

Quality first: Managing workload to deliver safe patient care

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Guidance for GPs in England, Wales and Northern Ireland

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Introduction

Context

GPs and practices are under unprecedented pressure. There are about 340 million consultations annually in general practice in England, an increase of 40 million per year from five years ago. This represents the single greatest rise in volume of care within any sector of the NHS. The increase has not been matched by an increase in GP numbers and staff, nor by an expansion in infrastructure, against a background of falling resource.

There is now a large and increasing gulf between the workload demands on practices and their capacity to deliver essential services to their registered patients. GPs are being overwhelmed by rising workload, particularly from a growing ageing population with complex health needs. At the same time, there is an emerging workforce crisis with shortages of GPs leaving many practices unable to recruit doctors, and evidence that some experienced GPs are considering leaving general practice altogether. Government policy continues to move services into the community, placing yet more pressure on overstretched GP services struggling to provide enough appointments, with consequential delays to see a GP. Cuts in resources to individual practices via imposed changes to correction factor and PMS reviews are exacerbating the problem for many. This has followed year on year cuts in practice funding.

In a recent BMA Tracker survey, 74% of GPs described their workload as unmanageable or unsustainable—significantly higher than any other category of doctor. Both the CfWI (Centre for Workforce Intelligence) and the HEE (Health Education England) workforce task group have reported that the current workload demands on GP practices are unsustainable, given current GP workforce levels.

In this climate, it is crucial that the safe provision of core services to patients remains GPs' overriding core priority. This guidance is intended to help practices ensure this.

GPs' duty of care to provide quality and safe care to patients

In spite of the current severe pressures, GPs' prime responsibility must always be to fulfil their contractual and General Medical Council professional duty of care to patients seeking GP services. The aim of this guidance is to help practices to manage their workload and work efficiently within safe and competent limits.

As CQC registered providers, practices are also under a specific obligation to review and take appropriate measures if workload is putting patient safety or quality in jeopardy.

This guidance is not about restricting GP services. It is about providing safe, quality and accessible care to patients, at time when GPs are being prevented from doing so by excessive and inappropriate or unresourced work, which is taking them away from their prime duty of care as GPs.

It is crucial that practices work appropriately with LMCs, CCGs and patient participation groups when implementing this guidance.

NHS England explicitly recognises the strain general practice is under in its recent Five Year Forward View. It proposes ways of relieving pressure on GPs by encouraging patients to see other appropriate health professionals such as pharmacists. NHS England has also commissioned a project as part of the Prime Minister's Challenge Fund to identify and reduce unnecessary GP appointments, especially those generated inappropriately from other parts of the system. In addition to this, another project has been commissioned to reduce bureaucracy in general practice. GPC is supporting and working with NHS England on these initiatives, which directly link to the purpose of this guidance.

What this guidance covers

This guidance covers the following:

- reducing clinical workload that is inappropriate for GPs or practices, so that GPs can be available for and improve access to patients requiring core primary medical care services.

It also emphasises the need for GPs to work within their competence in the interests of their patients, and their professional duty of care

- reviewing and limiting voluntary additional work, enhanced services or schemes that are detracting from practices' ability to focus on their prime responsibility to provide GP services
- measures to cease unfunded and under resourced work, given that this will result in GPs and staff time being taken away from their core duty of care to patients
- working in partnership with patients to empower them with appropriate self-care and management skills
- working in collaboration with neighbouring practices to manage workload, and provide systems of support
- developing new systems of working, including the use of IT, to manage workload and increase productivity
- measures to manage practice list size, if practices aren't able to fulfil safe and competent care due to lack of capacity
- guiding GPs to seek assistance if they feel their workload is impacting on their contractual and professional duty of care, or on their own health.

Keeping patients on side

It is essential that GPs inform patients of the reasons for any changes made in practice systems or services provided. It would be good practice to discuss this with your patient participation group, using direct verbal communication, posters, messages on waiting room screens, information sheets, the practice website, and/or any other available communication tools. Practices or groups of practices could work with the LMC to develop locally tailored material to use for patient information.

The overriding message to patients must be that any changes are in order for the practice to provide quality and safe care to patients. Practices can also continue to promote the messages of ['your GP cares'](#) to explain the reasons for the pressures on general practice, and continue to press for adequate resources for practices to be able to deliver on the needs of their patients.

What practices should do now:

- read this handbook and discuss this as a practice team in a meeting
- discuss strategies to take control of your workload
- involve other local practices, and work together to support each other
- discuss with your LMC how to tailor a local approach to support all local practices
- use your entitlement as a CCG member practice to influence your CCG to commission appropriate services, hold providers to account and put in place systems to support and manage general practice workload, commissioning alternative services if necessary
- involve your patients – work with them and ensure that you explain any changes as fully as possible.

We have written separately to LMCs and CCGs to ask them to help GP practices to manage their workload to ensure patient safety and the well-being of GPs and their staff.

Part 1: Protecting quality patient care by managing inappropriate demands

There are growing workload demands on GP practices which are either inappropriate, or outside a practice's capability or competence and which should be delivered by a more appropriate provider.

Inappropriate workload takes GPs and their staff away from caring for the core needs of the patients, and also wastes appointments which could be available for ill patients needing to see their GP. This can result in delays for patients if they have to then be re-referred to the most appropriate professional. The blocking of GP appointments for inappropriate reasons is also contributing to longer waits for patients to see their GP.

The government has acknowledged this, with NHS England having commissioned a project as part of the Prime Minister's Challenge Fund on reducing inappropriate GP appointments, and another on reducing bureaucracy in general practice. GPC is working with NHS England on both these initiatives.

The following are examples of inappropriate work that practices are often being asked to carry out, and that waste much needed GP appointments for those who really need them, causing delays for patients. Some of this work will need to be commissioned appropriately to avoid patients experiencing any difficulty.

- Automatic re-referrals resulting from patients not attending (DNA) hospital appointments
- Routine follow-up of hospital procedures where the GP is not best placed to follow this up, nor is it clinically appropriate
- Re-referral to a related specialty (eg physiotherapy referral requested by a rheumatologist) – creating unnecessary bureaucracy
- Hospitals referring patient to practices for fit note certificates when it is possible to do this in hospital at the time of discharge
- Patients referred by hospitals back to practices solely for the prescribing of medication which is the clinical responsibility of the requesting clinician (eg specialist prescriptions outside a GP's competence, acute prescriptions that should have been issued on the day by the specialist seeing the patient, or unlicensed medication). This should all be dealt with before the patient leaves the hospital
- Following up test results ordered in hospitals which are the responsibility of the requesting clinician
- Arrangement of hospital transport which could be done directly between the hospital transport service and patients (giving them control over timing) rather than involving practice staff
- Arranging other tests and investigations that should be part of the commissioned secondary care service

Services for housebound patients in the community

- Wound care management (including dressings and suture removal for procedures performed outside the practice) that should be delivered by the commissioned community nursing service
- Minor injury services that should be delivered by the appropriately commissioned service
- Completion of community nursing administration charts
- Nursing care of leg ulcers and other chronic conditions (including doppler assessments)
- Nursing care for incontinent and catheterised patients
- Ear syringing that should be provided by the community nursing service
- Prescriptions for conditions being managed by community nurses, where the provider can utilise independent nurse prescribers
- Requests for practices to prescribe at seven day intervals rather than the normal 28 day interval for patients having their drugs dispensed by means of multi-compartment compliance aids
- Request for a GP to visit a patient when another professional would be more appropriate, eg social care or district nurse. In these circumstances practices will need to inform the patient who to contact and how

Care homes

- Requests to write in the home's administrative records in addition to recording information in the patient's GP held record. If necessary, this should be done by care home staff. Care homes can obtain additional information from practices if necessary
- Requests to complete unnecessary authorisation forms for staff to administer over the counter remedies
- Requests for home visits for ambulatory residents, where the care home should enable the patient to attend the surgery

Shared care arrangements:

Shared care protocols are increasingly used to transfer care from hospitals into general practice, including the prescribing of specialist medication. It is important to note practices are not obliged to participate in shared care arrangements, which are voluntary. Shared care arrangements require additional competencies, and it is important that GPs do not undermine care for patients by feeling pressured to treat beyond their knowledge and skills. Shared care arrangements also require additional GP, nurse and administration time, and it is important that practices do not take on this additional optional work beyond their capacity to deliver. Practices should receive resources to provide this extra service, so that current staff are not diverted away from providing core needs of patients.

Accepting inappropriate and unresourced shifted work risks undermining the quality of patient care

Commissioners also have a duty to make sure that the quality of patient care is not compromised by the unjustified shifting of services that are not appropriate to be delivered in the community. Accepting inappropriate work from elsewhere risks undermining the quality of care for patients. If practices do act to reduce this work, however, they must ensure that measures are in place to ensure that patients are not placed at medical risk and that their treatment is not unacceptably delayed.

What practices should do

1. Remember, given practices are already overstretched, taking on work that should be carried out elsewhere will take GPs, nurses and staff away from delivering the essential services required in your contract and adversely affect the quality of care delivered to other patients as a result, and will reduce access to see a GP. In the interests of patient care, practices should not carry out work that has been inappropriately referred.
2. Practices should contact the source of the inappropriate referral to inform them of this and you may find the template letters provided in the appendices to be helpful. The templates can be modified to cover any form of work transfer into general practice that should have been carried out elsewhere. Some LMCs and CCGs already have similar letters in operation. Practices could also phone or email providers where this is more timely and appropriate
3. Practices should require their CCG, area team or local commissioner to address these issues
4. One of the appendices in [Part 11](#) is a template for practices to contact their CCG/area team asking them to re-assess the service specification for services that are responsible for transferring work into general practice that should have been carried out elsewhere.

CCGs and local commissioners

CCGs are key to stemming inappropriate or unresourced workload transfer to general practice, given their commissioning levers in the service specification and contract management of providers. Practices, as members of CCGs, can legitimately require CCGs to develop policies and specifications with providers that make the scope of service provision clear. In Wales and Northern Ireland, practices could also collectively and in conjunction with LMCs lobby their boards accordingly.

Your LMC will be able to provide you with advice about any local considerations when responding to this kind of workload transfer.

Ensuring the most appropriate doctor prescribes or treats the patient

Practices should be mindful of the GMC's guidance on [Good Medical Practice](#) which requires doctors to recognise and work within the limits of their competence. GPs who feel that they are under pressure to treat or prescribe for patients beyond their competence or skills are under a professional obligation to decline to treat or prescribe. In such cases, the GP/practice must ensure that the patient is re-referred to an appropriate specialist or other clinician in a timely manner.

Part 2: Enhanced services, other incentive schemes and additional services

Enhanced service/incentive scheme list

Enhanced services provide commissioners with an opportunity to fund additional work and services in the community, and fall outside the contractual work of GPs. They also ensure practices are provided with the necessary resources to increase their capacity to be able to deliver this additional work. **Provision of all enhanced services is entirely at the practice's discretion**, regardless of the format, commissioner, or service being commissioned. This includes CCG-commissioned LIS (Local Incentive Schemes) and AQP (Any Qualified Provider) community services. The list in [Part 10](#) shows examples of enhanced services that have been commissioned somewhere in the UK. They are therefore **not essential services** and provision is voluntary for practices. This guidance can help practices to decide whether they should take on an enhanced service, as well as ensure that they are being properly resourced to deliver patient care as part of this provision.

The practice can cease providing any enhanced service with the appropriate notice, but may wish to particularly consider doing so where the funding available does not adequately cover the cost of providing the service, or where providing the service would detract from their ability to provide safe and quality core GP services to patients. The LMC will be able to provide helpful advice on enhanced services in your locality.

Practices may benefit by regularly reviewing their existing portfolio of enhanced services and other incentive schemes and considering whether, in light of their individual practice workload and workforce situations, the continued provision of these services is appropriate.

Unresourced clinical workload moving into general practice

Any care transferred from secondary or community care, and which is beyond a practice's contractual duty should be resourced as an enhanced or similar service, if the practice is willing to take this service on. Additionally, if a practice is providing a service that is an established enhanced service elsewhere (see [Part 10](#) for examples), then the practice should require the CCG or equivalent commissioner to fund it accordingly. **If the CCG or commissioner does not fund workload shift, or an enhanced service, then the practice should decline to provide it, since it would result in current practice staff being diverted away from providing core GP services.**

Assessing whether to take on or continue an enhanced service

Checklist

- If you are providing care above your contractual duty, is it resourced as an enhanced service or similar?
- Does the enhanced service provide sufficient resources to deliver care effectively?
In assessing the resource provided, practices should factor in all expenses to include: employer pensions costs, and national insurance contributions, provision for staff absence, equipment, consumables and premises running costs
- Does the practice have the time, infrastructure and staffing capacity to carry out this work safely and effectively?
- What is the bidding or application process – some can be bureaucratic, time consuming and complex and detract from core duties
- Will taking on the enhanced service detract from or undermine the practice's provision of core GP services
- Keeping a record of non-core work done and the time it takes can be a helpful way of focussing the practice's attention on the work being carried out when considering making changes. It could also serve as a useful method of alerting area teams and CCGs to the extent of the problem. This also ties in with NHS England's initiative to shape workload and reduce bureaucracy.

Ceasing an enhanced service – notice period

If on review practices decide not to continue with an enhanced service then they must ensure that they serve the required notice period within the agreement in question.

Practices will need to be aware that where such contracts for enhanced services not nationally commissioned by NHS England are terminated, CCGs will be free to contract the services elsewhere and that there is no guarantee that the practice will get them back in future.

Patients must be given adequate notice of these changes, including if appropriate, how to contact the CCG or commissioner regarding alternative access to ceased services. It is important that all relevant people working in the practice are able to explain to patients, if asked, why the practice is making changes to its services and inform them who they should speak to if they have any concerns. Please contact your LMC for advice before ceasing a service.

Additional services

Most practices provide optional 'additional services' specified in the GMS contract that are in addition to essential services to patients but funded through their core global sum or PMS baseline funding. The list of additional services that can be provided is:

- cervical screening services
- contraceptive services
- vaccinations and immunisations
- childhood vaccinations and immunisations
- child health surveillance services
- maternity medical services
- minor surgery

While these services are not obligatory, most practices provide them. However, practices can opt out of providing these services on a temporary or permanent basis if they do not have the capacity to provide these services, and there is no consequential risk to patient safety and quality. The decision to apply for any kind of opt-out from additional services should not be taken lightly as it would have a significant impact on the practice's ability to provide a holistic service to their registered patients. Every possible action must be taken therefore to ensure services are not disrupted, including looking at subcontracting the service to a neighbouring practice. This should be explored, and could also be part of a wider discussion on collaboration with other practices.

A permanent opt out of additional services could have a significant long term impact for the practice, and there is no guarantee that a future application to resume them will be successful. Any practice contemplating such a course of action should discuss the situation with patients/PPG, LMC, CCG and neighbouring practices before making a formal application.

PMS reviews

As the funding of PMS practices is cut as part of local reviews, practices will need to assess which parts of their workload they were providing for the additional PMS funding above the contract. These additional non-contractual services could be recommissioned by the CCG, given that as part of the 2015/16 contract agreement, all PMS premium money must be reinvested in GP services within the same CCG as the practice. If the CCG or area team decides not to commission (and hence resource) the service, then the practice is entitled to give notice to cease the service, as in the section on ceasing an enhanced service. Patients should be advised of this decision by the CCG/AT.

It would be good practice to discuss decisions of this nature with the CCG, if they are not already involved, and to seek advice from the LMC.

Part 3: Bureaucracy reduction and non-NHS work

A considerable amount of practice time is taken up with bureaucracy that diverts GP and staff time from being available to care for patients. Practices are often asked to provide information or other administrative non-essential work that is time consuming and not contractually required. These requirements clearly take up time which should be spent with patients. Equally many GP appointments are taken up for such bureaucratic tasks, resulting in reduced GP access.

In [Part 11](#) of this guidance you will find a generic template letter to allow practices to explain why there is not time to respond to a particular request.

Please be aware that some requests for information cannot be declined. Under the terms of the contract, area teams (and their equivalents in Wales and NI) can request any information which is reasonably required in relation to the contract or the area team's functions. This information should not be refused, although you could seek clarification from your LMC.

Collaborative arrangements for non-NHS work

Some non-NHS work is a statutory and a professional obligation on practices and GPs despite being extra-contractual, for example, child protection and other safeguarding information sharing with local authorities. This work **must not** be declined.

However, practices are entitled to receive funding for some services that they carry out in cooperation with local authorities to ensure that these services can be delivered safely and effectively. This is a legal responsibility of the NHS under the 'collaborative arrangements'.

Non-compulsory, non-NHS work, not falling under collaborative arrangements may be declined, when appropriate:

- private sick notes –employers should accept statutory self- certification to cover the first seven days of absence, and not waste GP appointments for this purpose
- occupational health vaccinations and reports (most commonly Hepatitis B). See guidance on BMA website [here](#)
- requests for work related to research studies
- passport application countersignature –this can be done by a range of non-medical professionals
- insurance medical examinations, that can be carried out by an independent clinician
- blanket certification for school absence for minor illnesses that do not require a GP appointment. A template letter is attached at [appendix 8](#) for practices to use, pointing out that this is a parental responsibility in most cases. However practices need to be aware that there will be exceptions to this in specific circumstances (for instance when there could be a safeguarding issue)
- blanket requests to certify fitness to exercise, whether for local authority or private gymnasias or for any other activity, including travel. (Requests for a medical opinion on fitness are invariably inappropriate as GPs are not in a position to provide one; a simple statement of fact related to medical condition would be appropriate if the practice is happy to provide the service)

Other service provision that falls into the bracket of collaborative arrangements can legitimately be declined; where it is not essential for a patient's registered GP specifically to carry out the work unremunerated. This could include:

- requests for letters or reports regarding re-housing and 'Blue Badge' applications, where local authorities should have systems to assess applications from information provided directly by patients
- requests to supply patients with letters in support of benefit appeals, which is beyond the normal statutory processes to request medical information. Such informal information often does not carry weight, and takes up inappropriate GP and staff time.
- confirmation of identity and/or witness to signature, when this can be done by another non-medical professional
- assessment of mental capacity when it would be appropriate for another clinician to provide the service, recognising that in some circumstances it will be appropriate for the GP to do this

These lists are not exhaustive and if practices are in any doubt they should seek the advice of their LMC. The BMA has produced guidance on collaborative arrangements, which is available [here](#).

The GP contract regulations Schedule 5 [here](#) also provides a list of certain services for which GP contractors may legitimately charge. Information on services covered in this section that GPs should seek to secure funding for can be found [here](#).

Some extra- contractual work for which a fee is payable, such as Personal Medical Attendant reports for insurance purposes, and Criminal Injuries Compensation Board reports would be difficult or inappropriate for providers other than registered GPs to provide. When considering the needs of their patients, practices are unlikely to find that it is appropriate to stop providing such work. However many practices now provide computer generated reports that fulfil the requests from insurance companies. Whilst this can save time, care should still be taken to ensure the report produced is accurate and appropriate.

Bureaucracy from primary medical services contract administration

In England the move of primary medical services contracts (G/P/APMS) from PCTs to fewer Area Teams has in many cases resulted in additional bureaucracy for practices, who have reported delays in receiving information, as well as incurring extra administrative work in chasing up payments, or seeking clarification on queries. This is diverting staff time away from attending to their core work. A suggested template (see [appendix 9](#)) can be adapted to send to the Area Team.

Part 4: Patient partnership and self-empowerment

There is considerable benefit in working in partnership with patients to empower them to take more control over their own health, and to make informed decisions about which services they should access when in need of care. In any dialogue with patients, it is important that communication is not simply defensive of any changes taking place, but instead practices should proactively engage with patients and patient groups to explain why they are having to make the changes which result in services not being provided, and seek their views on how to manage the situation.

Encouraging patients to manage their own health issues is an important part of the solution to the current workload problems, but this should not be seen as an 'emergency' measure since it will inevitably take some time to achieve the culture change that is needed. This sort of change will require proper planning to encourage and coach patients to build their confidence in their ability to self-care.

This can range from self-care for minor illnesses, to self-management in patients with chronic diseases. Additionally patients can be signposted to see the most appropriate professional, such as the health visitor or pharmacist or other direct access services where appropriate. Not only will this benefit patients, and reduce the inconvenience of unnecessarily attending a GP surgery, it will also reduce pressure on practices, and free up appointments. This approach is endorsed in NHS England's recently published Five Year Forward View, which also supports greater use of community pharmacy to relieve pressure on GP practices; there may be mutual benefits from working with pharmacists on the promotion of self-care and in developing other processes to help patients access the most appropriate service.

Many CCGs have already developed their own guidance to patients on how to access the most appropriate service. An example of this (approved by the CCG) can be found in [Part 10](#).

Resources to direct patients to

Practices may find the following useful as a source to direct patients to.

- The **BMA** has produced guidance for patients on **self-care** which can be accessed [here](#) and a Q&A document [here](#).
- The **NHS Choices** website includes information for patients on the appropriate use of NHS services, accessible [here](#).
- Further information is available at the **Self-Care Forum** [here](#), with downloadable material.

In addition patients can be informed about appropriate local or national self-care groups and charities for information about their condition. Two examples of national groups are:

- the **British Heart Foundation** website contains a lot of useful information for patients with heart-related conditions [here](#)
- the **Diabetes UK** website is another excellent resource accessible [here](#).

The following are some methods that could be used to help empower patients towards self-care:

- newsletters or other information to patients, available in the surgery and if possible posted or emailed to patients,
- waiting room material such as posters and leaflets explaining the services the practice offers (particularly if there is to be any reduction in services) examples can be found in [Part 10](#) and the GPC will be issuing its own template leaflet for patients shortly
- practice website with self-care advice and management tools, and details of patient groups and charities
- during consultations, patients could be given suitable material, eg leaflets explaining that viral illnesses do not require antibiotics, and setting out how patients should help themselves to recover; or signposting to other patient supporting resources (eg NHS choices, patient.co.uk, patient information leaflets from GP clinical IT system)

This would reduce demand on GP services, and liberate appointments to be offered to other patients.

While there is now a clear national agenda towards the promotion of self-care, and seeking appropriate care from other services, it may be helpful to contact your LMC to help make sure that you present this advice in an appropriate, positive and supportive manner, taking care not to deter patients from seeking their GP's help when needed.

Part 5: New ways of working

Many practices are already finding new ways to work, and in particular are using technology to work more efficiently and improve services to patients. Practices may find it useful to look at ways in which technology, innovation and practice systems can be used to increase productivity and reduce practice workload. Although resources will be required to set up and embed new systems, there are potential medium and longer-term benefits.

However, innovation is not exclusively technological; it can also be achieved by re-assessing long-standing ways of working in light of workload changes, and considering the benefits of collaboration.

When introducing new ways of working it is a good idea to ensure that the full primary care team is up to speed with developments. The following are some ideas that may manage workload effectively, although the list is not exhaustive. The BMA GPC will be providing further support in these areas in due course.

Online appointment booking

Encouraging patients to book appointments online will reduce phone calls to the practice, or patients attending reception, thereby reducing staff time and workload. It also may reduce the number of missed appointments, given patients will be able to amend or cancel appointments. Findings from the accelerator sites involved in NHS England's patient online programme show that practices that offer a higher proportion of their appointments online find the systems work more effectively.

Remember that online appointments will not be appropriate for all types of patients, especially those who are unable to access internet technology, and practices should ensure they are not disadvantaged.

Online booking can also be used to reduce unnecessary booking of GP appointments, by providing information on practice websites with self-care information as well as signposting patients to the most appropriate way of dealing with their problem, which may not be a GP but another member of the practice team (eg practice nurse or health care assistant) or an external service eg (pharmacist, health visitor).

Online ordering of repeat prescriptions

Allowing patients to order their repeat prescriptions online can also reduce telephone and face-to-face contact with the practice and reduce administration, particularly for patients with long term conditions.

Patient booking kiosks and self-input of patient data

Self-booking appointment screens or kiosks for patients can reduce the need for contact with receptionists and lead to a reduction in staff workload. Some of these systems also allow patients to input data, eg health questionnaire, friends and family test, which can also reduce staff workload.

Telephone appointments and triage systems

Some practices have reported benefits from systems of telephone consultations and triage and they could be worth consideration. Practices can implement their own triage systems. Alternatively, a number of commercial products are available, such as Doctor First and Patient Access (not an endorsement-and there may be others). Some systems involve clinicians talking to all patients during the initial contact, and assessing them on a clinical priority basis, thereby reducing the number of patients requiring a subsequent face-to-face appointment.

Electronic Prescription Service

The EPS (Electronic Prescription Service) enables practices in England to send prescriptions electronically to a dispenser of the patient's choice, such as their local pharmacy. This can benefit practices by reducing the paperwork required in signing large volumes of repeat prescriptions, and may also be more convenient for patients. Where the patient nominates a

pharmacy, prescribers will no longer need to generate a paper token (unless requested by the patient), which reduces their workload and that of administrative staff.

Repeat prescribing

Practices that are under pressure may also seek to review their **repeat prescribing interval**. It may be appropriate to prescribe for longer periods of time in order to reduce the repeat prescribing workload. Practices can also make greater use of **repeat dispensing**. This enables practices to pre-issue an advance batch of repeat prescriptions for a period of say six months with a nominated pharmacist, and for patients to then collect these repeat prescriptions directly from the pharmacy at specified intervals, without the practice needing to issue further repeats in this period. All prescriptions must still be appropriately monitored and a longer repeat prescribing interval must be clinically appropriate, safe and justifiable. NHS Employers' guidance on repeat dispensing can be accessed [here](#).

GP2GP record transfers

Although there are some outstanding issues with GP2GP transfers still to be resolved, the benefits of electronic transfers are potentially significant. GP2GP enables health records to be transferred directly between practices when patients move. This can reduce workload when GPs see new patients, by having the medical records readily accessible. The alternative paper-based approach can involve printing out details of the patient health record and transferring these in hard copy to the new practice, which then has to be summarised and data re-entered into the clinical system. GP2GP allows entire lifelong records to be exchanged screen-to-screen in general practice.

eMed3

The eMed3 is the electronic version of the MED3 (fit note) and can streamline the use of the form. It can be accessed from medical records and consultations, with patient details pre-populated, which makes it quicker and easier to generate, record and print a fit note. It also enables the easy printing of duplicates for lost certificates.

Remote access to records

Secure remote access to clinical records can be helpful to GPs, offering flexibility to carry out patient administrative work when away from the surgery.

The use of tablets or other mobile technology that provide access to patient records could enable GPs to care for housebound patients and those in care homes more effectively, while also reducing the need to return to the surgery to access records. Data can also be input in real time, and seamlessly uploaded onto clinical systems without needing to be manually re-entered. Practices should contact their clinical supplier regarding this facility, and also their CCG or primary care commissioner to request funding, as well as seeking support from the LMC if necessary.

Patient online access to records.

In England, patients will have online access to the coded information in the GP records (not free text) during 2015/16, subject to the enablement of the technology as part of the GP systems of choice agreement. Some practices have piloted patient online access to records, and found benefits in patients self-managing their health by having access to medical information. One example would be patients with chronic diseases having access to test results, eg in diabetes, with a self-management plan of when to see the GP. This can reduce workload by reducing the demand on GP time, while offering convenience and empowerment to patients.

- Document management systems. These are systems of managing information between clinicians and staff within a practice. This would include daily hospital correspondence, and enables staff to route relevant letters to the appropriate clinician, and with an audit trail. There are ongoing improvements to clinical messaging between hospitals and practices so that documents (letters, discharge summaries, reports etc.) are delivered and the data automatically coded into the GP record;
- Greater use of ambulatory devices, eg patient's recording BP on own monitors.

Skill mix and efficient use of staff and allied resources

Practices should consider different ways of using staff to manage workload:

- there may be clinical tasks that do not need a GP appointment, and can be appropriately provided by other healthcare professionals such as a nurse, advanced nurse practitioner or health care assistant
- GPs may be doing administrative work that could be delegated to administrative staff, or personal medical assistants
- employing a good practice manager, or sharing a manager between practices, could have a major impact on workload reduction for some GPs
- there is potential for greater use of pharmacists in GP practices or in collaboration with community pharmacies, such as in medicines management or chronic disease management
- there is potential to work with third party organisations to support practices and patients. This could also include voluntary sector organisations, such as Age UK, or condition-specific charities (eg Parkinson's Society), who can provide resources and assistance to patients and practices. Some practices have found formal links with Citizens Advice Bureaus to be helpful with assisting patients with financial, social and legal matters and completing forms such as for benefits and disability.

Part 6: Working with other practices

There is real potential for practices to reduce workload and bureaucratic burden by working with other local practices in networks and collaboration, or if appropriate in formal mergers or partnerships or practices. There are a number of different approaches that practices could take to network development and a range of potential benefits.

Practices need to consider how they can support each other, including in practical terms, for example if a practice is experiencing severe staff shortages.

Workload and costs may be reduced and GP time freed up by:

- sharing HR management, finance management and other back office functions with other practices
- sharing practice managers across practices
- sharing clinical staff or joint appointments, eg practice nurses
- providing cross cover for staff absences or holidays
- joint staff training or education
- providing peer support for implementing common systems, eg CQC preparation, information governance, health and safety, infection control
- if necessary, subcontracting services to another practice.

The GPC will be providing further detailed guidance on collaborations and networks shortly.

Part 7: Reviewing other roles

If clinical workload done by the practice is exceeding capacity, individual GPs may need to review the degree of commitments outside practice, in order to provide safe and quality care to patients.

Many of the activities described below are valuable both to the practice, the individual GP, and the wider community so the only reasons for considering a reduction in such work would be in order to protect the core responsibility of providing safe, quality GP services to patients. Practices and individual GPs will need to consider carefully the full implications of reducing workload in this way, balancing the overall value with the time and capacity created to focus on core GP work.

Review CCG workload

The contractual obligations on practices in respect of commissioning engagement are fairly limited, with the regulations stating:

A contract must contain a term which has the effect of requiring –

a) the contractor to be a member of a CCG; and

b) that contractor to appoint one individual who is a health care professional to act on its behalf in the dealings between it and the CCG to which it belongs.

However, there may be some local agreements in place and the CCG constitution (which is binding on practices) may also have additional requirements so it is important that practices take this into account.

Practices may review whether to attend meetings or engage in CCG activities that are outside constitutional obligations, although when doing this they should consider the extent to which that will dilute their influence over the CCG. This may depend on the items for discussion at any particular meeting. Where there is an obligation to participate in CCG activities it is important this is adequately funded so that finite practice resources for patient care are not diverted onto non clinical administrative work. Practices can best challenge and influence CCG policies, including seeking amendments to their constitution, as fully engaged members.

Many practices now have GPs and other staff (including practice managers) engaging in CCG work on a sessional basis. If this is the case for practices with significant workload and capacity issues, they may wish to re-assess how much time is being given over to this work and whether it is sustainable.

Review of outside appointments and additional roles

Many GPs now choose portfolio careers which allow them to expand and develop their areas of interest and expertise.

The opportunity to take on additional roles and appointments is a highly-valued part of many GPs' careers and the BMA's GP committee believes that GPs should be encouraged and supported in making these choices. However, in the event that the workload pressure on the practice is such that patient safety or contractual and regulatory obligations are compromised, and efforts to tackle this workload have not been successful, then individual GPs and their practices may wish to consider reviewing external appointments, particularly when practices are facing difficulties with recruitment and retention.

These are difficult decisions for GPs and practices and the potential long-term repercussions should be taken into account. The types of activities which practices may wish to consider reviewing include:

- CCG and commissioning work, including CCG governing body membership and clinical leadership roles
- CQC inspection team membership
- area team medical advice

- work for professional bodies at local or national level
- undergraduate or postgraduate education
- out of hours or unscheduled care sessions
- PMCF seven-day working sessions
- clinical assistantships.

Part 8: List management

Formal list closure

GMS and PMS practices can apply formally to close the practice list, and may choose to do so if they find their level of workload is jeopardising their ability to provide safe care for their registered patients, or to carry out their contractual obligations to meet their patients' core clinical needs. The relevant contract regulations can be accessed [here](#).

Practices that do not wish to have patients assigned to their list by the area team must go through the list closure procedures set out in the regulations (*paragraphs 29-31 of Part 2 of Schedule 6*). If the area team or the assessment panel approves the closure notice, the contractor's list is officially closed to assignments. The closure period will be either for a maximum of 12 months, or if a range was specified in the closure notice, until an earlier point in time when the number of patients falls below the bottom figure of the range.

This process requires area team consent. We would however, expect all area teams to take an understanding and supportive approach to practices wishing to close their lists to ensure that all decisions are made with due consideration to patients' and practices' best interests.

Steps to take when considering the possibility of list closure

- Instead of list closure, is there an opportunity to negotiate with the area team for staffing support with other services?
- There will be a responsibility on both the practice and the Area Team/LHB (Local Health Board) to ensure that all options other than closure have been considered.
- Document what options you have considered in trying to address the problems being faced and the outcomes of those considerations, eg rejected or implemented and why.
- Discuss your individual practice problems at the **earliest** opportunity with your LMC who will provide you with confidential help and support in line with the rules and regulations
- Consider possible impact on neighbouring practices and meet with them including LMC representation to discuss the problems that the practice is facing.
- Could the neighbouring practices help in some way? Document the outcome of the discussions for future use.
- Request a meeting with the Area Team/LHB and let them know you will be accompanied by a LMC representative.
- Discuss with your patient liaison group to explain how and why you have come to this decision and to listen to any suggestions they may have to ease the pressures.

Informal list measures

In addition to the formal list closure procedure all practices have the contractual right to decline to register any new patients without having to go through the formal processes and without needing to obtain area team permission. However the formal closure does make it far more difficult for the area team to be able to allocate any new patients to the practice list.

A practice can decide not to register new patients, provided it has 'reasonable and non-discriminatory grounds for doing so', (such as protecting the quality of patient services.) In such cases, the regulations allow practice to refuse to register new patients.

Paragraph 17 of Part 2 of Schedule 6:

"(1) The contractor shall only refuse an application made under paragraph 15 or 16 if it has reasonable grounds for doing so which do not relate to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

(2) The reasonable grounds referred to in paragraph (1) shall, in the case of applications made under paragraph 15, include the ground that the applicant –

- (a) does not live in the contractor's practice area; or*
- (b) lives in the outer boundary area (the area referred to in regulation 18 (1A))*

(3) A contractor which refuses an application made under paragraph 15 or 16 shall, within 14 days of its decision, notify the applicant (or, in the case of a child or an adult who lacks capacity, the person making the application on their behalf) in writing of the refusal and the reason for it.

(4) The contractor shall keep a written record of refusals of applications made under paragraph 15 and of the reasons for them and shall make this record available to the Board on request”.

Should a practice be unable to accept patients routinely, a discussion between the practice and the area team could take place in an attempt to resolve the situation. This could involve, for example, additional support being provided by the area team or a formal closure of the list.

The contractor does not need to make an official declaration of its intention to refuse to register new patients. It must, however, provide the patient with a written notice as in paragraph 3 of the extract above.

The area team may still assign patients to the contractor’s list (*paragraph 32 of Part 2 of Schedule 6*) as its list is open to assignments within the meaning of the Regulations.

Practices should bear in mind that the area team may ask them to justify the decision not to register a patient. Practices must ensure that their actions do not discriminate between patients on the grounds of the applicant’s race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. A written acceptance policy will enable practices to refute any suggestion of improper rejection of applications. There are equivalent procedures in the regulations for the devolved nations.

Reduction of practice area

Many practices have already asked their area team to consider reducing the size of the practice area in order to help bring practice list size and workload down to safely manageable levels. This change would require a variation in contract and therefore the agreement of the area team. In considering such a request, the area team will consider the needs of patients, the availability of alternative practices in the locality and the effect that a practice area reduction could have on their own workloads, so area teams may not agree, but this option would work for some practices provided patients can be accommodated elsewhere.

Removal of patients from the practice list

This course of action should always be a last resort, when all other possible avenues of managing list size and workload have been explored, but where practices still feel they cannot continue to provide safe patient care and meet contractual obligations.

As with the regulations on refusal to register patients, the [removal regulations](#) must be exercised in an entirely non- discriminatory manner. BMA guidance on this can be accessed [here](#). In practical terms, this means that the only patients who could be considered for removal would be those living outside the practice area.

Practices could decide that this applies to:

- all out of area patients
- only those lying outside of the outer boundary (should the practice have opted to have one)
- to all out of area patients residing beyond a certain distance from the practice
- to all patients outside the boundary and beyond a certain travelling time for home visit.

A practice making the decision to remove patients could garner considerable attention from the local community and media.

Practices deciding to remove patients to manage workload must:

- make sure that their reasons for so doing are entirely reasonable, transparent and justifiable
- make sure that they act in a non- discriminatory manner and fully in accordance with the regulations

- make sure that they discuss the matter with their patients/PPG, area team, CCG and LMC, and ensure that alternative provisions are available and that patients are informed of these. Communication with patients at all stages is vital
- consider relationships with patients, the public and the wider community. This may include the involvement of the local MP.

Practices should also ensure that they seek the advice of their LMC when contemplating action of this kind.

Part 9: Looking after your own health

Successive surveys and policy documents have shown (BMA Tracker Survey March 2014, Health Education England Taskforce report 2014, Centre for Workforce Intelligence In-Depth review of the GP workforce, July 2014) that many GPs are suffering unprecedented levels of stress due to unmanageable workload, with some leaving the profession as a consequence. GPs must take steps to identify whether their workload is affecting their physical or mental health. GPs are often reluctant to seek help but it is vital that they do so, not only for their own psychological and physical health but also with a view to continuing to be able to provide safe, quality care for patients.

If you feel that stress is affecting your health, your first port of call could be your own GP. You can also get urgent help through your LMC and should contact them immediately. The BMA also offers a confidential counselling and advisory service which may be of assistance to GPs experiencing stress. More details can be found [here](#). A self-assessment tool for GPs is also accessible [here](#).

If there is an occupational health service in your area, you should contact them. Unfortunately there have been severe reductions in this service, which is no longer funded as it should be and the GPC has campaigned against these cuts. There may also be other services in your area, for instance in London there is a Practitioner Health Programme. You could also consider seeking some advice from these services on how to improve your work/life balance.

Part 10: Useful resources

The following resources have been sourced from LMCs or produced by GPC to assist you with you workload management.

A separate portfolio of suggested outline template letters for practices to use can also be found in Part 11 of this guidance.

Enhanced services December 2014

The following list shows examples of enhanced services that have been commissioned somewhere in the UK. This list is not intended to be exhaustive, but rather to provide practices with an indication of the kinds of services that they may be able to seek funding to provide to their patients on top of the normal core contractual requirements.

If you have questions about any of these enhanced services please contact the GPC on info.gpc@bma.org.uk or speak to your LMC.

- 24 hour ambulatory blood pressure monitoring
- Alcohol & drug misuse
- Asylum seekers & refugees
- Bank holiday working
- Cardiovascular health checks
- Chlamydia screening
- D-Dimer / DVT management in the community to avoid hospital admissions
- Shared care / specialist drug monitoring
- ECG recording
- Extended hours
- Flu immunisation
- Gonadorelin analogue treatment
- HIV in primary care
- Homeless patients
- Insertion of contraceptive devices
- Insulin initiation or conversion
- Minor injuries
- Nursing Homes – enhanced services
- Phlebotomy
- Post-op suture removal
- Pre and post ops
- Primary care sexual health scheme
- Prostate cancer follow up
- Provision of immediate and first response care
- Referral review scheme
- Ring pessary insertion
- Sigmoidoscopy
- Smoking cessation programmes
- Spirometry
- Student Health
- Alcohol and substance misuse
- Vasectomy
- Violent patients

Maintaining quality and managing workload – checklist

Remember your prime responsibility as a GP is to provide safe and quality care to patients who need GP services as in your contract. The following checklist is to help you fulfil your contractual and professional duty of care to patients at a time of widespread demands and pressures.

- When changing service provision in any way, you must always ensure that your practice is fulfilling the terms of its Primary Medical Services contract and considering the needs of patients. Please contact your LMC or the BMA GP committee if you are unsure.
- Don't accept inappropriate referral or workload shift that is diverting you from your core duty of care to patients:
 - Write to the service provider in question if general practice has not been commissioned to do the work, and use and adapt the template letters provided with this guidance
 - Contact the CCG/Area Team/Local Authority commissioner
- Do not take on any new **non-obligatory** work that is diverting you from your prime duty of care to patients which is:
 - unfunded or under-funded and therefore cannot be delivered appropriately to patients
 - not beneficial for patients
- Review enhanced service provision. Consider ceasing involvement, **after appropriate notice and evaluation of impact on patients (normally three months)**, in under-funded enhanced services
- Provide appropriate information (for example in the form of posters) to ensure that patients know why changes are being made, eg inadequate capacity and a need to protect the quality of 'core' services or no longer being commissioned.
- Promote self-care and appropriate use of other services where applicable, but be careful not to give patients any impression they cannot visit their local GP if they need care.
- Review the practice's provision of services under 'collaborative arrangements' and other non-NHS work, taking into account the actual cost to the practice of providing these services
- Consider the importance and feasibility of continuing in externally appointed roles
- Consider new systems of working or use of technology to assist workload management
- Consider working with other practices to alleviate workload pressures (see section 6)
- If other options are not available, consider reducing the size of the practice area, or closing the practice list. This may be considered if taking on new registrants could put pressure on the practice and damage patient access to, or the quality of, the services offered. Please consult your LMC for further advice and see section 7.
- With any changes to service, ensure there is sufficient consultation with patients and always ensure you follow GMC Good Medical Practice.

Information to patients

Follow this link for an example of the sort of information one CCG has provided to local patients www.kernowccg.nhs.uk/choosebetter

Below is a further example from another CCG:

Template information for GP practices in Devon, Cornwall & Isles of Scilly

Practice name:

Get the right treatment

Your GP surgery can provide a huge range of advice, examinations, treatment, vaccinations, prescriptions and other routine healthcare.

But did you know there are lots of other local services that you can go to directly for help? No need to see your GP first.

This guide sets out the main services that available and how you can contact them.

Minor ailments and conditions

DID YOU KNOW: You can get rapid advice, treatment and even prescriptions from your local pharmacy. Under the Pharmacy First scheme, the pharmacist can prescribe medicines for these conditions (normal charges and exemptions apply):

- Coughs, colds, sore throats, blocked nose
- Ear-ache
- Thrush and uncomplicated urinary tract infections
- Teething and nappy rash
- Threadworms
- Hay fever
- Athlete's foot
- Diarrhoea
- Cold sores and mouth ulcers
- Skin rashes, impetigo
- Eye infections

WHAT TO DO: Just drop in to your local pharmacy and ask to see the pharmacist. If you have difficulty finding a pharmacy, you can use the NHS Choices website – www.nhs.uk – or dial 111.

Muscular and skeletal problems

DID YOU KNOW: You may refer yourself straight to the NHS physiotherapy service for conditions including:

- Back and neck pain
- Sprains and strains
- Whiplash disorders
- Sports injuries
- Joint pain
- Muscle pain

WHAT TO DO: Staff will try to offer you a same-day appointment if you phone them Monday to Friday, between 8.30 and 12 noon, on 01626 883765.

Podiatry/footcare for patients aged 60-plus

DID YOU KNOW: You may refer yourself for podiatry and foot conditions, including:

- Painful foot problems or foot abnormalities
- Ingrowing toenails, verrucae
- ...but not corns, calluses or nail-cutting

WHAT TO DO: Please call 01803 217712 between 8.45am and 3.45pm, Monday to Friday. Or pick up a Podiatry Assessment Form from the Health Centre receptionist.

Minor injuries to adults and children aged 3-plus

DID YOU KNOW: MIUs (minor injury units) are able to help if you suffer:

- Lacerations, cuts, grazes, wounds
- Sprain, strain, muscle or joint injury
- Broken bone (fracture)
- Skin complaint – insect/animal/human bite or sting
- Foreign bodies like splinters
- Minor scalds and burns
- Minor head injuries from a low fall
- Localised allergic reactions and infections (to wounds, for example)
- Minor eye injuries and infections

Emergency contraception is also available

WHAT TO DO: Phone your nearest MIU – it will usually be open seven days a week, 8am to 9pm, but it's a good idea to check before you go

Newton Abbot Hospital = 01626-324500

Totnes Hospital = 01803-862622

Mental wellbeing concerns for over 18yr olds

DID YOU KNOW: you can refer yourself straight to the local specialist NHS anxiety & depression service if you are struggling with:

- Panic attacks
- Depression, low mood
- Anxiety, excessive worry
- Social anxiety/shyness
- Phobias
- Post-traumatic stress disorder
- Agoraphobia
- Obsessive compulsive disorder
- Health anxiety
- Bulimia

WHAT TO DO: Call 01626 203500 between 9am and 5pm, Monday to Friday They will also let your GP know.

Sexual health advice and treatment

DID YOU KNOW: You can get help if you have concerns or:

- Need contraceptive advice and implants
- Need tests for sexually-transmitted diseases
- Have symptoms such as vaginal discharge

WHAT TO DO: There are clinics at Newton Abbot Hospital and Castle Circus Health Centre.

You can get in touch, in confidence, by calling 01803-656500.

Babies, children and parenting

DID YOU KNOW: You can go straight to your named health visitor for advice and guidance on issues such as:

- Baby and child growth and development
- Childhood conditions, allergies and infections
- Breastfeeding, bottle-feeding and weaning
- Teething
- Post-natal depression, and parental mental and physical health
- Child behaviour issues, such as sleeping, eating, potty-training and tantrums
- Support with parenting, family health and relationships

WHAT TO DO: Phone 01803 874457 or dial 111

Community nursing support

DID YOU KNOW: If you are housebound patients and on the Newton Abbot locality district nurse caseload, you can get direct help with:

- Leg ulcers
- Dressings
- Enemas
- Catheters
- Syringe drivers

WHAT TO DO: Call the local Torbay & Southern Devon Health & Care Trust community nursing patient line on 07811 123875.

Life-threatening conditions

DON'T FORGET: Always dial 999 for life-threatening conditions such as:

- Severe chest pain
- Severe difficulty in breathing
- Unconsciousness
- Severe loss of blood
- Severe burns or scalds
- Choking
- Suspected stroke
- Fitting or concussion
- Drowning
- Severe allergic reactions

And if you aren't sure...

DON'T FORGET: For advice on health conditions and the availability of local services, you can dial 111 at any time day or night.

Dealing with system problems – example

Service alert form for primary/secondary interface issues

Complete this form for any system problems arising from patients referred, discharged or undergoing hospital care or when a consultant or GPwSI requests you to take action which you feel is his/ her responsibility.

Please return one copy of this letter to the Consultant/ GPwSI concerned and email a copy to the CCG

Patient Hospital No.	~[Hospital Number]	Date of birth	~[Date Of Birth]
NHS number	~[NHS Number]	Practice Reference No.	~[Patient Number]
Consultant Name	~[Free Text: Consultant's Name:]	Hospital/Trust	~[Free Text: Hospital/Trust Name:]

Appointments

Tick box	
	Patient appointment not received (standard 2 weeks after referral for non-urgent referrals)
	Inaccurate DNA notification requiring re-referral – choose from list below:
	DNA – patient had not received appointment notification
	DNA – patient contacted hospital to cancel in advance of appointment
	DNA – patient had not been able to get through to hospital to cancel appointment

Details:

Referral problems

Tick box	
	Failure to onward refer patient with a serious or urgent clinical need, eg suspected cancer as outlined in NHS Harrow's Policy on Consultant To Consultant Referrals
	Inappropriate request for GP to make new referral to a related service
	Inappropriate/premature discharge from service requiring new referral for ongoing problem
	Inappropriate return of referral to GP, eg insufficient details provided to CAS service

Details:

Investigations

Tick box	
	Request to organise investigations that should be arranged by hospital doctor
	Request to chase/act upon the results of investigations requested by hospital (this is the responsibility of the hospital doctor)
	Failure to act on an abnormal investigation result
	Not providing a patient/GP with information of an investigation carried out in hospital
	Request to organise a diagnostic procedure in 12/24/36 months. General Practice does not have reliable recall systems for arranging diagnostic procedures requested under a hospital specialist's care

Details:

Page 2 Patient's Hospital No: ~[Hospital Number] or NHS No: ~[NHS Number]

Discharge arrangements

Tick box	
	Inadequate information on discharge planning arrangements
	Discharged too early requiring re-referral

Details:**Correspondence problems**

Tick box	
	Delay in receipt of outpatient letter (standard is 2 weeks; quicker if urgent)
	Delay in receipt of A&E letter (standard is within 1 business day of discharge)
	Delay in receipt of discharge Summary (standard is within 1 business day of discharge)
	Illegible or incomplete letter from hospital

Details:**Communication problems**

Tick box	
	Lack of telephone access for patient, eg to cancel appointment, speak to secretary or hospital doctor regarding a management query
	Problems for practice to contact hospital doctor/departments/secretary

Details:

Other problems not outlined above (provide details)

What action do you want the hospital to take?

What action, if any, do you want Harrow PCT to take?

Contact details:

Practice Stamp:

NAME:
POSITION:
DATE: ~[Today...]
EMAIL:
TEL NO:
FAX NO:

Part 11: Templates for practice use

The following template letters have been drawn up to help practices manage workload, and should be adapted for local use as appropriate.

Use the [hyperlinks](#) to quickly reach each appendix.

[Appendix 1](#) – Template response to secondary care work transfer

[Appendix 2](#) – Template response to inappropriate prescribing requests

[Appendix 3](#) – Template response to requests to follow up investigations performed in other settings

[Appendix 4](#) – Template response to requests for post-operative checks

[Appendix 5a](#) – Letter to hospital provider regarding discharge of patients after missed appointment

[Appendix 5b](#) – Template letter to local CCG regarding discharge of patients after missed appointment

[Appendix 6](#) – Template letter to CCG regarding inappropriate workload transfer

[Appendix 7](#) – Template letter for request to complete non-contractual administrative task

[Appendix 8](#) – Template response to requests for work absence sick notes for less than seven days

[Appendix 9](#) – Template letter to Area Team regarding delay to information request or payment

Appendix 1

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 CCG
- 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 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.

Appendix 2

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 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 FPIOHP. 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:

Appendix 3

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 theinvestigations undertaken by your department.

A copy of your request is enclosed.

This result of this investigation will automatically be sent to you or your department as the requesting clinician. Please note that as per GMC guidance, 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 of chasing up results which are already in your possession, and which falls 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).

Appendix 4

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 Practice 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

Appendix 5a

Letter to hospital provider regarding discharge of patients after missed appointment (a similar adapted letter could be sent to the CCG 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.

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 CCG to inform them of this.

We look forward to hearing from you

Appendix 5b

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

Dear CCG 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.

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 has clinical governance concerns of delays to care or loss of follow up. 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 for 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 e.g. 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 workload management document "Quality First: managing workload to deliver safe patient care".

At a time when GPs are under overwhelming pressure and 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 actually save money, in reducing the unnecessary costs of administration and staff time both 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.

Appendix 6

Template letter to CCG 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.

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

Appendix 7

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. 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.

Appendix 8

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 having to review our work to ensure that we are able to focus on our key duty of care for patients, and so we are unable to provide sick notes for absences of less than a week.

Appendix 9

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

General practitioners committee

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

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