Visions of primary care in 2015

The forthcoming white paper is certain to result in changes in primary care, but the nature and effect of the reforms is unclear. We asked some people with an interest in general practice to predict the future

Good general practitioners will continue to be essential

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What will English primary care look like in 2015? The proposed new white paper on health and community services in England¹ will affect all of our futures—public, patients, and health professionals. The future is uncertain, but we can be sure that people will still get sick, or think they may be sick, and then they will value care from a doctor they know and who knows them. We present a vision of a values based, patient centred primary healthcare system that is consistently of high quality, safe, accessible, and accountable. We recognise that our aspiration will require considerable investment, system reform, and support for implementation but believe that it is a much needed yet achievable model to improve patient care.

What is primary care?

Primary care has been defined as: “The first level contact with people taking action to improve health in a community. In a system with a gatekeeper, all initial (non-emergency) consultations with doctors, nurses or other health staff are termed primary care as opposed to secondary health care or referral services.”² International comparisons of healthcare systems have shown that the United Kingdom ranks highly on scores of primary care orientation, and countries with good primary care systems show improvement in the health of individuals and populations, together with greater satisfaction with care.³

Within the NHS general practice is a central component of primary care. General practice is defined as: “An academic and scientific discipline, with its own educational content, research base and clinical activity, orientated to primary care and built on fundamental principles.”⁴

Patients’ values

Values such as a commitment to interpersonal care are highly prized by patients and flow from relationship based care and continuity.⁵ Such values are unlikely to change and in fact may become more necessary as complexity in health care increases. Patients do not like having to repeat information and value attempts to coordinate care.⁶ Continuity of care is a relevant concept to both primary and secondary care.⁷ The lynchpin of an effective and efficient NHS in 2015 will therefore be relationship based care, with primary healthcare teams responsible for a well defined population.

In addition, we need an approach to care that consciously adopts a patient’s perspective.⁸ Patients want more information and involvement in their care.^{9 10} In future, patients will be equipped with the knowledge and skills to navigate a complex health and social care

Still diagnosing, prescribing, and coordinating

system, working with a trusted health professional, often a general practitioner. Patients will take part in planning health services, management of demand, assessment of quality, self management, and in group education, as now happens with diabetes.¹¹ The implications of patient centredness for doctors are succinctly captured in the patient principle: “Being a doctor involves adoption of a moral principle that commands the doctor to place the needs of patients before his or her convenience or interests.”¹²

Role of general practitioners in reducing health inequalities

The clinical generalist providing care to patients with undifferentiated problems is critical to the clinical and cost effectiveness of the NHS and is highly valued by the public. The unique skills of a general practitioner are dealing with uncertainty and managing comorbidity.¹³ Given that poorer people have a greater incidence of comorbidity,¹⁴ effective management of comorbidity should help the NHS to have made considerable progress in reducing health inequalities by 2015. General practitioners will operate at a high biomedical level, focusing on diagnosis, prescribing, and coordination of care, including mediation between specialists.

Practices are at the heart of their communities and the local public health agenda will be hotwired into practice systems. Primary care professionals and public health doctors embedded in practice teams will take the health promotion agenda forward in schools and workplaces and will build partnerships with local people to provide leadership for healthy communities.

First contact care and multidisciplinary teams

A great strength of the current general practice model is the pre-eminent role of the primary care team. Such

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team based care allows patients to benefit from the range of skills that different professionals can provide in an integrated fashion and at a convenient location. The range and quality of skills available to patients in 2015 will be even greater as a wider range of professionals come to be based in primary care. The tension between access and choice has always been difficult, but improved skill mix and intelligent booking systems will have enabled the NHS to balance that equation by 2015. Although there will be multiple points of first contact within the practice, patients will be able to choose to see not only a general practitioner¹⁵ but a named general practitioner. General practitioners will work as a part of a highly skilled and expanded multidisciplinary team with clear lines of accountability and leadership.

Organisation of primary care

Patients continue to push for services to be delivered closer to home, and advances in technology should help realise this demand. The current infrastructure of general practices is well placed to deliver the services the public require. For most, in 2015 practices will be the normal unit of care within a network of care providers including social care. Practices will be separate entities but collaborate in community networks that will provide enhanced services, extended chronic disease management, and ambulatory care.

The networks will be different from current primary care organisations in that they will be championed and led by primary care clinicians. They may be virtual or operate from community hospitals with strong systems of leadership and governance that will ensure quality of care, support change in clinical behaviour, monitor use of resources, and commission care. The networks will enable increased responsiveness including enhanced access to health care, particularly out of hours or unscheduled care. General practitioners may also be responsible for some patients in hospital through greater collaboration with specialists.

Virtually all health problems—including mental health—will be dealt with in primary care, with short term referral to specialists as needed. By 2015 local general practices will have undergone major organisational development to become strategic learning organisations.¹⁶ Primary care will have specific strategies to promote “professional happiness,” including access to career opportunities and occupational health services. In future a much greater proportion of the NHS workforce will be trained in primary care, including nurses and doctors’ assistants. Practices and community networks will link formally to a medical school, deanery, and university in their area to foster teaching training and research.

Integration and coordination of care

Interfaces of care are dangerous places for patients,¹⁷ and their care is often disrupted when it crosses interfaces in health and social care.¹⁸ In 2015, systems will have evolved to ensure better coordination of care throughout the health and social care system.¹⁹ Access to specialists will normally be facilitated by general practitioners, who will act as navigators of care. The

Vision

Values of interpersonal care and continuity will be central in 2015, based on registered lists

General practices will be highly developed strategic organisations collaborating with each other in a community network

General practitioners will be advanced medical generalists dealing particularly with comorbidity, diagnosis, and coordination of care

Patient centred care will be delivered by expanded and integrated primary health teams offering a wider range of services in the community

Virtually all health problems will be dealt with in primary care, with short term referral to specialists as needed

Arrangements for public health, quality, safety, and accountability will be hotwired into primary care systems

NHS will have strong models of clinical governance, supported by sophisticated information systems that will help stop the worrying trend for fragmentation of care and define for the patient who is accountable and the responsible owner for a problem.²⁰

Intelligent systems will be in place to ensure the quality and accountability of individual primary care professionals, teams, and provider organisations. All general practitioners will be members of their standard setting body (the royal college) and will participate in fit for purpose professional development and regulatory systems.

Conclusion

Our vision is for a stronger and vibrant primary healthcare system that is patient centred, consistently of high quality, safe, and accountable. General practices will collaborate in a community network model that will be championed by primary care clinicians. Strong clinical and professional leadership will be required to develop and implement this model.

Our message to primary care professionals is this: adopt a progressive reform agenda focused on improving patient centred care. Our message to policy makers writing the white paper is to build on the strengths and values of general practice; avoid policies that run the risk of fragmenting care.

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The magic roundabout

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It is 2015, and what goes around has come around several times in the past 10 years. Back in 2005, Zebedee, or whoever it was who spun the magic roundabout from the Department of Health, seemed confused about the difference between change and progress. Change produced instant good-news stories but constant disruption within the health service. Progress was boring.

Circle of change

So, Dougal the doctor, Florence the nurse, and Ermintrude the practice manager scuttled around reorganising everything. They went from general practice fundholding, through primary care trust commissioning, to practice based commissioning. Primary care trusts merged to become what had been known previously as strategic health authorities. Then, in 2008, Zebedee, convinced that giving most of the health budget to primary care was a recipe for inequity, pulled much of it back to be controlled centrally.

The target set by Zebedee in 2005, that anyone who wanted to see a doctor should be able to do so within two days, proved hopeless, making it more difficult for working patients to get appointments rather than easier. So it was scrapped and the status quo restored. In 2009, after several years of huffing and puffing about general practices having to open around the clock, which proved entirely impracticable, the idea was quietly dropped. Instead, the General Medical Services contract was amended to make commitment to working out of hours more attractive to general practitioners, and to link them to the by now excellent NHS Direct telephone and internet advice service for patients. And we found ourselves pretty much back where we had started. While all this was going on, Brian and Dylan, as patients, looked on utterly bemused.

Patients accept more responsibility

What has really changed during the past 10 years, though, and very much for the better, has been the growing awareness that patients have responsibilities

as well as rights—not just in terms of leading healthy lifestyles, turning up for appointments, and conforming with care plans agreed with clinicians but also in terms of accepting the risks associated with treatments and using those treatments responsibly.

It is difficult to pin the beginning of this revolution to a particular event, but it probably began in 2007 with the ban on smoking in public places. Initial cries of “nannyism” from some sections of the media abated when, by 2012, the number of people smoking in Britain had almost halved, falling from 23% to 12%. Gradually, even the most liberal commentators began to acknowledge that the government is charged with managing the healthcare budget to best advantage, and that health promotion is a sensible and cost effective use of funds.

From the outset, the trend was accelerated by press and public repugnance at some of the scenes of binge drinking and its consequences after the introduction of 24 hour pub opening at the end of 2005. That law was rescinded two years later, but the ugly images remain in the public mind to this day.

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