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Department of Health and Social Care:
Consultation on reducing bureaucracy in the health and social care system

1. The Royal College of General Practitioners (RCGP) welcomes the opportunity feed into the DHSC consultation on reducing bureaucracy for those working in the health and social care system

2. RCGP is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 53,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The College is an independent professional body with expertise in patient-centred generalist clinical care.

3. The College is supportive of efforts to reduce unnecessary bureaucratic workload across the NHS, which takes valuable clinician time away from patient care. We support the ongoing review led by NHS England and Improvement (NHSEI) and DHSC into reducing bureaucracy in general practice, which we are feeding into. We also welcome the wider scope of this consultation looking across the health and social care system, which have a major impact on delivery of care in primary settings. In this response we also touch on several aspects which are not covered by the general practice bureaucracy review.

4. The early stages of the COVID-19 crisis saw a suspension of many bureaucratic processes in order to focus efforts to deal with the virus outbreak. As the initial crisis recedes and general practice prepares to deal with the health consequences of the pandemic, we have a unique opportunity to reduce the administrative burden on GPs and their teams so that they can devote more time to patient care. This will become more important as the population comes to terms with the health effects of national lockdown, the economic downturn, and the longer-term effects of COVID-19 itself.

5. Since March, there has been a significant relaxation of the administrative requirements of regulatory and contractual compliance. GPs have been trusted to implement the changes necessary for their patients, released from restrictions of heavy regulatory oversight: the suspension of CQC inspections, QOF, appraisal and revalidation, as well as a reduction in local assurance, audit and data requirements. The College recognises

that strong processes and good regulatory oversight are a vital element in delivering a safe and responsive health care service. However, an overly burdensome bureaucratic environment can hinder the delivery of care, and we would like to see a light touch, high trust approach that empowers GPs to do what they do best: plan and deliver care for their patients.

GP workload

6. Prior to the COVID-19 outbreak and national lockdown, GPs were experiencing excessive workload levels, leading to burnout and to many GPs leaving the workforce earlier than planned. [1] GPs were seeing an increase in both volume and complexity, without the resources to adequately respond.

7. In a survey by the RCGP in July 2020, GPs said that lower administration workload during the height of the pandemic, resulting from the relaxations of CQC and QOF requirements for example, meant that 67% of GPs felt less stressed and 54% felt able to deliver to higher quality patient care.[2] In the same survey, the vast majority of GPs said they anticipated several COVID-19 related issues impacting their workload in the future, including indirect consequences like longer waiting times for specialist treatments, which suggests workload is likely to rise in the coming months, especially as we approach winter.

8. Figures from the RCGP and Oxford University's Research and Surveillance Centre show that the number of GP appointments have moved back up to approximately pre-pandemic levels. While appointments over the last four weeks are down slightly on 2019 figures, this is fluctuating, and appointments were 15% higher at the end of August than in the same week in 2019. Anecdotal evidence also suggests that the length of appointments has become longer on average, and feedback from our members suggests this is likely due to remote consultations taking longer, as well as triaging for possible COVID-19 symptoms. This suggests workload could actually be higher than the current data is able to capture, as it currently only measures frequency. Clinical administration, including workload relating to referrals and communications with secondary care, requesting tests, reviewing and issuing prescriptions, has been significantly higher than the previous year for the last two months.[3] As workload levels continue to rise, it is vital that GPs are not encumbered by unnecessary processes that pull focus from their clinical work.

9. The following are three key areas we have identified that would benefit from a focus on reducing unnecessary bureaucracy:

Supporting the primary, community and secondary care interface

10. Our recent report '*General practice in a post-COVID world'* highlighted that there is a window of opportunity over the coming months to make significant progress on IT interoperability and improving digital communications between primary, secondary and community care, building on progress made during the COVID-19 pandemic, and ensuring patients are always at the centre of the decisions about their care. Poor IT

[1] https://blogs.bmj.com/bmjopen/2020/01/27/almost-a-third-of-uk-doctors-may-be-burnt-out-and-stressed-poll-suggests/
[2] RCGP survey data of 859 GPs, in field 8th to 23rd July 2020.
[3] The RCGP and Oxford University 'Workload Observatory' analysis is based on extracts from the clinical computer systems of approximately 500 practices in England, with a patient cohort broadly representative of the England population.

processes and interoperability between providers often take up significant amounts of time across the sector, which could be better used to focus on patient care.

11. There must be rapid improvement on technology interoperability between all health and care providers. Barriers to information sharing can unnecessarily complicate patient pathways and, at worst, jeopardise patient care. The College would like to see improved communication lines, supported by functioning technology and systems, such as online chat functions and resources to automatically and securely share information between primary and secondary care would promote better patient referral processes. An integrated patient record across providers of NHS care – primary care, secondary care, and community settings – would improve patient care, save patients and staff time, and ensure secure, accurate transfer of data. This should be coupled with investment into digital solutions in all care settings, which can support the delivery of best practice to reduce unnecessary administration and bureaucracy for all parties.

12. Improving interface working can be challenging, requiring strong relationships between providers, continued organisational focus on identify problems and developing solutions that can be implemented across a system. Providers across localities need to be supported to come together to address challenges as a united system. In Scotland, as part of a project funded by Scottish Government, interface groups that bring together clinicians from different providers create an environment for clinician-led solutions to be developed and implemented.[4] Systems should be incentivised to establish similar groups in England, supporting providers to take a whole-system approach to addressing the challenges of interface working.

Improving CQC inspections in general practice

13. CQC inspections and annual regulatory reviews are used to closely evaluate processes, with less focus on analysing the outcomes experienced by patients. GP practices are required to answer for their internal processes with excessive regularity, which adds little to the overall quality of care. Routine inspections are announced two weeks in advance, putting enormous pressure on practices to pull everything together while continuing with the day-to-day clinical work. The College would like to see the CQC move forward with a different approach in a post-COVID-19 environment, by removing annual regulatory reviews and moving to lighter touch, higher trust remote monitoring, perhaps with self-assessment tools, over a longer period of time.

12. We would like to see the CQC establish an inspection regime that is implemented on the basis of risk rather than blanket inspections for all practices. If we look, for example, following inspections, 95% practices in England were rated ‘good’ or ‘outstanding’ by the Care Quality Commission in 2019.[5] During the COVID-19 crisis, CQC implemented a regulatory approach that is based on risk rather than routine inspection. Practices that were identified as vulnerable, on the basis of externally available information or previous inspections, have been contacted by CQC to assess how they were coping and direct them to support. Inspections have been carried out where safety concerns have been raised, but these have been few.

13. The principles of this approach, which entrusts most GP practices to meet regulatory requirements, has the potential put in place a more proportionate and supportive

[4] https://www.rcgp.org.uk/rcgp-near-you/rcgp-nations/rcgp-scotland/primary-secondary-care-interface-working.aspx
[5] Care Quality Commission, The state of health care and adult social care in England 2018/19, 2019.

approach to regulatory oversight. This is informing the CQC approach in the immediate post-COVID-19 period as the systems begin to recover. We would like to see further detail on how a light touch, high trust model can be embedded in an inspection model in the long term. This will go some way to reducing regulatory workload that contributes little improving the quality of care for patients.

Improving QOF

14. QOF has been a useful tool to embed and standardised approaches and data across general practice, as well as an important source of income for practices. It is vital that any changes to QOF returns do not destabilise practice income at a time of significant economic upheaval, and instead enable GPs to continue using their professional judgement to deliver the care their patients need.

15. There is little evidence that many of the annual reviews for patients with long term conditions should be completed in that timeframe. A change to a two-year cycle would give GPs more scope to use their professional judgement to decide when these reviews are required and which patients to prioritise. Any changes that are considered for QOF cycles must maintain current funding levels in general practice, either attached to QOF or within other funding mechanisms.

16. QOF has been partially reintroduced in recent months, prioritising activity that is most important as the health service moves away from the immediate COVID-19 crisis. There are plans to reintroduce all indicators in April 2021, which will be challenging for an overstretched workforce that will still be in a recovery stage. It will make it more challenging for GPs to focus their attention on the basis of need and may introduce perverse incentives. With limited capacity available, GPs could potentially be encouraged to see patients that are easier to access in order to secure QOF payments, rather than focusing on the patients that would benefit more but are perhaps harder to reach. The content of QOF should be reviewed to ensure GPs are able to use their clinical judgement to deliver the best care for their patients.

17. The COVID-19 outbreak has the potential to radically change general practice for the better, and we hope we can work together with other key stakeholders to see some real positive changes as we move out of this crisis. We cannot return to pre-COVID-19 levels of regulatory and administrative workload, which consistently diverted GP energy away from patient care in a way that left GPs demoralised. The post-COVID-19 recovery period offers a chance to evaluate the activities that were paused in March and to permanently halt those which are unnecessary. We must grasp this opportunity to work towards a system that harnesses the professionalism of GPs to improve the quality of patient care across the country.