Southwark Council's Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee review into Access to Health Services in Southwark. – Southwark LMC's evidence

Southwark LMC welcomes the opportunity to contribute to the review into Access to Health Services in Southwark which is being undertaken by Southwark Council's Health, Adult Social Care, Communities and Citizenship Scrutiny Subcommittee. The LMC considers this is timely as it will help to highlight the issues which practices are currently facing including capacity and lack of resources which affects their ability to offer access to patients

The LMC would like to submit the following as evidence.

1. What service pressures are local GPs facing?

The pressures which Southwark GPs are feeling are identical to those experienced across the whole of London as demonstrated in the results of a GP Workload Survey which Londonwide LMCs conducted in August 2013. 666 GPs across London took part in the survey and 26 of those were Southwark GPs. 85% of the GPs from Southwark who responded to the survey believed that their workload is unsustainable and that increased bureaucracy is taking them away from care of patients, an increasing number of whom have complex and multiple long term conditions that need attention and care.

Examples of the service pressures GPs face are as follows:

Under investment in general practice
The Nuffield Trust's report 'The anatomy of health spending 2011/12' says that PCT spending on GP services has been static since 2005 and has fallen by 0.2% per year since 2007/8. In contrast the report says spending on secondary care has increased by 40% between 2003 and 2011.

Increasing bureaucracy
GPs spend valuable time having to complete paperwork in relation to a number of performance targets which have been set both nationally and locally. There is evidence that many of these targets do not necessarily improve quality or achieve the desired aim. Performance targets militate against the holistic care which GPs strive to achieve and which patients and families value so highly. They have many unintended consequences and can lead to a culture of ticking boxes that detracts from the aim of providing patient centred individualised patient care.

The Department of Health recognises that there is a 35% administrative 'tail' for every consultation. For every hour a GP sees patients there is a further 20 minutes of administration.

In addition to paperwork practices have having to spend a larger amount of administrative work related to the commissioning process. This involves staff having to attend meetings in practices , localities and at Borough level. Although many of these meetings are directly aimed at improving services to patients they do mean that time is spent away from the practice.

Requests for blue badges, housing reports etc
Many valuable appointment slots are taken up by patients attending surgeries in connection with local authority related issues such as blue badge applications and requests for housing reports etc. GPs are not contractually obliged to undertake such work. The LMC is aware of arrangements in other London boroughs for example, where the assessment service for blue badge applications has been contracted out. The LMC considers that this is a reasonable approach as it is an independent means of assessment and has no potential adverse impact on the doctor/patient relationship should the application be unsuccessful. The LMC looks forward to working with the local authority with regard to these issues.

A lot of people who attend surgeries are people on benefits who face reduction or suspension of their benefits. Often the assessments are unfair and inaccurate as evidenced by the fact that many appeals lead to reversal of decisions by ATOS only to face cuts again. We feel that this unfair.

Interface with secondary care
*V*ery often clinical information following outpatient consultations is not sent to GPs in a timely fashion and is often not received by the time that patients visit surgeries after their hospital appointment which can create issues as practices have to chase up the hospitals for information. In addition if a patient does not attend an appointment once GPs have to re-refer them to the hospital which causes huge bureaucratic issues for practices

The impact of this poor communication and the day to day referrals process means that practices can spend 6-15 hours a week chasing up information from secondary care. That is time which could be spent with patients, or more specifically between 36 and 90 patients per week per practice.

Possible reduction in the number of walk in centres
There has been coverage in the media recently regarding reducing the number of walk in centres nationally. It needs to be noted that the closures of walk in centres would have implications for practices in terms of capacity and workload.

Premises constraints
Many general practice premises are not fit for purpose as a result of under investment in general practice. Many GPs would like to expand the services they offer to patients but are unable to do so because of the limitations they face for premises development.

2. How easy is it for patients to access GP surgeries?

Practices have different ways of offering access to patients. Surgeries, in general, offer emergency/on the day appointments, pre bookable appointments and telephone consultations. GPs are aware of pressures on appointments and in some cases may have dialogues with patients via email, or via the repeat prescribing system, or messages relayed by texts. Many GP practices are signed up to admission avoidance schemes in Southwark that improve the care for the relevant patients e.g. Southwark and Lambeth Integrated Care and the Homeward.

Patients can make appointments either in person, on the phone or in some practices via email. Reception staff are trained to be helpful. If they are unable to offer the appointment of the patient's choice, they may go to great lengths to find another suitable appointment

Access to surgeries is affected by the following:

- There has been an increase in the volume and complexity of health and social care needs as more people live longer with long term and often multiple conditions. This means that an increased level of case management is required and consultations can take longer than the set 10 minutes.

- An increase in patient demand. Data quoted by the DH suggests that GP consultation growth averaged 3.9% per year from 2000 to 2008, while GP lists grew on average by only 0.6 per year. The DH attributed this to an ageing population.

- The transient nature of the patient population is a particular issue in London where a list turnover of 30% is not uncommon.

- It is recognised that consultation rates are 40% higher than the average rate in the first few weeks of joining a practice

- Patients whose first language is not English require extra time in consultations – mostly consultation times are doubled.

- The national policy, enforced by the Health and Social Care Act 2012, to move more secondary care work into primary care will mean sicker patients being cared for in the primary care setting which will increase the number of appointments without additional resources.

Most practices in Southwark are now offering extended hours for patients. The LMC also agrees that practices should be encouraged and supported to provide online access of services such as booking advance appointments and repeat prescription requests. There is also a move to have online consultations but there are key clinical governance issues which would need to be addressed at a national level before this could be rolled out.

It is important for the Committee to note that most practices in Southwark are opted in for providing out of hours care. This means that nearly all GPs in Southwark are providing the out of hours care for the registered population of Southwark. This is provided by the organisation known as SELDOC (South East London Doctors' Co-operative). This is unusual in that many GP Practices throughout England do not provide out of hours cover."

3. What could be better done by the Health and Adult Social Care system to reduce service pressures and better direct people to the right services?

The LMC suggests that patient education is needed around when a medical appointment is not needed and when it is inappropriate to attend A&E. Self-management of conditions should be promoted as should the help and advice pharmacists are able to give.

The Choose Well Campaign was good and a similar campaign should be repeated now we are in the winter.

Service pressures in terms of A&E and hospital admissions are intensified when a patient is prematurely discharged from hospital only to be re-admitted within a short period of time. This is what is commonly referred to as a 'failed discharge'. This issue mainly affects the vulnerable and elderly. Failed discharges not only lead to increased burden on A&E and hospital in-patient services but also have a domino effect on General Practice because it is the GP that will work tirelessly to try and prevent a re-admission. This problem can be tackled by ensuring all hospitals have an effective supported discharge team that can essentially act as the interface between primary, secondary and social care ensuring that communication happens smoothly between all parties. Hospital discharge summaries should be made accessible to the GP on the same day the patient is discharged or at least within 24 hours. This will allow the GP an opportunity to ensure measures are in place to prevent re-admission such as arranging a timely post discharge home visit.

Appropriate discharge planning will also allow the GP the opportunity to make better use of services such as the Homeward where appropriate. Additionally, any changes to social packages of care should be firmly in place at the time of discharge the GP should be promptly notified of any problems implementing these changes. Unfortunately over the years the amount of social support at home such as home help and support has evaporated which needs to be addressed.

The most intensive social care package for the most vulnerable does not run through the night and at maximum is four points of contact during the day. The consequence is that the threshold for readmission of these patients is very low.

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