

Access to GP care

March 2015



Health Committee Members

Dr Onkar Sahota (Chair)	Labour
Andrew Boff (Deputy Chair)	Conservative
Andrew Dismore	Labour
Kit Malthouse	Conservative
Fiona Twycross	Labour

Role of the Health Committee

The Health Committee is tasked with reviewing health and wellbeing across London, including progress against the Mayor's Health Inequalities Strategy, and work to tackle public health issues such as obesity and alcohol misuse. The Committee will consider the Mayor's role as Chair of the new pan-London Health Board and the impact that recent health reforms are having on the capital, notably NHS reconfiguration and the decision to devolve public health responsibilities to local authorities.

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Chair's foreword



General Practice is the core of the NHS and holds it together. As many as 90 per cent of all the consultations in the NHS are through GPs – our family doctors we know and trust. Yet in London we are seeing cracks and fractures which, if left unattended, could have disastrous results for patients and doctors.

In recent years, the number of consultations a GP performs has doubled but the number of GPs has not. This is completely unsustainable. To meet the needs of a rapidly-growing population, London needs to attract more doctors to the specialty of General Practice and retain the GPs it already has.

In England, 40 per cent of GPs are over 50 and in London almost 16 per cent of GPs are over 60 years old. With increasing demand on General Practice, many GPs are planning and taking early retirement. The smaller practices will be forced to close. Without GPs replacing those retiring, the patient lists will be dispersed, putting even more pressure on practices that are already stretched.

Progressive GP practices are embracing technology and new ways of locality-based working to improve patient access. However, more needs to be done and more can be done. We need to invest more in the premises and IT systems of General Practice, we need to develop networking between social care and healthcare, and we need to make general practice more attractive to new entrants so that they feel emotionally rewarded for their work.

Londoners expect and deserve a first class health service and General Practice is at its foundation. London is a growing city with a population of nearly nine million and a unique set of challenges. These require a co-ordinated strategic approach to new ways of working, embracing technology and ensuring that the frontline staff feel valued.

This report is not just ringing the warning bells; it also sets out some recommendations which we believe are constructive and useful in improving access to General Practice.

Social Care and Health Services need to work together, seamlessly, to ensure we have a NHS fit for the 21st Century. This is a challenge for all of us.

A handwritten signature in black ink, appearing to read 'Onkar Sahota', with a long horizontal flourish underneath.

Dr Onkar Sahota AM MBA FRCGP
Chair of the Health Committee

1. A mandate to shift care out of the acute hospital setting

Key issues

Shifting clinically appropriate care out of acute hospital settings into the community is welcome and necessary for cost-effective use of resources. But to work effectively the shift will require integrated care pathways across the range of providers involved in patient care. General practice has a pivotal role to play in an integrated care model and in providing care in the community.

- 1.1 Pressure on Accident and Emergency (A&E) departments in London has reached unprecedented levels with annual attendances increasing by nearly a third over the last decade to 3.6 million.¹ In November 2013, the Committee published a report on risks to A&E services, which included an analysis of how London A&E departments had performed against the Government-set four hour waiting time target.² The analysis showed that in the 52 weeks leading up to November 2013 over half of London Trusts had missed the target. Since publishing our report, the landscape for A&E provision in the capital has changed, but a re-run of the analysis for the year to November 2014 shows that some London Trusts continue to struggle to meet the four hour waiting time target, and in some cases performance has deteriorated.³ (Appendix 1)
- 1.2 As in the past, the Government provided additional funding to help support A&E departments through the winter months. In September 2013 departments under most pressure were earmarked to receive £500 million over a two-year period (2013/15). This funding has since been topped up by a further £300 million to provide more bed space and pay for additional clinical staff.⁴ Ten London NHS trusts were included in the initial allocation, destined to receive a share of the funding totalling £55.4 million between them.⁵
- 1.3 Unsurprisingly, there is an increased focus in London, and nationally, to shift care from hospital settings into the community, and alongside that, broad acceptance that general practice (GP) has a pivotal role to play in providing that care. The Government's announcement last November, on increased funding to cope with winter pressures included a £25 million allocation to improve access to GP practices.⁶ This is a welcome commitment in light of the findings of the Care Quality Commission monitoring report on GP

practices, which shows that 20 per cent of London GP practices fall within the two greatest perceived risk ratings.⁷ Poor access to GPs or practice nurses is one of the main reasons for the negative ratings.

1.4 Several factors are necessary for an effective shift in care. There will need to be a simultaneous bolstering of primary and community care infrastructures, and the development of truly patient-centred integrated care pathways across the range of care providers. As expressed by GPs themselves, NHS England, the London Health Commission, private healthcare providers and many others, the shift can only be achieved by re-examining healthcare delivery and taking bold steps to make the changes needed. This will need to include an honest assessment of the financial investment required to bring about change.

1.5 Shifting care out of hospitals into the community is necessary, if we are to build a sustainable health service over the long-term. There are benefits to be gained, including improved health and wellbeing of patients, greater patient satisfaction and more cost-effective provision of healthcare. Research shows that mortality rates can be reduced by 45 per cent, emergency admissions by a quarter, A&E visits by 15 per cent, and bed days by 14 per cent.⁸ It also shows that most people would prefer to receive treatment at home.⁹

Integrated care

A term that reflects a concern to improve patient experience and, achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease.

Nuffield Trust

1.6 The recently published report by the independent London Health Commission, convened by the Mayor of London, and chaired by Lord Ara Darzi, recognised a critical need for investment in infrastructure to realise a shift of care from hospitals, and, the reorganisation of more integrated models to fit around individual patient care. It recommends establishing a transformation fund for investment in strategic change and the launch of a five-year, £1 billion capital investment in GP premises. It also recommends revenue investment to rebalance expenditure from specialised services to primary and community services, to address the past decline in spending. It says, *“There should be an increase in the proportion of expenditure on primary care each year for the next five years.”*

1.7 The Committee recognises the key role general practice has to play in the shift of care out of hospitals and into the community. Statistics show that “90 per cent of patient contact with the NHS takes place in general practice.”¹⁰ At its best, general practice can provide a holistic approach to care, from prevention and diagnostics, to treating and managing illness and long-term conditions. GPs, practice nurses and other staff who provide health and care services in general practice, are quite rightly regarded as the cornerstone of the NHS. General practice needs to be proactively supported to play its part in any revision to health care delivery involving a greater focus on care in the community.

1.8 Fourteen integration pioneer models have been established across the country, four of which are in London.¹¹ These models were developed from pilot schemes started as part of a Department of Health two-year Integrated Care Pilot programme. The programme aimed to explore different ways of providing health and social care services to improve the health and wellbeing of elderly people, people with long-term conditions, dementia and other mental health problems, and people engaging in substance misuse.

1.9 The largest scale integrated care model in London spans eight boroughs and a population of two million people in the North West.¹² The model is designed to improve the coordination of care for people over 75 years of age, and adults living with diabetes. Establishing professional multi-disciplinary teams has played an important part in facilitating a collaborative working model, and nurturing a shared sense of purpose and objectives in patient care. Conclusions drawn from self-evaluation of the model confirm, that while the model of care has demonstrated increased staff commitment and motivation, and patient satisfaction, it has not been without difficulties. GPs particularly, have found the time commitment challenging.

1.10 According to National Voices, the national coalition of health and social care charities in England, the lack of availability of joined-up care is a source of frustration for patients, service users and carers. They

Greenwich Coordinated Care Model

Open to all adults living in the borough, the model aims to assist them to maintain independence in the community and prevent unnecessary A&E attendances, hospital and care home admissions and delayed discharges. The care model has helped to prevent A&E and hospital admissions, and reduce admissions to care homes. The model, first established in April 2011 has evolved and expanded to broaden the range of integrated services provided and demographic covered.

say: “achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety...If executed well, moving towards a new model of integrated care will help to create the foundations for sustainable delivery against the quality, innovation, prevention and productivity (QIPP) challenge in the longer term.”

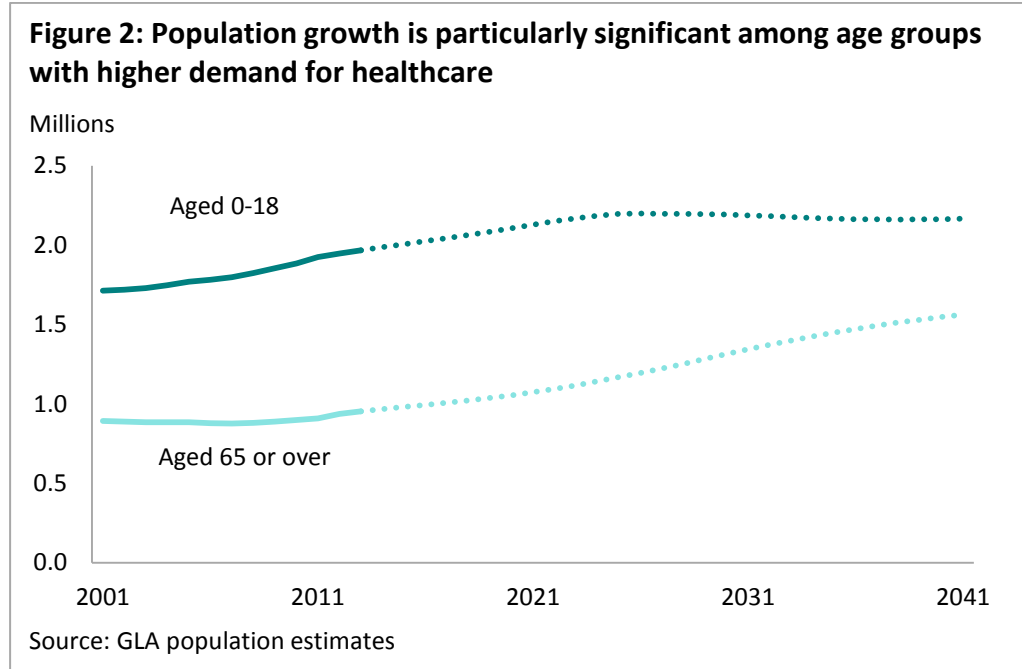
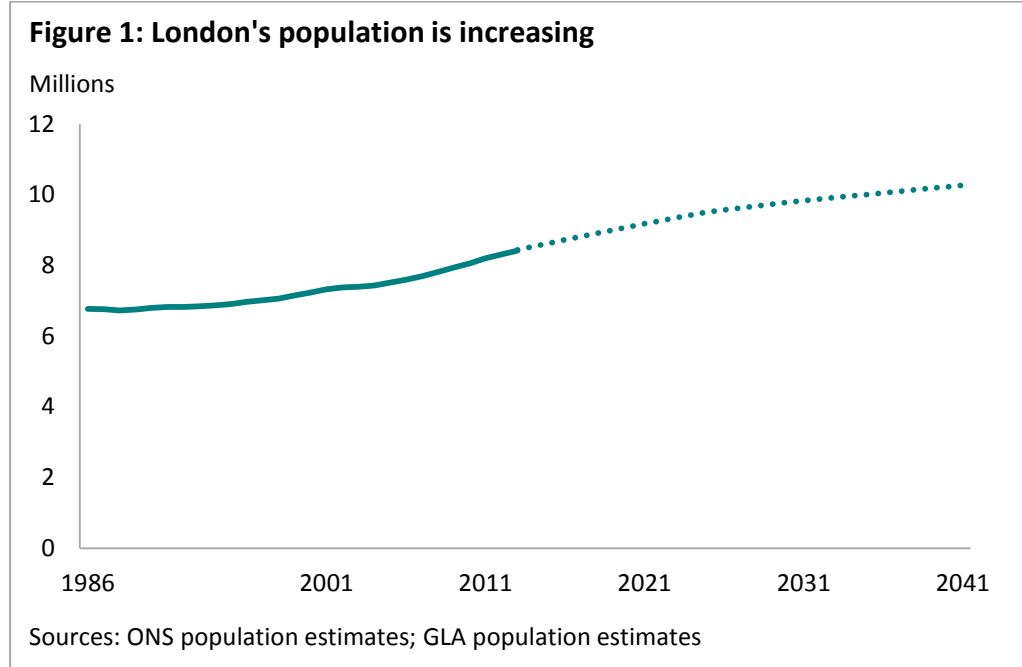
2. Addressing capacity in general practice

Key issues

As it stands, general practice in London does not have the capacity to accommodate the proposed shift of care. Its ability to continue to provide an accessible, quality service is already compromised; fuelled by, among other things, the steep rise in patient demand. London’s complex demography adds to the challenge to deliver optimal care and facilitate patient flow through general practice, and this should be factored into how care is structured, and delivered in London. Any proposals for change must be underpinned by action to address current supply and demand problems in general practice.

- 2.1 Patient demand for general practice care has increased significantly over the last decade. GPs now see 340 million patients annually, compared with 21 million who attend A&E each year.¹³
- 2.2 Dr Chaand Nagpaul, Chair of the British Medical Association, told the Committee that while patient consultations had doubled in London over the last decade, growth in GP capacity had not kept pace.¹⁴ He said *“there has not been any commensurate increase in GP or nurse numbers, so there is already this issue of demand not being matched by increased capacity.”*¹⁵ The number of patients seen has risen by 40 million year-on-year.
- 2.3 The rise in patient demand in London is unsurprising. The capital’s population has grown exponentially since the 1980s, and at a much faster rate than elsewhere in the country. In 1986 the population stood at 6.7 million, it is currently around 8.6 million, projected to increase to nine million by 2020, and ten million by 2030.¹⁶ The most rapid growth will be seen in the number of people over 65 years – over fifty per cent in less than 25 years.¹⁷ London’s relatively young population, of around two million people aged 18 years and under, is set to increase by almost ten per cent by 2035. Both of these groups use healthcare services more intensively than any other age group.
- 2.4 However, the “gate keeping” role of general practice is being undermined, as patients choose to bypass their GP when accessing medical care. The indication is that general practice is progressively viewed as a chronic disease

management service, rather than one which can provide immediate and urgent care.



Meeting the needs of a complex demography

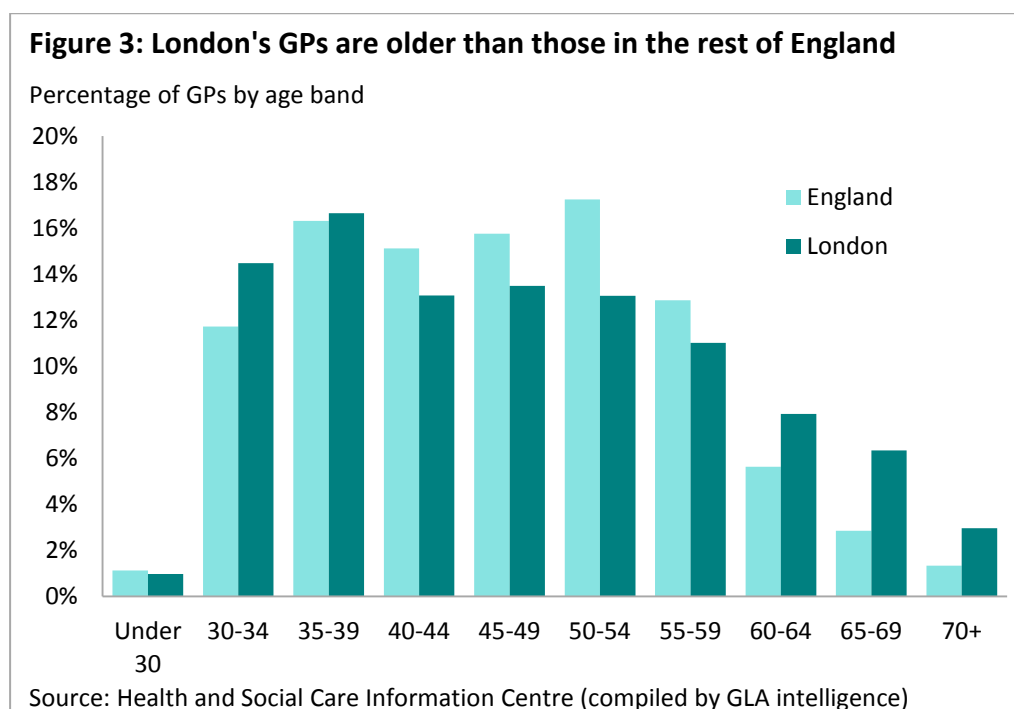
- 2.5 London's complex demography adds to the challenges faced by GPs, and should be factored into how care is structured and delivered, if equality of access to general practice care is to be achieved.

- 2.6 Language difficulties are just one of a range of factors contributing to the increased complexity of GP consultations. Census data suggests that over 300 languages are spoken in the capital, more than 300,000 people cannot speak English, and nearly 1.7 million do not have English as their first language.¹⁸ Language barriers, and the need for the use of interpreters, make patient-clinician consultations more complex.
- 2.7 A growing older population with greater, multiple morbidities, adds to the challenge. Projections show a doubling in the number of patients between 2009 and 2018, and data suggests that 50 per cent of GP consultation time relates to patients with long-term conditions. The ten minute consultation time allotted for such patients is not sufficient to deal with their problems, leading to further reduced capacity to meet the needs of patients requiring immediate or urgent care.
- 2.8 A highly transient population, with an estimated 10 per cent of households moving home each year, brings its own challenges and can disrupt continuity of care.
- 2.9 Some communities are at greater risk of certain illnesses: for example, the high and early prevalence of diabetes in the south Asian community. With some 40 per cent of Londoners coming from Black Asian and Minority Ethnic (BAME) backgrounds, managing high risk illnesses and the consequent challenges can demand protracted consultation time.
- 2.10 A Department of Health study was clear that solutions to better access for BAME individuals will need to embody the provision of a flexible, personalised model of care, as part of mainstream healthcare. The findings suggest more flexibility in patient consultation times where appropriate. It says *“Many patients say they feel the GP is pushed for time and rushes investigation into their condition. This points to a need for a more flexible appointment process, that can accommodate longer consultations, for those with complex and multiple issues or other needs such as advocacy or language support.”*¹⁹ The growing imbalance in the equation of supply and demand over the years has served to intensify GPs’ struggle to provide the flexibility needed. According to Dr Nagpaul, GPs *“are not able to provide patients with, not just the appointments, but the time they need.”*

Workforce issues

- 2.11 There is a national shortage of GPs. By 2021, around 16,000 more GPs will be needed than are currently available.²⁰ Almost 16 per cent of London GPs are over 60 years old, compared with 10 per cent nationally. The percentage of

GPs over 60 is typically higher in areas where there are many single-handed practices, which according to NHS England, also tend to be areas of greater deprivation.



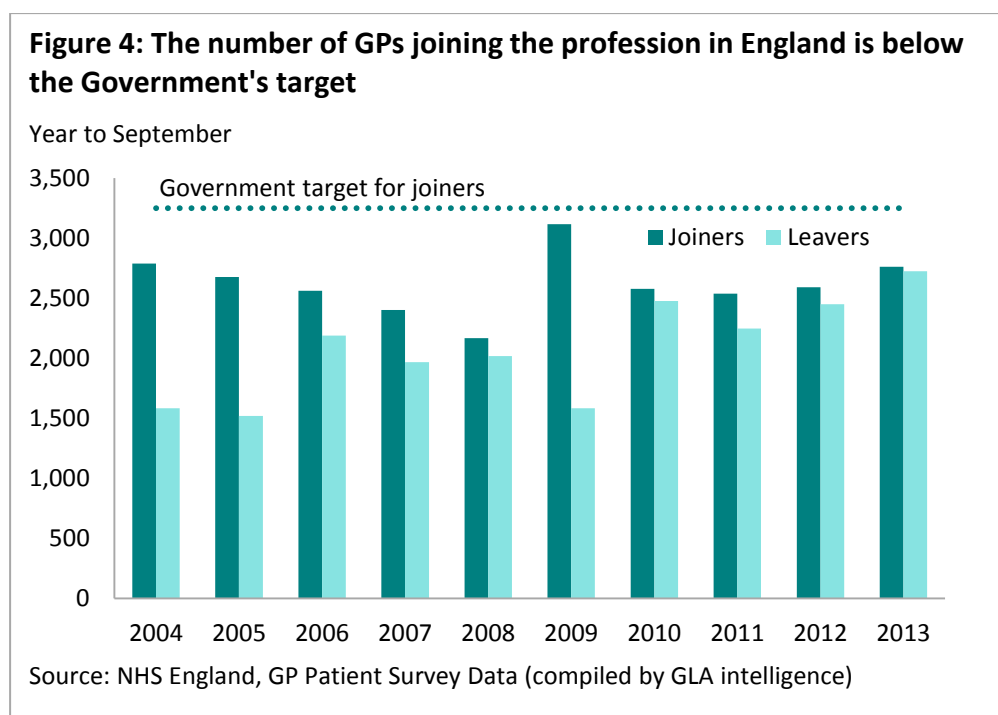
2.12 Many GPs are taking early retirement, and General Medical Council (GMC) figures suggest that growing numbers of them are considering emigrating. Applications to the GMC for Certificates of Good Standing (CGS), a document which enables GPs to register with an overseas regulatory body or employer, have risen by over 12 per cent since 2008. A total of 4,741 UK-trained doctors obtained CGSs in 2013.²¹

2.13 GP practices are failing to recruit partners. Vacancy rates have quadrupled in the past two years, and as many as one position in 12 is unfilled nationally.²² Anecdotal evidence suggests a growing reluctance to take on the liability of owning a practice, employing the staff, and the extra work that comes with being an employer, along with the workload demands.²³ Young doctors are opting for salaried or locum positions.²⁴

2.14 There is a case for NHS England (London) to consider developing a salaried GP service in London to extend the provision of service where needed, and to facilitate a career choice which newly qualified GPs are increasingly making. The workforce in general practice has seen a noticeable shift towards increasing numbers of salaried GPs, since the turn of the century. There was a 12-fold increase in salaried GPs nationally between 2000 and 2010.²⁵

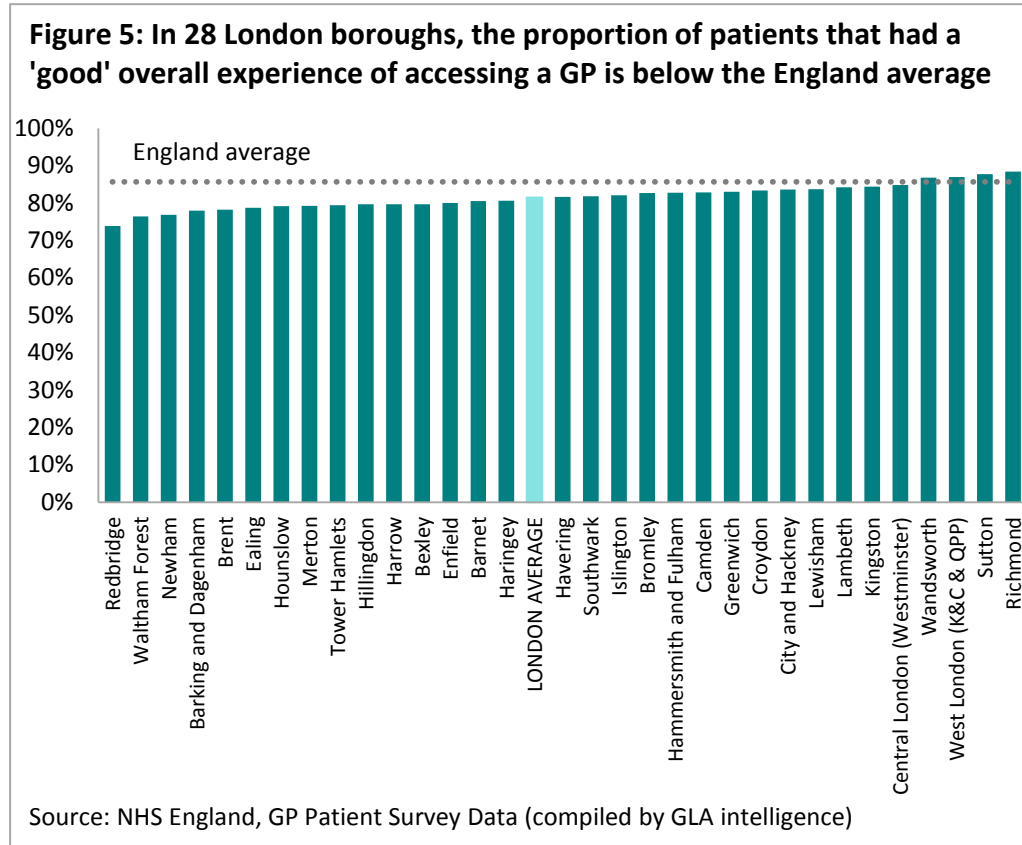
Practices also experienced increases in locum fees over the same period, averaging 9.5 per cent in 2012.²⁶ The rise in locum positions has implications for care continuity and quality, and for the long-term stability of GP care provision.

2.15 There is also a need to attract new talent. In 2013, there was an increase of 95 medical graduates starting a GP placement in England, bringing the total to 2,764. But there is still a large shortfall before the Government’s target to train 3,250 new GPs a year is met; this is the quantity needed to sustain supply and demand. The British Medical Association’s General Practice Committee says the shortfall is unsurprising given the crisis in recruitment and retention of GPs across the UK. It has called for urgent action to address issues of workload and demand on practices, to make the profession more attractive to junior doctors.²⁷ Anecdotal evidence suggests that student and foundation year doctors are not generally considering general practice as a career option, and when they do, they are opting to practice abroad.



2.16 If erosion of quality care and patient confidence is to be avoided over the longer-term, the supply and demand problem currently facing general practice must be addressed, alongside any proposals for service change. Understanding the drivers for early departure from the profession, and underlying reasons for the apparent reluctance to enter general practice, should be a first step towards a wholesale drive to addressing the recruitment and retention dilemma it faces. We would urge NHS England (London), in

partnership with Health Education England, to commission work to evaluate the drivers for low morale amongst serving GPs, and to look at ways in which new recruits can be attracted to the profession.



2.17 We accept that this research will require yet more outlay from what is already a constrained budget, but believe it to be a necessary short-term expense to generate long-term gain. The London Health Commission has recommended that a London Transformation Fund, jointly managed by NHS England (London) and the Clinical Commissioning Groups, be set up to fund investment in strategic change to improve care. Money from this fund could be set aside for research.

Recommendation 1

We urge NHS England (London), in partnership with Health Education England, to commission work to evaluate the reasons for low morale amongst serving GPs, and to look at ways in which new recruits can be attracted to the profession, and encouraged to remain. We recommend that money be set aside for this from the proposed London Transformation Fund, recommended by the London Health Commission, to fund investment in strategic change to improve care.

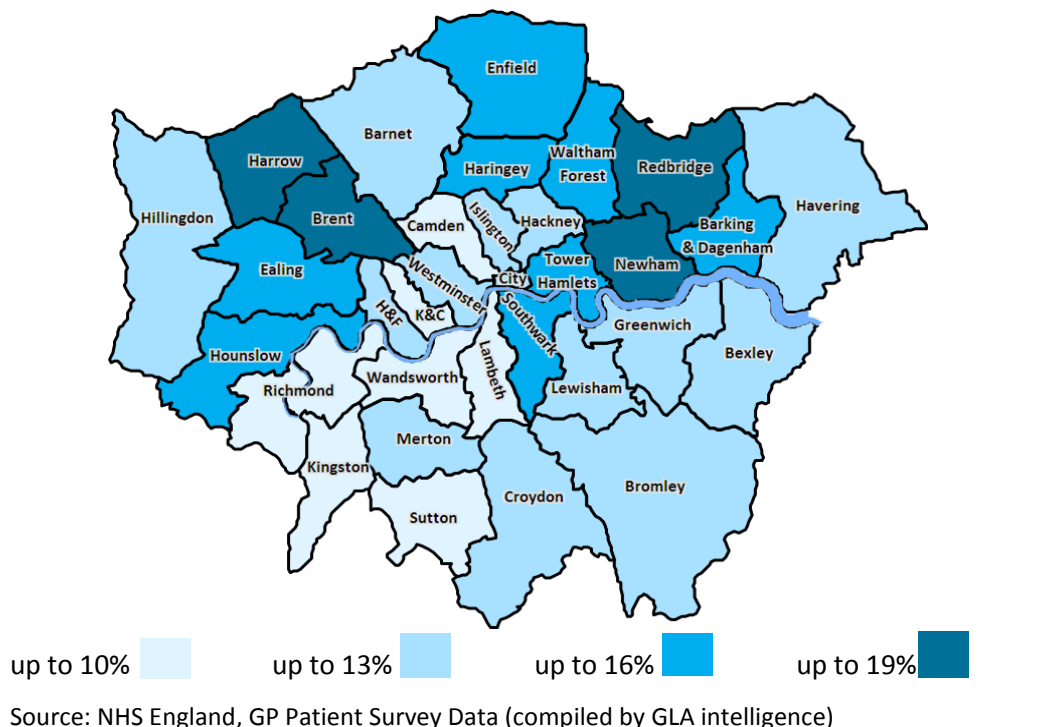
3. Addressing infrastructure and financial challenges

Key issues

There are signs that general practice is embracing technology and exploring new ways of working to better accommodate and improve access for their patients. But wholesale realisation of digital capability is slow. Ongoing financial constraints and wider infrastructure challenges add to the pressures felt by GPs. Moves to strengthen the wider primary and community care infrastructures, must underpin any shift in care to general practice, with an honest recognition of the limitations to what can be achieved.

- 3.1 There is a declining trend in satisfaction with GP services in London. Compared with other regions, patients in London tend to be less satisfied with access to care and the quality of care they receive. Of the bottom 30 boroughs in England for seeing a GP of choice, 22 are in London; 18 per cent of patients are unable to get an appointment in London, compared with 11 per cent nationally.

Figure 6: Percentage number of people waiting too long to see a doctor



Maximising digital capability

- 3.2 Digital capability could dramatically improve patient access. Dr Robinson, Medical Director INPS, told us: *“It is not that they (the technologies) do not exist. It is the uptake that is the issue. Less than half of practices offer online services to book appointments or order repeat prescriptions, and only three per cent offer online access to patient records.”* The inability to contact practices through digital channels is compromising access, particularly for the young. One third of London’s population is under 24 years old.
- 3.3 One third of patients responding to the NHS GP Patient survey said that they would like to use the internet to book appointments and request prescriptions, but only one per cent report that they are able to do so.²⁸ A representative from the local Camden Healthwatch also told the Committee *“there is a general sense among patients that there are some pretty basic level technological things that can be done that do not take a huge amount of investment.”* Examples included being able to text the surgery to confirm that an appointment is no longer required, or to email basic enquiries, rather than calling or attending the surgery.
- 3.4 Various models and examples of how technology can help improve access are being trialled and range from being able to book, cancel or check an appointment, to viewing medical records and ordering repeat prescriptions, and engaging in an email or video-style consultation.
- 3.5 In an age of advanced technology it is clear that more needs to be done to digitally enable GP practices. But there are limitations. Digital access may work well for younger and technology-confident patients, but may not necessarily prove attractive to older patients, whom, NHS England confirms, are typically the greater users of health services. Digital access could also exclude patients from deprived communities, who may not have online access, and who typically have higher representation from BAME groups.

The telephone triage system

Evidence presented to the Committee demonstrated a smoother patient flow, following the adoption of the GP Access telephone appointment triage model, and reductions in the number of failed GP appointments and A&E attendances. Despite the positive outcomes evident from the telephone appointment triage model, it will be best suited to multiple partner practices, and is not something that can be universally applied.

- 3.6 GPs have also expressed concerns relating to information management and governance. They cited the confidentiality risks of email communication, and digital incompatibility across the multiple systems currently in use, including EMIS Web, TPP System1 and Vision AEROS.
- 3.7 Furthermore, while digital access may reduce the need for face-to-face consultations, these will only be suitable for a limited range of patient consultations. An evaluation of the impact of technology on demand for GP appointments will be needed. Enabling digital capability should be integral to NHS England (London)'s current review and developing programme to transform primary care in the capital.

Recommendation 2

NHS England (London) should conduct a wholesale review of its Information Technology Strategy in the capital, and explore how it might provide general practice with the digital capability it needs, to improve patient access and care. We recommend that the review include an evaluation of the impact of technology, on demand for GP appointments.

Developing GP networks

- 3.8 The trend towards collaborative working through networks, mergers, or federations of GP practices is encouraged by NHS England (London). London has a high proportion of single-handed GP practices - one in five, compared with one in seven, nationally.²⁹ Their premises tend to be smaller, and this can limit the potential to improve the service offer. The Committee recognises that collaborative models, such as GP networks could allow for more efficient use of finite resources, broaden the service offer, and reduce the professional isolation that can occur. But as highlighted by the London Health Commission, financial investment is needed to develop new ways of working. Space also needs to be created for training and supporting affected GP practices in the interim.
- 3.9 Striking evidence presented to the Committee during its review of diabetes care in London, and briefing on out-of-hospital care, demonstrated the benefits of collaboration for both patient and service provider. GP consortiums in Tower Hamlets formed around the delivery of diabetes health care³⁰ and integrated care programmes in Greenwich and Islington³¹ have resulted in improved prognosis for diabetes sufferers, and reduced A&E admissions, respectively.

Recommendation 3

NHS England (London) should commission and facilitate general practice to explore and embrace alternative ways of working to ensure inclusive patient access that meets the need of London's diverse population. These can include the adoption of alternate service models and better use of technology where appropriate.

Strengthening primary and community care infrastructure

- 3.10 GPs provide care as part of a wider community team that includes community nurses and support staff, local authority-managed community care services, health centres, pharmacists and other specialists. The pressures of managing increases in demand for services, experienced by general practice are replicated across these other community support teams. As previously mentioned, these services are already dealing with increased workloads to cope with the challenges presented by managing long-term chronic diseases, a diverse population, and complex medical conditions. They too are seeing reductions in their workforce and to the quality and level of service they are able to offer. For example, the loss of nursing and residential home providers: 85 were lost in London during the year March 2012 to 2013.
- 3.11 Patients and professionals alike are confused about where and how to access care and support. Dr Michelle Drage, Chair of the London-wide Local Medical Committees, told us: *"We have totally lost the space between hospitals and general practice, the community support services, the district nurses have been decimated, and health visitors are virtually no more. Social services which used to work together in a co-ordinated ...integrated way with us and with those other providers, mental health services are all fragmented. They are all reduced. General practice has nowhere for those patients to go, so as well as hospitals being perceived to be overwhelmed, actually what is happening is we are getting it from both sides. [There is]...a lack of places to refer patients to in the communities."*³²

Re-thinking funding

- 3.12 It is widely accepted that general practice is chronically under-funded. Funding has declined in real terms over the last decade, and is, according to the Royal College of General Practitioners (RCGP), beginning to affect patient experience. Primary care receives eight per cent of the budget, while providing 90 per cent of NHS activity.³³ RCGP estimates that at least 10 per cent of the NHS budget will be needed to maintain primary care provision; a proportion of spend not seen for almost a decade.

3.13 The transfer of care out of the acute hospital setting must go hand-in-hand with financial investment: to provide the clinicians and infrastructure needed and to effectively deliver care in the community. The Committee believes that the London Health Commission's call for an increase in the proportion of expenditure on primary care in London for the next five years is a sensible one. The key consideration must be how to make better use of available resources to ensure that primary care receives the level of funding it needs. However, this re-distribution must be carefully considered, given the context of limited resources.

3.14 The Better Care Fund, due to come on-stream in the next financial year, is a shift in the right direction. Its underlying principles and aspirations are commendable, although some doubts have been expressed surrounding the lack of new money. This single, pooled budget for health and social care services presents an opportunity to build on the progress already made towards developing integrated care models. The Fund should help develop closer working relationships locally, built around a joint ownership of an agreed plan, between local authority health and wellbeing boards and clinical commissioning groups (CCGs). A joint plan should help address the increased demands on healthcare as the population ages and the number of people with long-term conditions rises. In London, the latter account for more than 50 per cent of all GP appointments, 65 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days.

The Better Care Fund

The £3.8 billion Better Care Fund (BCF), formerly the Integration Transformation Fund, was announced by the Government in the June 2013 spending round to ensure a transformation in integrated health and social care. The BCF creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. It is a critical part of the NHS two-year operational plans and the five-year strategic plans as well as local government planning.

3.15 Funding for the Better Care Fund will be sourced jointly from existing CCG allocations, and NHS money transferred to social care budgets. For most CCGs, investing in the Better Care Fund will involve redeployment of their resources. This could place additional pressures on providers already faced with the challenge of how to maintain and improve quality of care while

achieving financial balance. This is a discussion yet to play out fully in the lead up to implementation.

- 3.16 While it is acknowledged that the concept of a pooled fund has helped galvanise helpful conversations between local councils and NHS partners, serious concerns have been expressed about its long-term viability and whether it provides sufficient funding to address the cost of the service changes needed to reduce hospital admissions.³⁴ National guidance is clear that bringing the Fund online will entail a substantial shift of activity and resource from hospitals to the community, and should result in a 15 per cent reduction in hospital emergency admissions. The recent National Audit Office report also raises concerns that planning for the BCF is based on “*optimism rather than evidence*”.³⁵

Shared funding streams

- 3.17 There is strong evidence that there are financial savings to be realised from better use of out-of-hospital care, including GP care. Benefits can include reduced A&E usage and length of in-hospital stay, and savings through avoided admissions, or re-admissions to hospital.³⁶ The RCGP estimates that the cost per patient, for an entire year through general practice, is equivalent to the cost of only ten per cent of one day’s stay in hospital.
- 3.18 But clinicians and managers are of the view that, as long as the funding streams for hospital and community care are handled separately, and the incentives for the preferred outcomes remain misaligned, neither system will be able to function properly. Practical experience has shown that getting the resources to follow the patients (particularly out of the acute care setting to the hospital) is difficult, and the amount of cash transfer is, in reality, minimal. The current tariff system is a key barrier as it does not incentivise Trusts to consider treatment settings other than traditional in-patient care.

Recommendation 4

The increasing demands on NHS services, including primary care, necessitate a whole-system review so that services and financial flows can be integrated. Changes to one part of the NHS system will inevitably have an impact elsewhere and could lead to unintended consequences. We recommend that NHS England (London), in its review of general practice, incorporates analysis of the impact that changes to the wider primary and community care infrastructures could have on general practice service provision.

A multi-faceted approach to improving general practice

- 3.19 Any attempts to address the intense pressures faced by general practice in London will require a multi-faceted approach to: manage the increasing demand on services; effectively operate within current financial constraints; and tackle the wider infrastructure challenges raised previously.
- 3.20 The Government's recruitment drive for GPs must gain impetus nationally, but particularly in London. We cannot get away from the fact that increasing capacity in general practice, to cope with the challenges it faces, will require the recruitment and skilling-up of more personnel. Similar recruitment drives will be needed at London-level for community nurses and other essential primary care staff. The Commission's findings point to a "ticking time bomb" in respect of London's primary care workforce, noting that a large proportion (of GPs, midwives, and community nurses) are due to retire. Twice as many London GPs are aged 60 or over, than elsewhere in England – 15 per cent versus 8 per cent.
- 3.21 We spoke earlier of, and recognise the need to further explore, the London Health Commission's call for £1 billion capital investment in GP premises. We also recognise the need for increased revenue investment as a proportion of total NHS spend in London. Equally important is an holistic approach to NHS estate planning.
- 3.22 Of the 1240 GP premises across London, over 160 of them are in either a "poor", "very poor" or "terrible"³⁷ state and in need of significant refurbishment, or a complete rebuild. Over half will require renovation to bring them to an acceptable standard. Around 500 premises do not meet disability access requirements, and need adjustment. The London Health Commission estimates that around 60 per cent of the primary care estate is not fit for purpose.
- 3.23 Closing the gap in strategic capital planning and links to service planning, also highlighted in the Commission's report, will be essential. It says, "*The capital regime and estates planning have long languished in the 'too difficult' category. Fundamental reform has not taken place and, as a result, patients and their care have suffered, with services frequently being delivered in buildings and facilities which would shame any other city with global ambitions to offer its citizens the best quality of life and care of anywhere in the world*".
- 3.24 In addition to improving existing GP premises, it will also be necessary to look at whether new GP surgeries need to be opened, and in which areas, to meet

demand. In particular, the NHS needs to consider playing a more active role in London's planning system, to ensure that new GP surgeries, and other primary care facilities are provided, whenever new housing developments are proposed.

- 3.25 The phasing out of MPIG³⁸ may remove the incentive of opening a practice in more deprived areas. In some cases it may render the practice economically unworkable. Changes to the funding scheme must be monitored to ensure that, if necessary, funding is equitably distributed to support and encourage practices in deprived areas.
- 3.26 The NHS should also work closely with London Boroughs to ensure that health facilities benefit from the community infrastructure levy,³⁹ and section 106 funding."
- 3.27 As the largest land owner in London, the Mayor can, through better planning, play a major role in the crisis in general practice premises. Precedents have been set, with both the Metropolitan Police Estate, and the London Fire Brigade. The Metropolitan Police now has an estate strategy setting out a proposed overhaul, and reduction in running costs of the estate. The Fire Brigade has reviewed its estate, and used the information from the review to prioritise property improvements. The Committee urges the Mayor, to work with NHS England (London) to improve the primary care estate.

Recommendation 5

Alongside the need to develop and increase the primary care workforce, improving existing GP premises, and investing in new ones will be essential to enable the increase in capacity needed, to cope with the demographic and service challenges faced by general practice. As the largest land owner in London, the Mayor can, through better planning, play a major role in relieving the crisis in general practice premises. The Committee urges the Mayor, to work with NHS England (London) to improve the primary care estate.

Appendix 1 – Trust performance against waiting target

Table 1 Number of weeks out of the last 52 (to November 2014) in which 95 per cent under four-hour waiting target was missed by London Trusts with Type 1 A&E departments (*excluding North West London Hospitals NHS Trust and London North West Healthcare NHS Trust*)

London NHS Trust with Type 1 A&E department	Number of weeks of last 52 reported	Number of weeks of last 52 in which the target was missed	Total patients dealt with within four hours over last year
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	52	52	85.5%
BARTS HEALTH NHS TRUST	52	34	94.3%
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	52	7	97.0%
CROYDON HEALTH SERVICES NHS TRUST	52	23	95.0%
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	52	8	96.2%
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	52	3	96.5%
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	52	11	95.8%
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	52	15	95.2%
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	52	52	89.2%
KINGSTON HOSPITAL NHS FOUNDATION TRUST	52	15	95.5%
LEWISHAM AND GREENWICH NHS TRUST	52	51	89.1%

NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	52	23	95.1%
ROYAL FREE LONDON NHS FOUNDATION TRUST	52	10	95.7%
ST GEORGE'S HEALTHCARE NHS TRUST	52	30	94.4%
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	52	20	95.4%
THE WHITTINGTON HOSPITAL NHS TRUST	52	17	95.5%
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	52	25	94.7%

Source: NHS England, Weekly SitReps

Table 2 Number of weeks out of the last 52 (to November 2014) in which 95 per cent under four-hour waiting target was missed by London Trusts with Type 1 A&E departments (showing North West London Hospitals NHS Trust and London North West Healthcare NHS Trust only)

London NHS Trust with Type 1 A&E department	Number of weeks of last 52 reported	Number of weeks of last 52 in which the target was missed	Total patients dealt with within four hours over last year
NORTH WEST LONDON HOSPITALS NHS TRUST	43	43	84.0%
LONDON NORTH WEST HEALTHCARE NHS TRUST	9	9	88.6%

Source: NHS England, Weekly SitReps

Appendix 2 – Recommendations

Recommendation 1

We urge NHS England (London), in partnership with Health Education England, to commission work to evaluate the reasons for low morale amongst serving GPs, and to look at ways in which new recruits can be attracted to the profession, and encouraged to remain. We recommend that money be set aside for this from the proposed London Transformation Fund, recommended by the London Health Commission, to fund investment in strategic change to improve care.

Recommendation 2

NHS England (London) should conduct a wholesale review of its Information Technology Strategy in the capital, and explore how it might provide general practice with the digital capability it needs, to improve patient access and care. We recommend that the review include an evaluation of the impact of technology, on demand for GP appointments.

Recommendation 3

NHS England (London) should commission and facilitate general practice to explore and embrace alternative ways of working, to ensure inclusive patient access that meets the need of London's diverse population. These can include the adoption of alternate service models, and better use of technology, where appropriate.

Recommendation 4

The increasing demands on NHS services, including primary care, necessitate a whole-system review so that services and financial flows can be integrated. Changes to one part of the NHS system will inevitably have an impact elsewhere and could lead to unintended consequences. We recommend that NHS England (London), in its review of general practice, incorporates analysis of the impact changes to the wider primary and community care infrastructures could have, on general practice service provision.

Recommendation 5

Alongside the need to develop and increase the primary care workforce, improving existing GP premises, and investing in new ones will be essential to

enable the increase in capacity needed, to cope with the demographic and service challenges faced by general practice. As the largest land owner in London, the Mayor can, through better planning, play a major role in relieving the crisis in general practice premises. The Committee urges the Mayor, to work with NHS England (London) to improve the primary care estate.

Appendix 3 – Endnotes

¹ British Journal of General Practice (Committee report, Risks to A&E services this winter, November 2013, p6)

² The Government has set an operational standard of 95 per cent for patients being seen and discharged within four hours and uses this target to help ensure patients are treated quickly. This operational standard is designed to deliver patients' rights under the NHS Constitution.

³ For example, Chelsea & Westminster Hospital NHS Foundation Trust consistently met the target to November 2013, but in the current year missed it on 7 out of the 52 weeks; Kings College Hospital NHS Foundation Trust has consistently missed the target during the current year, but previously missed it 32 out of 52 weeks. Lewisham & Greenwich NHS Trust missed the target 51 out of 52 weeks, but previously 26 out of 52 weeks; St George's Healthcare NHS Trust missed the target 30 out of 52 weeks to November 2014, but previously missed it 25 out of 52 weeks.

⁴ Department of Health announcement on 14 November 2014

⁵ Press release dated 10 September 2013. The Trusts are Barking, Havering & Redbridge University Hospitals Trusts £7,000,000; Barnet & Chase Farm Hospitals NHS Trusts £5,120,000; London Barts Health NHS Trust £12,800,000; Croydon Health Services NHS Trust £4,500,000; Ealing Hospital NHS Trust £2,900,000; North Middlesex University Hospital Trust £3,800,000; North West London Hospitals Trust £6,400,000; South London Healthcare NHS Trust £7,700,000; Whittington Health NHS Trust £2,960,000 and West Middlesex University Hospital NHS Trust £2,300,000.

⁶ Department of Health announcement on 14 November 2014

⁷ The Care Quality Commission monitoring system uses 38 different indicators to determine the perceived risk of each practice in England. Each practice receives a risk rating from one to six, with one being the greatest perceived risk and six the lowest.

⁸ Whole System Demonstrator Programme: Headline Findings, The Department of Health, December 2011

⁹ Bupa satisfaction survey 2013 Reasons cited include: convenience and an opportunity to be with their loved ones at some of the more emotionally distressing times of their lives.

¹⁰ Transforming Primary Care in London: General Practice a call to action, NHS England London, November 2013

¹¹ North West London, Greenwich, Kingston, WELC care collaborative (Waltham Forest, East London and City)

¹² Two Integrated Care Pilots were established in North West London. The first, established in July 2011, to cover the boroughs of Westminster, Kensington & Chelsea, Hammersmith & Fulham and Hounslow; the second, to cover the boroughs of Brent, Ealing, Harrow and Hillingdon, was mobilised from summer 2012.

¹³ RCGP data requested by Dr Chaand Nagpaul at the Committee meeting on 8 July 2014 (p2 Transcript)

¹⁴ Drs Michelle Drage, Chief Executive, Londonwide Local Medical Committees, and Clare Gerada RCGP, 6 February meeting (p3&4 Transcript)

¹⁵ Transcript of 8 July meeting, p2

¹⁶ GLA Intelligence analysis of 2011 Census data; 2013

¹⁷ From 910,000 in 2011 to 1.5 million in 2035; Population Projection Round 2013; GLA Intelligence.

¹⁸ Census 2011; Office for National Statistics.

- ¹⁹ No patient left behind: how can we ensure world class primary care for black and ethnic minority people? Department of Health, May 2008.
- ²⁰ RGCP releases dated July 2013 and February 2015.
- ²¹ Pulse Today, online medical journal article, July 2014
- ²² Pulse Today online medical journal article. Figures correct at February 2013
- ²³ See articles: Pulse Today February 2013, and August 2014; Guardian May 2013, and October 2013
- ²⁴ Pulse Today, August 2014
- ²⁵ From 555 in 2000 to 6962 full time equivalents in 2010
- ²⁶ Pulse Today, February 2013
- ²⁷ Pulse Today article, May 2014
- ²⁸ GP Patient survey
- ²⁹ Based on 2011 data, single-handed GP practices make up 19.9 per cent of all practices in London, compared with 13.8 per cent nationally. General Practice in London: Supporting improvements in Quality, The Kings Fund, 2012
- ³⁰ Transcript of Health Committee meeting, dated 25 November 2013
- ³¹ Transcript of Health Committee meeting dated 22 January 2013
- ³² Transcript of the Health Committee, dated 6 February 2014
- ³³ NHS England (London), Transforming primary care in London
- ³⁴ The Better Care Fund: will the plans work? The Kings Fund, November 2014
- ³⁵ The National Audit Office published its highly critical report – *Planning for the Better Care Fund* – in November 2014
- ³⁶ Turning a vision into reality: a practical guide to moving care out of hospital BUPA, November 2011
- ³⁷ Categorisation as per the London Health Commission report, see the supporting technical pack, *Unlocking the value of NHS estates in London*, October 2014.
- ³⁸ The Minimum Practice Income Guarantee (MPIG) was introduced as a measure to protect the previous income levels of general practice and smooth the transition between the old and the new contracts, following the national contract changes in 2004. The MPIG has been in payment for 10 years.
- ³⁹ The community infrastructure levy is a levy that local authorities in England and Wales can choose to charge on new developments in their area. It is designed to be fairer, faster and more transparent than the previous system of agreeing planning obligations between local councils and developers under section 106 of the Town and Country Planning Act 1990.

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