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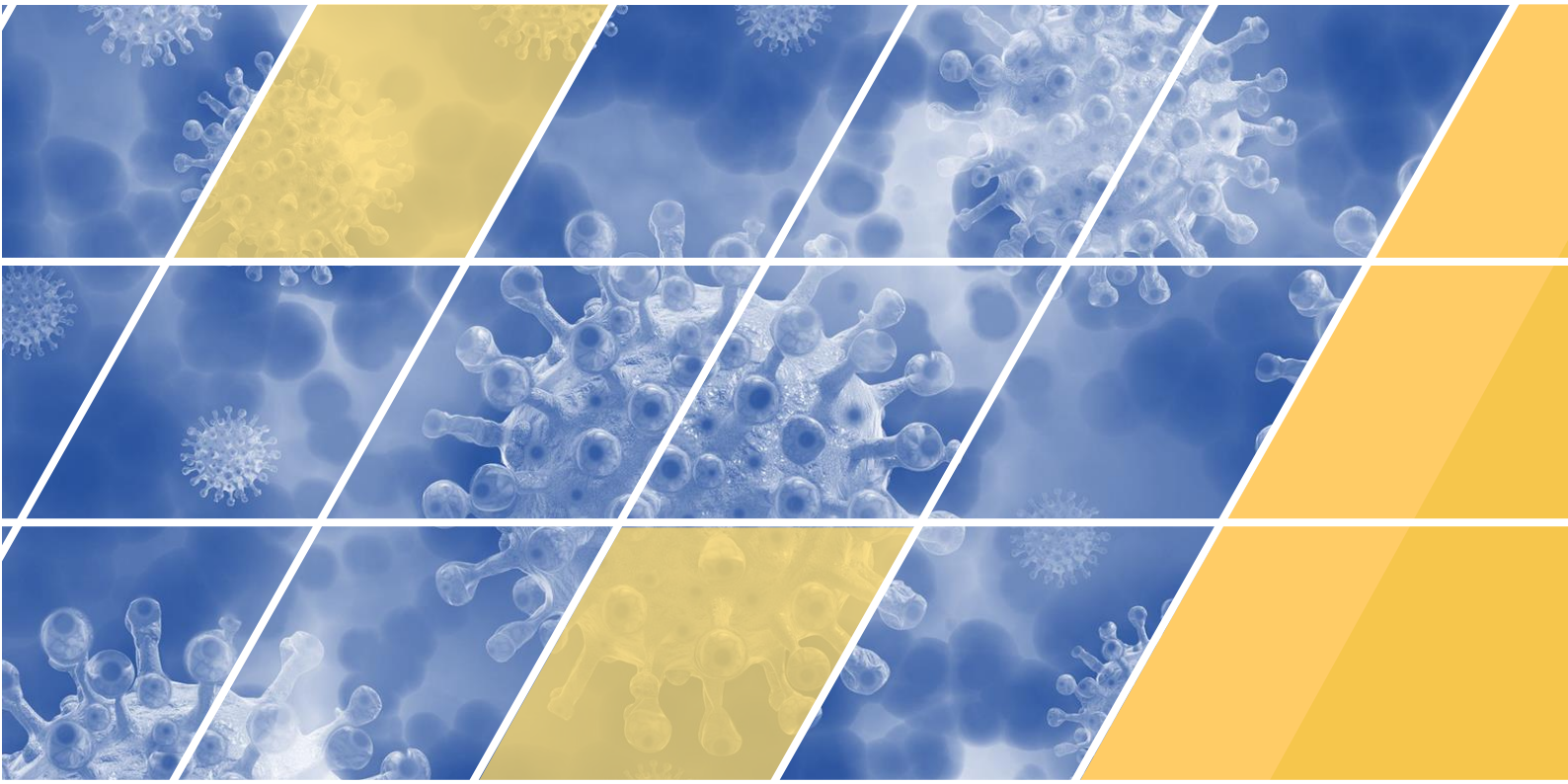

GENERAL PRACTICE COVID-19 CAPACITY & WORKLOAD TRANSFER ANALYSIS

November 2020

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1 EXECUTIVE SUMMARY

Cambridgeshire LMC and Beds & Herts LMCs[1] represent, support, and advise 267 constituent practices serving **over 3 million patients** across **three health systems** in the NHS East of England region.

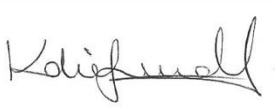
There is a recognised paucity of data around general practice activity[2]. NHS Digital acknowledges that it most likely significantly under-reports the work done by primary care. This has recently been acknowledged by NHSEI and external stakeholders, with a commitment in the 2019/20 GMS Contract for practices to work with NHSEI and the BMA around GP Appointments Data.

Covid-19 necessitated an overnight transformation in the operational delivery model across primary care. This led to a significant workload shift into practices, which exacerbated existing challenges, given the finite resources of practice teams, time and funding. Damaging misinformation in parts of the media has impacted upon the morale of an already saturated and exhausted workforce. It is unsustainable and unsafe for GPs to be working excessive hours at the expense of their own health, due to a lack of workload control.

The announcement on November 9 2020 of the Covid-19 vaccination programme, has added another layer of challenge, demonstrating the prescience of this piece of work.

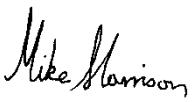
To fill the data gap, and better understand our constituent practices' experiences in each of our three systems, we sought quantitative data via a GP audit of **1 week in September 2019** compared against **1 week in September 2020;** and qualitative feedback via a workload transfer survey.

The strategic objective of this report is to promote system change, to allow the provision of safe general practice - which itself will be in the interests of all our patients, and help ensure financial balance and sustainability for all.



Dr Katie Bramall-Stainer

Chief Executive,
Cambridgeshire LMC



Mr Michael Harrison

Co-Chief Executive,
Beds & Herts LMCs Ltd

12th November 2020

[1]Since 1911, Local Medical Committees (LMCs) have been statutory bodies in the UK, recognised by successive NHS Acts as the professional organisations that represent, support and advise individual GPs and GP practices as a whole, and the views of GPs to any other appropriate organisation or agency.

[2]https://www.england.nhs.uk/gp/gpad/

FINDINGS AT A GLANCE

118 RESPONSES
To the capacity calculator received

Percentage of practices providing face-to-face appointments **100%**

Percentage of GP consultations delivered face-to-face

70% vs **17%**

SEP 2019 **SEP 2020**

6,906
MORE CONSULTATIONS
per week were delivered in Sep 2020 than Sep 2019. This represents a **10%** increase in the number of consultations

GP time spent delivering indirect patient care increased by **130%**

The combination of Covid restrictions, increase in indirect patient care and work passed from acute trusts resulted in a **56%** increase in the GP time required to deliver services between Sep 2019 and Sep 2020

95%
of practices reported additional requests from acute trusts

Percentage of practices who said the transfer of work was having a detrimental effect upon morale.
93%

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

In order to sustain this level of workload nationally, an additional **7,391** **FULL TIME GPs** would be required

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

2 INTRODUCTION

Throughout the Covid-19 pandemic, practices have continued to see the patients they need to examine, face to face and have managed extraordinary levels of demand safely and remotely.

As of November 2020, almost all practices are reporting that *activity levels are higher than at the same time last year*, borne out by NHS Digital's data which demonstrates that the utilisation rate for primary care across our systems is akin to *almost 1 in 2 patients accessing their primary care services every month.*

At the outset in March 2020, practices were planning for the possible failure of the OOH service and the acutes being overwhelmed. Some put in place plans to resume 24/7 care for their population. Practices acquired stocks of palliative medicines in case of need; rafts of smart phones; planned in-surgery sleeping quarters for staff able or willing to work overnight; and liaised with local places of worship and community centres about the potential volume of deaths. Additional security was factored in around dispensaries - all of which may seem rather surreal now, but given the Lombardy experience, this scenario was not without the bounds of possibility, and practices took heed.

As we enter the second wave, the biggest danger is fatigue in the workforce and a significant capacity gap, which is only compounded by the necessary steps taken to commission a Covid vaccination schedule as soon as practically possible.

General Practice is now facing several significant challenges which are increasing unresourced workload even further, and thus posing increased risk to patients and their clinical teams by impacting on the ability of practices to provide good quality care; keep our local health systems functioning; vaccinate our population against influenza; and Covid itself.

Our workload transfer analysis demonstrates overwhelming concern among practices in their capacity to manage:

- Increased illness presentations, both directly and indirectly related to Covid
- Clinical and operational inefficiencies caused by Covid (the need for total triage; video review and then face to face)
- Delayed secondary care interventions leading patients to present to primary care, including managing ongoing/increasing related symptoms and requests for expedited referrals
- The ongoing need to prioritise those with chronic and complex conditions, some of whom have deteriorated as a direct consequence of the pandemic's effects
- The need to respond to NHSE direction regarding resumption of 'regular' primary care services as quickly as possible; catch up on all cancer screening programmes and preschool immunisations
- The impact of Covid-related staff absences; premises patient-flow and limited estate
- The requirement to meet new PCN DES-related activity across Care Homes
- Increased diversions to primary care from 111 and other stretched community providers such as EEAST

- Delivering the largest influenza vaccination campaign in history
- Understanding the unprecedented challenge of the Covid vaccination campaign
- The challenge of working safely despite increasing clinician fatigue

What is clear is that at no point has there been a system consideration of the workload or the implications, or the resources required, upon practices to carry out this work.

The dangers we face are seen and unseen. Covid admissions are clear, but losing focus on general practice at the expense of other parts of the NHS could cause our health systems to collapse. Consider the following.

- What if every GP under the present strain refers just one additional patient per day into their local acute trust?
- What will the impact on patient flow be for those thousands of patients whose care is affected if their surgery site needs to close due to an outbreak?
- How will the Discharge to Assess (D2A) process be assured if community teams integral to its success are redeployed into acute provisions, and the GPs at the bedside have no recourse but to seek readmission?

As nascent integrated health systems, a solution is needed that ensures it does not cause any part of collaboration to be overrun by an inappropriate transfer of demand, from one sector to another, that is unresourced; unachievable or unsafe.

Workforce

Prior to the pandemic, General Practice was suffering from a significant workforce challenge whereby an additional 6000 GPs were required simply to stand still. Consultation rates in the UK are 2-3 times that of comparable EU populations. From 2010/11-2013/4 consultation rates in England rose by over 15%.[3] Alongside this the proportion of investment has fallen as workload has risen – leading to an exodus from the profession and a rise in the number of locum GPs, choosing to work flexibly, rather than take on unmanageable workloads.

The workload transfer we are seeing now, is primarily around indirect patient contact; and secondary care requests do not lend themselves to a peripatetic locum workforce, tending to be taken up by salaried GPs and partners in practices with their admin teams. Partners are also now acutely aware of the significant drop in non-NHS income work-streams, together with projections for the remainder of the financial year being far from certain.

Much of the locum workforce has been engaged in the Covid-CAS work; increased opportunities in 111 Out of Hours; with a minority deciding to undertake fixed term contracts of employment that afford benefits such as death in service. However, this is not expected to be a permanent outcome, but rather a reflection of the present.

The Primary Care Network DES aims to fund and support the employment of additional roles in the primary care team, e.g. clinical pharmacists, occupational therapists and physiotherapists. However, Covid 19 has led to a marked delay in recruitment to the scheme given financial uncertainty, and the transformation of the operating model of general practice. PCN Clinical Directors are reporting a huge rise in demand for their time and input

[3] King's Fund, 2016 (https://www.kingsfund.org.uk/press/press-releases/causes-gp-crisis-revealed-new-analysis)

– they have barely been in post a year, 6 months of which have been dedicated to crisis management as part of their individual practice teams.

The role of Clinical Directors is primarily in developing and implementing the PCN DES as part of the GMS contract; currently their framework and administrative support is not mature enough to enable them to diversify into non-PCN related work-streams.

General Practice provision has been significantly challenged during the pandemic much as it has been in secondary care, due to staff shielding, isolating, or being unavailable due to active infection. Whilst numbers impacted by this have reduced, there remain a number of clinicians unavailable for direct face-to-face contact because of the above issues.

General practice has no commissioned occupational health service, and GP partners are jointly and severally liable for the welfare of their employees without limitation.

Income

Partial and limited GP Covid funding was only guaranteed to 31 July. As of November 1st, practices will also incur a 20% VAT surcharge on any additional PPE procured for medical reasons. Like Trusts, practices have lost multiple small non-NHS income streams – which are essential to maintaining the business continuity of primary care, and the viability of General Practice within the NHS. For many partnerships, there is an understandable perception of risk around employing roles into a PCN, where the employment liability is unclear, and the position in the new operating model unproven. We need greater flexibility to recruit practice nurses, healthcare assistants and GPs with this funding.

For practices, additional charitable income (e.g. through the NHS Charities Together scheme, which received multiple millions of donations from the public) is not accessible, due to the restrictive and costly regulations attached to those that would wish to bid. Some systems have identified this imbalance and are seeking to redress it.

Even if practices were in a position to seek remuneration for private services, they are forbidden to in almost all circumstances under their national contract.

3 METHOD

4.1 The Covid-19 GP Capacity Calculator and Workload Transfer Survey

The calculator was initially developed and piloted with a number of practices in Beds & Herts via our network of LMC representatives. Following the initial pilot, the tool was modified to take into account the feedback received. In collaboration with Cambridgeshire LMC a new section was added to the tool to try and capture a more detailed understanding of the work being passed to practices from acute trusts.

The calculator was built using an online system called Cognito Forms, which Beds & Herts LMCs had used before to deliver their practice resilience tools.

It should be noted that the calculator only focuses on the impact of Covid-19 related changes on the GP workforce. We fully appreciate that in reality these changes have affected everyone working in primary care, and the additional workload has been borne by all staff, not just GPs. In the initial iteration of the tool we considered trying to capture the impact on all staff groups, however, we found this resulted in a much larger and more complex tool, which took the user significantly longer to complete, and produced inconsistent data depending upon the bespoke model used in each practice.

The tool had two sections.

The first section captures quantitative data about the practice's clinical activity for both a week in September 2019 and a week in September 2020. This included both the number of consultations delivered and the average consultation length. In order to categorise the clinical types of work GPs do, we separated the GP patient-facing workload into two groups, direct and indirect.

- Direct contacts - speaking to a patient via a face-to-face, telephone or video consultation.
- Indirect contacts - engagement with patients via electronic systems (e.g. AccuRx, eConsult, AskMyGP), patient email or patient SMS.

The second section captures qualitative data on the work being transferred from acute trusts, identifying the most common types of requests, the clinical departments within the acute trusts that most often made requests of practices, and the impact this transfer of work was having on the them.

4.2 Implementation of the Calculator

The tool was sent to all practices in Bedfordshire, Hertfordshire, Cambridgeshire and Peterborough at the beginning of October via their respective LMC. Practices were given a window of 18 days to complete the tool. During this period practices received a number of reminders via LMC communications channels to complete one submission per practice.

4.3. Data Cleaning and Analysis

Following the completion of the application window, we underwent a data cleaning process to ensure there was no erroneous data that could skew the dataset. In order to do this, we followed the process below:

Step One: Remove any duplicate entries

Duplicate entries were identified. Where the data entered for the duplicates was identical, one entry was removed. Where the two entries had differing data, the practice was contacted to confirm which entry was correct.

Step Two: Identify any practices who had outlying data points.

In order to allow us to compare practice's data and identify erroneous data we used the practice list size to normalise all the practice data to a list size of 10,000 patients. For example, if your practice had a list size of 5,000 patients and offered 150 GP face-to-face appointments per week, your data would be normalised to 300 GP face-to-face appointments per week for a 10,000 list size.

Once all the practice's data had been normalised to a list size of 10,000, we calculated the mean and standard deviation for all of the key data points. We then used this to identify any data points that fell more than three standard deviations from the mean.

Step Three: Interrogate the outliers

For each practice with outlying data points we went through a process of categorising the data into three groups:

1. An obvious data error that we could check with the practice and correct (e.g. a practice entering their list size of 13 patients instead of 13,000)
2. A justifiable cause for the outlying point (e.g. a practice that implemented total phone triage prior to Sep 2019 showing as an outlier in terms of the number of phone consultations they offered).
3. A data error that could not be explained and the practice did not respond when asked for clarifications.

Where the outlier was either a data error that could be fixed, or justifiable, the practice remained in the dataset. Where we were not able to clarify the error with the practice, or there was no justifiable reason for an outlying point, the practice was removed from the dataset.

The clean dataset was then analysed using Microsoft Excel.

4 RESULTS

5.1 Data Cleaning

In total 118 responses were submitted. We then followed the data cleaning process outlined in the method section to ensure there were no erroneous data points that could skew the dataset (identifying any responses that had data points that fell three standard deviations outside of the mean).

Table 5.1 outlines the number of responses identified in each step of the data cleaning process. Of the initial 118 responses, three were found to be duplicates, where a practice had submitted more than one response. From the remaining 115 responses, 18 showed one or more data points that were statistical outliers. Each of the 18 responses were analysed in detail and where appropriate the practice was contacted for clarification.

A further six responses were removed from the dataset because either circumstances in the practice meant that their data between the two time points was not comparable (e.g. a practice that underwent a merger between Sep 2019 and Sep 2020) or we were not able to confirm with them whether they had made a data entry error.

Four practices confirmed that they had made data entry errors which we were able to rectify (e.g. a practice mixing up their pre and post Covid data when they completed the response).

Eight practices had an acceptable reason why their data was presenting as an outlier due to their operating model (e.g. a practice that was an early adopter of eConsult showing as an outlier for the amount of time they spent dealing with indirect patient requests in Sep 2019).

Table 5.1

Data Review Process	Number of Responses
Total number of responses submitted	118
Duplicates removed	3
Total number of responses remaining	115
Responses identified as having outlying data points	18
Responses removed from dataset due to data concerns	6
Responses passed for data analysis	**109**

5.2 Response Demographics

The total number of responses analysed was 109, representing an overall response rate of 41%. The responses were split across the geography of two LMCs, covering five CCG areas across three systems. Table 5.2 breaks down the responses by CCG.

For convenience, the 83.5% response rate from practices in Cambridgeshire and Peterborough, were split into two sub-groups of the nascent ICPs: the Northern Alliance and Southern Alliance.

Table 5.2 also shows the representative list size for each of the CCGs. In total the combined list size across the two LMCs is just over 3.5 million patients.

Table 5.2

CCG	Number of Responses	Patient Population (in '000s)
Bedfordshire	9	498
Cambridgeshire and Peterborough	71	998
(Northern Alliance)	(34)	
(Southern Alliance)	(37)	
East & North Herts	14	611
Herts Valleys	10	661
Luton	5	241
Total	**109**	**3,009**

The responses came from a broad range of practices, representing the diversity seen across the area, from small single-handed practices to large multi-site practices and from urban cities to rural fens with a wide margin of deprivation to affluence. The smallest practice had a list size of 2,800 patients while the largest had a list of 85,000 patients. The average list size was 11,831. The responses also included practices holding GMS, PMS and APMS contracts.

5.3 GP Consultation Data

Table 5.3 shows the summary of the total number of consultations provided by the 109 practices both pre and post the outbreak of the Covid-19 pandemic (Sep 2019 vs Sep 2020). The table shows both the total number of consultations and the average number for a practice with a list size of 10,000 patients.

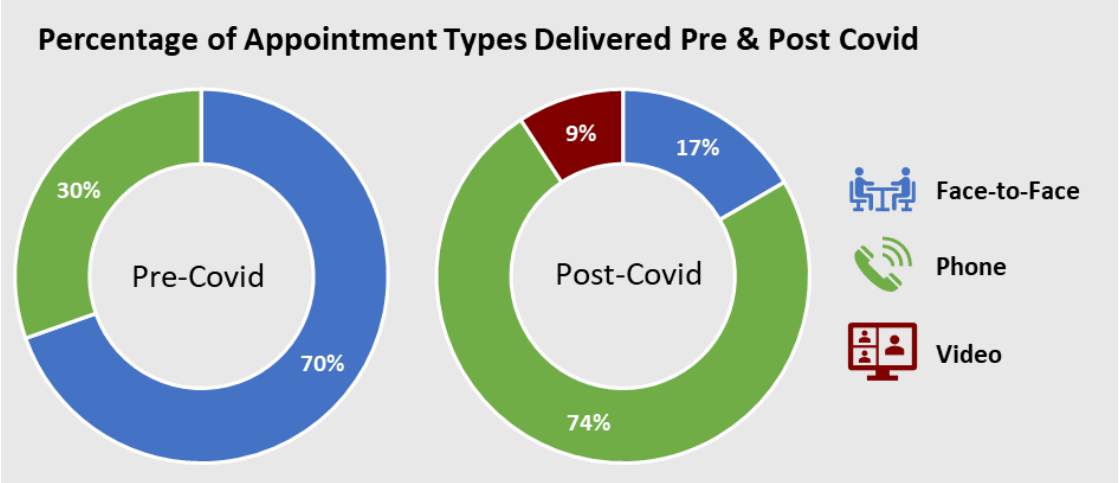
Table 5.3

Consultation Type	Pre Covid (Sep 2019)		Post Covid (Sep 2020)	
	Total	Per 10,000 Patients	Total	Per 10,000 Patients
Face-to-Face	49,062	380.4	12,863	99.7
Phone	21,413	166.0	57,382	445.0
Video	11	0.1	7,147	55.4
Total	**70,486**	**546.57**	**77,392**	**600.1**
Increase in Direct Patient Consultations				**10%**

The data shows a shift away from face-to-face consultation and towards the use of phone and video consultation. **However, the important point to note is the increase in the overall number of consultations offered by practices (10%).**

Figure 5.3 shows this data displayed as the percentage of total GP consultations delivered via each consultation type. The proportion of face-to-face appoints dropped from 70% pre-Covid to 17% post Covid. However, it is important to note that all 109 practices were offering patients both face-to-face and phone consultations post Covid. 81% of practices were also providing appointments via video consultation.

Figure 5.3



5.4 Average GP Consultation Appointment Length

Part of the calculator required practices to estimate the average GP consultation time for face-to-face, phone and video appointments pre and post Covid. These times included all the additional activities associated with an appointment (e.g. connecting a call or making clinical notes post consultation). Table 5.4 shows the average time (in minutes) for each type of consultation.

Table 5.4

Consultation Type	Pre Covid Time (minutes)	Post Covid Time (minutes)
Face-to-Face	10.98	19.12
Phone	7.63	10.58
Video	10.40	12.08

The post Covid face-to-face time reflects the additional measures that need to be put in place when seeing patients in person. **Discussion with practices suggest that the increase in the time taken for phone consultation is a result of the shift from practices using their phone appointments primarily for triage, to conducting full consultations over the phone.** The change in the video consultation time is likely to be the result of a very small sample size of practices offering video consultation pre-Covid, compared to a much wider sample post-Covid.

5.5 GP Time Allocation & Additional Workload

By combining the number of appointments practices were delivering pre and post Covid; the average appointment length each practice provided for face-to-face, phone and video consultations; the amount of time per week that GPs were spending delivering both indirect patient care (e.g. Doctorlink, AccuRx, AskMyGP, eConsult, email and text) and undertaking work from secondary care, we are able to analyse the change in overall GP workload and the change in the allocation of GP time across these different functions. Table 5.5 breaks down the combined time the 109 practices spent on each task (in minutes) and the average amount of time (in minutes) for a practice with a list size of 10,000 patients.

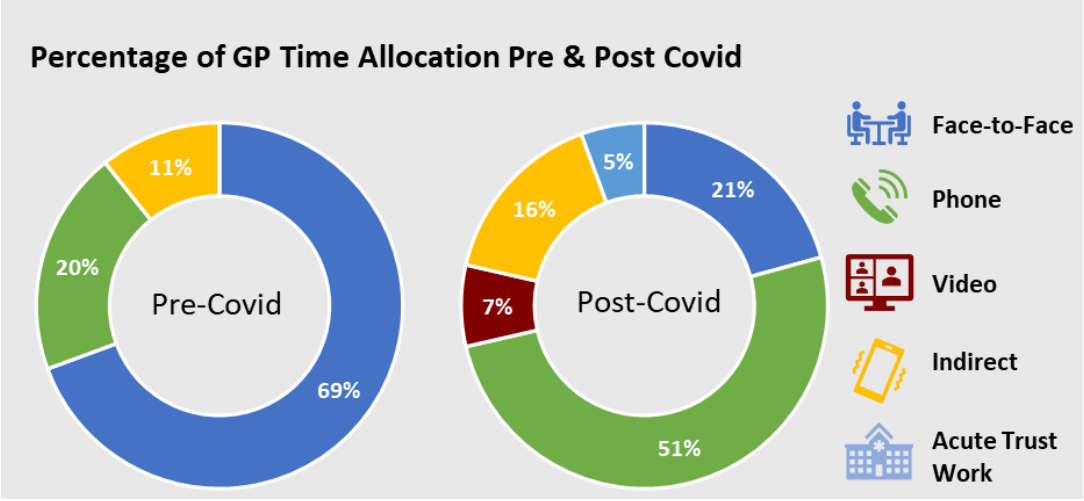
Table 5.5

Activity Type	Pre Covid (Sep 2019)		Post Covid (Sep 2020)	
	Total (minutes)	Minutes Per 10,000 Patients	Total (minutes)	Minutes per 10,000 Patients
Face-to-Face	529,604	4,107	246,533	1,912
Phone	151,744	1,177	602,347	4,671
Video	115	1	85,419	662
Indirect Care	81,766	634	187,903	1,457
Additional Acute Trust Work	-	-	66,613	517
Total	763,229	5,918	1,188,815	9,218
Increase in Total GP Hours Worked				**56%**
Additional GP Time per Week Required for a 10,000 List Size Practice				**55 Hours**

The data shows an average increase in the GP time required of 56%. This represents an additional 55 hours per week for a 10,000 list size practice.

Figure 5.5a below shows the breakdown of GP time allocation pre and post Covid, showing the shift away from face-to-face appointments towards, phone, video, indirect care and work from acute trusts.

Figure 5.5a



The challenge of trying to maintain services and meet demand is equivalent in both primary and secondary care; both face significantly reduced footfall to try and protect the public, both have to adhere to PPE routines for each contact. However primary care is faced with a significantly smaller capital estate, with smaller rooms, corridors, and access points to facilitate smooth patient flow through their buildings.

This will pose an impossible challenge under the proposals to roll out the Covid vaccination programme, and the need to keep patients for 15 minute observations, post-immunisation.

The total triage model, as it is described nationally under NHSEI's standard operating procedure for general practice, is actually a telephone consultation model with all consultations initially being via telephone (which take as long as face-to-face consultations) and which take place prior to a face-to-face consultation, *thus doubling the workload in relation to a single patient contact.*

Video – hailed as a potential saviour – had its shortcomings demonstrated early on. Ideal for acute, uncomplicated clinical episodes – its reach is limited when caring for the complex multi-morbid - many of whom lack the technical skill or smartphone know-how to engage with online consulting.

Figure 5.5b shows the scale of the additional GP workload required in September 2020 (compared to September 2019) when extrapolated up to CCG, ICS/STP and national level, identifying the number of full time GPs required to deliver the additional capacity needed.

The data shows that if the same increase in GP workload was seen across England, an additional 7,391 full time GPs would be required to sustain the additional levels of workload seen in September 2020.

This equates to:

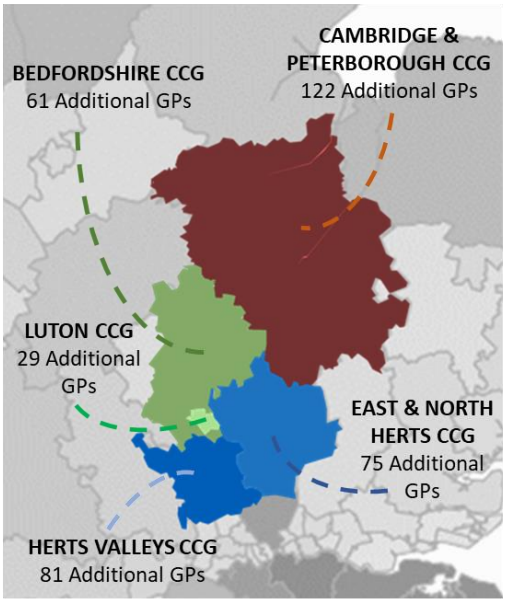
- **90 additional full time GPs in BLMK (1,042k pts)**
- **122 additional full time GPs in Cambridgeshire & Peterborough (998k pts)**
- **156 additional full time GPs in Hertfordshire & West Essex (1.6m pts)**

Figure 5.5b

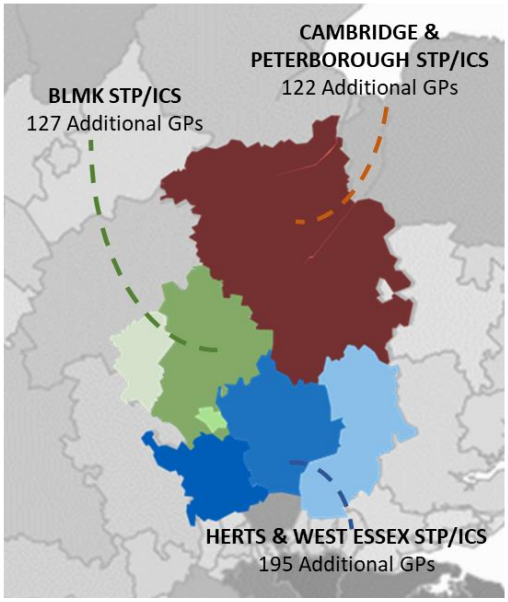
Total Additional GP Workload

These maps show the additional number of GPs required at CCG, STP/ICS and national level in order to sustain the increased workload seen in Sep 2020 compared to Sep 2019. The numbers are calculated by extrapolating the additional workload per 10,000 patients to the registered list size of the given geography. The number of GPs is based on the assumption that a full time GP will work 45 hours per week.

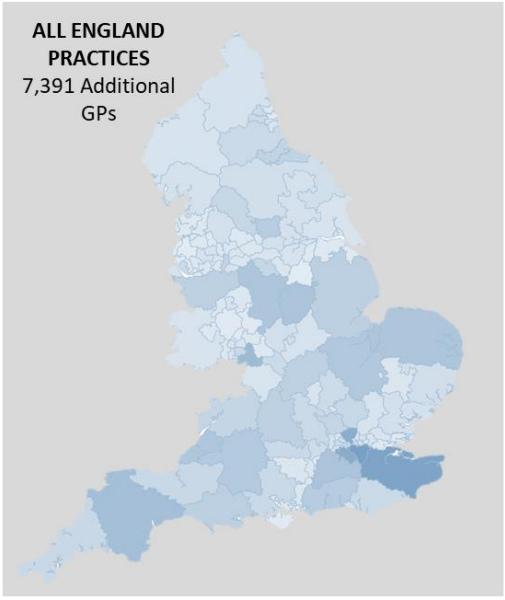
CCG Level



STP/ICS Level



National Level



5.6 Additional GP Workload Passed from Acute Trusts

5.6.1 Quantifying the Additional Work Burden

Of the 109 practices whose data was analysed, **95% said they had received requests from acute trusts.** Of these 102 practices, **88% said that they felt the workload being passed from acute trusts was increasing.**

As Table 5.5 and Figure 5.5(a) showed in the previous section, *GPs are spending around 5% of their time undertaking work passed to them from secondary care, that would have previously been undertaken by the acute trusts themselves.*

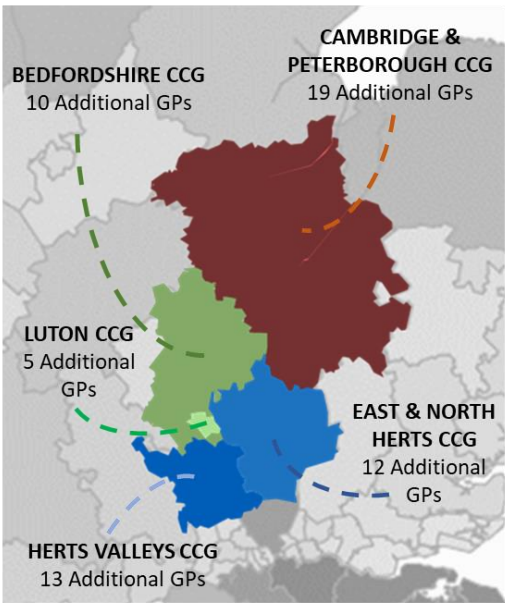
This represents a significant shift in workload, with a practice with a list size of 10,000 patients requiring an average of 8.6 hours of GP time to complete this work.

Figure 5.6.1

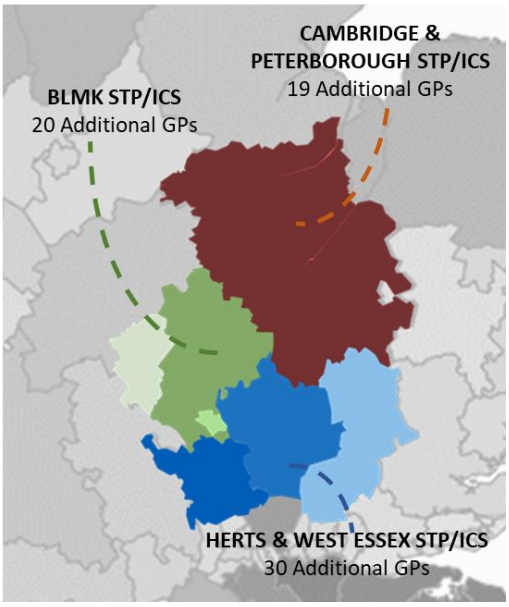
Additional Acute Trust Workload

These maps show the additional number of GPs required at CCG, STP/ICS and national level in order to sustain the increased workload seen resulting from work being passed from Acute Trusts.
The numbers are calculated by extrapolating the additional workload per 10,000 patients to the registered list size of the given geography.
The number of GPs is based on the assumption that a full time GP will work 45 hours per week.

CCG Level



STP/ICS Level



National Level

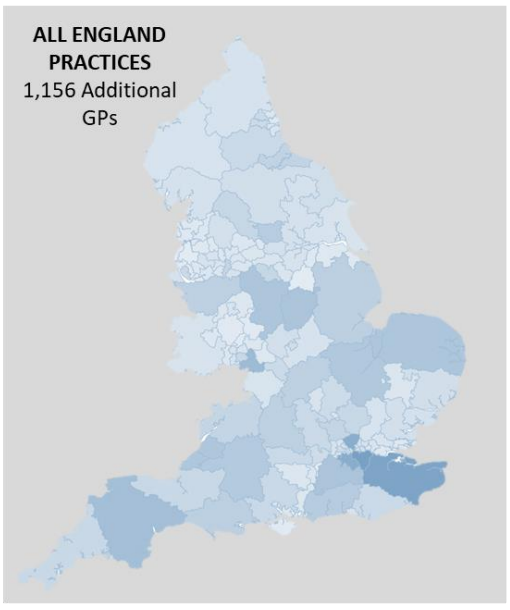


Figure 5.6.1 shows the scale of the GP workload required when extrapolated up to CCG, ICS/STP and national level, identifying the number of full time GPs required to deliver this level of secondary care work. The data shows that if the level of work from acute trusts was reflective of the picture nationally, an additional 1,156 full time GPs would be required across England.

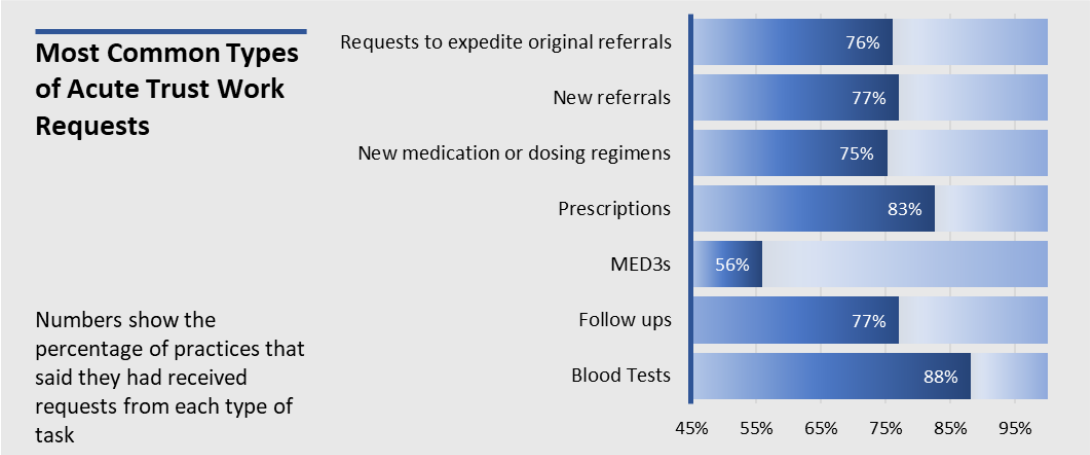
The absence of good communication and discussion prior to transfer of work taking place, is evident. This demonstrates a lack of collaboration and agreement; General Practice team colleagues and highly skilled General Practitioners, are left feeling they have become ‘community house officers’.

Several requests to facilitate radiology and re-referrals have been clearly demonstrated to be requests that are inaccessible to GPs - due to local restrictions within secondary care trusts, or a failure to restart the services. This makes the request impossible to achieve and leads to confrontation with patients that the GPs have to manage, despite it being no fault of their own.

5.6.2 Types of Secondary Care Requests

Practices were asked to identify the types of requests that they were receiving from their local acute trust. Figure 5.6.2(a) shows that blood tests and prescriptions were the most common form of requests.

Figure 5.6.2a



Over many years, primary and secondary care have collaborated successfully to ensure both safe and high-quality care is provided for their patients with examples such as:

- Shared care agreements
- CCG prescribing formularies
- Standard hospital contractual agreements which include the ability for consultants to make onward referrals without referring back to the patient's GP
- GMC guidance advising that the doctor requesting a test is responsible for acting on the results of a test, and should be able to interpret that result and communicate it to their patient
- Medical certificates being issued at the time of requirement, without asking a patient to attend their GP for that certificate

Sadly, it has become increasingly apparent that many of the advances made in the last few years have seen significant regression.

Phlebotomy, ECGs – these services are not universal. They are commissioned separately and locally by CCGs as a 'bolt-on' - but capacity to deliver these has been profoundly affected by infection prevention and control measures, and staff shortages due to Covid.

Radiology requests specifically put workload onto the GP, as only they are permitted to submit such requests. GPs may not be able to arrange the investigation requested, as they may not have access to the service due to local commissioning arrangements.

Follow-up requests assume a recognised call/recall system – which is not available in general practice.

Administrative requests on GPs to expedite patients; re-refer or simply 'contact your GP' means GP admin teams are spending a disproportionate amount of their working day managing secondary care 'fall-out', diverting resources from proactive patient anticipatory care.

Prescription requests new initiations of secondary care meds should not be passed to the GP who may be unfamiliar with the drug, and unable to prescribe on the CCG Formulary.

Figure 5.6.2(b) shows the areas where practices have seen the biggest increase in secondary care work. It is clear from Figure 5.6.2(b) below, that Advice & Guidance and requests to expedite original referrals constitute the largest volume of requests.

Expediting referrals is an exercise where the role of practices should be redundant, and we would be keen to urge Trusts to address this, and CCGs support this.

Covid-19 has transformed outpatient services, mandating the use of Advice & Guidance where possible. But combined with decreased elective procedures, this has led to a significant unresourced burden of patient activity being passed to primary care, that was previously undertaken by Acute Trusts, whose block contracts for this projected activity have not changed.

STP and ICS Boards need to decide how they will fund the staff undertaking this transfer of work, how they will protect practices by changing their processes, or a balance of the two.

Figure 5.6.2b

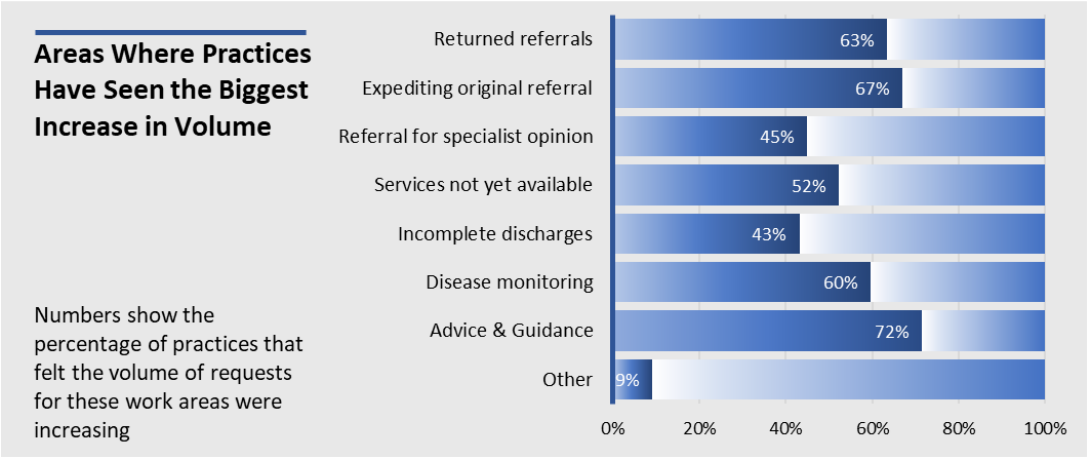
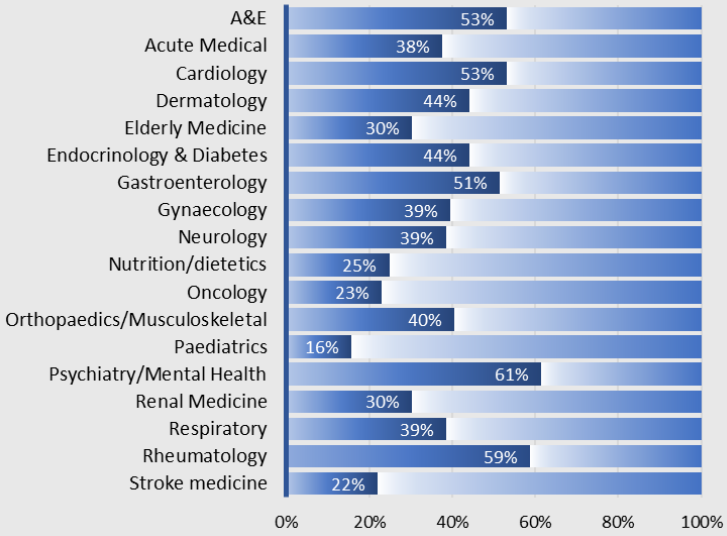


Figure 5.6.2(c) breaks down the increase in work passed from secondary care by speciality. While the data below is the combined output of all 109 practices, it should be noted that this was an area where there was significant regional variation across the five CCGs. However, A&E, Cardiology, Psychiatry/Mental Health and Rheumatology consistently scored highly across the region.

Figure 5.6.2c

Acute Trust Clinical Departments Most Commonly Identified as Making Requests of Practices

Numbers show the percentage of practices that said they had received requests from each clinical department



5.6.3 Assessing the Impact of Work Passed from Acute Trusts

It is clear that practices feel they do not have the capacity to continue working in this way. Continuing to exceed capacity is resulting in workload overload, burnout and fatigue within the General Practice workforce, and more broadly a lack of resource available within the community – challenging access for patients as GPs are diverted.

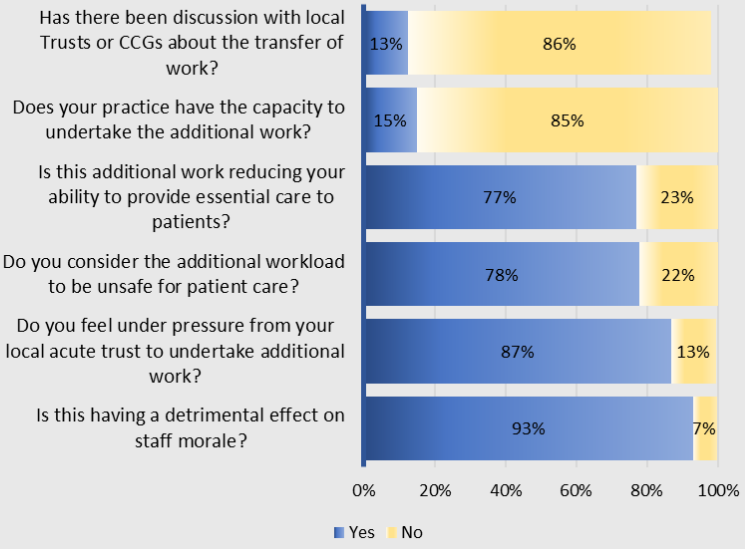
There is additional concern around a potential impact on quality and deterioration in patient satisfaction – whilst this is affecting morale and undermining system relationships now, this has the potential to disrupt patient flow, increasing unheralded patient ED attendances as they seek alternative routes to access.

Figure 5.6.3 shows the responses to six closed questions the practices were asked about the impact of work passed from secondary care on their practice.

Figure 5.6.3

Responses to Questions About the Impact of Work Passed From Acute Trusts

Numbers show the percentage of practices that answered yes or no to closed questions about work from acute trusts



78% of practices responding consider the additional workload to be unsafe for patient care. This should be seriously considered and reviewed by everyone within the local health system. Patient safety should be a system priority, resilience in General Practice was already at risk and has been for many years, and the survey demonstrates the vast majority of practices feel the additional workload is making provision of health care in the community unsafe.

87% of practices feel under pressure from their local trust to undertake additional work, and this can be seen as an indicator of the culture in relation to this transfer of work. The absence of communication and collaboration, and consideration for whether transfer of work is appropriate, resourced, or achievable within current capacity, is risking system partnership working.

This will have significant implications for a nascent ICS moving forwards. General Practice currently carries out an overwhelming majority of all patient contacts for less than 8.5% of the available NHS resource.

Finally, **93% of our responding practices state that the status quo of workload transfer is having a detrimental effect upon morale**. *This demonstrates the impact is not just on General Practitioners, but on the whole team within General Practice*. The drop in morale, sadly enhanced by recent media headlines, later compounded by NHS England, has led to a feeling amongst the General Practice workforce that they are unsupported, and unvalued. This is significantly impacting on resilience in General Practice whilst adding to the Covid19 fatigue. Recent negotiations around provisions for the Covid vaccination programme have only served to underline this point.

Put simply, the status quo is damaging the fundamental part of our NHS that keeps our systems viable. It has to change.

5 RECOMMENDATIONS

NHSEI has guided local systems into prioritising the protection of acute capacity and patient flow via:

- Expedited complex community discharges awaiting assessment for ongoing care;
- Redeployment of unheralded ED attendances via 111 to general practice; and
- Outpatient transformation into Advice and Guidance with ongoing management within primary care

These initiatives are not without merit – but all are taking place at the expense of primary care. To be truly collaborative as an ICS, there is a need to ensure that the impact of any new system and transfer of workload is considered at a system level, particularly with regards to ensuring resources are directed to where the work is undertaken.

Our concern, validated by our constituent practices' responses, is that a failure to address the capacity gap and workload transfer will necessitate practices being forced into taking action around agreeing a range of clear, quantitative limits to help primary care identify what safe practice looks like for them.

In practice, this could mean that we would propose a workload control strategy to enable general practice to improve quality and safety by setting reasonable safe workload limits; providing practices with practical tools and guidance across scenarios; proposing contractual innovations and supporting our constituent practices in reprioritising their activity around a defined set of criteria.

We rather hope for an opportunity for a system discussion to determine a stronger voice for general practice allowing wider effective planning in what is likely to be a winter unprecedented in its many challenges.

We advocate some quick wins:

- CCGs to review and pause all local contractual reporting targets during the second-wave of Autumn/Winter 2020.
- CCGs to support Trusts in ensuring any secondary care-generated phlebotomy requests; initiating prescriptions; medical certificates; radiology requests; and care plans are undertaken at source.
- CCGs to support Trusts in providing patients with a clear indication of estimated timescales they should expect for their care pathways; when and how to escalate clinical concerns within the waiting list as held by the Trust without the need to request a re-referral from primary care.
- Introduce an 'OPEL Alert' type system for use by practices and potential data tools at a system level to demonstrate activity across primary and secondary care to the wider system.
- Guarantee that GP teams are aware of imminent complex discharges under D2A; that patients are discharged with sufficient medications; that clear advance care plans have been discussed with the GP team with transferable documentation for the patient's health care record.

We advocate some areas of focus for STP/ICS action:

- The above recommendations relate to immediate concerns around current workload mid-Covid's second wave and clinical safety, but STPs and nascent ICSs need to acknowledge the level of demand; clinical risk and finite capacity in general practice:
- The STP/ICS needs to decide if it agrees with the principle of supporting proportionate resources accompanying patient activity and work transfer.
- The STP/ICS may wish to ensure a principle that the impact of any new transfer of workload is considered at a system level, particularly with regards to ensuring resources are then directed to where the work is undertaken.
- Compromises then need to be made and system priorities be identified e.g. agreeing the principle of transferring funds from acute providers into primary care budgets to fund the additional recruitment of staff for any additional workload that is set to continue. Given the changes to workforce may take time to establish, workload similarly needs to be addressed.
- Decisions will then be required around the expectation of parameters of work identified e.g. advice and guidance.
- Debate may be necessary to define the system priorities for the best use of primary care time and expertise.
    - Is it the expert generalist approach, managing the multimorbid patient in the community, supporting D2A processes and keeping them supported at home?
    - Is it taking on an agreed proportion of investigative and diagnostic administration previously arranged at a secondary care level requiring funding to support additional workforce to deliver this safely and sustainably?
    - How can the STP/ICS support general practice and empower its voice as a system?

Many of the comments within the survey demonstrate the emotion, frustration, and anger related to current circumstances; years of reduced investment into primary care against unmitigated demand. NHSEI has made clear that the allocations for 20/21 month 7-12 are for systems as a whole.

There is a clear case for an increase in primary care investment: to fund surge capacity and recruitment to manage the workload transfer - thus stabilising practices existing workforce, which will help keep patients out of hospital, and in time, reduce system stress.

6 CONCLUSIONS

The anticipated escalation in activity that we are already seeing, equates to a sustained clinical risk in which demand outstrips resource. A failure to address the capacity gap and workload transfer will necessitate practices being forced into taking action, and we will support them in doing so, including setting guidance around safe working and appropriate signposting of patients to the nearest available and appropriate resource, which may include community pharmacy, opticians, 111, urgent care centres, urgent treatment centres or, if clinically indicated, emergency departments.

For ICSs to succeed, it is important that the voice of primary care is heard equally to that of other providers, and there is a need to ensure that the impact of any pathway transformation is considered at a system level, particularly with regards to ensuring resources are directed to where the work is undertaken.

Many issues are within the gift of system partners to resolve, e.g.:

- Outpatients can ensure that blood forms, radiology requests, medication initiation and care plans are undertaken by the secondary care team
- Access to a community prescribing pad, or more ideally access to an electronic prescribing system that links into the national EPS system, would mean that outpatient clinical teams could complete any prescribing they wished to initiate and send an electronic prescription to a pharmacy as happens in practices.
- Medical certificates can be dealt with in a similar way.
- Patients should be provided with a clear indication of exactly what timescale they should expect; under what conditions they should recontact to escalate concern; and that process should be managed within secondary care

The comments within the survey demonstrate the emotion, frustration, and anger related to the current circumstances, when what we need at the current time is a closer relationship and a better understanding of the impact each of us has on the other – at an ICS level it would suggest we have not reached this shared understanding yet.

To mitigate against these scenarios, it is beholden upon those at the very highest level seeking to develop a true system approach, to consider the impact of what is currently happening - and try and put in place processes to make reparations to general practice, in order to secure system sustainability and patient flows of care going forwards.