Londonwide LMCs
The professional voice of London general practice

Keeping true to our values while under pressure

Ahead of our annual conference: 'Under Pressure: stabilise, transform, and sustain general practice for London', Dr Michelle Drage takes a look at some of the challenges facing London general practice. If you are booked onto our conference you can hear Michelle expand on these themes in her keynote speech tomorrow, 27 April 2017.

The London challenge

London general practice faces an unprecedented challenge with the a shortage of GPs and practice staff facing growing demand. Every six months we survey London GP practices and the results consistently show they’re running on empty; 46% of practices responding to our latest workforce survey had a vacancy, 45% had at least one GP planning to retire in the next three years.

This workforce is treating more patients; by 2020 the population of London will be 9.2 million, up 500,000 on 2014. These patients are increasingly unhealthy, with multi-morbidity that was confined to people in their 60s and 70s, being seen in people in their forties and fifties. On top of this, London has numerous areas with high levels of economic deprivation and the accompanying social factors that drive ill health.

Any GP or practice nurse will tell you they see these factors at play day in, day out, in the lives of their colleagues and the people they care for. Research support this view as well, one study gives healthcare a meagre 15% role in determining population health outcomes, with health behaviour patterns (40%) and social circumstances and environmental exposure (45%) being the real drivers.

Triple Aim to Quadruple Aim

Our workforce can only meet these demands if we are valued ourselves and still get joy from their work. The Triple Aim is a theory by Don Berwick that says a successful healthcare system needs to simultaneously pursue three dimensions:

Improving the health of populations
Improving the individual experience of care
Reducing the per capita cost of care

The Quadruple Aim, developed by Sikka, Morath and Leape, adds a fourth point to make these principles a better fit for modern primary care:

Improving the work life of health care providers, including clinicians and staff.

In terms of what it means for the people working in these health systems, the Sikka et al say:
“There is an internal gut-check, that needs to be answered affirmatively by each worker each day:

Am I treated with dignity and respect by everyone, everyday, by everyone I encounter, without regard to race, ethnicity, nationality, gender, religious belief, sexual orientation, title, pay grade or number of degrees?
Do I have the things I need: education, training, tools, encouragement, financial support, so I can make a contribution this organisation that gives meaning to my life?
Am I recognised and thanked for what I do?

If each individual in the workforce cannot answer affirmatively to these questions, the full potential to achieve patient safety, effective outcomes and lower costs is compromised.”

The value of coordinated community care

For years I’ve been making the case for investing in general practice and primary care as the answer to the health challenges created by our changing population, all the evidence suggests it is where the NHS can provide the best care in the most cost effective way:

In June 2016 Simon Stevens, the Chief Executive of the NHS said that 40% of NHS activity is related to ‘modifiable health risk factors’ and it spends £16bn a year on direct medical costs of obesity and diabetes – diabetes can only be prevented by behaviour changes driven in the community.

In 2015 the National Audit Office reported that a 1% increase in spending on community services is associated with a 3% reduction in the level of A&E attendance.
In 2014 Deloitte, hardly the greatest friend of the small business, said £72m a year extra spent in general practice would save the NHS £1.9bn by 2020 in reduced A&E visits, hospital stays and ambulance call outs.

How we’ve been told to do it…
So we’ve been told to make general practice fit into the structures created by sustainability and transformation plans (STPs) and the Multispecialty Community Providers (MCPs), which look set to be the STP’s deliver vehicle for primary care. These ‘new models of care’ are led by political imperatives rather than evidence, general practice is being pushed into them with the stick of contract changes and pulled into them with carrot of additional funding streams, which are all-too alluring at a time when many surgeries are struggling to keep the lights on. With this approach the ambition of providing care at scale results in the ‘at scale’ part taking up all the resource and the ‘providing care’ part coming in second place.
The values of general practice
General practice needs to transform in a way which keeps the values of general practice at the centre of how practices teams go about caring for their patients. These values are:

The registered list - individuals and ‘practice’ population.
Expert generalist care of the whole patient.
The therapeutic relationship with a consultation as the irreducible essence of delivery.
Based on the bio-psycho-social care, not a disease-focused model.
Advocacy and confidentiality.
Safe, effective long term and preventative care by promoting access to relationship continuity, balanced with timely episodic care.
Needs based, taking into account the wider determinants of health and the inverse care law, compared to wants.

How we should be doing it…
Community based general practice, supported by properly funded social care services, is best positioned to make the early interventions that can prevent ill-health developing into life-long conditions. This is a system which addresses the ‘wider determinants of health’, behavioural and environmental factors which compound the existing health inequalities that Londoners face. This winter’s Health Select Committee report on A&E pressures identified traditional general practice as the way to manage demand, while being unconvinced by GPs in A&E or extended access pilots.
We need the right kind of care, in the right place, working across local authority or health service boundaries. That doesn’t come from forcing all these components into a system, it comes from allowing services to connect across boundaries and meet needs; GPs, community services, third sector, local groups, schools and everyone else who can shape health and wellbeing. If you give GP practices the thinking space and autonomy to tailor services to meet the needs of their local population, consistent with the values of general practice, they will go out and make the local connections they need to care for London, connections that reflect its incredible diversity.
With this comes stability - GPs who have more time to think about what factors are making their patients ill, to think who they need to co-ordinate with mitigate them and the time to talk to these people. We can accomplish this by keeping the values of general practice at the heart of what we do.