Physicians and general practice: in conversation with Helen Stokes-Lampard

Professor Helen Stokes-Lampard (HSL) has been chair of the Royal College of General Practitioners (RCGP) since November 2016. She will conclude her 3-year term this November. She spoke to RCP president **Professor Andrew Goddard** (AG) about her time as chair, the interface between primary and secondary care, and leading a medical college in times of political turmoil.

AG You are coming towards the end of your time as RCGP chair. What are you most proud of?

HSL I'm really proud of some of the wins we got for the profession in the *Long Term Plan*. I'm pleased by the way we've built relationships behind the scenes with NHS England, the government and with other colleges and arms-length bodies. We've also had successes in the devolved nations, moving the agenda forward and building relationships and getting the impact of general practice recognised.

More specifically, I'm proud that we have got indemnity sorted for GPs and their teams. That's always felt like a burning injustice since 1990 when hospitals got their indemnity scheme. It irked me greatly when I was RCGP honorary treasurer, and so when we saw an opportunity to get a definitive fix, I grabbed it quite early on. It's taken the best part of two years to come to fruition, but as of April 2019 we've got that sorted. There have been a few hiccoughs and teething troubles but it's settled in very quickly and well. I suspect that two years from now GPs will forget that it was ever an issue. But that's the nature of what we do.

AG Is there anything that you look at as unfinished business that you'll be passing on to Martin [Marshall, the next RCGP chair]?

HSL Quite a few things, but that's the nature of these jobs. One huge piece of work that I've led has been our vision for the future of general practice. The vision is for the profession, but we have divided the report into the GP, the practice team and the wider landscape quite deliberately, recognising there is a distinction between the profession and the college. But it's always vital that a vision doesn't just sit on a shelf and gather dust. Visions are just pretty words unless they're put into action. To help bring our vision to life we're creating four road maps based on six 'enablers' to put it into practice. I know much of this will be signed off in Martin's era and not mine, and that's frustrating because I'd love to have ownership of it.

We have started thinking about our next consultation, which will be on assisted dying. I would like to get it wrapped up quickly and there is a small possibility of us doing so, but I suspect it will take longer. I've not been afraid of tackling difficult things, and our Council does it very well, but I don't like to hand over difficult things to other people if I don't have to.

AG In our lifetimes we've seen huge changes in healthcare, and the number of people working in the system has vastly increased. A lot of people I speak to say 'it's not as good as the old days', because that's what everyone has always said! When there were fewer of us in my hospital in Derby working as consultants, and fewer local GPs, everyone knew each other. There was much more of a sense of a health community than there is today. The *Long Term Plan* has suggested bringing in integrated care systems, which would hopefully begin to bring those links back. Do you think that's achievable?

HSL The competition that was inherent in the Health and Social Care Act 2012 was probably the big nail in the coffin. As healthcare scaled up and the numbers of those working increased, it inevitably created separation. Everything that has happened since then seems to have amplified that division. Our patients are mystified that we don't know one another, that we don't interact. It was one of the great professional joys earlier in my career to know my local consultant colleagues.

There's an awful lot of misunderstanding between specialties. It's a long time since I did a post-take ward round, and I suspect it's been a while since you sat in a Monday morning surgery. We both think we know about each other's lives, but so much of that is based on our days in medical school. I think we need to make conscious decisions to recognise the problem and do something about it. Offer to do a half-day swap with a colleague. Walk half a day in one another's shoes as one day of brilliant CPD. One of the things I've most enjoyed in this job is getting out and seeing what different GPs are doing around the country, but occasionally I get to see what my secondary care colleagues are doing and that's been a real eye-opener. The loss of the team structure in secondary care is something I'd heard about, but I hadn't felt it until I did that.

In reference to integrated care systems, I think the situation will get worse before it gets better. In the rush to create these new organisation systems the 'micro' level stuff will be lost because everyone will be concentrating on the macro level. There's a rush in general practice to get ourselves into primary care networks, each serving 30–50,000 patients. In some areas, such as the one I work in, that only involves bringing two practices together. But in other places there will be ten practices in a network, so there's a huge amount of learning, network-building and trust-building to be done. But then we should be in a position in which the integrated care system is the macro, and the primary care network is the micro, and then reaching across that divide will be next logical step. It's going to take a lot of work and I think the younger cohort of clinicians are the right people to lead this. They've got a great attitude towards collaboration.

AG I'd like to ask you about the partnership model. From my

perspective outside general practice, it seems that more and more GPs want to do salaried posts, work flexibly, and reclaim a work–life balance. The thought of taking on the business aspects of owning the equity and helping to run the business sounds rather daunting. It feels to me that the partnership model is on the wane. In Wolverhampton, for example, there's a single health employer (Royal Wolverhampton NHS Trust) that looks after both primary and secondary care, and in some ways that helps facilitate integrated care systems. Do some people in general practice see that as a threat?

HSL There's an element of horses for courses. There are some places, such as Wolverhampton, where the partnership model has gone already – these tend to be the areas that are hit by the workforce crisis first. Several years ago in Brighton seven GP surgeries all handed back their contracts in quick succession, forcing the CCG to step in and make quite radical changes, and we've seen similar situations in Wales. When that happens, it costs an awful lot of money to fix it. Once you start putting people on proper contracts – GPs particularly – a normal general practice day turns into three programmed activities, because we do paperwork, visits etc and that makes it quite expensive. You then need more experienced nurses with a high level of competence who can function autonomously. These factors mean that the partnership model is actually the most efficient way of delivering care. That realisation dawned on senior policymakers a few years ago and we've seen a real shift in attitude from government and from NHS England towards the partnership model and a real desire to reinvigorate it.

There was a review of the partnership model undertaken last year by Nigel Watson from Wessex, looking at what it would take to bolster, boost and enhance partnership and make it more attractive to people. We never had a formal response from the Department of Health to that report's recommendations, which were not radical, but very sensible, balanced and pragmatic. We're entering into a new era of politics and there may be an opportunity to reinvigorate the partnership model. Younger GPs tell me that although they're not attracted to partnership *right now* because it's stressful and not financially rewarding, they see the attractions of having more control and autonomy in future. They tell me 'not yet'; they don't tell me 'not ever'.

Part of this comes back to our very short training in general practice. While the exams ensure young GPs are competent, they don't feel confident to do much beyond the biological medicine element of general practice, which is the relatively easy bit. It's the social and psychological elements of providing good general practice care that add complexity. Added to that, of course, handling risk and uncertainty in a constructive way that's not over-medicalising or overdiagnosing our patients. In a world where patients are flooded with information, it takes a lot of confidence to do it well. It's right they want to concentrate on becoming the best GPs they can be, and then look to becoming the managers, the leaders, the educators of the future. But our systems aren't really set up that way. We want to launch them into partnership from day one and they're saying: not yet.

AG **We live in very interesting times. Boris Johnson has just become prime minister, and Brexit remains the elephant in the room. As medical colleges, we are both membership organisations and charities who represent the profession, but also have a political influence. When it comes to Brexit, the RCP position is that we don't oppose Brexit *per se*, but a 'no deal' Brexit would be a disaster for the health system. What's the RCGP's position and how did you reach it?**

HSL We're the only college to take a strong formal line on this. To begin with, our Council didn't really want to have a discussion about it, but last summer the situation got really heated and members asked us to debate the issue and take a formal position. We did, and our formal position is that we are opposed to leaving the EU, which is quite controversial as some of our members will have voted to leave. Our Council went further, not just opposing Brexit, but also calling for a 'People's Vote'. However, the exact question that vote should ask wasn't specified, and this put me in a difficult position as leader of the organisation in terms of relaying our message to government. As the leader of the organisation, I have to balance representing what our 53,000 members want, and also work with politicians and policymakers, and provide a coherent form of dialogue between the two.

AG **Do you think that it creates new challenges now we have a very clearly Brexiteer prime minister? We live in a very divided country now, and I sense we may be headed for a bit of a car crash.**

HSL I wrote to Boris Johnson on the day he became prime minister to express the RCGP's views about Brexit. This is such a concerning issue, especially the 'no deal' Brexit which has become a political mantra. We already spend vast amounts of time dealing with medicine shortages – the thought of that issue getting even 10% worse would be devastating on the care that we can give. We see more than 1 million people a day in general practice. If even a modest number of those have difficulties getting medicines then it's us that has to fix it.

AG **While the political turmoil rolls on, the NHS continues to struggle. There is a feeling in the RCP that we need to heavily invest in social care and the NHS. Are the RCGP also in favour of a big boost to health and social care spending?**

HSL Absolutely, without hesitation. Ask any GP where the headaches are and they'll tell you about the interface with social care and the interface with secondary care. We want far more boots on the ground to see the patients that come through the door, but the thing we spend our time on, the things that drag us down, is dealing with the interfaces. I recently had a sick patient in surgery, and had a terrible time trying to get him admitted to hospital. I knew that if I got through to a clinician it would have been fine, but I just couldn't get hold of anybody at the secondary care end because they're so busy.

In the meantime my patients were queuing out the door and I desperately wanted to give a coherent and professional handover for this sick patient, but in the end I just had to put them in an ambulance with a referral letter and apologise. I experience similar issues trying to get patients more help from social care, and sending letters seemingly into the ether because you can't speak to anybody. Once you get a human interaction so many things can get sorted swiftly and effectively. Once you put it in a written communication, something is lost in terms of the emphasis and the passion.

AG **Systems seem to be driving us towards technology and email and away from telephone contact. From our side as physicians, we see a huge range of written communication from primary care, and it may be a reflection of how much time people have. Sometimes you get a two lines, and some are really helpful and give you a good idea of the pathway.**

HSL I recently had a really interesting conversation with people from NHS Digital and NHSX about this issue. Their argument is that they can create the tools and the forms and the auto-populated things – whatever we want. But we as clinicians have to take responsibility for inputting the right information. This comes back to walking in one another's shoes. Sometimes secondary care clinicians get letters from GPs that say something like 'do the needful'. That's not helpful by any stretch of the imagination. Similarly, I get discharge letters full of acronyms that I don't understand, and that's a waste of time and inefficient. Yet most of the time the communication is good. The problem, and what takes the time, is the small number of examples when it's bad.

AG Do you think the solution would be a single electronic health record, available everywhere, that everybody uses?

HSL The problem with having one big system is that it would be enormous and we don't need all the information all of the time. The ideal solution would be a system where all the data are held centrally and we can draw down the bits we need. If I see a patient with renal failure I don't want every set of U&Es they've ever had – just the last two or three. Ideally, ten years from now, I would like to fire up the system when a patient walks through the door and be able to see their serious diagnoses and allergies, which doctor that patient saw last, and the changes that have been made to her medication, which will be automatically updated. When you make a change, the system should automatically send the prescription request through to the patient's local pharmacy, so she can pick it up on the way home, saving work for the hospital pharmacy and the GP. All these things are possible but we need to pull together, because our current systems don't talk to each other. Until we get the interoperability and minimum standards that we all sign up to, we won't get there. In the interim, what I think everyone is working to is a new set of standards that might mean some of us go backwards before we can go forwards again, but the long-term goal would be absolutely worth it.

AG Talking of looking to the future, both the RCP and RCGP's members are likely to see increasing numbers of patients who have had genomic testing, either done by the NHS or by some private company. How big a threat is this to you?

HSL It's not an existential threat because it's a real threat already. Two years ago my first patient walked through my door and told me she was going to have her whole genome sequenced, and then asked if I would interpret her results. I told her, as her trusted, long-serving GP, that there was nobody on the planet who could interpret her entire genome, and she should save the money and go on holiday instead.

She was in her mid-70s. We can both immediately see reasons why having one's genome sequenced isn't a helpful thing for that patient to do. It wasn't looking for a specific condition that somebody in the family had; it was a whole genome sequencing.

What we're seeing more now is people asking about specific testing. We've been very clear that as whole genome sequencing becomes available to the public, there is a massive learning need right across medicine and healthcare as to what this is and the limitations, and the limited benefits we've got at present.

As much as we can protest about the extra and unnecessary workload, the worried well, the impact on health insurance, the unintended consequences, and ethical issues (which is a whole hour's discussion in itself), we also have to push for good education and training for our members, because they're dealing with this already. There's a risk of us being seen as luddite if we don't embrace this and I'm actually quite excited about the increased personalisation of medicine. There are plenty of people shouting about the exciting bits of it, and so I feel a responsibility to call out the challenges. But medicine is always advancing. Genomic medicine isn't advancing at the pace that some would like it to, but that gives us time to train our members. How does it feel from your perspective as a physician?

AG I think people feel that it's going to be quite destabilising. Generally our patient clinics are becoming busier because the people we see are much more complex and have multimorbidities. We're using much more complicated treatments than we once did, and the side effects and risks are much greater. I am worried about health inequalities and the divide that this will create, and what existing issues this will aggravate. The green paper on prevention has just been sneaked out, and it talked a bit about social determinants in health, but didn't really tackle poverty and the difference that makes. I think the health community is starting to see that health inequality is very important for a patient's long-term health prospects. Do you think we can begin to close the gaps or do you think they will continue to widen?

HSL Working in general practice you do see the gritty side of life. We know that so much of health and wellbeing is determined by the social circumstances that you're born into. People seem to think that the NHS will fix all the ills of society, but so much is outside the NHS's control. I feel it's beholden on us as senior leaders to highlight this at the highest levels when we have the appropriate opportunity to do so.

I work in an area of relative affluence but we have pockets of deprivation and the contrasts are very stark. You can't fail to be affected by it, but what can we do about it? I think about the individual clinician, team and system approaches. At the individual

level it's important to be cognisant of it. As a GP you help people holistically, not just with their medical issues. If I see a patient whose challenges are principally social, then I need to be able to identify sources of help for them. I shouldn't sit in my surgery flicking through Google trying to find resources to help my patient with their central heating or their benefits, but if those things are adversely affecting their health I should be able to point them to somebody who can help.

The psychological and mental health and wellbeing challenges are enormous and it's great to see the conversation about parity of esteem has moved on massively, and it was good to see a strong narrative about this in the *Long Term Plan*. In general practice we tend to see more of the mild and moderate mental health problems, and we see them in massive numbers, and how they amplify a patient's physical challenges. I use the metaphor of the three-legged stool: the physical, social and psychological have to be in balance to do general practice care properly. Some people say that's quite idealistic but if you have a GP that knows their patient and the patient trusts their GP, it can be phenomenally constructive and helpful and save a massive amount of footfall through to secondary care.

AG You've called for consultations to last 15 minutes rather than ten. That's a big ask, and would presumably need 50% more workforce. How long do you think it would take to introduce 15-minute consultations, and do you have to wait for the workforce to expand, or do you stop doing other things, because you've only got a certain number of hours in the day?

HSL We can't work any longer than we are; people are already burning out. You don't need 50% more consultations to deliver 15-minute consultations, because although the arithmetic suggests that, you can achieve a lot more within a 15-minute consultation. Many surgeries now have a sign saying: 'Remember your appointment is only 10 minutes. Only discuss one problem with the GP.' That's naive because the reality is that patients don't know which of their problems are interrelated. It's quite common for patients to come in with a list of six or seven discrete problems, because they haven't been able to get an appointment so they've stored them up. So then suddenly in ten minutes we're meant to charge through all this. Whenever I see a list in someone's hand, I ask to see the list. Invariably, a new lump in the breast will be item six or seven, whereas a knee that's been aching for months will be top of the list. I'm not saying I can solve seven problems in 15 minutes, but if I can do four or five things instead of two or three, then I don't need seven appointments. I might be able to get away with three or four appointments.

AG Have any practices modelled changing this?

HSL A lot of practices have already moved to 12-minute appointments. That has been demonstrated to improve satisfaction with both patient and clinician and improve efficiency. Some doctors insist on working 15-minute appointments because they feel that's the only way to stay safe. They feel that it's worth the sacrifice in terms of productivity to be able to be good doctors and avoid burning out.

We need a significant influx of more clinicians, and that's not just GPs but also the wider healthcare team. We also need an education programme for the public, so they understand what other healthcare professionals do: their strengths and their limitations. And we need to be creative in using technology to help us work more efficiently. As we get more automation, and patients populate information into systems to help us, all this incrementally helps. The British cycling team talk about the aggregation of marginal gains, not revolution, and this is the same principle. It's going to take several years to get there and the next step for me is 12-minute consultations as the basic standard.

AG You touched on workforce there. What's your view on physician associates (PAs)?

HSL Physician associates are a welcome addition to the team. We need all the help we can get from confident, competent clinicians working alongside us. But I want to be really clear that when we talk about different professionals we're talking about task substitution and not role substitution. I don't want anybody thinking you can replace an experienced practice nurse with any other kind of nurse. If you need an experienced practice nurse, then that's what you need and we need to train more of them. Others can do tasks that our practice nurses do, but they're not substituting for them.

PAs don't replace GPs, they work alongside them and do some of the tasks that we did, and they do it very well. But we have to be realistic about what they're trained for versus what we're trained for. We are trained to hold risk, to handle complexity and to deal with the full spectrum of conditions. They are trained to be more focused and deal with the acute presentation of illness and to do it very competently, but that is substituting some of the tasks that GPs formerly did, and not replacing GPs. I run an anticoagulation clinic in my surgery, but I am not pretending to be a consultant cardiologist or haematologist, I am a GP who is doing some of the tasks that my secondary care colleagues once did. ■