COVENTRY LMC AND WARWICKSHIRE LMC'S RESPONSE TO THE FULLER STOCKTAKE.

In May this year The Fuller Stocktake was released outlining plans for integrating care and suggested changes to primary care. All stakeholders in primary care have now had a chance to read, analyse and discuss the report. As we are now moving into the new ICB/ICS structure, Coventry and Warwickshire LMCs (as the statutory representatives of GP practices) wish to put out a formal response to the report and express some of the potential benefits of collaborative working across the wider system, but also highlight some of our concerns about the implications for primary care if the Stocktake suggestions were to be implemented unilaterally.

General Practice is working under great pressure and those pressures are increasing. We have had to deal with many issues causing a 'perfect storm' for us. These include a large rise in patient demand and consulting rates, increasingly fast paced change in IT, recovering from the huge and exhausting effort to care for our patients through the pandemic whilst delivering the majority of the Covid vaccination programme, restructuring our work to collaborate together in our PCNs whilst also supporting, mentoring and training our ARRS colleagues. All this against a background of a falling workforce, increasing fatigue for those that remain, historic underfunding, an increase in 'top down' micromanagement, an increase in work transfer from secondary care as waiting lists increase, a lack of proper GP Estates and room availability as well as an unacceptable and totally unfounded campaign of hostility from certain sections of the Media and the Government.

We do not dispute that changes have to be made and that without thoughtful meaningful and funded change, the risks increase of seriously destabilising General Practice, damage to continuity of care for our patients and even the potential total loss of local patient-centred primary care in England. This would be a loss we would all come to rue and would result in poorer healthcare and higher costs to the system.

There are certainly elements of the Stocktake that are laudable; it does speak of the need for resilience around practices, the need to tackle health inequalities, the need to rebuild trust and working between primary and secondary care, a realisation that PCN Clinical Directors need more support and the need to simplify the different 'pots' of discretionary funding for Programme and Transformation work. LMCs do not stand in opposition to any of these goals, however these are not new or original points to raise. Indeed, LMCs have been raising them and advocating for them long before the Fuller Stocktake came out. We do believe there are definite opportunities to improve some of these situations and to improve patient care and experience through collaborative working. No one part of our system, not primary, secondary or social care can provide solutions on their own. We do need to work together and primary care certainly stands ready to do so. We wish, and intend, to be engaged with the ICS as we are passionate about our patient's care and the need to ensure the stability of their local GP Practices.

However, as responsible partners in the wider NHS we do feel we need to highlight some of the elements in The Fuller Report that give us concern.

The report highlights ‘access’ as a key theme and then makes the ambition of improving access as the need to drive change. We all appreciate the difficulty our patients have accessing a service that is under so much strain and increasingly unable to recruit. Practices continue to strive to maintain safe and appropriate access for our patients and continue to be innovative in doing so. However, access is not the main issue. The main issue is Capacity. The capacity of primary care to manage our current workload as well as managing patients who are on long hospital waiting lists ,who have complex medical needs and are getting more unwell the longer they wait. We do not believe that the Fuller Report understands that you cannot improve access simply by moving around and ‘rebranding’ the current workforce. Although it talks of the capacity issue, it does not offer any meaningful solution to the fundamental problems and issues.

We feel that it fails to adequately address the following key points:

- It mentions the fall in WTE GPs and the problems of recruitment and retention, but offers no meaningful solutions.

- It does not offer understanding of the real reasons so many GPs are reducing their sessions and looking to retire early. That is a huge omission as the reasons are well known - colleagues are having to protect themselves from increasing burnout, exhaustion and distress as well as dealing with a pension issue that will penalise many GPs.

- It does not mention the historic underinvestment in General Practice and wider primary care, nor does it argue for the reversal of this.

- It mentions Estates frequently but does not offer realistic solutions to this. We also have concerns about moving “Integrated Neighbourhood Teams’ into hubs. This risks removing any link between the Practices and the ARRS staff.

- It talks about separating acute, emergency care from routine care. We would strongly argue against this from a number of standpoints. Firstly, healthcare is complex. Our patients present in complex ways, often with multiple problems. It is over simplistic to say these can be easily, or neatly, broken down into urgent/routine pathways. Secondly, GPs chose and trained to be Generalists. It is our skills in listening to our patients, knowing them and their families and social situations, assessing and diagnosing their problems, formulating management plans with them and managing risk that makes GPs invaluable in the NHS. Our patients benefit from seeing us for both routine and acute presentations and the trust and continuity of the Doctor / Patient relationship is founded on this.

- It does not recognise that many GPs, both locally and nationally, have grave concerns about the direction the PCN DES is taking us in. There have been repeated motions passed at LMC Conference and recently at the BMA Annual Representative Meeting, for disengagement with the PCN model. It is true that the majority of Practices chose to remain in the DES this year but there will be a large element of fear of losing funding and the current ARRS staff we have. If you wish Practices to remain engaged with collaborative working then there needs to be flexibility for PCNs to develop without micromanagement and have the scope to employ staff less rigidly.

- It, like so many reports and plans issued in the last 3 years, fails to remember that the PCN ARRS scheme was set up in response to the fact that the extra 5000 GPs promised could not be found. This was funding and help for Practices to try and stabilise them and help fill a large workforce gap. Practices want the extra staff to work with them in Practices for our patients. To co-opt the staff into new wider teams working for 'the system' risks destabilising Practices further and disenchantment with, and disengagement from, the PCN model.

- It talks of better integration for primary care and easier pathways for patients to navigate but does not offer solutions to the many blocks in this, i.e. the inability for parts of the system to refer to other parts without the need to come via General Practice and the increasing ask of Practices to fill out complex and multiple referral forms.

- If implemented in full, and without local insight and wisdom, the Stocktake's suggestions would actually further fragment continuity of care for our patients.

LMCs will continue to advocate strongly for the Practices and colleagues we represent and we will continue to engage at all levels to ensure that Practices are stable and supported, to argue for flexible support for PCNs and to advocate for increased core funding and support to achieve appropriate staffing levels and premises. We will never hold back from critiquing any Healthcare plans that we feel will impact the stability of the Practice model and the high-quality care we strive to deliver to our patients. No plan is ever successful when implemented against the will of the stakeholders and we would argue strongly that as we move into the new ICS structure that the system must be made aware of our real concerns.

Whilst we cannot support the Fuller Stocktake becoming the unquestioned template for change in Coventry and Warwickshire, we feel there are opportunities within it to work together as system partners to look at areas where patient care, service stability and innovation can benefit. We stand ready to engage and feel this is also a time for the new ICS to put actions alongside the rhetoric. We look forward to being part of these discussions.

Best Wishes

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