GP ROLE DOCUMENT

September 2023

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GP Sub has been tasked with defining the GP role in order to clearly outline work that sits within GP remit and also define work which does not. The purpose of this draft document is to support provision of a sustainable GP service across NHS Borders and to increase GP practice resilience by defining an appropriate and manageable workload. It is important GP skills are used to the best of their ability and the workload they have is high value/ high return. The importance of allowing GPs to focus on workload that sits within GMS contract and support removal of task which prevent GP's doing their role is vital for management of GP workload, GP sustainability and ongoing recruitment & retention. This document should also feed into the work being carried out by PACS around GP sustainability.

From a discussion around GP Sustainability in May 2022 three themes were highlighted;

1. Equity -
    - For patients
    - GP workload
    - Services in comparison to other HB areas
    - In HB prioritisation decisions.
2. Infrastructure - fit for purpose premises and I.T.
3. Financial Stability

This document is defining appropriate GP workload tasks without defining quantity of work. It represents a consensus statement of NHS Borders GP opinion. There can be no expectation that a GP will perform tasks out with this work but there may be local variation within practices given individual GP skills. This would be additional work above core and would be non-obligatory; there should be alternative service provision for these tasks.

The role

GPs provide continuing medical care for patients in the community under GMS services. They are usually a patient's first point of contact either by telephone, being seen in the surgery, at home or within other settings such as care homes.

How we do this

Provide open access service in core hours 8-6pm Monday – Friday excluding Public Holidays
Defined practice boundary - Patients who are registered with a GP practice live within a defined area
Provide our core service to the best of our ability
Actively engage with Health Board to discussed new developments within health care where GP's believe the development to be within Primary Care Remit (Area Medical Committee/ GP Sub/ AMD PACS/ Clinical Interface Group/ Integrated Joint Board). When any potential changes to systems may have an impact on primary care, there is agreement that no part of

system changes their service without consultation/ collaboration with impacted service re workload

Tasks that sit within GP Role

- To review people who are ill, acutely ill or believe themselves to be ill under terms of GMS contract. Take responsibility for initiating investigations from GP clinical contacts as required. Onward referral within guidelines (ref-help or equivalent), applying consistent standards when appropriate
- Oversee Chronic Disease Management (classic QOF categories of T2DM- non injectables/ Hypertension/ CHD/ Heart Failure /Stroke& TIA/ COPD/ Asthma/ Thyroid/ AF/ Mental Health)

(Providing the above 2 tasks will be equivalent to having contact with approximately 5% of a GP practice entire list every week)

- Responsibility for results requested by primary care clinician (e.g. scans/ bloods/swabs /urine). This includes GP request for blood on young children where the actual taking of blood may be performed in ambulatory care but GP retains responsibility for these results
- Palliative Care/ End of life care
- Oversee repeat prescribing for drugs we are able to prescribe and are within own clinical expertise
- Admin work/ clinical email related to Primary Care workload
- Liaise with other clinicians in community and hospitals
- Fit notes when relate to Primary care episode; with recent legislation other clinicians in primary care can also complete this role
- Screening programmes e.g. providing service for taking cervical smears
- Life style advice and Health Promotion including Realistic Medicine principals
- Voluntary engagement with LES/DES e.g. DMARDS, Extended hrs, coils, implants
- Drug monitoring within LES list or agreed Shared Care Protocols with escalation to secondary care when appropriate
- Contactable by patient within core hours
- Follow up OOH microbiology results
- Intervention required immediately post discharge e.g. “U&E abnormal in BGH, please recheck in a week” but GP not to be asked to chase outstanding hospital results.
- Independent contractor- running business and employing staff
- Clinical support to practice team/ community teams
- Leadership Role within wider Primary Care team with a global overview of MDT team
- Educational role – e.g. medical students, student nurses, trainees, foundation docs
- Quality role – to be involved in cluster working and in quality improvement activities
- Provide clinical service in a cost effective way within a fixed financial resource
- Contribute financially to fund OOH - top sliced
- Work in a safe and sustainable manner

- Review and agree our working arrangement through GP Sub and Clinical Interface Group (CIG).

Tasks that do not sit within GP Role

- Arrange investigations requested by other clinicians unless requests are part of a pre-referral battery of tests for an agreed referral pathway (refhelp or equivalent) or in a collaborative agreement peer to peer for example in eating disorder case where holistic physical evaluation or investigation of abnormal results is required (e.g. anaemia). The clinician who has assessed the patient would be responsible for making any necessary onward referral.
- Follow up investigations of others clinicians. If a clinician feels a test is necessary, then test should be organised by the clinician at that time. Clinician has accountability for result and for organising follow on tests if requested as part of that initial investigation. If deviating from this, there should be in a peer to peer conversation. Regarding an issue identified in Emergency Department, which may require a follow up test the patient (or patient advocate) should be advised to make a routine appointment for follow up at GP practice to review any ongoing issues/need for further investigation. GP should not be directed to organise follow up test. In case of incidentalomas (adrenal and ovarian cysts) agreed protocols already in place.
- Pass on results of investigations organised by others. In the rare event it was felt GP may be in better position to share results of investigations organised by others this should only occur after peer to peer discussion and agreement from both parties.
- Perform examination as requested by others when not part of a patient pathway
- Arrange patient transport
- Fit notes following hospital admission - if absence is expected at time of secondary care contact or review the responsibility for issuing fit note should sit with secondary care for the expected period of time relating to that illness
- Prescribe medication requested by other clinician if out with scope of clinical competence/ regular use
- Acting as intermediary or go between patient and secondary care e.g. not asking GP to update a patient regarding an alteration to a plan that may have been agreed with patient at clinic. Responsibility to update patient should sit with secondary care/ copy of letter to patient informing of alteration
- Inform patients of GP referral being declined- should be from secondary care. This could be in form of standard template letter. As of 10-05-23 the declined referral pathway is to be discussed at CIG and this document updated
- Inform patients of change in priority of referral (urgent to routine). Standard template. As of 10-05-23 the downgraded referral pathway is to be discussed at CIG and document updated
- Initiate onward referral at request of others. Further defined; if the onward referral relates to initial referral reason or is deemed to be urgent / necessary by secondary care the referral should be made by secondary care clinician. If the decision is whether onward referral is required or not and the condition is GMS workload, then secondary care should advise patient to make a routine appointment with GP to discuss symptoms. If

required a peer to peer conversation may be beneficial at times to agree the best pathway when not clear.

- Undertake examination or investigation for forensic/ adult or child protection for purposes of documentation / evidence collection. Would only be GMS work if there is a medical requirement to do so
- Violent or challenging patients with risk or threat to practice staff. There is an alternative provision for this group of patients (Leaderfoot practice). This provides a Health Board run restricted access service for delivery of GMS services and has a contracted GP covering this role.
- Routine Antenatal care as carried out by Midwifery colleagues
- Spirometry- this may sit in Enhanced CTAC if the service is developed
- See patients out of core hours; out of hours' period or on Public Holidays (unless as part of LES above)
- Following up OOH (with exception of microbiology tests) e.g. results/ requests to visit/ GP to arrange review. Responsibility sits with patient to contact practice as default
- Private work
- Initiate investigations requested following private consultation/ procedure
- Issue prescription following private consultation; this is at the discretion of the clinician and may generate a charge. Rules around prescribing following a private consultation are being developed by NHS Borders but are in line with this
- Follow up patient following private work (including abroad)
- Organise routine planned follow up for monitoring that falls out with GMS Chronic disease categories. If ongoing requirement for monitoring this should sit with specialist. Locally agreed pathways for these areas are to be developed and Enhanced CTAC may be an opportunity to organise this workload. This will be updated as work progresses
- Undertake / complete any task that GP does not believe is clinically appropriate within their professional clinical judgement. This includes tasks which are requested without appropriate clinical information and sit out with GPs' clinical expertise
- Capacity assessment at request of third parties for guardianship assessments where specialist input is required. Please note, specialist does not imply GP or NHS Psychiatrist. Includes unnecessary requests from social work. This pathway was discussed at a short life working group following 30-8-23 and an alternative proposal is being taken to NHS Borders.
- Vaccinations including advice on whether appropriate to give or not. Vaccination delivery has been removed from GP's as part of their GMS 2018 contract. The vaccination service will advise on vaccinations required, timing and eligibility with support from Public Health in complex cases.
- Undertake or duplicate work when provided by another service e.g. PCIP staff / Treatment room/ District nurses.
- Prescribe urgent acute prescription on behalf of specialist who can prescribe when patient is present in clinic. Guidance regarding timing of scripts has been agreed at CIG. If medication is required within the next 7 days, then prescription should be done by secondary care. If can wait more than 7 days then email to practice admin box,

explaining time frame to patient and counselled regarding possible side effects, followed up with usual clinic letter.

- Prescribe off license medication unless GP is comfortable this is within their clinical competence or with exceptions of agreed paediatric medication.
- Take additional clinical risks or duties based on lack of capacity in other services
- Contact tracing or treatment of contacts on behalf of other departments (Public Health/ Sexual Health etc.)
- Providing clinical responsibility for decision making by Scottish Ambulance Service staff. GP's are content to discuss with SAS points requiring clarification / medications/ "usual baseline functioning" if known / e-kis type information. GPs will not take clinical responsibility for clinical decisions or decisions around non-conveyance to hospital following assessment by SAS. SAS clinicians have professional autonomy and their own escalation processes around decision making /risk.

Whilst GPs do have a role in coordinating care we don't oversee and organise all a patient's care needs. GPs should not be default position for care because they are geographically closest to patient. If GP workload can be contained as outlined above, the ability to deliver high value and high return care will be achievable in line with the four C's of General practice.

- Contact: General practice often the first point of contact, for the vast majority of patients seeking access to healthcare for the first time. Over 90% of NHS workload is provided in primary care.
- Comprehensiveness: It's not just about seeing the person and their presenting complaint. GPs see people in their lived experience. GPs are uniquely placed to deal with aspects of medical, social, and psychological factors. GPs ask people about something they didn't come in for and take the time to listen, identifying major issues.
- Continuity: GPs are there from cradle to grave, with care benefitting from long term relationships with patients.
- Co-ordination: Critically, GPs are able to oversee care from multiple providers and act as a 'system failure service' for the NHS. When anything goes wrong, GPs are usually the ones to hear about it. The co-ordination of services at primary care level is an important determining element in the responsiveness of health services provision and the health system as a whole.

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