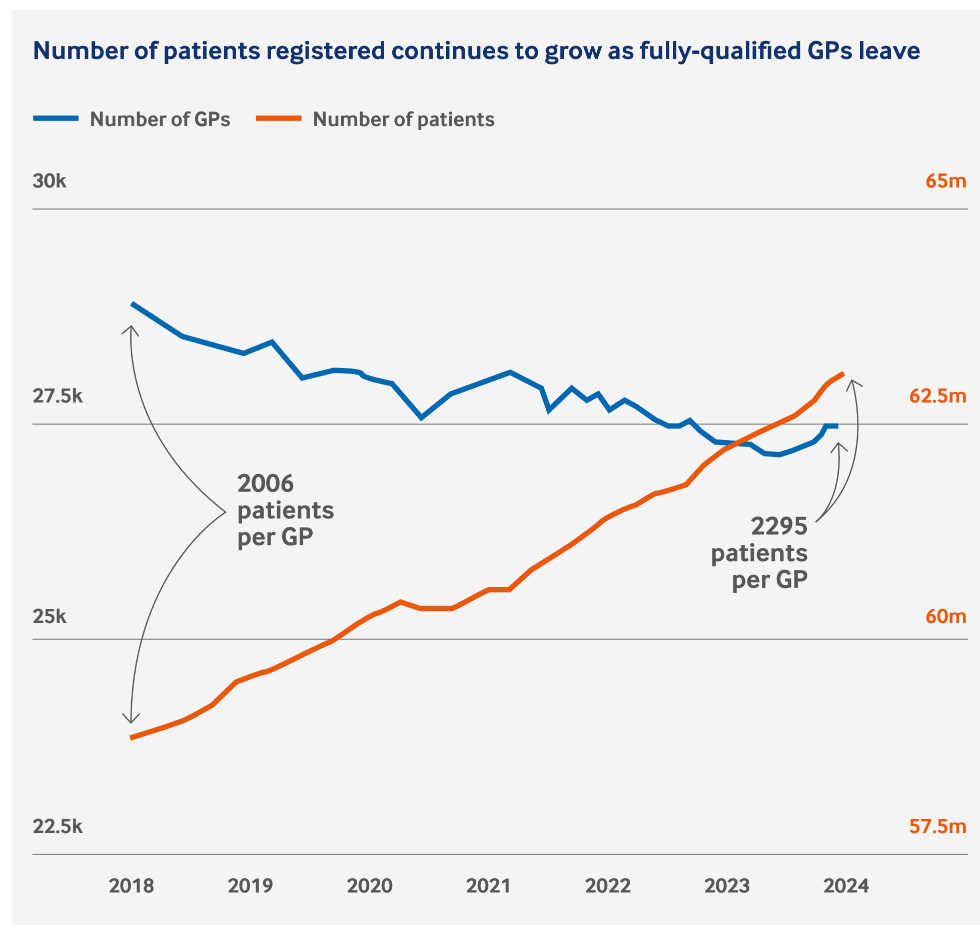
Safe working guidance in general practice – a summary

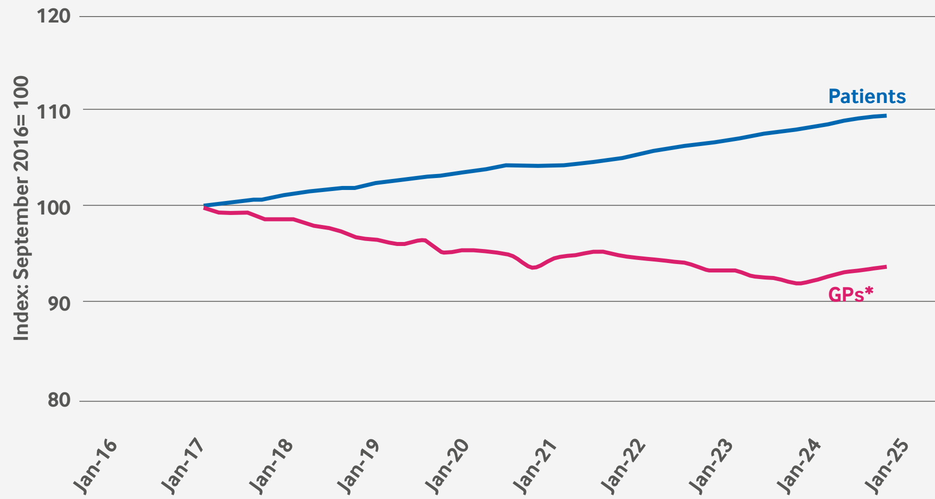
General practice continues to face extraordinary challenges, with unmanageable workloads and workforce pressures against the backdrop of years of underinvestment. The third year of contract imposition fails to recognise or acknowledge these pressures. General practice, GPs and practices need to take steps to safeguard their ability to deliver safe, sustainable, high-quality care.

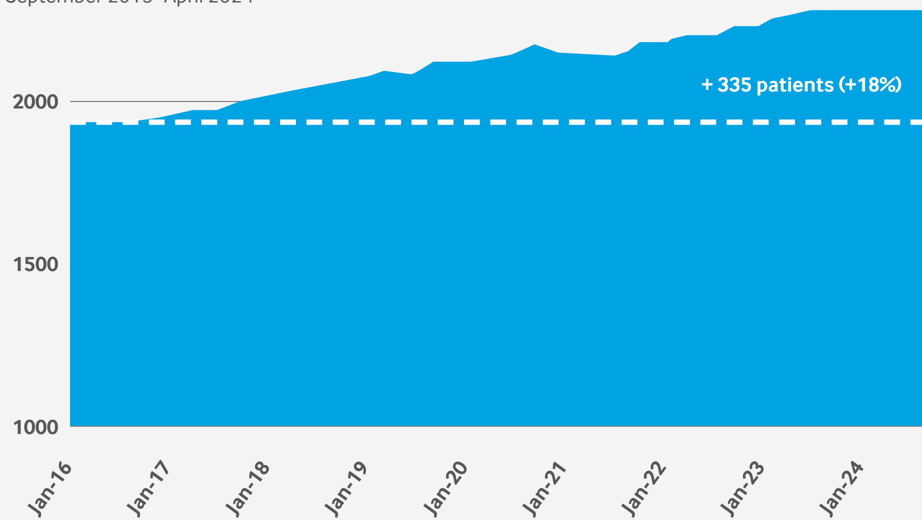
Increasing demand

The nation's population and demographics are changing, with more complexity and comorbidities. The number of patients each GP is responsible for has been steadily rising.

Workforce




Demand is growing faster than supply
Indexed trends in number of patients and GPs*
120
110
100
90
80
Index: September 2016= 100
Patients
GPs*
Jan-16
Jan-17
Jan-18
Jan-19
Jan-20
Jan-21
Jan-22
Jan-23
Jan-24
Jan-25
Sources: BMA analysis of NHS GP Workforce data • * Fully qualified, full-time equivalent


GPs are responsible for more and more patients
Number of patients per GP*
September 2015- April 2024
2000
1500
1000
+ 335 patients (+18%)
Jan-16
Jan-17
Jan-18
Jan-19
Jan-20
Jan-21
Jan-22
Jan-23
Jan-24
Sources: BMA analysis of NHS GP Workforce data • * Fully qualified, full-time equivalent

Worryingly, despite the undeniable need for more GPs, we are witnessing GPs being driven away from the NHS and – even more shockingly – GPs facing unemployment, due to the lack of appropriate investment in the GP core contract.

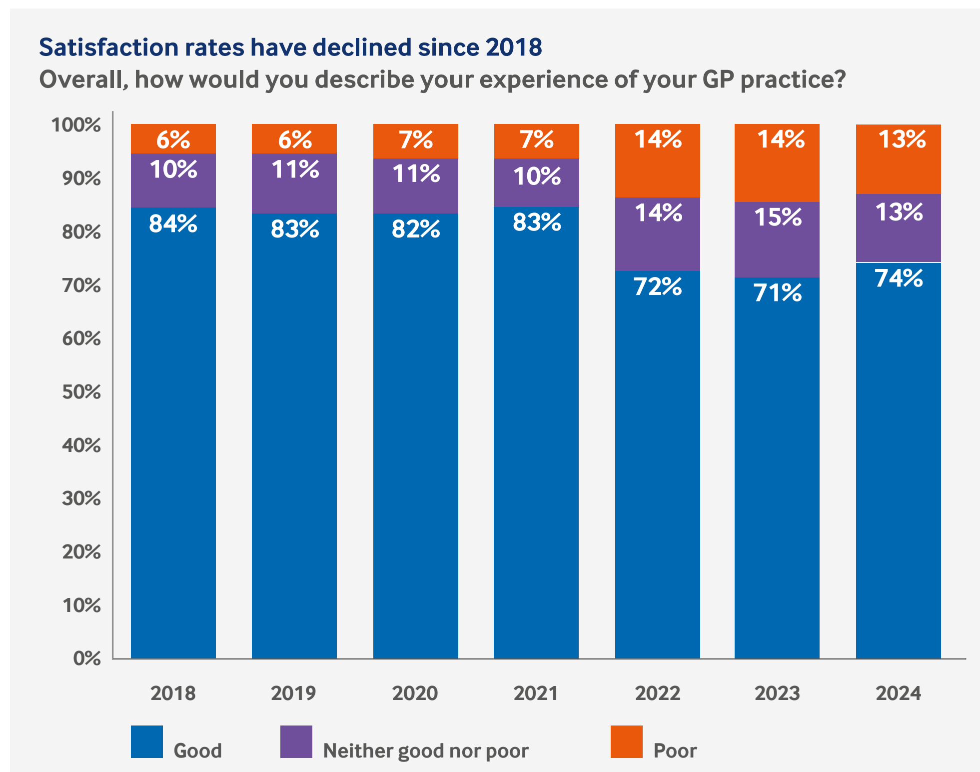
GPs and practices play a key role in helping their patients to understand and manage their health and wellbeing, providing holistic care close to home.

Inadequate practice resourcing/investment

Practices were initially offered an uplift of only 1.9% in the latest 2024/25 imposed contract. After a further uplift, recommended by the DDRB (Review Body on Doctors' and Dentists' Remuneration), the real-terms value of the core contract is still 3.6%, or £358 million, lower than in 2018/19. It is clear that the 2024 uplifts have failed to address the years of under funding in general practice.

Over £1.4 billion per year has been committed as part of the ARRS (Additional Roles Reimbursement Scheme). The recent addition of one GP per PCN (primary care network) via ARRS does not help individual practices and provides only a fraction of the support needed. The lack of core practice funding is stopping patients accessing the GPs they want and need to see.

The current situation is not tenable.

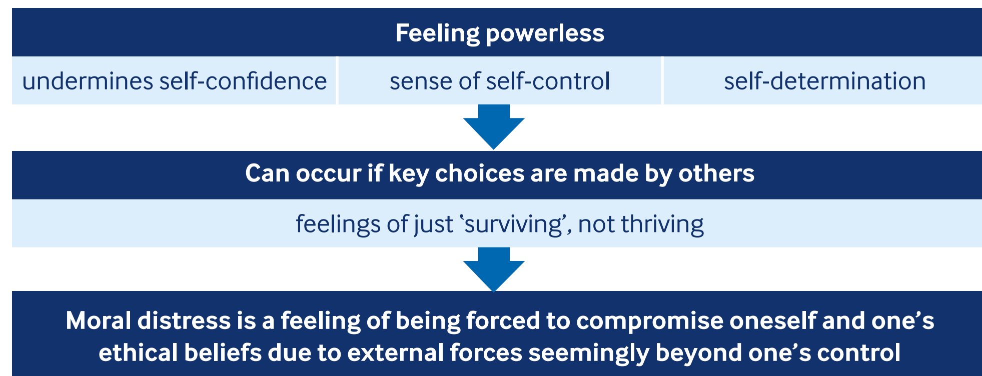


Access vs capacity: record-breaking appointments

GPs and practices are offering record-breaking numbers of appointments, regularly exceeding capacity in a bid to try and keep up with demand: they see nearly half of the country's population every month, with 31.7 million appointments delivered in July 2024.

Burnout and wellbeing

Not enough GPs means that fewer GPs are providing care for more patients. The never-ending 'hamster wheel' of continually trying to keep up with demand can increase the risk of harm and suboptimal care through decision fatigue. It also risks GPs becoming unwell and burnt out, leading to them being lost to the profession altogether, as shown in our survey of moral distress in the medical workforce.



What needs to happen next?

Empowerment

GPs and practices need to regain and retain their sense of agency, self-determination and autonomy, to create the headspace and capacity to deliver safe, high-quality patient care. GPs and practices **need to control the speed** of their hamster wheel, and are well placed to work with their patients and communities to help design and deliver the services that are required.

This can be achieved through using the BMA's safe working and workload control guidance.

BMA Safe working guidance

This is a set of recommendations and guidelines to help support GPs and practices in designing and delivering safe, high-quality care guided by the needs of their patients, staff and practice, within the framework of the GMS contract and their regulatory and contractual obligations.

– Safe working in general practice

Changes do not need to happen overnight – they can be incremental and reviewed regularly in line with the needs of your patients and practice.

Appointments and waiting lists

Practices need to provide appointments that address the reasonable needs of their patients, 'as determined by the GP partner/contractor'. We advise reviewing the patient population and practice needs to help guide the necessary appointment setup and delivery for safe, high-quality care.

We recommend moving to 15-minute appointments, enabling more complex issues to be dealt with during one episode. This can help reduce the need for multiple repeat appointments and support continuity of care, which is linked to improved patient outcomes and experience, and a reduction in demand across the healthcare system.

Appointment recommendations

Triaging requests for appointments can help with clinical prioritisation, identifying urgent and routine cases, and those better dealt with elsewhere. This can take place through a variety of methods, including online, telephone and face-to-face. It is important that any pathways are guided by the needs of your population and practice, and take into consideration vulnerable patients, and those requiring reasonable adjustments. Triaging can involve the whole practice team, spanning reception, administrative and clinical team input.

It is important to appreciate that wider supporting services exist, and these may be more appropriate for patients to access, and thus be signposted to. Emergency or urgent problems can be directed to emergency departments, 999, or 111. Some routine cases could be signposted to self-referral schemes within the community.

In the case of capacity being filled, this needs to be clearly communicated to patients, with the appropriate messaging via telephone, online platforms, email and SMS messaging services (eg Accurx).

Once appointments have been deployed in line with clinical prioritisation and capacity is reached, it may be necessary to inform patients who present with routine, non-urgent issues that they will be contacted once further appointments open up. This could mean a wait of a few weeks, and patients should be safety netted and advised to either get back in touch with the practice or to engage with the relevant services should their condition/situation change.

Daily contacts

The European Union of General Practitioners and BMA have recommended a safe level of patient contacts per day in order for a GP to deliver safe care at not more than 25 contacts per day.

Many GPs in England have daily patient contacts significantly in excess of this limit, increasing the risk of decision fatigue and burnout. GPCE (the BMA GPs committee England) recommends moving away from uncapped contacts and workload to enable the delivery of safe, high-quality, clinically led care, as directed by the needs of the patient population. Structured sessions which accurately and safely capture planned and unplanned contacts **protect patients, staff and practices.**

Triaging and the use of reception staff and care coordinators to signpost to other services within the system once capacity has been filled, can help manage workload and safe daily contacts. Refer to our advice on triaging workflow.

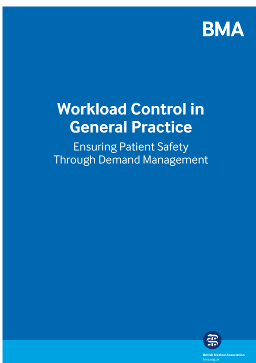
Sessional GPs are an integral and crucial component of practices. GPCE recommends involving sessionals in discussions at all stages when you are making changes. This is to comply with employment law related to changes in working practices, but also to use their expertise and experience to help shape the provision of patient services.

Read our sessional and locum GP guidance.

Engagement and patient participation groups

We recommend liaising and communicating with a range of stakeholders to aid the transition to safe working, including:
- patients
- local support including politicians
- your LMC (local medical committee)
- your ICB (integrated care board), on commissioning arrangements.

GPCE strongly recommends discussing any changes being proposed under the BMA Safe working guidance with your PPG (patient participation group). Experience has demonstrated most PPGs are very aware of the unrealistic pressures on all GP practice staff and will support the guidance, and may help in clearly communicating your changes to patients.



Workload control in general practice

Read the BMA's guidance on workload control and ensuring patient safety through demand management.

Workload transfer from other providers: external un-resourced and under-resourced workload

Externally generated and transferred work from other providers continues to have a huge impact on practice workload. This has become particularly problematic following the development of hospital backlogs and waiting lists due to the COVID-19 pandemic, with these pressures spilling over into practices.

LMCs will often engage with providers across the primary-secondary care interface through meetings to help influence and negotiate changes. Operational pressures escalation levels framework (OPEL), Situational reporting (SITREP), or General Practice alert state (GPAS) systems, can capture workload pressures within general practice, to help collect evidence and demonstrate themes.

Practices can also use the BMA's template letters to push back on workload.

Measurement of workload

NHS England measures GP workload based on appointment data; this significantly underestimates GP activity as non-appointment patient contacts such as prescriptions and documents are not accurately captured.

GPCE recommends the manual mapping of workload and patient contacts over a period of 2-3 typical days in the practice. This enables the practice to better appreciate and assess the sources and level of practice workload burden. Data is a powerful tool and supports wider national contract negotiations in addition to regional and local levels through LMCs.

Read further guidance on how to undertake this.

'Core' general practice: essential services

Practices need to focus their time and energy on delivering the essential services they are appropriately commissioned and resourced for. It is crucial that practices maintain their capacity to deliver core work, supporting safe, high-quality care for patients, without being distracted or diverted into delivering unresourced workload transfer from other parts of the system.

Generally, if a service is commissioned locally in one area of the country, it cannot be part of core GMS anywhere in the country. Our list of locally commissioned services shows the services that by definition are not core general practice, and should be locally commissioned nationwide.

Workload prioritisation

We strongly recommend that practices refer to the GP practice survival toolkit. Practices are obliged to provide care for their patients as defined in the core GMS contract; be aware that providing services outside this is voluntary and should attract a separate payment. Any additional services need to be assessed for financial and resource viability and sustainability, to ensure that practice core work and patient care are not adversely impacted.

Practice list closure

Practices should consider closing their list if they have reached the limit of their capacity to provide safe care to patients.

There is a clear protocol for undertaking this action within the GMS contract and regulations. Practices should initially consult with their PPG, seek support from their LMC, and then approach their ICB.

Our first duty is to our patients. The profession wants to be able to provide safe, high-quality care to our patients, without risking their health or ours.

Implementing this guidance

The changes detailed here are not exhaustive but provide an example for practices. The BMA and LMCs can support and advise practices further on specific proposals.

We cannot care for our patients if we do not care for ourselves and our colleagues.

For more detailed information about safe working in general practice, download the Safe working guidance: a handbook for general practice.

Visit the safe working web pages for up-to-date resources including posters, graphics and webinars

Safe working checklist

1. Assessing patient and practice needs, in discussion with your team and PPG
2. Mapping workload
3. Mapping resource streams and staffing
4. Practice discussion
5. Workload prioritisation – core and non-core – and where necessary using workload control template letters
6. Engaging stakeholders: PPG, councillors, Healthwatch, commissioners
7. Communication – eg letters, Accurx
8. Establishing triage process, using whole practice team
9. Signposting to alternative services
10. Safety net processes
11. Appointment set ups: 25 limit, 15 minutes
12. Monitoring and review: experience and numbers (qual and quant)
13. Reviewing job plans and clinics as appropriate

Main outline:

- Appointments 15 minutes in length
- No more than 3 hours out of each 4 hour 10 min session should be spent consulting
- Applies to all GPs (partner, salaried, locum), and clinical staff undertaking consultations
- Signpost to other services in the system once capacity reached
- Safety net plans for urgent cases – signposting/urgent slots/duty doctor
- Routine appointments may need a wait list if capacity reached
- Communicate systems to patients, outlining steps should condition change with clear safety netting
- Use whole practice team.
- Review appointment setup if regularly running over

Waiting lists should:

- Provide for the reasonable needs of your patients
- Have safety netting – clear instructions, website, telephone lines, text message, verbal
- Be addressed in communication, education and training
- Entail triage, pre-triage and re-triage
- Use the wider healthcare system

Conclusion

The BMA's safe working guidance aims to ensure patient safety and improve working conditions for GPs. It focuses on managing workload effectively, setting safe limits for patient contacts, and encouraging practices to adopt systems that protect both staff and patients. By implementing these measures, the guidance seeks to reduce burnout and improve job satisfaction for GPs.

The guidance suggests setting a safe limit on the number of patient contacts per day. It recommends a maximum of 25 patient contacts daily to prevent overload and ensure that each patient receives adequate time and attention. This can be adjusted based on the complexity of cases and individual circumstances of the practice.

To manage excess demand, the guidance advises practices to implement triage systems, use other healthcare professionals within the practice, and consider additional support through locum GPs. It also suggests practices collaborate with local networks to share resources and ensure patients receive timely care without overburdening individual GPs.

Practices should conduct regular reviews of their workload and working hours to ensure they comply with the recommended limits. Using tools like workload calculators and rota checkers can help practices monitor and manage GP working hours effectively. The guidance also encourages open communication in the practice to identify and address any issues related to excessive workload.

Team-based care is a crucial element of the guidance, promoting the involvement of multidisciplinary teams to distribute the workload more evenly. By integrating pharmacists, nurses, and other healthcare professionals into the care team, practices can enhance patient care and reduce the pressure on GPs. This approach helps manage workload and ensures comprehensive care for patients.

Practices should start by assessing their current workload and identifying areas that require immediate attention. Engaging the entire practice team in developing a tailored action plan is essential. Continuous monitoring and adjustment based on feedback and outcomes will help ensure the changes are effective and sustainable. Collaboration with local networks and adherence to the BMA's recommendations will support long-term improvements in practice working conditions.

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