NHS England Primary Care Reforms

Lessons for Aotearoa New Zealand

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Better Health Outcomes
through Great Primary Care

CAVEATS

Caveats to be noted with publication of this report in *New Zealand Doctor*

1. This is my report, not Federation of Primary Health thinking or policy. The Federation output may not include any of these elements.
2. These are items that I saw of interest in the UK, it is not necessarily what I would propose as a prescription for NZ health policy.

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1. Introduction

This document provides reflections from a 12-week sabbatical based at the Kings Fund, an independent think tank in London, and at the Health Services Management Centre in Birmingham.

The author met with a variety of key informants including:

- policy advisors, clinical leaders, and leadership development consultants at the Kings Fund, the Health Foundation, National Health Service (NHS) England, the Primary Care Home association, and NHS Scotland;
- academic leaders at the Health Services Management Centre and at RAND Europe;
- GPs, clinical leaders, commissioners, Non Government Organisations (NGO) partners, local authority management, and NHS Trust executives at University Hospitals Birmingham, Wolverhampton, Our Health Partnership, Modality, Torbay and South Devon, Nottingham, Queen Elizabeth Hospital Birmingham, Dudley, Tameside and Glossop, Oldham, and Greenwich;
- the Scottish national primary care adviser in Edinburgh;
- policy managers, GPs, World Health Organisation advisors, ICT developers, and Health Fund executives in Macedonia; and
- GP leaders, Local Authority leaders and Regional Funders in Denmark.

Discussions with informants were conversations rather than structured interviews. They involved a two-way exchange of views about the current challenges and opportunities in primary health care and integrated care.

The reflections recorded here are the opinions of the author and have not been tested with informants.

2. United Kingdom Context

In general, the United Kingdom (UK) system is not dissimilar to the New Zealand health system. The Government owns and funds most hospital services and funds general practice services through a national agreed capitation contract. Most general practices are owned by independent partnerships, but the majority of GPs are now employees or contractors rather than being practice owners. Both hospital services and general practice services are free at the point of delivery (although there is a pharmacy part charge for prescribed medicines). The GP population is ageing and considered to be insufficient to ensure ongoing good access. Wait times for routine appointments often exceed two weeks. Estimates of the shortfall in GPs numbers vary between 5,000 and 7,000 FTE. Shortages are more severe in parts of Scotland.

The biggest recent development in the NHS is the publication of the NHS Long-Term Plan, launched on 7 January 2019. The Kings Fund provides a detailed overview of the plan in this

explainer (www.kingsfund.org.uk/publications/nhs-long-term-plan-explained). The Long-Term Plan is strongly focused on building integrated primary and community care as the heart of the health system. The opening promise of the NHS Long-Term Plan is to "boost out-of-hospital care and finally dissolve the historic divide between primary medical and community-based services". [1]

The table below from Developing Integrated Care Systems in England[2] provides an overview of the in-progress structures.

Overview of integrated care system and their priorities from the NHS Long-Term Plan

Level	Functions	Priorities from the NHS Long-Term Plan
Neighbourhood (c.30,000 to 50,000 people)	• Integrated multi-disciplinary teams • Strengthened primary care through primary care networks – working across practices and health and social care • Proactive role in population heath and prevention • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).	• Integrate primary and community services • Implement integrated care models • Embed and use population health management approaches • Roll out primary care networks with expanded neighbourhood teams • Embed primary care network contract and shared savings scheme • Appoint named accountable clinical director of each network
Place (c.250,000 to 500,000 people)	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance	• Closer working with local government and voluntary sector partners on prevention and health inequalities • Primary care network leadership to form part of provider alliances or other collaborative arrangements • Implement integrated care models • Embed population health management approaches • Deliver Long-Term Plan commitments on care delivery and redesign • Implement Enhanced Health in Care Homes (EHCH) model
System (c.1 million to 3 million people	• System strategy and planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes	• Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system) • Collaboration between acute providers and the development of group models • Appoint partnership board and independent chair • Develop sufficient clinical and managerial capacity
NHS England and NHS Improvement (regional)	• Agree system objectives • Hold systems to account • Support system development • Improvement and, where required, intervention	• Increased autonomy to systems • Revised oversight and assurance model • Regional directors to agree system-wide objectives with systems • Bespoke development plan for each STP to support achievement of ICS status
NHS England and NHS Improvement (national)	• Continue to provide policy position and national strategy • Develop and deliver practical support to systems, through regional teams • Continue to drive national programmes e.g. Getting It Right First Time (GIRFT) • Provide support to regions as they develop system transformation teams	

The Long-Term plan is being implemented, in part, through the new five-year GP contract agreed in January 2019. GP practices were asked in February 2019 to come together into geographically contiguous Primary Care Networks (PCNs), each covering a population of 30,000-50,000 patients, and by July 2019 over 98% had done so. The GP contract provides significant new investment which will flow via these 1,300 PCNs. Some 20,000 additional staff will be supported to work in general practice through the new contract, including physiotherapists, social prescribing link workers, paramedics, physician associates, and pharmacists. The additional funding is in the order

[1] Source NHS England board report on primary care July 2019 https://www.england.nhs.uk/wp-content/uploads/2019/06/6-Primary-Care.pdf

[2] Available from: https://www.england.nhs.uk/publication/designing-integrated-care-systems-icss-in-england/

of $NZ600 million per year. Funding for primary care is guaranteed to increase faster than general health funding over the five-year period. More detail is available here: www.kingsfund.org.uk/publications/primary-care-networks-explained

Innovations in one country cannot be simply transplanted to another. Nonetheless, we have many challenges in common with other countries and it is often possible to learn lessons from what has gone well, or badly, in another jurisdiction. Both the UK and New Zealand are experiencing:

- a shortage of GPs, and a shift to more part-time work;
- increased demand and complexity from an aging population, in tandem with a reduction in use of rest home care;
- increased consumer expectations;
- a rise in the prevalence of non-communicable diseases; and
- difficulty adopting the digital innovations occurring in the rest of society.

The next section outlines some of the trends and innovations that I believe we might learn from.

3. Lessons for Aotearoa

3.1 A multiyear investment in enhanced primary care

Both the UK and New Zealand identify primary care as one of their priorities. The UK, however, in contrast to New Zealand has detailed and significant investment plans to boost the capacity and capability of primary care, and to encourage integration with community health services. The plans are being implemented through a new national contract that will pay 70% of the costs of employing physiotherapists, clinical pharmacists, paramedics, and physician associates, and 100% of the cost of employing social link workers in general practice led primary care networks (PCNs). Each PCN can decide on the balance of roles, and how they will be deployed. Not everyone is welcoming all the new roles, but there is a sense that the Government has finally developed a sensible policy response to the increasing demand for and diminishing supply of primary care services.

The changes will result in more comprehensive and accessible primary health care, however, there is a risk that these changes, along with the changes that have already occurred in relation to urgent care in the UK (such as walk in clinics), will continue to reduce continuity of care and promote less person-centred care. This is a particular risk in the UK where there are no meso-level organisations responsible for working with practices to support workflow changes in ways that will preserve these important attributes.

3.2 Clinical pharmacy embedded roles in general practice

In vanguard areas, the clinical pharmacist role in general practice is already well accepted and positively endorsed by GPs. In other areas the role is new and is being introduced as part of the 2019 five-year contract through PCNs. A broad range of clinical pharmacist functions were described, with different scopes in different practices. These included:

- individual patient contact focusing on case finding, cardiovascular risk assessments (CVRAs), medication adherence, and dose titration for statins, high blood pressure medications, anticoagulation monitoring, etc;
- medicines reconciliation post discharge / specialist outpatient clinic;

- repeat scripts service – often across a number of medical centres;
- quality / evidence-based use of medicines feedback to GPs;
- local formulary development; and
- general medication advice to GPs and other practice team members.

Many clinical pharmacists are also authorized prescribers, increasing their usefulness in general practice work.

Dudley is one of the trail blazers in the use of clinical pharmacists in general practice, having 55 clinical pharmacists, 50 of whom are prescribers, serving a population of just over 300,000.

The expectation is that under the new GP contract there will be about one FTE per 10,000 population. I heard estimates that, on top of quality gains, some 6% of GPs face-to-face work could be diverted to clinical pharmacists.

3.3 Physiotherapy embedded in general practice

Most physiotherapists in England are employed in NHS Trusts and see patients referred by GPs. First contact physiotherapy is predominantly fully private and unfunded. Estimates are that the new NHS GP contract will fund about one FTE physiotherapist per 10,000 population. The Health Foundation estimate is that a physiotherapist will be able to cover, on average, about 10% of a GP's patient-facing work.

GPs with physiotherapists in their teams talked about both referring patients with more complex musculoskeletal (MSK) problems to the physiotherapist, and also having them see patients directly. The physiotherapists are extended scope practitioners, able to order imaging and lab tests, to prescribe medications, and to refer to specialist services in the same way GPs do. Pilots suggest that Physios working in general practice, when compared to GPs:

- made 21% fewer orthopaedic referrals;
- wrote 12% fewer drug prescriptions; and
- ordered 10% fewer blood tests, for MSK patients.

The standard general practice appointment in the UK is 10 minutes, but the physiotherapist standard appointment length is 20 minutes.

Patients reportedly required some re-education as they expected to see the GP with, for example, back pain, but pilots indicate good acceptability from patients over time.

3.4 Paramedic roles embedded in general practice

Paramedic roles are less common in general practice. I heard that one reason paramedics were included in the new GP contract is that the UK has been training too many paramedics over the past few years. Hence there is an underemployed clinically trained workforce. Many GPs were sceptical about the value of paramedics in general practice. But those that already used them considered them a useful resource. They were mainly used for visiting complex frail patients at home, checking on their care and relaying any concerns back to the GP.

One GP in a large practice described the paramedic's role as follows:

"Her main role is home visitations. It's brilliant because they tend to be excellent at that important job of knowing - does this patient need to go to hospital or not. ... It's like they are her cohort of patients she knows them all really well. She can then come back and liaise with their usual doctor about that patient. It helps that she is extremely competent so there's a lot of trust that she's doing a good job. It's working very well those patients are getting continuity we've still got the duty doctor there to support her if she's got queries and if we think that things are too medically complex for her. There's actually very little that she's not pretty capable of doing and often it's just even if she's not sure she can go she can examine, she can present the clinical findings, and then she can leave the collaborative decision with the GPs. We are doing virtually no home visits now."

3.5 Social prescribing and social link workers

The UK has pioneered the concept of social prescribing[3], which involves intervening in the social and behavioural causes of ill-health. Social Prescribing Link Worker programmes, according to NHS guidance, are expected to have the following key features:

- **Personalised coaching approach** Link workers develop trusting relationships and give people time to tell their stories. It is crucial for link workers to start with 'what matters to me' and to value what motivates the person.

- **Workload** Link workers typically work with people over 6-12 contacts (including phone calls and meetings) over a three-month period (depending on what the person needs) with a typical annual caseload of up to 250 people, depending on the complexity of people's needs and the maturity of the social prescribing scheme.

- **Salary** The average salary of a social prescribing link worker is around £25,000 per annum (about $NZ 50,000).

- **Home visits and introducing people to community groups** Link workers organise home visits to make initial assessments and build rapport, especially to engage with hard to reach ethnic groups or where people are isolated from their community. It may be necessary for link workers to accompany people to community groups to facilitate and support that first step, where people don't have the confidence to do this on their own.

- **Care and Support Plan** An important element of social prescribing support is for the person and their link worker to co-produce a simple plan or a summary personalised care and support plan, which outlines:
  - what matters to the person – their priorities, interests, values and motivations;
  - community groups and services the person will be connected to;
  - what the person can expect of community support and services;
  - what the person can do for themselves in order to keep well and active; and
  - what assets people already have that they can draw on – family, friends, hobbies, skills and passions.

In practice, the nature of link worker roles varies widely. In some areas the main issue is social isolation in the elderly. In more socioeconomically deprived areas (eg Focused Care in Oldham,

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[3] For more information on social prescribing visit: https://www.england.nhs.uk/wp-content/uploads/2019/01/social-prescribing-community-based-support-summary-guide.pdf

Manchester) the job is working with households that have "failed to thrive'' by helping them to deal with family violence, drug misuse, and other symptoms of intergenerational poverty. In the areas I visited, the schemes often went beyond helping individuals to cope (eg by helping them join a local community group), to aspects of community development (eg by helping communities to set up new ongoing programmes).

In New Zealand terms the role has similarities to those performed by a health coach, health navigator, community worker, NGO support worker, or kaiawhina, but the role and purpose is more clearly articulated, and often well integrated into general practice teams.

3.6 Physician Associates in General Practices

This role is fairly new in England, and is practically unknown in New Zealand, though has been in use in the USA for decades. Training and regulation is still in development in England. The standard course is a two-year post graduate diploma with 1,600 hours of clinical training across a range of specialties

It's a generalist role covering

- health promotion;
- performing physical examinations;
- taking medical histories from patients;
- diagnosing illnesses;
- seeing patients with long-term conditions;
- undertaking residential, nursing and home visits;
- analysing test results;
- making referrals; and
- developing management plans.

The physician associate can prescribe / order in tandem with a GP in the USA. This is in development in the UK. This role is something of a surprise inclusion in the five-year GP contract. An attraction is the two- year training programme – which is split between theory and practice.

3.7 Quality improvement clusters in Scotland

The 2018 Scottish GP contract aimed to take away some of the compliance-based aspects of the previous Quality and Outcomes framework (QOF) and introduce an approach that provides paid time for quality improvement. Each practice has a practice quality lead funded two sessions per month. Practices are grouped into geographically contiguous clusters of around 30,000 population – about six practices per cluster. Every cluster has an appointed Cluster Quality Lead with four sessions funded per month. Clusters have an assigned data analyst to help them work on improving quality using an Institute for Health Improvement style collaborative Plan Do check Act quality improvement approach. There is a website with tools and guidance available here: https://www.sehd.scot.nhs.uk/pca/PCA2019(M)08.pdf .

Scotland is also working on wrapping enhanced primary care team staff (particularly allied health staff) around practices in clusters, but the extended staff are employed by the local hospital trust.

3.8 GP at Hand and Digital First: use of video and telephone consultations

A variety of video and digital first solutions are spreading throughout the UK. The most well-known example is *GP at Hand*, a video plus face-to-face service provided by Babylon in competition with local GPs. Patients enrolled with GP at Hand can access extended hours, same day video appointments with a GP, physiotherapist, dermatologist, or prescribing pharmacist. They can then be offered a follow up face-to-face appointment at a limited number of sites if deemed clinically necessary. The service is growing rapidly. GP Federations and Super Partnerships are now scrambling to offer video consultations using alternative suppliers such as Livi, who offer video consultations in cooperation, rather than in competition, with local GPs. Interestingly, an evaluation of GP at Hand found that the majority of GP at Hand users preferred voice only to voice plus video consultations, implying that rapid access to a GP by phone only would meet many people's needs.

Many practices also use E-consult (https://econsult.net/) or similar products. E-consult is a structured electronic consultation service. It provides a symptom checker type set of questions for a set of common conditions and a general e-consult option. The answers can lead to either self-help advice or be summarised as a request for advice type note to your GP.

The *Ask NHS* app also provides an interactive symptom checker, with a digital 'nurse' and has the ability to link to GP appointment books. The app is being extended over the next two years, and as part of the digital first strategy, all practices are expected to provide digital communication options by 2020. Most GP practices do not yet provide an option for patients to book online, nor do they provide electronic advice through unstructured secure messaging. In this respect the capability in the UK (including with GP at Hand), lags behind what is available in Health Care Home practices in New Zealand.

3.9 SH:24 online testing and treatment for STIs

SH:24 is an NGO that contracts with a number of local health commissioning bodies, and with some funders in other countries, to provide free to the user online testing kits and online advice and treatment for sexually transmitted infections (STIs) and for contraception.

Users can obtain self-help advice through videos and other resources on the SH:24 website, and can request self-testing kits for Gonorrhoea, Chlamydia, HIV and Syphilis. Kits can be sent by mail or using a ''click and collect'' type service. The kits are for sample collection only – the patient must return the sample in a postage paid return envelope. SH:24 will txt the lab results back to the user and can provide further information by txt.

Those with positive results are referred to the nearest sexual health clinic or their GP, except in the case of chlamydia, where treatment via the SH:24 team is an option. Users can also upload photos to get diagnosis and treatment directly from SH:24 for herpes and genital warts. Users with positive results are recommended to use SXT.org.uk for an anonymous online partner notification service.

Some services, such as the Family Planning Association in New Zealand has started providing in clinic self-sampling kits, and there are fully commercial STI services, but I am not aware of any providing a comprehensive service including mail order kits, and clinical advice by txt.

3.10 Health Information platform in Macedonia

Moi Termin (My Appointment) is the national health information platform provided by Sorsix in the Republic of Northern Macedonia, and in Serbia. By using an application programme interface (API), the platform connects to nearly all GPs and hospital clinics in Macedonia. Users can

continue to use their own patient management systems and simply interface, or, can use some or all of the PMS functionality built into the system. The system allows electronic referrals, electronic prescriptions, online appointment booking and waiting time visibility across providers, electronic claiming, as well as providing an identity management infrastructure. The Ministry of Health can see in real time the volumes and types of prescriptions, referrals, discharges, etc.

The platform very nicely integrates information across providers, without competing with existing PMS products.

3.11 Working with Local Authorities to improve Health and Wellbeing

Back in the mid-1990s New Zealand transferred the budget for rest homes, disability support, home help, personal care, aids and equipment, and most other nonmedical aspects of care, from Vote: Social Welfare, to Vote: Health. In the UK, local authorities are funded by central government to fulfill these 'social care' responsibilities. Budgets for social care are more likely to be cut in tight financial circumstances than the NHS budget. They are also subject to means testing. Sometimes lack of social care availability can increase length of stay in hospitals. Hence integration in the UK context often is about bringing together health and social care across budget and organisational silos.

The health and social care silos have meant that the NHS executives have a strong motivation to work closely with local authorities. In turn in some areas has resulted in joint local authority – NHS CEO appointments, and in a stronger understanding in local government of the importance for health and wellbeing of urban design elements such as active transport, green spaces, recreation facilities, alcohol and gambling outlets, and fast food availability. In New Zealand by contrast, there is often little ongoing purposeful engagement between health and local government leaders.

3.12 Primary Care Networks

The UK, Scotland and Denmark are all encouraging geographic communities of practices covering between 30,000 and 50,000 people – around seven practices and about 30 GPs. The focus is in part on collegiality, and on collaborative quality improvement. But there is also an agenda to promote community oriented primary health care. Particularly where local networks have social service link workers, practice teams are much more aware of local community organisations and services, and are able to be involved in community development to support better health and wellbeing. Examples can include connecting isolated individuals up to form new groups supporting shared interests (gardening, walking, etc), or lobbying for services to meet community needs such as day centres, recreation facilities, etc.

Some local networks are developing local neighbourhood plans that span both clinical improvement activities and work on some of the social determinants of health through local community action via link workers. For instance, I saw a neighbourhood health plan in Manchester that included specific plans for:

- their frail elderly population, (developing ACPs, risk stratification and admission avoidance);
- their patients with long-term conditions (case finding, optimal treatment, self-management support in group settings); and
- work on the social aspects of health with other community agencies (e.g. to become a dementia friendly neighbourhood).

I also saw examples where neighbourhood GP leads were funded to have a day a week in the local acute hospital, providing a useful link between the specialist teams and primary and community services. In many areas, relevant community services are being organised to be able to sensibly dock with local primary care networks and to provide a multidisciplinary response to patients with very complex needs that cannot be met by primary care services alone.

The primary care networks are seen predominantly as relationship-based constructs, rather than organisational entities or contractual agreements.

3.13 Leadership development for integrated care systems

Outside the UK, the Kings Fund is known primarily as an independent policy think tank, which produces influential and highly regarded commentary on health and social care. What is perhaps less well-known is that the Kings Fund is also a very active leadership academy which runs a suite of courses and action learning groups to improve people's capacity to lead change in healthcare.

I came across some specific concepts and resources that I found useful, some of which have been around for a while but I hadn't seen, including:

- **The concept of Teams and Teaming** presented by Amy Edmondson, the Novartis Professor of Leadership and Management at the Harvard Business School. It helps to explain why working across team silos is so difficult, and what leadership is required to achieve it. Her book Teaming explains some of the thinking.

- **The happy manifesto** by Henry Stewart. This book is available online https://www.huddlebuy.co.uk/upload-files/Happy-Manifesto1.pdf. It encourages managers to coach and support and to ''get out of the way''.

- **Leading with Kindness** by Bill Baker and Michael O'Malley, discusses the role of kindness in achieving superior results in business. Reviewed here: https://www.leadershipnow.com/leadingblog/2008/08/can_you_lead_with_kindness.html

- **Cascading Leadership** a model developed for the NGO sector by Lisa Weaks at the Kings Fund. The Cascading Leadership programme was developed in 2015 to enable voluntary and community sector leaders to share their expertise with peers, to talk about some of the challenges they face and to plan new ways of working. During the programme, a Cascading Leadership consultant (an experienced NGO leader) is matched with a Cascading Leadership partner (an NGO leader seeking support). The consultant and partner meet at least five times over a period of eight months. During these meetings, the partner has an opportunity to work through organisational issues and receive support. The consultant also benefits from being stretched to develop their own leadership and skills, while being supported and supervised by senior staff at The King's Fund. Cascading Leadership is distinctive in that it develops the skills of the leaders both receiving and providing the support, building leadership across the sector.

- **The Dawn of System Leadership** an article in the Stanford Social Innovation Review: https://ssir.org/articles/entry/the_dawn_of_system_leadership . The article posits that the great challenges of today (e.g. social disadvantage, climate change) require different leadership approaches that bring people together in collaborative action, and describes the skills and attribute needed for this type of system leadership. As a taster, the article quotes Lao tzu:

  ''The wicked leader is he whom the people despise.
  The good leader is he whom the people revere.
  The great leader is he of whom the people say, "We did it ourselves."

- **Contracting for integrated care** Work by the Kings Fund recommending a transition from arm's length contracting to collaborative relationships to solve complex problems across organisations. Available here: https://www.kingsfund.org.uk/sites/default/files/2019-03/payments-and-contracting-for-integrated-care.pdf

I was struck by the breadth of leadership development programmes that the NHS funded, including through universities and through learning groups such as those run by the Kings Fund. In contrast I am not aware of any New Zealand wide funded leadership development programmes.

3.14 Next Generation GPs

'Next Generation GP' is a development programme for emerging leaders and future 'change-makers' in general practice, designed by GP trainees. Next Generation GP is aimed at GP trainees and early career GPs (first five - seven years) with an interest in health policy and the wider NHS. It is essentially a leadership development and support group. It started in London and is spreading rapidly throughout the country. Those involved enrol in a form of action learning set. They usually complete five workshops / learning sessions.

Examples of workshop topics from the Next Generation website include:

- *The structure of the NHS*
- *How can we influence with impact?*
- *Learning about our strengths as leaders*
- *Staying resilient as a primary care leader*
- *What are new care models, and how will they affect us?*

The idea is to inspire people and to give them tools to lead. It started as a grass roots initiative but is now also supported by the NHS.

I am not aware of a similar group in New Zealand.

3.15 Mental Health

I did not see any mental health programmes in the UK that were as effective as the Te Tumu Waiora model. There was a great deal of concern about difficulty managing the increasing numbers of people presenting with serious distress, and the difficulty integrating with secondary care. Improving Access to Psychological Therapies programmes often had long waiting lists and were generally not well integrated with general practice teams.

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