THINK BIG, ACT NOW:
Creating a Community of Care
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THINK BIG: ACT NOW

Creating a community of care

A response to 21st century health challenges

NHS Alliance is the leading voice for providers of health and social care outside hospital, bringing together general practice, community pharmacy, community eye care, community services, and providers of housing and emergency services. It helps its members by actively shaping and driving new agendas and policies that affect patient care outside hospital. It aims to drive a new integrated and collaborative model of care and is focused on breaking down the historic boundaries and silos that get in the way of truly progressive and innovative patient care.

The NHS Alliance represents more than 9,000 clinicians and managers working across primary care.
Foreword

It is our belief that immediate action is needed to achieve the paradigm shift in the NHS, and especially in primary care, required to support a growing and ageing population living with long-term conditions. We must start implementing solutions to the challenges, rather than continuously analysing them. Procrastination is no longer an option.

GPs, practice and community nurses, practice managers, community pharmacists, and community eye and hearing specialists in England are under unprecedented pressure to care for a population imposing soaring demand1 on a health service that is financially constrained and struggling to retain a demoralised workforce.

This perfect storm of pressures facing primary care makes it likely that change will come, whether or not it is wanted. **We want to see change by design rather than default:** change led by those working within the service who best understand the issues they, and the communities around them, face.

Despite the severe strain on the system, we believe there is light ahead for the primary care sector. This report presents a new approach, what we are calling A Community of Care. This articulates the findings of six months of research and consultation undertaken by NHS Alliance in collaboration with its strategic and professional partners across the breadth of provision within primary care and offers a patient-focused, inclusive approach.

We believe the solution to creating a stronger, re-energised primary care workforce lies within the workforce itself and within the communities they serve; where general practice sits at the centre of a cohesive primary care team of multi-disciplinary health professionals and community leaders, and works closely with colleagues in the acute sector. We want to see an end to tribalism and the start of a true collaboration that has the potential to make an immediate difference on a system that is considered by many to be near breaking point.

**However, achieving this community of care will rely on a fundamental shift in thinking by all who interact with the health service,** one that moves from regarding the delivery of health care as transactional and process driven to one that relies on relationships.

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1 Estimated by DH to be 4% per annum and more recently by the People’s Enquiry into London’s Health Services as more likely to be between 7% and 8%
Our vision is that this paper will mark a defining moment for general practice and primary care, a moment where we take collective responsibility for the health and wellbeing of our NHS, whether we are policy maker, care provider or care receiver. A moment where we commit to delivering and using the service thoughtfully and respectfully. A moment where we recognise that unless we are prepared to change both our thinking and our actions, we may pay the ultimate price and lose a national health service that has provided us with free care at the point of need for more than 65 years.

**Think Big, Act Now: Creating a Community of Care** articulates our vision to preserve our national health service for future generations, and an outline of practical steps to support it.

Dr Michael Dixon  
Chair  

Rick Stern  
Chief Executive
Executive summary

Think Big, Act Now: Creating A Community Of Care sets out NHS Alliance’s position with regard to the future of general practice and primary care. It aims to provide a starting point for a practical guidance system and orchestrated campaign to champion and re-energise a tired and demoralised primary care workforce, especially within general practice; to help make general practice ‘special’ again; and to encourage the general public to see it as such; and to inspire a new generation of doctors, nurses and other health professionals to be part of a primary care that is a shining beacon for health in our communities.

We make the case for A Community Of Care, a new approach to health care with general practice at scale at its centre and an extended primary care team incorporating community pharmacy, community eye care, housing and emergency services radiating out from it. We also make the case for a fundamental shift in the way in which we all view and access the NHS, and the requirement for dedicated and appropriate funding to support this transformation.

Our report presents the findings of six months of research and consultation undertaken in collaboration with our strategic and professional partners across the breadth of provision within primary care.

We believe a fundamental shift in thinking is required by all who interact with the health service, one that moves from the delivery of health care as transactional and process driven to one that relies on relationships. We describe this as a responsive and responsible service with three underlying principles:

• a responsive and responsible system;
• a responsive and responsible health professional;
• a responsive and responsible patient.
In the report we articulate 10 points to support the delivery of our three principles:

1. **A reduction in the bureaucratic workload that would allow primary care to take on an increasing role in patients’ health and deliver more care out of hospital.** General practice now requires a system that restores professionalism in its best sense rather than one that reduces clinicians to ticking boxes. Core funding should include more of what is currently paid for under Quality Outcome Framework and Direct Enhanced Services contracts with less specification of how this will be delivered.

2. **Recognition that a restructured workforce is needed to deliver change.** Current pressure on primary care may be relieved in the short term by making better use of some of the practitioners already available; such as extending the role of the community pharmacists by increasing their involvement in prescribing, or by practices directly employing primary care pharmacists, which would reduce pressure on GPs.

3. **Access to premises that support the kind of care patients want and need to receive, and primary care practitioners want and need to give, in locations that are accessible and convenient to patients.** Primary care premises have transformed in many areas over the last 10 to 15 years but this process needs to be revitalised following a period of relative standstill. This should be driven by exploring what kind of premises will deliver community-led solutions: for example, primary care provision might be sited in shopping centres or leisure facilities, or could contribute to regeneration on unused land.

4. **Greater co-ordination with community healthcare services and social care.** An essential requirement for general practice at scale will be greater co-ordination with community health services and social care. The interaction between healthcare professionals and their colleagues in social care is vital for patient wellbeing and avoidance of hospital admissions.

5. **Demedicalisation of care, where appropriate, and a recognition that a solely medical approach cannot solve underlying problems such as unemployment, inadequate housing and social isolation.** Health professionals need to be able to offer a ‘social prescription’ as an alternative to medication to patients who present with issues related to their social circumstances.

6. **Embracing use of new technology enhanced care service and wider access to patient records.** Making the most of new technologies such as telehealth, electronic patient records and IT connectivity should be at the heart of general practice at scale and the key to improving access, quality and outcomes within constrained resources.
7. A new role: Community Health Connector. The success of general practice at scale relies on multiple connections across health, social care and local authority sectors. We believe each distinct geographical community of 30,000 to 70,000 patients clustered around practices should have a Community Health Connector to champion improving local health rather than managing disease.

8. Review of core funding

- A significant uplift in funding to primary care – a return to its previous 10 per cent of the NHS budget.
- A financial model for the NHS that encourages co-operation rather than competition between primary and secondary care.
- A contracting and commissioning system that is based around patient benefit and supports the development of general practice at scale when it can bring better outcomes.

9. Transformational funding

- A General Practice Development Fund to kick start the process of transformation. Monies should be ring fenced for a primary care development fund that would be available in all areas and recognise the wider nature of primary care beyond general practice and seek to engage with community pharmacists, and voluntary and third sector organisations.

- A willingness by providers in primary care (GPs, practice nurses, district and community nurses, community pharmacists and eye health specialists) and the general public to consider radical ways of funding extended primary care that enables practices to work together, for instance as co-operatives or integrated care organisations.

10. A proactive focus on self care to help reduce demand and increase patient confidence. Consultation rates within general practice continue to rise, with approximately one million GP consultations every day. Reducing demand on general practice by actively promoting self care and responsible use of NHS services must be key objectives for general practice at scale.
Key facts and stats

Stats

• District nurse numbers have dropped by 40% in the past 15 years.

• Only a quarter of doctors now choose to go into general practice.

• General Practice share of the NHS budget has reduced from 10% to 7.5% between 2005/06 and 2012/13.

• Approximately 80% of all contact with health services in the UK involves primary care, although this is not reflected in the funding allocation.

• NHS net expenditure has increased from £57 billion in 2002/03 to £105 billion in 2012/13. Planned expenditure for 2013/14 is almost £110 billion.

• NHS England directly commissions primary care contracts for dentistry, general practice, pharmacy, audiology and optometry. The total direct commission budget is £20 billion per annum.

• Between 1995 and 2009 the number of appointments in general practice increased by more than 80 million.

• Reflecting the growing number of complex cases, the average appointment time is getting longer.

• By 2031, it is expected there will be 20m people aged over 60. The number of people over 85 will double in the next 20 years.

• The typical over 80 year old will have more than 12 GP consultations a year compared with around four for those aged between 5 and 40.

• Applications for GPs to join training schemes in 2014 fell by 15% compared to last year. The target for 3,250 new GPs a year by 2015 has slipped.

• 35% of GPs are over 55 years of age and half say they are planning to retire.

• The general practice nurse population is disproportionately over 50 years old.

• 99% of the population is registered with a GP.

• Annually, approximately £2 billion and around a fifth of a GPs workload is spent on treating common ailments such as coughs and colds.
• Long term conditions such as heart disease, diabetes or asthma affect over 15 million people – or around one in three of the population. This figure is expected to rise in line with an ageing population and increasing levels of obesity.

• There are approximately one million GP consultations every day, amounting to an average of 340 million per year.

Facts

• Primary care is a term used to describe care provided outside hospitals.

• The most recent Commonwealth Fund report showed that despite tremendous pressure, the NHS is performing relatively well. The NHS was the top performing healthcare system for long term disease planning and overall public satisfaction. It was also one of the lowest in terms of health spend.

• Primary care has an even greater role to play in prevention and dealing with medical conditions before they become serious. Patients who are pulled into the hospital system unnecessarily will be more expensive to treat and could threaten the finances of the NHS.

• As the number of people with one or more long term conditions increases, so too will the time GPs and practice nurses take to manage them.

• There is no clear career route in general practice nursing and routine training placements are unusual.
In sickness and in health: better together

General practice stands at a crossroads. Those working in primary care are hit by rising demands from patients, tightening funding and a workforce crisis. Many feel there is no option but to do more of the same or to run faster to stand still. Others believe the traditional model of care is doomed and patients will be offered an impersonal service, rarely seeing the same doctor or nurse twice.

There is an imperative to raise morale in primary care and our proposals address that imperative. We know that GPs, practice and community nurses, practice managers and colleagues in pharmacy and eye care are frustrated with the gap between the vision of primary care in the future, and the realities they are coping with now.

In this paper we argue that change is inevitable and we need to act now to shape the future of primary care. We believe a return to simple values, combined with a clear vision for the future and the tools to help achieve them now, will help save a national health service, which many argue is very sick indeed.

The majority of patients are managed and supported in the community through primary care services so we need to find better ways to work together at a local and national level, including commissioning and payment systems which encourage co-operation across a community of care.

If NHS services are to remain accessible and available to all, there needs to be a responsive and responsible system, which is based on mutual trust and respect for health professionals and patients.

A responsive and responsible system:

- respects professional ability and professional integrity;
- accepts that mistakes happen but encourages an open ‘look and learn’ culture, so that mistakes are not repeated;
- encourages collaboration between professional colleagues and the wider community; and,
- expects to pay fairly and focus on what matters – the health and wellbeing of patients.
Responsive and responsible health professionals:

• want to provide the best care for their patients;

• know they are accountable for their actions and are responsive to both their patients and their peers; and,

• recognise that a restructured workforce is needed to deliver health and social care and are open to new ways of working which are inclusive of community and voluntary sectors.

Responsive and responsible patients:

• are prepared to educate themselves and their families about health and wellbeing and work in partnership with their various health and social care advisers;

• are open to the idea of a community of individuals providing health and social care and accept they need to take ownership of their own health and wellbeing through supported self-care; and,

• understand that there are limits to NHS funding and that they need to embrace new ways of accessing health services so that NHS services are accessible and available to future generations.

Creating a community of care

We believe the healthiest future for people and the NHS is based on what we are calling communities of care. We believe the solution to creating a stronger, re-energised primary care workforce lies within the workforce itself and within the communities they serve; where general practice sits at the centre of a cohesive primary care team of multi-disciplinary health professionals and community leaders, and works closely with colleagues in the acute sector. We want to see an end to tribalism and the start of a true collaboration that has the potential to make an immediate difference to a system that is considered by many to be near point.

However, achieving this community of care will rely on a fundamental shift in thinking by all who interact with the health service, one that moves from regarding the delivery of health care as transactional and process driven to one that relies on relationships.
We believe the most direct route to a community of care is by reforming general practice. But that doesn’t mean we need to throw out all that we know and love. There is a way ahead, which combines the benefits of continuity of care that general practice can offer so well, with those of practices working together to provide some services over a wider area – what we call general practice at scale.

General practice at scale, a practice federation model which allows practices to work at scale, share resources and to make links across the extended primary care network and into the wider community, as well as hospitals. This, we believe, will offer significant benefits for patients, for those working in primary care and for the NHS as a whole. These potential benefits include:

- addressing unwarranted variation in practice and outcomes;
- giving patients greater access to care and advice through collaborative working and multi-disciplinary primary care teams;
- new roles which better meet patients’ and the NHS’s needs;
- a new relationship between health professionals and the general public that focuses on keeping well and, where appropriate, help people manage long term conditions themselves;
- new opportunities for GPs to specialise in particular clinical areas; and,
- extended care to patients to avoid unnecessary access to secondary care, which may be more cost effective for the NHS and more convenient for the patient.

We have no appetite for widespread reorganisation and any changes are likely to be largely within the existing structures. This does not mean that practices cannot work together or even merge or work within a federation. We don’t believe clinicians and patients want to abandon all aspects of the traditional model of general practice, such as the longitudinal relationship between patient, practitioner and family, which can extend over decades and generations. Continuity of care is particularly important to older patients and those with long term conditions, and has been shown to be cost effective. General practice at scale should allow this continuity of care to be retained and ideally strengthened. There are benefits of size just as there are strengths of the individual practice and named GP model: the aim is to get to a solution which combines the best of both. We should not seek to become larger organisations without first identifying the benefits this would deliver for patients.

Many attempts to build services outside hospital – an essential step if the shift in care is to happen – have general practice and the wider primary healthcare
team at their centre. We welcome that but believe we cannot put more work into general practice without increasing the resources available to it.

Although general practice at scale is our preferred model for delivering a community of care, we recognise that it will not be appropriate in all situations and we actively encourage the development of local solutions. Our research indicates there are three other models which have the potential to enable a community of care.

• A model with a community trust at its heart and linking community services with practices and connecting with hospital services.

• A hospital led model. This would involve a foundation trust taking responsibility for wider system leadership, developing patient pathways in conjunction with other organisations that would shift care into the community and primary care.

• An accountable care organisation. An ACO would typically have salaried staff from secondary and primary care with corporate responsibility for the health and services available to the local population.
In practice

Our report describes two case studies of general practice at scale drawn from urban areas with dense populations. Practices are close together and perhaps find it easier to share services or work together. Solutions such as these may work in towns and cities but a different approach may be needed in more rural areas.

Rural GPs are already concerned that they face difficulties in keeping services going and making a living from their practices, which often serve smaller populations. Locum staff can be difficult to find, support staff are potentially unaffordable and yet patient demand continues to increase. While the details of solutions may differ for these areas, working as part of a network – potentially with some shared staff – may still offer opportunities.

Ten practical steps

Based on extensive consultation with those delivering services within primary care, we propose ten practical steps to create a community of care through general practice at scale. Some proposals require the system to change, others are predicated on healthcare professionals and patients taking responsibility for doing things differently.

1. Reduced bureaucracy

A reduction in bureaucratic workload is the single change most NHS Alliance members believe would most improve their working lives and enable primary care to take on an increasing role in patients’ health, delivering more care out of hospital. Currently, paperwork around the Quality and Outcomes Framework (QOF) and Direct Enhanced Services (DES) is significant. While there have been steps to reduce this for QOF, the requirements around DES for frail elderly patients are onerous. The last high level attempt to tackle bureaucracy dates back to 2001.

One practical step would be for core funding to include more of what is currently paid for under QOF and DES contracts with less specification of exactly how this will be delivered. This single action would remove an administrative burden from practices and signal greater trust in the professionalism of frontline professionals.

General practice now requires a system that restores professionalism in its best sense rather than one that reduces its clinicians to ticking boxes. We believe tackling this issue will enhance the ability of GPs and other primary care professionals to provide better care for their patients and to develop a mutually agreed agenda with them.
2. Restructured workforce

It is clear to us that a restructured workforce is needed to deliver the change we require. Current pressure on primary care may be relieved in the short term by making better use of some of the practitioners already available – such as extending the role of community pharmacists to manage common ailments, or by increasing their involvement in prescribing, or practices directly employing primary care pharmacists, which would reduce pressures on GPs.

In the longer term we need to move towards a workforce which is designed to deliver the sort of care we want to provide. Partly this will be about making primary care a great place to work and attracting more doctors and nurses into it: we are particularly concerned about the decline in GP registrar numbers, and community and district nurses. Doctors – both GPs and hospital doctors – need to be leaders in some situations, and partners in others and be open to working with people with different skills and competencies, including from outside healthcare. Training for doctors needs to change to stress the importance of working in partnership with other healthcare professionals, and provide the skills they will need to do so effectively. The future workforce for a community of care will require new roles such as health trainers or facilitators. Planning to establish the training places and funding for such roles needs to start now if we are to deliver the right workforce five or 10 years in the future.

3. Transforming premises

General practice at scale needs premises that support the care patients want to receive and primary care practitioners want to give, in locations that are accessible and convenient for patients. Primary care premises have transformed in many areas over the last 10 to 15 years. However, following a period of relative standstill, this process needs to be revitalised as the new shape of primary care provision becomes clear. Forward looking CCGs are already assessing proposed developments against the sort of services they want to see delivered and the best locations.
Much thinking around premises at the moment is purely about small additions to existing surgeries rather than transformation, and many small practice premises would not be capable of extending to accommodate these changes. We need to go further than this and to be more imaginative, asking ourselves what sort of premises best lend themselves to community-led solutions. Perhaps primary care provision might be better sited in shopping centres or leisure facilities, or co-located with other health and social care services. General practice at scale, working with other partners – potentially in housing as well as health and social care – could contribute to regeneration on unused land. Another option is to look at sharing space with other community-based organisations, such as housing providers, which are seeing their need for office space decline as staff adopt mobile working. This co-location might also drive better partnership working and a greater understanding of how each partner can contribute to the holistic care of the local community.

4. Co-ordinating health and social care

An essential requirement for general practice at scale will be greater co-ordination with community healthcare services and social care. Many patients, particularly the frail elderly, are receiving care from both a practice team and community nurses, and may have social care needs as well as health ones. The interaction between these healthcare professionals, and their colleagues in social care, is important in maximising patient wellbeing and avoiding deterioration and potential hospital admission.

A district nurse who has concerns about a patient needs to be able to talk to a GP about them and agree a care plan or actions to address the concerns. GPs may feel that a patient would benefit from a period of increased community nursing input after an illness or admission. All care providers, whether health or social care, need to be clear about which professionals or care providers they need to share information with. All parties providing care for the patient need to know that their concerns can be taken on board by other members of the community of care, without having to go through a bureaucratic process of requests and assessments – and often delays.

One option would be to have community healthcare staff attached to or linked with a practice or small number of practices. Outcomes are more important than structural form: this proposal is about improving working relationships and co-ordination, rather than GPs taking formal control by bringing community healthcare under one roof with a common management. The social care workforce is also an important point of contact with patients – some may have several visits a day from a care assistant – and more could be done to facilitate information sharing between social care providers and healthcare teams within the community of care, with the ultimate goal of improving the patient care and experience.
5. Demedicalisation of care

Responsive and responsible healthcare professionals recognise that a solely medical approach cannot solve many patients’ underlying problems, such as unemployment, inadequate housing and social isolation. As an alternative to medication, GPs, nurses and community pharmacists need to be able to offer a ‘social prescription’ to patients who present with issues related to their social circumstances. At the moment there is a danger that what is fundamentally a social problem becomes medicalised. This may result in the patient spending many years on medication while the underlying issue remains unsolved.

Improving the health of the whole local population will also mean developing a new alliance with the local communities we serve, moving towards supporting social action throughout life. Diseases such as diabetes have clear links to lifestyle factors such as obesity, lack of exercise and inadequate diet and require a co-ordinated approach to commissioning across local authorities and the NHS. From a public health perspective we believe a community of care has far greater potential for preventing ill health and improving the health and wellbeing of local communities than individual providers or professional sectors working separately, and we need to think more broadly about who makes up the community of care. Housing organisations, for example, have a great deal to contribute, along with local advice services, the police and patient and community groups.

Working with these groups – and that might include inviting them into practices or co-locating services with them – could offer many patients more effective care or enable them to support each other. Healthcare professionals could work with community assets such as leisure facilities or libraries to tackle these social determinants of health. Community development is likely to be the prime approach. Ultimately, we would like to see patients and those around them, as well as frontline healthcare professionals, actively involved in defining what outcomes and key performance indicators are meaningful for their own local community.

6. Embracing new technology

Making the most of new technologies such as telehealth, electronic patient records and IT connectivity should be at the heart of general practice at scale and the key to improving access, quality and outcomes with constrained resources.

The Government has guaranteed that all patients will have access to their personal health records by April 2015. UK and global experience shows that giving patients access to records is safe, improves trust between clinicians and patients, promotes the patient’s involvement in their own care and enables data-sharing across key parts of the NHS. However, the current agreements have been negotiated in a way that limits access and GPs only have to offer access to the summary care record, or have plans in place to do so, by this deadline.

We know that many patients find limited access unhelpful and obstructive and anecdotal evidence suggests GPs can refuse to give record access and can switch
“More effective integration of health care professionals to improve medicines optimisations for patients and more effective use of pharmacists.”
off access any time they like so there is a real danger that meaningful patient record access will never happen. NHS Alliance stands by the Government’s commitment that anyone who wants access to their own patient record should have it by April 2015. The NHS should not stand in the way of a safe, simple and effective way of integrating different parts of the system and empowering patients and practices. General practice at scale and a community of care can only work effectively if patients and all relevant professionals have full access to patient records.

7. Creating Community Health Connectors

The success of general practice at scale relies on multiple connections across health, social care and local authority sectors. We believe each distinct geographical community of 30,000 to 70,000 patients, clustered around practices, should have a Community Health Connector. A Community Health Connector would be an individual with the standing and vision to champion improving local health rather than managing disease.

The Community Health Connector could be a GP, a nurse, practice manager or community pharmacist who commands the respect of their colleagues and the broader community. Their ability to form strong relationships with a wide range of people and promote the health of the local population is more important than their professional background. The Community Health Connector would help to co-ordinate work with other local stakeholders – such as education, housing, transport, local authority and voluntary services, and local retail and business organisations – to address some of the social factors underlying many patients’ problems in the local area.

Funding for this key role could come from either the Better Care Fund or the local authority and CCG, with joint accountability to local GP practices and the local director of public health. We believe Community Health Connectors would be catalysts for change and use the registered GP list to ensure that health initiatives reach every part of the community, and that individual and community assets are used to promote health. It will strengthen a previously under-recognised public health role for general practice.

8. Reviewing core funding model

General practice at scale and a community of care must be based on a financial model for the NHS which encourages cooperation rather than competition between primary and secondary care, and rewards primary care for producing health, not just treating ill health.

Currently, general practice receives a payment per registered patient while secondary care is largely dependent on payment linked to activity, which means
incentives will continue to see a disproportionate flow of funds into hospital. We need a contracting and commissioning system which is based around patient benefit and supports the development of general practice at scale when it can bring better outcomes for patients, irrespective of where the care is delivered. We firmly believe payment mechanisms must be developed to encourage and enable win-win situations where the two sectors collaborate – something that will also be vital to drive forward a community of care.

Despite the rise in demand for GP services and a policy drive to shift more care from secondary care into primary care, the budget allocated to general practice has fallen over recent years to around 8 percent of the total NHS budget. We believe it needs to return to its previous 10 per cent within the next three years, during which time a new financial model can be developed which works across primary and secondary care. At a time when general practice is being asked to do more, and services are increasingly moving out of hospital into the wider community, the NHS is also facing a £30 billion shortfall. We respect the challenge caused by the fiscal limitations, and are not seeking additional funding, simply a more appropriate distribution of the existing NHS budget. Restoring the GP allocation to the baseline of a few years ago would allow the development of new roles within general practice at scale, including more staff and improved premises, with the ultimate aim of providing better care for patients and better value for the NHS. The purpose would be to provide better care and build a system which works better for patients, healthcare professionals and the NHS as a whole.
9. Transformational funding

Many GPs recognise the need to change, but struggle with the immediate practicalities of doing so. The greatest barriers to change are pressures of work, lack of time, and change management expertise among grassroots healthcare professionals. We also need to support those professionals who are still struggling to see what the solution could be and help them towards this. A General Practice Development Fund could kickstart the process by providing backfill or funding for new innovations or pilots. It would be important that such a fund should avoid being too short term, with tight deadlines to put forward ideas or to spend money. The fund should be available in all areas and recognise the wider nature of primary care beyond general practice and seek to engage with community pharmacists, voluntary and third sector organisations.

In his address to the Royal College of General Practitioners (RCGP) annual conference, chief executive of NHS England, Simon Stevens agreed to move funds from NHS England to primary care. One option would be to ring-fence this money for the General Practice Development Fund we propose should be introduced.

At the moment, a large sum of money – thought to be close to £1bn a year – is spent on primary care support and commissioning support, with commissioning support units playing a major role. We think there could be opportunities for this money to be spent differently, to help the move towards general practice at scale and provide broader support to GPs. Data and analytics could be a major part of support function, but it might be that these new organisations would also need support in areas such as user-centred design and developing case management.

Pump-priming would enable GPs and other members of the community of care to consider radical ways of funding extended primary care that enable practices to work closely together, for instance as co-operatives or integrated care organisations. Practices might want to develop a social enterprise or community interest organisation to enable them to become practice at scale, thus increasing social capital. New social enterprises, and a commitment to financial transparency, would overcome many potential issues around conflict of interest. Currently, primary care funding is tightly controlled and is allocated separately to different professional sectors within primary care. A more radical approach might be to trial pathfinder projects such as integrated primary care contracts that would remove the divisions between general practice, pharmacy, optometry and dentistry. Such funding models could eventually be extended to cover community healthcare and even social care and provide a mechanism to transform the ‘fee for service’ approach of many healthcare practitioners, to a system which recognises the importance of patient-centred, relationship-based care. We expect and welcome local variation in the models which are developed, how they work with communities and the criteria for success or failure they are judged by.

GPs may also be concerned about the financial impact and personal risk involved in change. In the past, GPs who introduced a model of extended general practice have had to take on some level of personal risk and often losses at the start of
the project, which may mean they are less willing to consider radical structural changes. A changing workforce demographic – more female GPs, more part-timers and many GPs without a financial stake in the practice – may also affect what is seen as an acceptable level of risk.

We need to ensure that competition and procurement law, and fears around conflict of interest, do not prove a barrier to innovative schemes. Earlier adopters may require legal advice so that schemes are devised in a way which does not fall foul of the regulations and GPs may need assurance that they can enter into these arrangements without concern. While competition and tendering may have a place, there is a need for their use to be proportionate rather than uniform. Formal tendering for every piece of work can impose a tremendous burden on practices and the healthcare professionals required on the front line. In practice, we would expect many general practice at scale initiatives to offer significant benefits to the local community because services and health initiatives can be built around the registered patient list, which might outweigh concerns about the need for a competitive procurement process.
10. Promoting self-care to patients

Consultation rates within general practice continue to rise, with approximately one million GP consultations every day, amounting to an average of 340 million per year. Reducing demand on general practice by actively promoting self-care and responsible use of NHS services have to be key objectives going forward.

Enabling people to self-care has the potential to significantly reduce GP consultation rates. It is estimated that the treatment of common ailments, such as coughs and colds, accounts for around one fifth of a GP’s workload, incurring a cost to the NHS of £2 billion annually. The majority of these ailments could be effectively treated by community pharmacists or self-care with over the counter medicines. This also reinforces recent messages from the Department of Health that there is an imperative to reduce usage of antibiotics.

Over 15 million people – or around one in four of the population - are living with a long-term condition such as heart disease, diabetes or asthma, and this figure is expected to rise in line with an ageing population and rising levels of obesity. Supporting and enabling people with long-term conditions to self-care and to have an active involvement in decisions about their care and support is likely to improve outcomes. Providing appropriate and accessible information to enable patients to look after themselves when they can, and visit a healthcare professional when they need to, gives people greater control of their own health and encourages healthy choices and lifestyles that help prevent ill health in the long-term.

We can learn from the way in which some fire services have enhanced their preventative and community engagement work and seen a 40 per cent reduction in domestic fires. Supporting patients to become more engaged or activated around their own health and focusing on patient defined and centred outcomes could put the NHS on a more sustainable footing. It is important to recognise that a community of care also includes the patient themselves and their family and support network.
“To see the NHS adopt our clinical proven specimen collection system wholesale, embrace right-first-time analysis and treatment whilst saving money and reducing repeat appointments.”

4 The success factors

We recognise that different models may work more effectively in different localities and therefore a prescriptive approach won’t work. However, the models that will succeed are likely to share the following characteristics:

• **A strong vision of how change will improve services for patients.** This has to be the primary outcome by which any change is measured – and is also the motivator for many healthcare professionals. Articulating this vision will drive support and engagement;

• **Reduced stress from workload pressure for those working in primary care.** This is currently reaching unbearable levels and is affecting recruitment and retention. There is an urgent need for solutions that will relieve this and improve working lives to stem the drain of skilled and experienced staff;

• **Buy-in from a significant percentage of GPs in the area** reflecting the role in linking other primary care professionals and the role they play in clinical commissioning.

• **Committed leaders with the enthusiasm to drive forward proposals.** These are likely to be – but need not always be – GPs. They will need support in terms of time and headroom to allow them to develop and implement these ideas;

• **Involvement of other healthcare professionals.** This may include practice teams but also other primary care practitioners such as pharmacists, optometrists or dentists. Schemes should also allow practices to access a wider array of clinical skills than are likely to be available ‘in house’ and to get input from specialised support staff such as data managers.

• **Connection and partnership with community-based providers of support and health and wellbeing services,** with a view to reducing demand and improving patient and community outcomes.
• **A scale large enough to make a difference.** There are many worthwhile changes which can be made within practices, or with specific patient groups, to relieve pressure and improve care, but the situation is so serious that we do not believe change at this level will be sufficient to provide a sustainable solution for primary healthcare as a whole. The transformations we are suggesting will be across a number of practices, if not a whole CCG area, and will affect tens of thousands of patients. They will potentially allow greater specialisation among GPs or for consultants or other specialists to work with a critical mass of patients.

• **A mechanism for sharing information between all partners in the patient’s care.** This will be a strong lever in improving care especially when several organisations are involved. It is particularly important for patients who are at risk of unnecessary admissions or who are approaching the end of their lives. Shared information and better working relationships between health and social care and other partners can considerably improve care for these groups.

• **While we are not suggesting that all GPs should take back provision of out of hours care, general practice at scale should support good provision of care round the clock** – through commissioning or influencing commissioners in their approach to this. This might include practices working together to provide joined up care across day and night, or commissioning a service which is better integrated with the rest of primary care, community and social services. It will also need to dovetail with extended hours provision, regardless of how that is provided. Out of hours contracts may cover a smaller area and be more nuanced to local circumstances.

• **Patient and carers can’t ‘see the join’ between different health and social care providers.** From a patient perspective, experiencing seamless care is important – but it is about relationships rather than structures. Integrated care
can be provided through a variety of models – many of which do not involve organisational mergers.

- **A means of retaining the most valued parts of primary care amid these changes.** Many patients – including the most vulnerable – want continuity of care from their primary care team. GPs and practice nurses may also value these long-term relationships with patients and families. Any move to general practice at scale needs to recognise the virtues of ‘traditional’ general practice and aim to build on these while gaining the benefits of scale. At the same time, it needs to reduce the workload of those working within general practice to a sustainable level.

- **A solution that has a degree of future proofing.** We have seen too many changes which have not lasted more than a few years – yet we are trying to build sustainable services which will attract healthcare professionals into primary care for a lifetime. While the future is always uncertain, and general practice at scale won’t solve every problem, it is important that it is ‘for keeps’. It must also be financially sustainable and not present such substantial financial risk that practices and other partners are deterred from joining.

- **An approach which encourages patients to become more actively engaged in their own health,** for example through lifestyle changes or healthy choices or through self-monitoring of long term conditions. This will help to address the sustainability issue facing the NHS.

- **A connection to community resources and non-medical solutions offered by voluntary and community-based organisations.** Not every patient who seeks help can be treated through medication or surgery. Often a different sort of help may be more effective or boost the effectiveness of other interventions. Peer support, exercise or tackling loneliness can improve patients’ health and reduce pressure on the NHS. Access to advice on housing options could help patients who are in inappropriate or inadequate housing.

- **A wider view of what community can contribute to healthcare and a willingness to work with that community rather than impose solutions.** Such schemes can contribute to community development and harness the enthusiasm and strengths of the community, encouraging volunteers (who may in return get valuable experience). GPs also have much to contribute through working with other organisations: one way to harness this would be to devise contracts which support or expect GPs to spend time working in partnership with non-healthcare organisations.
A number of organisations have suggested solutions to this, although in some cases the details and how this shift can occur in the current circumstances lack sufficient practical details.

**The Nuffield Trust** (*Securing the future of general practice, New models of primary care: practical lessons*, both 2013) has looked at a range of models for primary care provision, from accountable care organisations to federations. A key message was that there is no one organisational model of primary care provision which will suit all areas, but it did identify a number of models which are potentially able to deliver the personal care which characterises general practice but which gain from organisational scale.

These models included federations (practices voluntarily working together); super partnerships formed through mergers; regional and national multi-practice groups; and community health organisations.

*Commissioning and funding general practice* from **The King’s Fund** (2014) highlighted how GPs are well placed to meet some of the challenges of the future, with the model of a registered list of patients providing a way to both tailor treatment and act preventatively. While there is a lot of innovation in general practice, there are many barriers to achieving what is needed, but it suggests federations or networks offer an opportunity to move towards more integrated services. New skills are likely to be needed within these organisations around aspects such as risk stratification, and financial and clinical risk management.

**NHS England’s** *Improving general practice: a call to action* covers much of the same points and also identifies the key role of general practice and wider primary care in meeting the challenges of the future. It concludes general practice needs to deliver this at greater scale and in greater collaboration with other organisations. Again federations or other means of practices working together were advocated.

A recent paper from the **Nuffield Trust** and **KPMG** (*The Primary Care Paradox*) added an international perspective to the debate and suggested many of the challenges UK primary care faces are common in other healthcare systems. The paradox was that while the role of primary care was seen as a crucial part of a sustainable healthcare system, its capacity and capability to bring about change was doubted. While not specifying a single solution, it recommended four design principles to address these issues – access and continuity; patients and populations; information and outcomes; and management and accountability.
The BMA has stepped into the debate with a 2013 paper on Developing General Practice Today. This calls for more integrated care with the practice team at its heart, improved urgent and out of hours care, improved accessibility and local accountability, and for patients to be empowered as partners. NHS Alliance agrees with much of what has been concluded and advocated by these other organisations. However, we believe our membership – which covers all aspects of general practice and primary care – affords an extended insight into the issues facing general practice as it tries to move to a new future, and how these can be overcome.

We believe the NHS and primary care practitioners must avoid the danger of dealing with ‘the next problem.’ The future holds many challenges and a piecemeal, tinkering solution is unlikely to achieve the sort of transformation we believe will be necessary to meet them. Busy clinicians inevitably focus on the problem in front of them; while that may address short term issues, it is important to also deal with the more fundamental issues – and that may require a more all-encompassing solution.
ADDITIONAL 2:
From practice to perfect

Brighton and Hove Integrated Care
This was set up seven years by GPs and now offers a wide range of community based services to patients. Over the years it has evolved; it started with the intention of supporting general practice to be reflective about the quality of care on offer and to support in working together on new services.

Over the years it has taken on services ranging from community gynaecology to musculoskeletal services and anti-coagulation. It has won a major musculoskeletal service contract covering three CCG areas which will involve working with other health service partners.

A major development for it has been winning £1.9m in funding from the Prime Minister’s Challenge Fund to improve general practice for its Extending Primary Integrated Care project (EPIC).

Eighteen practices will work together in the service – along with pharmacies and Age UK - which has five main components:

- nurse practitioners and extended nursing teams help to offer access from 8am to 8pm, Monday to Friday and for six hours on Saturday and Sunday;
- sharing medical records with local pharmacies allows for many repeat prescriptions to be dealt with without the GP being involved;
- the voluntary sector helps to provide ‘care navigators’ whose aim is to reconnect patients with their local community which may make them less likely to access GP services or unscheduled care. These navigators will also train volunteers in practices;
- an examination of the possibilities of combining or centralising some back office work which could offer some respite to hard pressed practices;
- front end GP triage to ensure patients are seen by the most appropriate health professional.

Bristol: ‘Getting Big to Stay Small’
‘Getting big to stay small’ has been the unofficial motto of the One Care Consortium in Bristol, North Somerset and South Gloucestershire. One of the hallmarks of the consortium has been working together to allow members to continue providing the sort of care they want to give.
The Consortium – which includes 23 practices, the out of hours provider Brisdoc, and GP Care, which offers a number of in hours services – has recently been awarded £5m by the Prime Minister’s Challenge Fund to develop some of its services over the next two years. Its membership is open to any practices in the area which can meet a set of basic criteria, and it wants eventually to include all the practices within a one mile catchment area. ‘Our aim is to make it a no brainer that you would want to be part of it’, says Dr Ray Montague, project lead.

If successful, its schemes will improve care for patients across the day and week but should also make life easier for GPs by standardising some processes, re-allocating some urgent work to the healthcare professionals best placed to do them, and freeing up GPs’ time for the patients which need it most.

There are different streams to the work including:

• ensuring that doctors can access information about patients they may see who are not part of their practice population – for example, if they see them out of hours. They will be able to read and update records, helping the next doctor seeing the patient to know what has been done;

• co-operative working across practices with, for example, common templates for referral letters and care plans. These can be automatically populated with information about the patient, picked up from their records, reducing the amount the GP has to write and saving time;

• joint standards for answering the telephone and the ability for calls to be picked up anywhere across the practices. This will help stop patients going elsewhere – such as A&E – out of frustration because they can’t access the GP. Key to this will be a new telephony system across the practices and then agreement on how calls will be handled when they are not for the practice which answered it;

• weekend appointments – although these will be controlled and will be for urgent patients whom a clinician decides needs to be seen or for those who need reviews by a clinician after having been seen at the end of the working week;

• potentially using other healthcare professionals to see cohorts of urgent patients with suitable conditions. This would be unlikely to be feasible on a single practice basis but if the consortium found, for example, a number of urgent calls were from patients with back pain who would be better managed through physiotherapy access, it could look at employing a physiotherapist to deal with these.
Working together in Herefordshire

Herefordshire has a small, widely dispersed population which presents challenges for the health service. With one acute trust, community hospitals are an important source of care for many people and access to services is important.

GP practices in the county have been working together to improve services and hopefully reduce pressure on both primary care and the acute trust. With the help of money from the Prime Minister’s Challenge Fund, Taurus, a GP-owned federation, is opening three hubs – at Hereford, Leominster and Ross-on-Wye – which will provide extended hours primary care seven days a week.

Key to this is shared information – patients will be asked to give consent for their records to be shared as they are booked in. Patients will access the service through 111, A&E and by calling their normal practice. Taurus chair Dr Nigel Fraser says it is hoped that the improved access will take pressure off practices, especially on a Monday morning, and will stop some patients deteriorating over the weekend.

The federation also has a number of other projects including work with nursing homes to identify patients who are deteriorating – akin to the early warning systems used in trusts – a discharge link nurse who will co-ordinate patient care for those moving from hospitals to primary care, and improving access to confidential care for adolescents through colleges (in rural areas they are often reliant on their parents to reach services). An urgent care doctor will provide additional home visits and work to avoid these patients being admitted to hospital.
NHS Alliance, Novo Nordisk and Capita have been working as strategic partners throughout 2014 to explore the future potential and role of primary care within the NHS.

**NHS Alliance**

NHS Alliance is the leading independent voice for providers of health and social care outside hospital. It is the only not-for-profit membership organisation to bring together frontline clinicians and organisations of all kinds in our communities – from general practice, community pharmacy to providers of housing and emergency services.

It is driving a new integrated and collaborative, community-based model of care for an ageing population living with long term conditions, and is focused on breaking down the historic boundaries and silos that get in the way of truly progressive and innovative community-based patient care.

**Novo Nordisk**

Headquartered in Denmark, Novo Nordisk is a global healthcare company with 90 years of innovation and leadership in diabetes care. The company also has leading positions within haemophilia care, growth hormone therapy and hormone replacement therapy. Novo Nordisk employs approximately 38,000 employees in 75 countries, and markets its products in more than 180 countries.

**Capita**

Capita works in partnership with public and private sector organisations to help them deliver their services more efficiently, and more importantly, to transform their services to better meet the needs of their customers and users. Our work, usually behind the scenes, helps our partner organisations make better use of the resources available to them, use information and technology more effectively, improve the performance of their assets and transform the way they interact with users of their services.