Evidence Set 1

Heath Scrutiny Committee

13 October 2021

The provision of GP services in Suffolk

Information in this report was produced on behalf of:

	NHS Ipswich and East Suffolk CCG and NHS West Suffolk CCG
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Introduction

1. The following information has been provided in response to the key areas for investigation set out in paragraph 3 of the covering report.

What are the issues leading to additional demand pressures in general practice in Suffolk and to what extent are these reflected nationally?

2. These include:

   a) Population growth;

   b) Ageing population, and as a result, patients have more complex conditions that require them to attend their local practice more frequently;

   c) Patients who have not sought advice for problems during lock down now presenting with greater acuity;

   d) Patient expectations have increased;

   e) Abuse by patients has increased causing more staff to leave general practice;

   f) Staff sickness due to operating under significant pressure for long periods of time plus increased covid infections;

   g) Daily demand resolved due to telephone/video conference consultations leading to the expectation that this is ongoing every day;

   h) Other health partners transferring out of contract work towards the practices;

   i) Checks and medication reviews missed during 2020 need to be completed 2021;

   j) Practice staff, especially GP, recruitment issues on going;

k) Older GPs and other members of the workforce reducing hours / looking to retire;

l) Pressure of enhanced Flu campaign;

m) Pressure of covid Phase 3 (even if practices are not taking part - national media points patients to their GP);

n) Pressure to meet national targets, eg health checks;

o) Logistical issues eg, Roche.

Why are GPs leaving general practice and what can be done to address this?

3. There are multiple pressures on GPs and GP partners in particular. These include:

a) Personal liabilities. The historical effect of NHS regulations means that GP practices are private businesses (in contrast to most other NHS organisations) and are almost all run as 'true' partnerships. This means the individual partners are liable for costs incurred by the business as well as benefitting from any profits derived. Such liabilities, in the event of 'handing back your GP contract' usually run to very large amounts and include practice premises as well as staff redundancy payments. New GPs are increasingly preferring portfolio careers, viewing partnership with its attendant risks and considerable additional responsibilities as unattractive.

b) A lack of control over workload. There is no accepted mechanism by which GP practices can seek to work within safe limits.

c) Excess Demand. This is multifactorial, but, at its heart, includes the profound impact of demographic change coupled with the attendant demands of an increasingly broad and effective set of medical interventions upon the wider health care system

d) Until recently there has been no attempt by national systems to quantify or remedy the effects of various system changes on primary care. For example, the campaigns around mental health awareness and cancer symptoms have failed to model or compensate for the associated increase in primary care work.

e) As an illustration, in other primary care systems (Australia, NZ, Holland) it is generally accepted that around 25 patient interactions is a safe and reasonable workload and one which is generally adhered to. In contrast it is now not uncommon for Suffolk GPs to be expected to consult, in various formats with 40-50 patients per day alongside 20-30 blood test results, review, action letters from a multitude of sources, prescriptions, home visits alongside the supervision of junior staff and oversee the running of a small/medium sized business.

f) Adverse media coverage, coupled with a slow societal devaluation of GPs, when compared to hospital colleagues.

g) 'Care in the community' is a mantra that is accepted by the system as inherently good and has been the strategic direction for many years. There are often good outcome-based reasons, alongside cost savings, for schemes based on this rationale, but it has resulted in vast amounts of work moving out into the community and is coupled with a system pressure to

avoid hospital admissions. The default provider of medical cover in such situations is primary care.

h) Reduction in job satisfaction. It is self-evident that dealing with 40-50 patients per day results in less time to spend with each patient. This, in turn, means it is very difficult to provide a high quality, caring service. The result is not only a poorer service, but one in which practitioners derive less job satisfaction.

i) Recruiting and retaining new GPs is a significant challenge. In several places across Suffolk it is commonplace for adverts for GP partnerships to lapse without a single applicant. Recruiting other clinical staff is also a challenge for Suffolk – the PCN programme provides funding for significant numbers of (non-GP) additional staff, but recruiting primary care trained clinicians remains difficult such that a proportion of this national budget looks to remain unspent.

j) Monitoring of prescription medications has become a significant workload burden. An average practice of 10,000 patients will be responsible for the safe monitoring & prescribing of over 20,000 prescription items every month. Mixed amongst the routine medications are high risk drugs such as immunosuppressives (devolved from hospitals over the past decade to create capacity) and high dose antidepressants requiring monitoring.

4. Solutions are available to mitigate the above, these include:

a) Open access clinics for presentations where primary care adds little. For example, it is widely recognised that primary care adds nothing (other than a referral form!) to the management of patients with symptoms such as breast lumps, blood in stool, etc. Encompassed within this is a recognition that primary care has become a speciality in its own right and the traditional 'gatekeeper' role is becoming less appropriate.

b) Digital/AI technologies – particularly in the management of skin lesions and some longer-term conditions. This technology is very much still in its infancy.

c) A mechanism by which healthcare revenue follows workload. The current system having to fund large fixed costs (hospitals, large trusts) leaves commissioners little scope for flexibility and by extension, primary and community services relatively underinvested.

d) A mechanism by which the liabilities of individual practices/partners are underwritten.

e) Making Suffolk a GP friendly county by recognising, at every level of the system, that alternative routes exist for the majority of requests for information and help.

f) Self-care including self-referral to physios, podiatrists, mental health is prioritised. Where delays in accessing this self-care exist it should not fall to primary care to be the default provider.

g) Devolution of work to other providers & encouraging such providers to provide a comprehensive service rather than liaison/advice or ad hoc input.

h) Reduction in referral barriers and bureaucracy.

i) Redefining clinical responsibility for patients by pathology rather than location.

j) Re-emphasising and valuing continuity and quality of care rather than quantity. This has system benefits in addition to those derived by the primary care practitioner. A 0.25% rise in referral rates across the board in Suffolk would equate, in a month, to doubling the entire ESNEFT waiting list.

k) Widening the scope of local training hubs (such as the Integrated Care Academy) to improve the supply of clinicians with a local attachment. Where this is not possible collaborative or subsidiary training arrangements (such as the graduate medical training programme run at West Suffolk Hospital in conjunction with University of Cambridge) should be encouraged.

l) Providing tangible support is needed, at a system level, to alleviate some of the risk from partnerships and rebalance the risk:benefit ratio.

m) Acknowledging that instant access to your GP is not necessarily a good thing in all instances. A reducing proportion of patient contacts seen each day in practices are for self-limiting conditions which do not require GP input. This applies to a wide range of conditions including mild mental health and muscular skeletal issues.

n) Streamlining access to Section 106 monies. The proportion of s106 that eventually reaches frontline practices is far too low and represents a missed opportunity.

o) Where other providers are struggling with service delivery pressures an explicit acknowledgement of ownership rather than 'transformation by devolution (to primary care)'.

p) Valuing our GPs and in particular dispelling the myth, in multiple forums, that system pressures ('I can't get an appointment') is as a direct result of GPs not working hard enough and that the solution lies in primary care working harder. The fact that primary care in Suffolk provides sufficient appointments, catering for complex medical needs, for around 40% of the entire population each month on a budget, at an individual level, less than that of most veterinary insurance premiums should be more widely known.

q) Making some attempt at a public health and system level to model demand on primary care across Suffolk in a 5 and 10 year timeframe.

Recruiting and training new GPs

5. One outcome of the pandemic is a substantial increase in the number of university applicants for medical school. The issue is having sufficient student placements.

6. This is a key priority for the Primary Care School and Training Hub. We have received substantial funding to increase the number of placements for GPs and all clinical roles.

7. The process to become a training practice is being reviewed and a new system comes into place in September 2021.

8. This work will be devolved to Training Hubs which will give us a stronger link with our Practices and PCNs - the Primary Care School have developed a system that will allow all practices within a PCN to be quality assessed as a learning environment once rather than separately. This will reduce paperwork and encourage practices to work collaboratively to support students.

9. Training will form part of the CQC audit.

10. The majority of current GP trainees are International Medical Graduates (IMGs) (they achieved their primary medical qualification outside the UK). Last year 90% of trainees in Suffolk and North East Essex (SNEE) were IMGs

11. The Primary Care School know they have the greatest challenges to graduating as a GP and staying in the area.

12. Last year a pilot project “Transition into GP” developed a bespoke programme to support these trainees. This is currently in year 2 so it will be next year before we see the outcome.

13. Materials/training developed being used across year 2 and year 3 trainees.

14. Primary Care School have also appointed additional TPDs to support all trainees to address differential attainment issues and ensure everyone achieves in a timely manner.

15. Key issue for SNEE is the problem of trainees not achieving at the end of year 3. This creates pressure on training placements and delays trainees moving into the workforce.

16. Incentives to encourage GPs to become trainers/educators:

Newly appointed GPs

a) New to Practice programme offers a two year funded programme to support GPS into their first post - consists of further academic training, mentoring;

b) Networking offered through “First Five” groups;

c) Portfolio GPs to reduce workload most GPs only work 2-3 days clinically;

d) Increase in GP fellowships in either clinical, educational or leaderships roles.

Retaining GPs

a) New to Partnership offer;

b) Mid-career fellowships;

c) Portfolio careers increased opportunities for GPs regionally and at system level with NHS England/Improvement (NHSEI), HEEoE (Health Education East of England) Training Hub and Integrated Care System (ICS);

d) Welcome Back to Work programme to support GPs with health issues who may leave or want to return;

e) Flexible working contracts;

f) GP Support Hub local initiative to support GPs through the mirage of different national, regional and local offers;

g) Review taking place of GPs who supported Covid work to explore options to keep them in the workforce;

h) It is important to remember that one of the keys to retaining GPs is for the role to be manageable.

Data

a) Better data collection to enable us to have a more accurate picture of our GP workforce as many now work as locums or on schemes such as GP+.

Wider workforce

a) Increasing the workforce to ensure patients are seen by the most appropriate clinician;

b) Training Hub is increasing clinical placements to support the growth of the whole workforce and ensure other areas do not suffer if we recruit into General Practice;

c) Provide support for existing staff and training to ensure they can deliver new procedures and look after patients with Long COVID, mental health issues etc;

d) Network existing clinicians to provide mentorship and peer to peer support;

e) Make General Practice the preferred place to work for all staff and use it to offer work experience for all age groups.

To what extent are COVID-19 restrictions continuing to have an impact on the availability of GP services?

17. The need to adhere to the NHSE GP Standard Operating Procedure (SOP) and infection control guidance restricts free movement in practices, but this in turn has meant that no practices have closed due to a covid outbreak.

18. Compliance with the SOP and infection control processes have also taken up additional staff time, which could have otherwise been used to treat patients.

19. The SOP also requires all patients to be triaged, prior to being seen, which is sometimes construed as patients not being able to see their GP.

To what extent do internal processes within the wider health and care system impact upon practice workload?

20. Whenever a wider partner organisation is under pressure the net result will be additional pressure to the GP practice eg if an ambulance refuses to convey – the GP is called - if a patient is on a long waiting list the GP is called to expedite them, if a patient is planning to have an operation out of area – their local GP is called to perform the “pre-op”. The recent blood tube shortage resulted in GPs having to call patients to cancel clinics.

    <u>Making referrals to other health and care providers.</u>

21. Some referral processes appear to be more involved that they need to be. DXS (the referral template software used in Suffolk) currently holds more than 100 different referral forms. Many of these forms extend to more than 1 page and contain some mandatory fields.

22. Some of this workload could be reduced by simplifying the process of requesting assistance in the first instance (using tasks to providers that indicate the patient has been reviewed in primary care & would benefit from their input – further details on the shared record; the same system (in reverse) operates for GP+, podiatry and some community services), simplifying/mail merging referral forms to a maximum of 1 page and having shared IT records (necessitating common IT systems) across providers. To this end, the recent news that Turning Points are to use SystmOne has been celebrated by both TP & primary care.

23. Of particular concern to primary care staff is the time consumed whilst waiting to discuss a case with the CRISIS team (NSFT), admit a patient to EAU (hospitals) and the downgrading/lengthy of acutely unwell patients in practices/with primary care staff by Ambulance services (EEAST).

Health and care providers holding waiting lists

24. This is increasing significantly. Where this does occur, the default position is that primary care should manage the patient until they are seen – the system continues to define patients by their location (community = primary care, hospital = secondary care) rather than their pathology or need.

25. The impact of this could be reduced by altering the above culture & increasing capacity in those organisations who are holding significant waiting lists. Whilst the latter is difficult, an interim solution, whereby organisations holding waiting lists are able to field patient queries and allow a 2-way dialogue around worsening symptoms would create capacity in primary care. A good example of this is the way in which West Suffolk Hospital Foundation Trust (WSHFT) are seeking to pro-actively manage orthopaedic waiting lists using Allied Health Professionals (AHP) physios.

26. A single point of contact for waiting list information would also greatly assist alongside disseminating the idea that your GP cannot upgrade you on the list unless there has been a (preferably objective) change in your clinical circumstances and that, as above, the first port of call in these circumstances should be the organisation holding the list.

Receiving information from health and care providers following an episode of care

27. There can be a delay in receiving this information. This can be a particular issue in regard to updating a patient's medication list following an outpatient encounter.

28. The impact of this could be reduced by enabling hospital teams to update a patient's GP clinical record directly, possibly adopting a common IT system and as previously noted, to facilitate the wider use EPS (with paper prescriptions as an interim measure).

Requests for primary care to undertake specific tasks by other health and care providers

29. Some providers are requesting primary care to undertake tasks such as blood tests when it is their role to do this. The drivers behind this are multiple and include:

    a) Understaffing/lack of senior medical cover in a particular service - in the case of CAMHS and Suffolk Eating Disorder Services, who frequently request primary care perform regular physical examinations, bloods and an ECG, this arises out of an apparent inability to access appropriate senior medical input. In a similar vein the Community Heart Failure team in West Suffolk are not set up to monitor renal function or to prescribe diuretics (both core functions in the management of such patients).

    b) Clinical governance is set up in such a way that the requestor of a test is, by default, the person responsible for reviewing and actioning the results. There is, therefore, an inherent driver to avoid becoming the initiator of tests particularly where there are not robust systems in place to deal with results received.

c) The very necessary need to avoid duplication in pathology testing.

d) Specific regulations – the local implications of IRMER regulations, for example, prohibits some physios from ordering X-Rays (in contrast to the pathway design which seeks to divert such patients away from GPs).

e) Inability to prescribe – podiatrists, community outreach teams including palliative care & midwives all often seek prescriptions for interventions recommended by their service via primary care. The widespread use of PGDs (Patient Group Directions) and independent prescribing qualifications would solve this issue.

f) Whilst the single solution for the cumulative effect of the above factors is not available there is an urgent need to recognise that a properly commissioned service ought to include the ability to (a) initiate & act on its own investigations & (b) prescribe and monitor an intervention without recourse to primary care. The new Gender Identity Service, with its inherent inability to prescribe or monitor hormonal manipulation therapy, is only one such example.

Accessing professionals from other health and care providers

30. Providing care necessitates working with professionals from other health and care providers but getting hold of them can be challenging (see previous examples around CRISIS mental health services and Ambulance services).

Internal NHS requests for information

31. Primary care receives a large number of requests for data, often at short notice. This has been particularly marked during the COVID vaccination campaign when multiple requests for data were made on an almost daily basis.

32. The impact of this could be reduced by filtering such requests via a single responsible officer who would collate and review such requests. Outside of COVID vaccinations the current regulations require practices to record multiple different types of appointments including that which would have previously been considered administrative time. This creates an addition burden which is often borne by clinical staff.

33. Central data extractions which do not require practice level input and where the information governance model is robust (noting GPs personal liability in this regard) can assist in this regard.

What can be done to improve patient experience in relation to telephone and digital (on-line) access?

34. A National campaign around when to use which services needs to be initiated before winter 2021 to try to reset patient expectations and ensure scarce resources are deployed effectively.

35. Many patients have found this approach more convenient and preferred it to a face to face appointment. One aspect of utilising this approach that can be improved in some practices is to provide a better indication of when they are likely to be phoned back by surgery staff. In addition, best practice in website layout to help patients navigate some of these approaches needs to be developed and rolled out across all practices.

36. Access to practice staff via phone and digital means is helpful but is not the rate limiting factor in provision of primary care - clinical capacity remains key.

To what extent are system partners, (eg Integrated Neighbourhood Teams and pharmacies) alleviating the pressures on general practice? Is this consistent across Suffolk?

Integrated Neighbourhood Teams

37. There are eight Integrated Neighbourhood Teams (INTs) in Ipswich and East Suffolk. The team comprises community health and social care staff who work with primary medical care teams, social prescribing and mental health teams. Core Leadership Teams for each INT are now well established in most areas with a GP lead, community and social care team leader, mental health and voluntary sector lead. Each INT has a senior manager as a sponsor to support their development.

38. Each team has created its own local plan. Through weekly meetings during Wave 1 and 2 of Covid and the One Team development programme, relationships and understanding between the teams have progressed significantly and there is a strong sense of mutual aid and common purpose within the leadership teams however there is significant work to do to grow these day to day partnerships across all team members. Co-location of staff and shared or aligned digital systems are or will make a significant difference to the efficiency and effectiveness of integrated team working. The Alliance has made significant commitment to further developing and resourcing Integrated Neighbourhood Teams in support of admission avoidance, care in the community including on discharge.

39. Community and social care teams have experienced many of the same demand and capacity challenges which GP practices have. It is important to convey that INTs are intended as partnerships of equals, all focused on supporting patients and the public which they collectively serve.

40. In summary, there has been positive progress in the development of Integrated Neighbourhood Teams and joint working with GP practices but there is significant further ambition and support required to realise their full potential for patients and staff.

Local Pharmacies

41. NHS England recently introduced a scheme aimed at enabling patients who could be safely seen by a pharmacist rather than their local practice.

42. This scheme is being incrementally rolled out across Suffolk. When a patient contacts their practice, the care navigator using a pre-prepared list of conditions will, if appropriate and safe to do so refer the patient to their local pharmacy. The patient is then seen by at the pharmacy of their choice. If for any reason the pharmacist believes that the patient needs to be seen by someone at their practice, there is a mechanism in place to enable the patient to be referred back. This is currently running at 8%. The pharmacies are paid for providing this service.

What is being done to raise public awareness of the issues being experienced in general practice and to help manage patient expectations?

43. Significant work has been undertaken to improve public awareness of the issues facing general practice. They include;

    a) Social media communications;

b) Press and radio interviews with local GPs and others on these issues;

c) Programme of media releases that deal with these issues;

d) A local health reporter recently spent a day in a busy Ipswich surgery in order that future articles are well informed.

How can we move to a more sustainable model for the future?

a) Value Primary Care;

b) Encourage patients to spread the calls throughout the day;

c) Encourage patients not to 'save it up for Monday;

d) Encourage the improved utilisation of GP+, especially at weekends;

e) Better information to enable patient's expectations to be managed so that patients who need to be seen can be seen quickly and those who want to be seen may have to wait a little longer;

f) Increased utilisation of PCN roles to provide additional capacity.

44. It is widely acknowledged that primary care is struggling at present. Any improvement will need to be achieved in the face of escalating demand.

45. The challenge is perhaps best illustrated by data derived as part of the Future Systems Program (a delivery team designed to deliver a replacement hospital in West Suffolk). Modelling done from this work shows that in order to accommodate growth in demand over the next 10 years the new hospital would need to be almost three times the size of the existing building (from 45,000 sqm to 111,000 square metres). Such a hospital would not be affordable and, as a result, the pressures are likely to pass into the community.

46. It is important to acknowledge that the magnitude of pressures placed upon primary and community care services is likely to be an order of magnitude greater than that produced by the mitigations offered. We therefore need to reframe the discussion around prioritising needs, be explicit about demand management, waiting times, patient/system expectations and, where possible, narrow the scope of general practice.