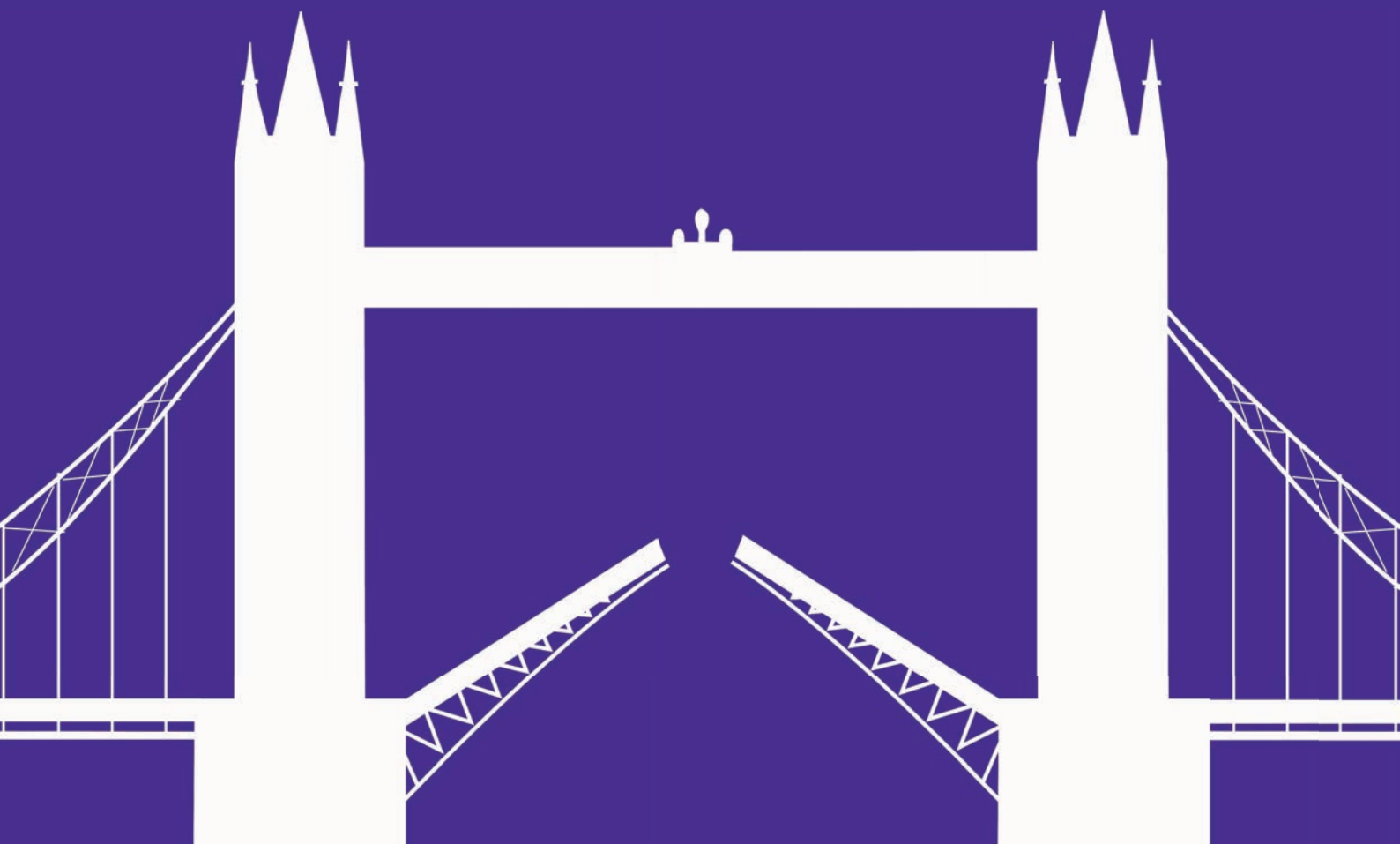
Londonwide LMCs

The professional voice of London general practice

# Securing the Future of General Practice in London

**September 2013**



# Foreword

Londonwide LMCs' document *Securing the Future of General Practice in London* sets out the building blocks which London's GP providers believe are essential to ensure safe and sound delivery of general practice. The statements and concepts contained within are based on sound evidence, and are supported by the local leaders of the 6000 GPs and their teams who provide general practice services to their registered patients and local populations that make up the millions of service users in the Capital.

The NHS in London, as with the rest of England, continues to move through a period of constant change and *Securing the Future of General Practice in London* is designed to offer solutions to the many concerns of patients, their GPs and commissioners alike. We focus on demystifying the complexity of care that GPs and their teams provide for the individuals that make up their practice populations, on how improvements to local community and social services can underpin that care and enable practices to manage the demands on all levels of the service while retaining the cost benefits to the public purse and healthcare that arise from our unique system of expert generalists working in the neighbourhoods where Londoners live and work. We offer ways forward to help those who commission NHS and Social Care in London meet the challenges that face our massively complex and diverse city of growing populations, huge health inequalities, and increasingly limited funding.

Our document is timely and relevant. It comes at a time when the focus has been on the structure of the service, with its emphasis on commissioning, to one which is shifting towards service design and provision. It comes at a time when NHS England has just published its Call to Action on primary care, and when the NHSE regional office in London is contemplating its 'transformation' strategy. *Securing The Future of General Practice in London* is designed to provide direction to those in a position to effect change. We believe that effective change in London will only be achieved by underpinning the role of general practice and strengthening community-based services to support the millions of patient consultations that take place each day and each week in the capital. Strong general practice is both the root of and route to better care for Londoners and requires a paradigm shift in the way services are commissioned and transformed.

Londonwide LMCs and London's GPs want our patients to have the best. *Securing The Future of General Practice in London* charts the path towards achieving it.

**Dr Michelle Drage, FRCGP**

CEO Londonwide LMCs

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# Introduction

Strong primary care is essential in health systems as a means of providing cost effective health care and securing health improvement. In the UK, general practice is the bedrock of primary care provision in the NHS (Watt, 2012; Smith et al., 2013; University of Glasgow, 2013). If the NHS is to meet the demographic and financial challenges it now faces in delivering high quality care and improving health outcomes, primary care and community care must be fully integrated, developed and sustained (RCGP, 2013; Thorlby, 2013).

In this paper we set out an alternative and achievable approach to transformation of GP provider services in London.

We detail below the principles, core values and building blocks of general practice and offer a clearer understanding of what GPs and their practices do and what they could deliver over time. We set out to show how a realignment of the balance of commissioning resources between secondary and primary care could deliver health and economic benefits to London's population, in particular in terms of access to primary care and usage of A&E, health inequalities, long term conditions, complex multi morbidity and care of those growing older.

We describe how strong general practice lies at the at the root of the solutions to London's health and health system challenges, and how the familiar local delivery of general practice through a registered list needs to be sustained and developed together with strengthened community, social and mental health services coordinated around general practices and their teams.

***Any case for change must be built on the strengths and professional values of general practice as an expert generalist community based service providing timely access to personal continuity of care with a well-trusted clinician, otherwise patients' health will suffer and workforce morale will plummet even further.***

## The National Context

The NHS is facing a decade of austerity, in which demand will have to be balanced with financial constraint (Roberts et al., 2012) and the national and local policy direction is towards more community based services and integrated care (National Collaboration for Integrated Care and Support, 2013).

As a result, the pressure on general practice is increasing, with timely access and the ability to provide continuity of care becoming progressively more difficult to deliver.

Overall the NHS will be required to achieve optimistic financial savings of £20billion over the next 3-5 years, with ambitious QIPP targets needing to be achieved across the NHS. Although the current administration has stated that NHS spending will be protected, the changing nature of services, continued increases in demand, and the needs of an ageing population mean that in real terms investment is falling. Although in recent years health spending has increased rapidly, the rate of increase has differed markedly between different types of health care (Jones and Charlesworth, 2013). Spending on community services has increased by 6%, spending on secondary care by 40% and spending on GP services has fallen by 1.2%.

The overall financial pressures have contributed to a number of assumptions regarding solutions to the financial deficit. Increasingly the Government and press are portraying general practice as a solution to acute trust pressures, but seem reluctant to realise that this requires investing in and supporting general practice in order to reap far greater benefit and cost efficiencies in the NHS. Current policy focus include shifting services out of hospital, service integration, managing hospital demand (including blocked beds), increasing access to GP services and the quality of out-of-hours services. Transformation of Primary Care has become a national NHS priority, yet already general practice is the largest provider of services outside the hospital setting, with 90 per cent of all health care consultations taking place within primary care. Transformation is fast becoming an agenda for 'fixing' general practice, based on assumptions that GPs are failing to deliver good quality care and that faster access to general practice will result in fewer A&E attendances and costly hospital admissions. The document 'The NHS Belongs to the People: Call to Action' confirms that the transformation of primary care will continue to be a NHSE priority. (NHS England, 2013).

## The London Context

The health care workforce is ageing and recruitment is falling. Premises are underdeveloped, and in many places are unsuitable, for the delivery of integrated care closer to patients' homes. The threat of widespread burn out within general practice is very real.

The current NHS England (NHSE) London Primary Care transformation approach emphasises the variability within general practice and seeks to improve outcomes by focussing on standards. However there is very little evidence for "failure" in general practice in London although there is undeniably room for improvement. This approach largely ignores the overall success story of general practice in the UK (Osborn, 2012) and fails to fully acknowledge the particular challenges that face London.

NHS England London and the CCGs of London face particular challenges across the capital. London has a highly diverse, mobile and increasingly migrant population and the gradient of health inequality in many boroughs are steeper than in most other major cities. The three English local authorities with the highest levels of income deprivation are all in London (Tower Hamlets, Newham and Hackney) and over 26 per cent of London falls within the most deprived 20 per cent of England.

A higher proportion of patients living in deprivation have multi-morbidity and complex conditions, compounded by poor mental health and difficult social circumstances (Raleigh, et al., 2012). In deprived populations multi-morbidity is not just a characteristic of old age but is occurring at much younger ages. This in itself adds to the pressures GPs work under and requires the expert professional approach of the medical generalist since most secondary and tertiary care, medical research and medical education is configured according to a single-disease framework (Barnett et al., 2012). This emphasis on managing diseases not people, combined with an often single-minded approach to access (quantity not quality), usually at the expense of lasting therapeutic partnership through relationship continuity, is undermining the ability of general practice to perform at its best (NHS Evidence, 2012).

An alternative strategy is needed, supporting generalist clinicians to provide personalised, comprehensive continuity of care, which is needed more than ever before in socioeconomically deprived areas. London's GPs should be recognised for the provision of high quality services despite the challenging environment; this should result in the development of appropriate support and investment in general practice in London.

This requires a new approach in London where investment in primary care and general practice has been reduced year on year over almost two decades. GPs need the headroom to manage their services appropriately to the needs of their list and the context of their practice locality. They need to be able to provide longer consultations to patients who are vulnerable and who have complex medical needs. They need to be able to design and expand their workforce and to drive the co-ordination of support services locally (University of Glasgow, 2013).

## What GPs and their practice teams do

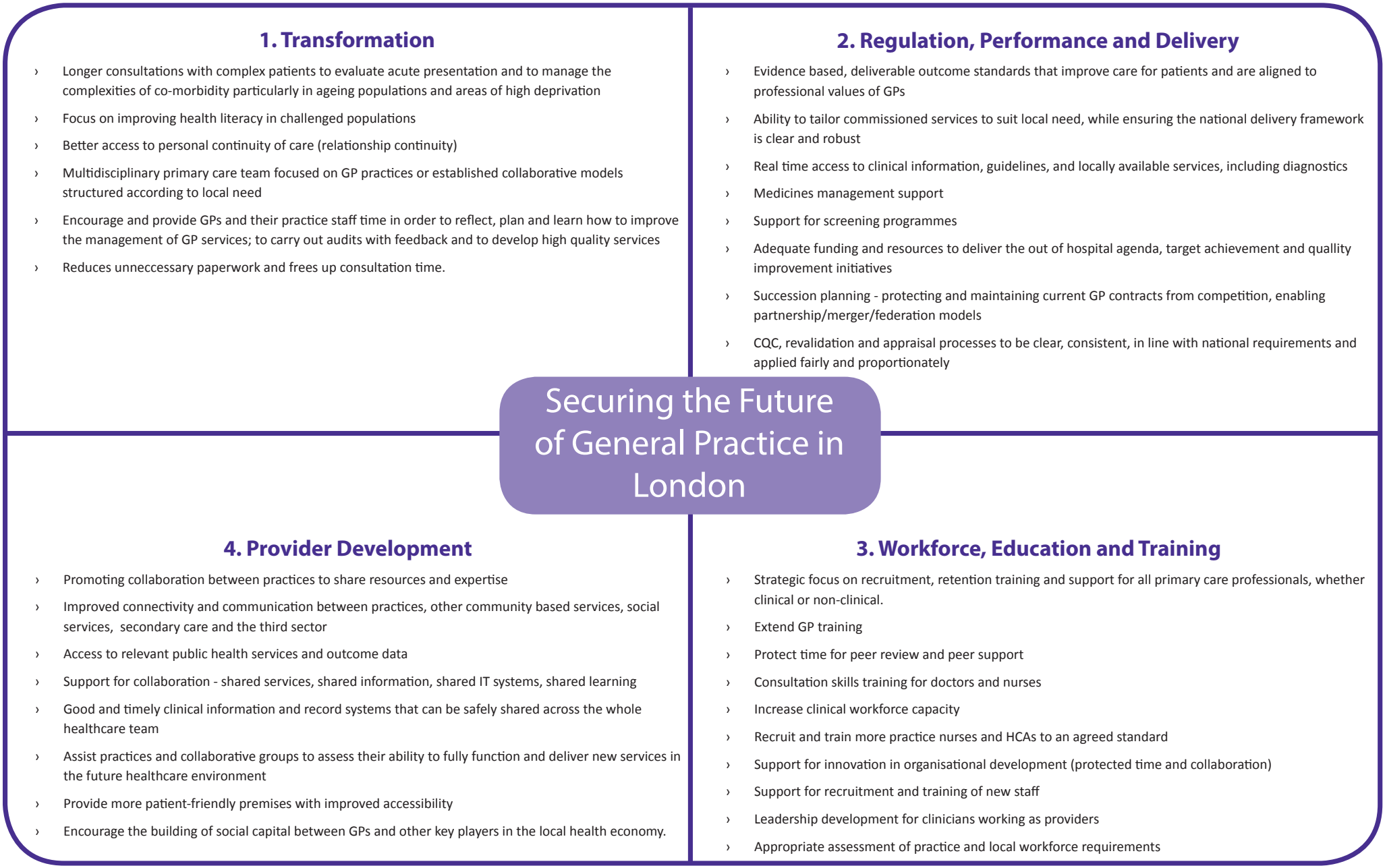
In the NHS the particular strength of general practice is the delivery of this service based on a registered list of patients. This allows GPs to get to know their patients and the circumstances under which they live, and crucially it allows patients to know and trust their GP and their practice team. This continuity of care (relationship continuity) is increasingly strongly associated with improved quality and cost effectiveness of care (Smith, et al., 2013).

Our alternative proposals are based on the principles that make general practice the most cost effective, efficient, valuable and high quality generalist healthcare service:

- it focuses on the needs of individuals by providing confidential personalised care across their registered populations
- it is flexible, comprehensive, continuing and longitudinal care
- GPs and their teams provide:
    - first contact care through treating a wide range of health problems in the community by managing patient risk safely and effectively
    - responsive, episodic care in a local, familiar and trusted environment
- preventative care for people of all ages
- coordinate care between all other health and social care settings and across organisational boundaries
- prevent disease, reducing harm and building self-sufficiency by enabling patients to understand and contribute to their care
- GPs demonstrate professionalism in terms of training and continuous reflection

In our alternative proposals for general practice we have drawn up a practical strategy that outlines four key areas and their interventions to be addressed over the next three years in collaboration with our stakeholders (figure 1).

## Figure 1: Practical Strategy



# 1. Transformation

## Resources

Londonwide LMCs has long advocated for practices to be enabled to work more closely together. Further, we have demonstrated that in order for this to become a reality the right support and investment need to be in place (RCGP, 2013; Smith et al., 2013). This support must cover the general practice workforce, infrastructure and technology. In addition, it also requires the right investment in the services which underpin effective general practice such as community nurses, health visitors, community mental health services, social services and timely access to diagnostics.

***"There seems to be an expectation nationally that practices will somehow achieve system transformation whilst getting on with the day job."***

***Local GP Practice***

To shift care and education out of hospitals to good effect, resources must be released and those resources must be used to underpin delivery of primary care. This will allow local GPs and their practice teams protected time to develop innovative ways of delivering community based care coordinated around general practice. In order to deliver real improvements to patient care, change must be driven and encouraged from within and we want to see London's GPs and their patients at the forefront of delivering this change.

The scarcity of resources over the next 10-15 years will require many practices to rethink the way they currently work or risk loss of any funding made available by the shift of care into the community being awarded elsewhere. The same applies to the discontinuation of Local Enhanced Services and their replacement with Community Based Contracts available to Any Qualified Provider.

## Medical Generalism

The essential feature of strong primary care in the NHS is that GPs provide an expert medical generalist service. The generalist approach treats the whole person regardless of age, gender or the nature of the illness. It is a quintessential feature of first contact health services (RCGP, 2012). In an effective health care system there is a place for both generalist and specialist services but they must communicate well and be focussed round the needs of the patient.

Generalists deal with undifferentiated problems, uncertainty and risk. The GPs' expertise allows them to take into account the particular social and emotional context of the patient which will affect the choice of intervention. They use their professional judgement to manage tensions and ambiguity in making decisions with patients about their management. They are adept at using investigations wisely and basing treatments on best evidence in a way that takes into account the unique circumstance of each patient. They can deal with complex situations and are learning to work in partnership with patients to allow them to take an active part in their own health care. With the increasing prevalence of multi-morbidity, it is the expert generalist approach that will secure the best outcomes for patients (Ahluwalia et al., 2013).

It is essential that any approach to transforming primary care does not undermine this essential feature of general practice in the NHS.

## Continuity of Care and Access

There is significant evidence that continuity of care is integral to dealing effectively with the sorts of complex conditions which London's populations are particularly susceptible (Roland and Paddison, 2013). In addition there is much to suggest that it is what patients want, especially those with complex conditions (University of Glasgow, 2013). There is also evidence that a good relationship with a freely chosen primary care doctor, preferably over several years, is associated with better, more appropriate care, better health outcomes and much lower healthcare costs (Starfield, 1994; Starfield, Shi and Macinko, J, 2005; Hill and Freeman, 2011). In order to promote patients' access to a clinician of their choice, GPs need the support to test and develop more flexible and varied approaches to access such as email without compromising safety or confidentiality.

The policy push towards faster access has been a key contributor to the move away from individual continuity and the fact that patients can now access multiple services directly has meant that it has become increasingly difficult to manage demand and to coordinate care (Hill and Freeman, 2011). This has contributed to a demand led service rather than a preventative service that is responsive to individual needs (Thorlby, 2013).

The commitment to put the individual at the centre of health care and to ensure they are directly involved in planning holistic care for the whole person, not just for a disease or dependency score (National Collaboration for Integrated Care and Support, 2013) is supported by Londonwide LMCs. However, much work has been done to explore the barriers to integrated care and there seems to be a general consensus that it 'costs before it pays' (Leutz, 1999).

Early investment to bring into primary care the necessary resources to facilitate any service reconfigurations is a key factor. Taking note of this evidence, commissioners should ensure that GPs in deprived areas are fairly funded to meet the increased needs of their patients. Additional resources in primary care would support integration of services.

### The Patient Consultation

The consultation is the cornerstone of general practice and QOF related activity, for example, is only 12% of what general practice does (University of Glasgow, 2013). It is within the consultation that GPs can use their expertise to work with patients to find the best ways of managing their problems with the overall knowledge of their social situation. With increasing complexity, the 10 minute standard consultation time is inadequate.

New approaches to the consultation are being developed which focus on empowering patients to take more control of their health and to be active partners in their own care. As patients' medical problems become more complex as outlined below, more time is needed for some consultations. At present many practices lack the capacity and flexibility to deal with consultations more effectively.

Pressure on GPs, especially the more experienced, to take on wider roles in the health care economy means that they spend less time with their patients than they would wish. This is compounded by the increasing bureaucratisation of general practice which has increased the amount of paper work that GPs themselves have to find time for. This takes time away from attending to patients' needs. There is an urgent need to rationalise these requirements, to de-clutter the consultation and allow GPs to focus on the needs of the patient in front of them. These concerns are confirmed by the responses to the 2013 Londonwide LMCs' workforce survey [Londonwide LMCs, 2013).

## 2. Regulation, Performance and Delivery

Despite government initiatives to reduce red tape and regulation, it is likely that NHS England will continue to seek to regulate the service in the name of performance management. In addition GPs must be able to meet their professional self-regulatory responsibilities. The regulatory environment must enable professionalism and the values of general practice to flourish in order to allow GPs to deliver high quality care services for patients as circumstances change (Lester et al., 2013). Working with NHS management to develop policies that do not lead to unintended consequences is a key priority for Londonwide LMCs.

## 3. Workforce, Education and Training

There are trends within primary care that show a fall in the number of single handed GPs, an increase in sessional and salaried GPs and fewer partnership opportunities. There are also projected shortfalls in the number of GPs and practice nurses due to predicted retirements over the next decade (Smith et al., 2013).

To support the identification of the needs of a future workforce to enable strong general practice in London, collaboration with Health Education organisations (LETBs), NHS England and Clinical Commissioning Groups is required to deliver the right workforce for effective delivery of general practice in the capital. This involves attracting,training and retaining the right numbers of GPs, nurses and practice staff to match local need and sustain the service. It requires support for reflection and CPD, and it requires clinical leadership from general practice.

## 4. Provider Development

There is a wealth of literature which advocates practices working together to reduce back office function running costs, bid for resources, support the development of high quality local services and for GPs to be given the freedom to use any savings they make to invest in innovation for their patients (RCGP, 2013; Smith et al., 2013; Thorlby, 2013;). But for this to be possible the right foundations need to be laid through investment and support and local determination by the GP community of its own priorities, functions and organisational form (Smith et al., 2013). Practices need to be supported to innovate and create change for themselves and their communities.

For GPs to be effective in coordinating personalised care for their patients, investment for transformation must encourage the building of social capital between GPs and other key players in the local health economy. This can be done through facilitating collaboration between different providers and health care sectors and learning together in the process of system redesign.

Developing and delivering integrated health services would be facilitated by the sharing of information and IT communication, which Commissioners should prioritise. Practices will require support managing the information governance implications of using such systems.

# Delivery, Support and Enablers

Currently, changes to the NHS including procurement, choice, competition and threats of AQP models of commissioning mean that general practice needs to adapt in order to develop and grow within the newly-developing competitive arena.

Our pragmatic proposal is to realign the commissioning framework to make general practice and the coordination of community services around GP practices the first priority for funding and thereby provide the opportunity for patients to be cared for in the right setting from the very start of their journey. In essence this means turning the focus of commissioning on its head.

### Support should focus on:

- Allowing adequate time for general practitioners to spend with patients, both in terms of evaluating acute presentations and managing the complexities of co-morbidity in ageing or deprived populations and playing a real part in reducing A&E attendances, health inequalities and providing better access.
- Assisting practices and collaborative groups to provide and deliver services in the new healthcare environment.
- Promoting collaboration between practices to enable better delivery of a wider range of services within primary care.
- Ensuring access to good IT systems.
- Providing better, more accessible and more patient-friendly premises for general practitioners and their teams to work together and in networks of practices to provide the widest possible range of high quality services for patients.
- Improving communication, in the first instance at secondary care level, in terms of access to diagnostic facilities, agreement on patient pathways and on the commissioning of services.
- Centring community services around general practice either individually at practice level or through networks.
- Encouraging GP and staff time to reflect, assess, plan and learn how to best manage GP services, to carry out audits with feedback and to develop high quality services.

**Practices in London should not feel alone in addressing the challenges and implementing the solutions. Londonwide LMCs is developing practical tools and solutions, and is currently working with fledgling networks in a number of areas supported inter alia through:**

- **Tailored toolkit(s) for collaborative working between practices**
- **Expert/Legal advice and procurement workshops**
- **Practical guidance and support**

This requires (see Figure 2):

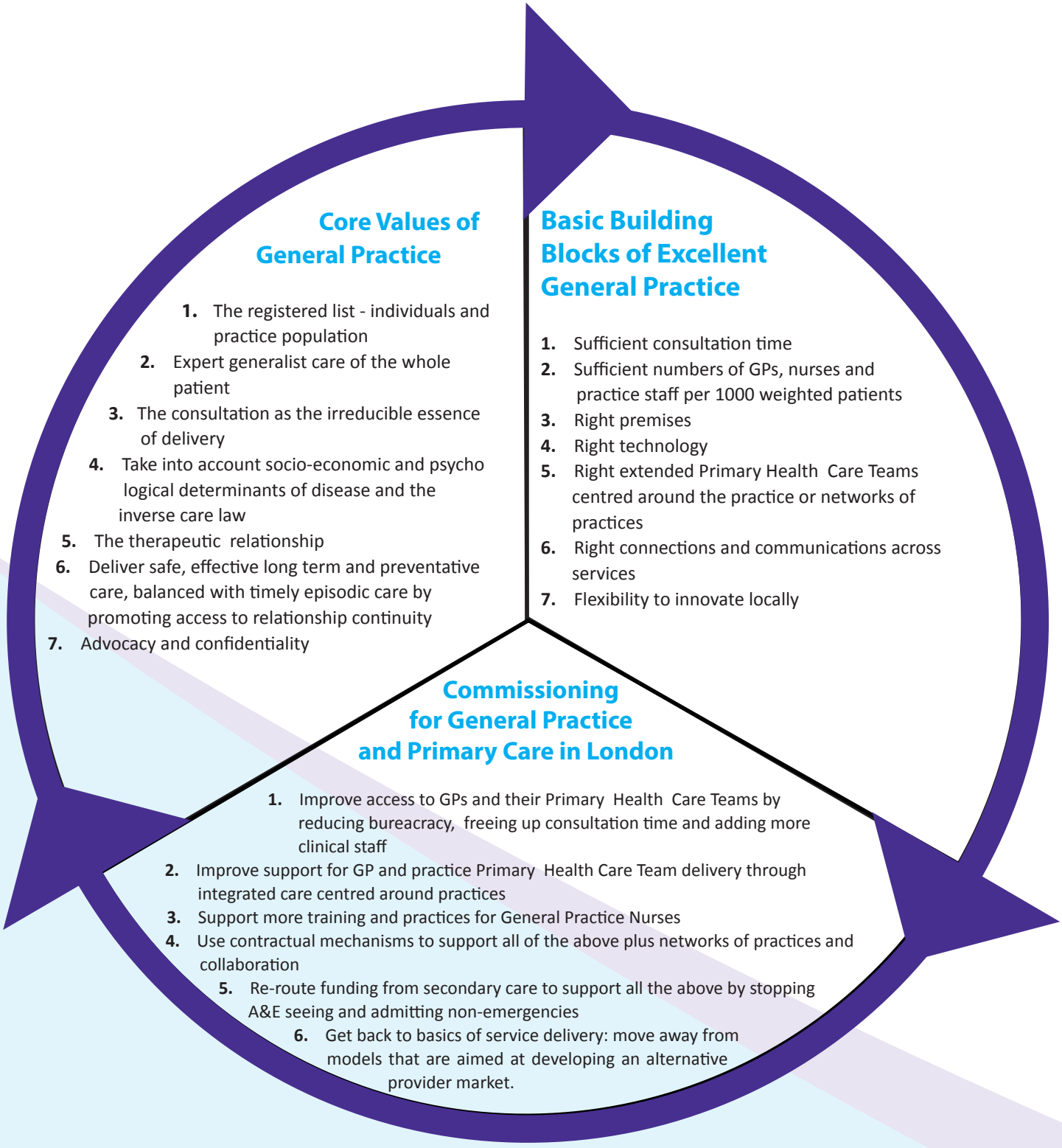
- being mindful of the values of general practice
- focussing on the building blocks of excellence
- employing the enablers of change

Practices need to be actively discussing how they will work together in the future. A clear priority for Londonwide LMCs will be to develop practical tools and programmes to support practices as they begin to develop new ways of working. These will be developed, disseminated and promoted across key stakeholders and influencers and policy makers.

## Conclusion

Any transformation of primary health care to meet the needs of Londoners must build on the strengths and values of general practice and must invest in the capacity of GPs and their teams to deliver appropriate and responsive care to their patents. Care must be taken to support the personal therapeutic relationship between a patient and their local GP, and safeguard the role of the GP as an expert generalist working in their community.

## Figure 2: Values, Priorities and Building Blocks




**GPs** will be alert to opportunities to develop what and how they provide and to improve the quality of what they do.

**Commissioners** should prioritise support for the development of primary care based on registered GP lists, in moving care out of hospital, and encourage groupings of practices to foster collaborative working between GP practices and other providers to deliver co-ordinated care and integrated services close to patients' homes, together with the necessary investment into infrastructure.

GPs and their teams are already working to full capacity. Investment in enabling them to rise to the challenge of transformation has the best chance of meeting the increasing health care needs of Londoners.

Londonwide LMCs fully recognises the successes of general practice. Our priorities are to build on successes and make improvements where there are shortcomings. As such, this document outlines the beginning of practical support for general practice in London where we as Londonwide LMCs:

1. can deliver to support practices and our LMCs
2. can influence - in relation to commissioners and policy makers - in their plans for the transformation of primary care in London
3. can support commissioners to help them deliver service and contractual changes in a way that preserves and builds on the strengths and values of GPs in London

Further guidance to take this practical approach forward will follow.

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