



Londonwide LMCs

The professional voice of London general practice

Securing the Future of General Practice in London:

*Maximising the Value of General
Practice in London*

May 2016



About us

Londonwide Local Medical Committees is the clinically led independent voice of GPs in the capital and 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 over 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.

Local Medical Committees are recognised in statute under the NHS Act as the representative organisation for NHS general practice, and have supported GPs for over a century. They remain the only local, independent, elected, representative body for GPs, providing independent advice, guidance and support on a range of issues that affect general practice.



Introduction

Strong primary care is essential in any health system as a means of providing cost effective health care and securing health improvement. In the UK, general practice is the bedrock of primary care provision in the NHS¹.

If the NHS is to meet the demographic and financial challenges it now faces in delivering high quality care and improving health outcomes, primary care and community care must be fully coordinated, developed and sustained.

The state of the NHS appears to have worsened since 2013 (see our response to the case for transformation of health services in London, "Securing the Future in General Practice in London"²) with little evidence that attempts at transformation are dealing effectively with the increasing volume and complexity of demand for health services. Most providers now face worsening financial positions and GPs are no exception.

The reality is that the whole health service in London is under stress due to increased demand, complexity of workload and falling resources. General practice is buckling under the increased workload and work intensity related to the growing complexity of clinical work and the pressure on hospitals to discharge patients earlier in their health care process and with long term, complex technical health care needs. The sense of being overwhelmed is further fuelled by increased demand for external meetings, unnecessary bureaucratic tasks, complex performance management targets imposed by commissioners, increasingly burdensome requirements from regulators and difficulties recruiting to practice teams. Added to this are new requirements from commissioners for major reorganisations requiring practices to "work at scale" to transform the health system.

The Five Year Forward View (FYFV)³ recognises the need to join up primary care, social care and acute care and sets out a practical route to making health care services more efficient. The vision will likely cost an extra £8bn. It sets out the need to move away from the short-term answers into longer term more radical solutions. Over a year on from its publication there is no evidence in London that funding is shifting toward primary care or that commissioners are commissioning services in such a way as to support and strengthen the efforts of general practice and to cope with increasing demand. Indeed the first tranche of transformation funding is available only if stringent requirements are met, which many view as unobtainable without immediate attention to the sustainability of the service. Much of the focus in the latest NHS planning guidance is on sustaining the acute sector, to the detriment of general practice. NHS Planning Guidance issued in November 2015 suggests that funding will continue to flow and be prioritised into secondary care. Unless attention is given to supporting primary care and focussing resources there, secondary care cannot hope to manage the increasing numbers of acute admissions.

The 2014 NHS England London (NHSEL) primary care transformation approach emphasises the variability within general practice and seeks to improve outcomes by focussing on specifications. However, despite this narrative, evidence of "failure" in general practice in London is scant. General practice in the UK is acknowledged in independent international analyses to be the strongest and most effective primary care system⁴.

The recently published General Practice Forward View (launched April 2016)²⁵ highlights transformation as a means of delivering community primary care services and managing access demands. But GPs are too busy fire-fighting to access and use money earmarked for "transformation". They are so deeply involved in the crisis of trying to manage an increased workload with diminishing resources that they are unable to see ahead and look for opportunities. We argue that the funding identified to support the transformation of primary care is being targeted ineffectively and must be made easier to access.

The developing Sustainability and Transformation Plans (STPs) as described thus far take the form of providers working together to enable a locally based plan to work and deliver better care within a defined budget. In addition the delivery of the General Practice Forward View (GPFV) has become an important aspect of this, with its commitment to stabilise general practice funding, also by October 2016. General practice must be involved in these discussions. And, as the statutory body for general practice, Local Medical Committees are a key partner. Only LMCs can speak authentically and expertly about the impact of new plans and spend on GP service, workforce, whole patient care, and patients themselves.

Whilst we wait to see what commissioners and providers can do to relieve the pressures on practices, we have declared a GP State of Emergency - supporting GPs and their teams with practical tools and resources as the workforce in general practice continues to reduce and the number and complexity of conditions presenting continues to rise²⁶.

Numerous surveys and research have been published describing and explaining the workforce crisis in general practice and its component challenges of practice funding, recruitment, and retention. Without urgent and effective action from government and commissioners, the threat of mass exits is fast becoming a damaging reality.

In this document we outline our analysis of the current issues facing general practice and call for a collaborative approach between those who commission health services in London, those who commission education and training of health care professionals, the providers of health care and support services themselves, and those who can impact the health and well-being Londoners including the health care professionals who live and work here.

The Challenge for GPs in London 2016

1. The health of Londoners

London has a highly diverse, mobile and increasingly migrant population and the gradient of health inequality in many boroughs is steeper than in most other major cities. 2010 Indices of Multiple Deprivation data shows that the three English local authorities with the highest levels of income deprivation for children and older people are all in London (Tower Hamlets, Newham and Hackney) and over 26% of London falls within the most deprived 20 per cent of England for the same measure.

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%. In London's fastest growing borough Tower Hamlets, this will be an increase of 28,717 or 9% whilst two thirds of London has above average levels of deprivation, the highest of any UK region.

As Marmot highlighted⁵ health inequalities resulting from inadequate housing, employment issues, or domestic or work-related stress may underlie the presenting health complaint. Rather than resorting to medical intervention, more effective action might include signposting to the Citizens Advice Bureau, support self-management, social prescribing, faith support, counselling, or other community-based services; whether in primary, social or voluntary sectors.

A higher proportion of patients living in deprivation have multi-morbidity and complex conditions, compounded by poor mental health and difficult social circumstances⁶. In deprived populations, multi-morbidity is not just a characteristic of old age but is occurring at much younger ages. Social and income deprivation add exponentially to the pressures GPs work under and yet requires, above all, the professional generalist expertise of the GP. However, since most secondary and tertiary care, medical research and medical education is configured according to a single-disease framework, the growing service emphasis on managing diseases not people, is undermining the ability of general practice to perform at its best.

GPs deal with patients' unfiltered problems arising from medical, psychological, and social disease, and take all these factors into account holistically, episodically, and summatively over time, building a partnership of trust delivered through consultations with the patient to effect better health and wellbeing for that individual. This relationship continuity is the essence of general practice and, with the right enablers in place, is key to achieving better outcomes for individuals. And, when this is scaled-up to practice or communities of practices, is key to achieving better outcomes for populations.

Relationship continuity, and the trust underpinning it, delivers improved outcomes, whether episodic, urgent or self-care is required. Underpinning this is the consultation and one of the core GP skills: the capacity to act as a therapeutic agent. It is the expertise of the GP that improves a patient's sense of wellbeing as much as the prescription written or referral made. This therapeutic relationship is key to the 'less is more' approach to delivering better outcomes with less unnecessary prescribing, fewer unnecessary

referrals to specialists, fewer costly investigations, and more self-care and trusted reassurance. The value of this essential feature of general practice must not be underestimated.

London GPs are facing unprecedented rises in patient demand. Surgeries now last four or five hours and consultation rates rise year on year. Half of all GP appointments are now for people with chronic diseases which require management and prevention. Office for National Statistics (ONS) data shows that 50% of all GP appointments are for people with 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. 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.

One of the key concerns expressed by London GPs in our recent surveys and listening events (not only those working with deprived communities) is the need for longer consultations. GPs also find the intensity and complexity of the work they now do makes them feel that, under this time pressure, they have no thinking time. They worry that the safety and quality of the services they provide is suffering as a result. Many resort to reducing their working hours, creating vacancies in the service⁷. Commissioners need to remove the structural, resource and bureaucratic barriers to giving patients the time they need with their GP.

An estimated 60% of GP consultations 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 coordinated care including talking therapies.

Significant variations in the prevalence of some conditions across London boroughs can mean that averages hide the reality of the high needs of specific communities. 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 GPs providing the required enhanced care at uneconomic contract values.

Health literacy refers to a set of knowledge and skills that give individuals the knowledge, understanding and confidence to access health and social services appropriately and to help manage their own health. Low health literacy is associated with unhealthy behaviours, and is associated with increased morbidity and premature death.⁸ It is widespread in deprived communities. To help patients develop these skills to improve their health outcomes requires trust and supportive relationships to be built with GPs. This takes time and care, and the support of community based agencies.⁹

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 yet are not widely or flexibly available. Additionally, non UK nationals presenting to general practice often have different expectations, experiences, and understanding of how best to access and use NHS services.

2. Increasing demands of regulation and bureaucracy

London GPs regularly express frustration at increases in their non-clinical workload. National surveys also link this to the political pressure to provide clinically ineffective services. There is a broadly held view amongst practitioners that commissioners and politicians undervalue (figuratively and literally) the professional clinical work for which general practitioners are trained and which gives them the most job satisfaction. New health policies require them to meet increasingly bureaucratic targets, undertake clinical tasks that have no apparent evidence base for effectiveness, and provide activity and process data to a growing number of agencies, usually in different formats. The increasingly bureaucratic approach to local commissioning by Clinical Commissioning Groups (CCGs) is undermining the principle that CCGs should be clinically led. Managerialism is a culture GPs do not recognise and find increasingly frustrating. They tell us that relentless focus on access as opposed to meeting patients' preferences for relationship continuity in normal surgery hours, and increasing "box-ticking" increase their sense of frustration and being undervalued. This is compounded by the increasing inspection pressure from the CQC, and NHS England's revalidation requirements.

Meanwhile, agencies including social services and schools are placing unrealistic demands on GPs to attend meetings, complete forms, supply certificates, and provide all manner of letters – often on matters far beyond the GP's remit. And acute trusts are involving GPs in extra tasks and raising patient expectations of what their GP can provide, and by when, to relieve the pressure on their own services and performance targets.

3. Lack of coordinated commissioning of primary care and community services

GPs and practice teams cannot provide best quality prevention and care in isolation: outcomes depend on the availability, accessibility and quality of other services in the communities they serve; and the outcomes of other services depend on the 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.

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, patients revisit their GP looking for solutions: increasing pressure on GPs and A&E.

Increasingly, GPs and practice teams are learning to cope and maximise existing resources through collaborative working, formal and informal, in larger partnerships, networks and federations across the capital. We have yet to see details of any plans to better coordinate community based multi-disciplinary teams to support general practice, or for a shift in funding to general practice to support the increased out of hospital workload that is overwhelming primary health care.

4. Supply: current and future workforce and infrastructure challenges

Retention and morale

General practice (both medical and nursing) is facing a workforce crisis of retention and morale, exacerbated by falling recruitment, with fewer doctors choosing general practice, and many leaving it. The whole primary health care workforce in the capital is ageing. The demography of the workforce shows that in London 16% of GPs are of retirement age (in some boroughs this as high as 25%) and over 30% of practice nurses in London are planning retirement in the next five years, over 6% in the next year¹⁰. But more worryingly, early retirements or increased part time working to deal with the work intensity or family commitments, are creating clinical vacancies where none were expected.

Recent surveys by Londonwide LMCs (May 2016) and the BMA's General Practitioners Committee (GPC) (January 2015) reveal that GPs are frustrated by increasing administrative burdens which limit and reduce their clinical time with patients. These findings are triangulated by national and international research.^{11 12}

For GPs the key barriers to retention are workload and work-intensity, along with a sense of being undervalued, and struggling to maintain professional standards of care. The lack of local supporting services in primary care is also key. These contribute to low morale, and in some cases burnout and mental illness related to stress. GP practices also say that they find it hard to replace retiring partners as newly trained GPs do not want what they see as the unsustainable work life balance of a GP partner, and they cannot afford to live in London. One way practices are mitigating the workforce challenges is through collaborative working. Increasingly in the capital, formal and informal work through larger partnerships, networks and federations are helping to maintain the provision of general practice services to patients. Practices also say that with rising costs and falling income, together with contractual uncertainty, they cannot afford to offer staff competitive salaries, or plan their workforce even a few years ahead. They are reluctant to invest in training as they do not have the financial stability or the spare capacity to do so. 51% of practices have vacancies, of which 30% are for salaried GPs. 11% have practice nurse vacancies²⁷.

The biggest challenge GPs and their teams in London face is declining morale resulting from increasing workload, falling practice income, reducing workforce and increased media and commissioner criticism. These issues all impact on the morale of both the existing/remaining practitioners, and those who might previously have considered a career in general practice.

Whilst we wait to see what commissioners and providers can do to relieve the pressures on general practice, the calls for support from London practices have been so great that Londonwide LMCs has declared a GP State of Emergency²⁶ - supporting GPs and their teams in their provision of continuity of care with practical tools and resources as the workforce in general practice continues to reduce and the number and complexity of conditions presenting continues to rise.

Half of member practices say financial uncertainty about the future of the general practice model is hindering staff recruitment to the practice



GPs love the clinical work they do. They are highly motivated to help their patients to improve health, value working in highly skilled teams and want to do a good job. Yet morale is low and the threat of widespread burnout within general practice is real¹³. Burnout is a term used to describe the syndrome of emotional exhaustion, depersonalisation, low productivity and feelings of low achievement. Doctors who are at risk of burnout tend to feel shame acutely, deny their vulnerability and score very low on self-compassion. We also know that high quality patient care relies on motivated and skilled staff that are physically and mentally well enough to do their jobs, feel valued, well supported and engaged.

Morale for professionals depends on the ability to provide high quality work, in the context of their professional values, with a degree of autonomy and a feeling of control over their workload. Key factors contributing to burnout include excess workload, insufficient reward and value conflict, all of which are increasingly apparent in the survey results.

Burnout occurs when passionate, committed people become deeply disillusioned with a job or career from which they have previously derived much of their identity and meaning. It comes as the things that inspire passion and enthusiasm are stripped away, and tedious or unpleasant things crowd in.

The emotional impact of working as a GP should not be underestimated. GPs describe the unrelenting demands placed on them as front line clinicians. Yet increasingly GPs stay alone in their consulting rooms, as surgeries lengthen and administrative tasks at the computer increase, leaving them unable to find the time to meet their colleagues and to benefit from peer support.

In addition, commissioners, who do not appear to GPs to understand the pressures they face, nor the value of general practice, are putting pressure on GPs to work together at scale. For most GPs, working in a large organisation appears to undermine the values that underpin their motivation to work as GPs. Developing the social capital and *raison d'être* for successful working at scale takes time, which no-one in general practice in London seems to have.

To add to this pressure, government policy to extend normal hours access to general practice seven days a week is being proposed without the funding or workforce to support this policy.

A high proportion of London's GP workforce consists of self-employed, sessional, doctors working as locums. This essential sector of the workforce values the flexibility and independence that this way of working brings, but, it could be argued that, GP employers should explore offering more flexibility and benefits to their salaried GPs to increase the balance of this workforce.

Recruitment

A changed perception of what general practice is and how it should operate has resulted in reduced recruitment into general practice. Our recent survey show high vacancies across the capital. Anecdotally, where there used to be 80 trainees applying for one vacant trainee position a decade ago, it is more likely now to find one applicant choosing between two practices. And trainee GPs in London tell us that they want to go on working in London but cannot afford housing, and worry about their ability to reach a reasonable standard of living and bring up a family in London.

Work-related concerns and frustrations are very similar for GP principals. With high rents and outgoings many GPs are unable to afford the traditional partnership route in general practice. The unsustainable funding structure and inherent financial risk in GP partnership is no longer something that newly qualified GPs can take on. Many choose to work as locum or salaried GPs with perceived better work life balance or higher levels of remuneration, and less responsibility, often covering unsocial out-of-hours activities. Younger GPs are generally more amenable to considering working abroad in places like Dubai, Australia, and New Zealand where working conditions can offer a more attractive work-life balance. In recent years we have seen an increase in the number of overseas healthcare providers actively targeting young British GPs as part of their recruitment strategy.

Undergraduate placements in general practice and the community would encourage students to opt for a career in this sector, but at present there is inequitably low funding for GP undergraduate placements, which means that involving GPs in undergraduate teaching is unaffordable, and there is no funding for nurse placements. Practices could benefit from such involvement, but present infrastructure and funding simply do not support it.

5. Training

Since the reorganisation of the NHS resulting from the NHS Act 2012, and the establishment of Health Education England (HEE), the resources available to support GP continuing professional development have reduced. There has been a long history of training GPs in London, but little expansion of training places. London is a net exporter of trained GPs. Practice nurse training is unfunded, although some Local Education and Training Boards (LETBs) are now piloting supported practice nurse training places. The situation with Health Care Assistants (HCAs), often a pathway into nursing or other health care professions, has also lacked support. We welcome the new discussions between commissioners and providers about workforce strategy and planning, but to date these have not involved GPs as employers.

For sustainable and increased training for clinical roles in general practice and the community, more flexible training pathways need to be developed. Practices are finding that their capacity to support training and undergraduate education are being restricted by underfunding, lack of recognition of the teaching, mentoring and supervisory roles, lack of time to teach and backfilling for the service, and lack of room in their increasingly inadequate premises. For recruitment to clinical roles to improve in general practice and the community services, this must be addressed.

The effective transformation of primary care calls for strong

leadership at all levels and for professional management. General practice in London has a wealth of experience and talent amongst the practice management workforce, but there is no recognised training for the role. Any professional development tends to be unfocused and haphazard. There is no funding or professional recognition for this increasingly important role.

6. Premises

The GP estate in London is recognised as being inadequate for the delivery of modern general practice. However, affordable land or buildings suitable for new GP premises are hard to find and to afford. There has been an unacceptably long period of lack of funding for premises improvements or new premises to support modern general practice. Such funding as has been made available has been very difficult for practices to use because of bureaucratic application processes and very limited time scales.

In fact a number of practices are having to look to private companies to purchase, manage and maintain properties in the capital as some premises fall into disrepair. We welcome the move by commissioners to develop an estates strategy for primary care across London and in smaller localities, which we trust will be based on accurate and realistic estimations of the issues. These strategies also need to be properly resourced, and urgently driven or they will fail.

7. Increasing patient demand

Much hope is being focussed on the use of digital technology in managing demand. The increased demand experienced by London's GPs relates to increasing numbers of patients, their increasing mobility, and the increased complexity of the health and social issues presented. Whilst some of the new digital technologies providing triage systems, on line prescription ordering, and appointment booking, patient access to their notes, increased speed and viability of access to pathology and radiology services, easier referrals to other agencies, can all speed the work of GPs, they do not necessarily reduce the intensity of work.

"Technology is useful when it lightens labour; not when it's a replacement for human care or when it creates unnecessary demand through over diagnosis, overtreatment, and over-action. Until we value sharing knowledge and the importance of human relationships in healthcare we are doomed to repeat the cycle of believing that more and faster is always better—while failing to understand why we get diminishing returns."

M McCartney, BMJ 2016;352:i620

Extending the service to cover seven days a week will not necessarily help GPs to manage demand. Current experience with the Prime Minister's Challenge Fund and other initiatives show that demand remains focussed in office hours and that patients prefer to see their own doctor in their own practice for routine care. Current funding and well documented difficulties in recruitment do not allow expansion of the GP workforce, which is required to extend normal hours working, since GPs are already working beyond their capacity. Extending opening hours for GP practices will not significantly shift the normal hour's workload, or allow more shift based working to cover the extended hours.

8. Working at scale

NHSE transformation plans for primary care in London, in line with the Five Year Forward View, assumes that general practice services delivered at scale will be of better quality, more accessible to patients and more efficient. There is no independent evidence to suggest this. There is also a view that vertical integration of services where primary care services including general practice are delivered by acute trust will be easier to commission and more efficiently run. With the current deficits in the acute sector, and the invisible but equally dire deficit in general practice, bringing these organisations together would be financially unviable. In addition, evidence from the US shows that such integration does not save money and may over medicalise patient management¹⁴. The GP's vital role in managing uncertainty and avoiding excessive or unnecessary treatment¹⁵ is something foreign to the values of the acute sector.

GPs recognise that there is currently no evidence that working at scale will deal effectively with the urgent issues they face, and which are undermining the transformation programme. Whilst a number of GPs and practice teams work collaboratively via larger partnerships, networks and federations, such decisions should be based on improved patient care rather than a necessity resulting from workforce challenges or diktats to work at scale.

GPs can see some benefits in collaboration and integration, as evidenced by collaborations and accountable care organisations (ACOs) such as those developing in New Zealand, to share administrative services, HR functions, and to support high standards of practice, and career development for practice members, but these collaborations cannot be forced into being for spurious reasons or at speed. They must confer advantages on patients and on individual member practices. They may seem to promise an easier life for commissioners, but promises of increased efficiency may be a mirage. GPs need to understand good reasons for working together at scale, and this must be supported by time to develop such organisations, start-up funding, and much better IT connectivity and locally commissioned support services. There is still much to be done to sort out the governance structures of these organisations. Whilst the Vanguardians may seem to be a pilot study, these are now recognised to be, for the most part, small scale, partial and underfunded.

This is being hampered, as is the whole transformation agenda, by the lack of refined leadership skills at all levels in primary care. Commissioners recognise this but we have yet to see any realistic plans to address this gap. The implementation of the Five Year Forward View planning guidance¹⁶ has set out the need for place-based Sustainability and Transformation Plans (STPs), which must include plans to support the sustainability of general practice. But GPs as providers and as employers are not party to planning discussions.

9. Funding

The income of London practices is falling. Contracts are relatively short term, especially the add-on local contracts that give GPs the opportunity to balance their books whilst delivering core general practice. The core contract is inadequately funded and does not take account of the increased complexity of routine work. London GPs say that this contractual uncertainty (eg, changes to the

Minimum Practice Income Guarantee (MPIG) allowance, PMS contract reviews, threats to reduce the GMS contract value) is destabilising practices and means they worry about their survival, let alone have any mental space to consider collaborative working or the rest of the transformation agenda. Funding needs to support not only the sustainability of practices but their growth and development to meet the shift in care from the acute sector. The current round of PMS reviews is tying funding to hard outcome measures in a totally unrealistic way and threatens to slash practice income to unsustainable levels.

All of this adds to the risk of increased retirements and practice closures as GPs fight to keep realistic funding deflects them from developing and adapting their practices.

Our recent surveys show that financial uncertainty and increasing difficulty in making ends meet mean that practices cannot afford the doctors that they need, nor can they compete with the acute and community sectors for nurses.

There is an increasing tendency for commissioners to contract for specific services and measurable quality targets but the performance management of general practice defined by routines processes often has negative unintended consequences and many GP now perceive that this is negatively impacting on quality of care. Less than half the problems presenting to GPs are related to specific disease processes, yet they have health implications and need skilled management. Dealing with uncertainty is a key skill. It involves GPs having to manage conflicting priorities and working carefully with patients' beliefs and values. This work cannot be measured, may lead to lower performance as measured and by process indicators.¹⁷ The core contract, which recognises the value of this undefined and therefore unmeasurable but never the less important work, is vital to the survival of the service.

10. Blocks in the system: access and flow

When patients' pathways or journeys are not appropriately completed, the extra consultations needed not only disrupt the flow of their own journey, but also that of other patients through the practice. Smarter working within practices may help, but the reality is that saturation point has been hit by even the most competently working practices. General practice in London is beset by blockages in flow; diverting staff from consulting, coordinating or planning care; reducing access for patients and demotivating health professionals as we have presented in our evidence to the Health Select Committee Primary Care Inquiry¹⁸.

Pressures on general practice are also cited as causal factors in practice closures. Closures mean dispersed patient lists, increasing pressures, on remaining practices and creating a vicious circle of workload crisis, threatening the comprehensiveness and safety of the service. HSCIC figures¹⁹ show that in the past ten years (from 2004/5 to 2013/14) there have been 990 practice closures in England, of which 162 (over 16%) have been in London. London practices make up just over 16% of all of the 7935 practices in England (as at May 2015 - HSCIC data²⁰) so the findings of our March 2015 survey of London general practice - that 10% of London practices are considering closing and terminating their contracts with NHSE - are truly concerning.

The Response

We need a new approach to maximise the value of general practice to local placed base health plans and service delivery. When free to do so, generalist clinicians provide personalised, comprehensive continuous care, now needed more than ever before in socioeconomically deprived areas. General practice must survive, and thrive, albeit with changes, and to do so it needs significant investment that supports the core values of general practice to ensure that all the things our patients value don't disappear. London's GPs should be recognised for providing high quality services in a challenging environment. We need more appropriate support and investment in general practice in London, without more delay, and a coordinated approach to commissioning the primary health and community services around general practices so that they can work in a coordinated way.

This step change in investment implies a fresh approach to commissioning the primary health and community services around general practices so that they can work in a coordinated way, supporting general practices in their increasingly complex and demanding task. GPs and practice teams are learning to cope and maximise existing resources through collaborative working, formal and informal, in larger partnerships, networks and federations across the capital. But such decisions must be based on an assessment of what will improve patient care, rather than a forced reaction to policy statements.

To improve the flow of patients through general practice, we must first clear existing blockages, then increase capacity; and commissioners and educators must work closely with Local Medical Committees, GPs and practice staff to do both, or neither will succeed. There is a range of solutions that would benefit staff and patients in general practice, from increasing training and staffing capacity through to improving IT systems and halting system reconfigurations.

In 2013 we published a practical strategy²¹ which we now call on commissioners to work with GP providers to implement.

Figure 1. A practical strategy for general practice



Funding

In making place based STPs, core funding to practices must be protected, so that it cannot be siphoned off to pay for other services, to shore up financial failure in other sectors, and must be increased to take account of the chronic underfunding of general practice and the shift of work from the acute sector. GPs need a stable, reliable income on which to base their plans for development and to sustain them to deliver current and future workload. Until that is secured, GPs must be able to refuse to take on unfunded work.

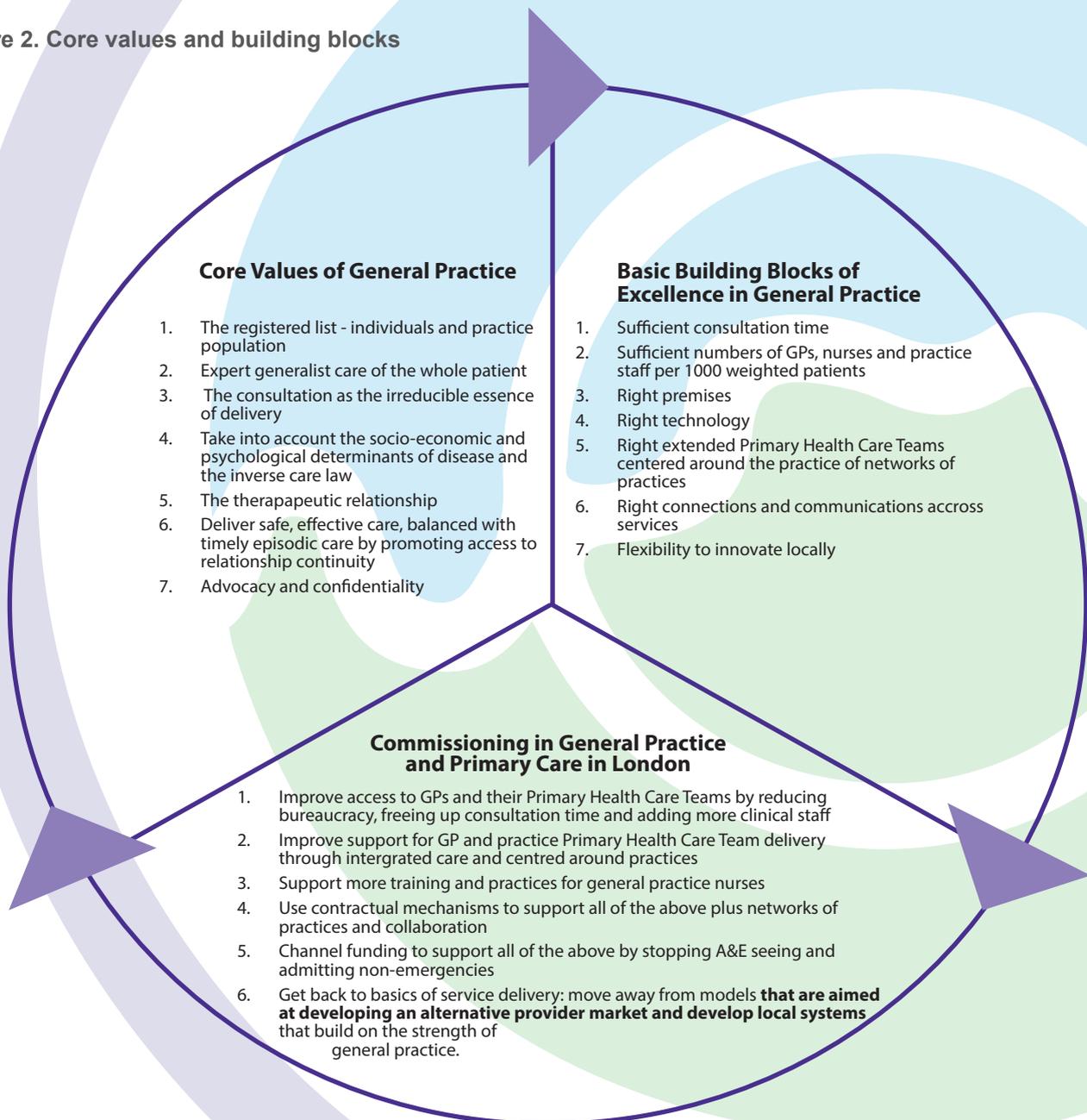
The model of general practice

There has been much talk lately of the model of general practice being broken. But it is unclear whether this means the model of care - providing holistic, person-centred care for patients - or the model of delivery - in a community setting, closer to need, and able to coordinate service provision across a range of primary, secondary and tertiary providers. To support transformation of the NHS general practice in London must: remain based on registered lists; be local, and; be able to prioritise personalised care. GPs must be able to use the trust invested in them by their patients, and their skill as expert generalist in the community to provide a balanced approach to the needs of the individual, the local population and the expectations of taxpayers and commissioners²². It is this model of personal care based on knowledge and trust provided by personal continuity that is the keystone of primary care, and which must be preserved. Any attempts to develop a model that works at scale must value the basic principles that have made general practice in the NHS so effective.

GPs need, longer face-to-face consultations with patients and, whilst digital solutions to managing workload can assist, digitally based access to medical advice cannot and must not replace face to face consultations when these are needed.

The building blocks we described in 2013²³ are largely unchanged.

Figure 2. Core values and building blocks



The workforce

GPs are expert generalists trained in the bio-psycho-social model of medicine. They differ in their approach from specialist and general hospital physicians who are trained to operate in the narrower bio-medical model. Their value has been described in detail in this document. They cannot be substituted by doctors with different training and experience, nor by new roles, such as Physician Associates (PAs), who may have place in general practice, as yet undefined or tested, but who cannot replace the key expertise of a GP.

To secure a strongly engaged clinical workforce, transformational policies need to make sense to clinicians in their consulting rooms and play to their professional values. GPs need longer consultations with patients, freedom from the burden of constantly renegotiating contracts, and the removal of low clinical value additions to their workload if they are to improve patient access and maintain the financial viability of their practices. They need stable funding and support to attract and train the right workforce. They want to feel valued for what they do.

It is time to consider the motivation and values of the GPs and practice teams, to address morale, retention and recruitment as a matter of urgency. This must involve taking action to improve GPs' working lives. London GPs have told us what they need to stay in the profession. One said she needs "Resources: time to breathe, reflect and improve".

Support must be given for GPs and their staff to develop coping strategies and outside interests. The tendency to reduce to part time working in the face of increasing work intensity should not be ignored and has important implications for any recruitment plans, and will need to be managed through more creative approaches to maintaining both access and continuity of care. This work intensity relates more to what is currently going on in the consultation rather than the increase of nonclinical, administrative work that GPs are also faced with.

More of HEE resources need to go directly to training and developing GP practice staff at all levels and community primary care staff, managing the work of moving care out of hospitals. Community Education Provider Networks (CEPNs) could be an appropriate model for this. However, attention must be given to the blocks and drivers, including: support and mentorship for those providing practice placements who may not be qualified educators; 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.

Developing new models of primary care demands a level of managerial expertise that few of today's general practitioners possess. As we contemplate strategies to reinvigorate primary care, we must not fail to plan and budget for the development of the necessary management skills and leadership skills for those doctors and practice managers to whom the work of implementing reform will fall.

We need to develop a culture of improvement that supports an iterative process where everyone is identifying better ways to get the practice's work done. This centres on optimising management, integration and adaptability to increase effectiveness and efficiency so that a practice can achieve its goals.

The Healthy London Partnership, CCGs and practices, must work in collaboration and build on the existing provider development work stream to support the delivery of organisational development and support leadership training through the development of workshops, implementation tools and online modules.

GP premises

GPs and patients need access to more suitable, affordable practice premises as a matter of urgency. GP premises must be approachable, local and connected. Commissioners and local authorities could do more to facilitate the development of suitable, affordable local premises, and to release funding to deal with urgently needed upgrades and repairs.

As money is now being made available for premises upgrades and building work, practices should be supported to access this funding easily, minimising the bureaucratic process that deters GPs from applying for these funds.

As Lord Darzi's 2014 "Better Health for London"²⁴ 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 of 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..."

Collaborative models

Local commissioning plans should support GPs to work collaboratively, and to develop new ways of working which support core values, and also enable GPs to meet with increased demand and services being shifted from secondary care. Such collaborations, or federations, should focus on peer support high quality professional care, and focus integrating health care such that the most is made of NHS resources and patient care is flexible, personalised and values the patient's time.

GP practices need support in setting up new organisations and structures which ensure GPs maintain all that is good about general practice and provide robust, safe and efficient delivery. Commissioners should support the sharing of best practice.

Next Steps

London's primary care providers face special challenges. In order to avert the current crisis and empower London's GPs to cope effectively with increasing demand and create a sustainable GP service, commissioners must work collaboratively with a focus on providing investment, support and increased funding for general practice. They need to invest in improving the working lives of GPs and their staff, and allow general practice the freedom to innovate. The system and its workforce need to be reinforced and sustained.

To improve the flow of patients through general practice, we must first clear existing blockages, then increase capacity; and commissioners and educators must work closely with Local Medical Committees, GPs and practice staff to do both or neither will succeed. There are a range of solutions that would benefit staff and patients in general practice, from increasing training and staffing capacity through to improving IT systems and halting system reconfigurations.

What do practice teams need:

- Funding to current and future workload, reflecting the real contribution and value of general practice to the NHS.
- Stable and realistic funding to support workforce and organisational development, through a core contract.
- Support, investment and freedom to innovate and transform how they work to manage and meet demand.
- Increased clinical time with patients, longer consultations, and the controlled and safe introduction of innovative ways for patients to access health advice.
- A reduction in the demands of bureaucracy and regulation, so that they are proportional to the clinical and financial risk of the sector.
- Time away from clinical work, during the working day to review and plan and learn; and access to relevant data about patient need and how they are meeting this.
- Psychological and peer support - practice leaders need to be able to care for themselves and their staff.
- Support for workforce development – training to take on new work and support to develop new roles.
- Support for leadership development and organisational development at practice and group level.
- New models of care commissioned so that they remain based on a registered list of patients, allowing practice teams to deliver personal care to a registered list of patients.
- Coordinated commissioning of primary, community and social care services to support general practice, complemented by the commissioning of local acute care.
- Support for affordable premises development in buildings accessible to their patients.

With the transformational effort now being focussed on developing place based care, and Sustainability and Transformation Plans in the making, the sustainability and stability of general practice is vital. Yet GPs, as providers and as employers are being left out of the equation. Londonwide LMCs' calls on commissioners and on provider trusts to involve local representatives of general practice in their planning discussions and to act immediately to relieve the crisis of funding and morale.

Both the Five Year Forward View and the pending Sustainability and Transformation Plans outline the need to stabilise general practice and primary care provision. Londonwide LMCs believe that it is critical that funding for general practice is stabilised before embarking on a transformation agenda. To try and deliver stability, sustainability and transformation simultaneously is to risk not delivering anything at all.

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