GENERAL PRACTICE

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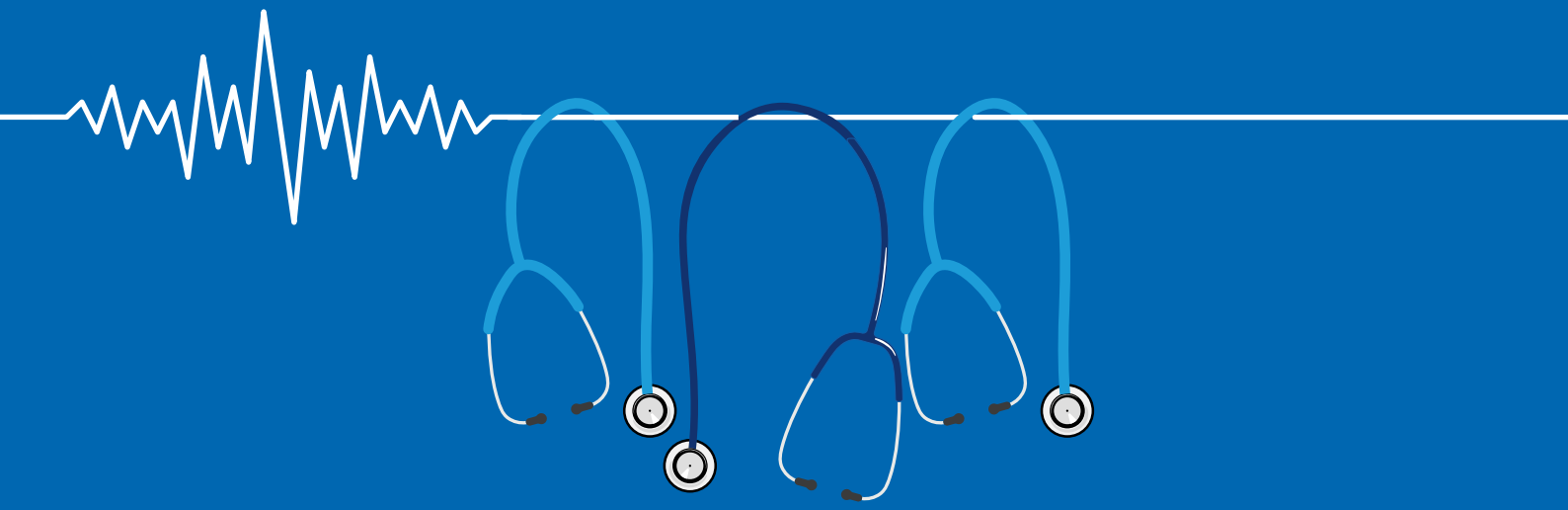

CRITICALLY ENDANGERED – FACING EXTINCTION

BMA GPC England
Bitesize Briefing

Why This Campaign, and Why Now?

When GPCE agreed the 2025/26 GMS contract, arguably the most strategically important contingency was the written commitment from the Secretary of State, Wes Streeting, to negotiate a new substantive GMS contract in good faith with GPCE.

Almost a year on, we have seen:

- HM Treasury's Comprehensive Spending Review
- DHSC's 10-Year Plan proposing Multi and Single Neighbourhood Providers but no comment on GMS reform
- The abolition of NHS England
- ICB mergers from 42 to 26 with uncertain futures for the commissioning of primary care
- Widespread redundancies across teams supporting primary care including wholesale removal in some systems of experienced GP clinical leads and voices

But no meaningful progress on a new GMS contract. General practice is being asked to anchor neighbourhood reform while the contractual foundation beneath it remains unresolved. We are facing an existential risk.

Why "Critically Endangered"?

Extinction occurs when a species can no longer survive or be sustained in its environment, or when its environment rapidly changes and becomes hostile. It can happen gradually, or it can happen suddenly.

Habitat loss General practices' working environment is under threat – premises are not fit for modern care and there is no ring-fenced investment; time for continuity of care is being wiped out by access targets; work is being shifted from Trusts without matching commensurate resource. Ultimately the 'ecosystem' of the NHS ICB is no longer supporting the species of general practice.

Over exploitation GPs are being expected to absorb rising demand; greater clinical complexity; hospital left shift of workload; bureaucracy and compliance – all with fewer GPs per registered list. This is classic *over harvesting.*

Pollution Not chemical pollution, but administrative and bureaucratic pollution leading to cognitive overload. Administrative and compliance pollution via paperwork and tasks; IT structures and regulators' annual requirements and periodic inspections. The Trust-based culture of box-ticking and over-regulation clogs clinical thinking, drives burnout, crashes productivity and morale subsequently collapses.

Role substitution GP substitution has gathered pace since the arrival of the additional roles reimbursement scheme (ARRS) within the PCN DES from 2019. Roles have been introduced without clear boundaries, leaving GPs to supervise risk without authority or time – this has destabilised general practice instead of strengthening it.

Climate change The climate change for general practice is characterised by constant policy churn; relentless reforms; annual contract changes or in-year contract variations with access drives and media pressure. There is no time to adapt before the next reorganisation lands

Human-driven pressures in GP terms

- **Habitat loss ➜** Erosion of partnership viability
- **Overexploitation ➜** Unlimited workload without safeguards
- **Pollution ➜** Bureaucracy, micromanagement and target creep
- **Invasive competition ➜** Alternative provider models displacing list-based GP care
- **Climate instability ➜** Structural reform without stabilising core funding

What facing extinction looks in general practice:

Gradual decline

- Fewer full-time equivalent (FTE) GPs
- Shrinking continuity of care and rising 'taskification'
- Expanding list sizes and GP to patient ratios
- Quiet exits – the loss of over 6,000 (around 28% of) GP partners since 2015

Sudden changes

– Pandemic work shifting to online and remote assessment
– Practice hand-backs
– Accelerated retirements
– October 2025 contract variation pushed through by Government without agreed safeguards leading to overwhelm and no clinical capacity

We have been seeing warning signs of both trajectories for a number of years.

The Front Door Lesson: Expertise Reduces Risk and Waste

Recent experience across the NHS reinforces a simple truth. Predictions that the NHS would collapse during resident doctors' industrial action before Christmas 2025 did not materialise. One key reason: **senior doctors were making decisions at the hospital front door.** When experienced clinicians assess patients:

– Fewer unnecessary investigations are ordered
– Fewer avoidable admissions occur
– Risk is managed more confidently
– System flow improves

This is not surprising. Clinical decisions to *not* investigate or admit require experience and professional authority. The same principle applies in general practice and GPs as expert generalists. An effective general practice system requires its most qualified clinicians deciding:

– Who requires investigation
– Who needs referral
– Who can safely self-manage with safety-netting

In Barking and Dagenham, a GP-led respiratory hub moved to an entirely doctor-delivered model. Early data show lower reattendance rates compared with more mixed skill models. Patients either recovered more quickly or felt sufficiently reassured not to re-present. The lesson is clear: Cheap staffing models that "tick boxes" may appear efficient locally but create inefficiency and cost elsewhere in the system. In a service funded from a single national pot, the rational design is obvious: **expert decision-making at the front door reduces total system cost and improves patient experience.** Yet this principle has not consistently shaped service design.

The Real Risk: System Redesign Without Securing the Core Foundations

General practice is being asked to:
– Deliver more access
– Lead neighbourhood integration
– Support left shift from acute care
– Manage rising complexity
– Improve prevention

But without:
- A reformed GMS
- Workforce and workload safeguards
- Investment guarantees
- Safe GP-to-patient ratios
- Financially viable vaccination programmes

We cannot sustainably put the most experienced clinicians at the front door if partnership becomes unattractive and sessional work becomes unsustainable. If we hollow out GP expertise, the whole system pays the price.

What Is Needed:

A new substantive GMS contract, which must:

1. Preserve the viability and attractiveness of partnership
- Stable funding
- Predictable risk
- Protection from unfunded transfer of workload

2. Deliver fair remuneration for sessional GPs
- Sustainable career structures
- Recognition of clinical intensity
- Retention of experienced doctors

3. Introduce workload safeguards
- Safe boundaries
- Realistic expectations
- Protection for patients and staff

We are clear about the foundations and required structural commitments:
- **Registered list-based practice populations**
- An evidence-based aspiration toward safe GP-to-patient ratios
- A **minimum general practice investment guarantee**
- Carr-Hill reform, embedding a defined journey to levelling up and supporting transition of resource from acute settings into primary care
- Genuine prioritisation of continuity of care
- A GP-led neighbourhood model

Government may consult widely. But negotiation must be between Government and the BMA's GP Committee England as per the written commitments from the Secretary of State for Health in March and August 2025.

If general practice declines further towards extinction, hospital admissions will rise; investigations will increase; reattendance will grow; costs will escalate and patient confidence will fall. The "cheapest" model at practice level may be the most expensive for the NHS as a whole. We have recent proof that senior clinical expertise reduces waste and improves outcomes. Destabilising the very workforce that provides that expertise is not reform; it is flawed short-termism.

Extinction rebellion?

General Practice is critically endangered facing extinction. Government must bring it back from the brink. We can turn this round. The Giant Panda has recently been removed from the WWF's critically endangered list thanks to successful reproduction programmes. We need to secure partnerships and drive-up partner numbers as a priority to stabilise our profession in the same way.

This campaign is not alarmist. It is precautionary. General practice remains the most cost-effective part of the NHS. It absorbs risk, complexity and uncertainty daily. But extinction does not require catastrophe, it requires only sustained environmental pressure without adaptation – in other words more of the same and no action.

As a profession we are ready to negotiate in good faith and lead neighbourhood reform; but without a substantive new GMS contract that secures the future of partnership and protects GP expertise, the NHS risks weakening the very front door that keeps the whole system functioning.