Managing workload and taking time to reflect on wellbeing for GP practices

As we continue to face overwhelming pressures in general practice, we encourage practices to focus on their own team's wellbeing, the *BMA and GPC England is encouraging all GP practices to take some time* to meet to reflect on their wellbeing and what they can do to protect it. Practices might also want to consider embedding this time of reflection as a monthly practice event to support wellbeing in the future.

The Quality and Outcomes Framework (QOF) quality improvement (QI) modules for 23/24 are Workforce Wellbeing and Access. This meeting to reflect on workforce wellbeing would meet the criteria for the former.

We suggest that practices use this time to identify how each practice can support the health and wellbeing of their practice team. As part of this time to reflect we also suggest that you think about how you manage your workload. This could include looking at your access and how to incorporate our Workload and Safe working guidance into your practice, and how to use Operational Pressures Escalation Level (OPEL) scoring to determine a locally agreed escalation plan. Read our guidance on GP access targets

We have provided a few discussion points below to consider.

Health and wellbeing of GP practice team

Identify how you can support the health and wellbeing of your practice team. You can use our poster with the 10 top tips to help maintain support and wellbeing of your colleagues and yourself as a guidance:

1. Check in with each other – let someone know if you are struggling and look out for signs that colleagues might be in need of help
2. Senior staff – stay visible and available and demonstrate that it's ok to not be ok
3. Rotate staff between high and low stress activities
4. Pair up less experienced staff with more experienced colleagues
5. Arrange small support groups and safe spaces for staff to speak openly
6. Facilitate access to food and drink and encourage taking a break
7. Encourage colleagues to connect with support
8. Call on tried and tested healthy coping strategies
9. Be kind to yourself and your colleagues
10. Ensure colleagues are aware of where they can access support

A range of wellbeing and support services are available to doctors and GP practices - from the BMA's 24/7 confidential **counselling and peer support services** to networking groups and wellbeing hubs with peers, as well as the **NHS practitioner health service** and non-medical support services such as **Samaritans**.

NHS Practitioner Health has now also published a customised mental wellbeing app which can be used to monitor and track your wellbeing and identify areas where you might need some additional support. The app is available to any member of the Primary Care team who can register for the app here

Please visit the BMA's dedicated **wellbeing support services page** and for further information see our **extended directory**.

Workload and safe working in General Practice

There are some things practices can do to control workload and try to mitigate the worst impact of unsustainable demand and overworking. Our *Workload Control in General Practice* and *Safe working in general practice* provide guidance on workload control and advice to enable practices to prioritise safe patient care within the present bounds of their contract with the NHS, such as:

Appointments
To ensure that clinicians are providing safe care and advice, we recommend that they limit the number of direct patient contacts (face-to-face, by telephone, or remotely) to 25 to 35 per day. This will enable clinicians to provide longer and more holistic contacts for their patients whilst also preserving the clinician's wellbeing. This will require some patients waiting longer for a clinical contact but will improve the quality of care provided when this contact happens. For occasions where the patient perceives their need to be urgent alternative sources of support should be utilised.

OPEL and escalation plans
The GP contract from 1 April 2023 includes a clause which stipulates that practices should assess the clinical need of all patients who contact the practice and offer an appointment or signpost them to another service. Many practices do not have the workforce capacity to achieve this. We recommend that practices measure their capacity and demand so this can be reported as an Operational Pressures Escalation Level (OPEL) and agree locally what the escalation plan is in response to this. Read our guidance on GP access targets

Patient Participation Groups (PPGs)
PPGs are a crucial ally and resource for practices. We encourage practices to engage their PPGs, and to discuss openly the challenges being faced by all practices, and specific pressures locally. PPGs can support practices with messaging and patient education regarding any changes made to protect wellbeing and patient safety.

Measuring workload
It is vital that practices take account for all patient contacts within your appointment books so that all workload carried out is measured. Work undertaken on repeat prescriptions and documents can be counted separately when assessing workload, but it is not currently collected by NHS England. All clinical encounters should be recorded in the appointment book, and administrative clinical encounters should too.

External un-resourced workload
Practices have no contractual obligation to undertake un-resourced, noncontractual work coming from other agencies and from secondary care and should pass requests back to the provider they came from. The BMA has produced a pack of template letters for this purpose.

Practice list closure
Practices may consider closing their list if they are not able to provide safe care only to their present number of patients, given their existing workforce. Practices should initially consult with their PPG and subsequently with their Integrated Care System (ICS).

Workload prioritisation
Providing patient care outside of the core GMS contract, such as DESs, LCS, QOF and IIF arrangements, is voluntary for practices, and attracts payment separate to core GMS. Practices may consider prioritising those areas of non-core work that provide safest and most effective patient care, and deprioritise those that either do not provide direct patient care or are underfunded to provide that care efficiently for the practice (within restraints of the relevant contract documents).

PCN DES
Practices will need to consider if the PCN DES enables them to offer safe and effective patient care within the context of their wider practice, and their present workforce. There is a process by which practices may express that they no longer choose to continue within the DES between 1 April and 30 April 2023 to their ICS, or at any point at which there is a change to the PCN DES by NHS England.

It would be the case that on leaving the DES, the payments associated with it would cease to practices, ARRS staff would no longer be able to provide services to patients on the list of the relevant practice, and the PCN itself may be at risk. If practices remain within the DES, they are contractually obliged to provide the requirements as set out, though the IIF is paid on activity.

GP workload management and triage tool

As there is currently no standardised triage system for GP practices, to help with the increasing workload, we have developed a workload demand management tool, which aims to provide a cost neutral aid to reduce the administrative burden on staff, to ensure patients are seen by the right clinician at the right time and allow GPs to spend their time where it is needed the most. The toolkit includes also includes some case studies.

Summary

We encourage practices to consider these suggestions for controlling their workload to ensure safe patient care and better staff wellbeing which could make a significant difference in the coming weeks and months.

Guidance what GPs can say 'no' to contractually

The GMS contract requires the practice to deliver 'essential services' as defined in the Regulations, which are:

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,*

which are delivered in the manner determined by the contractor's practice in discussion with the patient.

Beyond these essential services are many examples of inappropriate work that practices are often 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. The following are examples, but this is by no means a definitive list:

- 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 (e.g. physiotherapy referral requested by a rheumatologist) – creating unnecessary bureaucracy
- Hospitals referring patients 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 (e.g. 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