BMA GP Practice Survival Toolkit Summary

This document summarises the 10 collective actions, what they mean and how you undertake them.

Full version is available here [GP campaigns (bma.org.uk)](https://www.bma.org.uk/our-campaigns/gp-campaigns#contracts).

We strongly advise you use the [patient facing communications from BMA](https://www.bma.org.uk/our-campaigns/gp-campaigns/patients/gps-are-on-your-side) on your social media, website and in waiting rooms to help direct and inform patients on why GPs felt they had to take collective action to protect practices and their patients. We have also created some **additional LMC summary communications** you may wish to use.



Those actions highlighted as “**strongly advised**” are those we feel as an LMC, and with feedback we have had from practices, will have the biggest impact on the system, while trying to minimize patient impact and additional workload for practices. As always, the LMC is here to advise and support, not mandate. The decision rests with you as GPs in your own practices and PCNs. We will support whatever action you wish to take.

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| **GP SURVIVAL TOOLKIT**  **ACTION** | **WHAT DOES THIS**  **MEAN** | **LMC ADVICE/COMMENT** | **LMC ACTIONS** |
| Action3.  **Stop doing work you are not funded to deliver.** | This is a link to the list of [services that the BMA defines as non-core](https://www.bma.org.uk/advice-and-support/gp-practices/gp-service-provision/enhanced-services-gp-practices-can-seek-funding-for) – **if you are delivering any of these without funding or an enhanced service contract in place, it is unfunded and voluntary.**  Serve notice on any voluntary services currently undertaken which plug local commissioning gaps.  Examples of this might be spirometry if no enhanced service is in place; monitoring of patients with eating disorders, monitoring MGUS.  **Enhanced services** are also voluntary and while funded, many are not financially viable so you could serve notice on these. | **Strongly advised for all practices.**  Historically practices have delivered additional services and absorbed the cost into their bottom line. This is not a viable business model and stops the system recognising the huge volume of additional work your practice does. It removes your staff from being able to deliver core services to the patients on your practice list. **We encourage you to identify this work and inform the ICB you will be stopping delivery of them**.  As no contract is in place, while practices could stop delivery immediately, we would **encourage you to provide 28 days’ notice so ICB can make alternative arrangements.**  **For Enhanced services you are signed up to, you would have to give the commissioner of that service (ICB/LCC/NHSE) the notice period stated in the enhanced service specification.** | **ICB have confirmed notice for non-commissioned work is sent to** [**licb.primarycarelincs@nhs.net**](mailto:licb.primarycarelincs@nhs.net)  **Letter to serve notice for non-commissioned work – Tick any you want to stop that you are not signed up to an enhanced service.**    **ICB have confirmed notice for enhanced services to be sent to** [agcsu.dcacontracts@nhs.net](mailto:agcsu.dcacontracts@nhs.net).  **Enhanced services calculator embedded for you to identify your financial losses.** |
| Action 3.  **Push back against all interface workload transfer** | As part of stopping unfunded work, stop delivery of interface related workload that is transferred from other providers. | **Strongly advised for all practices.**  We have provided a summary of the interface workload,but examples arerequests for GP chase hospital results and GP to make onwards referrals.  That document will help your practice respond to the most common workload transfers and what to do when you encounter one.  **Please use the LMC template letters in S1 which highlight the type of interface breech and sends a copy to the provider and the ICB.** [**(**screenshot of Ardens template letter location)](https://www.lincslmc.co.uk/secondary-to-primary-care-workload-shift-2/)  If after reviewing the interface priorities document you are unsure of the interface situation for a particular example, please contact the LMC for advice.  **We would advise you do action any urgent patient safety requests and then report the breech with the template letter.** | **The LMC has informed the ICB and Trusts** that they are likely to see an increase in the levels of rejection from general practice and they must have mechanisms in place to action the returned workload.  **Interface workload document to identify work you should not receive.**    **Serve notice interface workload letter**    **ICB have confirmed notice for interface work is sent to** [**licb.primarycarelincs@nhs.net**](mailto:licb.primarycarelincs@nhs.net) |
| Action4.  **Stop spending hours waiting on the phone when making acute referrals.** | Don’t risk- hold to protect the system over the patient.  If you have a patient who requires acute admission, attempt to contact the relevant specialty/acute medical unit/admission coordinator depending on local arrangements.  If they are not available within the patient’s appointment, provide an appropriate **referral letter** and **direct the patient to A&E.** | **Strongly advised for all practices.**  GPs spend valuable time waiting to speak to the specialist when trying to admit a patient acutely. While this should always be your first step and is in line with GMC guidance, being left waiting to be connected causes delays in delivery of care to your other patients, as well as the individual.  **BMA does not advise sending patients to A&E as a first step**, but doing so when you are unable to access the specialty and providing a referral letter to avoid A&E needing to see the patient is in the interests of both the patient being referred, and the other patients waiting for your help. | **The LMC has advised ICB & ED that this action may see an increase in ED attendance.**  **We have embedded the template ED letter for practices to send with the patient or by email to ED to highlight that you tried to admit by a non-ED route.** |
| Action 4.  **Stop using referral forms.** | **The use of referral forms and templates is not a contractual requirement.**  They are largely designed for the convenience of the receiving provider and can represent a significant workload in general practice. The BMA advises you **only use these where they are of benefit to the patient and yourself**. Refer your patient for specialist care when it is clinically appropriate to do so, via eRS.  We advise you **Continue using urgent cancer referral forms as normal.** | **Strongly advised for all practices.**  If you have referral forms you find helpful, continue to use these. For any others we suggest **you dictate/write your referral** letter using the headings of any existing form to **ensure appropriate clinical information** is provided.  Clearly a one-line referral letter will be returned. But a professional letter with the necessary information **should never be rejected.**  We would suggest you state the following in your referral letter:  **“NHS providers can only reject a referral on the grounds of insufficient clinical information. We are referring using a letter rather than referral forms so please accept this referral as outlined in the standard NHS hospital contract”**  The BMA has provided a focus on document on the use of referral tools, and[**a template response**](https://www.bma.org.uk/media/rhjfkmu2/focus-on-proformas-and-referral-forms.pdf)to send **if your referral is rejected. If** you send this template and still have the referral rejected, **please escalate to the LMC.** | The LMC has reminded local providers (acute trusts, mental health, community providers) and the ICB of this requirement **and that a clinically appropriate referral cannot be rejected.** |
| Action 10.  **Defer making any decisions to accept local or national NHSE Pilot.** | Pilots had large incentives to enroll but BMA and LMCs have **significant concerns** around the speed of the introduction, governance and impact on both pilot and non-pilot practices due to the s96 agreement. | **Strongly advised for all practices**.  As we highlighted in our mailings to practices, we advise again signing up to this pilot, while noting practices would welcome the funding.  **Practices should inform their PCN Clinical Director or the ICB of their decision to withdraw.** | The LMC has signed a **joint letter with the other pilot region LMCs** to NHSE citing concerns and seeking clarity.    **BMA S96 concerns**    **VWV s96 agreement analysis** |
| Action 2.  **Stop engaging with Advice & Guidance.** | Where advice and guidance works well for you and your patient, use this. Where it doesn’t, or there is an excessive wait over the recommended 48hr response, you do not have to use it.  **Instead of sending an A&G, simply send the usual referral letter to the relevant specialty.** | **Strongly advised for all practices**.  **The BMA has provided a focus on document on the use of referral tools, and** [**a template response**](https://www.bma.org.uk/media/rhjfkmu2/focus-on-proformas-and-referral-forms.pdf) **to send if your referral is rejected.**  If you send this template and still have the referral rejected, **please escalate this to the LMC.** | The LMC has reminded all providers and the ICB that if a specialty operates an “A&G first” model as the only route to referral, this breaches the [NHSE standard contract](https://www.england.nhs.uk/nhs-standard-contract/) and there **must be a mechanism for referral without using A&G and that a referral cannot be rejected.** |
| Action 3.  **Give notice on Shared Care agreements (SCFs) that impact on your ability to deliver patient care.**  **Decline to sign any new SCFs.** | Shared Care agreements are a mechanism for specialist medication to be prescribed in general practice, with support and supervision from a consultant in another provider. The funding received for this is to cover the additional workload this represents in general practice.  **Many shared agreements do not work well due to the monitoring burden, drug shortages or barriers liaising with specialists so give notice on those.** | **Strongly advised for all practices**.  Please see further detail in our [**Enhanced Services Calculator**](file:///C:\Users\nicktu\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\1ME9SJ7S\Practice-Enhanced%20Services-Summary%20Viability%20Calculator-V2.0.xlsx)**.** If you have SCFs in place that are helpful for patient care and you find it easy to access support as needed, keep these in place.  Ensure all SCAs are up to date, have been reviewed by secondary care. **Give notice on those that aren’t as this places the prescriber at unnecessary risk.**  Review those agreements requiring additional investigations e.g. phlebotomy or injections and use the **Enhanced Services Calculator** to ensure it is financially viable to deliver these.  Give **notice to hand back SCFs in line with any defined notice period** for those that are not viable. | The LMC have discussed this with the ICB who were concerned about patient safety. We have advised that having specialist drugs monitored by specialists is a safe approach and have advised that this is raised with providers to ensure they are ready to maintain monitoring.  **Enhanced service calculator**    **ICB have confirmed notice for enhanced services to be sent to** [agcsu.dcacontracts@nhs.net](mailto:agcsu.dcacontracts@nhs.net). |
| Action 1.  **Limit daily patient contacts per clinician to the** [**UEMO recommended**](https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/safe-working-in-general-practice)[**safe maximum of**](https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/safe-working-in-general-practice)[**25.**](https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/safe-working-in-general-practice)  **Divert patients to local urgent care settings once daily maximum capacity has been reached.** | Focus on delivering high-quality services for your patients.  Make your standard appointment length 15 minutes.  Deliver gold-standard care to every patient.  Once you have reached 25 patient contacts in a day, use NHS 111, your local walk-in centre, or other available urgent care settings. | This is the single most important thing you can do from this list.  The biggest risk to your patients is losing their GPs to burnout, because the current pressure is unsustainable. The biggest risk to you is making a mistake because of a failing system and ending up in front of the GMC. Some practices are already working like this.  Use the BMA [patient facing comms](https://www.bma.org.uk/our-campaigns/gp-campaigns/patients/gps-are-on-your-side) to support this change.  **The LMC is strongly supportive of this approach but** recognises it marks a major shift for those practices who do not currently work in this way and will require staff time to implement. It is for this reason alone it is not strongly recommended.  **If you do choose this action,** we would advise you **discuss with your practice staff and perhaps PPG using the national** [**BMA materials**](https://www.bma.org.uk/our-campaigns/gp-campaigns/patients/gps-are-on-your-side)and consider **any patient cohorts** you may consider fall outside of the maximum 25 contacts action e.g. Palliative care.  Providing **safe and high-quality** care is more important for your patients than volume. The quality of the care you give them is what they and others will judge you on. High volume not only increases patient safety risks, but also is more likely to burn out your colleagues.  **Appropriately signpost patients to alternative services once safe capacity is reached.** | The LMC has advised the ICB/ED/UTC/111 and Community Pharmacy of the potential impacts on activity in those services.  We have advised the ICB that the DOS should be updated for practices who chose this action so once the practice has reached their capacity, their DOS will be updated so 111 cannot divert back to the practice.  The LMC has created the **summary document** you may wish to share with your patients, or for your reception team to give to patients if they ask questions or have complaints about why you are taking action. |
| Action 8.  **Switch off Scriptswitch / Medicines Optimisation Software embedded by the local ICB.** | As the data controller, you are able to choose which software solutions are linked into your patient record.  Prescribe appropriately for the clinical presentation, and act in your patients’ best interests when making prescribing decisions. | Medicines optimisations software exists for the purpose of making system financial savings, rather than for the clinical benefit of your patients. Some practices have the use of medicines optimization software linked to a local enhanced Service **(prescribing incentive scheme**). If this is the case, you can only switch this off if you give appropriate notice to the ICB. Prescribing should always be in the best interests of your patient in line with [GMC](https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices) [guidance](https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices). | The LMC has advised the ICB medicines optimisation Team that this action may see changes in prescribing.  **GPCE How to videos pending.** |
| Action 5, 6 & 7.  **Stop putting yourself at risk as the data controller. Withdraw permission for data sharing agreements which exclusively use data for secondary purposes i.e. not direct care.** | GP partners (and any other contract holders) are the data controllers. **They are personally responsible for any data sharing agreements in place.**  Practices are often asked to sign numerous data sharing agreements without fully having chance to review and understand them. The liability for this does not exist for any other individual clinician in the NHS and represents an unfair risk to GP partners. | Switch off GPConnect functionality that permits the entry of coding into the GP clinical record by third-party providers. **An estimated 80% of practices have already done this.**  Freeze sign up to any new data sharing agreements or local system data sharing platforms. One local practice has over 40 separate data sharing agreements currently in place. We advise you to identify and review those you currently have, review the [BMA guidance](https://www.bma.org.uk/media/q0gbxoag/focus-on-data-sharing-v2.pdf) and carefully consider whether you feel you are able to provide informed consent to continuing these as the data controller. The majority of these are for system benefit but the risk remains with you. | The LMC has advised the ICB of these actions and that any new data sharing agreements may not be signed.  We have asked for ICB contact details for practices to advise of any agreement withdrawals.  The LMC has liaised with the ICB digital team and Community Pharmacy around GP connect.  **GPCE template letters pending** |
| Action 9.  **PCN Capacity & Access payments**  **Defer sign up to “better digital telephony” and “simpler online requests” elements of the Capacity and Access payment until further GPC England guidance is issued in early 2025.**  **Do not agree yet to share your call volume data metrics with NHS England.**  **Do not agree yet to keep your online triage tools on throughout core practice opening hours, even when you have reached your maximum safe capacity.** | “Better digital telephony” - Practices who have not declared or received monies need not agree to share call volume metrics before October 2024, beyond which NHS England has signalled its intention to issue a contract variation notice to make the sharing of the eight call data metrics they have identified contractual within GMS / PMS.  “Simpler Online”  Requests” - Practices who have not declared or agreed to share data as part of the “online consultation systems in general practice” publication, nor received monies, may continue to switch off their online triage tool during core hours, when they have reached their maximum capacity. | More detailed guidance is available [here](https://www.bma.org.uk/media/a0pnqcmb/focus-on-spending-the-pcn-des-capacity-and-access-payment-funding-v2.pdf). **This is an action a PCN can take collectively, or an individual practice can opt to take.**  While you will eventually need to provide assurances to your PCN CD that your practice has undertaken these actions in order to receive 30% of the PCN Capacity & Access funding payment, do not do this earlier than you need to. It opens your practice to additional scrutiny and further unrestricted workload.  **Discuss these with your PCN CD** so you and they know how your PCN is approaching this action. | The LMC has written to PCN CDs to ensure they are aware that this may be an action undertaken by practices and have informed the ICB. |

With thanks to BMA and Humberside LMC