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The NHS Alliance sees a bright future for primary care, one that makes the most of the traditional values of locally-based healthcare provision. One that delivers continuity of care and builds on the assets held in the communities in which people live and work. It is time, we say, for a true primary care led NHS.

This manifesto calls for all of us – patients, professionals, managers and policy makers – to break the boundaries that too often disable people from caring for themselves and prevent clinicians from delivering high quality, cost effective, integrated care with a new focus on health and wellbeing and prevention. We believe that such a shift will be necessary to deliver a sustainable NHS.

It is built on practical ideas and solutions from within the NHS Alliance, as well as from a wide range of partners, and aims to offer a clear, positive and compelling vision for the future – not just of primary care but the NHS as a whole. We would like every patient to have the chance to create a personal health and wellbeing plan that can be used as a gateway to wider community services – not just in health and social care but also in housing, crime prevention, personal safety and wellbeing. This will require those working in primary care to reach out beyond the boundaries of their own front doors to create new partnerships and working relationships across their communities.

We would like to see secondary care liberated from the boundaries of the hospital. We want to see the boundaries between in hours care and out-of-hours care removed to provide patients with the all-important continuity of care they require.

Doing nothing and harking back to a golden age is not an option, barriers need to be broken and the system needs to change. We do not need new structures and new barriers but new relationships. Unless we tackle these long-standing boundaries the NHS will struggle to realise the benefits of patients and their wider communities working as equal partners with primary care clinicians and hospital specialists.

The manifesto is a starting point for what we hope will be a stimulating and challenging debate and will inform our future campaigns. Not everyone will agree with everything we say here. Whatever your views, we would like to hear from you.

Rick Stern, Chief Executive, NHS Alliance
Dr Michael Dixon, Chairman, NHS Alliance
Introduction

There are those who would have us believe that primary care is on the brink of collapse. So overwhelmed with demand that patients would rather spend four hours waiting in A&E than brave the general practice switchboard at 8am on a Monday morning. Too fragmented and operating at too small a scale to deliver care closer to home; too disrupted by structural change in the NHS to look much beyond its own navel, let alone start to tackle clinical variation and inequality of access.

The NHS Alliance does not subscribe to this view

Over the last few months we have been gathering the thoughts of members and friends with an interest in primary care provision. They do not dismiss the anguish that many in the primary care system feel in the face of inexorably rising demand and unrelenting change – they are experiencing it too. But they also see a bright future for primary care, one that makes the most of the traditional values of locally-based healthcare provision delivering continuity of care and building on the assets in the communities in which people live and work.

It is time, they say, for a true primary care led NHS

Primary care needs the freedom to deliver the care that people want – close to their homes where they are viewed as partners rather than passive recipients. To do that we need to break the boundaries between:

- Patients and clinicians
- Clinicians and managers
- Clinicians working in different silos
- Primary care providers and the communities they serve
- Specialists and generalists
- In hours care and care out-of-hours

This manifesto calls for all of us – patients, professionals, managers and policy makers – to break the boundaries that too often disable people from caring for themselves and prevent clinicians from delivering high quality, cost effective, integrated care with a new focus on health and wellbeing and prevention. We believe that such a shift will be necessary to deliver a sustainable NHS.
It also sets out our vision of how to make that happen. In particular we call for:

* All patients to have the opportunity to develop a health and wellbeing plan jointly with a named healthcare professional.

* Primary care providers and social care providers to stop operating in silos and start to form new structures and co-operatives in which they work together to benefit individuals and communities.

* Primary care to take a leadership role across the whole healthcare system. This should include a GP or other primary care professional at the Department of Health or National Commissioning Board, who is visibly working at the same level as the Chief Medical Officer or the NHS Commissioning Board Medical Director.

* Primary care to take a new role in coordinating community activities which improve health and wellbeing.

* Consultants contracts to be held by the NHS Commissioning Board enabling these valuable specialists to take a community-wide responsibility for groups of patients and become an expert resource for primary care clinicians.

* A rethink of the separation of the care provided in hours by general practice and that provided out-of-hours.

* A review of the current financial systems in which general practice is paid per head of population but hospitals are paid for activity.

* Sharing patient data across boundaries in different services and settings, making sure patients are involved and feel safe and secure.

* A new culture that focuses on people not numbers.

This is a radical agenda, although much of what we describe is already happening on a small scale. It is developed from the lived experience of our members and friends. The key question is not how primary care can do more for less, but how we can do more with less. The answer lies in breaking the boundaries that prevent us delivering high quality, cost effective, sustainable healthcare.
The challenge facing the NHS in the short to medium term is well known. How do we make a high quality, publically funded NHS – free at the point of need – sustainable when money is tight, demand is rising and public expectations are changing? Among the many proposed policy solutions are the notions of moving care closer to home; integrating health and social care services around the needs of patients; placing the budgets for commissioning healthcare into the hands of frontline professionals; creating a new local government-led focus on public health and prevention; and encouraging people to self care.

All this has profound implications for the way in which health and social care is organised and delivered. This manifesto argues that to deliver these policies, we need a primary care led NHS that works in the interests of people and populations.

“It is essential to focus on the role of primary care in health improvement and the integration of healthcare provision, and not seek to dwell on past inadequate definitions that are rooted in organisational arrangements. We have an opportunity to galvanise the whole healthcare system in the interests of patient and population health gain – we must seize it.”

Michael Sobanja, Director of Policy, NHS Alliance

“The imperative for current providers and the new clinical commissioners 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.”

Michael Dixon, Chairman, NHS Alliance

For this, we need to break some boundaries and deliver freedom to frontline clinicians, managers, individuals and communities.
We need to break the boundaries between all of us as patients and our NHS

We need to ensure that patients can share decision making with healthcare professionals, rather than being passive recipients of advice and care. Care and compassion must be valued and rewarded alongside biomedical guidelines and financial targets. At the same time, primary care needs to become a partner with the wider community, valuing the resources of the local authority and the third sector, and working with partners to find solutions to problems that lie well outside the traditional remit of the NHS, creating healthier communities rather than just seeking to treat illness. We call for responsive proactive primary care; healthcare that is people powered.

Key proposals:

1. Patients should each have the opportunity to develop a health and wellbeing plan with a named healthcare professional to help them understand their own risk profile and how they can best care for themselves.

2. We need new partnerships between primary care and communities to shape the healthcare and services we deliver. We need, for example, to see frontline healthcare professionals and councillors working with local people on housing estates to identify and address their concerns and to develop social prescribing initiatives.

3. We should harness the registered list, data captured through IT systems, local knowledge, our privileged relationships with individuals, families, communities, the local authority and third sector partners to support communities and patients to take and share power with us.

4. We need systems that support and develop asset-based community development, emphasising the strength of a community working together to solve its problems.

5. Community health workers and community advisors should become new members of the practice team linking practice services with voluntary agencies and the local community, improving overall local health and providing a focus for families who make the greatest demand on the NHS.

6. New payment systems should support working partnerships and reward primary care for producing health, not just for treating ill health.
“Practices would see linking with voluntary groups in their patch to be just as important as keeping up with their colleagues in the clinical commissioning group or reading the British Medical Journal. They would offer support to the residents’ group on their estate in their fight against damp. They would be in regular touch with the diabetes group and the Chronic Obstructive Pulmonary Disease group and the MIND group – listening to their ideas for improving services and discussing with them ways in which patients could be encouraged and supported to follow best practice in treatment. Practices would see these as efficient ways of supporting self-care, as well as places where feedback on services could be received and discussed.”

Dr Brian Fisher, NHS Alliance Public and Patient Involvement Lead

Where is this happening already?

There have been various initiatives to build healthy communities. One model, HELP [http://www.healthempowerment.co.uk](http://www.healthempowerment.co.uk), is an accelerated form of community development. HELP supports residents to collaborate, grow leaders, gain confidence and work in a coordinated and effective way with statutory agencies to shape services to meet the needs of their estate. The residents work in equal partnership with a range of services, including health, education, housing, police – it becomes a hub of activity and change.

HELP started as a Department of Health funded project that uses a tried and tested seven-step process that helps communities move towards a resident-led partnership. Harnessing trained community development workers, HELP works with residents and NHS and other local staff to develop a sustainable and cost-effective intervention in local estates selected by the CCG and local authority.

Experience with HELP shows surprisingly rapid change. Statutory agencies begin to see new ways of working as they meet residents in new and collaborative ways. Leaders in the estates emerge, problems get solved – not always easily, but, often for the first time, there is a movement for improvement.

In addition, evidence suggests that the process is cost-effective, with estimated savings for local statutory services of £655,162 over three years on a £145,000 investment in community development over the period.

Professor Chris Drinkwater, President and Public Health Lead for the NHS Alliance

Dr Brian Fisher, NHS Alliance Public and Patient Involvement Lead
We need to break the boundaries between the different parts of primary care – including health, social care, self care and the wider community

General practice, community health services, mental health services, pharmacy, dentistry, optometry and social care, working alongside community and voluntary groups and the wider community, are all part of extended primary care. Together, they have far greater potential for improving health and wellbeing rather than working apart. All professionals have a part to play in the health service and health improvement. Let’s use this precious resource.

Key proposals:

7 The strength of primary care is its first contact with patients, involving general practice, community pharmacy, and a full range community health and social services. We need to find more and better ways for all these partners to work together, including new payment systems that pay for service, rather than activity carried out by a single provider, and that reward improved patient outcomes.

8 Primary care providers themselves – general practice, community staff, pharmacists and others – will need to coordinate their initiatives to provide better local health in liaison with local Health and Wellbeing Boards and Clinical Commissioning Groups.

Where is this happening already?

The National Housing Federation is already reaching out to primary care, arguing that the two sectors have a lot to offer one another.

“Where people live is a key determinant of health and safety, healthy homes underpin good health and wellbeing. Settled housing improves health and reduces the incidence of respiratory and other diseases. It is critical to the recovery of people with a mental illness. Primary care professionals see this link every day and they understand that good housing is in itself a preventative investment. In short, housing has a huge amount to offer primary care.

“We envisage a system in which general practitioners and other primary care professionals know how and where to access advice on housing options and specialist care and support solutions at the different stages of diagnosis, care planning and condition-management. We would like to see primary healthcare professionals develop clinical partnerships across a range of specialisms that enable general practice to be the hub of a network of local community and home-based services. We want jointly to develop new models for delivering health services in the community, which build on the housing associations’ role as an experienced neighbourhood manager and service provider, which is able to reach and support vulnerable groups who may find it difficult to stay in regular or frequent contact with mainstream services.”

Jake Eliot, Policy Lead, National Housing Federation
Similarly, the Medicines Management Partnership (MMP) has called for closer collaboration between general practice and the pharmacy profession to improve the way in which medicines are prescribed, ensuring that patients understand why they have received a prescription and what the expected outcomes of taking that medicine correctly, or incorrectly, might be.

A recent report, commissioned by the Department of Health, produced by the York Health Economics Consortium and The School of Pharmacy, UCL, considered medicines wasted. The report indicated that the gross annual cost of prescription medicines wastage in England is currently in the order of £300 million per year. The report also indicates that in welfare terms, significantly greater returns could be generated by better medicines use as opposed to waste reduction per se. Improving adherence in medicines taking can improve health outcomes. The estimated opportunity cost of the health gains foregone because of incorrect or inadequate medicines taking in just five therapeutic contexts, is in excess of £500 million per anum.

MMP argues that this could lead to better patient outcomes as well as reduced waste when medicines are incorrectly prescribed or incorrectly taken. To achieve this, we need three important changes:

★ The embedding of medicines optimisation within general practice through the employment or attachment of medicines optimisation pharmacists.

★ A new community pharmacy contract that supports the wider introduction of medicines optimisation and clinical services in community pharmacy.

★ A change in CCGs where the focus is in medicines optimisation to deliver improved outcomes rather than cost reduction, clinician engagement and joined up services.

Mark Robinson, Director, Medicines Management Partnership

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We need to break the boundaries between general practices

Primary care and general practice will need to develop from its current model if it is to take on much of the work currently done in hospital. To achieve this it will need to keep its best elements – personal, holistic and continuing care and patient advocacy – but extend to provide diagnostic, outpatient-type services and treatment services closer to patients’ homes.

General practices will need to work together and pool resources and talent creating services either within their constituent practices or in other community assets so they can extend their scope to provide care for patients. This includes working together across groups of practices to look at variation in performance, as well as exploring a range of opportunities for practices to work together. To support this, we also need to move towards a new era of an integrated information landscape that can support the development of a knowledge culture, based as much on maintaining health and wellbeing as providing treatment for illness.

“Across the country there are examples of practices coming together to work in more cohesive forms that vary from loose associations through to mergers into one new organisation. The shape and governance structure of these new enterprises depends upon the vision and objectives of the practices involved. There are significant benefits for practices in creating the ability to work at scale to provide a more robust level of business sustainability, viability and some real opportunities as the NHS transforms into a predominantly localised integrated service caring for patients either at home or close to their home.”

Caroline Kerby, NHS Alliance Practice Manager Network Lead

Key proposals:

9 Support and encourage practices to look at new ways of working together across practices as well as with patients and the wider community to improve patient outcomes and their focus on patients is at the centre of what they do.

10 GPs need to unleash the power of the registered list, using it to take full responsibility for the health of those on their list, in partnership with statutory and voluntary agencies.

11 Introduce effective systems for practices within CCGs or localities to explore clinical variation, understanding why there are differences among clinicians and across practices and making changes where necessary.

12 To support this, we need to develop our thinking around data sharing to ensure that data is not only used for the care of the individual but also shared responsibly to allow for effective planning and resourcing and to support peer review to drive quality improvement. General practitioners in particular have a responsibility to spread the belief that well-founded knowledge is absolutely fundamental to ensuring better care – with a shared sense of ownership and responsibility among clinicians and patients alike.
Where is this happening already?

The notion that general practice in its current form is not suited to take on a new role in delivering care closer to home is not new. There have been various reports published on the future of general practice, including the RCGP’s *A Plan for Primary Care in the 21st Century* (2008), The King’s Fund report *Improving Quality of Care in General Practice* and the recent Nuffield report *Primary Care in the 21st Century*. All three reports suggest there are benefits in closer collaboration or federation of general practices. We support this view – and indeed new models are already developing.

There is no agreement about the precise form such organisations might take – and it is probably inherent in the very idea that they would be shaped to local needs and by local relationships. The ideas proposed include:

- Federations of general practices that work at scale.
- A co-production model in which public services begin to prevent, address and provide solutions to social problems like crime and ill health, understanding that this is only possible by providing a catalyst for citizens to broaden the range of what they already do or can do in the future.
- A “primary care home” where GPs and other primary care providers come together in an integrated, population-based provider organisation that is commissioned on a devolved, population-based, holistic NHS budget to disburse on the “make or buy” principle – either it provides the service the patient needs or refers them to another provider.

“A test for future English general practice is to retain our heritage of being a local resource to our patient population while being the major influence in clinically-led commissioning. The key challenge is to be both local and small and yet big enough to be the strategically important NHS provider. The individual practice may lack the capacity, capability and willingness to provide an extended service, but if they are part of a locality or federation of provider practices, that organisation can provide the strategic and operational management skills and staff needed. What general practice has most to offer other providers is the need, without removing patient choice, to take on a population responsibility. Where population and individual care clearly conflate is in better support and care for those with long-term conditions; conditions that have a major impact on health inequalities. To pull many of these strands together, I am recommending the concept of the ‘Primary Care Home’, a home for all care professionals based on GP practice population(s) and commissioned to have budgetary responsibility for ‘making or buying’ services.”

*Professor David Colin-Thomé, Independent Healthcare Consultant*
Tackling inequalities: an NHS Alliance perspective

2013 marks the third anniversary of the publication of *Fair Society Healthy Lives*, where Sir Michael Marmot reviewed the state of the nation’s health inequalities and found it wanting. The NHS Alliance remains firmly committed to addressing social injustice. We call upon our members to work with us and we offer our unstinting support to you.

When it comes to reviewing our CCG public health outcomes and then looking our population in the eye, members are going to need 21st century evidence-based thinking. After all, if the fire service can change from putting out fires to preventing the causes of fires (not even preventing fires, you will note), then so can we. To put out our own fires in primary care means linking arms not just with the obvious partners like local authorities and police but housing, fire and rescue, education, faith groups, social enterprise, the media, business leaders and the voluntary sector. Some members are already trying to reduce spend on paediatric asthma admissions through joint projects with general practice, schools and parents. Others are working with the third sector on fuel debt and insulation to keep homes warm. It is about joining up and a common desire to improve.

The social determinants of health remain a crucial cornerstone, but we are working with colleagues in the Institute of Health Equity, Health Equalities Alliance and others who share our passion for social justice, to bring you the latest thinking on not only what prevents ill health but what actually creates health - the ‘new’ public health. There is no mystery in this – it is about simple things like:

- Helping residents to feel more in control by listening and then working with them on the things they say are most important.
- Enabling residents to lead in finding creative solutions using their own skills and talents.
- Being together – this builds residents’ strength and resilience and avoids loneliness, which in health terms is the equivalent of smoking 15 cigarettes a day.

This may mean that we work through our partners and residents rather than, as trained professionals, constantly ‘fixing’ and healing people. It means sharing power and control, letting go – maybe even making a few mistakes as we learn.

Our aim is to focus and do a few things well. We are starting our work on inequalities with a look at housing, fuel poverty and homelessness, which costs the NHS an estimated £600m per annum. How can we integrate housing issues more closely into what we do in primary care?

Our plan is to stimulate debate, challenge orthodoxy and incubate ideas.

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* Heather Henry RGN is Managing Director of Brightness Management Limited and is leading work for the NHS Alliance on changing culture and behaviour.

* Colin-Thomé, D (2011) ‘The primary Care Home’ Available online at www.dctconsultingltd.co.uk
We need to break the boundaries of the hospital

Hospitals should be seen as places of last resort for healthcare and the staff within their walls should be liberated to work with their colleagues in the community to improve access to specialist advice and diagnostic tests. Some people will still need to go to hospital for planned operations, but we should aim to develop a healthcare system where far fewer people go to hospital for an unplanned admission.

There will always be some genuine emergencies but these are exceptions - the vast majority will have either short-term or long-term interventions that could have avoided that admission. We need to start concentrating our efforts on preventing the catastrophes that necessitate emergency admissions. Commissioning should remain separate from provision. What does not have to remain is the clinicians realignment of purpose. It is unacceptable that we allow concerns over so-called conflicts of interest to stop specialists and generalists coordinating care on an individual or population basis. We should demand the converse: that generalists and specialists have, as part of their duty of care, a requirement to be involved in developing population-based commissioning strategies.

“We have directed major development and resources towards ensuring that the patient has access to high quality care when there has been a catastrophic collapse in their health. There are few other places in the world that are better at provision of emergency care at times of crisis. This does raise the question as to why we have a system that allows the crisis to develop in the first place? Why do we, in effect, deny access to specialist skills until damage has progressed significantly for that individual?”

Dr Minoo Irani, Clinical Director in Berkshire and NHS Alliance Specialists Network Lead
Dr Donal Hynes, Co Vice Chair, NHS Alliance

Key proposals:

13 We should liberate specialists’ contracts from the institutions to which they are bound. They should be community based, by default, and support health improvement. In future, hospital specialist contracts should be held by the National Commissioning Board, the clinical commissioning groups or academic institutions.

14 Generalists and specialists should have, as part of their duty of care, a requirement to be involved in developing population-based commissioning strategies.

15 We should explore new structures that free clinicians from the traditional organisational and professional boundaries to deliver care along clinical pathways and new payments that support clinicians to keep people out of hospital.

16 All unscheduled admissions should trigger an analysis of cause to see whether it could have been prevented – and how.
Key proposals (cont):

17 Specialists (consultants) and generalists (such as GPs or nurses or pharmacists with out-of-hours contracts) should work together to construct joint rotas to cover 24-hour service provision.

18 We should develop a feedback system between specialists and generalists to share comments on quality of referrals and quality of responses.

Where is this happening already?

In some areas consultants have already taken on a new responsibility for a population of patients, for example diabetes. This has seen services transform as consultants move from working as hospital-based clinicians attached to beds, to working in the community as an expert resource for generalist clinicians.

Others have tested step-models to integrate physical and mental health services, for example in Sandwell, as outlined here by Professor Chris Drinkwater and Dr Brian Fisher:

“The stepped approach to provision supported by the NHS Confederation and adopted by Sandwell and West Birmingham CCG starts with better provision of self-help information and education in community settings and ends with centralised specialist mental illness services. The steps in between progress from guided self-help and triage in community settings, through low intensity one-to-one support including IAPT, high intensity support and psychological interventions for people with long-term conditions, to integrated mental health teams and liaison psychiatry. The advantage of this framework is that it inverts the current focus on high-dependency specialist needs for the few, with more of a focus on population wellbeing, prevention and primary care. Importantly, it also fosters an integrated whole systems approach to what needs to be available at the various steps, at the same time as it forces clarity about the flow across the interfaces.

The Sandwell team report improved access to community mental health and wellbeing services and to talking therapies, producing hypothetical savings of £1.4 million. Effective liaison psychiatry between GPs and specialists might produce even more dramatic cost savings. A recent report on the Rapid Assessment and Discharge Team (RAID) operating in the A&E Department at City Hospital, Birmingham identified accrued cost savings of £3.5 million in a year through early discharge and fewer re-admissions.”

Professor Chris Drinkwater, President and Public Health Lead for the NHS Alliance and Dr Brian Fisher, NHS Alliance Patient and Public Involvement Lead
A developing idea: Care Delivery Groups

We need to ask why we need GP surgeries, acute hospitals and community hospitals, all functioning in their own professional and organisational self-serving manner, rather than simply services designed to meet the needs of patients and serve the health of populations? Why is it that the more structures and processes we create, the more commissioning and provision ‘gaps’ we create at the same time too? Is it time for a model in which patients can choose to go to groups of healthcare clinicians with a range of clinical skills incorporating generalists, various specialists and a wider group of non-medical clinicians, and also choose where they would prefer treatment (primary care centres, community hospitals or acute hospitals) within the limits of clinical safety and effectiveness? Is it time to think of de-linking clinicians from structures, professional and organisational loyalties? Is it too much to ask of clinicians and services to maintain unwavering loyalty towards patient care and let professions, structures and organisations facilitate that process rather than the other way round?

We propose that our current understanding of integrated care within the NHS is extended to allow provision of healthcare by groups of clinicians who work outside organisational and professional constraints. This could be a group of medical generalists and specialists with a range of nursing and allied healthcare staff, commissioned by Clinical Commissioning Groups and supported by a management framework. Social care providers whose services are involved in patient pathways would join these groups of healthcare clinicians and managers. These Care Delivery Groups (CDG) would offer a range of clinical services from a number of Healthcare Support Estates (HSEs) including primary care centres, community and acute hospitals. Patients would be able to access CDGs for the whole spectrum of healthcare needs and would be managed along clinical care pathways within them, without the problem of navigating different health systems with different access criteria in different locations. HSEs would be used to facilitate episodes of care for the patients without being the organisational gateway to clinical services.

Dr Minoo Irani, Clinical Director in Berkshire and NHS Alliance Specialists Network Lead
Dr Donal Hynes, Co Vice Chair, NHS Alliance
We need to break the boundaries between in hours urgent care and out-of-hours urgent care

Patients are confused about where and how to access urgent care and advice. General practices, A&E departments, the ambulance service, as well as a host of new community facilities seeking to prevent hospital admissions, all offer a different range of services available at varying times. The one thing that seems to reduce demand for urgent care is continuity of care, and we need a shift in focus from keeping people out of A&E departments to one in which primary care is seen as the frontline for managing urgent care.

“The reality is that there is no short cut to providing effective urgent care, no ‘magic bullet’. Our systems are complex, often unnecessarily so, and the answer is to make each part work effectively and then joining it all together. So general practice, in and out-of-hours, needs to ensure that patients can get appointments more easily and spot the few cases that need to be seen quickly; community services must be better at identifying patients who, with the right support, can stay at home; ambulances need to ensure that more patients are treated away from hospital; urgent care centres need greater clarity about how they work and link with the rest of the system; A&E must be seen as an integral part of the wider system rather than as the backstop when all else fails; and hospitals need to ensure that there is a constant focus on doing everything they can to get patients out quickly. And if nothing else, the last few years has re-established primary care as the front line for managing urgent care. Small changes in 8,200 practices will have a much more profound effect than focusing on keeping patients out of A&E. Improving care may be challenging but it is within our control.”

Rick Stern, Chief Executive, NHS Alliance

Key proposals:

19 We need to develop 24/7 primary care with all of us able to access the care we need at the time we need it.

20 We should rethink the separation of the care provided in hours by general practice and that provided out-of-hours. This is not arguing for a return to general practitioners’ 24 hour responsibility but for a closer alignment of in and out-of-hours care, including allowing local GPs to provide out-of-hours care if they wish and of supporting clinicians who work in hours to also work out-of-hours.
We need to break the boundaries between professionals to create new roles and new skills in the primary care workforce

We need a new way of structuring the primary care workforce to enable it to carry out more proactive and less reactive work and bring a new balance within primary care between unselected triage, elective care and systematic proactive management of long-term conditions to include support for self-management, signposting to community services and coordination of care.

We need new kinds of workers to deliver this vision. Community leaders who can link professionals and people together, for example, and specialists who are able to switch from a focus on their beds and their unit to a responsibility for a population. We need people capable of working in new ways with unified data. We need clinicians skilled in using new assistive technologies such as telehealth and telecare. We need people able to work at the boundaries of health and care and to move between sectors. At the same time, we must not forget that for many patients, most of the time, the critical skills will be in maintaining relationships and providing the most basic physical care; including feeding, cleaning, and turning, which should be recognised for their importance. We are seeing repeated breaches of the psychological contract between employer and employee – if staff don’t feel cared for then what chance do their patients have?

We need a greater focus on shared values and intrinsic reward. This will require the re-design of care and therapy assistant roles to be more attractive to a wider proportion of working age adults; and the formal development and reward of compassion and commitment, rather than taking these for granted as inherent attributes of a previously largely female workforce.

“Chronic conditions require a different skill and workforce mix, orbiting around primary care. This means fewer specialists in hospitals, but more nurses, allied health professionals and para-professionals (for example, fitness and nutritional experts) working in the community. Interestingly, workforce innovation is most advanced in countries such as India or Brazil, where the key challenge is a shortage of skilled professionals. We have much to learn from their experience.”

Professor Lord Darzi, Chair of the Institute of Global Health Innovation, Imperial College London

“There seems little doubt that compassion in healthcare has suffered at the expense of an over-emphasis on technology and technique, however we shall do the public and patients no favours by a nostalgic shift back to an imagined more caring world – a world which actually produced such hospital scandals as Ely for people with learning disabilities and South Ockenden in mental illness. The real challenge facing the healthcare workforce now is to continue to realise the huge opportunities of technical advances, while never forgetting that it is human relations, which lie at the heart of all excellent health service experiences.”

Sophia Christie, Director, UKPrime Ltd

Key proposal:

21 We need to understand the new roles and skills that will be required in the future, and ensure that primary care is fully represented within the new Local Education and Training Boards and at Health Education England.
We need to break the boundaries that prevent funds flowing into primary care

For new services to be developed out of the hospital and in the wider community there will need to be a flow of money from secondary to primary care.

Current payment/contracting mechanisms militate against this. While secondary care continues to be paid by activity (Payment by Results) and primary care/general practice by capitation, the incentives will continue to see a disproportionate flow of funds into hospitals.

Key proposals:

22 We need to move towards integrated services that are funded on a capitation basis and to simplify commissioning/contracting mechanisms that enable more services to be provided in primary care. Tendering for contracts, for instance, on average costs £100,000 and take six months. We will need to cut the red tape from these processes and ensure that the any qualified provider model remains under the control of clinical commissioners.

23 We need to develop a new community pharmacy contract that moves away from dispensing and retained profits to the delivery of clinically based services and full integration within the new primary care.
We need to ensure that primary care takes on a leadership role across the whole healthcare system

Following the Francis report, there is a clear role for general practice, as the gateway to the NHS, to be the first place that patients and communities go to make their voices heard.

It will be essential that GPs play the role of the ‘critical friend’ – the one person who has insight both into patients’ concerns and experiences and into the institutions providing care. GPs need to ensure the patient voice is heard loud and clear, and that the quality of local services remains high. This should also involve leadership at the highest levels of the NHS reflecting the key role of primary care.

Key proposals:

24 General practice should actively monitor quality and safety of their health system and actively drive up health outcomes.

25 All staff in primary care need to be supported by their clinical commissioning group to respond to feedback from patients about any part of the healthcare system and to see this guardianship of overall quality as an important part of their role.

26 We need leadership at the highest levels of the NHS reflecting the key role of primary care. If the “Primary care led NHS” is moving from rhetoric to reality then there needs to be a GP or other primary care professional at the Department of Health or National Commissioning Board who is visibly working at the same level as the Chief Medical Officer or the NCB Medical Director.
We need to break a culture that avoids acknowledging errors to create a culture that learns from mistakes and has the freedom to innovate

Millions of decisions are made every day about patients’ care. While many will be good decisions, made alongside the patient, some will be poor and a few will be disastrous. Currently, too many people fear talking openly about what has gone wrong and what we can learn about improving care.

At its extreme, systems prioritise finances over patient care and ignore warnings from patients and staff. We need to make it easier for staff to discuss problems with each other as well as with patients and their families or carers. We also need to ensure that the learning and the changes we make are openly shared on our websites.

“If there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experiences that lie behind statistics and benchmarks and action plans that really matter, and that is what must never be forgotten when policies are being made and implemented.”

Robert Francis QC

Key proposals:

27 Local health systems should create new mechanisms for staff to share and discuss things that go wrong.

28 Equally, primary care professionals should seek to develop a culture in which they are able to innovate, with a concomitant duty to audit the impact of innovation.
Where is this happening already?

Out-of-hours services have been the subject of widespread investigations and negative media attention and may well offer lessons applicable to primary care. The investigation into the death of David Gray by a drug overdose, or what the coroner more correctly called an “unlawful killing”, found the provider organisation had not learned lessons from complaints and previous incidents, had poor governance systems and did not have transparent reporting mechanisms or clear data. PCTs were also criticised for failing to commission properly or manage the performers’ list with adequate scrutiny and controls. This theme of governance and control of systems and processes is likely to resonate for general practice as it develops from its “cotage industry” history into the general practice of the 21st century.

The NHS Alliance developed its own response to this particular catastrophic failure. Rather than focusing on tightening rules and guidance, we developed a new system for rapidly sharing failures across a dozen out-of-hours services. A website allows services to make anonymous reports as soon as possible after something has gone wrong so that others could learn and explore how to avoid repeating the mistake within their own service. Clinical leads meet to share learning and there are signs that the culture and behaviour of clinical staff is beginning to change, as people feel more able to discuss, share and learn from things that go wrong. Two years on, there may now be scope to extend this approach to groups of in-hours practices, working within CCGs or localities, providing quick and easy systems to learn from each other and improve patient safety.

Rick Stern, Chief Executive, NHS Alliance and
Yvonne Sawbridge, Senior Fellow, Health Services Management Centre,
University of Birmingham and Co Vice Chair, NHS Alliance
A new culture for primary care

“The question before us, as primary care professionals and supporters, is how to develop a culture that ensures people come before numbers and individual experiences matter above all else in the NHS?

We are fortunate at the NHS Alliance to have the benefit of a wide range of talented, independent and open-minded thinkers among our membership: not just from primary care, but from patients, the third sector, the independent sector and other public services. We will be engaging our membership in an open and frank discussion about the culture of primary care. We cannot assume that what happened in Mid Staffordshire will not happen in the community. Primary care is subject to similar pressures: targets, resource constraints, reorganisation and a constant requirement to ‘feed the beast’ rather than focus on meeting the needs of patients. In addition, there is the risk of professional isolation.

The importance of general practice as both a sentinel - and often as confessional – for patients is one of its many strengths. We need to therefore find effective ways to garner and share any concerns that we find about problems in any part of the system. In some cases this might mean disruptive challenge – the Alliance will not shrink from this if it is needed. But we also need to look to the culture in our own back yards. We know that culture is enduring and one of the most difficult things to change in any organisation.

One of the main ways for leaders in primary care to start is by ensuring that we find effective ways to listen to our patients and staff and to support each other. We can also encourage these groups – our main assets – to identify the good things and do more of them and also to tell us where change is needed. Where possible, we can empower staff, patients and the wider community to find solutions and lead change where this is appropriate. In the NHS Alliance we have longstanding expertise in involving not only patients, but also residents, in improving health as well as their healthcare. Our approach is therefore to listen to and empower those in primary care at every level to put patients first.”

Heather Henry RGN is Managing Director of Brightness Management Limited and is leading work for the NHS Alliance on changing culture and behaviour.
How we developed this manifesto

This manifesto was developed with the help of NHS Alliance members and friends, including Dr Judith Smith and Dr Rebecca Rosen at the Nuffield Trust, Nicola Walsh at the King’s Fund, Professor David Colin-Thomé OBE, and Professor Paul Corrigan CBE to whom we are most grateful. We would also like to thank Hunter Healthcare and Novartis for their support.

We are very grateful to all those who provided the articles (details below) that informed our thinking and those who attended and facilitated a workshop to develop these ideas.

The future of primary care
Dr Michael Dixon, Chairman, NHS Alliance, outlines why primary care can – and must – become the designer of the new NHS landscape.

Can policy save the NHS?
Michael Sobanja, Director of Policy, NHS Alliance, explains why primary care must seize the current policy agenda to deliver value, shared decision making, strong accountability and better outcomes for patients.

What does good look like for patients?
Jeremy Taylor, Chief Executive of National Voices, explains what patients want and how “person-centred co-ordinated care” can help deliver this. The challenge is to find how the myriad new structures in the English health and care system can now pull together to make it a reality for patients and their families.

Care without boundaries: the future of information
Dr Mark Davies, Medical Director of the Health and Social Care Information Centre, on GPs’ duty not only to make sure patient data is kept safe and used responsibly for individuals, but also made available to support populations. He describes his vision for sharing patient data across boundaries in different services and settings making sure patients feel involved and feel safe and secure.

Tackling clinical variations in primary care
There is evidence of widespread variation in the quality of general practice. The use of primary care data to support improvements in the quality of care delivery is key to tackling variations, say Anna Dixon, Yang Tian and Veenagh Raleigh of The King’s Fund. General practice needs to be supported to understand variations in the quality of care and to identify areas where improvements are needed.

Practical tools for tackling unwarranted clinical variation in practice
Ruth Chambers, GP and Clinical Director of Practice Development and Performance and Tracy Cox, Practice Development and Performance Manager, NHS Stoke-on-Trent CCG outline a practical approach.

What does CQC inspection mean for primary care?
The CQC explains its new inspection regime.
THE FUTURE OF GENERAL PRACTICE

Should clinical commissioners shape primary care?
Shane Gordon, Amit Bhargava and Julie Wood argue that although CCGs do not commission primary care they could help shape its future in a changing world if general practice will let them.

A series of papers explore what shape general practice might take to break existing boundaries:

★ Caroline Kerby and colleagues explore whether the small general practice, locally known and trusted, should be superseded by super practices based on economies of scale? Or do we need new models that take the best of both worlds?

★ Dr Brian Fisher explores a co-production model for the NHS in which general practice looks outwards to local neighbourhoods to create supportive social networks, seeking out local energy, where it exists, to help deliver and broaden services, and seeing clients for what they can do, not just what they need.

★ Professor David Colin-Thomé argues for creating a new “primary care home” in which organisations can work together to provide services at scale, but maintain the values that come with being small and local.

★ The communities we live in affect our health. Professor Chris Drinkwater and Dr Brian Fisher argue that primary care needs to take a wider approach to building healthier communities that focuses on people not places.

★ Dr Minoo Irani and Dr Donal Hynes argue for vertical integration by breaking down the organisational and professional boundaries that have limited the success of delivering integrated care.

CHANGING THE CULTURE OF PRIMARY CARE

Changing the culture of primary care
Everyone understands that the culture of primary care matters – but what does good primary care look like? Yvonne Sawbridge, Senior Fellow, Health Services Management Centre, University of Birmingham, kicks off the discussion and argues for a dose of anarchy.

Building our own community
Heather Henry argues that the primary care community is showing the same symptoms of disempowerment as other disadvantaged communities – and could use the same tools to address this.
Housing and primary care: making integration meaningful

**Jake Eliot**, Policy Lead, National Housing Federation, argues that closer working between primary care and housing associations is vital to delivering high quality, sustainable services.

Sharing successes and learning from failure

**Yvonne Sawbridge** and **Rick Stern** argue that leaders in primary care need to focus on developing a culture that prevents failure and learns from past mistakes.

NEW MODELS FOR INTEGRATING SERVICES

Integrating physical and mental health

**Professor Chris Drinkwater**, NHS Alliance Public Health Lead, and **Dr Brian Fisher**, NHS Alliance Public and Patient Involvement Lead, argue that integrating mental and physical health services and promoting mental wellbeing makes sense for people, populations and the public purse.

Integration in the new environment – what is the vision and how do we advance it?

**Dr Donal Hynes**, Co Vice Chair, NHS Alliance, and **Dr Minoo Irani**, NHS Alliance Specialist Network Lead, argue for an integrated system that sees care organised around individuals’ and populations’ health in which emergency admission is viewed as a failure.

Responding to the challenge of complex long-term conditions

**Professor Chris Drinkwater**, NHS Alliance Public Health Lead, argues for a life cycle approach to managing long-term conditions which addresses people’s needs as they change.

What is the future for integrated urgent care?

**Rick Stern**, Chief Executive, NHS Alliance, argues that general practice must take a whole system approach to urgent care – starting with a critical look at whether patients can access their services.

Personalisation

**Mo Girach** explores the implications of personalised healthcare budgets.

NEW WAYS OF WORKING

Medicines optimisation: a new currency for primary care

**Mark Robinson**, Director of the Medicines Management Partnership, calls for a new approach to medicines optimisation to help ensure good outcomes for patients.

We’d like to share your record with a new expert – you

**Dr Brian Fisher**, NHS Alliance Public and Patient Involvement Lead and co-director of PAERS Ltd, says it is time to overcome resistance to giving patients online access to their own records – and not just because the government says so.
Shared decision-making: being the change we want to see

Georgina Craig and Dr Brian Fisher argue that shared decision making must become the way we do things – not just with patients but at community and practice level too.

The future workforce

Sophia Christie, director of UKPrime Ltd, argues that the primary care workforce must get ready for a new technology-based health service, without forgetting the human skills of compassion and caring that lie at the heart of excellent health service experiences.

Telehealth

In two articles, Lynn Young, member of the national Telehealth Forum, and Former Primary Care Advisor to the Royal College of Nursing, explores why general practice needs to take up telehealth – but so far has not done so.

Ruth Chambers, GP and Clinical Director of Practice Development and Performance, NHS Stoke-on-Trent CCG and Phil O’Connell, Global Project Lead for Simple Telehealth explore some of the tools and outcomes from using this technology.