The People's Inquiry: One Year On

Evidence presented by Dr Michelle Drage (Chief Executive, Londonwide LMCs – Local Medical Committees)
Thursday 11 December
Queen Elizabeth II Conference Centre, Broad Sanctuary, London SW1P 3EE, Shelley Room

Present:

Roy Lilley (Chair; RL); Dr Louise Irvine (LI); Naledi Kline (NK); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

RL:
Michelle, you know us all I think. You know why we are here. We are re-visiting our inquiry, it was a year ago. I can't believe we're all a year 'younger'! We'd love to have your views and comments.

MD:
A lot has happened in the last year. I should point out that Londonwide LMCs is an organisation that represents GPs and their practice teams. It's all about how we can support everyone to look after the patients better and get better satisfaction. You know the figures. In terms of general practice, given the unbelievable diversity and challenges and barriers and requests from the organisations we have to deal with, they remain significantly high despite having dropped a bit.

But that provides a number of challenges. The biggest challenge at the moment for GPs and their teams in London is morale. Morale, recruitment, retention, and the absolute frustration of GP teams to do the job that they believe they are trained to do – helping people get better and help prevent illness.

They have seen structural change throughout the NHS which initially had the potential to put GPs in the driving seat, help them commission services better. That to me has always meant, how can you build community services and social services and diagnostic services around practices where people are? How do you make sure that hospitals have managed their budgets. But that doesn't mean to me that we don't need hospitals. It's a very complicated environment that GPs are in.

What GPs want to do, most of them, is provide services. That has pushed some of them into this commissioning role that they can actually make a difference in favour of services around practices. They have been restrained from doing that by the complexities and the financial and management demands in the system. Which means that there has been no investment in the services around practices, or very little bar one or two exceptions.

They should have done much better by now because in London we have had CCGs for 3 years from shadow through to the real thing. At every twist and turn their hands have been tied. On top of that we had a disempowered [NHS England] Local Area Team arrangement in London. So any decent management there once was in strategic development has been diluted down. We've had McKinsey after McKinsey after KPMG after Magical Consultants telling everyone how to do their job better. But they already know how to do their job better. This is just a recipe for talking down General Practice for the fact that we have very few people coming in to vacancies in practices. You used to find 80 doctors applying, 80 trainees applying for one vacancy: now you are likely to get one between two practices.

Very, very few partnerships are offered now. The story goes, young doctors don't want partnerships. Not true. Despite a more feminised work force we also in London have quite an ethnicised work force, where people do want to take on the challenge of having their time in partnerships, but the core national local funding does not actually deliver the ability to employ someone or take someone on, so there is a blight.

Then we have the *Daily Mail* telling everyone how bad General Practice is a lot of the time. We have a recipe for people not coming in, and people leaving. We aren't able to retain anyone because there are no incentives in the system do so.

On the workload front what I would say is that when the system looks at demand management it always looks too far down the line. So it always looks at demand on hospitals, on A&E, as if that is the point where all the activity comes. Sure, it's a point where all the serious action should happen and I think some hospitals have lost their way in that.

But what has happened over time, particularly in this last year, but it has been going on for a long time in London, is that we have increased demand at the front door of General Practice. We've got back flow of backdoor general practice. There are no services to support GPs any more, and A&E and hospitals are full, and turning things around quicker. So you have an absolute pressure cooker going on every day in GPs' surgeries.

You cannot access community nursing services because they don't exist, because no organisation is providing them in a really solid way. Ditto district nurses, social services and mental health. You're very lucky if you can get access to all the investigations you need to keep people away from outpatients because they cater for the secondary care sector.

If I could have a system where I and my colleagues working perhaps in their work specialisations, super-partnerships or even on their own could find and access all of those services in a way that coordinates care for their patients, then that for me would be the best outcome from all this change. Sadly, we seem to be light years away although are now talking it up.

If you have this pressure cooker going on in practices, and you've always got to see the people coming in, you cannot turn people away, it is not possible to turn people away and you've got decreasing contractual remuneration coming in, so the income from your practice is either static or dropped in real terms since about 2007 … again you end up with demotivated staff. And we haven't got any practice nurses coming through either – so when I say GPs I mean nurses as well.

Health Education England have spent the last year reconfiguring themselves three times, and haven't been able to focus again because they are following a kind of strange topsy-turvy idea that if you could get the hospitals sorted everything else will be OK. They are only just beginning to wake up to the fact that we have a welfare crisis in London. So is NHS England.

As a result of this change, we've got to this point where people recognise what's been going on. But we're still stuck. The hope is that in the 5-Year Forward View we do have some leadership coming through which could be powerful, it could recognise the autonomy of practice on the ground and the need for that GP-patient relationship to really drive the system as opposed to be just being a part of is. At least it has thrown in some opportunity and some money.

I think on a larger scale Simon Stevens has finally started in a direction to bring out some points in a 5-year electoral cycle and has pulled down money that we could be starting to spend. That actually is a bit of good news.

I am forever the optimist. But my philosophy is and has always been to see patient at the centre, with GP practices around them and supporting them. But actually the action is to be placed in communities, so connections between all of those community services and diagnostics need to be the first thought about in commissioning budgets not the end point, which is where they are at the moment.

RL:
I'm exhausted! But we do love data. You have given us a lot to think about. Let's unpack some of this. You have given us a view of this, not that it needs corroborating but I mean it's corroborated whenever you look across the landscape. Some of the things we have discussed during the course of the day.

I made a little note here, about the lack of strategic involvement to get some form of planning. We are wrestling with that. It was one of our initial recommendations, now we're wrestling with what that looks like. I would love to try and get to a crisper resolution this time of what that strategic overview might look like, and then we discussed it from the Mayor through to just people getting together and doing their stuff. Do you have a view on what the strategic 'interlocutor' might look like? Don't go down the road of strategic health authorities but what do you think?

MD:
In this city, you have to have an overview. You have to have a framework that is enabling for the communities of local people to determine how much they want to involve themselves and receive from their health services, and what's helpful to them as services. If you are going to have a strategic view it has to reflect both of those parts, so we need the city-wide view. To be fair to Lord Darzi, this time around he has given us a much better perspective.

RL: Well he copied our recommendations.

MD: Of course, that it why it was so good!
But I like people to impress us with their drive and their skills. I like it when they empower local people. By that I mean communities and individuals at every level, to actually get involved and help determine.

RL: Could the LMC take the lead?

MD: We do. In all honesty, that's….

RL: To provide strategic opportunities?

MD: I have a pack here which will give you our resource documents.
But certainly one of the things that we've done is a constant. We've got various incarnations. But the one thing I did for membership is I try and instil the big-picture view so we able to engage with all of those different parties.

RL: That's interesting. Because we hadn't really thought about that.

JL: I was going to ask you one thing because it came over very strongly. We could all sympathise with the fact that a lot of these things just wind up being dumped back into primary care. There is no doubt that pressure of work is a factor, but it does seem striking that so few GPs appear to respond

and point out these flaws in these plans as they are being driven through. We have just had a discussion about North-West London. The GPs are almost entirely silent on the question.

MD:
It's interesting that discussion, because I was a patient in Northwick Park casualty last year just to be a bit anecdotal. I was lying around for 3 hours. So I've got a very strong affinity to what was being said. I'm a patient in just about every hospital in London to be honest. I do see it from both sides. But what I do see, particularly in North-West London – and it's been a long, sustained time – is GPs sleep walking into a kind of life of oblivion or obliviousness. It's because of they are totally cleaned out by heavy handed, non-motivational change. Everything at the end of the day depends on relationships and enthusing people, leading people in a way that makes them feel they want to belong.

PT:
Do you think if they were given a steering wheel from the CCGs who told them 'take it, it's yours'.

MD:
With their hands tied behind their backs.

RL:
I'll come to that in a minute. But Polly is right. The whole raison d'etre of this was to put the docs in the driving seat. I know that it got messed about but we've been really rather surprised to see the lack of GP engagement not only in the big decisions but actually in the day-to-day work of the CCGs. John, you had a figure I think you mentioned what was it, the number of docs in the CCGs?

JL:
Par for the course is just 3-5 GPs on a CCG Governing Body, and very seldom do you get them going back to consult their colleagues in the rest of the CCG over decisions.

MD:
I saw the evidence. It concurs with all of ours. Part of what we've been doing is to build a resilience campaign. Part of the resilience campaign is to ensure GPs wake up and challenge many of the decisions of the CCG, their governing body. But you have to remember, there is the governing body, and there is the body of the kirk. The term venture organisation is a useful term to those that created CCGs.

PT:
What kind of things do you want them to challenge on? What sorts on things?

MD:
Every decision that impacts on their ability to deliver their services. So when you get decisions that come along that say we have to make cuts here there and everywhere I want them challenged, because every time we let them cut here that means work is going to end up at the back door of General Practice and actually we've got enough volume coming through to be able to manage what we've got. So those that are bad, those decisions need to be properly challenged. But many, many of them are hidden.

NK:
The 5-year plan. To me the 5-year plan needs to be in place in 5 years' time if we are ever going to make any significant difference to the health of London's population. What do you think needs to be in place for us to get to something reasonably good because you clearly want get the gold-star approach.

MD: We want it to be good enough.

NK: Yes. So what needs to be in place.

MD:
The first thing we need to do is actually stop looking at organisational structures. We had to start with patient review but we know we've got a growing elderly population but we also through diversity have people in parts of London who in terms of their complexity will have the same complexity when they are 75 as when they are 45 – if you take Tower Hamlets. This kind of fits in with the old Healthcare For London tune, we have to recognise there is no one size fits all. We have to have a total reversal of the commissioning process.

RL:
You've just said something really important. About the fact that people will have three or four co-morbidities at 40 and they will have the same at 70.

MD:
They may not reach 70, because they are ill so young. So you have to have a core of services in each area. You have to have specifications and standards that are generic but are flexible to meet the basic minimum. Just like I think GPs have to have basic minima.

RL:
Let's look at the numbers. I'm constantly berated by Maureen Baker [Chair of RCGP] Rory Butler and numbers of GPs, who say 'OK, we haven't got any GPs, we can report to you and we can put in place training facilities'. It takes too long and we haven't got too long it seems to me. So if we wean out, if we segmented the flow and we said to certain people 'ok you've got a long-term condition, we're sorry you've got diabetes but it's your diabetes, you've got to look after it.'

MD:
I actually don't believe in segmented care. I think it's an industrial tool to allocate resources and in the wrong way. Every single contact that I see in general practice or my colleagues see has a value whether it's high-risk to the system or individual or low-risk is being perceived. If you scratch the surface with anyone coming through to see me I guarantee that within 15 minutes I will pull out three areas that they wouldn't have even thought of, and you wouldn't have thought of that probably connect them to social services, mental health etc. Over 60% of consultations have a mental health component – those are the services we should be investing in and they are not as expensive.

Actually if we start to look at it that way around, you unblock the flows, you don't have to segment the care because you will free up the time. What I meant was 'bureaucratic nonsense'.

If you strip out bureaucracy you could just let doctors get on with the job and reduce the time spent from each ten minute consultation on the system as opposed to the patient in front of them – say from what is now 5 minutes out of the 10 back to 1 minute out of the 10 – and you clear the back-offices so that the managers can sort out the appointment systems and staff ratios rather than ticking boxes to suit the CCGs and tick the area team's boxes. If you take that bottom-up approach you have got play within the system to free up time. Practice systems will change to suit that. The reason practice appointments have been difficult is in many occasions because they have just clogged up.

RL:
Ten minutes per patient. Eight minutes of that might be patient facing and two minutes doing other stuff. But 10 minutes is still 10 minutes. Isn't it the case that there are too many patients and not enough 10 minutes?

MD:
That is part of it. Absolutely I would argue that. But there aren't too many patients there are too many blockages to us being able to deal adequately with patient need. Of course there is high volume. But as you said, how do you make it good enough? Let's do something. And the something could actually be picking off the things that you don't need to do, that don't relate directly to the patient in front of you – and cutting through that, and helping patients flow to the services they need.

Traditional General Practice would say a patient can have as many 10 minutes as you like because they can come back. I think that is now outmoded. I think we want one-stop solutions. We are not able to give them because we don't have that structure, those connections, that integration with community services as opposed to integration vertically with hospitals.

RL:
I went to the Wirral, to look at a GP practice there. They had Relate, the Citizens' Advice Bureau and social services in offices right next to the GPs. People were directed really to them – there was a debt counselling person as well.

MD:
You used to have all that in London. Back in the eighties, nineties. That was all in place and growing. I won't go into the history, we could spend hours doing the history, but I had them in my practice.

SR:
Can I pick up about why don't GPs revolt against the CCGs. Have you got any examples around the country where that's happened? I was very interested to hear this morning about the kind of machismo-driven South-East London CCG that's tendering the contract for children's services at massively below the likely cost of any reasonable service. So why don't those GPs who that's going to fall back on actually deal with it there?

MD:
I will tell you really why. We really care about the people we are dealing with. GPs cannot face the uphill burden and struggle that it takes to actually challenge and revolt. The systems and processes just aren't there. Some of this is habit. Some of this is just brow-beaten.

SR: But are there annual elections to CCGs, if that will make a difference?

MD:
There are. There are periodic elections but I think this is a dead duck. I don't think this route will deliver what is needed.

RL: CCGs are a dead duck?

MD: I personally think they are outdated concepts.

RL: They seem to have run out of enthusiasm. What about the GPs in hospitals? How do you feel about that? Vertical integration?

MD:
Our horizontal integrating might work out. I don't think believe that where you've got successful examples of general practice working collaboratively with a hospital that that shouldn't take place. We've got lots of out-of-hours examples going back to the nineties, where you put GPs in A&E in some form, or work in outpatients as specialist GPs, or whatever that can be a useful way of helping with the workload.

But you have to remember that 90% of the activity takes place in surgeries, it doesn't take place in the hospital setting. If you take GPs out of the practices that are overwhelmed, it doesn't add up. So you might not be able to do that at scale, and in any case why would you need that if you have a system geared right back to the patient, and the patient's needs?

If you have come from a foreign country, a European one or otherwise, you have a totally different understanding of what health services are there to do. It's all of that stuff. It's why we have the Commonwealth Fund saying we are recognised as the most economically and clinically valued service in the world. It's because we have GPs doing General Practice. If you start having GPs doing anything else I don't think it works.

Hospitals in London in particular have no idea what General Practice is about. It starts at medical school entry. It really does. So the whole focus of medical training is 'hospital it best, general practice is a throw-on, and add-on', and you've got to go through this 6 weeks or 2 months and that's basically it. Even when you get to F1 and 2's it still just a chore to have to go to. Your whole culture has been changed so that big and technical is important, the hospitals are very powerful, and nobody wants to work in Cinderella-land, do they?

I think there is a whole anxiety around vertical integration, not just about the services but actually about the culture and attitude. The loss you get if you turned it into a segmented outpatient service. You would lose what I was describing earlier, which is the kind of whole-patient care and the ability to keep people closer to home.

RL:
Can I just take you back because we are in the last closing minutes. Can I take you back to the 'good-enough' argument, which I thought was interesting. Can you just reflect on that again. Because it does have a powerful simplicity really, doesn't it? It's attractive because of that.

MD:
We hear endless things about transformation. There are two ways to transform things. You can do the Gatwick Airport thing and use management techniques and totally transform the way people connect all the links together. You can do it in 6 months because you have real strong leadership and you don't take no nonsense. The alternative is you end up taking forever because you've got to engage with everyone and you've got to make it all connect. By the time you get there, things might have changed or it's got worse.

If you go down that route which is what the NHS does there is always a gap. My view is you start by creating facts on the ground. You start with what you have got and you take a bit of what you would like to deliver. You let that happen first. So clearly from the way I am describing things I very much think that we should start building those networks around practices, around those community services. If you start with something that enables your district nursing to be targeted at patients who are getting older, that's a really big difference. That's good enough for me this year.

By the way, my son is a community mental health worker so I kind of have these connections! If you start by getting some of the best practice into London instead of just ticking a box you actually programme some decent mental health interaction – and keep them around – that's year 2.

So you grow it. It ends up, in 5 years' time, with a better service, and would have been transformed because you have let the professionals and the local people who are managers actually get to that point. For me, that's what good enough means good enough for now, better than it was, moving forward a bit. You haven't got a magic wand, but when more opportunities arise you might be able to move forwards faster.

JL:
Just one other question. I've been looking at a whole range of CCG documents. But the only place that seems to me to have any kind of an approach to developing this care outside of hospitals thing with GPs in the middle seems to be North East London, especially Redbridge, Barking & Dagenham and Havering, where they seem to be operating a different system and they seem to actually put some resources into it. Do you have any feedback on this? Does it come back to your LMC at all?

MD:
We don't have Barking and Dagenham but we do have Redbridge and Waltham Forest and the connections: we have a relationship with Barking and Dagenham. Again, it's early days. As you often find with these things there's a lot of hype and perhaps not as much delivery. The talk might be 'good enough'!

JL:
I wonder if there was some way we could get some information to balance the CCG hype. Because what we don't want to do is end up in a situation where we dismiss everything and we haven't noticed something positive taking place.

RL:
Finally we must close. We are running out of time now. We haven't thought about making the LMCs more robust to provide the strategic overview. I think on balance from what I have heard today I have kind of gone off the idea of giving the Mayor even more power. I've gone off the idea of having a middle-ranking something else. I've gone off the idea of getting people working together to something or other because they are not interested in doing what they are doing now.

I hadn't thought about LMCs. You run an exceptional organisation which is why you are talking to us. But if there was a way of empowering LMCs, to make them the masters of change, it's beautifully flat, they are small organisations but they are plugged in, they know the local geography, know the local players, know who they can trust, who are the ideal people – I don't know why I hadn't thought about it – in some places to be that strategic. They are just big enough but small enough to be in touch. What do you think?

MD:
Well, thank you for the compliments, thank you for the challenge. I think there's something in it. What I would say to you is this. We are as good as the quality of our local medical communities but we're a bit better than that, if you know what I mean.

We are going through a quality programme for our LMCs. The one thing that would really get them excited would be to have strategic involvement that meant something. If I was in a position to be able to lead them down that route as opposed to what happens, where we have the London LMCs, the overarching organisation doing its stuff, but the GPs in the local LMCs doing the local stuff but in

isolation. If we had something that would enable us to achieve what we are trying to achieve here to move a bit further forward it might be very attractive.

RL:
Perhaps NHS England should think about taking out its Local Area Teams? Because you could provide that service.

MD: Certainly, yes.

RL: If it could work in London which is a hugely populated market it could work in simpler places.

MD: Yes.

RL: I think that's the reason I got up this morning!

MD: You've made my day!

RL: Thank you very much. Thank you all.