

Future of Primary Care Report





Welcome

The National Primary Care Network gathers in London to discuss the future of primary care

The National Primary Care Network (NPCN) is an informal group of over 500 healthcare professionals from across primary care including GPs, nurses, dentists, optometrists and pharmacists and was launched on 17 September 2013.

Each meeting is split into two parts. A discussion forum takes place during the day in which the NPCN's members examine a specific, pre-agreed topic. And in the evening, members take part in a networking dinner, which at the first meeting included a welcome speech by Sir David Nicholson, chief executive of NHS England.

This report is intended as a record of the afternoon's discussions. It contains three chapters. The first includes summaries of the presentations that were given by Deborah Jaines (NHS England), Catherine Picton, Gerry Mclean and Dr James Kingsland. The second sees *The Commissioning Review's* senior reporter Lalah-Simone Springer give her overview of the member's reactions and feedback to those presentations. The very last chapter sees Dr James Kingsland OBE – the NPCN's chair – give his personal view of the day's proceedings.

Presentations from GP Care's Phil Yates and Robert Varnam from NHS England will be available to view on the NPCN website.

Cogora Ltd, the integrated media and marketing services company behind *The Commissioning Review* and *Pulse*, supports the NPCN financially but has no impact in the NPCN's discussions. This meeting was also supported by the Royal Pharmaceutical Society and Assura Properties.

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Contents

1. Introduction to the National Primary Care Network
2. Flexible funding – Deborah Jaines presents new models of contracting in primary care
3. Now or never – Catherine Picton explores the changing role of pharmacy
4. 'Never full' practice – James Kingsland on new ways of working
5. Driving social enterprises – Gerry Mclean presents top tips for creating federations
6. Future models of primary care – Lalah-Simone Springer summarises the discussions from the National Primary Care Network
9. Final word – James Kingsland concludes the work of the NPCN meeting on the future of primary care
10. Attendee list

PRESENTATION

DEBORAH JAINES

Flexible funding

NHS England's head of primary care policy offers a glimpse into how existing and future funding flexibilities could be used to improve primary care at scale

Some funding flexibilities are available now – without the need for any change to contract models or legislation. However, as these flexibilities are not in wide use and may not be well understood, NHS England will produce a helpful guidance document by mid-March. Before its launch, this guidance will be tested with clinical commissioning groups (CCGs) and area teams.

The guidance will outline 'principles for investment' that should guide the approach to be taken. Depending on whether the investment is to achieve an extension to existing GP services or an extended range of services available in primary care, different investment routes should be followed.

Existing flexibilities in the GP contract, including personal medical services (PMS) flexibilities can be used to extend GP services. Since this has to be enacted through the GP contract, this should be carried out by the area team or the CCG acting under delegated authority from the NHS England area team.

CCGs can already commission services from primary medical care providers in their own right to achieve an extended range of services provided that they:

- Are commissioning services that go beyond what is required under GMS or the local PMS/Alternative Provider Medical Services (APMS) contract.
- Use an appropriate procurement route, such as a competitive procurement, framework for local patient choice or a single tender as appropriate.

- Manage any potential conflicts of interest in accordance with NHS England guidance.
 - Use the NHS Standard Contract.
- But for investment in pharmacy services:
- Only NHS England can commission pharmaceutical services - this power cannot be delegated to CCGs.
 - However, CCGs can directly commission 'locally commissioned services' from pharmacy providers.
 - Local authorities can also directly commission services from pharmacy providers.
 - Such 'local services' are usually enacted through the NHS standard contract.

The introduction of the e-contract (with pre-population of many of the standard elements) should help with the use of the standard contract for relatively modest financial values.

The funding flexibilities that many practices are most interested in (what is often referred to as 'alliance' or 'prime' contracting) are not widely in use and it is currently not clear if their widespread use might require changes to contract models or legislation.

NHS England has commissioned a piece of work relating to these novel contract forms and this is expected to be complete by the summer.

This is expected to provide the guidance and advice that practices have been seeking on alliance and prime contracting. •

Deborah Jaines is head of primary care policy at NHS England.

“CCGs can already commission services from primary medical care providers in their own right to achieve an extended range of services”

CATHERINE PICTON

Now or never

Late last year the Royal Pharmaceutical Society published a report into models of care delivered through pharmacy. Catharine explains her findings to the NPCN

In November 2013 we published the report of an independent Commission into future models of care delivered through pharmacy. Chaired by Dr Judith Smith, director of policy at the Nuffield Trust, the Commission was charged with developing a coherent narrative for the future of the pharmacy profession in the NHS in England. Pharmacy is the third largest healthcare profession, pharmacists are highly qualified but their skills have long been underutilised. Pharmacist numbers are increasing just as other primary care health professionals numbers are under threat.

The 'Now or Never' report points to the potential of pharmacists and their teams in helping the NHS to address many of its current challenges. An extensive network of community pharmacies, often open long hours and frequently found in areas with high levels of deprivation, provide a potential access point to NHS services. When fully integrated into primary care, community pharmacists and their teams can help people with common illnesses, provide out-of-hours services, manage long-term conditions, monitor medicines use and help people to stay healthy. In addition, primary care pharmacists

are becoming key members of primary care teams, often employed by, or in some cases partners in GP practices. Primary care pharmacists are helping practices and their patients to optimise medicines use, at the same time, reducing waste and improving the safety and efficiency of medicines management systems. Hospital pharmacists for example, are increasingly forming

needs to be done" section of the report outlines ten themes that tackle what must happen to unlock the potential of pharmacy. These themes can be found in full in the report but they include pharmacists acting as advocates for their own future by focusing on their role as providers of care to patients. The need for stronger local and national leadership,

"When fully integrated into primary care, community pharmacists can help manage long-term conditions and help people stay healthy"

part of multidisciplinary teams providing outreach services to patients at high risk of hospital admissions or readmissions.

The *Now or Never* report points to new models of care that patients experience from innovative pharmacists and pharmacy teams who are fully integrated into the primary care system. For example, GPs and accident and emergency teams referring patients for domiciliary medicines use reviews from locally trained community pharmacists. However these services remain relatively rare, with pharmacists often marginalised in local healthcare systems. The "what

and the opportunities offered by better use of skill mix and technology to provide patient facing services are both required. There was considerable emphasis given to the need to develop services through bold commissioning, by using existing contractual mechanisms and by pharmacists forming new consortia or federating to enable them to deliver at scale locally.

The report finishes by saying that there has been more than enough analysis of pharmacy and the potential for pharmacists to ease some of the challenges bearing down on the NHS is clear.

The imperative now is to make this change happen. ●

Catherine Picton is co-author of *Now or Never, Shaping Pharmacy for the Future*, Royal Pharmaceutical Society project lead and secretary to the Commission.



PRESENTATION

JAMES KINGSLAND

'Never full' practice

Primary care should be able to treat illness when it is presented, Dr Kingland says

There is too much unwarranted variation in the opening times of general practice in England. Some already provide appointments in the early morning and into the evening. Some still provide list based weekend services. However, others have unacceptable waits, still restrict opening, and indeed close for half days.

International evidence has established that health services incorporating a comprehensive system of primary care achieve better health outcomes and greater equity in health than systems oriented more toward specialty care. Health resources are also more efficiently deployed by strengthening primary care.

Waiting for access to NHS care has always been the public's main concern about our most loved public service.

The main endeavour of the Labour government's 2000 NHS plan was to introduce an 18-week target in secondary care from referral to treatment, and no longer than a four-hour wait in emergency departments. Access to general practice did not receive such detailed attention.

Too often access has been regarded as a single activity, focusing on the time to see a healthcare professional from the moment of request. Equally important is the type, range and quality of care as well as the availability of services throughout the week. There seems little point in expanding the capacity of the primary care system with

longer opening hours without enhancing the capability to complete more episodes of care out of hospital. It is a central focus of the current NHS reforms to describe and demonstrate a remedy for the increasing demand on urgent care systems. Emergency departments are, ever increasingly, being used by patients for non-emergency care, with more and more routine ambulatory and sometimes simple self-limiting illness presenting to these overstretched departments. Recent research has shown that more accessible general practices in England have fewer emergency department visits per registered patient with some patients self-referring to emergency departments when unable to see a GP within two weekdays.

Walk-in centres and NHS Direct have not had the impact that was expected in reducing inappropriate or unnecessary contacts with emergency departments or GP out-of-hours services. To provide the necessary solutions to the current fiscal

challenge in the NHS and the potential compromise to its productivity and quality, a central focus should therefore be on improving access to primary care services, in both the availability and range of services provided.

A 1% increase in the proportion of patients able to access their doctor in general practice is associated with a £20,000 annual cost saving for the average practice.

Judging by

the government's plans to improve access to general practice through a £50 million access fund, it has been recognised that improving access to primary care services needs appropriate resourcing. While this is a non-recurring cash investment, these pioneer sites will need to demonstrate how cash can be released from other current less efficient services. There also needs to be further development of the primary care home model to enable delivery, with multidisciplinary teams working across organisational barriers. With extra funding from our clinical commissioning group at £30 per head of registered population, my practice has been able to devise new ways of working, facilitating same day, urgent, and pre-bookable appointments within extended hours to meet the needs of our registered population. We call this the 'never full practice'. We have also focused on delivering a good work-life balance with staff involved in the design and choice of new working hours, appropriate rewards for new innovative services and creating high personal esteem among the team. Properly aligned incentives must be part of improving access.

I was recently lecturing at a college of further education, rated by Ofsted as outstanding. They have a range of innovative courses providing training to allied healthcare professionals and carers. The college's maxim is, "training tomorrow's health carers today". It made me consider for how much longer we can tolerate some general practices continuing to treat today's illnesses tomorrow? ●

Dr James Kingland OBE is a GP and chair of the National Primary Care Network



GERRY MCLEAN

Driving social enterprises

Creating a federation can be complex. Gerry McLean gives a step-by-step guide

With hindsight, my first collision with the federation model came when I moved from a hospital director's post to take up a position with a GP-led multi-fund in Belfast back in 1996. In recent years I became involved with the establishment of over 48 practice-based commissioning groups. In many cases they were configured in terms of a 'not-for-profit' commissioning organisation with the status of a limited liability partnership, and a 'with profits' provision organisation wing usually configured as a company limited by shares.

Today I am working with the Ulster Chemists' Association (UCA), who have recently launched their social enterprise organisation and the British Medical Association in Northern Ireland on the establishment of GP federations in the province.

With the UCA approach, the support and sponsorship for the social enterprise model has originated from the Department Of Enterprise, Trade and Industry, with on-the-ground support from Invest Northern Ireland with the Department of Health, Social Services and Public Safety deciding on the 'need' aspect of the agenda.

What we have here is a change in our traditional starting point, from a health perspective to an economic perspective,

which while delivering services also will examine how expertise from the private sector can inform the education, housing and voluntary sectors and vice versa.

So, what are the reasons behind the change in approach? Research indicates that it can be for a number of reasons including:

- Response to a perceived external threat.
- Desire to gain economies of scale.
- Sharing risk in healthcare providing or commissioning.
- Bid for primary care service contracts.

When I commence this work the first thing people seem to want to concentrate on is what type of organisation they should have. This will depend completely on what you want it to do. Form should follow function.

I suggest you plan not for where you are today but where you might be in the medium and longer term. Start with 'strategic intent' (ie. the strategy for the organisation).

Then look at 'unity of purpose'; that is a common understanding of what we are doing and why.

Now get to grips with the 'purpose of the organisation'. Now we can select the 'legal identity' that best fits for today and beyond.

These organisations will have some common components engrained in their establishment namely:

- Independence from the statutory sector.
- The maximisation of potential budgetary control levels.
- Clinical leadership.
- Good quality management and support.

There are a number of organisational models commonly used in establishing federations, such as:

- Unlimited.
- Limited liability partnerships.
- Community interest companies (mutual, social enterprise).

Take time to examine each against your strategy direction and examine the pros and cons of each for your group.

A key component of any organisation will be a members' agreement, the design of which will have as its central pillar those things you must do as dictated by law. It will also include many of the following components:

- The name of the consortium and the identification of GP member practices.
- How its day-to-day functions will be carried out.
- How it deals with conflict of interest.
- How members participation is obtained.
- Selection and expulsion.

In all models I would advise that the major governance must lie with the membership while, day-to-day devolved authority rests with the board.

Finally, there will be a number of key milestones on your journey:

1. Establishing a steering group.
2. Selecting the organisation type.
3. Choosing the names.
4. Organisational formation.
5. Signing the agreements.
6. Notifying membership to Companies House, if required.
7. Engage with statutory sector and other 'like-minded' organisations. •

Gerry McLean is a consultant with the Ulster Chemists' Association



REPORT

LALAH-SIMONE SPRINGER

Future models of primary care

A summary of NPCN members' discussions on improving primary care

It's clear that the current model of primary care is not sustainable. With an ever increasing funding gap, an ageing population and an emphasis on provision in primary and community care, the sector is becoming more and more squeezed.

The National Primary Care Network (NPCN) met at the Royal Pharmaceutical Society headquarters in London to address this very question. Dentists, nurses, optometrists, pharmacists, GPs and other healthcare professionals listened, shared, discussed and disagreed.

Although no definitive answer was reached, the sparks of best practice dispensed could ignite changes across the country.

Alliance and outcomes-based contracting

NHS England has defined alliance contracting¹ as "separate contracts with individual providers but with shared objectives". Potential benefits include improved efficiency and pathway co-ordination, however, there is a need to be "clear on where responsibility lies for delivery" and "strong working relationships" between providers are necessary, NHS England claimed.

Outcomes-based commissioning,

on the other hand, sees payments for individuals based on achieving good outcomes¹.

Deborah Jaines, NHS England head of primary care policy said that England does not currently have a framework for alliance or outcomes-based contracting which would provide guidance for how the schemes could be implemented locally.

However, guidance on flexible forms of contracting is due to be released later this year [see page 2]. But Jaines said that although it would be "exciting" to move towards alliance contracting, ultimately

on the frontline to utilise ideas such as alliance contracting, CCG budgets are already tight.

"I think it's perhaps difficult for [CCGs] to consider what money they can put into primary care as well because they are being squeezed from both directions. I'm not saying it's wrong to put into primary care but there is only so far the CCG allocations will go."

Although Jaines agrees that the NHS budget is stretched, she has "faith that if you put more money into primary care that it prevents secondary care interventions

"We need to incentivise the system so that people's imaginations begin to work properly"

Hemant Patel, North-East London Local Pharmaceutical Committee

the NHS is "an awful long way off".

Mukesh Lad, chairman of Pharmacy Northamptonshire points out that having no guidelines is currently a "big stumbling block". He said templates, which could be easily used by Local Pharmacy Committees (LPCs), could make it easier to engage clinical commissioning groups (CCGs) to commission for local priorities.

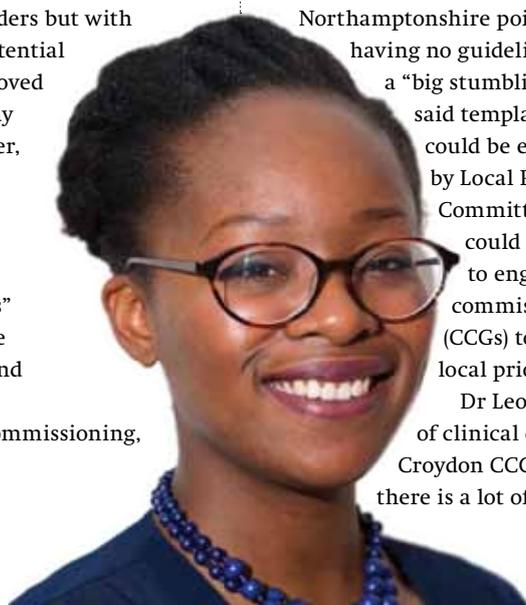
Dr Leon Douglas, head of clinical engagement at Croydon CCG said that while there is a lot of enthusiasm

and expenditure further down the line" and that the argument for change needs to be made to the area team or CCG. However, Dr Charles Alessi, chair of the National Association of Primary Care, felt that the issue was whether NHS England's area teams are experienced enough to handle new models of contracting.

"There are concerns around the sophistication that is required for area teams to actually manage this process because equitable mediocrity is something people have been talking about since around 2008 or 2009... It is very difficult to create an environment where people are allowed and actually encouraged to do more for populations," he said.

Liz Butterfield pharmacist consultant

Lalah-Simone Springer



at the Royal Pharmaceutical Society added that focusing on outcomes could increase the value of the prescribing budget.

She said: “We’re still really in the same place we’ve been for years in terms of admissions due to medicines and poor outcomes for long-term conditions. I think it would be a great step forward if we could get much better value out of that prescribing integrated budget, if we’re looking at quality rather than cost as the outcome.”

Ending the discussion, Steve Foster pharmacy superintendent at Pierremont Pharmacy said: “Everybody is in agreement that things can’t continue as they are. The £20bn challenge we had a couple of years ago has grown to £30bn and it will continue unless we do something about it.

“What we could do is [begin to look from] a population health perspective, but that can only happen in a collaborative way. Charles [Alessi] and James [Kingsland] in particular have been very supportive of this collaborative working model, but we are limited at the moment by our contract, in that we need an outcomes-based contract which fits in with the other contractor professions. Delivering our contract should be helping to deliver GMS.”

Pharmacy: Providers of care?

NPCN members, although vehemently disagreeing on the details, were clear that the future of pharmacy is in delivering direct patient care.

In a presentation that tipped the room towards in-depth debate, Catherine Picton [see page 3] called on pharmacists to raise patient expectations. “We must be loud, clear and consistent with the message that pharmacy provides patient care,” she said.

“Pharmacy has to continue to develop direct patient services. The more patients experience services as being delivered by pharmacists, with pharmacists as clinical providers, the more you come to expect that. It’s about raising expectations,” Picton added.

However, she felt that the way to increase pharmacy’s role in provision of care is to “encourage pharmacy to be commissioned in a much bolder way”.

Ash Soni OBE, pharmacist and clinical network lead at NHS Lambeth conceded

that pharmacy has been slower than the rest of the health service at “recognising both the challenges and the opportunities” currently faced. For him, it is clear that contractual arrangements must be “broken down” in order to make population health central to everything done in primary and community care – through an overarching contract.

But Hemant Patel, secretary of the North-East London Local Pharmaceutical Committee, was not convinced about the idea of pharmacists becoming more involved in direct patient care. He believes only a negligible amount of pharmacy funding comes from “knowledge-based services”.

He asked: “Is it any wonder that pharmacists stick to shifting boxes? We should stop providing services – we should start talking about providing joined up care with other professionals. I think it’s easy to [give pharmacists a remit for] chlamydia testing or smoking cessation, and it’s completely random. Let’s get real. People will focus their attention where there’s money. We need to incentivise the system so that people’s imaginations begin to work properly.

“Pharmacists went to school to study medicines, and now they’re being asked to do all sorts of things. We have to be realistic.”

At Nethergreen Surgery, pharmacists have been employed on a part-time basis for more than ten years, GP principal Dr Eithne Cummins revealed. At her practice, she said, they “recognise the value of pharmacists” knowledge.

“We have considered having a pharmacist as a partner in our practice, and I think that day will come. It’s a very simple way of trying to incorporate and integrate within the community setting. You don’t even have to consider contracts – you can get around that.

“More than anything you need the cultural change towards working together. Having an integrated dispensing pharmacist is not that hard! But we have to consider the opportunities we have within the existing framework.”

Ash Soni agreed that having

“I’m not saying it’s wrong to put money into primary care, but there’s only so far CCG allocations will go”

Dr Leon Douglas, Croydon CCG

pharmacists at diagnosis point for long-term conditions is one way to encourage more effective use of medicines from patients. “A pharmacist can talk through the medicines and non-medicines options. This could make a difference to lifestyle and to outcomes, because the patient is in control and can then buy into the offer in a way that we don’t do well currently.

“It’s one of the reasons why the linkage and integration from federations could help us work more effectively than we currently do.”

Bexley CCG chair, Dr Howard Stoate felt that Soni’s vision of pharmacists talking patients through new diagnosis is the way forward, but agreed with Patel that there is currently no incentive for change.

He said: “In my area we had an anticoagulation contract, but the only bidders were GPs. The pharmacists, although there were a few toes dipped into the water, essentially didn’t want this £500,000 contract.

“Pharmacists aren’t coming forward, and I think it’s because they’re not frightened enough yet. I think in five years time community pharmacy will be dead because a company like Amazon will have taken over a medicine’s management service, which is better than anything we have in this country.”

According to the Royal Pharmaceutical Society’s report, *Now or never: Shaping*



Dr Howard Stoate

REPORT

Joe McGilligan

pharmacy for the future³, the business model of community pharmacy is being challenged by technological developments that enable new forms of dispensing, “such as the use of robotics”, which has become widespread in some countries, such as the Netherlands.

With reference to this, Dr Stoate said he has seen services in America which deliver medicines within two hours, offering 24-hour support for patients on a nurse-led telephone line. According to Dr Stoate, this costs a fraction of the current pharmacy service.

“Pharmacy has only one future, and that future is clinical services – things you can’t get online. Unless pharmacists change rapidly there will be no community pharmacy. Unless they do, pharmacies will go the way of bookshops.”

Premises: Physical or virtual?

Premises has become a key issue in primary and community care, with NHS England halting investment in GP premises while a “consistent” national process to evaluate funding bids is developed³.

When the process comes to a close, clinical commissioning groups (CCGs) and area teams will have solid advice on which to base future planning. But at the NPCN meeting, Graham Roberts, chief executive officer of British-based property business the Assura Group, said that new buildings which bring together primary and community services could revolutionise care for patients.

“I feel very strongly about developing

“We have confidence that if you put more money into primary care it prevents secondary care expenditure further down the line”

Deborah Jaines, NHS England

new buildings, bringing all the services we’ve been discussing today under one roof,” he said. “It’s a way of transforming the entire way in which the services are delivered, and importantly it’s what patients want – to have a beacon of the community which patients recognise as a medical place, rather than a converted house.”

However, other NPCN members were not convinced that a physical home for



community care would bring about transformational change.

Dr Hasan Chowhan, board member and urgent care lead at North East Essex CCG recognised premises as an important issue, but said there is no need to be “so fixated on locations”.

He said: “Care can be delivered anywhere. The fundamental step that’s stopping us [from working together] is the sharing of data.” Citing reports from the medical press and the nationals⁴, Chowhan noted that one GP in particular is writing to patients, urging them not to share records through NHS England’s care.data scheme.

“I think that’s a real block. At the

minute, the urgent care system is a waste of space if you can’t see clinical records. Healthcare professionals are treating people, but they have no idea what their long-term condition care is like! If patients don’t understand that if we could all see their records their care would be 200 times better, we won’t move anywhere.”

Dr Luigina Palumbo, GP and clinical chair of East Riding of Yorkshire CCG believes that the future of premises

is virtual. She said: “We thought that hospitals were the answer once upon a time – I’m concerned that we might think these One Stop Shops will now be the answer.

“Yes, I think we should all be working together, but it doesn’t have to be surrounded by walls.” ●

Lalah-Simone Springer is senior reporter for Cogora, writing for *Nursing in Practice, Management in Practice and The Commissioning Review*.

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JAMES KINGSLAND

Final word

A raft of ideas were floated at the NPCN event in London. Dr James Kingsland, chair of the organisation, ponders how we can implement innovation in practice

Does anyone, clinician or patient, really want or need a revolution in primary care?

Reform is undoubtedly required, but not necessarily a major programme of restructuring. When the NHS talks about re-engineering services, too much time and energy is focused on the operational models for delivery rather than transformational change in the provision of care. Similarly, strategy often flourishes at the expense of implementation. So it is with the current 'calls to action' for primary care contractors, the debates about federating and the future of the independent contractor status.

Four separate call-to-action documents, one for each of the primary care contractor services, have been produced at a time when the word Integration is on everyone's lips. Wouldn't an innovative approach, in an environment of collaboration and Integration of services, have been to take the opportunity to show real thought leadership and produce a unified, or at least a linked action plan across all primary care services?

This meeting of the NPCN tried, and within this report succeeded in creating some new thinking. The strength of the network is in the participants, who are not restrained by the usual rhetoric or jargon that compromises so much clinical enthusiasm.

While the Royal College of General Practitioners' roadmap, produced some seven years ago was commendable, it had low impact in realising its ambition. Much

of the subsequent debate about reforming primary care, in particular, general practice, has been blighted by a lack of organisational memory and more questions continue to be asked than effective solutions provided.

Previous ideas such as polyclinics, one-stop shops, Darzi centres and access to primary care through walk-in centres or NHS Direct have not delivered. The future must be built from within existing best practice on the cornerstone of the NHS - primary care. It must be recognised that the current provision of primary care, within the NHS, has been developed through a considered evolutionary processes over the last 65 years. List based (the panel) general practice has been delivering continuity of care to a registered population since at least 1911, the time of the epoch breaking Lloyd George National Insurance Act. Primary care is not where it is by chance, and those who have not been involved in the provision of primary care or do not understand at least the history of the internal market, created in 1990, may not be in the best position to plan or direct the future.

The former government's White Paper for health in January 2006, first described the programme of 'out of hospital care'. The concept of the 'primary care home' for such

care has been evidenced for over 20 years and already exists in parts of England. This is a model of an integrated (all primary care contractor and community services, social care and third sector) financially responsible provider organisation. Such an aspect of a health service assures person-centred care over time to a defined population and facilitates receipt of care when it is first needed and a comprehensiveness of care, so that only rare or unusual manifestations of ill health are referred elsewhere. The merits of such a first-contact primary care system brings higher patient satisfaction, lower overall health service expenditure, better population health indicators, fewer drugs prescribed per head of population and lower hospitalisation rates.

Is it now the time for action; but through utilising current evidence, existing best practice development and an investment programme in primary care, rather than further calls for debate.

Indeed, the NPCN meeting did conclude there is nothing really new in current thinking around primary care reform, only that which has been forgotten. ●

Dr James Kingsland OBE, is chair of the National Primary Care Network



