RCGP response to the NHS England 'Red Tape Challenge'
December 2024

The Royal College of General Practitioners (RCGP) welcomes the opportunity to submit feedback and examples of best practice to the Red Tape Challenge. Bureaucracy and red tape are significant factors contributing to GP workload and we commend this work to reduce this.

The RCGP's latest survey of 2,000 members found that on average GPs say they spend 23% of their time on admin and bureaucracy that does not improve patient care. This is at a time when our survey showed that 76% of GPs say that patient safety is being compromised by excessive workload.

This red tape is also one of the key drivers of GPs wanting to leave the profession. When GPs were asked what one thing could be done to make it more likely for them to stay in general practice, more selected 'reduction in administration work' than any other option.

This response draws on input from the wider RCGP membership on the red tape and bureaucracy which unnecessarily contributes to their workload. Many of the responses that we received from GPs were about the increased workload they face from care that was previously carried out in secondary care being transferred to general practice. This included both administrative work and clinical patient care, which would not be classed as red tape. While we have not gone into these points in depth it is important that any scheme such as the NHS 'Advice and Guidance' programme includes full analysis of the workload implications for general practice and allocate extra resources to meet these needs.

To tackle challenges with red tape for general practice, the RCGP has developed the following recommendations:

1. Improve the interface between primary and secondary care

GPs report that the biggest driver of red tape and unnecessary workload is the poorly designed interface between primary and secondary care. This came through strongly in our surveys of members and feedback from members specifically related to the red tape challenge.

a. Require all ICSs to implement interface guidance and to report on progress annually

The RCGP has published guidance for improving communication and working between primary and secondary care professionals. It is based on consensus work by Cheshire and Merseyside Health and Care Partnership. We need every ICS to adopt this guidance and ensure effective implementation across all areas of the country. This would result in a more efficient health system and would also improve patient experience.

b. Ensure effective and safe data sharing

Our most recent member survey found that 61% of respondents felt that improving the digital interface between primary and secondary care would help improve their workload. Fully integrating digital systems across not only primary and secondary care, but all parts of the system, would reduce red tape, benefiting both practitioners and patients. Such integration would enable all practitioners involved in patient care to access the information necessary for that care with patient consent, reducing the need for patients to repeat themselves, minimising errors and duplication and reducing the use of letters and other less reliable forms of communication between parts of the system.

There is an important role for the NHS and the Government nationally to introduce the right rules and invest in the right IT infrastructure to ensure the necessary changes can be made, as well as for ICSs to support effective collaboration between parts of the system.

c. Create a unified online referral system linked to GP IT systems

A key issue flagged by our membership is the lack of standardisation in referral forms, which creates inefficiencies and confusion. An agreed e-template would streamline workflows.

Specific examples of difficulties with referral methods we have heard from our members include:

- GPs being asked to complete poorly formatted Word documents with no ability to input clinical consultation data when referring patients to secondary care services and community services such as weight management or lifestyle referrals.
- Forms requiring excessive information such as measurements for a wheelchair just to refer to a service which will then take their own patient details.
- Services that use web-based forms that do not auto populate and are not synced with primary care records.
- Referral systems that refuse any patient referral that does not list the ethnicity of the patient.
- The care portal used by London Ambulance Service (LAS) and NHS 111 to access GP records, including crucial information such as DNACPR forms, requires manual and separate uploads rather than automatically updating from GP IT systems.

Addressing these systemic issues through the implementation of fully integrated, fast, and user-friendly IT solutions would greatly improve the NHS's operational efficiency, reduce delays in care, and enhance the experience for both healthcare professionals and patients.

d. Ensure patients are referred directly from one service to another when appropriate without having to go back to their GP

Secondary care teams should be empowered to make direct referrals for further care where it is directly related to the condition for which the original referral was made, or the patient has an immediate need for investigation or treatment, rather than relying on GPs as intermediaries, which creates duplication and delays.

Our 2024 member survey found that a significant 76% of respondents believed that allowing specialists to refer patients directly to other specialists when appropriate, rather than requiring GPs to re-refer, would greatly improve their workload.

Examples of issues relating to re-referrals that have been shared with us include:

- When a patient is sent for a scan and a possible cancer is identified, the scan report is sent to the GP requesting that we make a "2 week wait" referral to the hospital, to start the cancer pathway. It should be the responsibility of the referrer to arrange the urgent onward referral.
- Departmental referrals from one secondary care setting to another for ongoing care when the patient moves should be organised by the secondary care provider. For example, a patient with Inflammatory Bowel Disease moved from one ICS to another. The service providing their care in the first ICS said that it was impossible to refer directly to the new ICS so the patient had to see their new GP, who then had to assemble the most recent clinic letters/investigation results and send a new referral to a new gastroenterology team.

d. Change how services mange DNAs and re-referrals

Providers should no longer ask GPs to re-refer DNA appointments. Many GPs told us about situations where if a patient misses an appointment in a secondary care service, they are struck off the system and need to go back to their GP for a new referral. This includes examples where patients miss appointments due to miscommunication by secondary care providers and lost letters. Such cases can be frustrating for patients, result in care delays and increase GP workload.

e. Improving communication with patients

As per NHS England guidance, providers must put in place efficient arrangements for handling patient queries promptly and publicise these arrangements to patients and GPs, on websites and appointment/admission letters and ensure that they respond properly to patient queries themselves, rather than simply passing them to practices to deal with. Similarly, they should communicate the results of investigations and tests to patients directly and ensure patients are aware of any follow up plans.

f. Improving the Advice and Guidance system

The NHS Advice and Guidance (A&G) has been set up to provide GPs with access to specialist advice as an alternative to making a direct referral. In some areas this has worked well for patients and GPs.

However, in other places, instead of being an optional service to help GPs access advice, it has become a blockage to referrals. Some services have stopped accepting referrals until a GP uses the Advice and Guidance system. This sometimes results in GPs having to undertake complex investigations and deliver specialist care in the community without extra resources.

GPs have also expressed concern that once they have carried out all the tests recommended by a specialist through the Advice and Guidance system, they have to fill in a whole new, separate referral form, rather than the patient being automatically referred.

2. Ensure patients can get the prescription they need without another appointment

One of the other main concerns raised by RCGP members is the need for GPs or members of the MDT to carry out unnecessary appointments or other activity to issue a prescription when this could have been done by other parts of the NHS.

Many GPs gave examples of secondary care services telling a patient that they had to go back to their GP to get a prescription. Some specific examples that have been shared with us include:

- Secondary care specialists recommending a new prescription but not issuing it.
- Dieticians being unable to prescribe dietary supplements.
- Nursing teams being unable to prescribe appliances such as compression stockings or catheters for patients in their care .
- Pharmacists being unable to alter prescriptions to deal with shortages or minor discrepancies. This means that patients are being sent back and forth to get a new prescription from the GP.

One way to improve this area of red tape and unnecessary workload would be the introduction of e-prescribing in secondary care so that prescriptions can be sent electronically to a dispenser of the patient's choice. In our recent member survey, 55% of GPs said this would help their workload "a lot".

In line with the Royal Pharmaceutical Society's work on medicines shortages, the RCGP would also like to see changes to legalisation to enable community pharmacists to make minor amendments to prescriptions in line with existing hospital practice. This would

allow for pharmacists to make minor changes to substitute alternative formulations, strengths or quantities of a medicine within an agreed formulary without the need for patients to return to the GP for a new prescription, reducing workload for general practice.

3. Improve the system for issuing fit notes

Having a longitudinal relationship with patients can allow GPs to holistically assess their needs and make informed decisions upon issuing a fit note.

However, the RCGP does not consider it a good use of GP time to be responsible for extending fit notes first issued in other settings. For example, when patients receive a fit note post-surgical treatment in secondary care, this should cover the full recovery time (3 months post hip surgery instead of 2 weeks). In these instances, all fit note issuers should provide the appropriate length to accommodate recovery time, informed by an individualised patient approach.

It is positive that secondary care specialists and the wider members of the multi-disciplinary team (MDT) can sign fit notes when appropriate. This collaborative approach enhances care quality, aids in patient recovery and return to work, and provides employers with comprehensive guidance on managing workplace health issues. However, as set out by the DWP, 91.6% of fit notes are still signed by GPs. Training should be made available to ensure that all those involved in issuing fit notes have sufficient knowledge of the full fit note process as well as the health and wellbeing implications.

In addition, members feel that better support should be provided for GPs and their teams to support patients in advising on the appropriate adjustments needed from their employer. This is likely to include providing access to support outside primary care to help patients back into the workplace where appropriate and ensuring that employers provide comprehensive occupational health assessments. The limited time, resourcing and lack of information makes it difficult for GPs to comprehensively assess whether the workplace conditions meet the needs of the patient or how to best support their employment journey.

4. Reduce the administrative and bureaucratic burden from regulatory inspections,

The Care Quality Commission (CQC) has been found to be 'not fit for purpose' by the recent independent Penny Dash review of the regulatory service. The RCGP has, for several years, raised concerns about the way the CQC operates in England including the excessive workload and negative experiences associated with inspections and the potential bias during inspections of ethnic minority-led GP practices. GPs have reported that CQC's requirements are inconsistent, not reflective of what constitutes best practice and take large amounts of time to prepare for and provide the administrative information required for an inspection. The administrative burden of this takes valuable time away from GPs which would be better used in prioritising patient appointments.

To improve this situation, the RCGP is calling for a temporary pause of routine CQC inspections and for an end to the one-word rating system currently used in CQC reports. Significant improvements are needed in CQC processes to deliver an improved, cost-effective and evidence-based approach to assessments and inspections, that is more proportionate and does not place undue administrative or bureaucratic burden on practices.

In addition, there is a need to promote a supportive working culture which does not result in fear and anxiety in relation to CQC inspections and potential related disciplinary actions. GPs have expressed that they feel this environment fosters excessive caution, leading to inefficiencies and a drain on clinical time. Addressing the challenges associated with regulation of general practice will improve efficiency and allow GPs to focus more on patient care, ultimately enhancing outcomes for all involved.

5. Reduce mandatory training requirements for GPs

At present the requirements on GPs to undertake regular and extensive mandatory training represents a significant burden in terms of time that could be better spent providing patient care.

There is a need to review the mandatory training requirements for GPs and their teams to ensure that these are proportionate, appropriately designed and evidence-based. The lack of incorporation of general practice within the statutory and mandatory training programme (latest update 14 November 2024) is a significant missed opportunity and the RCGP would like to see much greater efforts made to reduce the mandatory training burden for GPs and their teams.

6. Reduce bureaucracy through reforming the GP incentive schemes

The Quality and Outcomes Framework (QOF) and Investment and Impact Fund (IIF) contribute significantly to bureaucracy within general practice. The tick box nature of the work required to demonstrate that practices and Primary Care Networks (PCNs) have met indicators and access funds is seen to be a significant contributor to unnecessary general practice workload. In 2023, on average, GPs said that a quarter of their time is spent on work generated by QOF that is unnecessary and/or does not have a positive impact on patient care. Similarly, our latest survey of GPs found that 43% would like to see a reduction in the number of indicators needed to access QOF funding. The administrative burden generated by QOF is particularly illogical given that a 2017 systematic review of QOF concluded that there was no convincing evidence that QOF can promote better integrated care, personalised, holistic care, or self-care — or, indeed, improve any other outcomes in people with long-term conditions.

It is also concerning that achievement of QOF indicators can be more difficult for practices in areas of socioeconomic deprivation, where patients often have more complex needs and there are often additional workforce shortages. NHS payment

figures show that practices in deprived areas receive 29% less QOF incentive payments than those in the wealthiest. Given that the bureaucratic workload of incentive schemes not only diverts GP resources from patient care but exacerbate health inequalities, significant improvement is required.

Overall, we believe there is potential to streamline incentive schemes by reducing the number of indicators and reallocating the associated funding into core general practice budgets. However, we recognise that there is likely to be a continued role for incentives schemes within general practice in some form. As part of this, there needs to be improvements to ensure these schemes better support general practices. In our submission to the Department of Health and Social Care's consultation on the future of incentive schemes in general practice, we specifically proposed:

- A significant reduction in the number of QOF and IIF indicators (to retain in the region of 5 QOF and 2 IIF indicators) and a move to higher-level and higher-trust indicators.
- Streamlining systems to reduce the administrative burden created by the OQF and IIF indicators.
- Increasing the emphasis on health inequities, sustainability and prevention.
- Greater flexibility in disease-specific indicators to allow for the addressing of multimorbidity and frailty.
- Increasing the scope for ICBs to deliver locally tailored, flexible incentives schemes, with appropriate input from GPs in those local areas.
- A significantly increased focus on quality improvement. The RCGP has previously supported quality improvement modules as part of QOF and would be pleased explore this further.

7. **Improve general practice IT systems**

While not strictly "red tape", many practices across the UK struggle with poor IT infrastructure. In our latest member survey, 30% said that their computer software was not fit for purpose and 40% said the same of their Wi-Fi quality or speed. By improving speed and reducing faults, valuable clinical time can be redirected, resulting in better patient care and staff satisfaction.

Basic processes, such as accepting a prescription, are slowed by technical delays like the appearance of a revolving blue circle during authorisation. This minor but repetitive inefficiency occurs thousands of times daily in general practice, significantly impacting productivity. The overall speed of GP IT systems also needs to be improved, as their sluggish performance creates a substantial drag on day-to-day efficiency.

8. Address wider workload and workforce challenges

Whilst the above recommendations offer some key solutions in reducing red tape and unnecessary administrative workload, and addressing ongoing issues with the primary and secondary care interface, it is also important that this is understood in the context of

the broader workload and workforce crisis in general practice. As of October 2024, NHS data reports the average number of patients per fully qualified FTE GP as one GP per 2,271 patients in England. This is an increase of 333 patients per GP (over 17%) since 2015. There must be sufficient resourcing for general practice to support and engage with patients. Without an accompanying significant increase in the number of FTE GPs, the recommendations outlined above will have limited impact to improve patient care.