Collective Action

Protect your Practice

Protect your Patients

Aims of the presentation

- Historical context
- Changing workload, funding and staffing of Primary care

Possible Actions your practices might take

- Safer Working, IT, Pushback
- Discuss Rotherham plans
- How can your LMC help?

Historical Context

The overall population in England has increased from 53.5 million in 2012 to 67.9 million in 2024.

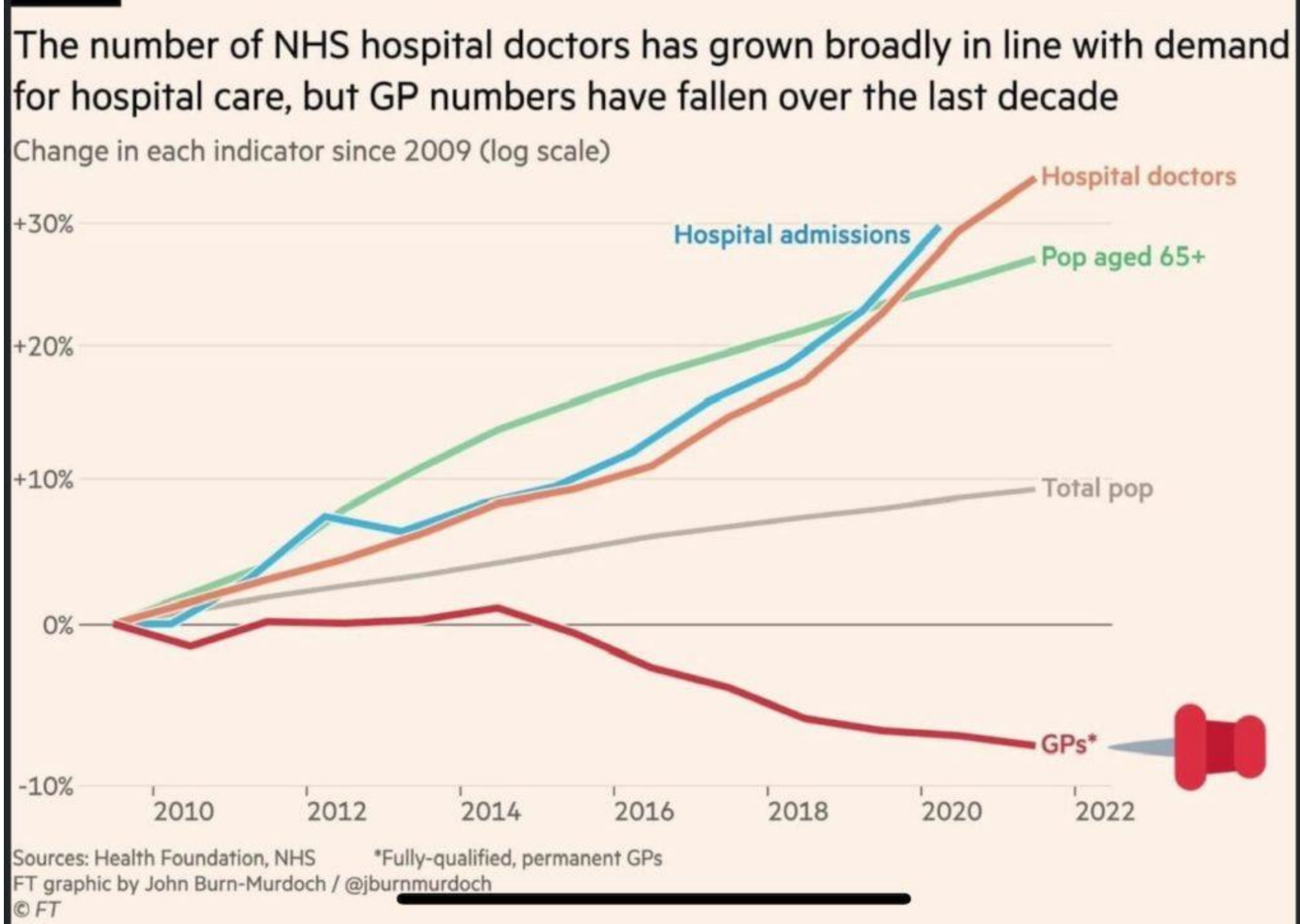
The number of GPs is falling. There are approximately 2000 FTE GP's and 1300 GP practices less now compared with 2015.

Government investment into primary care has fallen. Primary care gets only 6% of the NHS budget now (was 8.9% in 2015/16).

The GP contract is worth £660million LESS than it was 5 years ago.

Your practice receives just £107.57 per patient per year from the core contract which is 30p a day (less than the cost of an apple).

The government has offered us a 1.9% uplift to our contract, and we would need an 11% uplift to be equal to real terms value of the 2018/2019 contract.


The number of NHS hospital doctors has grown broadly in line with demand for hospital care, but GP numbers have fallen over the last decade
Change in each indicator since 2009 (log scale)
Hospital doctors
Hospital admissions
Pop aged 65+
Total pop
GPs*
+30%
+20%
+10%
0%
-10%
2010
2012
2014
2016
2018
2020
2022
Sources: Health Foundation, NHS
*Fully-qualified, permanent GPs
FT graphic by John Burn-Murdoch / @jburnmurdoch
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We need to slow down the pace we are running on our hamster wheel.

A single full-time GP is now responsible for an average of 2,294 patients. This is 356 more than in September 2015.

General practice is providing 20% more appointments than it was in 2019.

A total of 30.5 million appointments were delivered in general practice in April 2024 in England, with an average of 1.45 million appointments being delivered per working day.

Equivalent of 1 in 2 of the entire population are seen in General Practice EVERY month.

Picture in Rother Valley Constituency:

https://www.bedshertslmcs.org.uk/resilience/parliamentary-constituency-tool/ for Rotherham / Rawmarsh/ Conisborough data)

Between 2014 and 2024 Rother Valley practices have had a:

- 1.2% population increase
- 23.8% FTE GP decrease
- 38.9% GP Partner decrease
- 32.5% increase in patients per FTE qualified GP

Background to the GP contract dispute

- **The ballot and the referendum**
- Following March's unequivocal referendum result, where 99.2% of BMA GP and GP registrar members returned a resounding vote AGAINST the 2024/25 GMS contract, we are now in dispute with NHS England.
- The responsibility to deliver the GMS / PMS contract is held by the GP contractor / partner(s) of the practice. They are not NHS employees, but independent GPs who contract with the NHS. Unlike other NHS employees in other branches of practice, such as resident (junior) doctors and consultants, GP contractors / partners are not subject to TULCRA legislation. The ballot is therefore indicative rather than a statutory one.
- It is a means of gathering momentum ahead of organised collective action, which will commence from 1 August.
- The BMA GPC England is asking members to vote YES to Protect Your Practice, Protect Your Patients.

GPC England non-statutory ballot - Vote YES

- The ballot is now open and will close on 29 July at midday. To ensure you have a say you must:
  - be a GP contractor/partner member of the BMA. Non-members can **join now** for 3-months free membership
  - update your personal and place of work details for all your roles
  - Civica – bma@cesvotes.com – will send your voting link to the email address you have registered with BMA

https://www.bma.org.uk/our-campaigns/gp-campaigns/contracts/gp-contract-202425-changes

Non-Statutory Vote Question :

Are you prepared to undertake one or more examples of collective action as outlined in the BMA campaign to Protect your Patients, Protect your Practice?

"Here comes Edward Bear now, down the stairs behind Christopher Robin. Bump! Bump! Bump! on the back of his head. It is, as far as he knows, the only way of coming down stairs. He is sure that there must be a better way; if only he could stop bumping for a moment to think of it."

What will action by GPs look like?

- If the ballot is successful, GP's will be invited to determine the actions they will be willing to take.
- They should enact these actions across the whole practice team working with their practice managers.
- LMCs will also be vital in supporting practices and advising on the locally commissioned services and ICB asks that are not supporting the sustainability of local GP practices.
- Each of these actions is outlined in the 'GP practice survival toolkit'
- None of the following possible actions constitutes a breach of contract:

The current menu of actions

1.Limit daily patient contacts per clinician to the UEMO recommended safe maximum of 25. Divert patients to local urgent care settings once daily maximum capacity has been reached.

2.Stop engaging with the e-Referral Advice & Guidance pathway – unless it is a timely and clinically helpful process for you in your professional role. See BMA Advice & Guidance Update

3.Stop supporting the system at the expense of your business and staff. Serve notice on any voluntary services currently undertaken that plug local commissioning gaps.

Possibilities for this may include:

a. Serve notice on local contracts where these are either financially non-viable or lack sufficient clinical governance (e.g. some shared care agreements).

b. Stop voluntary services – e.g. stop in-house ECG's, stop in-house Spirometry, stop in-house dopplers, continue to push back on the HF meds titration, insulin titration & Inclisiran.

c. Bounce back all unfunded transfer of care from secondary care / community services.

https://www.bma.org.uk/pay-and-contracts/contracts/gp-contract/gp-contract-202425-imposed-changes-guidance

https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/primary-and-secondary-care/primary-and-secondary-care-working-together

4. Stop rationing referrals, investigations, and admissions.

- Refer, investigate or admit your patient for specialist care when it is clinically appropriate to do so (no risk-holding to benefit the system over the patient).
- Refer via eRS for two week wait (2WW) appointments, but outside of that write a professional referral letter where this is preferable. It is not contractual to use a local referral form/proforma – see our guidance and sample wording

5. Switch off GP Connect functionality to permit the entry of coding into the GP clinical record by third-party providers.

6. Withdraw permission for data sharing agreements which exclusively use data for secondary purposes (i.e. not direct care). See our guidance on GP data sharing and GP data controllership.

7. Freeze sign-up to any new data sharing agreements or local system data sharing platforms. See our guidance on GP data sharing and GP data controllership.

8. Switch off Medicines Optimisation Software embedded by the local ICB for the purposes of system financial savings and/or rationing, rather than the clinical benefit of your patients.

9. Practices should defer signing declarations of completion for “better digital telephony” and “simpler online requests” until further GPC England guidance.

- Defer signing off ‘Better digital telephony’: do not agree yet to share your call volume data metrics with NHS England.
- Defer signing off ‘Simpler online requests’: 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.
-See our guidance on this.

GPC England is not recommending which action(s) practices take.

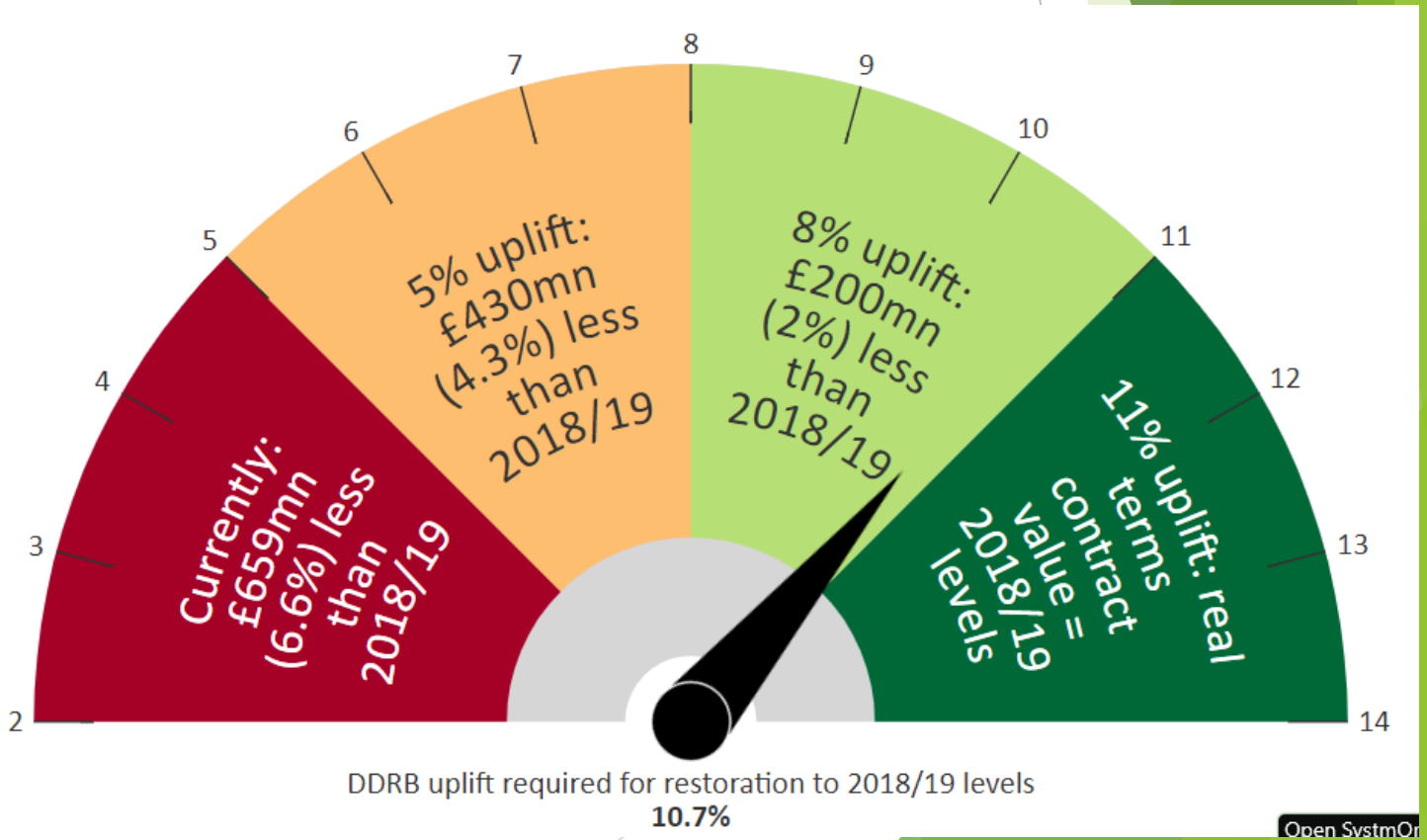
It is for each practice to pick and choose as they see fit. You may decide to add to your choices over the days, weeks, and months ahead.

This is a marathon, not a sprint.

Some of these actions can be permanent changes – professional, collective and a single opportunity to embrace sustainable and safe change. Others may be de-escalated following negotiations with the new Government.

What is a good outcome of Collective Action?

- **DDRB Uplift Swingometer**
- What will each possible % DDRB uplift really mean, in real terms, for core contract funding compared to 2018/19?
- This Swingometer shows you the effect of each potential DDRB % uplift on core contract funding erosion since 2018/19.



How Can Rotherham LMC help?

- Template bounce letter- see Rotherham LMC website.
- Sheffield LMC letter to patients re collective action – see Rotherham LMC website.
- We are looking at the financial viability of our LES's and Shared Care agreements to inform your decisions for point 3 of the BMA Collective action menu.
- We've written a Powerpoint to share with your PPG's - see Rotherham LMC website and also BMA Campaigns Webpage
- Clare Bannon from Barnsley LMC is on the SYICB Secondary/Primary Interface Group and is producing advice. Documents so far are on Med3 and Onward Referrals - see Rotherham LMC website.
- Rotherham LMC have regular meetings with the Rotherham DGH Medical Director, and Rachel Garrison is collecting data on phlebotomy and other workload transfer issues to feedback to the trust so they can focus communications (although general communications have been sent out and consultants are aware).