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In progress - full submission pending

Londonwide LMCs
The professional voice of London general practice

Headlines from Londonwide LMCs' response to the Government's NHS 10 Year Plan consultation

Following news last month that the Government is holding what it terms "the biggest national conversation about the future of the NHS", and in advance of the 2 December closing date to submit responses, we are sharing headlines from Londonwide LMCs' response to the consultation's five key questions.

Members of the public, as well as NHS staff and experts, are invited to share their experiences views and ideas for fixing the NHS. The Government's 10 Year Health Plan will be published in spring 2025 and will be underlined by three big shifts in healthcare - hospital to community, analogue to digital, and sickness to prevention.

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

- **A full understanding of the role of general practice and local practices.**
- An acknowledgement that safe and strong general practice is essential as a means of providing cost effective health care and securing health improvement.
- Recognition that UK general practice is the bedrock of primary care provision in the NHS and the model of general practice and local, practice based, care is well evidenced to lead to high patient outcomes and system financial efficiency.
- The 10-Year Health Plan must address the sustainability of the GP workforce, fair funding, and operational autonomy within general practice and protect the core characteristics of our "cradle to grave" system, including: holistic care, continuity of care, appropriately managing complex undifferentiated illness, simultaneously managing the acute and chronic health problems, coordinating care, and promoting the health and wellbeing of individuals and local communities and the prevention of ill-health.
- We need more doctors and nurses in general practice, each full-time-equivalent GP providing care to fewer patients, to be able to provide safe and effective patient care; satisfy patients and optimise health and wellbeing outcomes; and to enable the continued evolution of care and services to tackle the NHS' challenges and deliver an NHS fit for the future.
- The 10-Year Health Plan and the new Government need to work with general practice to:
    - Give those closest to the challenges/problems– those delivering care, in collaboration with those receiving care – autonomy and ownership to identify well-informed solutions.
    - Create the conditions for innovation to thrive: thinking time to collaborate and develop new ideas, funding, the freedom to try, learn and adapt.
    - Widen strategic alignment: of elements such as contracts, national prioritisation, policy and regulation to enable adoption and spread of successful innovation.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

- The shift from hospital- to community- based care is critical, but not achievable without significant investment:
    - investment of time, to ensure that the pathways and models of care are appropriate and suitable to provide equity and recognise the differing needs of the disparate communities served by GPs and practice teams in neighbourhoods across the Capital and England;
    - investment of trust, allowing practitioners the capacity to determine the actions and interventions that work for them and their localities rather than imposing rules from on high, and;
    - investment of funding, to enable the staff, premises, equipment and capacity meet patient needs appropriately, which in turn will help liberate capacity in secondary and tertiary care.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

- Poor IT infrastructure; technology needs to support clinicians to be more effective and needs to be designed by those using it to avoid unintended negative consequences/ complications.
- Greater use of digital tools and technology across the healthcare system must be balanced with considerations around safety, privacy and inclusivity. Government must work with GPs and other health professionals to ensure that data is managed sensitively and that patients are clear on what is and is not going to be done with their information.
- Evidence shows that primary care is best delivered by expert generalists working with registered lists in defined geographic communities. The core funding that allows and supports this care delivery at individual and population level must be maintained and, where possible, increased rather than diluted and supplemented with call-centre care.
- There are significant infrastructure issues relating to digital working that also need to be addressed. There are also additional costs – often referenced as the “Market Forces Factor” – borne by general practitioners operating within the greater London area, including elevated property and staffing costs, which are reflected in current resource weightings. There must be a full, independent and robust analysis of the clinical and cost effectiveness of diversion of funding, to any new delivery model, on all populations.
- There are also a number of unresolved issues regarding historic records and redaction which need to be considered, and a need to consider safeguarding around vulnerable patients who might be coerced into sharing access to their personal information, putting themselves at risk (including those subject to coercive control, domestic violence, and/or those with concerns about privacy for accessing certain procedures or services).
- Developments such as the NHS App and e-consult can be assistive technologies, but commissioners and providers alike must be mindful of equity challenges which can impact on access and accessibility, ranging from poverty and lack of financial access to technology (no smart phone, no credit, no wifi) through to limiting factors such as language barriers, literacy, sight or other disabilities. And services and access to them should always be designed on the basis of equity and that all can access them with assistance/ adaptation, rather than based on equality, whereby all must overcome the same hurdles.

- Similarly, AI technology, when deployed effectively and thoughtfully, can aid automation of tasks and analysis and be assistive. But the ongoing concern is that we continue to ensure that such technology is introduced on the basis that it is a support, and not a replacement, and that it is done sensitively and cautiously so that the impact can be measured and assessed.
- For investment in digital health tools to fit with the values of general practice, such tools must directly reduce health inequalities, or free up resource which can be directed to other methods of care delivery which are proven to do so.
- Consultations mustn't be automated – we are seeing the significant constraints of online mechanisms that force patients to force their issues into a transactional medical model of care, rather than reframing technological assistance to auto-populate the forms and referral process by taking consultation information and referring to access the most appropriate next service or step in care, without losing the human loop or failing to recognise the immense value of "Dr as a drug".

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

- The capacity/ capability mismatch within general practice, in a system under immense pressure, is a significant challenge to the immediate introduction of new initiatives which will drive-up numbers of prospective/ opportunistic/ preventative appointments and divert resource from those with identified need.
- Without increased staff, premises, and capacity to deliver screening or other interventions it is challenging to envisage more activity than is currently taking place.
- There is currently a significant challenge in that there is effectively "rationing" of safe care and access, on a number of levels, which leads to further workload shift and greater demand on over stretched GP services, and results in people operating beyond the remit of GP expertise and, often, burning out and leaving the profession that they have spent many years training for.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:
• Quick to do, that is in the next year or so
• In the middle, that is in the next 2 to 5 years
• Long term change, that will take more than 5 years

Government needs to:

- Give those closest to the challenges/problems– those delivering care, in collaboration with those receiving care – autonomy and ownership to identify well-informed solutions.

- Create the conditions for innovation to thrive: thinking time to collaborate and develop new ideas, funding, the freedom to try, learn and adapt.

- Widen strategic alignment: of elements such as contracts, national prioritisation, policy and regulation to enable adoption and spread of successful innovation.

Specific areas to prioritise include:

- Be open and transparent with the public about rationing decisions: eg the increase in demand for GP services, the worsening the demand: capacity/ capability gap, and the safety impact of rationing (of all types).
- Employ robust clinical governance processes in deciding priorities, to address the increase in demand for GP services, the worsening the demand: capacity/ capability gap, and the safety impact of rationing (of all types).
- Conduct regular workload and capability impact assessments on all providers when deciding priorities and consider operational deliverability before announcing structural or contractual changes that might increase demand for GP services, worsen the demand: capacity/ capability gap, and lead to an increased in rationing (of all types).
- Assess and consider the impact on the different GP services within a practice (eg reactive care vs pro-active care vs preventative care, holistic care vs transactional care etc) of changing commissioning priorities or decommissioning services: eg Initiatives which would drive up the number of appointments required without increasing the number of required, appropriately qualified, staff available to meet that need.
- Employ robust clinical input and clinical governance processes when designing services and pathways, considering issues such as the unsafe transfer of clinical risk from secondary care to other areas of the health system, the practical and safety aspects of assumed, not agreed, shared care with general practice as a way of managing demand/ releasing capacity in other parts of the system, and investing in improvements to currently unsatisfactory communication processes at the interface between different services.
- Ensure that safety is pre-eminent, and that innovative delivery and structures are safety-assessed before introduction, including: are funded fairly; can be delivered safely with the workforce available; are clinically appropriate and do not exacerbate health inequalities; have appropriate outcome measures; are contracted at the right scale for function; do not involve needless bureaucracy, and; do not compromise the characteristics of effective general practice or the trusted relationship with patients.
- Ensure appropriate resourcing, support and time for change management processes, and ensuring that the change is a positive change for patients and the workforce, including but not limited to the introduction of new roles, the introduction of new technology, and the introduction of new ways of working (at scale and in other ways).