How to improve the safety of your service and wellbeing of your workforce

General practice in the UK is almost unique in the depth and breadth of the services we provide. Practices see patients with undifferentiated illness, make diagnoses, initiate management, provide care and support for long-term conditions, manage complexity and frailty, and carry out prevention.

In our March 2018 document Workload Control in General Practice we advised that general practice clinicians should carry out no more than 25 patient contacts per day. With the advent of remote consultations and "Total Triage" we are now delivering way more contacts than this daily.

General practices currently deliver 44% of appointments on the day they were booked, and 74% are within a week. Whilst the workload and pressures remain high, GP numbers continue to fall as shown by the latest GP workforce data, leading to a threat to patient safety. Such a significant mismatch between demand and workforce means that waiting times for non-urgent appointments will have to grow to enable safe management of urgent problems, and avoid unsafe demands on GPs. Inevitably this will mean that practices need to operate a waiting list for appointments.

We would therefore encourage practices to control their workload to mitigate the impact of unsustainable demand and overworking, and to ensure safe patient care, and better staff wellbeing. Our Safe working in general practice document enables practices to prioritise safe patient care within the present bounds of the GMS contract. We will also produce further guidance on safe working.

Why is it safer to limit the number of contacts each clinician provides?

Decision fatigue is a well-documented phenomenon. The more decisions we make, the poorer these decisions become. Carrying out excess clinical activity is not safe for patients and the quality of decisions reduce as we undertake more contacts. Carrying out excess clinical activity is not safe for us, as we burn out and suffer moral distress.

Between 2015 and July 2022, we lost over 1,800 fully qualified full-time GPs and for every GP lost from the workforce, 2,000 patients lose access to their GP. This increases the pressure on the clinicians and teams who remain and reduces the capacity of general practice to provide safe care even further.

Not limiting contacts creates an unsafe environment for both patients and clinicians.

If we limit the number of contacts each clinician has per sessions, these contacts have higher quality. These contacts could be longer, and thus provide more opportunity for holistic care for those patients seen. Patients could be booked in advance to see the clinician most suited to deal with their problem, and who can provide continuity of care, which has been shown to improve safety and outcomes. In addition, having longer appointments could save both time and money, allowing patients the time to discuss several issues and reducing the need for multiple appointments.

If we limit contacts what happens to those people who we are currently dealing with?

Although in the short term, general practice waiting lists might grow, the care provided would be better quality and reduce the need for repeat visits, clinicians' wellbeing would be protected, ensuring we retain more of the workforce.

General practice is not an emergency service. Patients should be redirected to 111, UTC, or secondary care ED as appropriate, and this will need to be the case when safe capacity is reached in the practice. Provision still needs to remain in place to advise and direct those patients with emergency problems.

Does the GMS contract allow practices to direct patients to other services?

The GMS contract allow practices to deliver services "in the manner determined by the contractor's practice in discussion with the patient", but what services do practices have to deliver? The GMS contract defines essential services as:

services *required for the* ***management*** *of a contractor's registered patients and temporary residents who are, or believe themselves to be—*

a) ill, with conditions from which recovery is generally expected;
b) terminally ill; or
c) suffering from chronic disease

"Management" is defined as including:

a) offering consultation and, where appropriate, physical examination for the purposes of identifying the need, if any, for treatment or further investigation; and
b) making available such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services under the Act and liaison with other health care professionals involved in the patient's treatment and care.

The services practices must deliver are (paragraph 6A):

the provision of appropriate ongoing ***treatment*** *and care to all of the contractor's registered patients and temporary residents taking into account their specific needs including—*

a) advice in connection with the patient's health and relevant health promotion advice; and
b) the referral of a patient for services under the Act

The GMS contract in respect of emergencies states:

A contractor must provide primary medical services required in core hours for the immediately necessary ***treatment*** *of any person to whom the contractor has been requested to provide treatment owing to an accident or emergency at any place in the contractor's practice area.*

Primary medical services are defined above as advice or referral, thus if an **emergency** occurs in the practice area, the contract requires that you provide **advice or referral.** The practice can thus advise the person to call 111 or 999 or make a referral to another service which is more suited to managing the emergency.

If a person presents with a non-emergency condition the practice has to "offer consultation" but the timeframe for this is not specified. If the person deems their condition to be an emergency, the above paragraph applies.

Considerations for practices when instigating limits for clinician contacts

How many contacts should clinicians do?

> The BMA recommends no more than 25 contacts per day depending on complexity. Practices can define how many of each type of consultation are safe. Practices should ensure that consultations are long enough for clinicians to make management decisions jointly with patients, as this improves compliance and safety.
>
> Administrative tasks also involve clinical decision making, so time should be protected in the clinicians' day for this activity.
>
> Over time practices should analyse their working days and identify whether more or fewer contacts should be carried out.

If we advise more people to contact 111, UTC, or ED will these services have capacity to cope?

> The responsibility for commissioning urgent and emergency care services is held by ICSs, it would be sensible for you to inform your ICS of your decision to move to this new safer system. It would also be sensible to co-ordinate this change with other practices in your neighbourhood (PCN) and to liaise with your LMC.
>
> You may choose to increase the number of 111-bookable slots, so that patients who 111 triage can be booked in with a clinician in your practice for continuity purposes.

How long in advance should patients be able to book appointments?

> To enable safe working, patients will need to be able to book contacts with clinicians further in advance. We recommend that appointment rotas should be open at least six weeks in advance. This will allow the practice to ensure patients see the clinician most suitable to deal with their problems, and to increase continuity.
>
> It may be necessary for practices to have waiting lists or have rotas open for longer than this.

When should practices make the change to limiting contacts?

> Practices can move to this model of delivery whenever they choose. If practices believe their current model is not safe for patients and clinicians, they should make the change as soon as possible. We are advising all practices to move to this model immediately if they believe that they are currently operating beyond safe capacity.
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> Practices should engage with their Patient Participation Groups (PPGs) to explain the rationale for the change. A template letter is available for this purpose.