Sheffield LMC's Response to Our Plan for Improving Access for Patients and Supporting General Practice

On Monday 18 October 2021 Sheffield LMC sent the following email to representatives at Sheffield Clinical Commissioning Group (CCG) and South Yorkshire and Bassetlaw (SY&B) Integrated Care System (ICS):

Dear Colleagues

At a time of well-recognised crisis in general practice and primary care I am writing regarding NHS England's poorly received Our plan for improving access for patients and supporting general practice.

I am concerned by a report that admits it is based on anecdotal evidence in the media (page 3, point 4) and claims it is addressing the GP workforce crisis (page 5, point 6) when data shows falling numbers of GPs and FTEs since 2015. We have adapted to new technology of remote consultations during the pandemic, according to our patients' needs, and have been incentivised to provide more remote and on-line access with a "digital-first NHS". Page 12, point 34 even admits that it is unknown what is the optimal performance of face to face and remote consultations.

Statements such as *"In August 2021 over 15% of practices recorded less than 20% of their GP appointments being held face to face. That is **likely** to be contrary to good clinical practice, **even if it were to reflect the preferences** of their patients"* (page 5, point 8) are unhelpful and contrary to the GP contract of *"… meeting the reasonable needs of the patient… as determined by the contractor".* This is not a statement you or I or any system or Care Quality Commission (CQC) (page 14, point 44) or even the Secretary of State can determine, as it is between the doctor and patient. Trying to influence this core tenet of patient care by demanding systems review and punishing practices offering lower levels of face to face appointments will lead to conflict, disillusionment and, ultimately, even fewer GPs.

I have already been contacted by GPs in higher risk groups due to age, ethnicity and concurrent illness, indicating the rising numbers of COVID cases (even higher than reported due to failure of the Test and Trace reporting), and the demands to have more patients in waiting rooms by reducing social distancing rules.

The updated guidance, however, will not apply to GP premises as we cannot determine if patients reach the criteria recommended by The UK Health Security Agency before they attend - "*This reduction in physical distancing will only apply to clinical areas where patients are asymptomatic, not a contact of a suspected / confirmed case of COVID-19 and have a negative test for SARS-CoV-2 and fully vaccinated."*

Across Sheffield and South Yorkshire and Bassetlaw (SY&B) Integrated Care System (ICS) we have been having meetings and discussions to try and manage the crisis in general practice. Offering money to increase appointment numbers and shaming those that fall into the bottom 20% (there will always be a bottom 20%) will not achieve any improvement for patients or GPs. Developing digital locum banks (page 8, point 17) does not create GPs to work in them. It is well recognised that there are not enough GPs, there are not enough qualified staff to recruit into the Additional Roles Reimbursement Scheme (ARRS) roles, and these roles are not necessarily targeted at the acute problems faced. Trying to make a flagging workforce work even harder and then vilifying some of them will accelerate the loss of experienced staff - my constituents are already telling me this.

Moving to cloud-based telephony does not mean receptionists can answer the phone any quicker or create more urgent appointments. It is creating another highway into a road block of chronic lack of investment into core general practice services, to allow us to make general practice an attractive employment proposition for clinicians and administrative staff alike.

We welcome initiatives that might reduce the bureaucratic burden on practices, and welcome the initiative to review the unnecessary transfer of workload from secondary care. A proposal that we have long felt would reduce burden and increase capacity in general practice. We also welcome the recommendation to redirect Locally Commissioned Service (LCS) capacity, but would have liked to see the same national support through the Quality and Outcomes Framework (QoF).

The fact that the problems are to be addressed at system level, yet consider actions that cannot be implemented contractually, eg *"smaller practices offering unacceptable access may be expected to partner with other practices"* infer that smaller practices are the problem, which is not necessarily true.

We would like to propose an urgent meeting to address how this programme can be developed to genuinely support general practices and our patients across Sheffield and SY&B, rather than destabilise the whole system by forcing a number of our experienced colleagues to retire even earlier.

Kind regards

Alastair Bradley
Chair