



**Londonwide LMCs**

The professional voice of London general practice

**Londonwide LMCs Response to the Kings Fund Report:  
General Practice in London – Supporting improvements in  
quality**

**Produced by Professor Roger Jones on behalf of Londonwide LMCs  
5 December 2012**

## Foreword

The Kings Fund's 'General Practice in London' should be welcomed for bringing into sharp focus the demographics and diversity of London, for linking these to health and social outcomes, and for making clear how these differences make London different to the rest of the country. It does much to highlight the positive health outcomes that London's General Practices deliver against many of the social challenges that our patients face in the Capital. For that it is to be welcomed. It also reminds us that the last real attempt to support improvements in general practice in London was as long ago as 1992, where the Tomlinson report inspired the notion of collaborative working across practices, skill mix solutions to long term condition management, hospital at home care, investment in premises, improvements in education, training, recruitment and retention.

It is concerning, however, that having highlighted these differences, the report repeatedly makes comparisons with national data leading it to qualify that London's general practice is outmoded and somehow in need of 'a new model'. That said, we share many of the key areas identified by the report for attention which include:

- Better, more accessible and more patient-friendly premises for general practitioners and their teams to work together and in networks of practices to provide the widest possible range of high quality services for patients.
- Optimum communication with secondary care, in terms of access to diagnostic facilities, agreement on patient pathways and on the commissioning services.
- Effective, information technology that is genuinely helpful to patient care, GP and staff communication and primary: secondary care communication.
- Adequate time for general practitioners to spend with patients, both in terms of evaluating acute presentations and managing the complexities of co-morbidity in ageing or deprived populations.
- GP and staff time to reflect, plan and learn how to best manage GP services, to carry out audit with feedback and to develop high quality services.
- To ensure that structures and resources remain in place to enhance recruitment and retention of general practitioners, associated clinical staff and non-clinical practice staff.

In short, as we argue in our response to this report, what general practice in London needs is investment in its human resources and infrastructure – that is clinical staff, clinical time, clinical training, premises adaptations, and incentives to work collaboratively in a way which enables it to meet the complex needs and demands of the Capital's diverse patient population and improve on existing health outcomes. These should be measured in London, for London, rather than relying on spurious comparisons made with national averages based on wholly different population demographics.

And so we suggest that we move away from the idea of radical model re-design and instead start working with the successful model we have. Relatively modest investments can make a huge difference to patient experience and outcomes. Given that General Practice sees 85% of all patient activity, with only 15% of the total healthcare budget, a modest percentage investment could of itself, with careful management and monitoring, enable practices to better educate patients, relieve pressure on A&E and secondary care, supply additional and potentially skill-mixed

capacity to better manage complex long-term conditions and complex multi-morbidities in a primary care setting, and to improve collaboration and networks across practices and across other vital primary care and social services. With that in mind it should be stated that general practice can only perform at its best when other primary and community services are also performing at their best. Which opens another set of questions which the report does not address. It is time it did, and if there is to be any new modelling, perhaps it should be around rebuilding those other primary, community and social services around networks of practices in a way which was so strongly developed during the early nineties.

Londonwide LMCs has a track record of acknowledging and improving the shortcomings of General Practice in London, but also of recognising its success, much of which as the author of our response, Professor Roger Jones, states, is “nothing short of miraculous”. Our response to the Kings Fund report should be seen as coming from a critical friend, which shares the same concerns for patient care as the report’s commissioners and authors, and as such see ourselves as strong partners in securing excellent general practice service for London’s complex and diverse population.

## Introduction

At a time of major National Health Service reform, coupled with severe pressures on healthcare resources, it is of great importance to ensure that general practice provision in London is sustained and developed. London is a major biomedical centre, with a number of recently-established large academic medical sciences centres based on its major teaching hospitals. It can be difficult for commissioners and others to remember that general practice is key to the provision of health care for Londoners, and that over 90% of all medical contacts take place between patients and their general practitioners.

Perhaps unsurprisingly, previous reports on healthcare in London have concentrated on shortcomings, rather than celebrating successes, although there is much to celebrate in terms of the health of Londoners and a gradual improvement in overall health indicators. Another major theme of reports on healthcare in London has been that of variation in the quality of care, in health indicators and in harder endpoints such as life expectancy. The well-known tube map depiction of the seven year difference in life expectancy between Westminster and the East End of London emphasises part of the problem. But it also highlights the fact that socio-economic deprivation, low levels of education, high concentrations of mixed ethnicity and of recently-arrived immigrant patients are clearly associated, and almost certainly causative, factors. Compared with many major cities outside Europe, London is relatively affluent, but is in part characterised by steep economic gradients between its richest and poorest citizens, a factor known to be key in determining health outcomes.

It is important to appreciate that practice variation and health outcomes related to an uneven distribution of affluence and deprivation are characteristics of many large cities. In Birmingham, UK, life expectancy in the lowest fifth of wards is five years less than in the highest fifth of wards in the city. In New York City, although there has been a significant increase in estimated life expectancy at birth over the last 20 years, there is still a four year gap between life expectancy in the Bronx compared with the boroughs of Queens and Manhattan. In Madrid and Barcelona, as other examples, differences in educational attainment, controlled for other factors, account for a difference of two years in life expectancy between city areas with the highest and lowest levels of education.

This is part of the background against which this report needs to be read, and credit given to the achievements and attainments of individuals, practices, PCTs, academic initiatives and policy developments across the city in raising standards and health outcomes in a number of ways. Problems still remain, of course, and it is evident that further efforts and resources need to be applied to overcome them.

Although probably not within the original remit of the report, the need to assure continued recruitment and retention of high-quality, well-trained general practitioners in London must be emphasised. Recruitment to general practice in London has followed a cyclical pattern in recent decades. At times major financial initiatives, such as the London Implementation Zone Educational Incentive (LIZEI) programme in the mid 1990s, have been required to try to make the inner city a more attractive place to work and live for general practitioners. At present, undergraduate medical students' interest in careers in general practice is not particularly high, and may be falling. The demographic characteristics of the current general practice workforce, described in this report, mean that recruitment to general practice needs to accelerate to fill the anticipated vacancies. Any changes in the way that general practice and primary care are organised and delivered need to take account of the possible impacts on undergraduate teaching, postgraduate training and the appeal of general practice in the inner city as a career.

At present around half of all London general practices are engaged in either undergraduate teaching or postgraduate training. There are around 15,000 medical students in London, comprising over a quarter of all medical students in the UK, as well as approaching 6000 pharmacy students and over 2000 dental students. Much of the clinical teaching of undergraduate medical students now takes place in general practices, and future general practices need to be able to sustain and, if possible, expand this role. There are around 515 GP registrars in London, 14% of the English total, with foundation doctors with other career destinations also spending time in postgraduate attachments in general practice.

Now that the educational case for extending GP vocational training to four years has been accepted, it is essential that the structures which support postgraduate training in general practice are protected and strengthened in the course of service developments, to ensure that the GP workforce in London remains fit for purpose.

## General remarks

The report from the Kings Fund is important because it provides an account of the successes of general practice in London, often achieved under extremely adverse circumstances. As well as recognising the need for further development of services in response to changing demography, patterns of disease and the financial and policy environment.

Using a range of data sources, the report makes a convincing case for the need for continued development in the provision of general practice in London. Although the design of the study on which much of the report's recommendations are based (in which, by and large, London data are compared with English averages) does not provide evidence for some of the more extreme statements in the report, such as that "the current model of general practice in London is not fit for the future " and that "the model of health and social care needs to be radically change in order to respond to the changing needs of the population". The data suggest that evolutionary change is needed, rather than system re-design.

Much of the report is written from a public health perspective, with its 'academic' input coming from two specialists in public health medicine, not from academic general practice. This leads to a number of difficulties which are mentioned later.

The tone of the report is often grudging. Whenever it identifies London data which indicate better than average performance, there is almost always a qualification, usually about practice variation. In fact, the ability of many London practices to achieve high quality outcome metrics in communities in which over 150 languages are spoken and where socio-economic deprivation is rife is, to many people's minds, little short of miraculous.

Variation in the provision of health and in health outcomes across London is well recognised and has been the subject of previous reports. This variation is largely due to the uneven distribution of wealth and poverty across the city, combined with the consequences of Tudor Hart's inverse care law, which observes that the provision of medical care is least good in areas of greatest need. Practice variation is ubiquitous throughout medicine, and is not a London phenomenon. The report should recognise that and not suggest that inter-practice variation is a particular feature of London general practice. The contribution to this variation of a number of innovations in health care, such as the SE London stroke register project at KCL and the work on diabetes in Tower Hamlets and Bart's, should also be acknowledged. The contribution of variations in hospital care across the capital may also contribute significantly to variations in health outcomes and processes of care, although this is frequently overlooked.

Detailed comments on each section of the report are as follows:

## **Executive summary**

This provides a full, if rather lengthy, summary of most of the relevant data and proposals. Variation in processes and quality of care and in health outcomes once again feature strongly, as does a long list of comparisons between London data and English national averages, many of which are unhelpful.

The summary of key areas for improvement (p 23) is a distinctly mixed bag. It isn't clear what general practice is expected to do to 'reduce inequalities', to 'adopt a more systematic approach to the early diagnosis of all chronic conditions' and still less to 'encourage high risk groups to present earlier'. This, and many other passages of the report, demonstrates a conflation in thinking between general practice, primary care and public health, which runs the risk of placing undue expectations on general practice alone.

The comments about prescribing and medicines management are surprising, given that improving the quality of medicines management has been a strong theme in general practice in London for many years. The observations on lower prescription rates made later in the report emphasise this. The fact that unplanned hospital admissions of patients with long-term conditions are lower in London than in the rest of the country is an extremely positive finding, and it seems inappropriate to qualify this success by a further comment about chronic conditions and best practice.

## **1. The importance of primary care**

This is a welcome section, in which powerful statements, supported by robust research evidence are made to emphasise the value of a strong system of primary

care, and in particular, the success of the UK model of general practice. There is also a welcome acknowledgement that general practice in London has delivered significant health gains over the years (p25).

However there is also a statement that the health care needs of London “will require different models of delivering primary care”, and this 'new model' theme permeates the report, although the evidence for this statement is not provided, and little information and few clues are given as to what these new models might look like.

The authors' comments on the present report (pp 28 to 29) indicate that the time constraints under which it was produced have prevented a detailed analysis of the crude data, so that some of the analyses, such as the interpretation of comparative performance indicators are inevitably superficial. It would have been helpful for the authors to have obtained comparative data from other large cities in the UK – some comparative information has been supplied by Dr Mark Ashworth and Dr Peter Schofield at King's College London, and is referred to later.

## 2. London's population

This is a comprehensive account of the changing social and medical demography of London, and contains extremely interesting and important information. What is perhaps missing from this section is a greater emphasis on the social gradients that exist within London: The extent of social isolation and its impacts on physical and mental health; the extent of family breakdown and fragmentation; the transience of the population, with significant implications for the provision of continuity of personal care in general practice; and the high costs of property, travel and in employing staff. All of which present challenges for general practice.

It is also important to emphasise that the 2011 national census demonstrates increased growth in London's population ranging from 10 to 30% in different boroughs, with higher levels of growth in the most deprived areas, placing even greater strain on GP services. These statistics underline the difficulties London GPs have faced where GP list validation exercises (carried out by mail shots rather than relying on census data) have resulted in reduction of funds for providing care to these growing and needy populations.

The confusion between primary care and public health is well demonstrated on p32 where the report states that London's health profile “underlines the importance of strengthening the primary care system which, working with local authorities, is best placed to reach all segments of the population”. This is not an entirely appropriate expectation of general practice per se.

Pages 32 and 33 summarise some of the differences between London and the rest of the country and many of the health indicators, including: hospital stays, admissions for self harm, rates of diabetes diagnosis, life expectancy, smoking-related deaths, road injuries and suicide indicate better outcomes in London. As well as lower adult rates of smoking and fewer adults with obesity and unhealthy eating patterns. The difficulties of making comparisons with national averages are well demonstrated on p 39, under Premature Mortality, where the report comments that whilst London's rate of premature years lost was lower than the English average, “all surrounding southern regions have lower rates than London”. This is hardly surprising given the differences in socio-economic status between London and the stockbroker belt.

Page 40 discusses cancer and cardiovascular mortality, with London indicators for cancer mortality showing an encouraging trend, although rates of premature death



from cardiovascular disease in London are rising. Whether or not these changes, in either direction, can really be attributed to general practice alone, without considering primary community, secondary and tertiary care provision, is open to question. The concluding paragraphs at pp 45 to 46 of this section are unsatisfactory. The statement that "the greatest public health challenge for London is how to close the gap between areas of deprivation and affluence" seems more like a political, than a health services, question. Dealing with childhood obesity (p46) entails much more than 'identifying those at risk of ill health'; the interventions required at individual, family and community levels are extremely complex.

### 3. Workforce

In this section the changing demography of the general practice workforce in London is helpfully described. Although London practices have lower average total sizes than the national average (because of the higher proportion of single and two-handed practices, 38% in London), the average list size for each London full-time equivalent general practitioner is 2018 compared, for example, with other cities such as a Middlesbrough (1569), Liverpool (1865) and Manchester (1957) {Data from Mark Ashworth and Peter Schofield, 2012}. Ashworth's work is quoted on the next page (p54), where there is a welcome discussion about the strengths, as well as the weaknesses, of small practices.

In the following discussion on premises (pp 55 to 50) the authors might have given more consideration to the high costs of property in London and the relatively low level of investment in the general practice estate that has been made in recent years.

The report makes a welcome statement about the importance of recruiting and retaining more GPs, practice nurses and other support staff in the capital (p 57) and also asks reasonable questions about the opportunities that changing skill mix might have in enhancing the provision of a wider range of services. However other sections of this report emphasise the importance of experienced clinicians in the management of the increasingly large numbers of patients with complex diseases and numerous co-morbid conditions. As well as the key diagnostic skills and expertise that well-trained general practitioners bring to the evaluation of acute, undifferentiated illness presenting in primary care. There is little convincing evidence that role substitution would be a straightforward answer to workforce planning in primary care.

### 4. Clinical quality of general practice in London

This is an important chapter because a number of the dimensions of clinical care are analysed, largely by comparing them with English national averages. The chapter examines health promotion and illness prevention, diagnosis, referrals (particularly referrals for cancer), prescribing, acute, emergency and urgent care, the management of long-term conditions, mental health and dementia, and end of life care. Many of the indicators concern public health data where GPs may have little influence over health outcomes. The authors barely mention the Health Service Journal award winning NHS London GP Outcome Standards (GPOS), which are arguably more useful in promoting quality of clinical care in general practice.

#### Health promotion

London is doing well on a number of health promotion indicators. A remarkably high proportion of London practice (93%) are offering smoking cessation advice at the level required by the QOF, with only a small minority falling below the 90%

benchmark. Rates of adult obesity are low in London, and general practice must take some credit for getting the right messages across to patients in South Asian and other minority ethnic groups in which there are considerable challenges in dealing with dietary and metabolic problems.

### Vaccination, immunisation and screening

Childhood vaccination, influenza vaccination and breast and other cancer screening programmes still face considerable challenges in London. There is good evidence that a combination of poverty, language difficulties and ethnicity play a significant role here, with very low as levels of uptake of, for example, colorectal cancer screening in the most deprived and ethnically dense boroughs. It is probably worth noting, however, that breast and cervical cancer, in which general practice plays a significant role in organisation and conduct of screening procedures, have considerably higher rates of uptake than colorectal cancer screening, in which general practice currently has little part to play. Much of the variation in the proportion of patients with cancer diagnosed following emergency admissions, in which London appears to do no worse than the rest of the country, closely parallels this geographical variation in screening uptake and its links to deprivation and ethnicity.

### Referrals

Variations in hospital referral rates are ubiquitous and the three-fold variation reported across the London practices is not out of keeping with previous studies in many other locations. It is not clear whether the finding of the lower percentage of urgent referral resulting in a cancer diagnosis (7.6% in London compared with 9.8% nationally) is statistically significant. Statistical analysis to establish meaningful differences between many of the variables described in this chapter is lacking. Because so many comparisons been made it is probably appropriate to look for statistical significance at the  $p < 0.01$  level, which may mean that some of the reported differences between London data and national figures are statistically insignificant. An example might be the difference between the rates of newly diagnosed cancers that do not arrive through the two week referral route (p 72, 55.7% in London v 54.1% nationally)

Notwithstanding these differences in means, the frequency distribution graphs (e.g. figures 4.7 and 4.8) indicate overlap between the performance of PCTs in London and the rest of England, indicating comparable performances of some London and non- London PCTs.

### Prescribing

The section on prescribing is unduly critical. Variations in prescribing patterns are also ubiquitous across general practice in the UK. It is difficult to reconcile the observation that several London PCTs are in the highest quintile for prescribing non-insulin anti-diabetic drugs (likely to be because of high levels of Type II diabetes in Asian populations) with the subsequent statement that London's lower spend on primary prescribing might represent under diagnosis of chronic disease.

### Urgent care

Accident and emergency services in London represent a particular case, which has been well rehearsed in previous reports. It is a commonplace to find that areas, usually with poor economic indicators, surrounding the large teaching hospitals, have tended for many years to use their accident departments in preference to out-of-hours services. With changing out-of-hours provision it is not surprising that this trend



has continued. It is probably an important factor in understanding the apparent over-use of A&E departments by Londoners. However to imply (p76) that relative ease of access to these services is a problem seems inappropriate.

The hospital admissions data are surprisingly encouraging, with London's rate of emergency admissions for acute conditions being lower than the national average (p 78), with the highest levels in the capital predictably reflecting pockets of poverty and multiple ethnicity.

In terms of the patient experience of out-of-hours services, the inclusion of comparisons with England may be inappropriate – to say that 6% of Londoners were mostly satisfied with how quickly care was received compared to 8% nationally, and that 7% reported a good overall experience compared with 9% nationally is unhelpful and potentially misleading. It is essential to make comparisons such as these with conurbations such as the large cities of the Midlands and the north of England. These comments apply with equal force to the section on hospital admissions for chronic conditions/ambulatory care-sensitive conditions (pp83 -84). The differences between London and national rates are numerically very small, may not be significantly different and, once again, the national comparison is misleading. London should be compared with other large cities.

### Stroke

A helpful, illustrative case concerns blood pressure (BP) control amongst stroke and TIA patients (p87). Here the comparison between London and the rest of the UK shows a negligible difference. But, when data from other cities are analysed, the existence of an urban effect generally, and confirmation that London is doing relatively well, becomes apparent. For example, when comparing the achievement of the key stroke QOF indicators (6, 8 and 12) between London, Middlesbrough, Liverpool and Manchester, data from Mark Ashworth and Peter Schofield demonstrate that practices in London are doing as well or better, with consistently better results than Middlesbrough in all respects, with mixed comparisons with Liverpool and Manchester. When these data are adjusted for differences in deprivation and ethnicity, London continues to do better on indicator 6 (BP control, regarded as a more general indicator of the quality of clinical care in a practice), with, interestingly, larger practices doing worse than smaller practices. London results for indicators 8 (cholesterol control) and 12 (use of aspirin and other anti-thrombotic agents) do not show a significant difference between the capital and the other cities studied. There appears to be an 'urban effect' in the attainment of quality metrics, and London does as well or better than some other large English cities.

### Diabetes

The presentation of the diabetes data, and in particular the achievement of the nine key care process indicators, is distinctly coy. Although English data are presented, London comparisons are, on this occasion, not included. However, it looks from the National Diabetes Audit Report 2010/11 that many practices in London are exceeding the English average overall and doing extremely well in diabetes management. If this is the case it is an extraordinary achievement because of the well-known factors which militate against the achievement of these targets.

### Mental health

The mental health section contains some information which is likely to be specific to conurbations and pockets of ethnic density and deprivation, and which are probably applicable across the UK, for example, the diagnosis of dementia – this is unlikely to

be a London-only problem. There are, however, problems with the diagnosis, management and outcomes of patients with severe mental illness (SMI) particularly in London's Afro-Caribbean population. To say that the physical health of those with SMI is not receiving attention in London on the basis of trivial differences between (very high) achievement of preventive advice targets (p94) seems over-critical, particularly as QOF exception rate reporting in London the lower than the English average. The picture of mental health provision in London on the basis of these data is relatively positive.

While it is true that more might be achieved by integrating mental health support with primary care and chronic disease management programs (p 96), there is little to suggest that radical system re-design is required in relation to mental health care in London to achieve this.

### End-of-life care

Finally, end-of-life care. It is a tragedy that poverty and isolation mean that many Londoners cannot die at home. This is not a general practice problem per se, but a reflection of the steep gradients between affluence and deprivation, integration and isolation that exist in many parts of the capital. However, it is to be hoped that that the new structure linking Local Authority Health and Wellbeing Boards to clinical commissioning will begin to make some improvements to end of life care in the community.

## 5. Patient experience

Patient satisfaction levels are remarkably high in London, and this is surprising given the fact that many people coming to London from other countries have no idea about the structure of our health service and what to expect from it. Experience in working in a multi-cultural practice in south-east London, with patients coming in to register from West Africa, Eastern Europe, South America and North Africa, suggests a poor understanding of the role of general practitioners and of primary care. Not understanding the relationship between general practice and hospital medicine lies beneath many of patients' concerns about at the services they receive. Particularly when they are used to seeing doctors who work in hospital settings (with all the trappings of secondary care) and are unfamiliar with the role of GPs as generalist clinicians of first contact and gatekeepers to secondary care.

Providing personal or relationship continuity of care (p13) is inevitably a challenge in a city in which there is a remarkably high turnover of patients on general practitioners' lists. There are few data on patient turnover in this report, but there is evidence to show that a 20% annual patient turnover of this size is by no means unusual in inner city practices. Under these circumstances it can be difficult to provide personal or even organisational continuity to patients who require it, particularly where a number of sessional or portfolio GPs are providing care, when organisational rather than personal continuity becomes important. It is also worth remembering that the other side of continuity is access. Where there is high demand for consultations for acute illness, it may be appropriate to re-balance the emphasis on access to acute care and personal continuity with a nominated general practitioner. Some patients will prioritise fast/convenient access over an appointment with a specific doctor; on the other hand, research shows that more people want personal continuity than can get it. Increasing evidence of the link between patients being able to see a doctor they know and trust and better health outcomes (and control of care costs) should encourage GPs and their staff to find innovative ways to

balance accessibility with continuity and to be able to spend more time with the patients who need it most.

Factors similar to those affecting patient-reported satisfaction may be at play in understanding the difficulties of engaging patients in practice management through patient participation groups and other initiatives (p104).

## 6. How does general practice need to change in London?

The 2011 Kings Fund report, mentioned at the beginning of this section, was specifically focused on the quality of care of acute illness in general practice. So the core themes enumerated in para 6.1 (p109) about skill mix, sharing care, striking a new deal with patients and meeting the health needs of the wider population are not directly relevant to that publication, although they may be for the present report.

### Skill mix

This section is written as if general practitioners have never collaborated with other health care and social care professionals. Nothing could be further from the truth. General practice has a long history of multidisciplinary team working and, while there is room for improvement, it is misleading to suggest that this is a new idea.

Incidentally, the statement that well over half of general practices in London have only one or two GPs (p109) is incorrect – the figure is 38%.

The skill mix arguments on pp109-110 are confusing, particularly because of the statement that multi-morbidity and complex health needs are likely to require patients spending more time with experienced GPs and general practice nurses, and that GP contact time needs to be freed up, allowing them to have longer consultations with patients with complex needs. Primary care workforce development is not simply a question of reducing the number of doctors and increasing the number of non-doctors – it is almost certain, given the changing medical and social demography of the capital, that more, not less doctors will be required.

In addition, the question of access to specialist advice is mentioned, and GP colleagues with specialist interests and skills are also referred to. With an increase in the length – from three to four years - of vocational training, general practice now has a major opportunity to continue to develop greater specialist skills to cope with increasing numbers of patients with complex health needs.

### Collaboration and co-ordination

This section of the report contains a number of unsupported statements which have potentially misleading implications. For example on p111 there is a suggestion that more “formal partnerships with community service providers” could prevent admissions and ensure more timely discharges. The evidence of the effectiveness of case management and other similar innovations in this regard is thin and certainly not strong enough to predicate changes of this kind. Particularly when the ‘social fabric’ to which vulnerable patients may be discharged is so precarious.

On p112, second paragraph, the authors seem to have re-discovered an essential truth about general practice, which is its role in the co-ordination of care. Co-ordination is one of the key features of primary care, as described by Barbara Starfield, along with comprehensiveness and continuity. It is well-recognised in

general practitioner training and clinical practice, and is an essential role that general practices are currently discharging for many patients with complex needs and who have frequent contacts with multiple hospital specialities.

The report has, from time to time, mentioned the need to “strike a new deal” with patients. Although the nature of the deal is not defined. The report returns to this theme on pp122-113 but again fails to clarify how this might work. It is well-accepted that we need to engage patients in decisions about their care, and well-recognised that negotiated and mutually agreed plans for care are more likely to work. The need to encourage and support self-care is a well-understood principle of the management of chronic illness in general practice.

The final paragraph of the section, on access for patients with urgent needs (p113), is important. Although the idea that this will be solved by “a fundamental redesign of urgent primary care” is not really supported by the evidence or by experience of current practice. It is perhaps worth remembering that out of hours care is often provided by general practitioners who’s ‘day job’ it is to work in their surgeries in the very area where they are providing out of hours care.

### Premises

The section on the primary care estate is short, and probably inappropriately so. Whether some surgeries are fit-for-purpose or not, the financial challenges of new builds and conversions present very considerable challenges for individual practices in London’s commercial context. More thought needs to be given to this critically important component of the development of London’s primary care system, but given the short timescale of the transformation programme, little progress is likely. GP premises should be approachable, accessible and based on recognised neighbourhoods.

### IT

Good information technology is clearly essential, and the recommendations on ethnic coding, the sharing of data on variation and quality, and the use of performance data are all excellent proposals, many of which already been taken on by practices and CCGs in London and elsewhere. It may also be possible, with appropriate safeguards, to use information technology to improve patients’ access to their chosen clinician and to their own health information, assisting self-care.

### Training

The training and development of the workforce may or may not require “new and different professional roles”. These roles are not clearly defined and considerable thought need to be given to the inclusion of new professionals such as physician assistants and graduate workers in psychology when evidence of cost-effectiveness is lacking. However the training provision and funding for the existing workforce of general practice nurses, nurse practitioners, reception staff (care co-ordinators) and practice managers must be improved if general practice in London is to rise to the challenges it faces. Resources available to the Local Education and Training Boards (LETBs) should be unlocked and used to support the development of general practice teams.

## Primary care teams

Finally, the authors of the report deserve congratulations on identifying the needs for protected time to allow general practice staff to reflect on quality improvements, audit, and on their practice, together and in teams, and to engage more with patients (p117). The formal opportunity to do this has been missing from the GP contract since 1948, and the recognition of reflection, planning and review as core activities of team, practice and locality development is extremely welcome. Primary care teams across general practice and community services have been lost in many parts of London and need to be more closely linked around the needs of patients.

The idea that effective networks of practices should be developed is welcome, although the idea of collaboration with other practices is hardly new, going back many years to initiatives such as the prescribing clusters and other sub-PCT practice groupings. Experience with the LIZEI scheme demonstrated that rewarding practices for collaboration for practice review and other shared learning activities, increased GP engagement. This may well be something that future CCGs need to consider as part of their remit, recognising, as stated on p115, that a variety of models, rather than overall system-redesign, can be applied.