

# RESTORING PRIMARY CARE TEN KEY PRIORITIES

May 2021





## ABOUT NHS RESET

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The coronavirus outbreak has changed the NHS and social care, precipitating rapid transformation at a time of immense personal and professional challenge. One message from leaders and clinicians across the UK has been clear: we must build on the progress made to chart a new course.

NHS Reset is an NHS Confederation campaign to help shape what the health and care system should look like in the aftermath of the COVID-19 pandemic. Recognising the sacrifices and achievements of the COVID-19 period, it brings together NHS Confederation members and partners to look at how we rebuild local systems and reset the way we plan, commission and deliver health and care.

Find out more at [www.nhsconfed.org/NHSReset](https://www.nhsconfed.org/NHSReset) and join the conversation at [#NHSReset](https://twitter.com/NHSReset)

## ABOUT THE NHS CONFEDERATION

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The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales.

We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

The NHS Confederation is committed to providing a strong national voice for primary care. Its PCN Network provides dedicated support to primary care networks across England, and will soon be complemented by a new network for GP federations.

To find out more, visit [www.nhsconfed.org](https://www.nhsconfed.org) and follow us on Twitter [@NHSConfed](https://twitter.com/NHSConfed)

# FOREWORD

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As lockdown eases and the public starts to see services return to normal, we have been talking to our members in primary care about the challenges of recovery and what needs to be in place to deliver services safely and sustainably.

There has been much discussion about whether the health service is resetting, recovering or restarting. Yet how we describe the next phase of the pandemic is less important than the principles that underpin it. Across the healthcare system, we must learn from and build on our experience of the last year – working in new ways, innovating and developing local solutions, collaborating across the system and using our patients and the public as our assets.

We should not lose the opportunity to ensure that we emerge with a renewed focus on the health and wellbeing of our staff, real action on health inequalities, and protection of the collaborative working that will underpin future system working.

This briefing is a summary of the ten key themes that have emerged from our discussions, as presented by a range of our primary care members. Each theme is outlined by a different clinical director from primary care networks and primary care federations throughout England.

The insights point to three key issues that must be front and centre of the health sector's planning as we enter the next phase of the pandemic:

## 1. Building back better and different

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We must take this opportunity to finally make the paradigm shift to population health management that has long been needed. This will require more seamless pathways between primary and secondary care rather than transactional hand-offs. We will need to adopt a system and place-based approach to common problems which put the patient at the heart of our response. There is a risk that as pressure builds, people revert into silos. That would be the wrong approach. We need to capitalise on the opportunities that working as part of new integrated care systems present.



**Ruth Rankine**

Director of Primary Care  
NHS Confederation



**Dr Graham Jackson**

Senior Clinical Adviser  
NHS Confederation



## 2. Setting priorities and managing public expectations

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Primary care is the front door of the NHS and carries out 90 per cent of contact with patients. It faces rising demand, growing complexity, higher expectations, increased administrative burden and the continued challenge of rolling out the largest ever vaccination programme in the UK. Yet public debate is mainly focused on the pressures facing hospitals. This needs to change. A key requirement is setting clear priorities and being open with the public about what is achievable.


## 3. Investing in infrastructure

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Primary care provides huge numbers of high-quality consultations, but outdated infrastructure holds back progress. New services based on patients' needs are being set up, but more could be achieved by expanding the primary care workforce and creating more space within primary care premises. The government needs to invest in management support, estates, IT and digital solutions to unlock the full potential of primary care. This needs to be accompanied by more regulatory permissiveness that empowers primary care professionals to get on with the task at hand. And, above all, we need to support primary care staff to recover so that they can best support their local communities.

We cannot underestimate the challenge ahead for primary care, with an increasing and more complex workload, a tired workforce and the ongoing vaccination programme. We recognise these issues are felt right across the health and care system and this reinforces the need, as we move forward, to tackle these issues together and not in isolation. There is a risk that, as the pressure builds, people revert into silos and focus on their own challenges. That would be the wrong approach.

We need to capitalise on the opportunity for integrated care systems and integrated care partnerships to bring clinical leaders and managers together across providers to design solutions that protect services for those who need them, enable a more proactive approach to keep people well and locks in a more innovative and permissive culture. Some might argue that emerging from the height of the pandemic is an unhelpful time to seek change; others will share the view that we can look for opportunity on the back of adversity.



Above all, we need to support primary care staff to recover.

# Trust

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National bodies need to agree a common purpose and engage the workforce. Trust and support us to find and implement solutions, and give us autonomy with accountability.

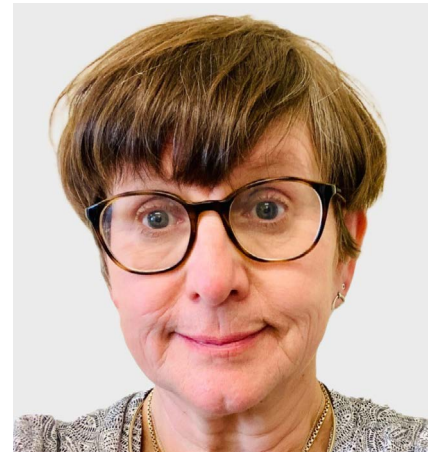
Our workforce understands the community it serves and places the individual at the centre, but we need the headspace to think differently about the future and engage in the recovery of the system.

COVID-19 demonstrated that we could make decisions quickly at a local level – and it worked. We need to exercise a paradigm shift in thinking to population health management because it will reap rewards. There is a courageous conversation to have about what it will take.

Trust primary care to do what it does best – understanding the community and responding to those needs – and provide the resources and flexibility so we can respond in the way we need to.

# 01

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**Dr Brigid Joughin**

Clinical Director  
Outer West Newcastle PCN

# Priorities

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**We need clarity on national priorities coupled with analysis of our local need. We can't do it all and we need a sense of prioritisation.**

COVID-19 has enabled us to be honest with the public about what is achievable. We need a national framework to support potentially difficult local decisions and avoid creating further inequity.

Balancing day-to-day activities, tackling the backlog, dealing with greater complexity in those presenting while continuing to manage COVID-19 and the vaccination programme is a tall order.

# Economies of scale

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**Redefine what services are delivered where – inside and outside primary care – reduce duplication and maximise economies of scale. Deliver it at scale: support planning, infrastructure, delivery and person-centred practice with, and across, individuals, neighbourhood, place and system.**

General practice needs to be thinking about anticipatory care – we need to rethink the whole access agenda by moving to a different model where we get improved access and economies of scale.

Extended access needs to be integrated with urgent and out-of-hours access. Primary care needs to be able to do things at scale to be able to manage the workload and deploy the workforce more effectively. We can have a shared vision of patient-centred care delivered at scale across NHS providers and working closely with the local authority and voluntary sector. COVID-19 has provided opportunities to be more radical.

# 02

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**Dr Hannah Morgan**

Clinical Director  
Hayling Island and Emsworth PCN  
Hampshire

# 03

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**Dr Andy Hilton**

GP and Chief Executive  
Primary Care Sheffield Federation

# Workforce

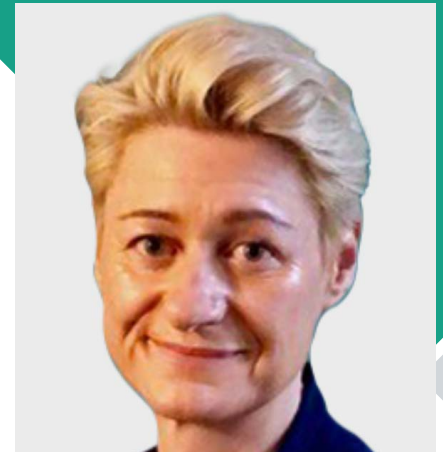
# 04

It's not just about the GP. Our biggest asset is our workforce. We are recruiting to new roles and COVID-19 has shown how we can use our workforce differently.

General practice is now a multidisciplinary service rather than GP-first – it is a new narrative we have to deploy right from the top to our patients. We need to focus on delivering care to the right people at the right time and by the right person to improve health equity.

If we are to deliver true person-centred care, the approach needs to be defined by the individual's needs being met by the right professional. We need to be able to use the Additional Roles Reimbursement Scheme (ARRS) funding more flexibly. We will, for example, have underspends as a result of delays in recruitment – this could usefully be deployed to help with the backlog and to support the system in the validation and management of waiting lists.

But first and foremost, we must recognise that, as well as recovering services, our staff need support to recover too. However, with an eye on the longer term outlook, there has been one enduring message that we have heard from NHS leaders: the health and care system must build on the remarkable progress of recent months to chart a new course.



**Kat Dalby-Welsh**

Clinical Director  
Yeovil PCN

# 05

## Infrastructure

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We need to invest in management support, estates, IT and digital solutions to secure an infrastructure that's fit for the 21st century.

We have fantastic multidisciplinary teams which have adapted to new systems and tools so quickly. Primary care continues to provide huge numbers of high-quality consultations but is limited in progress by infrastructure. We are building new services based on our patients' needs, but this requires us to expand our workforce and we have insufficient space within our premises.

We would like to innovate, particularly around looking after our under-served communities, but need more management support and joined-up IT systems with our health and care partners. Sustained investment is the only way to support our teams to better manage demand, create capacity, reduce bureaucracy and support localities to operate at scale. The current model is unsustainable. We need to be forward planning together with more responsive, less bureaucratic processes to get to the right solutions for our workforces and populations.



**Dr Sunaina Khanna**

Clinical Director  
GPS Healthcare  
Birmingham and Solihull

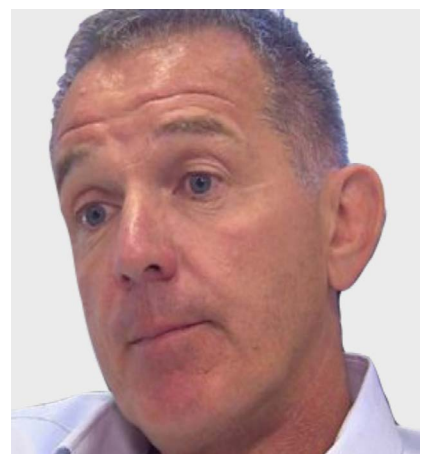
## Public engagement and ownership

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Have a public conversation about priorities and behaviours, and transfer power and knowledge to individuals and communities to enable them to take ownership of their health and wellbeing.

Being open and transparent over secondary care waiting lists would help, so we set the correct expectations for our community and have more honesty about the care the NHS can provide.

# 06



**Dr Mark Spencer**

Clinical Director  
Fleetwood PCN  
Lancashire



# Collaboration

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Reset and recovery need a system-wide approach – we in primary care need to connect with the wider system. Long-term conditions care sits as an integrated pathway across primary and secondary care and the system needs to recognise the role of primary care.

What has worked well is when we have had a common purpose: COVID-19 flushed out the interdependencies in the system and we worked together to one common goal. We need to think about how we can take that approach into the future in a more complex system.

We need more seamless pathways between primary and secondary care – shared ownership and better access to community diagnostics – rather than transactional hand-offs. And we need to have a system/place approach to common problems, with the patient/citizen engaged and involved in their care when possible. The bureaucracy of territorial working in the system is one of the most motivation-killing drivers for frontline staff.

# Bureaucracy

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We need to retain regulatory permissiveness, balanced with proper accountability.

During the pandemic, we have seen a significant adoption of innovation and change, undertaken in the absence of much of the regulatory or contractual requirements. We have been empowered to work differently, thinking outside the box and working with partners on innovative solutions.

While we recognise the need for regulation and contracts, experience has shown that this oversight can be implemented in such a way so as not to add to our workload or lose our ability to innovate.

# 07

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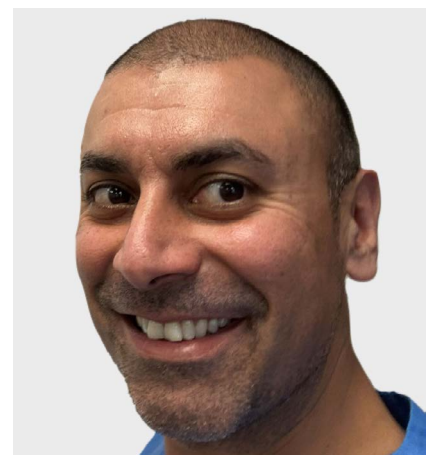


**Professor Aruna Garcea**

Clinical Director  
Leicester City and Universities PCN

# 08

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**Dr Aamir Munir**

Clinical Director  
Valens PCN  
Northumberland

# 09

## Investment and outcomes

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Address disproportionate investment and recognise that to fully embed a patient-centred approach will need different solutions for different groups of the population.

The current funding model via the Carr-Hill formula needs a radical overhaul. We know that increased investment in primary care is associated with lower healthcare costs and improved population health. We need to invest more, incentivise outcomes not processes, and make them relevant to different populations.

For example, let's move away from targeting each of our diverse populations and expecting the same outcomes. Let's think: what are the best outcomes we can achieve for our population and what is needed to do this? Let's be honest about what is included within our general medical services remit, what's possible through the PCN work and where we need to further work with partners and other organisations to achieve this.



**Dr Neil Modha**

Clinical Director  
Central Thistlemoor PCN  
Peterborough

## Workload

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How do we really understand primary care workload to keep people (patients and staff) safe? We are very good at looking at system metrics such as the four-hour target, but there are no measures of primary care pressure.

During the pandemic, we all saw the level of detail evidencing the pressures on secondary care. While primary care was under immense pressure, we had little evidence to back it up – nothing that measures the rising demand, growing complexity, higher expectations, increased administrative burden and rising thresholds for referral to other parts of the system.

Along with a comprehensive measure of workload, we also need to look at developing the operational pressures escalation level (OPEL) system used in secondary care for primary care so that we can manage our work safely and work within a system that recognises pressure right across it, not just within individual parts.

# 10



**Dr Sian Stanley**

Clinical Director  
Stort Valley and Villages PCN  
Hertfordshire

# CONCLUSION

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Primary care has played a leading role in local responses to COVID-19. The insights presented here represent the views of frontline clinical leaders across England. Leaders who, over the last 12 months, have innovated to serve their patients and communities, and who have an acute sense of what is needed to build back primary care. Their reflections point to three core issues that must lie at the heart of planning for the next phase of the pandemic.

## 1. Building back better and different

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Through adopting population health management and a system and place-based approach to common problems.

## 2. Setting priorities and managing public expectations

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By being open with the public about what is achievable.

## 3. Investing in infrastructure

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By investing in management support, estates, IT and digital solutions, and supporting primary care staff to recover.

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Join the conversation The logo consists of a green square containing a white hashtag symbol (#), followed by the word 'NHS' in white bold uppercase letters, and the word 'RESET' in white italicized uppercase letters.



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