



FOREWORD BY:



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It is important that all front-line health professionals concentrate on providing high quality health services to the public. Anything preventing this, particularly unnecessary red tape and bureaucracy, needs to be removed. General Practitioners highlighted the need for a reduction in bureaucracy when they were consulted about the NHS Plan in July 2000. Good progress has been made in achieving this following the first report into reducing General Practitioner paperwork 'Making a Difference'.

This second report builds on a wide range of measures to reduce and remove cumbersome procedures that hamper General Practitioners and their staff from providing the service that the public expect. The Cabinet Office's Regulatory Impact Unit and the Department of Health have worked together with doctors, nurses, managers, professional bodies, other government departments and agencies, to ensure that these burdens are removed. Equally important is the prevention of new burdens being placed on primary care. This report outlines areas where such regulation has been reduced. We believe this will lead to less pressure for GP appointments and more clinical time for patients.

We will continue to work to ensure that the changes agreed will deliver real and useful benefits for GPs and their patients.

Lord Macdonald

Lord Hunt



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EXECUTIVE SUMMARY

In April 2000 the Prime Minister announced ten key ideas that once delivered and implemented, would lead to a faster, better service from General Practitioners (GPs) to patients and greater job satisfaction for family doctors. This project supports the aims to reduce bureaucracy sought by the many thousands of staff consulted on the NHS Plan by the Department of Health in July 2000.

The purpose of this latest GPs project was to deliver practical measures to further reduce levels of paperwork with which GPs have to contend. The report continues work set out in our first GP Report (published in March 2001)¹.

The Regulatory Impact Unit's (RIU) Public Sector Team together with the Department of Health have worked in partnership with stakeholders, including practising GPs, to identify the areas where immediate action could be taken. There are also areas within the report where progress may take longer to achieve and we continue to work with our partners to facilitate improvements and ensure that reductions in bureaucracy are achieved.

The outcomes outlined in this second report relate to six main areas:

- Medicines Management and Prescribing
- Children
- Disability and Benefits
- Interface with Departments and Agencies
- Hospital and GP Interface
- Other Burdens on GPs

Fifteen significant new outcomes around the above areas are outlined in this report. Four areas from the first report have also been revised in detail in addition to these *new* areas of work. These are summarised overleaf:

¹ See Annex 1 for the progress made on the implementation of outcomes from the first report.



Outcomes	Target date for action	Potential Savings
Medicines Management and Prescribing		
Extension of Prescribing Responsibilities: Extension of independent nurse prescribing rights through the use of training and supplementary prescribing will reduce GP involvement in cases of minor ailments, minor injuries, health promotion and palliative care	Ongoing	2,545,455 appointments
Gluten Free Foods: ** A reminder will be issued via the Chief Executive Bulletin to Primary Care Trusts about the potential use of direct supply of gluten free foods without GP input	July 2002	(209,000 appointments) (20,000 hours)
Medicines Management and Prescribing: A significant issues group will be set up of all stakeholders to support Primary Care Trusts deliver effective strategies on prescribing, medicines management and pharmacy issues	August 2002	unknown
Repeat Prescribing and Dispensing: GPs can issue a single prescription for stable long-term conditions, dispensed in instalments by the pharmacist	December 2004	2,730,000 hours
Children		
Childcare, Fostering and Adoption – children 'looked after': Health Assessments are to be conducted by the most appropriate medical professional, e.g. paediatricians/etc., wherever possible	July 2002	n/a
Suitability of potential carers for fostering and/or adoption: GP involvement in adult suitability assessments will be evaluated with a view to limiting their contribution	July 2002	n/a
Certification of sickness for missed examinations: Need for GP input to be reviewed. Revised guidance issued to schools by the Joint Council for General Qualifications	July 2002	47,000 appointments

** Revised from the first GP report published in March 2001. The potential savings for these outcomes have not been included in the potential savings from the new outcomes in the second report. This is to avoid double counting.



Outcomes	Target date for action	Potential Savings
Disability and Benefits		
Motability Contract Hire Scheme: GPs will only be approached to provide advice on appropriate adaptations to vehicles where there is no other appropriate medical professional to advise	Now completed	5,300 requests for information
Appeals: Advice and guidance outlining the limit of GPs' responsibilities in appeals against unsuccessful benefit decisions has been published	Now completed	15,000 hours
Disability and Benefits: The GP's role in the process is to be simplified and benefit forms modified through several pilot studies	Ongoing	662,000 appointments (dependent on pilots)
Veterans Agency Medical Reports GP input to war pensions applications will be both minimised and simplified	End 2003	30,000 requests for information
Interface with Departments and Agencies		
Clinical Governance Reviews by the Commission for Health Improvement (CHI): The GP's role, in most cases, will be streamlined (2-3 hours approximately) in the clinical governance reviews of Primary Care Trusts	Now completed	n/a
Social Housing Applications: ** GPs will only be approached to provide clinical evidence regarding housing allocations where they are the most appropriate health professional	November 2002	(181,000 appointments) (12,000 hours)
Documentation, faxes and e-mails: Department of Health documents will contain a summary sheet of information forming a reader box	April 2003	unknown
Infectious Disease and Food Poisoning Notification: Prior to the planned review of public health law, revised guidance on food poisoning notifications will be considered to remove the need for GPs to report all isolated cases	April 2003	up to 45,000 requests for information
Hospital and GP Interface		
The Modernisation Agency will select three demonstrator sites to simplify processes and to cut out steps in the patient journey. These sites will build upon the work from the already established programmes	September 2002	unknown

** Revised from the first GP report published in March 2001. The potential savings for these outcomes have not been included in the potential savings from the new outcomes in the second report. This is to avoid double counting.



Outcomes	Target date for action	Potential Savings
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Other Burdens on GPs		
Providing reports and sick certificates for employers:** GPs no longer have to sign a certificate of sickness for an absence of less than seven days	Now completed	(2,430,000 appointments) (37,000 hours)
Access to Records: The process of checking records and the fees that GPs can charge for them will be considered as part of a review	Ongoing	n/a
Countersigning of gun applications: ** GPs will be removed from the list of appropriate countersignatories for shotgun applications	November 2002	(36,000 appointments) (6,000 hours)

Assuming the outcomes illustrated in the tables are achieved, the total numbers of new potential savings will be as follows:

Appointments freed	3.2 million
Additional hours saved	2.7 million
Number of requests for additional information removed	up to 80,000

The combined total savings² of both reports therefore is potentially 10.3 million appointments and 3.4 million hours saved per year, with up to an additional 80,000 requests for medical information removed. This will be the equivalent to the number of appointments conducted by 1,200 typical GPs in a working year.

The estimates have been based on the results of a questionnaire completed by 36 GPs and are both conservative and prudent, highlighting the potential for further additional savings in addition to the ones listed above. Whilst savings have been made, GPs may find it appropriate to continue with some practices, especially when dealing with vulnerable patients.

Every individual – whether a GP or other medical professional, a business or a member of the public – has a role to play in ensuring that as much time as possible is used for patient care.

** Revised from the first GP report published in March 2001. The savings for these outcomes have not been included in the new savings generated in the second report. This is to avoid double counting.

² A summary of savings made from the first GP report can be seen in Annex 1 (pages 31-35)



CHAPTER 1 INTRODUCTION

General Practitioner (GP) Paperwork

In April 2000 the Prime Minister announced ten key ideas that once developed and implemented, would lead to a faster, better service from General Practitioners (GPs) to patients and greater job satisfaction for family doctors. Achieving faster and better GP services means reducing the time GPs spend on:

- administration;
- providing repeat prescriptions;
- dealing with coughs, colds and other minor health problems;
- undertaking unnecessary out-of-hours calls;
- chasing up test results and arranging hospital appointments for patients;
- dealing with the administrative needs of other organisations;
- unproductive training;
- routine staff management functions, such as recruitment and pay;
- finding the latest evidence of the effectiveness of new treatments and drugs; and
- administrative processes involved in managing groups of patients.

These occupy staff and hamper effective delivery of patient care. Some paperwork is inevitable for GPs but the diversity and complexity of the current administrative bureaucracy erodes time available for patients.

As part of the Government's commitment to reduce unnecessary burdens and bureaucracy on GPs, the RIU's Public Sector Team undertook a comprehensive study in 2000/01 with front-line members of staff to identify cumbersome procedures and implement action to reduce them. The Team worked collaboratively with the Department of Health (DoH), other professionals, representative bodies and stakeholders. The aim of the first study was to deliver specific, tangible outcomes that would not expose the NHS to mis-use or error, but would reduce the existing amount of GPs paperwork. The first joint report was published in March 2001, identifying 36 agreed measures³.

The initial report was the start of a continuing process of deregulation. Changes have already been implemented from the first report that free up 1.8 million appointments and 440,000 additional hours. This second study of General Practitioners' paperwork was undertaken in 2001/02 which identifies and outlines the further measures. The work reported has increased momentum to reduce and remove further unnecessary paperwork and red-tape on General Practitioners. This is especially important if GPs are to meet targets set by the Prime Minister – for example, seeing patients within 48 hours of initial contact with the surgery. The removal of unnecessary bureaucracy and paperwork will go some way towards helping GPs to meet those targets.

³This report can be accessed at: www.cabinet-office.gov.uk/regulation/PublicSector/reports.htm Progress of the implementation of the report can be found in Annex 1 (pages 31-35).



It has been estimated⁴ that should all the new outcomes from this second report be fully implemented, the potential annual savings will amount to:

- **3.2 million appointments freed;**
- **2.7 million additional hours saved; and**
- **Up to a further 80,000 requests for medical information removed.**

The combined total savings⁵ of both reports therefore is potentially 10.3 million appointments and 3.4 million hours saved per year, with up to an additional 80,000 requests for medical information removed. This will be the equivalent to the number of appointments conducted by 1,200 typical GPs in a working year.

Analysing the Burdens – Methodology

A series of face-to-face interviews with doctors in GP surgeries was undertaken during the first GP Making a Difference Project in 2001. From this, over 100 issues were identified as being burdensome and creating a large amount of unnecessary paperwork. Thirty-six of these issues were tackled in the first project and agreements or commitments were made by departments and agencies to implement them⁶.

Subsequently, the remaining issues became the focus for the second project. The key objectives therefore were to:

- consider new regulations and processes impacting on GPs' time and to negotiate with the relevant departments and agencies to ensure that they were not making excessive demands on GPs' time away from service delivery;
- identify, research and prioritise new issues raised by GPs as overly bureaucratic;
- challenge rigorously why such paperwork and processes are required and explore alternative options;
- assess the implications of their removal or amendment; and
- agree and implement action with appropriate departments or agencies to make practical changes and so reduce the burden on front-line staff, namely General Practitioners⁷.

To ensure that the Team had consistent specialist advice throughout the project the GP Advisory Panel established for the initial project, was retained. Links were maintained with doctors who contacted the Team via correspondence, to offer further advice and information. In addition to this qualitative work, an experienced medical professional was seconded on a part-time basis to work with the Project Team. For further information about the GP Advisory Panel and its participants, refer to Annex 3. The Public Sector Team's role is outlined in detail in Annex 4.

⁴ Further information about the quantifications can be found in Annex 2 (page 36).

⁵ A summary of savings made from the first GP report can be seen in Annex 1 (pages 31-35)

⁶ Annex 1 (pages 31-35) provides a summary of the implementation progress from the first report

⁷ A more detailed consideration of the methodology used to conduct 'Making a Difference' projects can be found in Annex 4 (pages 40)



CHAPTER 2

BURDENS ADDRESSED

Changing the Culture

The Public Sector Team's (PST) second GP project seeks to deliver nineteen specific outcomes, each described in this chapter. However, although some of the reasons for patients to approach GPs have been removed or reduced, it will take longer for a change in the way both patients and organisations view GPs before unnecessary requests to GPs will begin to reduce.

Essentially, this project is an integral step towards a culture change from the way GPs work and are regarded as 'countersignatories' for a swathe of social and welfare related administrative procedures. This change will take time for full and effective implementation and all stakeholders, including professional bodies and central government, have a part to play in achieving this.

Reducing Inappropriate Approaches to GPs

The outcomes and achievements recorded in this report fall into two categories:

- The removal of a restrictive rule, revision of guidance or simplification of a process. e.g. Removing the need for GPs to sign certificates of short-term sickness for employers.
- An agreement with, or commitment from, the relevant stakeholders or 'process owners' to remove a restriction, change guidance, simplify a process or pilot a new way of working. e.g. The commitment to undertake a series of pilots to examine simplifying the GPs' role in the benefits process.

Steps have been taken to both reduce the number of instances where individuals are prompted to approach their GP for non-clinical purposes and to minimise bureaucratic procedures that are instigated by government departments and agencies. The Team has worked directly with stakeholders to deliver changes through obtaining a series of firm commitments with the relevant government departments and agencies. The savings presented are based on estimates provided by GPs and are dependent on implementation at the front-line⁸.

GPs may find it appropriate to continue to undertake some of the tasks mentioned in this chapter when dealing with a vulnerable person. Some of the areas covered can attract a fee for specific services: e.g. certification of sickness for a missed academic examination. The view of the GP Project Advisory Panel of stakeholder representatives, and many individual GPs, is that they should be freed from performing these services so that they can focus on clinical care. However, GPs can retain the choice to continue to provide services, such as countersignatories and reports, for a fee should they wish.

⁸ See Annex 2 (page 36) for more detailed information about the quantification of outcomes.



The remainder of this chapter outlines the various issues highlighted as an unnecessary burden on GPs and the associated outcomes and agreements negotiated to reduce or remove GP involvement. The report focuses on 19 outcomes around the following subject areas:

- Medicines Management and Prescribing (4 outcomes)
- Children (3 outcomes)
- Disability and Benefits (4 outcomes)
- Interface with Departments and Agencies (4 outcomes)
- Hospital and GP Interface (1 outcome)
- Other Unnecessary Burdens on GPs (3 outcomes)

Quantification of these outcomes is described in more detail in Annex 2.

Medicines Management and Prescribing

The prescribing of medicines is an important part of a GP's role in order to ensure that patients' conditions are monitored properly, that they are prescribed the right drugs, in the right dosage at the right time, and that the system is not open to fraud by patients. Current systems for prescriptions are long standing and take up a considerable amount of time both for doctors and other surgery staff members.

There are a number of long-term initiatives in medicines management as part of the Department of Health's modernisation agenda, the subsequent *NHS Plan* (July 2000) and *Pharmacy in the Future* report (September 2000). These include the plan for Electronic Transmission of Prescriptions (ETP), repeat dispensing and the extension of prescribing responsibilities for other health professionals. However, some of these changes will take a number of years to be developed, tested and fully implemented. It is important to ensure that interim measures running parallel to the wider modernisation agenda are implemented in the short term to ensure that red tape is minimised.

Action: A significant issues group, with representatives of all stakeholders, will be established to support Primary Care Trusts (PCTs) in delivering effective strategies on prescribing, medicines management and pharmacy issues.

The Modernisation Agency has agreed to set up a significant issues group to consider medicines management, including the widening of prescribing responsibilities. All key stakeholders will be invited to join the group and the first meeting will take place in August 2002.

Benefits:

The simplification of the medicines management system and the widening of prescribing responsibilities will reduce the burden on GPs and free up appointments.



Repeat Prescribing and Dispensing

Currently a repeat prescription requires a GP's signature. In the vast majority of cases, a GP or other authorised person is required to sign every time a patient requires a fresh supply of prescribed medicines or other items, even where it is not necessary to examine the patient. There are up to 410 million repeat prescriptions generated every year – equivalent to an average of 200+ per GP per week. Repeat prescriptions represent between 60% and 75% of all prescriptions annually. Changes to this activity are essential since the accumulated time burden is excessive and affects every GP in the country.

Action: GPs can issue a single prescription for stable long-term conditions, which can be dispensed in instalments by the pharmacist.

The Department of Health is committed to improving the management of repeat prescribing and dispensing procedures for patients with stable long-term conditions. A repeat dispensing system will start in Autumn 2002 with 30 Pathfinder Schemes. This will allow GPs to issue a single prescription that can be dispensed to the patient in instalments by the pharmacist. Repeat dispensing schemes will be in place nation-wide by December 2004.

Benefits: It is estimated that up to 330 million (80%) of all repeat prescriptions could be replaced with repeat dispensing over time. This could yield a saving of up to 2.7 million hours of GP and practice time⁹.

The system should also result in better management of repeat medication and increased patient satisfaction.

Gluten Free Foods

There is a range of gluten free foods that patients with coeliac disease may obtain on prescription. Patients with this condition cannot tolerate food containing gluten. However, the wide range of this type of food, some with a short shelf life (for example bread and biscuits), means that patients can make requests for up to 20 to 30 items per prescription. This is a life-long condition and consequently the cumulative number of repeat prescriptions is large. One in every 400 prescriptions is for gluten free foods. The UK is one of a few European countries that provide these food items by prescription. Some EU countries provide them by direct supply (for example through food shops) or by other means.

⁹ This figure excludes the additional 20,000 hours saved through the Gluten Free Foods item outlined on page 12.



Action: Remove the need for GPs to repeat prescribe gluten free foods through highlighting the local use of direct supply to Primary Care Trusts.

The Team has been working extensively on possible approaches to freeing up this burden for GPs. A meeting of gluten free food stakeholders was convened which represented, amongst others, the views of GPs. In addition, a survey of coeliacs was conducted that informed a broad ranging consultation exercise looking at various options for change.

The balance between appropriateness and cost effectiveness of a number of options has been explored, and this, in part, has led to the slippage of the intended implementation timetable outlined in the first GP report.

Repeat dispensing schemes to be rolled out nation-wide by the end of 2004 will include gluten free foods.

Meantime, the Department of Health will issue a reminder to all Primary Care Trusts outlining the local options available for the supply of gluten free foods. Such local options including the use of direct supply, will build upon the current examples of pharmacists supplying medicines for common ailments to people who would otherwise seek them on prescription – July 2002.

Benefits: Removal of the requirement to issue repeat prescription for gluten free foods could potentially save 209,000 appointments plus 20,000 hours.

This can become a burdensome process for GPs who have to use valuable appointment time to process, in effect, a patient's shopping list while adding no real clinical value to patient care.

Extension of Prescribing Responsibilities to other Medical Professionals

Before April 2002, GPs, dentists, district nurses, health visitors and some practice nurses were the only medical professionals who could prescribe medicines or dressings through the use of a signed prescription form. Practice nurses, who also held a district nurse or health visitor qualification, could train to prescribe from a limited formulary of medicines, dressings and appliances (known as the Nurse Prescribers' Formulary). The burden of patient appointments and preparing prescriptions therefore fell to the GP.



Action: Extension of independent nurse prescribing responsibilities following training and supplementary prescribing.

The Department of Health is increasing the type and number of nurses who can train to prescribe, and widening the range of medicines from which they can prescribe.

As from January 2002, nurses including practice nurses, can attend a degree-level training course to prescribe medicines for a range of minor ailments, minor injuries, health promotion and palliative care. This will allow greater scope for patients to see nurses, potentially reducing the number of GP appointments. The course is based on credits and spans a three-month period. In 2003, the Department will review whether the course can be spread over a longer period of up to six months, following concerns from GPs about locum cover for absent staff.

In addition, since April 2002, the Department of Health and the Medicines Control Agency have been consulting on plans for supplementary prescribing. This will allow nurses or pharmacists to prescribe medicines within the limits of a patient-specific clinical management plan for patients with non-acute medical conditions or health needs.

Benefits: A full time nurse prescriber, whose working week may typically include 4 independent surgeries, should see at least 1,760 patients per year who would otherwise need a GP appointment. This could mean that patients being seen and treated by nurse prescribers would potentially free at least 2.5 million GP appointments in 2002.

The potential for practice nurses to train and undertake independent nurse prescribing for minor ailments, minor injuries and health promotion, as well as the opportunity for practice nurses to become supplementary prescribers for non-acute conditions and health needs, will free up further appointment time for both patients and GPs alike. However, the savings calculated relies on the assumption that nurse prescribers would take work directly away from GPs. There would be an element of new demand, including enhanced patient follow-up, possibly more referrals to GPs from nurses, and certainly a new need for team meetings. All of these will reduce the time saved.

Children

The Government, through Social Services Departments, GPs and the wider health sector protects children and plays an important role in their well-being. However, there are a number of areas where other health professionals are better placed to provide the level of care and medical supervision needed for children. These are outlined below in more detail.



Childcare, Fostering and Adoption – children ‘looked after’

As part of the process of promoting their health and well-being, all ‘looked after’ children are required by law to receive a full Health Assessment by a medical practitioner. In practice, the GP is often called upon to provide this examination as a matter of urgency. GPs have expressed concern over whether they are the most appropriate medical professional to carry out examinations and to identify possible problems, especially where there are concerns about child protection issues. It was expressed by GP representatives that this is a specialist area and that examinations require a high level of expertise in order to ensure that the child is not placed in potentially damaging environments or in danger due to a lack of specialist knowledge.

Action: Health Assessments will be conducted by the most appropriate medical professional wherever possible. This means that GPs will largely be removed from this process.

Due to the shift of responsibility for the health of ‘looked after’ children to Primary Care Trusts (PCTs) in April 2002, the Department of Health will change the Children Act regulations by July 2002. This will require the first health assessment of ‘looked after’ children to be conducted by an appropriate registered medical practitioner. This may be a designated paediatrician, but could be any suitably trained registered medical professional or a GP with a special interest. Thereafter an appropriately trained nurse or midwife may undertake review health assessments. The British Association for Adoption and Fostering (BAAF) have agreed to change their medical forms to reflect these changes – July 2002.

Benefits: It is expected that these changes will reduce the need for GPs to undertake medical examinations for approximately 34,000 children entering the adoption and long term fostering system each year.

GPs will potentially be removed from the process allowing not only time-savings but, perhaps more importantly, a more specialised assessment and examination of children entering the care system.

Suitability of potential carers for fostering and/or adoption

GPs are often asked to provide medical examinations on potential carers of children for fostering or adoption. The data collected as part of the examination is extensive and ranges from lifestyle issues such as smoking or drinking, to known or current family medical conditions. Perhaps more significantly, GPs are asked to offer an opinion as to an applicant’s suitability as a provider of care to a potentially vulnerable child. GPs argue that they do not necessarily know applicants sufficiently well to form an authoritative opinion. Furthermore, such a request potentially compromises the doctor-patient relationship. This issue is finely balanced, as many GPs will have an extensive knowledge of the applicants and their families. Where this is the case, they may be able to make a valuable contribution to the final decision process by identifying the potential risk factors which would affect the applicant’s ability and appropriateness to provide care for a child.



Action: GP involvement in adult suitability assessments will be evaluated with the view to limiting their contribution.

The British Associations for Adoption and Fostering (BAAF) has agreed to review the use of the medical form AH1 with a view to the patient completing the lifestyle elements of the form. GPs will then be able to use this information together with information from the medical examination and patient history to identify risk factors, which may affect their ability to provide care for a child. The statement at the end of the form will be revised so that it provides an assessment of the clinical information gathered and identifies the risks that need to be taken into consideration in determining an applicant's ability to care for a child, rather than a subjective opinion – July 2002.

Benefits:

In addition to time-savings for GPs, the proposed changes will reduce ethical concerns of GPs and make the process much more objective by being based on clinical facts rather than imprecise opinions.

Certification of sickness for missed examinations

Requests for sickness certification can rise steeply amongst pupils and students over examination periods. GPs are asked to provide a certificate to prove illness and schools often ask for medical certificates to support applications for 'special consideration' to the examination board.

A similar issue is the recovery of exam fees by some schools from parents where the child does not take the examinations in an attempt to reduce the attrition rate for examinations.

Action: Need for GP input to be reviewed.

The Joint Council for General Qualifications has agreed to review their guidance on special consideration with a view to limiting the circumstances requiring GP input. Schools to be given clearer guidance on situations where either a statement from the school or letter from parents will be sufficient evidence to support applications for special consideration – July 2002

Benefits: 47,000 appointments freed (or 6,000 hours saved).

By reducing GP involvement in sickness certification for school children in exam situations in a similar style to general sickness certification, the potential amount of appointments saved is huge especially in urban areas where the school population is higher.



Disability and Benefits

GPs are often asked to provide medical reports or to supply additional medical information in relation to patients who are claiming benefits on the grounds of sickness or disability. This medical information is used to ensure that decisions on state benefit entitlement are made promptly, fairly and in accordance with the law. The award of a benefit can make a difference to the quality of life of a person who is sick or disabled and can have a positive impact on their overall health. However, in many cases a return to work, allowing for any adjustments or restrictions imposed by the condition, can be the best route to financial self support and a more healthy life.

State Incapacity Benefits – Further Medical Evidence: GPs are required to supply factual information to a medical officer on a patient to whom they have issued a medical statement and who is being assessed by the Department for Work and Pensions in relation to State Incapacity Benefits.

Job Seekers Allowance: in a few cases where a Job Seekers Allowance claimant with a medical problem or disability is being assessed for a specific job or type of job, a medical report may be requested from the patient's doctor. GPs feel that they add little value to the process.

Disability Benefits: reports may be requested in relation to a patient who is claiming Disability Living Allowance (DLA) or Attendance Allowance (AA) – these reports are requested by the Department for Work and Pensions decision makers or by a Medical Services doctor.

Action: The GP's role in the process is to be simplified and the benefit forms to be modified accordingly through a number of pilot studies.

The Department for Work and Pensions is conducting a number of pilots around the country to see if alternative methods of gaining medical evidence will be viable and sustainable. Should these pilots be a success, the GPs role would be simplified considerably. Pilots commenced in January 2002.

The pilots include:

- new arrangements for gathering evidence by the Medical Officers who provide advice to Benefit Decision Makers in relation to the Personal Capability Assessment;
- a revised form DP2 which, subject to successful evaluation of the pilot exercise, will be rolled out for national use later in 2002;
- a new training package for Benefit Decision Makers, aimed at ensuring they seek the right form of corroborative evidence.

The Department for Work and Pensions is also planning a review of the forms and processes used to seek evidence from claimants' GPs. The review started in the early part of 2002. The PST will continue to work with the Department as the various proposals coming from this review are developed, piloted, and evaluated.



Benefits: 662,000 appointments or 71,000 hours saved.

By removing the GP from the process almost completely, it would free up a considerable amount of time. It should be noted that the savings quoted above have been derived purely from requests of information for the Disability Living Allowance and State Incapacity Benefits and exclude Job Seekers Allowance statistics. Therefore the savings could be higher. The calculations have not been based in terms of appointments saved as all the report forms can be completed by the GP without the need for an appointment.

Motability Contract Hire Scheme

The Motability Scheme often approaches GPs when an individual considers that changes in their disability affect their ability to use their current vehicle. GPs are asked to give advice on what adaptations to the vehicle would be necessary to enable the patient to drive or use the vehicle in both comfort and safety.

Action: GPs will only be approached to provide advice on appropriate adaptations where there is no other appropriate medical professional to advise.

Motability have agreed to revise the procedure for obtaining information about necessary adaptations to vehicles following a disablement. The Termination Forms will be revised so that any medical professional contacted will be able to provide information on how a condition has affected an individual's ability to drive. These would include for example, Hospital Specialists/Consultants, Occupational Therapists and Specialist Nurses. Prior to new stock being delivered, the standard letter, which accompanies the termination form, will be amended to reflect this change in procedure – March 2002. **Now completed.**

Benefits: The acceptance by Motability of advice from specialists other than GPs should reduce the number of requests for opinions by GPs by around 5,300 per year.

The revision of the Termination Forms will free up both GP time (and appointment time) otherwise spent on advising on appropriate adaptations for vehicles.

Veterans Agency Medical Reports

When applicants seek a War Pension, Ministry of Defence Medical Advisers may contact the applicant's GP requesting a factual report. This occurs when MoD medical records contain insufficient information on which to determine the application. The information provided by the GP helps to establish whether there is a causal link between the applicant's medical condition and their previous service in the forces. This can take up considerable time, as it may be necessary for the GP to consult a patient's complete medical history to gather the information needed.



Action: GP input will be both minimised and simplified.

As part of an ongoing review of the compensation arrangements for injuries, illness or death related to service in the Armed Forces, the Ministry of Defence will consider ways in which to simplify and reduce the need for GPs to be involved. As part of this review, a consultation exercise is underway, the results of which are currently being analysed. Any changes will require the introduction of primary legislation so it is not anticipated that any changes will be introduced much before 2004.

The Veterans Agency has agreed to work with the Public Sector Team to consider how best to effect change and the extent to which a Regulatory Reform Order could be used to shorten the change process – July 2003.

Benefits: The work to streamline the War Pensions system could help to simplify, or reduce the need for up to 30,000 medical reports per year.

Currently in the United Kingdom, there are approximately 300,000 'live' pensions and an additional 15,000 – 20,000 new claims and applications each year. A significant number of these claims will require some input from the GP and so by minimising their input into the process, will mean significant time-saving.

Appeals

There have been some concerns voiced by GPs about the referral of unsuccessful benefit applicants to their GP in order to gain support for their appeal. Whilst there is no statutory requirement on GPs to provide such information, many doctors feel a moral obligation to support those patients in their appeals, which adds to both the paperwork and imposes an unnecessary burden on GPs. A GP may still choose to provide this information, or alternatively, another health professional.

Action: Advice has been issued regarding the GP's role in appeals.

The Department for Work and Pensions Chief Medical Advisor has issued guidance and advice to certifying doctors about their limited legal responsibility in appeals. This information can be found at: www.dwp.gov.uk/medical/faq.htm

Benefits: 15,000 hours saved per annum.

There are approximately 450,000 requests for information to support an appeal. Through clarifying the role of GPs, there is the potential to save both time and free appointment time.



Interface with Departments and Agencies

Within any organisation or business, there is significant interface with a whole series of other organisations. Sometimes these interfaces need to explore tensions and competing priorities: GP Practices are no different.

There are a number of different issues arising from contact with government departments, other public bodies and related agencies, which GPs see as burdensome and unnecessary. These are explored in further detail below.

Documentation, faxes and e-mails

Doctors, practice nurses and practice managers receive documents from a number of bodies within the health sector – either sent through the post, electronically or faxed. The documents differ considerably – from lengthy documents that require a response to an urgent single page bulletin about the prescribing of a particular drug. Often, documents are not summarised and a considerable amount of time is spent determining the content, who it is aimed at (doctor, nurse or manager) and what action is required. Potentially, documents that are important may not get read due to the time constraints already placed on GPs and their surgeries.

The Department of Health is already taking action to ensure that documents issued centrally are managed through its Gateway Project. One function of this new Gateway is to ensure that documents are sent out to the NHS only where it is absolutely necessary to do so, in all other cases documents are summarised in weekly bulletins, with complete texts being made available over the internet.

The documents issued through this Gateway may be made more usable by the adoption of a universal documentation classification system which would add a summary description of the advice contained, and clearer definition of the actions to be taken, by whom and by when.

Action: Documents generated within the Department of Health will contain a summary sheet of information forming a universal document classification system and reader box.

Commitment has been obtained from the Department of Health to consider the development and introduction of a simple and understandable reader box. This means that all documents generated would have a simple summary sheet that outlines the content of the document and key actions required.

The Department of Health will consult on this over the following year with a view to introducing such a system nation-wide and promoting its use across the health service – March 2003.



Benefits:

There is a potential for real and significant time-savings both for GPs and for practice managers. They will be able to identify quickly what information is expected and when. This will also remove the need to spend time reading unnecessary communications. In the longer term, and if the approach is adopted generically within the Department, there will be further time-savings for NHS managers and recipients of guidance.

NB. It has been difficult to quantify the amount of potential time saved through implementing such a scheme as the amount of documentation received varies on a daily and weekly basis.

Infectious Disease and Food Poisoning Notification

As part of the arrangements for preventing and controlling infectious disease, doctors are required by law to report cases of certain diseases. Many of the laboratories that analyse the samples that GPs take from patients also report cases of notifiable disease, although on a voluntary basis. These reports make an important contribution to the data needed, not only to trace individual outbreaks to their source, but also to identify changing trends and patterns in disease so as to inform action by the health service to avoid further spread. Nevertheless, there is some duplication of reporting under current arrangements, where both the laboratory and the doctor report the same case on the basis of the same laboratory analysis.

Some notifications of food poisoning may also be unnecessary as current guidance to doctors specifies a very wide-ranging definition for such illnesses.

Action: In the short-term, the Department of Health will consider implementing changes to the system of notification of food poisonings that do not require amendment of the existing relevant laws. In the medium to longer term, a formal review of the public health legislation is planned to follow the establishment of the Health Protection Agency in 2003.

The Chief Medical Officer published a strategy for infectious disease control, *'Getting Ahead of the Curve'* in January 2002. This strategy proposes that responsibility for various aspects of work to protect the public from infectious diseases and other aspects of health protection should be placed in a new body. The aim is to establish a Health Protection Agency by 2003.

The Department is committed to a review of public health law following the establishment of the Agency in 2003, although it has agreed to consider whether any changes can be in advance of this.



Benefits: Changes in the way that food poisoning is notified could remove the need for GPs to notify some of the 45,000 cases of food poisoning or suspected food poisoning they notify each year. Changes to other notification requirements could also reduce the burden placed on GPs.

Any changes made will take account of the need to maintain surveillance of conditions which pose significant health threats, and of the fact that the main purpose of notification is to ensure prompt investigation and control of potential outbreaks.

Clinical Governance Reviews by the Commission for Health Improvement (CHI)

The Commission for Health Improvement¹⁰ is currently undertaking a series of clinical governance reviews of Primary Care Trusts that started in January 2002. Primary Care Trusts will be subject to these reviews every four years. These reviews will involve GPs, some to a greater or lesser extent than others. Concerns were voiced when the consultation document and seminar outlined the extensive inspection processes that could be undertaken and the volume of work that might be required.

Action: The GP's role, in most cases, will be minimal in the clinical governance reviews of Primary Care Trusts.

The clinical governance reviews will be focused on the Primary Care Trusts and the processes and systems that they have in place to assess and monitor clinical governance. CHI has committed itself to conduct several pilots that will be used to test their inspection procedures before the nation-wide rollout. CHI have indicated that they do not expect the burdens on GPs to exceed 2-3 hours maximum in most cases.

In order to streamline inspection regimes and quality assurance accreditation, CHI has agreed to recognise the Royal College's Quality Team Development (QTD) certificate that some GP Surgeries already have. This certificate aims to assess the quality of primary care patient services; CHI will not assess those surgeries on issues covered by this certificate. This should avoid some potential duplication and bureaucracy – January 2002 (now completed).

CHI is committed to consult, continuing their involvement with the PST and Department of Health officials in the pilot consultation and feedback sessions to ensure that the future inspection regimes generate as little additional burden as possible – May 2002.

¹⁰ The Commission for Health Improvement is a health inspection body.



Benefits:

Through early collaboration by CHI with other stakeholders prior to the reviews starting, measures that may have been burdensome were screened out. All acknowledge that over-burdensome paperwork and administration is counter-productive to achieving good service delivery and standards, thereby allowing GPs to focus on the patients. CHI is very mindful of the need to keep the amount of paperwork and bureaucracy required by a review to the minimum compatible with the requirements of public assurance.

Social Housing Applications

The allocation of social housing is a complicated issue and in some cases, medical information is required from GPs. However, there appears to be a rising misperception that a letter of support or recommendation by a GP is always required and increases the likelihood of being allocated housing. Applicants often go directly to the GP and ask for a letter of support, wasting valuable appointment time. In reality, individual requests for GP support do not always have a significant bearing on the outcome allocation of housing.

Action: GPs will only be approached to provide clinical evidence regarding housing allocations when their input is essential and no-one else can provide it.

Revised DTLR guidance regarding the allocation of social housing is to be issued for consultation by November 2002. It will remove the need for medical evidence to be provided solely through the GP. Instead, the information should be gathered through the most appropriate medical professional, with health visitors, midwives and occupational therapists being cited as possible alternative sources of information – November 2002 to issue consultation document.

There is a commitment to ensure that all Housing Association or Local Authority guidance states that where appropriate, supplementary medical evidence will be gathered by them.

Benefits: 181,000 appointments freed plus 16,000 hours saved.

Unnecessary appointment time will be saved once applicants are made aware that a GP letter of support or recommendation will only be sought when GPs are the most appropriate medical professional in relation to the allocation of social housing. In addition to this, GPs are freed from unnecessary paperwork and administration.



Hospital and GP Interface

General Practitioners and hospitals communicate daily in various ways. Patients referred to hospital, either for diagnosis or for an appointment with a consultant, want to know that they will receive high quality care; that they will be seen quickly, at a date and time convenient to them, and that their care will be seamless as they move between different parts of the health service.

To provide this service requires openness and good communications at all stages of the patient journey.

There are concerns however, that this interaction between primary and secondary care is not as effective as it could be. This has been recognised by the establishment of the Department of Health's Modernisation Agency. The Agency's programmes are helping local health communities to simplify processes and cut out the steps in the patient journey that add no value. This work also helps different parts of the NHS improve the way that patients move between different parts of the system, and considers the patient pathway from before, and up to the point of discharge. The focus of this work puts patients at the centre of their journey and ensures good systems are in place so that communication between clinicians take place at the right time and place.

These interaction issues will also be considered as part of the Hospitals 'Making a Difference' report¹¹.

Patient Referrals

GPs refer patients to hospitals for either diagnostic tests, consultation or in some cases, direct for surgery. Where they deal with more than one NHS Trust, they may have to follow different processes in order to make the referral.

Hospital referral forms – Where GPs are asked to complete referral forms, these vary from hospital to hospital and in some cases from specialist to specialist, requiring different information depending on the hospital or speciality.

Referral acknowledgements – Where hospitals acknowledge a referral, the acknowledgement letter does not include any clinical content (or even information on when the patients will be seen) and creates an administrative burden on hospitals and GP Surgeries.

Referral to another hospital department – Where patients need to be seen by a different hospital department/specialist they are often referred back to the GP for a new referral. This interrupts the patient journey and also slows down the process for the patient.

Referral to medical appliances department – GPs seeking medical appliances from hospitals need a referral from a hospital consultant. For example, where a patient has been recommended special shoes from a community chiropodist, approval is needed from an orthopaedic surgeon.

¹¹ The 'Making a Difference: Reducing Burdens in Hospitals' report will be published in July 2002.



Appointments and Admissions System

GPs have expressed concern over the amount of time spent following up hospital appointments for patients. For example, patients return to their GPs if they want to be seen earlier by the hospital, to change the appointment or simply to make sure that the referral has been made.

Programmes such as the Booked Admissions Programme (including electronic booking), the Cancer Services Collaborative, the Coronary Heart Disease Collaborative, and Action On initiative have been set up and will help address the GP-Hospital interface.

Action: A number of programmes will be established to consider the Hospital-GP interface.

The Modernisation Agency has agreed to select three Demonstrator sites to develop best practice between GPs and acute trusts. Over 12 months, Demonstrator sites will examine ways of simplifying both the referral process, appointments and admissions systems, drawing on work from the already established programmes. Processes developed will form part of the PCT Competency Framework – Demonstrator sites will be established in September 2002.

Benefits:

The Demonstrator sites will be used to further develop a consistent approach to referrals, appointments and admissions to remove unnecessary steps in the process. This will help streamline the care system and reduce the amount of time GPs have to spend on referrals and in making enquiries about appointments on behalf of patients. This will free up valuable appointment time.

Other Burdens on GPs

In addition to the main topic areas as outlined above, there are a number of other single issues where red-tape and burdens have been reduced or removed.

Access to Records

The number of cases of patients or their representatives seeking access to medical records is increasing; the majority of such records are paper-based. Increased demands for records causes a huge administrative burden on GP Practices and diverts time away from patient care and appointments. In addition, there is currently a long standing requirement for doctors to screen all records prior to patients seeing them. There are also concerns about the level of fees that GPs are able to charge for such requests.



Action: The process of obtaining records and the fees that GPs can charge will be considered as part of a wider review of access to medical records.

The Department of Health is undertaking a broad review of the Data Protection regulations that govern individuals' rights of access to their health records. Part of the remit of the working group will be to establish fair and equitable guidance on NHS charges for access to records by patients and their representatives. The review will look at treatment of family history data, the continuing applicability of the long-standing requirement for doctors to screen records before patients see them, and regulations around the use of individuals' NHS numbers. The working group will report its recommendations to Ministers in August 2003. The Department of Health has agreed to consult the Team on the development of proposals coming from the working group.

Benefits:

A Department of Health study in 1998 indicated that there are approximately 500,000 requests for access to personal medical records. It is estimated however, that the 1998 figure has more than doubled in the last five years.

Countersigning of gun applications

As part of the first GP project, a Home Office commitment was secured to remove the requirement for GPs to countersign shotgun and firearm applications. However, it was recognised that a review of the whole system and process was necessary, which additionally required changes in primary legislation.

In the interim, the Home Office, Cabinet Office and other key stakeholders have worked actively to discourage applicants from making an appointment with their GP for the purpose of countersigning an application form and highlighting other possible countersignatories to be used in place of a GP. To that end, a letter was issued to the police and shooting organisations on 3 August 2001.

Action: GPs will no longer need to countersign applications for shotgun applications.

Whilst the target from the first GP Project has not yet been achieved, the intention to change from a system of countersigning remains to bring the application process in line with the firearms process. The Home Office has committed itself to fulfilling this through the change in primary legislation – November 2002.

Benefits: 36,000 appointments plus 6,000 hours.

Removing GPs from the application process frees up time that can now be spent on patient care.



Providing reports and sick certificates for employers

The Managing Absence Campaign is an outcome of the Public Sector Team's first '*Making a Difference – Reducing GP paperwork*' report. The key message is that private and public sector employers should take greater responsibility for managing short-term sickness absence, rather than demanding sick notes from GPs. By shifting the responsibility from GPs to employers, limited NHS resources are freed up, and employers are in a better position to manage sickness absenteeism effectively. The campaign is being run by the Doctor Patient Partnership (DPP), and is supported by a wide range of employer, employee, and healthcare representative bodies, as well as the Department of Health and the Department for Work and Pensions.

Action: GPs no longer have to sign a certificate of sickness for an absence less than seven days.

The campaign began with the BMA's General Practitioners Committee distributing 500,000 leaflets to all 41,000 GPs via Local Medical Committees in December 2001. The leaflet is also available in bulk from the DPP, and in a downloadable form on the DPP campaign website. The Managing Absence' website (www.managingabsence.org.uk) provides employers with information and links to organisations which can offer advice on the most effective ways of managing absence. In addition, key employer organisations including the British Chamber of Commerce, Confederation of British Industry and Federation of Small Businesses, have published the campaign message through direct communications to members via newsletters, updates and journals. It is expected to reach approximately 308,000 of their member employer organisations. The Cabinet Office has contacted all personnel departments in the Civil Service and other public sector organisations to ensure that their sickness absence management practices conform to the campaign's recommendations.

Benefits: 2,430,000 appointments plus 37,000 hours.

The effectiveness of the campaign will continue to be monitored and evaluated by the Doctor Patient Partnership. It is estimated that, over time, the campaign could save 2.4 million unnecessary GP appointments plus an additional 37,000 hours of GP time each year.



CHAPTER 3

WHAT CAN OTHERS DO TO REDUCE BUREAUCRATIC BURDENS?

Everyone has a role to play in delivering real change, and this chapter highlights action that can be taken to reduce burdens on GPs without compromising their provision of a high quality and responsive service.

Citizens

- **Do not contact your GP for non-medical reasons.**

The time taken by your GP to countersign documents such as passport applications and driving licence applications, or to complete forms such as a Housing Application Form, could be spent treating patients and reducing waiting times.

- **Consider alternative sources of advice or information where appropriate.**

For example, pharmacists and NHS Direct can offer you advice and information and will be able to advise you of the correct route to take to resolve some medical problems. Alternatively, Practice Nurses may be able to offer you advice or deal with minor medical conditions or procedures such as immunisations – ask your GP Surgery Practice Staff for further information. NHS Direct can be contacted on 0845-4647 or via their web-site at: www.nhsdirect.nhs.uk/

- **Unsure about whether to make an appointment with your GP? Speak to the practice staff at your GP Surgery.**

Practice staff are trained to deal with your enquiries and treat all information as confidential. They may advise you that other professionals are better placed to provide you with the appropriate advice or information.

- **Consider if your GP is the most appropriate person to provide medical information if you are asked for it. Other medical professionals may be better suited.**

Some organisations may ask for medical information, and a name of a medical professional that they can approach. Your GP may not have the most up-to-date information. Could someone else – such as a health visitor or nurse – provide more accurate and up-to-date information about you?

Public Sector Organisations, including Government Departments

- **Do not automatically seek information from a GP.**

Find out what relevant information is available from another source such as other government departments and agencies. For example, the individual may receive certain benefits for which a medical assessment has been already been necessary. Please contact the Cabinet Office Public Sector Team if data sharing appears to be a problem. Contact details can be found on page 39 of this report.

- **Investigate the use of self-certification.**

Ask the individual to complete a medical assessment form themselves for example. Where there are barriers to this, consideration should be given to a two phased approach, whereby initial self-certification is practised with a follow-up assessment if further information is needed. Follow-ups should be the exception rather than the rule.



- **Consider other appropriate people to provide the required information.**
Ask yourself whether the GP is the only, or the most appropriate person, to obtain the information that you are seeking. Use other professionals or persons who may be in regular contact with the individual to gain such information. They may be better placed to give you precisely what you want.
- **Contemplate the use of other medical professionals where appropriate.**
Occupational health specialists and other medical professionals are trained to advise on the effects that a medical condition will have on a person's ability to undertake particular tasks.
- **Where the information from a GP is essential, ensure that only factual clinical information is requested.**
GPs should not be asked to offer opinions about the effects of a condition where factual information alone will suffice. Asking for an opinion can cause subjectivity, which may lead to misleading information being given, and it can also compromise the relationship between a GP and their patient.

Businesses

- **Consider whether medical information or forms for employees need to be provided or completed by the GP.**
Before asking an employee to consult their doctor for a letter or form asking for medical information, consider whether it is absolutely necessary.
- **Employee Absenteeism and Sick Certification – use self-certification for periods of absence less than seven days.**
Employers are in the best position to manage employees' absenteeism. Under self-certification regulations introduced in 1982, GPs are not required to provide a statutory 'fitness for work' statement if the employee has been absent for less than seven days. Ensure that sickness absence management policies reflect this, and ask that employees use self-certification for the first seven days of absence. You may also wish to consider additional procedures to support the use of self-certification, such as 'Return to Work' interviews.
- **Contemplate the referral to occupational health specialists following recurrent periods of illness.**
This may help to give a more accurate picture of an employee's health to assist in sickness absence management.



General Practices

- **Help to publicise the outcomes of this report to inform your patients on how they can avoid asking you for information that you are no longer required to provide.**
The Cabinet Office and Department of Health will be running a poster campaign outlining areas where GPs are no longer required take action.
- **Train and educate your practice staff to query why an appointment, letter, verification or certificate is being requested.**
Encourage your practice staff to ask questions and to refer the patient or organisation to a more appropriate information source where necessary.
- **If a patient or organisation asks you to do something that you think is unrelated to clinical diagnoses or treatment, then contact those responsible for the request and let them know.**
The communication to patients and organisations about the limits of GP involvement will take a long time to filter through and it is therefore important that everyone takes responsibility for this. Where organisations or individuals are placing unnecessary burdens on GPs, they should be informed of these to avoid such a situation occurring in the future.



CHAPTER 4 CONCLUSIONS

GP commitment to improving standards in the health service and providing a high quality, responsive service to the public remains strong. However, both of the *'Making a Difference'* reports on GPs have found many examples where this is hampered by unnecessary red tape and paperwork. Over the last eighteen months, the Cabinet Office Public Sector Team (PST) and the Department of Health (DoH) have worked extensively with front-line members of staff and other stakeholders to determine the bureaucratic barriers to an effective service. The Team has collaborated with the relevant stakeholders in an attempt to reduce or remove these burdens.

It has often been found that, over time, numerous small administrative burdens have accumulated. Cumulatively these hinder effective implementation. From experience, it has transpired that many of these obstacles have occurred due to the considerable organisational distance between front-line members of staff and those imposing the burden through operational policies, plans, rules and demands for information. Many of the stakeholders were simply unaware or underestimated the extent of the burden that procedures were placing on GPs. In all of the measures presented in this report Government bodies, agencies and other bodies have worked with commitment to reduce or entirely remove the burdens wherever possible.

It is perhaps important to note that establishing a permanent 'culture' to ensure that minimal paperwork burdens are placed on GPs is not a short-term project and cannot be achieved in the lifetime of a single project. The Team will continue to work in partnership with the key stakeholders to ensure implementation of the changes agreed and reported. This partnership approach is in itself an effective way to embed the right attitude to promote change and less burdensome ways of doing things.

In order to support the implementation and monitoring of the outcomes in this report, it is anticipated that the GP Project Advisory Panel will evolve to undertake this role. The Panel will remain in existence and will continue to facilitate and monitor the implementation of the outcomes in this and the previous GP reports in partnership with the Department of Health. Its purpose will be to ensure that the objective of saving GP time is met and will conduct an implementation review on an annual basis. Ownership and implementation of the outcomes primarily remains the responsibility of the organisation, agency or department stated in the report.



ANNEX 1

GP I 'MAKING A DIFFERENCE' PROJECT (MARCH 2001) – PROGRESS UPDATE

Since the publication of the first GP 'Making a Difference' report in March 2001, the Public Sector Team has continued to work with the stakeholders responsible for making changes to published agreements and commitments. This was to ensure, where possible, that they are delivered on time and benefit front-line staff. The purpose of this annex is to outline the progress made to date and to identify those areas still being developed.

Further, more detailed, information can be found in the Public Sector Team's *Making a Difference Progress Report 1999-2001*:

Achieved outcomes from the GP I Report

A total of 24 out of 36 outcomes have now been achieved. These are:

Identified Burden	Responsible Department or Agency to carry forward change	Action Taken
The number of medical reports produced by GPs for life insurance companies is being reduced	Association of British Insurers (ABI)	Circular issued to all ABI members, advising reduced referrals (March 2001)
GPs will no longer be expected to provide patients with a certificate to explain a short-term absence from an attendance centre	Youth Justice Board for England & Wales (YJB)	Circular issued to all Attendance Centre Officers in Charge, advising that GPs need not be consulted for short term sickness absences (March 2001)
GPs do not need to certify whether private pensions holders are still alive	Association of British Insurers (ABI)	The Association of British Insurers has issued guidance to annuity providers to remove from forms sent to annuitants the suggestion that the GP could countersign to confirm their existence (March 2001)
Surgery staff other than GPs will be allowed to 'sign off' pre-notification breast & cervical screening lists	Department of Health (DoH)	Revised procedure notified to GPs via a DoH GP Bulletin (March 2001)
GPs should only be asked to certify 'dial-a-ride' applications in exceptional circumstances. On these rare occasions, GPs will be asked to provide factual clinical information only	Department for Transport, Local Government & Regions (DTLR)	Article advising of change appeared in 'Community Transport' publication (March 2001)
The development of local protocols on child health & education – covering the most appropriate role for a GP – will be encouraged	Cabinet Office (CO) in liaison with the Department of Health (DoH), Department for Education & Skills (DfES) and the Local Government Association (LGA)	Letter issued by the Cabinet Office to all Directors of Education advising Local Education Authorities (LEAs) and Heath Authorities (HAs) to co-operate at a local level to formulate joint child health policies (April 2001)

Identified Burden	Responsible Department or Agency to carry forward change	Action Taken
GPs should only be approached regarding the entitlement of a disabled person to a free telephone (or related equipment) or help with minor alterations to their home , when no other professional can provide the information	Department of Health (DoH)	Revised procedure notified GPs via a DoH Chief Executive Bulletin (<i>April 2001</i>)
Practice nurses will be able to issue certificates to jurors in the event of sickness during service	Crown Court Operations Directorate (Court Service)	Circular issued to all Crown Court Managers advising them of new arrangement (<i>April 2001</i>)
GPs will no longer be expected to sign applications for a Disabled Persons Railcard for people with severe epilepsy	The Association of Train Operating Companies (ATOC)	Revised guidance issued in ATOC 'Rail Travel for Disabled Passengers' booklet (<i>May 2001</i>)
GPs should be approached regarding applications for concessionary bus fares only when their input is essential. On these rare occasions, only confirmation of clinical information will be requested.	Department for Transport, Local Government & Regions (DTLR)	Changes published in guidance on 'Concessionary Fares for Disabled People' under the Transport Act 2000 (<i>May 2001</i>)
GPs are not required to record injuries for police purposes	Association of Chief Police Officers (ACPO)	Circular issued to all Chief Police Officers advising of revised practice. (<i>June 2001</i>)
GPs do not need to provide jurors with a certificate to excuse them from jury service	Crown Court Operations Directorate (Court Service)	Court Service circular 'Juror Update' issued to all courts advising of revised procedure (<i>June 2001</i>)
GPs are not required to certify immunisation returns	Department of Health (DoH)	Local arrangements under the terms of the 'Red Book' notified to Health Authorities (<i>June 2001</i>)
GPs no longer need to make a declaration in support of patients who wish to have a postal vote	Department for Transport, Local Government & Regions (DTLR)	Legislative change made. Representation of the People Act 2000 now applies (<i>June 2001</i>)
The maternity certificates (form MATB1) completed by health professionals (incl. GPs) as part of the Sure Start Maternity Grant (SSMG) claim will be reviewed	Department for Work & Pensions (DWP)	MATB1 & SSMG forms reviewed (<i>June 2001</i>) SSMG form revised removing reference to GPs (<i>October 2001</i>)
GPs will no longer be expected to countersign driving licence applications	Driver & Vehicle Licensing Agency (DVLA)	Licence application form D750 now revised, removing reference to GPs (<i>June 2001</i>)
GPs will no longer be expected to countersign passport applications	UK Passport Agency (UKPA)	Passport application forms now revised, removing reference to GPs (<i>June 2001</i>)



Identified Burden	Responsible Department or Agency to carry forward change	Action Taken
GPs will no longer be expected to sign the statement at Part 1 of the Attendance Allowance or Disability Allowance application forms	Department for Work & Pensions (DWP)	Changes made to the Attendance Allowance & Disability Living Allowance forms removing the need for GPs to sign Part 1 (July 2001)
Sick certification will be integrated into the hospital discharge process so that hospital doctors and consultants will not refer patients to a GP solely for the purpose of obtaining a sickness certificate	Department of Health (DoH)	A letter has been issued by the Chief Operating Officer (DoH) to all NHS Trusts, authorising local arrangements between hospitals & GPs to be established (July 2001)
GP's role in the mental health assessment process will be clarified to reduce unnecessary involvement	Department of Health (DoH)	Guidance for GPs: Medical Examinations & Medical Recommendations under the Mental Health Act 1983 issued by DoH (July 2001)
The feasibility of allowing community mental health practitioners to certify severe impairment of mental health for the purposes of obtaining a council tax discount is being investigated	Department of Health (DoH)	Feasibility study undertaken which concluded that the costs outweighed the benefits (August 2001)
Certificates Med 3 & Med 5 (which record the doctor's advice to the patient on their capacity for work with and without an examination of the patient on the day of issue) will be available in a single pad	Department for Work & Pensions (DWP)	New combined certificate pads now available to GPs (September 2001)
GPs and midwives will be able to sign maternity certificates (form MATB1) from 20 weeks before the estimated week of confinement rather than the existing 14 weeks.	Department for Work & Pensions (DWP)	New regulations (and revised forms) have come into effect (September 2001)
Best practice guidance to minimise referrals to GPs by the legal profession will be issued	Cabinet Office, Department of Health, Association of British Insurers (ABI), Association of Personal Injury Lawyers (APIL), British Medical Association (BMA), General Practitioners Committee, Law Society, Royal College of General Practitioners & Small Practices Association	Guidance issued (October 2001)
Health professionals other than GPs will clarify, if necessary, that a patient is suitable for loans of some Red Cross medical equipment such as self-propelled wheelchairs	British Red Cross (BRC)	The British Red Cross have adopted a self-referral policy removing GPs from the process (May 2002)
Proposals to reduce the GP role in the disabled parking permit system will be invited in a discussion paper	Department for Transport, Local Government & Regions (DTLR)	Consultation exercise completed. Discussion paper prepared and presented to Ministers on options to reduce GP burden (May 2002)
Total possible savings:		1.8 million appointments freed 440,000 additional hours saved



Outcomes from the GP I Report that are still in development

Identified Burden	Responsible Department or Agency to carry forward change	Action Taken
The DWP is actively working to ensure that it will only approach GPs for Attendance Allowance & Disability Allowance factual reports where their input is essential & cannot be provided by anyone else	Department for Work & Pensions (DWP)	Piloting of a new training package for Benefit Decision-Makers, aimed at ensuring that they seek the right form of corroborative evidence – January 2002 onwards
The Electoral Commission will be asked to consider whether attestation of long-term proxy vote applications should continue to be required from GPs and others	Department for Transport, Local Government & Regions (DTLR)	Electoral Commission launched a review of absent voting, including the future of proxy voting, in November 2001 and is due to produce final recommendations in October 2002
Access to death records by insurance companies will be incorporated into the review of civil registration services	Office of National Statistics (ONS)	Civil Registration Services White Paper was published on 21 January 2002. ONS are preparing a Regulatory Reform Order (RRO) to carry forward the proposed changes – November 2002
The Attendance Allowance or Disability Living Allowance factual report will be revised to focus on clinical facts rather than subjective opinion	Department for Work & Pensions (DWP)	On track for implementation for late 2002
GPs will be approached regarding Disabled Facilities Grants for major structural alterations only when their input is essential & no-one else can provide it	Department for Transport, Local Government & Regions (DTLR)	Revised guidance on good practice to be published later in 2002
Subject to successful pilots which, began in 2002, the power to certify incapacity for work will be extended to nurse practitioners	Department of Health (DoH), Department for Work & Pensions (DWP) and Cabinet Office (CO)	Research to begin in 2002/3 financial year
Total potential savings:		2.5 million appointments freed 250,000 additional hours saved



Outcomes further considered as part of the second GP 'Making a Difference' Project

Identified Burden	Responsible Department or Agency to carry forward change	Page Number
GPs should no longer need to issue repeat prescriptions for gluten free foods	Department of Health (DoH)	<i>DoH reviewing alternative supply arrangements that avoid GPs signing repeat prescriptions</i> Please see pages 11-12
GPs should only be approached regarding housing allocations only when their input is essential and no-one else can provide it	Department for Transport, Local Government & Regions (DLTR)	<i>DLTR to consultation on housing allocations by November 2002</i> Please see page 22
GPs should be removed from the list of countersignatories for shotgun certificate applications	Home Office (HO)	<i>Change in law required to bring shotguns in line with firearms. Scheduled for November 2002</i> Please see page 25
The role of GPs and other health professionals in providing reports and certificates for employers should be clarified	Cabinet Office (CO) and Department of Health (DoH)	<i>Publicity campaign launched by DoH and Cabinet Office regarding sickness certification in January 2002</i> Please see page 26
Total potential savings:		2.8 million appointments freed 75,000 additional hours saved



ANNEX 2

QUANTIFICATION OF OUTCOMES

In order to quantify what difference the project's outcomes could make, practising GPs on the GP Advisory Panel were asked to estimate how much time they would save for each outcome. This was done in the form of a voluntary questionnaire and asked about time spent in appointments and time conducted outside the scheduled appointment times. In addition to the Panel, the questionnaire was also posted on both the British Medical Association (BMA) and NHS Alliance web-sites to offer other practising GPs the opportunity to respond.

Estimates of the numbers of requests for information, reports, certificates, examinations and other services detailed in the report have therefore been prepared by reference to a small survey of general practitioners workloads.

The published estimates are the lower 95% tolerance limit on the median numbers of requests etc. reported as being made in the survey responses. The amount of time consumed as a consequence of these actions has been calculated from the product of the mean time value reported as needed to undertake a given request and the lower tolerance interval for numbers of requests etc. as calculated in the report.

For example, sickness certification for children taking exams:

1. Median value for numbers of requests per General Practitioner per year from survey was 7
2. Lower 95% tolerance limit is 1.7 requests per General Practitioner per year
3. Assuming that there are 26,500 whole time equivalent General Practitioners (from DoH Workforce Survey for 2000, Office National Statistics + 0.2% uplift to correct to 2001), this results in $26,500 \times 1.7 = 47,000$ appointments
4. Assuming that each appointment takes 8 minutes, this equates to $47,000 \times 8 / 60 = 6,000$ hours (approximately)

The values reproduced in the text may, therefore, be interpreted as being conservative and our best predictions on the 'at least' amount of time / requests currently devoted to these areas of practice. The values are presented only for the purpose of illustrations of the likely magnitude of time-savings possible.

It should be noted that whilst there may be savings for other health and medical professionals, these have not been calculated: the emphasis of the project was to reduce unnecessary burdens on GPs.



ANNEX 3 PARTICIPANTS

Stakeholders (July 2000 – April 2002)

Association of British Insurers
Association of Chief Police Officers
Association of Train Operating Companies
Axa Insurance
British Associations for Adoption and Fostering
British Chambers of Commerce
British Medical Association (BMA)
British Red Cross
Carmarthenshire County Council
Commission for Health Improvement
Communicable Disease Surveillance Centre
Community Transport Association
Confederation of British Industry
Court Service
Criminal Injuries Compensation Authority
Department of Education and Skills
Department of Health
Department of Transport, Local Government and
the Regions
Department for Work and Pensions
Doctor Patient Partnership
Driver Vehicle Licensing Agency
Federation of Small Businesses
Food Standards Agency
General Medical Council
General Practitioners Council

Home Office
Immigration Advisory Service
Institute of Directors
Joint Council for General Qualifications
Law Society
Local Government Association
Modernisation Agency, DoH
Motability
NACAB
National Audit Office
NHS Alliance
Office for National Statistics
Passport Agency
Patients Association
Primary Care Collaborative
Public Health Laboratory Service
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal Sun Alliance
Small Business Service
Small Practices Association
Society of Occupational Medicine
Trade Union Congress
Veterans Agency
Youth Justice Board
Zurich Municipal Insurance



Medical professionals contacted (July 2000 – April 2002)

Alexander Practice, Manchester	Grove Medical Centre, London
Aston Clinton Surgery, Buckinghamshire	Grovehurst Surgery, Kent
Bincote Surgery, London	Kingsdowne Surgery, Surrey
Bourne Hall Health Surgery, Surrey	Maples Medical Centre, Manchester
Bowland Road Surgery, Manchester	Merton, Sutton and Wandsworth H.A.
Brunswick Health Centre, Manchester	Morecambe Bay Health Authority
Cambridgeshire Local Medical Committee	New Chapel Surgery, Oxfordshire
Calderdale Primary Care Group, Yorkshire	Ridgeway Primary Care Group
Chatham Primary Care Group, Kent	Shadbolt Park House Surgery, Surrey
Chorlton Health Centre, Manchester	Southborough Lane Surgery, Kent
Court View Surgery, Kent	South Peterborough Primary Care Trust
Dr Kay and Partners, London	The Maidstone Road Surgery, Kent
Dr Burch and Partners, Oxfordshire	Trinity Surgery, Norwich
Dr Mohan, Kent	Walderslade Medical Centre, Kent
Dr Palta, Surrey	Waverley Primary Care Group, Surrey
Dr Hume and Partners, London	Wendover Health Centre, Bucks
Fitznell Manor Surgery, Surrey	

In the addition to the above, a wide range of GPs provided data on potential time-savings and corresponded with the Team. Many thanks to everyone involved in the projects.

GP Advisory Panel

A GP Advisory Panel was constituted to provide specialist advice throughout both projects. All the members were involved in the project. Its membership is as follows:

- Ms Sheila Evans (Department of Health)
- Dr Michael Dixon (NHS Alliance)
- Dr Peter Holden (British Medical Association)
- Ms Liz Kidd (Department of Health)
- Mr John Maingay (British Medical Association)
- Dr Joe Neary (Royal College of General Practitioners)
- Dr David Pickersgill (British Medical Association)
- Dr Philip Sawney (Department for Work and Pensions)
- Dr Michael Taylor (The Small Practices Association)
- Mr Simon Williams (The Patients Association)



The bodies represented on the Panel all have an important stake in the efforts to reduce unnecessary burdens on GPs and the associated paperwork. Invitations to join the Panel were issued as part of the first project, following advice from practising GPs, the Department of Health and others on who should be represented. All the individuals and organisations on the Panel strongly support both projects.

The RIU's Public Sector Team's GP Project Team

If you require any further information or clarification on the points raised in this report, please contact one of the Project Team:

- Tanya Otley (Project Manager) – psinfo@cabernet-office.x.gsi.gov.uk
- Andrea Farmer
- Mark Williams
- Tony Part (*GP and Hospital Interface Issues*)
- Dr Nick Gent – part-time secondee from the former Morecambe Bay NHS Health Authority

Alternatively please telephone us on: 020 7276 2194.

The Project Team would like to make a special thanks to Lois Willis, Chief Executive of the former Morecambe Bay NHS Health Authority who released Dr Gent to work on this project.



ANNEX 4

PUBLIC SECTOR TEAM, REGULATORY IMPACT UNIT (RIU)

The Public Sector Team was established in November 1999 in response to the Government's concern about the increased bureaucratic burden on the public sector. The Team is located within the Cabinet Office's Regulatory Impact Unit (RIU).

Remit and responsibilities

- To identify the major bureaucratic and regulatory burdens on the public sector staff and services;
- To distinguish those burdens imposed by central government from those imposed for other reasons (e.g. as part of internal management systems); and
- To recommend and agree with the relevant department or agency, ways in which the regulatory burden might sensibly be reduced.

Team Structure

The Team consists of secondees from the private and public sectors and permanent civil servants. Through this mix of backgrounds, knowledge and experience, the Team is able to draw comparisons and contrasts between attitudes and approaches in the private and public sector, allowing lessons to be learnt and best practice disseminated.

The Team's key aim is to achieve practicable results that make a tangible difference to the work of front-line staff and their service delivery. The Team works with front-line staff to identify unnecessary bureaucratic burdens and then with stakeholders to resolve them. The focus is on outcomes and achievements rather than simply gifting recommendations for action by others.

Methodology Tools

The remit is to devise ways to deliver a demonstrable reduction in bureaucratic burdens and paperwork. Consequently, the approach is one of a catalyst by working to:

- a) Get front-line staff to identify the changes they would like made, then
- b) Negotiate with stakeholders (such as central departments and government agencies) to agree to make changes (termed 'outcomes') by a target date, and subsequently,
- c) Collaborate with stakeholders to ensure the changes promised are implemented and disseminate this news back to the frontline.

The 'Making a Difference' process seeks out front line knowledge, jointly identifies improvements and then gets those with operational or policy responsibility to make changes. Millions of hours of time previously wasted on unnecessary bureaucracy have been freed up and redirected to the delivery of essential public services.



Previous Reports

Up to the present time, four other 'Making a Difference' projects have been completed and their outcomes have been, or are being, implemented. Estimates of the time saved by front-line staff are noted below:

- **Reducing Police Paperwork** – Identified measures to simplify prisoner custody and traffic accident paperwork, as well as standardisation of criminal case file preparation. The outcomes were estimated to free up 166,000 hours of police time, equivalent to 90 police officers. To date 156,000 hours of police time has been saved.
- **Reducing School Paperwork** – Up to 4.5 million hours of time would be saved when all of the outcomes focussing on head teachers' burdens, principally primary heads, are implemented. An estimated 2.7 million hours of time have been saved up to the present time with more outcomes scheduled to be implemented during 2002.
- **Reducing General Practitioner (GP) Paperwork** – 36 outcomes, spanning sickness certification to health records and requests for tests, were identified to ease the clinical and other paperwork affecting GPs. An estimated 750,000 hours of time will be saved when all of the changes have been implemented, as well as eliminating 7.2 million GP unnecessary appointments. A summary of the outcomes from the GP project is presented in Annex 1.
- **Reducing Local Government Paperwork** – This report includes greater freedoms for local administrations on statutory planning, legal consents from central government, children's services, and wider flexibility in the ways services are provided and paid for.

In addition, the Team has produced a Progress Report that reviewed the implementation of outcomes on the first three reports.

All of the above reports can be downloaded free of charge from the Public Sector Team website, at the following web address:

<http://www.cabinet-office.gov.uk/regulation/PublicSector/reports.htm>



Reports in development

In addition to the reports mentioned above, joint work is also being undertaken on a further four 'Making a Difference' projects to tackle other topics where bureaucratic burdens exist:

- **Reducing Burdens in Hospitals Project** – Identifying a wide range of administrative burdens and red tape in acute hospitals (publication July 2002).
- **Criminal Justice Project** – Concentrating on the paperwork surrounding criminal prosecutions from detection to judicial disposal and involving the Police Service, Crown Prosecution Service, and Court Service (final report July/August 2002).
- **Schools II Project** – Revisiting the paperwork burdens on teachers and other bureaucracy imposed by external agencies and organisations (final report September 2002).
- **Health Inspection Project** – Considering the rationalisation of health inspection bodies (final report in December 2002).



