Londonwide LMCs
The professional voice of London general practice

14 December 2021

Dear Mr Hunt

Londonwide LMCs' response to the Parliamentary Health Select Committee Inquiry into "The Future of General Practice"

Londonwide Local Medical Committees (Londonwide LMCs) welcomes this opportunity to make a formal response to the Health Select Committee's Inquiry into the future of general practice.

As the clinically led independent voice of GPs in the capital, we aim to secure the future of general practice in London by collaborating with partners in the health and social care sector and beyond. We represent over 7,000 GPs and 1,152 practices in London through 27 locally elected committees. We ensure London's GPs and practices have access to the information and support they need to help them provide the best possible service to their patients.

Local Medical Committees are a stable part of the NHS landscape and have been in place, supporting GPs, for over a century. Recognised in statute under the NHS Act as the representative organisation for NHS general practice, LMCs remain the only independent, elected, representative body for local GPs, providing advice, guidance and support on a range of issues that affect general practice.

Summary Response

To maintain the high standard people have come to expect from UK healthcare within the Capital, London's health and wellbeing must be built on a strong, coordinated, supported general practice. As an expert generalist medical service based in communities, general practice supplies vital cost-effective health care and secures health improvement.

Important steps which would help ease the growing pressures created by decades of under-funding in general practice include: prioritising support for practices and investing in the provision of high quality, timely, safe care at a community level; removing the bureaucratic barriers preventing expert generalist GPs from referring directly for critical diagnostic tests; addressing the erroneous perception that general practice is not working harder than ever before, with record number of consultations month on month; ensuring accurate reporting of workforce headcounts without conflating with trainees and others that work under the supervision of GPs, and; recognising the importance to patients and clinicians alike in allowing sufficient time for consultations, rather than a handful of minutes.

If the NHS is to be sustainable it needs GPs and practice teams to be properly resourced to do what they do best: keeping people healthy in their communities, so fewer need hospital care.

Yours

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Chief Executive, Londonwide LMCs

THE ROLE OF GPs AND GENERAL PRACTICE TEAM

1. For most people, their GP is the first point of contact when they are concerned about a physical or mental health problem.

2. GPs operate in the complex space outside disease-specific approaches: providing patient-centred care, working in partnership with patients to manage complex multiple co-morbidities, physical and mental health conditions, and to optimise wider well-being. Clearly, general practice can't prevent mental ill health, or provide conditions in which people can lead fulfilling lives. Tackling the social determinants of ill-health at a wider, pan-Government, level is essential to enable the delivery of a truly preventative health agenda.

3. Increasingly, conditions which have previously been outwith the expertise of GPs and the remit of hospital specialists now form part of normal GP care. Over time, care of patients with long term conditions has shifted from hospital specialists to GPs. GPs are the expert generalists managing clinical risk, preventing over-medicalisation, facilitating appropriate access to specialist services and investigations.

4. At a population level general practice serves defined local communities and offers prevention services, health promotion, and treatment of disease. GPs understand their neighbourhoods and promote social inclusion, linking patients to local groups and VCSOs. They plan and deliver services to meet the specific needs of their local communities, considering potential barriers to access, such as language and literacy, and culturally mores. If the NHS continues to consider PCNs as the smallest scale of delivery, the vital role of practices in local communities will be lost.

PROFESSIONAL ENGAGEMENT

5. The future of general practice is reliant on securing and supporting a strongly engaged clinical workforce. over the past decade we seen an erosion of that workforce, and of the trust that GPs and their teams have in a system that has undermined, undervalued and underfunded general practice in London for some time – to the point that it is barely equipped to deliver core services to patients, and not sufficiently resourced to meet the forthcoming challenges of providing health care for Londoners. Our own documents "Securing The Future of General Practice in London" and "Meeting The Challenge" (https://gpsoe.org.uk/gpsoe/#pricing) set out many of the challenges which have beset London practices over recent years.

6. Transformational policies need to make sense to clinicians in their consulting rooms and play to their professional values.

DEMAND, SUPPLY, MORALE AND ACCESS

7. When demand outstrips supply health professionals become stressed, demoralised and suffer from moral injury as they strive to maintain the safety and quality of care which they were trained to provide.

8. The most recent survey of London general practice conducted in June 2021 by Savanta Comres saw 82% of London practices report concerns about the impact of current levels of demand on staff wellbeing, and over a third reporting concerns about the impact of demand levels on their ability to provide safe patient care. This is in the context of 49% of practices reporting staff vacancies, over half of which are for GPs. Associated sickness and absence from work due to stress and burnout can also compound these problems.

9. Increasingly GPs in London report feeling ***"overwhelmed by "demand" which is squeezing out and straining the far more important element which is "need". Failure to meet the demand brings in the political necessity to do something for the public vote and that is not always in the best interests of the system."***

10. The system assesses demand on other services, eg in hospitals and 111, but fails to understand demand on general practice. GPs deliver 90% of NHS services with 9% 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.

11. Considering the developing plans for ICS powers and accountable areas, we are concerned that proposed amendments to primary legislation to "free the NHS from overly rigid procurement requirements" give cause for concern. Given the patchy engagement of community and primary care providers across the recently introduced and still maturing STPs, there is a sparsity of confidence in the suggestion that any such ICPs would equally involve and consider different levels of care provision without favour for form. Londonwide LMCs has spent months working with NHS England London to adopt a position of collaboration rather than integration and partnership rather than direction and we would be disappointed if changes to national legislation were to roll these agreements and arrangements back – either in perception or reality.

DEMAND : Current and future workload and need

Population growth

12. London's population is growing rapidly, with increasing complexity of need. Yet despite unprecedented rises in patient demand and a nearly 20% increase in the number of appointments being provided across London general practice (672,291 more appointments Sept'19 to Sept'21 (3,448,631 – 4,120,922)) concurrent with a nearly 5% reduction in the number of open practices (1260 -1205 Sept'19 to Sept'21) the persistent and prevailing narrative is relentlessly negative towards general practice.

13. Practices are also seeing an increase in the number of patients registered per GP, which has increased from an average of 1900 to an average of 2500. With a reducing workforce and a growing population something must be done to address this growing problem.

Complexity and consultation time

14. Undifferentiated, multiple presenting complaints have to be identified, assessed and managed in an inadequate period due to the unsafe number of clinical contacts each day. Half of all GP appointments are now for patients with complex co-morbidities.

    a. Long Term Care (LTC)

    At an individual level, the GP expert generalist role is increasingly important as needs become more complex. Conditions previously exclusively managed by specialist hospital care are now part of normal GP responsibilities... Across London, but particularly in the more deprived areas, GPs are seeing patients in their mid-forties with complex multiple long-term conditions and issues which would normally only present in those over 70. Managing multiple co-morbidities and frailty pro-actively in partnership with patients, with an understanding of their healthcare beliefs, values, and preferences, is vital to keeping people well and at home. Shifting time away from this has a significant negative impact on patients, and the wider health care system.

    b. Prevention

    General practice offers prevention, screening and health promotion services at a population level. The vaccination programme has shown the vital place of GPs in supporting vaccine hesitant people to make an informed decision.

    c. Gate keeper

    And at a health-system level, general practice manages clinical risk and delivers efficient care by preventing over-medicalisation and facilitating appropriate access to specialist services and investigations.

Ethnicity

15. 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 eg 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.

SUPPLY : Current and future workforce and infrastructure challenges

(We will expand on these comments in January in our further evidence to the recently announced Workforce Inquiry.)

Morale

16. we believe that the aim of the NHS should be quadruple, and not triple, and include consideration of staff well-being. Recent surveys by Londonwide LMCs (June 2021) and the BMA's GPC (March 2021) 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. GP retention and recruitment and increasing concerns regarding the rising levels of GPs considering or anticipating 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.

17. The fourth aim is important for patients. Studies show that when physicians are unwell, the quality of the care they deliver drops. Higher rates of burnout have been associated with poorer personal well-being and a greater risk of involvement in medical errors.

Recruitment

18. Our six-monthly surveys of general practice in the Capital show high vacancies and low morale. The lack of confidence in the national negotiation processes to ensure that the partnership model of general practice remains viable is resulting in GP partner recruitment challenges.

19. 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, with less responsibility.

Training

20. Substantially more training resources need to go directly to supporting and developing GP practice staff at all levels; and to community primary care staff However, attention must be given to: supporting and mentoring those providing practice placements; 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 : safe, high-quality care for patients

21. A focus on finding affordable solutions that incentivises and supports 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”, many of which are poor proxy markers for quality of care, and some act to the detriment of addressing health inequalities and inhibit effective use of finite clinical time.

22. We have recently collaboratively produced a guide to support GPs to maximise their access. However, no quality improvement exercise is going to change the fact that GPs are working beyond capacity to the detriment of safe patient care because demand exceeds supply. It is irresponsible of the NHS to fail to acknowledge and address this through addressing the significant issues outside of the gift of practices.

23. Other services cross the health and wellbeing spectrum frequently signpost to GPs when they cannot meet the needs of the patients, eg due to gaps in

commissioned services or delays to accessing the right care, despite the inability of GPs to fill the gaps. This is poor use of finite clinical time and contributes to the moral injury experienced by GPs.

24. 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 care journey, which in turn improves the flow of patients through practices, frees up consultations and improves access.

25. 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 and have a marginal impact on access, and we have recently worked with HLP and NHSE to explore where improvements to access can be made, 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.

26. We regularly hear that the frustration experienced by patients in navigating the system is exhibited in criticism, abuse and even violence directed at general practice staff, often cited as causal factors in practices losing staff or closing, resulting in dispersed patient lists, increasing pressures, on remaining practices and creating a vicious circle of workload crisis.

Premises

27. 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. 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 help the development of suitable, affordable local premises, and to release funding to deal with urgent upgrades and repairs.

INTERDEPENDENCIES

28. Marmot highlighted that if a patient experiences health inequalities through inadequate housing, employment issues, or domestic or work-related stress those factors may underlie the presenting complaint eg obesity. If factors stay 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.

29. Care coordination cannot be underestimated, but it is of no value if there are no services to be coordinated with.

30. Patients cannot adequately access community nursing services which have been extensively pared back. Similarly health visitors, social services, cessation support services, and mental health services have been reduced over recent years. When this range of local services is unavailable or overloaded, a revolving door of consultations within the practice ensues, increasing demand.

31. We also welcome the increase in practice based partnerships with other specialisms, including specialists nurses, pharmacists, physiotherapist, mental health experts, paramedics and others, However, the funding of these additional roles does not include London Weighting, which means that London practices wishing to recruit at a salary level reflecting the higher cost of living in the capital are unable to employ as many staff as a non-London practice. AHPS can play a valuable role, but they cannot fulfil the role of GPs and PNs to deliver core general practice.

PRIMARY/ SECONDARY INTERFACE

32. We need a new model of care that enable primary and secondary colleagues to work effectively together, maximising the value that both can bring. The form needs to follow function, and this includes the scale of delivery. One of the challenges is that hospital colleagues cover large geographies. Networks of practices may offer opportunity here: if GPs in practices across PCNs had named consultants with whom they could work for the benefit of patients then even specialties where there are fewer referrals from primary care would benefit from being part of a system to provide prompt discussion, advice and support.

33. When a patient's need falls outside GP expertise, be that for investigations or for treatment, patients often wait for help. The recent pandemic has placed significant pressures and strains on all parts of the health system, but as the "front door" or first point of access for nine out of ten health encounters, patients in need of further help are often stuck in limbo: at the limits of the expert generalist's expertise and not yet accepted by the specialist in another setting. That conflict between acting firmly within expertise versus leaving someone suffering or at risk is a daily challenge for GPs.

34. Similarly, the increasing shift of clinical accountability badged as "shared care" or the inappropriate utilisation of "Advice and Guidance" between general practice and other settings can add to the GP burden and cause delays to patient care. In London, there are significant concerns about care pathways being switched to 100% advice and guidance without discussion without all parties being engaged.

35. We need to develop new whole system approaches and think differently - always recognising the impact on patients and the workforce of any change, irrespective of provider. Rather than passing administration tasks to GPs, it would be more cost effective for the hospital colleagues to simple solutions, such as having access to a team who can complete forms on their behalf and enabling hospital colleagues to issue Med3s (we re told they cannot currently because forms aren't available in hard copy or electronically), or send a prescription directly to a patient's pharmacy.

CONCLUSION

36. 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 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 help staff and patients in a general practice environment.

37. To maintain the high standard people have come to expect from UK healthcare within the Capital, London's health and wellbeing must be built on a strong, coordinated, supported general practice. As an expert generalist medical service based in communities, general practice provides vital cost-effective health care and secures health improvement.

38. A key starting point for change, welcomed by practitioners and patients alike, would be to recognise the need to extend the core consultation time to at least 15 minutes, if not longer. Longer appointments equal improved outcomes and better staff retention.

39. There is no doubt we need a new understanding of what general practice can reasonably be expected to deliver. Agreeing to deliver unrestricted work for an inadequate fixed fee is unsustainable and does not reflect the role and value of general practice, its place in the community, and the care given to our patients. Only by adequately resourcing practices to have the workforce needed to deliver care safely and work collaboratively and seamlessly with other providers can we give patients the care that they need.

40. Despite the reduced GP workforce, we have no way of limiting demand in general practice; there is no black alert divert system. The workload pressure cooker of general practice has no safety valve. We don't struggle to recruit trainees, but qualified GPs aren't staying. In one Vocational Training Scheme in London last year 26 GPs were trained, but only two accepted permanent GP posts. Retention is a huge problem both for younger GPs not taking up work or leaving the profession, and for older GPs retiring early. The workload pressures are simply intolerable.

41. The key to keeping and protecting the future of effective general practice is to focus on function rather than form. Complex core general practice is in more demand than ever before and the need for GPs is greater than ever before. Collaborative networking across practices and PCNs is good but contractualising relationships is not.

42. Other steps which would help ease the growing pressures created by decades of under-funding in general practice include to: prioritise support for practices and invest in the provision of high quality, timely, safe care at a community level; remove the bureaucratic barriers preventing expert generalist GPs from referring

directly for critical diagnostic tests; address the erroneous perception that general practice is not working harder than ever before, with record number of consultations month on month, and; ensuring accurate reporting of workforce headcounts without conflating with trainees and others that work under the supervision of GPs.

43. If the NHS is to be sustainable it needs GPs and practice teams to be properly resourced to do what they do best: keeping people healthy in their communities, so fewer need hospital care.

Further Information:

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