The future of primary care

Dr Michael Dixon outlines why primary care can – and must – become designers of the new NHS landscape.

By Dr Michael Dixon, chairman, NHS Alliance

We have all had our fill of documents with grand ideas and quick solutions. This is not one of those. There can be no “ultimate solution” but providing a clear vision of what we are trying to achieve set out alongside the values, culture and relationships needed to deliver it could provide the starting point for great things to happen. All the more so if that vision is the production of those people who will be carrying it out – frontline clinicians and their patients. That is what this piece of work aims to be – the amalgamated thoughts of those whose day job is at the frontline of NHS primary care and of those on the receiving end of that care. Frontline commissioners and providers, frontline clinicians and managers, patients and local people with the added spice of academics and those who have been involved in the success and failure of previous health policy have all contributed to produce this vision of what primary care could and should look – and feel – like for those who work in it and those who use it.

Why is this work so urgent – now?

The NHS faces the full blast of three prevailing winds. The first is the wind of necessity. If the NHS remains unchanged at a time of relatively reduced funding, increased demand and higher costs then only one of two things can happen. Either the increasing financial gap will lead to less services, which are less available and of lower quality. Alternatively, the NHS becomes unsustainable as a system of health provision altogether.

Thoughts on potential solution have been written large in several previous NHS Alliance documents and several government white papers. We all accept that we should be investing in care closer to home and creating healthier individuals and communities. Yet in spite of the exhortations and rhetoric none (or hardly any of) this happens. Patients remain over hospitalised, community provision remains insufficient and scant resources are left for improving community health. This has created a huge wind of frustration among primary care commissioners and providers who have been held back by a leadership that has been (historically) non clinical, centralist and dominated by secondary care.

As we write, a third wind of change is now blowing hard and could well unblock a system that has all too often been dominated by complacency, self-interest and organisational suffocation. On 1st April 2013, 211 CCGs and clinical commissioners will become the new kids on the block. They will need to challenge everything including the ground rules set by those of the old order who have been responsible for creating the environment in which CCGs will work. CCGs are likely to forge new relationships between commissioners and providers and encourage new relationships between local providers themselves. They will challenge a system that deemed it logical to pay hospitals by activity but reward primary care on capitation. They will question previous arrangements that set budgets without involving clinicians and local people in helping to prioritise or demand manage them. That same wind of change will loosen the grip of centralism and secondary care domination and begin to allow frontline clinicians and patients to move from being the problem to the solution.

This new order will leave primary care in prime position to determine its own destiny. It is therefore particularly important that primary care should now provide an understanding of where that journey is heading and where it is likely to end.

Defining the new landscape

The new clinical commissioners and their CCGs will now be busy defining that journey and its destination in local terms if they are allowed to do so. Much of the tapestry of this new system has been organised ahead of their arrival and one of their first tasks will be to tear up the rules and restrictions left by the old order that stand in the way of enabling them to enter the new. If nothing, these new clinical commissioners will be innovators and re-designers (that is why most clinicians signed up in the first place) but they will need to be in the driving seat of local development and not at the receiving end of instructions from the NHS’s traditional barons.

Primary care providers will also be designers of this new landscape. More enabled than previously to work with their commissioners in producing plans for redesign and meeting mutual aims as they work with other providers towards service integration.

GPs and their practices will be at the very frontline of this new world of primary care provision. They will need to be empowered to extend their services and they will need to
be empowered to extend their services and they will need to become enthusiastic about their new role in improving population health. With many general practices working collaboratively at local level, they will also need new organisational models and accepted and simple processes for taking on new work.

Community providers, apart from general practice, will need an equally clear idea of where they and primary care are heading. 2011’s “Transforming Community Services” was less about transforming services and more about finding them a parking place. The transformation must now begin. Community services are now provided by a diversity of organisations, including community foundation trusts, acute trusts, mental health trusts, social enterprise organisations, the voluntary sector, private and sometimes as an extension of GP practice services. The last thing that this heterogeneous and chaotic organisational system requires is another “re-disorganisation”. The imperative for the new clinical commissioners and current providers will be to work together to make sense of their current organisation and then focus on redesign, innovation and improving the integration of services. At the same time, they need to allow for challenge and new entrants, where there are gaps in service provision or they are unsatisfactory.

If we can provide answers that appeal to primary care commissioners and providers as well as to frontline clinicians and their patients then we should find it easy to sell this vision to our political masters and thus enable it to happen. Our first document “Restoring the Vision” (1997) has now finally culminated in clinical commissioners being given the green light. Now, 16 years later, the NHS Alliance is embarking on our first major attempt to describe the future of primary care provision. There is an urgency to our task because we cannot afford to wait 16 years or even 16 months for the green light that is needed to transform primary care.

In short, our aim is to create from those three winds of necessity, frustration and change a fourth wind of hope and optimism that will enable general practice, community providers and clinical commissioners to create better health and services for all our patients and all our communities.