
# A Study of Workload transfer to NHS General Practice from other providers

By

Kent Local Medical Committee
(Dr John Allingham FRCGP and Mr Carlo Caruso)

27th August 2020

# Contents

# Summary of Recommendations

- Patient safety must be paramount. All episodes where there is potential for patient harm should be treated as significant events and thoroughly investigated, and system and individual learning demonstrated

- Resources must follow the workload. Commissioners and Providers should have appropriate mechanisms to ensure this happens.

- Complete pathways of care must be commissioned and provided. Service design should follow the core principles of the NHS Standard Contract[2] and Kent LMC Standards[11].

# Introduction

In 2015 concern was raised by the Primary Care Foundation in 'Making Time in General Practice'[1] about how much time is taken performing tasks like chasing discharge letters and changes in medication.

A survey of 250 Practice Managers reported that 27% of GP appointments were avoidable and that 4.5% of demand was created by hospitals. The 56 General Practitioners audited noted that 2% was related to hospital staff specifically instructing patients to contact their practice for a prescription or intervention that was part of their hospital care.

Some of the recommendations of the report have been enacted. For example, in most cases Electronic Discharge Notes are available within 24hours of discharge. This is mandated in section 11.5 of the 2016 NHS Standard Contract[2].

The NHS Standard Contract[2] also mandates in section 8.4 that the onward referrals relating directly to the condition for which a patient was referred should be managed by the secondary care specialist and not passed back to the General Practitioner.

The legal responsibility for prescribing lies with the doctor or health professional who signs the prescription and it is their responsibility to prescribe within their level of competence[3]. Although commissioned pathways exist for appropriate shared care, General Practitioners are often placed in a difficult situation with a patient needing medication they do not consider themselves to be competent to prescribe.

The responsibility for issuing a Med 3 (Statement of Fitness for Work or Fit Note) lies with the Doctor clinically responsible for the patient. The Med 3 was revised in April 2010 and there has been guidance issued to hospital doctors[4]. Despite this some hospital doctors remain unaware that they can issue Med 3s and that it lies within their clinical responsibility.

The British Medical Association has attempted to help General Practitioners deal with the workload shift including referrals, prescriptions and Form Med 3s[5][6] and has produced template letters to accompany work returned to hospital doctors and others.

Local Medical Committees represent General Practitioners and have negotiated with Commissioners and Providers to try and ensure the guidance is followed. However, challenges remain with non-contracted and non-resourced work being passed to General Practice.

Essex Local Medical Committee[7] surveyed their practices during 2020 and 96% felt the volume of workload shift was increasing and 82% felt it was affecting their ability to provide basic primary care to patients.

Kent Local Medical Committee have sought to quantify the workload shift. No published evidence demonstrating the quantity of workload transfer has been identified.

Covid-19 induced changes in working practice appear to have accelerated the workload shift and the guidance and contractual requirements are often ignored when devising new ways of working.

# Method

The 204 Practices that serve a population of registered patients (July 2020) of 1.9 million people living in Kent were asked to complete an on-line survey recording each individual episode of workload transfer under broad title descriptions. The survey was divided by provider and further sub-divided into departments.

The survey was carried out over 10 working days during July 2020.

Practices responded to the survey in different ways. Some used administrative staff to review all incoming communication and to record the workload transfer episodes. Others used individual GPs opportunistically recording episodes. Others were unable to participate due to staff or workload pressures.

One of the authors conducted an additional detailed analysis of the responses from a single practice by reviewing the written communications identified by administrative staff.

# Results

Responses were received from 112 of 204 practices representing a registered population (July 2020) of 1.2 million people.

There were a total of 1037 episodes of transfers of workload identified in the survey.

2 Practices (Table1) who use specially trained administrative teams to process communications attempted to record every episode of transfer of workload that occurred during the study period. It is accepted that it is impossible to capture every single episode but for these practices it is believed to be as close as possible. It should be noted that these 2 Practices did not have the highest response rate per capita.

### Table1 – Episodes of Transfer of Workload

| Practice | Episodes of Transfer of Workload |
|---|---|
| Practice A | 65 |
| Practice B | 58 |
| Total | 123 |

The combined registered patient population (July 2020) of these practices is 35,493. If this sample is a true reflection of the frequency with which work is transferred it equates to 5 million episodes of workload transfer across England (Population 55.3 Million) and 171,000 across Kent every year.

We estimate that each transfer of work takes an average of approximately 10 minutes of GP time and 20 minutes of administrative time to resolve. The cost each year to English General Practice is £130m across England and £700K across Kent in GP time [(10)] alone.

If considered in working time it would require 16.5 full time GPs to manage this workload in Kent. England wide removing this work would free up 480 whole time equivalent GPs. As the average full time GP offers approximately 135 appointments per week this could free up time for 3 million additional patient slots.

GP administrative staff earn an average of £12 per hour. The total cost is shown in Table 2.

### Table 2 – Total cost

| | England | Kent |
|---|---|---|
| GP Cost | £130m | £4.5m |
| Administrative Costs | £60m | £2.1m |
| Total Costs | £190m | £6.6m |

Table 3 demonstrates the range of workload transfer. The high number in the other category demonstrates the vast range of workload transfer that occurs.

## Table 3 – Range of workload transfer

| Type of workload | Total Number of episodes of workload transfer |
|---|---|
| Follow up | 258 |
| Referrals | 243 |
| Prescriptions | 123 |
| Med 3s | 18 |
| Other | 395 |

A significant amount of work using BMA template letters[5] and Kent LMCs own versions of these letters has been carried out to try and reduce workload transfer since the National Contract[2] was launched in 2016. Special effort has been made to try and remind clinicians that the responsibility for certifying fitness to work (Form Med3) lies with whoever is responsible for the condition that affects the ability to work. Despite these efforts there were still 18 requests for GPs to issue Med3s on behalf of other colleagues.

The survey attempted to record the source of workload transfer by provider (Table 4).

## Table 4 – Source of workload transfer by provider

| Number of episodes by Provider | Frequency |
|---|---|
| **Acute Trust A** | 53 |
| **Acute Trust B** | 357 |
| **Community Provider A** | 36 |
| **Community Provider B** | 10 |
| **Acute Trust C** | 93 |
| **Mental Health** | 51 |
| **Acute Trust D** | 174 |
| **Community Provider C** | 7 |
| **Other** | 203 |

The differences in response reflects the different working practices and areas of clinical activity of the providers. More than half of all episodes (577) came from the 4 Acute Hospital Trusts in Kent and differences between them are partially explained by their size range.

The large number of others (203) represents the number of responses where the GP or staff member was able to identify the service but not the provider. This also included a collection of ‘Any Qualified Providers’ who provide stand-alone services and of tertiary providers.

This survey considered the range of specialities generating workload transfer (Table 5) within the Acute Trusts.

## Table 5 - Episodes of Transfer of Workload by Department

| Departments (Acute) | Frequency |
|---|---|
| A&E | 85 |
| Anaesthetics | 3 |
| Breast screening | 0 |
| Cardiology | 45 |
| Critical care | 1 |
| Diagnostic imaging | 20 |
| Ear Nose and Throat | 13 |
| Elderly Medicine | 19 |
| Endocrinology | 29 |
| General surgery | 49 |
| Haematology | 12 |
| Maternity | 7 |
| Microbiology | 1 |
| Neonatal | 1 |
| Nephrology | 3 |
| Neurology | 35 |
| Nutrition and dietetics | 1 |
| Obstetrics and gynaecology | 29 |
| Occupational therapy | 0 |
| Oncology | 12 |

The larger numbers directly reflect the throughput of departments. The exception is neurology which is a relatively small speciality compared with the number (35) of episodes of transfer of workload it generated.

Each episode of transfer of workload potentially represents additional steps in the care pathway for the patient with potential harm. An analysis of the submissions to the survey was conducted (Table 6)

## Table 6 – Analysis of submissions to the survey

| | |
|---|---|
| Cases where there was a potential patient safety issue | 7 (12.7%) |
| Cases where GPs were asked to accept responsibility for initiating a new medication that should have been started by the secondary care clinician | 9 |
| Cases where GPs were asked to order tests, investigations, conduct examinations or follow up results on behalf of secondary care | 26 |
| Cases where GPs were asked to refer to another service in response to a decision made by secondary care | 15 |
| Cases where transfers of care were outside the National Contract Guidance but there was a good patient specific reason why the transfer could be considered reasonable | 5 |

A total of 55 letters and discharge summaries were reviewed. Note some patients had multiple requests and appear in more than 1 category.

Patient Safety issues were considered where the addition of a step in the pathway by the GP being used as a proxy for the decision made in secondary care could have led to a delay or missed referral.

Examples included:

- Deteriorating Renal Function and needing specialist care
- Co-incidental finding of a significant cardiac issue that needed investigation and cardiology care
- Chest Pain not referred on to cardiology
- Consultant to consultant letter with instructions to monitor a significant condition where review was not planned for 6 months

**If the 12.7% potential patient safety issues identified in this small sample is representative there will be 635,000 potential incidents in England and 22,000 in Kent.**

# Discussion and Recommendations

The NHS delivers a vast amount of care on a daily basis and most of this is completed successfully without inappropriate work load transfer but this survey does demonstrate that the NHS Standard Contract 2016[2] and the campaign to reduce workload transfer into primary care are failing to impact on the overall quantity of demand.

The strain on General Practice in terms of workload and cost is substantial. The shift to remote working is reportedly increasing the workload transfers.

**Evidence from this survey demonstrates that the NHS Standard Contract[2] is being widely ignored**.

Commissioners include penalties in contracts to ensure providers discharge their contractual responsibilities. This is not happening in the elements of contracts identified in this report. Penalties could be introduced by establishing a mechanism for primary care to invoice commissioners on an item of service basis and for the monies to be reclaimed from the secondary care and other providers. This would have significant transactional costs and be expensive to implement.

An alternative would be to incentivise compliance with the NHS Standard Contract. Financial resources could be withheld from a provider's overall budgets and released on demonstration of compliance with the National Contract[2]. Practices could record inappropriate transfers of workload with codes in their computer systems. This data could be extracted and inform the level of quality premium withheld from providers. Resources recovered could be re-distributed to practices to cover the costs of transferred work with a baseline payment to cover the administrative cost of coding.

This report highlights that many transfers of workload represent a risk of harm to the patient and the preferred option is not to manage the financial consequences but to ensure these episodes are eliminated and regarded in patient safety terms as 'never events'.
This could be achieved by extensive education programmes for all Doctors and for this to be included in undergraduate medical training.

Patients could be educated and informed so there is an expectation that the clinician caring for you will complete your care and not hand off administrative tasks to GPs.

All inappropriate transfers of care should be treated as significant events and the secondary care providers should be required to hold regular reviews with the Doctors responsible obliged to attend.

At present if GPs are subject to performance review under the performers list regulations[9] or General Medical Council (GMC), Good Medical Practice[8] they are held wholly responsible even when acting outside of their normal scope of practice due to an inappropriate transfer of care. Regulators should consider the mitigating circumstances demonstrated by the volume of workload transfer demonstrated in this survey.

More services are being delivered by clinics led by Allied Health Professionals, often Nurse Practitioners. These services are often provided by staff who are unable to prescribe and whose supervising prescribing clinicians are not present when care is given. This was not identified specifically by this survey however it is recommended that commissioners and providers ensure services delivered in this way have access to prescribers. It is also recommended that services are commissioned with a requirement that the Allied Health Professionals delivering them are qualified as non-medical prescribers or are on the training

pathway to qualify within a reasonable time frame. There may need to be an expansion in places for this training.

At present the Electronic Prescribing System which allows a prescription to be sent to the community pharmacy of the patient's choice is not available to Acute Hospital Trusts and other providers. This needs to be commissioned and provided urgently.

# References


*(1)* Making Time in General Practice: Primary Care Foundation: Clay and Stern 2015 *http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/*

*(2)* NHS Standard Contract 2016/17 Service Conditions: NHS Standard Contract Team March 2016 *https://www.england.nhs.uk/nhs-standard-contract*

*(3)* Responsibility for prescribing between Primary and Secondary/Tertiary Care: NHS England/Direct Commissioning Change Projects Jan 2018 *https://www.england.nhs.uk/publication/responsibility-for-prescribing...*

*(4)* Statement of fitness for work: a guide for hospital doctors: updated Dec 2016 *https://www.gov.uk/government/publications/fit-note-guidance-for-hospital-doctors/statement-of-fitness-for-work-a-guide-for-hospital-doctors*

*(5)* Pushing back on inappropriate workload: template letters: BMA 2019 *https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/pushing-back-on-inappropriate-workload*

*(6)* Pushing back on workload from Secondary Care: BMA 2020 *https://www.bma.org.uk/advice-and-support/gp-practices/managing-workload/pushing-back-on-workload-from-secondary-care*

(7) LMC Survey of Practices June/July 2020: Personal Communication

*(8)* Good Medical Practice 2013 *https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice*

*(9)* The National Health Service (Performers List) (England) Regulations 2013 *https://www.legislation.gov.uk/uksi/2013/335/pdfs/uksi_20130335_en.pdf*

(10) Unit Costs of Health and Social Care 2019: University of Kent Personal Social Services Research Team. *https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2019*

(11) *https://www.kentlmc.org/covidrecoveryprinciplesforgeneralpractice*