Londonwide LMCs
The professional voice of London general practice

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LONDONWIDE LMCs' RESPONSE TO APPG INQUIRY INTO MANAGING DEMAND

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 nearly 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. GPs and practice teams as experts in generalist health, care and wellbeing, have immense expertise in addressing patients' unfiltered and interdependent problems arising from medical, psychological, and social causes, building a strong partnership of trust over time. GPs diagnose and manage short and lifelong conditions, and, in collaboration with other professionals, work with people to help them to take preventative measures to avoid ill health. But they 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.

4. 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.

5. Indeed, patient trust and the expertise of the GP in seeing patient as a whole complex being, rather than a sum of their parts, enables the GP to act as an advocate and a therapeutic agent who improves a patient's sense of wellbeing and safety as much as the prescription written or referral made. It is important to recognise that less than half the problems presenting to GPs are related to specific disease processes, with more than half relating to dis-ease. Hospitals operate on the disease-based biomedical model alone whereas GPs and practice teams operate on a bio-psycho-social model of health that these identified groups of health expertise listed above can seamlessly fit into. The general practice hub/surgery is ideally placed to collaboratively deliver what is needed to manage patient demand.

6. 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 in the practice ensues, increasing demand, and the pathway of least resistance is likely to be over-used i.e. A&E.

DEMAND, SUPPLY, MORALE AND ACCESS

7. 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.

8. GP practices are firmly embedded in the communities they serve and perfectly placed to provide continuity and coordinate the journeys of people needing or using these services. GPs clearly cannot meet all wellbeing needs in isolation and practices are well placed to sign post to other services; a strong collaborative working arrangement with other wellbeing service partners

including the third sector is vital if the wellbeing of local communities is to be maximised. They are also trained to work within and across wider primary, community, mental health, social and voluntary services to oversee the coordination of peoples' care in avoidance of a hospital referral; and yet these services which hold the key to the co-ordinated care needed to ensure only people who need to go to hospital end up there are no longer designed around the practices in the communities where people live. This lack of coordination across community based services, along with a lack of funding, is unsustainable, and over and mis-use of hospital services is often the result. Indeed, the National Audit Office (2015) reports that a 1% investment in community services results in a 3% reduction in A&E attendances.

DEMAND : Current and future need

Population growth

9. 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% and in total, akin to the population of a medium sized country. In one borough alone - Tower Hamlets – this represents an increase of 28,717 or 9%.

Ethnicity

10. 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

11. **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.

12. **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 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.

13. **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.

14. **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.

15. **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

Retention

16. 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.

Impact of 5YFV & GPFV

17. The evidence that general practice is experiencing a crisis of both supply and demand is inescapable and compelling. Initiatives targeting vulnerable practices, building practice resilience, releasing capacity, underpinning the workforce and improving morale must not be viewed in isolation. Whilst it is too soon to measure the success of such measures, with nearly half of all of London's general practices reporting current vacancy and a further half projecting pending retirements within three years it is clear that there is a state of emergency within general practice.

18. Whilst commissioners have not yet identified where every practice sits in the continuum of practice stability and sustainability, it is clear that the scale of need us dramatic and that practices must be supported to determine their own degree of stability; external measures only will miss key factors such as imminent retirements that are only known to members of the practice.

19. For system transformation to succeed, there must first be stability thence sustainability. We are cognisant that general practice is operating in the midst of a GP and practice nurse workforce crisis: our Nov/Dec 2016 workforce survey revealed that nearly half of London's practices are short staffed. Nearly a third are missing at least one GP; over 40% have a GP planning to retire in the next 36 months. The remaining GPs and their teams are at breaking point: delivering the current service with fewer staff is unsustainable and unsafe in the long term, let alone stretching to an extended seven-day service and taking on additional activity from the acute sector.

ACCESS : The quality and standards of care for patients

Premises

20. 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.

21. 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.

22. 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)."

SELF CARE

23. It is necessary to identify what the NHS can feasibly deliver, and what it should deliver. Identifying needs such as support for parenting in early years through Childrens' Centres; appropriate long

term condition community support and identifying what works as a driver in targeting the right information with the right resources at the right time and in the right place. Self care doesn't have to mean isolation; the NHS and social care system should take responsibility for guiding patients towards effective self care utilising technology such as self monitoring/diagnostic devices, support groups, education programmes, access to records/care plans, home adaptations, and telecare through the use of apps via a smartphone/tablet offer opportunities for consistent reliable and timely information.

24. The type and location of the self care being offered/ supported will largely determine the training needed for primary care staff supporting its delivery. Strategies can range from those targeted at prevention across the general population - designed to promote good public health and prevent illness – and those specifically focussing on managing minor ailments such as headaches and nosebleeds, through to those seeking to address the almost 20 million individuals in the UK living with one or more long term conditions.

CONCLUSION

25. So what's the answer? Hospitals should be supported to do what hospitals do best. For the rest – invest in general practice.

26. Services for people who have health and wellbeing needs that do not require hospital care or for which the advice of expert specialists is not needed should be based where such services are best delivered; in the communities where people live, co-ordinated by the GPs and practices with whom they are registered, working in multi-disciplinary community Health and Wellbeing systems (MCHWSs) which are sufficiently financed to meet the health and wellbeing needs of people in those communities. These could be virtual systems and London's way of delivering the objectives within the NHS England Five Year Forward View, (which allows for variants of the main MCP models proposed), shaped in a way which meets the very specific health and wellbeing needs of the people of this Capital, and this would work across the nation.

27. London primary care providers face special challenges; not least the need for service planning and infrastructure design to effectively recognise and capture the need for healthcare to be considered when mapping out the built and public service environment.

28. "Good" and effective care is person-centred; based on the GP registered list; empowerment by shared record approach (not dissimilar to maternity care now); with services co-ordinated by the registered GP practices working collaboratively with other community-based services in local Virtual Multi-disciplinary Community Health and Wellbeing Systems (MCHWS) to allow health, care and wellbeing to be delivered/ achieved within and across organisational and local government boundaries; and has the potential, once sufficiently developed, for one contract across the multi-disciplinary community system under which all component services work to deliver care outside hospitals; with hospital contracts redrawn to enable appropriate funding for the services for which they are best designed to provide. All intended 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 infrastructure and halting system reconfigurations there are a range of solutions that would benefit staff and patients in a general practice environment.

Further Information:

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