Londonwide LMCs
The professional voice of London general practice

23 December 2021

Dr Claire Fuller
Chair, Fuller Review
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Dear Dr Fuller,

Londonwide LMCs' comments for consideration as part of your Review's stocktake into the future of integrated primary care

Londonwide Local Medical Committees (Londonwide LMCs) welcomes the invitation to participate in your work looking at how best primary care can be supported within the emergent integrated care systems.

As the clinically led independent voice of GPs in the capital, our aim is 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.

We know that 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.

As such, we would welcome the opportunity to further discuss your Review and to facilitate engagement, including for example a deliberative event, from across our constituent LMCs. Overleaf are links to recent documents which represent the London experience within general practice in the Capital at present. 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.

For further information please contact Sam Dowling, Director of Communications on sam.dowling@lmc.org.uk.

Yours,

Dr Michelle Drage, MBBS, FRCGP
Chief Executive, Londonwide LMCs

Turning to the specific questions posed in your stocktake:

Q1. **What are the key priorities for ensuring a more integrated and effective NHS primary care service in future?** With particular focus on:
(i) supported self-care and self-management
(ii) urgent and emergency care
(iii) management of long-term conditions, multi-morbidity and anticipatory care
(iv) elective care
(v) mental health and wellbeing
(vi) services for people with learning disabilities and autism
(vii) services for children and young people
(viii) support for people at the end of life

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 beyond 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 more. If the NHS continues to consider PCNs as the smallest scale of delivery, the vital role of practices in local communities will be lost, along with the nimbleness of reaction and patient care decision-making that only small organisations can bring. We outlined these and other concerns in our recent submission to the Health Select Committee's Inquiry on the Future of General Practice.

5. The GP and practice team continue to play a key role in meeting the needs of patients with Covid-19 infections in the community and in delivering the vaccination programme. There is now a pressing need to consider how we will provide safe effective care given the immense complex patient need and immense pressures and back logs across the system, in the context of a workforce crisis. Currently, undifferentiated, multiple presenting complaints must 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.

6. General practice services are essential to deliver proactive and preventative care to maintain the health and wellbeing of our populations. The values of general practice have not changed, and GPs must continue to preserve continuity of care for their registered patients wherever appropriate. Practices, GPs and their staff must also maintain and understand their vital role in their local communities. Practices as providers are truly clinical led, with a history of being innovative, adaptable, agile and flexible in how they best meet the needs of their local population; never before have these characteristics been more important.

7.

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.

8. This paper, produced by Londonwide LMCs' Deputy CEO Dr Lisa Harrod Rothwell during the first wave of the pandemic last year, adds to the current picture and provides a clear and accessible breakdown of the role played by the GP and practice team across emergency and urgent care, long term conditions, prevention and health promotion, end of life care, and patient and community led advocacy through the height of the pandemic.

Q2. What practical enablers are needed to realise this vision, and how should these best be put into practice?

(i) digital and data, including care records; patient monitoring; population health management, risk stratification and health inequalities; and demand/capacity planning

(ii) workforce models, including expanded primary care teams, changes to education and training, different employment models across multiple PCNs, flexible and portfolio careers
(iii) estates models, including the use of community assets, and flexible space
(iv) local funding and local contracting models.

DIGITAL

9. Over recent months we have responded to Government and NHS England consultations and proposals across a range of areas, and our thoughts will hopefully be of value to your Review

10. With regard to practical enablers and digital developments, we have expressed concern that the digital agenda introduces barriers to those who cannot afford the IT equipment, do not have the connectivity, the eyesight and dexterity, nor the IT skills and confidence. Many people experiencing these barriers will also have higher levels of healthcare need and the digital first model will add to health inequalities. There must be evaluation of whether time diverted into addressing online consultations supports or impairs making the most effective use of the finite GP time to meet patient need over want.

11. We believe that digital services should be developed in an integrated way, alongside other services within existing practices so that they are there to be used if required. Evidence shows that primary care is best delivered by expert generalists working with registered lists in defined geographic communities. The core funding that allows and supports this care delivery at individual and population level must be maintained and, where possible, increased.

12. In order for investment in digital health tools to fit with the values of general practice, such tools must directly reduce health inequalities, or free up resource which can be directed to other methods of care delivery which are proven to do so. It is critical that more focus is placed on understanding the high turnover rate for patients registered with digital first providers; a point made in the published ‘independent evaluation’ of Babylon GP at Hand, conducted by Ipsos Mori in 2019.

13. For the potential of digital health to be realised, all practices need the infrastructure to provide it, the knowledge to use it effectively, and the right balance of impact on workload and impact on patient outcomes to justify the investment of time/money in new systems and ways of working. Online access and consulting could reduce the need for attendance at GP practices and appointments in the long-term. How to apply the technology in ways which actually do this needs to be established by rigorous evaluation, rather than rolling out more online services in the expectation that it will somehow inherently reduce workload. A problem which is increasingly being reported with E-consult and other tools which increase access, but not the capacity to manage the subsequent increase in demand.

14. You can read our responses to the 2018 NHS England consultation on digital first, the 2019 consultation (which focussed more on APMS and procurement) and our response and comment to the NHS England Board statements on digital first here.

WORKFORCE

15. 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 September 2019 to September 2021 (3,448,631 – 4,120,922)) concurrent with a nearly 5% reduction in the number of open practices (1,260 - 1,205 September 2019 to September 2021) the persistent and prevailing narrative is relentlessly negative towards general practice.

16. Practices are seeing an increase in the number of patients registered per GP, juxtaposed with this increasing demand, our six-monthly surveys of general practice in the capital shows declining numbers of practice, and regularly sees practices reporting high vacancies and low morale. You can view selected slides from the summer 2001 workforce survey here. Half of responding practices have vacancies for any role, almost a third have one or more GP vacancies and over a third have one or more GPs planning to retire in the next three years.

17. The future of general practice is reliant on securing and supporting a strongly engaged clinical workforce. Over the past decade we have 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" set out many of the challenges which have beset London practices over recent years.

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

19. 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.

20. We believe that the aim of the NHS should be The Quadruple Aim, and not The Triple Aim, thus including staff well-being at its core. 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. This 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.

21. Our 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.

22. The system assesses demand on other services, e.g. in hospitals and NHS 111, but fails to understand demand on general practice. GPs deliver 90% of NHS contacts 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.

23. General practices are hampered in doing their best for patients by the current policy culture of non-investment in essential (core) services, which leaves them scrambling for short term pots of money directed at other priorities and for which there are so many strings attached that there is little incentive to claim them, and which add to, not diminish as they were pledged to do, the workforce and workload problems at practice level. The AARS scheme is one such example. The result is that significant monies remain unspent and open to return to the treasury, or rapidly diverted to other parts of the system.

LOCAL FUNDING AND CONTRACTING

24. Earlier this year we responded to the NHS England consultation on changes to the procurement regime as set out in the recently published White Paper, including circumstances under which ICS can extend, amend or cancel existing contracts, appoint new providers, or begin a "test the market" procurement. Our Londonwide LMCs response can be seen here.

25. It is important that any contracting and procurement changes, even those presented as the removal of bureaucracy, do not result in unforeseen consequences/ perverse outcomes. And that any contracting process places a premium on safety as a non-negotiable priority above all other criteria considered.

26. We want to understand how the system would work with regard to providers of all sizes with the intent of ensuring that appropriate national quality and assurance standards are agreed, managed and met appropriately, but without placing unwieldy requirements which detract from effective service delivery. Regard

should also be given to understanding what safeguards are in place regarding accountability and transparency of process.

27. There are concerns that the centralisation of contracts and commissioning power within structures perceived to be secondary care led structures may marginalise the presence and ability of primary care providers to influence commissioning decisions. Comfort is sought that measures will be put in place to ensure that this is not the case with regard to decisions impacting on community based general practice services and providers. Particularly in any instance where a single preferred provider selected without procurement protocols is not the existing provider.

28. It is not clear at present who will be responsible for the 'primary care perspective' identified at ICS level, nor whether the partnership board is the ICS Board itself or a board, with or without delated decision-making authority, in the lower governance structure of the ICS. As such, it is our considered view that the concept proposed focusses on the integration of organisations as opposed to the integration of the caring and will fail to achieve the consultation document's intention of simplifying the process of commissioning and procuring care for our patients to remove bureaucracy.

29. The decision-making process must be as transparent as possible. Particularly if/ when determining that there is a single appropriate provider for community-based contracts. If it is not transparent, there is a significant risk based on GP experience on the ground that providers may perceive the ICS to be unfairly favouring trust partners on the ICS and/or not recognising or taking into consideration the community benefit of awarding contracts to smaller providers.

30. Similarly, at a hyperlocal level, procurement decision regarding short term contracts and local contracting models should be considered in the round. In response to the 2019 consultation on APMS Digital First contracting, we expressed concern that APMS contracts are notoriously unstable and poor vehicles for the provision of the continuous and effective health care relationships beneficial to patients and staff. Considering the benefits of stable and continuous patient care and a sustainable and stable workforce, we maintain that commissioners would see improved patient outcomes through increased investment and support for GMS contracts which are nationally negotiated and provide long term stability for patients and staff. You can read our response to that consultation here.

Q3. What type of leadership, engagement and decision-making structures are needed? In particular:
(i) leadership capacity, capabilities, support and development
(ii) governance and supporting infrastructure
(iii) working within communities
(iv) engagement structures

31. 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 ICPs, 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. You may find our response to the ICS legal structures consultation conducted by NHS England earlier this year of interest.

32. The long-term plan emphasises the need for increased clinical collaboration, but we are concerned that the new structures will promote the needs of organisations over the needs of patients, and employ tokenistic clinical advice and expertise. Local Medical Committees, as the statutory representatives of GP practices under the NHS Act believe that ICSs should be held to account for ensuring that all sectors are involved, represented, engaged and heard, and ICSs should be evaluated on this, ideally by the partners themselves.

33. 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. the role of the practice and practice autonomy, and its place in local communities, in meeting the particular needs of our diverse communities must never be overlooked.

34. 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.

35. We need a new model of care, designed by local clinicians, that enables 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.

36. 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.

37. 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.

38. 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 are told they cannot currently because forms are not available in hard copy or electronically) or send a prescription directly to a patient's pharmacy.

CONCLUSION

39. 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, developing systems, 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 meaningfully engaging with general practice prior to any system reconfigurations, there are a range of solutions that would help staff and patients in a general practice environment.

40. 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.

Further Information:

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