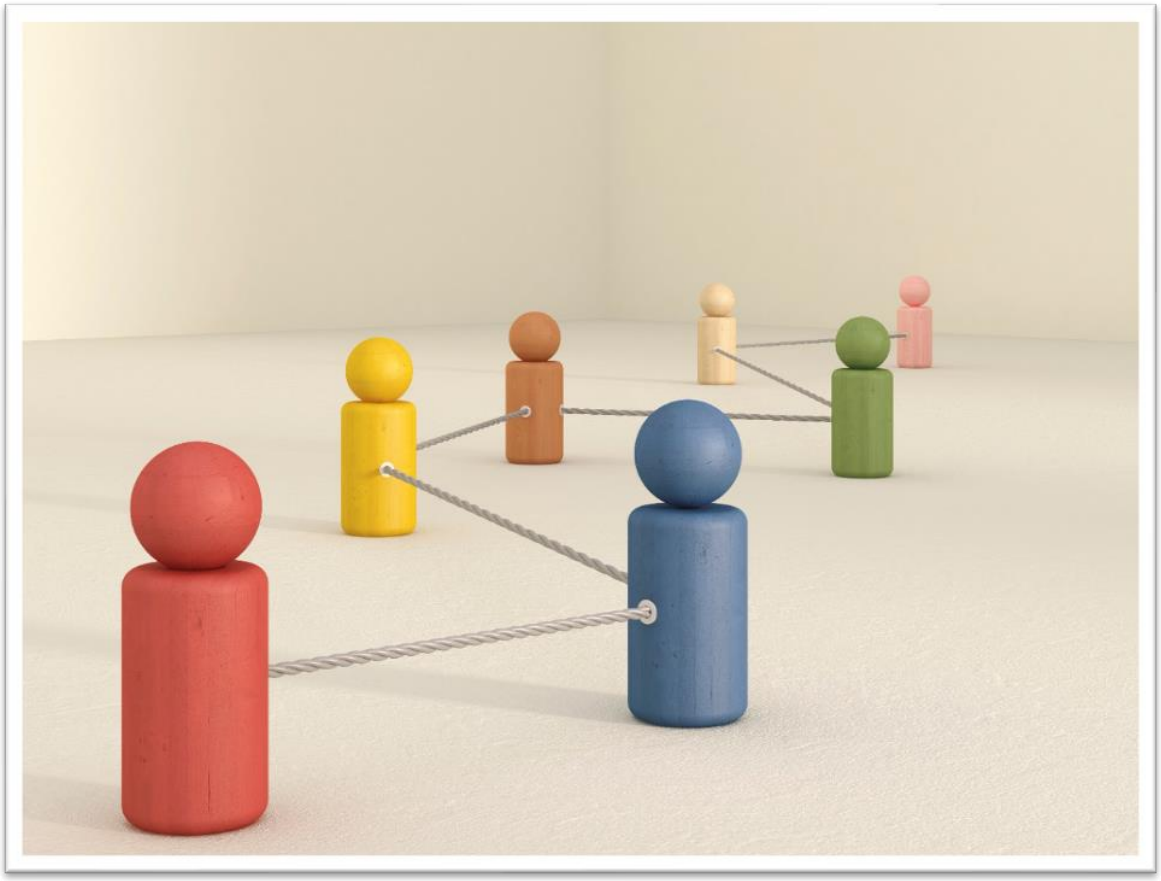
The Big GP Consultation



Summary Report for Session 1:
What is the role of the GP in the Integrated Care System?

Session Date: Wednesday 9th February 2022
No. of Participants: 120

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on behalf of The Big GP Consultation Team

This report represents the views of the participants of the consultation and not the authors themselves

The Big GP Consultation

Introduction

The Big GP Consultation is a platform for GP Trainees and Early Career GPs to collectively discuss their vision for the future of general practice, and how they can shape the future system that they will be working in. This programme consists of six sessions, each on a key theme relating to the future of general practice.

This programme is endorsed by Faculty of Medical Leadership and Management (FMLM). For more detail about the wider programme, please visit our website here.

Session 1 Findings

This report details the findings of **Session 1: What is the role of the GP in Integrated Care Systems (ICSs)?** Both the report, and the infographic, collate insights gathered from a pre-session survey (n=58), a post-session survey (n=39), and the facilitated breakout room discussions, which 120 participants took part in.

The topics covered in the breakout rooms were as follows:

Breakout Room 1: The role of General Practice in the ICS

Breakout Room 2: Future models of General Practice Care

Breakout Room 3: Primary Care Networks (PCNs), and what makes them a success

Breakout Room 4: Additional Roles in General Practice

Key Themes

The key themes of the session are summarised in the infographic below.
A high-quality copy of the infographic is available to download from our website here.

Breakout Room 1: The role of the GP in the ICS

Integrated care has the potential to bring significant benefits, but a number of obstacles must be surmounted before these benefits are realised in practice.

Colleagues were positive about the benefits of moving towards an Integrated Care System (ICS). Multi-sector collaboration gifted by integration could bring significant benefits to primary care through achieving economies of scale. This is a prospect we cannot take for granted and needs further thought and work to ensure success. Integration will lead to new ways of working, such as fostering closer ties to the voluntary, community and social enterprise sector, as well as sharing records, risk, workforce, budgets, and data and analytics across the system.

Colleagues highlighted the importance of bringing the whole of primary care on the "journey" towards ICSs as essential. There was a desire to avoid an "us vs them" scenario developing with other organisations, and being subsumed by bureaucracy. A potential gap for educating GP Trainees and GPs was identified, on topics such as healthcare administration, leadership and management. This education is essential to ensure the next generation of GPs are not entering a new landscape on the back foot.

There was widespread concern that general practice would not be sufficiently represented in ICS leadership and decision-making forums. There were questions about whether there would be a mandatory GP representative on the board, and even if this was the case, whether the size and scale of the ICS would mean that the GP representative would be able to accurately understand and represent the views of the whole area. Proposed solutions included (a) mandating adequate GP representation on Integrated Care Boards (i.e., more than one and not in a tokenistic fashion), and (b) ensuring everyone, at all levels, understands the importance of general practice as the bedrock of population health and wellbeing. This this will be crucial for influencing budget and workforce allocations.

There were some concerns about how an ICS would function in practice, and that significant resource, time and funding will be required in order to be effective. Colleagues were worried that GPs would struggle to be released for ICS management. Protected time to provide this clinical leadership and management would make the ICS more successful.

Breaking down barriers between primary and secondary care is essential to result in more pathway continuity, and a more co-ordinated approach to tackling local health inequalities and improving social care. However, there was concern that further integration could mean that with current pressures and waiting lists in secondary care, primary care will be increasingly asked to reduce referrals and manage the downstream consequences of these pressures.

Breakout Room 2: Future Models of General Practice

The future model of general practice care should be sustainable, should respect the autonomy of those working within it, and should allows GPs to focus on what they do best.

Colleagues explained that the current model of general practice needed transformational change to ensure sustainability and to instil an improved work-life balance. It was felt that the autonomy of the profession, in particular being able to organise care based on the local populations needs, was a key positive attribute of the current model. Participants felt this would be eroded by working at scale or in a nationalised system.

Colleagues highlighted the need to capitalise on the momentum for change, stimulated by the pandemic. They supported the future ongoing use of remote consultations both for convenience for patients, but also for efficiency while managing the increasing demands on GPs. To manage these increased demands, participants felt that an ICS-wide resilience alert system should be developed. If a practice is short of appointments, the system should trigger an ICS-wide response to assist with the pressure. Currently general practice receives emails from hospitals when they reach maximum capacity, but there is no communication when general practice is at, or has surpassed, maximum capacity.

It was mentioned that continuity is the best way of achieving efficiency and sustainability in general practice. We are moving towards expert generalists, with a focus on long term condition management and preventative medicine. Primary care does have a role in urgent care as it falls within the remit of our gatekeeper role. There was mention of task shifting to other allied healthcare professionals such as physiotherapists, social prescribers etc. which can lead to unintended consequences where GPs are left with only the complex, multi-comorbidity, frail patients. This affects the nature of their work and subsequently impacts upon GP wellbeing and how they perceive their jobs. Dealing with complexity in 10-minute appointments is difficult and unsafe.

Colleagues felt that the current model of general practice was unsustainable without an uplift in funding and, more importantly, a significant increase in the GP workforce. There were concerns that without addressing the significant GP workforce constraints, the current model would eventually fail and be replaced by one not of our choosing, but rather one of necessity, led by private, at scale companies. Attendees felt this would be detrimental to the delivery of patient care and would compound the issues of general practice becoming an unpopular generalist specialty.

Breakout Room 3: PCNs, and what makes them a success

PCNs present an opportunity to improve patient care, but dedicated time to both lead, and to learn to lead, within them is vital.

Colleagues felt that the size of the PCN footprint allows them to deliver services designed to meet the needs of their community through taking a population health approach. Their size also facilitates economies of scale (such as sharing workforce, knowledge, and backroom functions), without them being too far removed from their patients and communities. That said, though it may be more efficient to provide services such as vaccination clinics and out of hours services at a PCN level, this does risk making care more inaccessible, as the care will likely be delivered further from the patient's home.

Colleagues felt the benefits of PCNs are predicated on having a motivated, collaborative team, operating under effective leadership. This leadership is required to both develop a common vision, as well as to make decisions regarding the services delivered and the workforce recruited. An effective PCN leader has a good knowledge of their community. Colleagues felt that this leadership does not necessarily need to be from a GP.

Colleagues recognised that there will likely be a significant amount of variation between PCNs. Factors beyond a PCN's control (such as their location), may hamper recruitment and drive variation. Both the skills of the workforce and their appetite to collaborate will also vary between PCNs. The fact that patient populations will vary in the diversity of their characteristics will further increase variability between PCNs. Though some variation may be a positive, this ought to be balanced with the need to avoid a "postcode lottery" of patient access, experience and outcomes.

Moving forward, colleagues identified key themes through which PCN effectiveness can be improved, including:

- Dedicated time and space to share best practice and learn from other PCNs;
- Ensuring that trainees receive dedicated training on primary care structures and how to lead effectively within them. Fellowships can support this;
- Support to innovate and adapt services to meet the needs of their population.

Breakout Room 4: Additional Roles in Primary Care

Improved understanding of both the skill sets that Additional Roles bring, as well as how to most effectively supervise their practice, will bring additional benefit to patients.

Colleagues felt that Additional Roles in primary care are a much-needed addition, particularly in the current climate of workforce shortages. This is particularly true for the "expert" roles who can offer expertise beyond what a GP may be able to offer; social prescribers in supporting the patient's more holistic needs, for example. That said, steps can be taken to ensure that these roles are deployed as effectively as possible.

Supervision was identified as a key challenge. Colleagues felt they are not adequately trained to provide this supervision, nor are there recognised supervision models that they could implement. Not only does this increase anxiety around risk management, but it also creates additional workload – some GPs feel it necessary to re-review patients after they have seen another member of the MDT. Additional guidance on supervision requirements, as well as training on how to supervise effectively, would help to alleviate this issue, and free up time for GPs to see more patients. A defined baseline level of knowledge and skills for each role may support further.

Colleagues felt the need for greater familiarity with the skills and expertise that these roles offer. This would help all staff to ensure that the patient sees the right person, at the right time. Multi-professional teaching, which includes both GPs and Additional Roles taking part in the same educational sessions, would support this. This could be implemented as early as medical school

One issue that colleagues felt needed more recognition was the risk that the introduction Additional Roles may lead to skill loss in the GP workforce, particularly in both MSK presentations and in long term condition management. This often leaves GPs managing the more complex cases, for which they may not feel adequately prepared. Those responsible for education should be conscious of both the risk of losing skills, and the need to manage complexity, when refining their programmes.

High Impact Actions

This session has identified the following actions as those that would have high impact upon achieving this positive, co-produced future for general practice:

- General practice must be **sufficiently represented** at all levels of ICS decision making architecture.
- GPs and GP Trainees should be **sufficiently educated** about the systems in which they operate, in order to lead most effectively within them.
- GPs should receive adequate **training in the leadership and management** skills required to be a clinical leader within the system. Any time spent either developing these skills, or leading clinically, should be protected time that is adequately reimbursed.
- Dedicated time and space should be created to facilitate the **sharing of learning** between PCNs.
- Work should continue, as a priority, to significantly **increase the number of full-time equivalent GPs** practicing within general practice.
- ICSs should develop **resilience plans** which detail how the wider system will respond in support of general practice when demand outstrips what practices can safely deliver.
- Guidance on how to effectively **supervise Additional Roles** should be developed, which should include example supervision models. Specific training should be developed for those clinicians who are expected to supervise Additional Roles in practice.
- **Multiprofessional teaching**, which includes GPs participating in training alongside Additional Roles, would lead to greater familiarity with the expertise that colleagues possess.
- Greater consideration must be given to the **risk of skill loss** amongst GPs following the introduction of Additional Roles.

Next Steps

The Big GP Consultation Team now aims to work with key stakeholders who have a responsibility for each of the areas on the previous page, in order to explore how these actions may be implemented.

The session outlined in this report is the first of a series of six sessions, which are listed below. The Big GP Consultation Team will collate the insights shared in these future sessions and will continue to share them in the form of infographics and reports.

Session 3: How do we most effectively recruit and retain our workforce?
…with guest **Dame Professor Helen Stokes-Lampard**
15th March 2022, 7.30pm

Session 4: GPs in The Big Picture Part I (Health inequalities, traditionally underserved populations, Equality, Diversity, Inclusion)
…with guest **Dr Bola Owolabi**
20th March 2022, 7.30pm

Session 5: GPs in The Big Picture Part II (Primary/secondary care interface, greener practice, holistic medicine)
…with guest **Professor Martin Marshall**
11th May 2022, 7.30pm

Session 6: Participant led session on Innovation in General Practice
June 2022, guest and date to be confirmed.

Session 2, How do we best prepare the next generation of GPs?, took place on 22nd February 2022. The infographic and report will be circulated as soon as it is available.

More information on future sessions can be found on our website here.

If you are a GP Trainee or early career GP and would like to participate in the remainder of the programme, please do let us know via our website.