Editorials

Breaking boundaries:

reinventing general practice for the 21st century

Front-line general practice is feeling the squeeze: demand is rising, access targets are hard to meet, and practice income is falling. In addition the government is imposing a new contract that includes four new requirements that relate to dementia: early diagnosis; telehealth; patient record access; and managed care for those at high risk of hospital admission. These requirements will further increase workload, although the evidence that they will improve outcomes is somewhat uncertain. In the meantime much of the brightest talent in general practice is hard at work establishing clinical commissioning groups that are expected to control hospital costs while having relatively little influence or control over general practice and community services where risk and unsustainable demand needs to be effectively managed.

The 1950s is the closest parallel to the current state of demoralisation but this era saw the foundation of the College of General Practitioners and a new deal for general practice with financial incentives to form group practices, to employ ancillary staff, and to create practice teams with attached district nurses and health visitors.[1] The NHS Alliance document *Breaking Boundaries*[2] suggests that we need to use the current crisis to push for another step change that redefines general practice and community service provision for the 21st century.

The evidence that countries with strong primary care systems are more cost-effective with better outcomes and better patient experience is indisputable.[3] Despite this an increased proportion of health funding, both nationally and internationally, over the past 20 years has gone to disease-specific projects rather than more broad-based improvements in population health, such as preventive measures, primary care services, and health workforce development.[4] One reason for this is predominance of advice to the higher reaches of the NHS from hospital managers and specialist clinicians, rather than generalists. A good start would be to ensure that there is a GP or other primary care professional at the Department of Health and the National Commissioning Board who is visibly working at the same level as the Chief Medical Officer or the Medical Director of the Commissioning Board. This person would then lead a programme and *Breaking Boundaries* suggests that this will need to focus on a number of discrete areas.

BREAKING BOUNDARIES BETWEEN PRIMARY CARE AND PATIENTS AND THE PUBLIC

The NHS is currently uneasily poised between a 20th century system in which health is produced by clinicians working in hierarchical organisations, delivering packets of care to waiting deferential users, and a 21st century system in which health is co-created through partnership and effective sharing of information between clinicians, patients, and the wider public. Movement towards a 21st century system, which is more than telehealth and access to information, needs to accelerate if the savings of £30 million per annum that the 2002 Wanless Report[5] predicted would arise from a 'fully engaged' scenario are to be achieved. It requires GPs to take a more active role as advocates for their local community and it needs to move from a model, where expert health professionals are responsible for health production influenced from the outside by consumer voice and choice, to a model where co-productive engagement between health professionals and patients at the point of service delivery becomes the norm.[6]

Some of this is already happening with projects such as the Deep End Project in Scotland[7] and the Health Empowerment Leverage Project in England.[8] Both of these projects are about GPs in disadvantaged communities working with and developing local assets and resources to address the wider determinants of health. In addition, at the level of individual patients with long-term conditions, there is a need to move from the current episodic monitoring approach, to a care planning approach that supports active engagement of patients in understanding and managing their condition.[9] Bringing these two elements together provides added value with care-planning training, sensitising professionals to a wider range of social prescribing options,[10] at the same time as capacity and competence to deliver these options is increased in the local community. The further essential component of this approach is increasing the role of community health workers such as health trainers and community health champions[11] so that they can improve levels of health literacy and act as conduits to a range of healthy options for non-clinical support.

BREAKING BOUNDARIES IN THE HEALTHCARE SYSTEM

Much of the current drive for integration derives from the fact that the NHS is bedevilled with boundaries: between practices; between the various tribes in community services; between primary and secondary care; between out-of-hours and in-hours care; between health, social care and the voluntary sector; between specialists and generalists; and between physical and mental health. Integration is about much more than structural realignment or competition as a driver of change. It is about how local health and social care economies make best use of all available assets to provide holistic, integrated care wrapped around individual needs.

Freeing up capacity to scale up and do things differently has to come at both practice level and through practices sharing staff and resources. The RCGP proposal for primary care federations is one option. The North American concept of a 'primary care home'[12] where GPs and other primary care providers come together in an integrated, population-based provider organisation covering a local population takes this a step further with the added option that it can include specialists for care of the elderly, mental health, diabetes, children, and other community-based specialities. This requires a complete re-think of

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specialist roles separating technical interventions from enhanced community specialist responsibilities. Instead of seeing an ever increasing number of individual referrals, community specialists would work systematically to develop high-quality cost-effective population-based services; supporting primary care to take on new roles and responsibilities. Incentive and reward systems would need to be completely redesigned, replacing the current payment for episodic interventions with rewards for local quality improvement and population outcomes. These specialists would also have a role as advocates for preventive approaches and for community reablement. The RCGP and specialist registration bodies may need to think about finding the capacity to include GP attachments in the training of these specialists.

An additional part of this local population-based provider approach would be responsibility for 24/7 care. This is currently fragmented, varies in quality, and is in danger of undermining trust in general practice by both patients and hospitals. This is not about individual GPs having 24/7 responsibility, it is about the local primary care provider community developing a system with shared collective responsibility that has close working relationships with local A&E departments and a local approach to social marketing of out-of-hours services.

The RCGP and the wider general practice and primary care community should focus on re-thinking primary care provision for the 21st century. This requires change and breaking existing boundaries. The alternative is vertical integration with hospitals as lead providers and clinical commissioning groups left with the unpopular role of rationing demand through managing a local healthcare market.

Chris Drinkwater,
Emeritus Professor, University of Northumbria, Newcastle upon Tyne, and President and Public Health Lead for the NHS Alliance.

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ADDRESS FOR CORRESPONDENCE

Chris Drinkwater
30 Battle Hill, Hexham, NE46 2EB, UK.
E-mail: chris.drinkwater@gofo2.co.uk

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