

Londonwide LMCs' response to the Parliamentary Health Select Committee Inquiry into Primary Care – September 2015

LONDONWIDE LMCs

1. Londonwide Local Medical Committees is the clinically led independent voice of GPs in the capital. We aim to secure the future of general practice in London through our work with all partners in the health and social care sector and beyond. We support and represent over 7,000 GPs and over 1,300 practices in London through our 27 locally elected committees. We ensure that London's GPs and their practices have access to the information and support they need to help them provide the best possible service to their patients.
2. Local Medical Committees are recognised in statute under the NHS Act as the representative organisation for NHS general practice and remain the only independent, elected, representative body for local GPs.

PROFESSIONAL ENGAGEMENT AND INTERDEPENDENCIES

3. To secure a strongly engaged clinical workforce, transformational policies need to make sense to clinicians in their consulting rooms and play to their professional values. That is why they are asking us to secure for them a reduction in perceived bureaucratic requirements, and increase time spent with patients.
4. GPs and practice teams cannot provide best quality prevention and care in isolation: outcomes depend on the presence, availability, accessibility and quality of other services in the communities they serve; and the outcomes of other services depend on the presence, availability, accessibility and quality of general practice. These interdependencies mean that what goes on within a general practice depends on what happens outside, and vice versa.
5. Just as importantly, what happens to a patient depends on what happens:
 - a) before GP advice is sought,
 - b) within the practice and essentially within the consultation, and
 - c) beyond the practice.
6. As Marmot highlighted, if a patient experiences health inequalities through inadequate housing, employment issues, or domestic or work-related stress, those factors may underlie the presenting complaint e.g. obesity. If factors remain unidentified, the outcome might well be a medical prescription or referral to hospital rather than a more effective signposting to CAB, advice on self-management, social prescribing, faith support, counselling, or other community-based services; whether in primary, social or voluntary care and support sectors.

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7. Patients cannot adequately access community nursing services which have been extensively pared back. Similarly many health visitors, social services, and mental health services have been reduced, despite over 60% of GP consultations having a mental health component. When this range of local services is unavailable or overloaded, a revolving door of consultations within the practice ensues, increasing demand, and the pathway of least resistance is likely to be over-used i.e. A&E.

BOX 1: Factors which block flow at practice level

Access and Flow

When patients' pathways or journeys are not appropriately completed, the additional consultations that arise affect not only the flow of their own journey, but also the flow of other patients through the practice. Smarter working within practices can ameliorate these effects but the reality is that the saturation point has been hit even by the most competently working practices in London. General practice in London is beset by blockages in flow; diverting staff from consulting, coordinating or planning care and both reducing access to patients and demotivating professionals.

Workforce and leadership issues

- Recruitment, retention and retirement
- Treadmill culture
- Poor resilience
- Low morale
- Loss of control

Workload issues

- Un-resourced transfer of work from secondary care
 - Prescribing, certificating
 - Poor communication, information and care coordination
 - Friday evening discharges
 - Patient bounce backs from missed appointments
- Bureaucracy
 - Chasing low health value and unsustainable local contracts
 - Managing regulation: CQC, GMC, multiple performance targets
 - Lack of care coordination across multiple boundaries
 - CCG pressures to engage taking key staff out of practice
 - Unnecessary 'mandatory training'

Revolving door

- Wider determinants of health
- Impact of commissioning culture based on non-holistic, non-generalist biomedical model and failure to understand the consequences of not supporting the biopsychosocial GP model of care Inadequate community, social and mental health provision
- Benefit letters, housing letters, school absence certificates

Practice inefficiencies

- Inadequate support or time or energy for good productive practice systems and management, staff wellbeing, staff training and customer service

Contractual and resources pressures

- Reduced finance squeezes staffing levels
- Blame and bullying culture (perceived and actual)

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DEMAND, SUPPLY, MORALE AND ACCESS

8. When demand outstrips supply health professionals become stressed and demoralised as they strive to maintain the quality of care which they were trained to provide.
9. When the health system looks at demand management it always looks at demand on hospitals and on A&E. This is too far up the line. GPs deliver 90% of NHS services with 8% of the budget and are increasingly reporting that there are issues with referrals and pass-backs from acute trusts and others in the health system resulting in even greater demand on GPs' time.
10. The most recent BMA survey of GPs conducted December 2014 to February 2015 saw 93% of responding GPs say that their workload has impacted negatively on quality of care given to patients.

BOX 2: About GPs and Practice Teams

GPs are expert generalists trained in the bio-psycho-social model of medicine. They differ in their approach from specialist and general hospital physicians who are trained to operate in the narrower bio-medical model.

GPs deal with patients' unfiltered problems arising from medical, psychological, and social disease, and take all these factors into account holistically, episodically, and summatively over time, building a partnership of trust delivered through consultations with the patient to effect better health and wellbeing for that individual. This relationship continuity is the essence of general practice and, with the right enablers in place, is key to achieving better outcomes for individuals. When scaled-up to practice or communities of practices this is key to achieving better outcomes for populations.

Relationship continuity, and the trust underpinning it, delivers improved outcomes, whether episodic, urgent or self-care is required. Underpinning this is the consultation and one of the core GP skills: the capacity to act as a therapeutic agent. It is the expertise of the GP that improves a patient's sense of wellbeing as much as the prescription written, or referral made. This therapeutic relationship is key to the 'less is more' approach to delivering better outcomes with less unnecessary prescribing, fewer unnecessary referrals to specialists, fewer costly investigations, and more self-care and trusted reassurance.

GPs work best in teams of professionals, support workers and volunteers; from those at the front desk to those providing social, mental or clinical care and support in communities who's culture of care aligns far more closely with the bio-psycho-social model than the biomedical hospital model. Multi-disciplinary teams based in and around practices in communities where people live: supporting education, self-care, navigation and co-ordination of patients' journeys is essential to keeping patients from unnecessary expeditions to hospitals.

Care coordination cannot be underestimated, but it is of no value if there are no services to be coordinated with. The distraction of forming and storming organisations negatively impacts the very resources that GPs, practice teams, and wider MDTs so desperately need for service provision.

The Importance of "The Consultation"

The Consultation (face to face, phone, skype, email) is the supply currency of general practice and available in finite amounts. The quality and standards of care that patients receive will be determined not only by access but also the GPs time listening, the ability of the GP to hear and problem-solve, and the availability of other services.

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DEMAND : Current and future workload and need

Population growth

11. London's population is growing rapidly. Short term population predictions from the GLA in 2014 say that by 2020 the total population of London will be 9,195,449, an increase of 538,820 or 6%. In London's fastest growing borough - Tower Hamlets – this will be an increase of 28,717 or 9%.

Complexity and consultation time

12. London GPs are facing unprecedented rises in patient demand. Surgeries now last four or five hours and consultation rates have gone up. In deprived areas GPs are seeing patients in their mid-forties with multiple long-term conditions and issues which would normally only present in those over 70. These have to be identified, assessed and managed in an inadequately short 10 minute appointment. Half of all GP appointments are now for people with illnesses that cannot be cured by medicine or the course of time, instead only managed or prevented - diabetes, heart disease and obesity chief among them. By 2018 over 2.9 million Britons will live with one or more of this type of illness, up by a million since 2008 (DH figures).

Ethnicity

13. Significant variations in the prevalence of some conditions across London boroughs can mean that averages hide the reality of the high needs of specific community's e.g. high prevalence of diabetes in Asian communities in pockets of London. Current funding systems are not specific or sensitive enough to reflect these pockets; resulting in further pressure on the system and increased reliance on third sector and pro-bono support outwith the contracted services model.

LONDON'S VULNERABLE GROUPS

14. **Homeless people and rough sleepers:** These groups tend to be mobile. We would welcome a consistent approach across the Capital for them and other vulnerable groups such as sex workers, travellers, ex-offenders, and people with learning disabilities. Services must remain locally responsive, flexible, skilled, and holistic to meet effectively the needs of people who may struggle to access mainstream services.
15. **Non-English speakers, refugees and migrants:** Some London boroughs, such as Brent, have over 150 first languages spoken. Translation services are crucial to support GPs and their teams in providing effective care. People from different places often have different expectations, experiences, and understanding of how best to use NHS services. In most countries it is not the norm to have a GP, and

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people look to white coats and hospitals as their first port of call. 'Health literacy', although not an ideal expression, requires trust and supportive relationships to be built with GPs. This takes time and care. In particular, refugee patients are deeply suspicious of perceived state control of personal data, and what seems naturally acceptable for system managers, may feel abhorrent to these patients.

16. **Mental Health and Wellbeing:** An estimated 60% of GP consults involve patient mental health and wellbeing issues and the Capital is particularly challenged by the volume of people with severe mental health problems. GPs need access to reliable, expert, local help for their patients ranging from rapid access to urgent specialist care to co-ordinated care including talking therapies.
17. **Deprived communities:** A higher proportion of patients living in deprivation have multi-morbidity and complex conditions, compounded by poor mental health and difficult social circumstances. In deprived populations multi morbidity is not just a characteristic of old age, but of poor housing, diet and environment. Over 26% of London falls within the most deprived 20% of England based on 2010 IMD data, whilst two thirds of London has above average levels of deprivation, the highest of any UK region.
18. **Young people and older people:** Based on 2010 IMD data analysed by the GLA, the five English local authorities with the highest proportions of areas in the worst decile for children and older people in income deprivation of any local authority in England are all London authorities: Tower Hamlets, Islington, Hackney, Newham and Haringey. ONS data shows that 50% of all GP appointments are for people with a long term conditions; 58% of those over 60 and 14% of those under 30 have a long term condition, and; 25% of those over 60 have two or more long term conditions. The rise of diabetes and obesity among children presents additional challenges; too much junk food, sugar and sitting on the couch mean that London is the worst area in England for childhood obesity – 11% of children in primary school reception classes are obese, rising to 22% by year six. This frequently results in diabetes, which will affect 569,000 or nine percent, of Londoners by 2020.

SUPPLY : Current and future workforce and infrastructure challenges

Morale

19. Recent surveys by Londonwide LMCs (May 2015) and the BMA's GPC (January 2015) reveal that GPs are frustrated by increasing administrative burdens which limit and reduce their clinical time with patients. The biggest challenge GPs and their teams in London face is declining morale resulting from increasing workload, and reducing workforce. Concerns regarding GP retention and recruitment, and increasing concerns regarding the rising levels of GPs considering or anticipating

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early GP retirement within London practices, impact on the morale of existing practitioners and the perception of those who might previously have considered a career in general practice.

Recruitment

20. A changed perception of what general practice is and how it should operate has resulted in reduced recruitment into general practice, with our recent survey showing high vacancies across the capital. Anecdotally, whilst there used to be 80 trainees applying for one vacant trainee position a decade ago; it is more likely now to find one applicant applying for/ choosing between two practices.

Retention

21. With high rents and outgoings many GPs are unable to afford the traditional partnership route within general practice. Some actively choose to work as locum or salaried GPs where better work life balance and higher levels of remuneration, with less responsibility, often covering anti-social out-of-hours activities. Meanwhile, younger GPs are more amenable to considering working abroad in places like Dubai, Australia, and New Zealand where working conditions are perceived to offer a more attractive work life balance. Indeed, a number of overseas healthcare providers actively target young British GPs as part of their recruitment strategy.

Training

22. Substantially more of Health Education England resources need to go directly to training and developing GP practice staff at all levels, and community primary care staff, to take on the work of moving care out of hospitals. Community Education Provider Networks can be an appropriate model for this. However, attention must be given to the blocks and drivers, including: support and mentorship for those providing practice placements who may not be qualified educators; back filling costs for practices hosting disciplines other than GP trainees; supporting co-operation between undergraduate education providers in the acute and community sectors, and; an understanding of the service incremental costs and implications in all sectors.

ACCESS : The quality and standards of care for patients

23. A focus on finding affordable solutions would incentivise and support collaborative working across current organisational boundaries through a model of care coordination, rather than forming yet more organisations, would better recognise that there is no one-size-fits-all solution for general practice across London. Many of the factors impacting on patient care are not within GPs control. Moreover, GPs are subjected to an increasing and unmanageable number of “standards”, some of which do not impact on performance, all of reduce personal consults and smarter

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working. Using value or outcome based commissioning models would be more effective at improving patient care across London.

24. Given current need, the best way to achieve improvement is to urgently and aggressively tackle factors that block patient flow to appropriate health and wellbeing solutions. Managing demand and access depends on improving the flow of patients to their rightful journey destinations, which in turn improves the flow of patients through practices, frees up consultations and improves access.
25. We also hear such pressures on general practice cited as causal factors in practice closures. Closures result in dispersed patient lists, increasing pressures, on remaining practices and creating a vicious circle of workload crisis. HSCIC figures (PQ5222) show that in the past ten years (from 2004/5 to 2013/14) there have been 990 practice closures in England, of which 162 (over 16%) have been in London. And our March 2015 practice survey found 10% of London practices are considering closing and terminating their contracts with NHSE. London practices make up just over 16% of all of the 7935 practices in England (as at May 2015 - HSCIC data cited in PQ1750).

Premises

26. GPs and patients need access to more suitable, affordable practice premises as a matter of urgency. GP premises must be kept approachable and local and yet connect together.
27. Many London GPs struggle to find suitable and affordable premises in their practice area. Experience tells us that sites for new buildings or premises suitable for conversion are limited across London. Commissioners and local authorities could do much to facilitate the development of suitable, affordable local premises, and to release funding to deal with urgent upgrades and repairs.
28. As Lord Darzi's 2014 report made clear, the NHS is one of the largest owners of land and buildings in London with a hospital footprint three times the size of Hyde Park, a book value of the entire estate of £11 billion, and responsibility for 1,400 GP practices (including those outside Londonwide LMCs remit). We look forward to an update on progress toward: "...establish[ing] an unused NHS buildings programme in London so that trusts are encouraged to transfer assets for redevelopment and disposal (receipts would revert back to the trusts)."

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CONCLUSION

29. London primary care providers face special challenges. To improve the flow of patients through general practice, clear existing blockages, increase capacity and reinforce, maintain and sustain the existing system and workforce, commissioners and educators need to work closely with Local Medical Committees, GPs and practice staff. From increasing training and staffing capacity through to improving IT systems and halting system reconfigurations there are a range of solutions that would benefit staff and patients in a general practice environment.
30. We have worked closely with GPs to identify areas of pressure and produced guides to help practices reduce demand for non-contract activities which regularly take up precious consultation time. You can see these materials here: <http://www.gpresilience.org.uk/>.

Further Information:

For further information about Londonwide LMCs' response please contact Sam Dowling, Director of Communications on sam.dowling@lmc.org.uk.