausing the multiple NHSE transformation schemes and nascent test sites into the offer.
- **Include practice nurses in ARRS** and allow **Training Hubs** to ring-fencing existing monies to **fund GP Practice Nurse Fellowships** once again. Provide practice nurse colleagues with deserved parity of terms with their trust-employed colleagues in parental and sickness leave and pay via a **reimbursement scheme into the SFE**.

As soon as possible within the current financial year, we must urgently resource practices to stem the tide of NHS GP Practice closures and costly re-provision which is almost always more expensive to the taxpayer

- We must **reverse the past 5 years' £660m contract value erosion by supplementing DDRB for 24/25**; by placing urgent additional transparent investment into correcting CPI erosion to the **item of service tariff for vaccinations and immunisations, and locum reimbursemen**t for GP parental and sickness leave, which has not been uplifted since 2018/19
- The current growing wave of Covid threatens to overwhelm us this winter and paralyse elective recovery. All at-risk patients need access to free testing; care homes need testing regimens in place now; and all **ICBs need to recommission centralised CMDUs** to ensure eligible patients receive Paxlovid/Molnupiravir as soon as possible. The current circulating Covid FLiRT variant almost evades vaccination with anything other than the XBB Monovalent vaccine - we have an NHS workforce and millions of patients with no neutralising antibodies against existing variants. The previous Government's response was to reduce the Covid vaccination tariff to £7.54 when co-administered with influenza vaccination, making the seasonal vaccination programme financially unviable for many practices and PCNs. **This needs to be urgently redressed, starting with uplifting the Covid vaccination IoS (Item of Service) fee and, correcting CPI inflation erosion of the standard vaccination and immunisation IoS fee, which has been frozen since 2019. Practices should then be allowed a further opportunity to sign up to ensure the best population coverage and greater financial stability this winter**
- Government must take immediate steps to protect the most in-need and vulnerable in our society, by **allowing personalised care adjustments** for childhood vaccinations and **resourcing child and adult safeguarding nationally via a DES** to resource vital, but complex and time-consuming work for practices

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Stability

Ahead of 2025/26, we need the Government to work with GPC England to agree a 2025 Family Doctor Charter and a minimum general practice investment standard to provide clarity and commitment to the core and irreplaceable role of general practitioners

- A 2025 Family Doctor Charter would signal a commitment from Government, DHSC and NHS England to **rebuild a universal GP-led continuity of care model for England NHS general practice with a minimum general practice investment standard**
- **Incentivise continuity of care – it saves lives**. Reduce bureaucracy in Extended Access for practices to prioritise their own patients.
- We must **restore core funding**. The decline of the GP practice contract funding value must be reversed with a clear roadmap towards a minimum general practice investment standard. There must be a commitment to additional investment that enables an **incremental journey to increase the proportion of NHS funding for general practice by 1% year on year**, towards an **eventual proportional funding floor of 15p per NHS pound** for primary medical services, whilst protecting existing funding across the wider system
- Work with the profession to understand where simple tech could revolutionise pathways and speed Acute flow, e.g. **investing in EPS in Trusts**
- Listen to how we must give **parity to the primary care voice at the ICB table** if we wish to reallocate proportions of NHS resource and prevent spiralling financial losses
- The GP patient record is integral to patients' trust in their GP, that integrity and confidence must be maintained. **Practice data controller liabilities** need to be covered by **adding clinical information governance to the CNSGP**. We should use the richest source of health data in the Western world to raise NHS funds – but maintain integrity, professional standards and public confidence to do so via following the Goldacre Review recommendations. We must tell patients how their data is used, for both direct care and secondary uses as per the National Data Guardian's mantra of "no surprises"
- What patients want is more time with their clinician of choice. The opportunity for meaningful change sits with a focus on continuity of care. PCN workforce reforms to general practice have resulted in less GP access. Some additional roles have been welcomed, but speed of roll-out with a lack of evidence has led to onerous bureaucracy potentially creating delays to diagnosis, greater inefficiency and unknown patient outcomes. We know the **PCN DES is worsening health inequalities – but we have an opportunity to achieve the right balance**. The decision to invest in associate roles within primary medical care was undertaken in the USA before England. The evidence did not support the hypothesis, and the findings prompted policymakers to move back to a model of a doctor being the primary provider of family medicine.

Hope

Fix the contract, not the model. Labour has spoken of no major new investment without major reform – we gladly accept this challenge and call for a new substantive GP practice contract to be negotiated in this Parliamentary cycle

- We want to work with the new Government to fix the GP practice contract, to provide the necessary transparency to invest, to permit GP contractors and partnerships to have the resources to transform, rebuild and reinvigorate general practice at a neighbourhood level, and to restore general practice as the bedrock of universal care offered by the NHS
- Despite clear evidence from the NHS Confederation showing how every £1 invested in primary medical care results in up to a £14 return of economic growth, general practice has been significantly underfunded in England. The model of general practice is not broken – it has been intentionally dismantled by successive recent governments. **Real-terms re-investment must be channelled into General Practice to retain and return our GPs to safe numbers, to guarantee continuity of care for the population**

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

- Our nation is now older, and frailer. Many live with more than one chronic condition. We need to intervene in pathological processes before they present through a preventative agenda – to do this we should learn from exemplar nations, **be bold and aim for a gold standard 1 FTE GP per 1000 patients**

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- **Practices need safe GP to patient list size ratios to ensure manageable workloads and patient safety.** List sizes have grown far beyond safe levels across England. The BMA's Safe Working Guidance, based upon UEMO (European Union of General Practitioners) guidance, recommends that GPs deliver no more than 25 consultations per day while also safely managing other responsibilities such as pathology results; clinical correspondence; prescribing; patient tasks; home visits; palliative care; clinical training and supervision; associated clinical governance and non-NHS work (e.g. Local Authority, DWP, DVLA, safeguarding). Our early 2024 survey of general practice across England showed that only 11% of respondents deliver 25 or fewer appointments on a typical day. 89% of GPs told us they deliver 26 or more, with 52% of those delivering between 31 and 50. Improving general practice capacity to facilitate continuity of care through safe patient list sizes will provide the best, as well as the most cost-effective, care for our nation
- Build neighbourhood and community health transformation around the value for money, productivity and efficiency of general practice, which guarantees accountability via a named GP and the registered patient list at the core of the NHS, which is the natural anchor point. **Allow general practice to flourish by wrapping community services around the practice footprint** – make it personalised and GP-led with the resources, modern premises, and diagnostics to match. **This could reduce costly crisis care expenditure, which could be re-invested in primary medical care year on year**. We need to start conversations around transformative plans and funding for our ageing estates and infrastructure – neighbourhood health centres provide an opportunity. We also have resources which could potentially be repurposed from network level to practice level

In September 2022, the House of Commons Health and Social Care Committee published a report on the future of General Practice, which set out the values of GP-led care focusing on prioritising both continuity and the gatekeeping role of the GP as the expert generalist. Considerable academic evidence demonstrates how this model reduces overall NHS activity and improves patient self-care; prevents avoidable and costly crisis interventions; delivers better patient and public health outcomes; and reduces NHS costs and provides greater job satisfaction. Unfortunately, recent years have seen NHS England move further away from this model of delivery, and the new Government needs to enact the **recommendations within the report** and reverse this.

We need to commit to transform the NHS over the next decade into a home-first, community-second, admission-last model which prioritises prevention and builds back preventative care through expert-generalist GP-led general practice.

Continuity is key to prevention. It will solve the 8am rush. Use the productivity and efficiency of general practice to secure innovative initiatives to assist with managing the elective care backlog.

To protect a health service free at the point of use, you must protect the gatekeeper. If the Government and NHSE r**esource GPs, they will see activity, referrals, prescribing, investigations, unnecessary interventions – and costs – fall**. Fix general practice – you fix the NHS. **Work with GPC England in focusing on the short, medium and longer-term needs to not only create a safe and sustainable general practice, but a safe and sustainable NHS too.'**

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