Stronger Together:

COLLABORATIVE PRIMARY CARE AT SCALE - INTERIM REPORT
This document was prepared following a series of roundtable discussions with senior leaders from all four primary care contractor services, as part of a State of the Nation Series into the challenges and opportunities facing the primary care sector.

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It is pre-emptive in its thinking and approach, in the development of powerful ideas that bodies across health and social care are actively investing in.

In short, Healthworks is about:

• Truly innovative ideas
• Ideas that are experiential and evidence-based
• Ideas that will actively transform
We are grateful to the primary care leaders who have contributed their thoughts and views in this report. Their views were all expressed in a personal capacity and do not necessarily reflect that of their organisations.

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Stronger Together: Collaborative Primary Care at Scale is a report written by, and for, all four of the independent contractor services that constitute the level of primary care in the NHS.

It is relatively uncommon for the collective views of general practice, community pharmacy, dentistry and the optical sector to be expressed in one publication. Stronger Together tackles historically siloed approaches to addressing and reforming primary care – highlighting challenges that are both unique to each contractor service and those that are shared across the sector.

Furthermore, this report’s contributors are all senior leaders of their respective sectors, making it not only vital reading but highly relevant to the ambition in the NHS Long Term Plan for developing integrated care services within the new construct of Integrated Care Systems.

Our report deliberately avoids simply reframing the well documented challenges facing the NHS. Restating the need for more funding and workforce shortages in a post covid environment with increasing demand in an aging population is no longer helpful. Instead, we have tried to create a new perspective by sometimes “thinking the unthinkable” and describe a system of primary at scale that focuses less on process and transactions to a more qualitative improved, patient centric model.

Several key themes have emerged from the deliberations, some specific to a particular discipline, others that are aligned to all.

Foremost is the sometimes uncomfortable, but necessary blend of NHS and private funding, which currently exists, but may need to be remodeled. Our view is that this need not be an intractable issue and that more efficient and truly integrated use of contractors’ resources would better support both the NHS and the strengthening of independent contractor provision.

Stronger Together also calls for a much better understanding of what each service does within a local health economy over and above purely contractual obligations. We present an authoritative opinion that there is much more potential – and appetite – for braver collaboration that would be to the benefit of all parties.

We also propose a rethink of the largely contract-driven, performance managed approach to expanding primary care provision and move towards the outcomes-based commissioned model with metrics that matter to patients.

I am enormously grateful for the time and expertise from so many people who have contributed so generously to the report. They have demonstrated that primary care at scale, incorporating all four independent contractor providers is a very real possibility, indeed a necessity, and can be achieved by being Stronger Together.
Recommendations

The authors’ recommendations are that the four primary care contractors and their commissioners should:

Seek to develop a culture in which co-production of care between four primary care contractors is paramount, working towards helping ensure each sector knows and understands how best it can work to support improved outcomes for patients.

Confront the challenges of addressing inequalities through the adoption of population health principles and techniques.

Acknowledge that the mixed economy supports the NHS.

Adopt a more meaningful mantra than “building back better” – perhaps “achieving fair and sustainable health improvements”.

Note the importance of the principle of national consistency in design and delivery of some services, but that contractors and commissioners work to “acceptable variability” tailored at local level.
Primary care provides the majority of a population’s preventative and curative health needs, health promotion and care monitoring requirements, mostly in community settings. It is the anchor around which wider healthcare services are provided.

Primary healthcare can be considered as both a level in a health system (its form) and a strategy or philosophy for organising approaches to care (its function).

In this State of the Nation series, we relate to the four independent contractor services which constitute that level in the NHS, and consider how to achieve a more collaborative, at-scale approach.

The report’s focus is on how primary care providers could work together more productively to improve patient access and outcomes of care.

Stronger Together is made up of contributions from thought leaders within the health and care sectors and representatives of the wider communities of primary care providers and professions. The team represents a microcosm of the way care services will be designed and delivered outside hospitals.

The report casts a fresh perspective on the true importance of values in healthcare - compassion, tolerance and understanding - as well as the practicalities of delivering services to a population whose attitudes and expectations are changing.

These State of the Nation reports offer a ‘critical friend’ appraisal of the policy landscape, an academic assessment of current delivery plans and are a showcase for innovation and scalable best practice.

Collaborative Primary Care at Scale will mark the start of an annual report series, which will also include a programme of events that will bring together the collective views of leaders from across the wider health system.
Assessing the appetite for change

The assertion for the discussions was that if one were designing a new healthcare service today, from scratch, it would be unlikely to look like the current model with its demarcation of services, and managed largely through contractual and transactional mechanisms. It would also move away from process-dominated to quality improvement metrics.

Contributions were invited on the basis of avoiding simply re-stating the obvious flaws and well described problems in the system – traditional and much debated “issues” that the health sector has faced perennially, namely funding and workforce shortages, the shortcomings of current contractual arrangements and the increasing expectation and demand on the system related to population demographic changes.

They were asked to approach the discussions and solutions by “thinking of the unthinkable”, particularly in relation to the long-term sustainability of funding the NHS through the public purse.

Several key themes emerged, some specific to a particular discipline, discipline, others that are more generally applicable.

Celebrate a mixed economy

Three of the four disciplines, pharmacy, dentistry and optometry, rely heavily on their continued existence on non-NHS contract funding. Indeed, the gaps between NHS funding and private-pay work is widening. This is a fact in a national health service whose guiding principle is to be free at the point of need and not based on an individual’s ability to pay for healthcare.

However, there remains considerable institutional distrust and misunderstanding of “profit-driven” care providers among the public, and even within some healthcare professions.

It was pointed out by panelists that while the blend of “private” and NHS funding may not be ideal, without being able to promote the independent contractor status and the contribution of those citizens who can or choose to pay for health services, the NHS simply could not cope, either with the extra demand on resources or the associated increase in costs to the public purse.

The solution could lie in the consolidation and more efficient use of assets such as consultation rooms. Currently, each of the contractors have such spaces, which could be used for services outside of their remit, for example, blood pressure or diabetes checks could be undertaken at optometrists’ premises.

There should be no barrier to this in the form of sharing data – there are systems available that would enable this functionality and ensure unification of a patient’s record.

In the unlikely event that any UK government introduced a European-style insurance scheme in the coming years, would it not be better to more openly acknowledge and appreciate that a mixed economy is possible and a positive advantage to both contractors and the tax paying public? If not, it seems that successive governments will either have to consider tax rises, whether national insurance income tax or VAT, borrow more and increase inflation, or move money from other public services (as has been happening over several years).

The current government has chosen to break its manifesto promises and increase tax – possibly an even more emotive issue for the voter than even the NHS. A solution may be inherent in the current largely self-employed sector in the NHS.
Enhancing understanding of what each service does

The optometry panel highlighted the need for a better understanding of what each contractor discipline does. How can people be expected to work collaboratively, create new care pathways and to break down traditional professional barriers when there is little knowledge of what the other primary care contractors do, how they go about it, and not least their current contractual arrangements with the NHS?

Equally, it is also important for better understanding and collaboration from within the different areas within a contractor discipline.

Rethinking contract-driven, performance management – moving towards outcomes-based commissioning

Changing behaviours is about more than simply altering contractual arrangements and incentives – contractual and clinical incentives need to be aligned. Possibly the best definition of integrated care is the integration of behaviours across organisational boundaries.

How can NHS dentistry be reformed?

The dental profession has become broader, and the new cohort of graduates coming into dentistry now demand different ways of working. Their preference is for portfolio careers and greater working flexibility. They do not believe the current contract supports this, and the reality is that in terms of business planning and clinical activity, their focus is increasingly outside of the NHS.

There is little appetite to change the current contractual model, but there needs to be strong moral leadership that encourages collaboration and understanding.

There also needs to be a clear understanding that to sustain any reform of healthcare, there will ultimately be a need for payment and contractual reform to support new care pathways, which in the longer-term will lead to institutional reform.

Without this recognition, or to begin any reform programme without the acceptance that institutions will need to change, then care reform will be short-lived and the service will revert to its former efficiency and effectiveness (the very reason that reform was started in the first place).
Covid has forced radical changes to the way we access care. It has also highlighted stark inequalities in UK health outcomes. Further, the concurrent challenges of Covid-19 and Brexit have amplified already acute workforce shortages across health and social care, creating a ‘perfect storm’ for people working in the health sector and those who use it.

There is now a pressing need to reset models of care delivery in order to develop sustainable healthcare delivery. Now must be the time to apply some fresh thinking to the concept and definition of Primary Care at Scale (PCaS). It is crucial that the sector learns from past mistakes and does not opt for a ‘business as usual’ approach following Covid-19.

PCaS entered the lexicon of healthcare in the NHS in England some 10 years ago. It is a set of principles rather than an organisational form, albeit when these principles are applied, the end result often resembles the organisation of a larger provider. However, there are many ways of delivering PCaS:

• PCaS should be anchored in data-driven population health improvement, with a combined focus on personalisation of care, with improvements in population health planning, provision and outcomes.

• Population health management facilitates a move away from episodic care to managing the care of a population utilising data and focusing on predictive and preventative care.

• Scaling the provision of primary care is predicated on an ability to provide improved first contact care to a larger population than individual list-based practice, and is more complex than merely the aggregation of local general practices.

• Its purpose is to extend the provision of health and care services within a community setting through an integrated team-based approach. To be successful, a cultural shift is required by both clinicians and patients which changes the dependency on the GP being invariably the first point of contact and creates new models of care management. This often requires a tiered approach to facilitate team-based care, resulting in ‘the right size of organisational form to do the job’.

• Comprehensive provision of care is then delivered by creating a multi-disciplinary workforce based on the needs of a defined local population with an emphasis on the integration of primary, community, secondary, mental health, social care and third sector.

• The final core principle for PCaS is to improve the deployment of health and care resources (human as well as financial) and reduce per capita costs of care. This often requires the alignment of clinical and financial drivers aligned with the health needs of the defined population and through the management of a whole population budget. This supports the improvement of outcomes through value-based interventions. A knowledge and responsibility for health and care resource utilisation is needed by the teams that do the work.
POLITICAL CONTEXT

Following the publication of the Government’s white paper, ‘Integration and Innovation: Working Together to Improve Health and Social Care for All’ in February 2021, the Health and Care Bill was introduced to the House of Commons in July and is now beginning its lengthy parliamentary course towards becoming law.

As the title of the white paper suggests, the government’s clear intent is to mandate further integration of health and care provision, with the ambition to “create a system that is more accountable and responsive to the people that work in it and the people that use it.”

The Bill’s focus is largely on the detail of how a new health and care system, based on collaboration rather than competition, will be structured. This includes specifications on how integrated care systems (ICSs) are to be set up and the distinct statutory functions for the integrated care board (ICB) and integrated care partnership.

To be successful, ICSs must, as a minimum, achieve four aims:

1. improve outcomes in population health and healthcare
2. tackle inequalities in outcomes, experience and access
3. enhance productivity and value for money
4. help the NHS support broader social and economic development

Same problems, new solutions

Recent NHS reform has yet to deliver sustainable transformational change. As such, a strong evidence base will be required to deliver the Bill’s ambition for another structural redesign of the health service.

When passed, the Bill will represent legislation following practice, as many ICSs are already formed, albeit with variable operational progress across England.

While the most contentious area of the Bill arguably centres on the greater powers of direction, locally and nationally, that will be afforded to future Secretaries of State, there is nothing in it that fundamentally changes the NHS as a publicly funded service, free at the point of need. The central theme, the “duty to collaborate” and ambitions for more integrated healthcare is nothing new, and therefore why wouldn’t this be broadly welcomed?

The content is, however, short on the real detail that will define care provision of the future and offers little in the way of a compelling vision of the benefits for service users. It requires more in terms of pragmatic policy guidance, at the same time, allowing local permissiveness.

Without measurable improvement to patient experience, any healthcare system will ultimately fail in its prime directive, and new constructs may merely be an attempt to ‘reinflate the flat tire’.

Finding a meaningful mantra

The government’s ‘build back better’ slogan originates from the 2015 Sendai Framework for Disaster Risk Reduction and focused on rebuilding – often literally – physical damage. That the pandemic is a disaster is not in question – however its effect is on people rather than buildings, with a key result being the widening of health inequalities.

Perhaps a better mantra for repairing and remodeling health service delivery than ‘build back better’ might be ‘build back fairer’. Adopting a focus on fairness may provide a better focus for healthcare reform as the
disproportionate impact of the pandemic on different parts of society may be far reaching and long lasting.

A new world

While the concept of PCaS is compelling, there are some fundamental questions that need to be addressed in the context of a technologically evolving society.

A new integrated health system will, by definition, be more complex with multiple points of first contact. From a practical point of view, seamless data will need to flow between the extended range of community and primary care providers - this could take the form of a local healthcare record. However, for data to flow in this way, greater trust will need to be built between agencies and the populations they serve.

Patients who become accustomed to this system will naturally become more demanding, and will expect excellent customer/patient service in all transactions, with digital engagement at the core.

What, for example, is really meant by ‘place-based care’, when physical boundaries between local authorities, list-based and non-list-based practices (such as pharmacy and optometry) and areas of health inequalities can vary considerably?

What are the new workforce and training requirements for the new normal in an unready world?

How will funding and contracting work practically across all provider sectors? Can an improvement in the deployment of NHS resource utilisation be achieved with huge, vested interest in current organisations and restrictions of current contracting and currencies?

And, as hospitals face backlogs reminiscent of the pre-Blair reforms in 1997, how can primary care play its part in alleviating them?

The Health and Care Bill refers to “a real opportunity to strengthen and assess the patient voice...not just as a commentary on services but as a genuine source of co-production.” The patient voice is crucial to developing a progressive care system based on patient-centric and value-based care models, and the principles of population health. A central challenge is in understanding what that patient voice will be saying in the next few years.

Our country’s population is changing rapidly. There will be nearly 3 million more citizens in the UK within ten years. The number of people aged 65 or older will rise by more than 60 per cent. A new post-Generation Z cohort will shortly be reaching adulthood – and what comes after generation Z?

Whether we have embraced it or not, we now conduct our most mundane daily transactions in a digitally oriented, but less-personal environment. A large proportion of society are digital immigrants, but do not necessarily want the majority of their first contact interactions for shopping, banking and increasingly, health, are becoming less personal, and yet healthcare is a very personal subject for most. Patients have always valued the interpersonal attributes of care, often termed ‘the bedside manner’, which is difficult to reproduce in digital consultations and requires a review of the skills and competencies of the clinician consulting remotely.

At the same time, “customer” expectations rise as the likes of Amazon move in to compete with existing providers on the basis of reducing friction and cost in the system.
How will regulation have to change to address this?

What, then, will be demanded of our health system (and, specifically primary care) as we move towards a more patient-centered, value-based model of care? How can, or should, primary care be delivered to populations who, at one end of the scale have only ever known about and used technology, and at the other, may have been largely technologically deprived?

Will that change, as younger technophiles reach old age and demand a more humanistic approach to primary healthcare? How do we make value-based principles a reality?
GENERAL MEDICAL PRACTICE

The family doctor is still considered to embody most people’s definition of “primary care,” including by many policymakers and commissioners. This status can be seen in the current development of Primary Care Networks (PCNs), which are largely aggregates of general practices and performance-managed through the GP contact. Although this has partly changed, as single-handed GPs are replaced with practices offering a wider range of primary medical services, it is important to include all disciplines when describing primary care – particularly at scale. The slipshod interchange between the use of primary care and general practice needs to cease and knowledge and understanding of the wider primary care sector should be improved.

General practice provides well over 300 million patient consultations each year, compared to 23 million A&E visits in England. So, as often quoted, “if general practice fails, the NHS fails.”

However, this is not well understood by politicians and their apparatchiks who sometimes simply pay lip service to general practice and the wider primary care providers in the NHS and often become overly focused on the pressures on hospital services as a result.

Yet a year’s worth of GP care per patient costs less than two A&E visits, and we spend less on general practice than on hospital outpatients. For the past decade funding for hospitals has been growing around twice as
fast as for family doctor services. This is not to diminish the importance of the hospital sector, but a rebalance in funding between sectors is required, with the commensurate expectation for extended delivery with new funding.

The key differentiator for general practice (compared to other primary care providers) is that it offers a free service to all registered people. While it does provide some privately funded services, this is significantly smaller as a percentage of practice turnover.

Traditionally, this has made general practice the first port of call for health services for the majority of users - although this trend is being challenged as community pharmacy’s role develops. It does however remain the gateway to most secondary care services.

The creation of PCNs has been largely driven through general practice in recognition of the need - and desire - to move to population-based health care and trying to balance registered lists with a geographic fit.

While considerable media coverage has been given to the response of the hospital sector to the Covid pandemic, it has been general practice at the forefront of the national vaccination programme along with community pharmacies. Practices have proved themselves to be both resilient and flexible, in the rapid adoption of technologies that ease pressure on face-to-face consultations. Disproportionate value has been placed on the different sectors of the NHS who have all been impacted by the pandemic. Further, general practice has come under unfair criticism for its reaction to protecting patients.  

However, the sector faces similar post-Covid issues to that of the wider NHS: burnout among its workforce, greater demand for consultations and a backlog of appointments, as well as longer-term demographic and societal changes shared by other disciplines. It could be years before the true impact of Covid-19 on the reduction of screening and preventative care and the ability for early detection of disease can be measured.

With a significant cohort of GPs approaching retirement age in the next two-three years, current workforce shortages will likely worsen. This potential shortfall is exacerbated by demands of newly qualified GPs who want more flexible working conditions and are less keen to become partners.
COMMUNITY PHARMACY

With over 11,000 community pharmacies in England, equating to around 8-9 per PCN, there is great potential for the sector to be a significant provider within a scaled primary care service. Every day about 1.6 million people visit a pharmacy in England.

Community pharmacies are situated in high street locations, in neighbourhood centres, in supermarkets and in the heart of the most deprived communities. Many are open long hours when other healthcare services are unavailable. There are several different types and sizes of community pharmacies, ranging from the large chains with shops on every high street or on the edge of town supermarkets, to small individually owned pharmacies in small or rural communities. Pharmacy presence is inversely proportional to deprivation.

However, as described in the 2016 General Practice Forward View, pharmacists were still “one of the most under used professional resources in the system”. This Forward View has yet to provide the practice steps to significantly change this situation.

The Community Pharmacy Forward View also promoted pharmacy’s potential to work more collaboratively with the wider primary care sector, in particular with general practice. NHS England’s response, a £42 million Pharmacy Integration Fund (PhIF) to support the sector to integrate into a wider range of primary care settings, appears to have had little effect on under use.

The current national community pharmacy contract framework is evolving, with the development of PCNs and their DES delivery work in mind. It offers much scope to expand the scale and scope of community pharmacy-based clinical delivery. What is needed is a grid of ideas - matched by a will and ambition to commission and to be contracted. Equally importantly, the framework also addresses:

• The shift toward wrapping services around the supply of medicines and deploying services that impact patient care. Essentially, this has led to the blurring of traditional lines between practices and pharmacies. For example, treatment for minor ailments is moving from practice to pharmacy through the Community Pharmacy Consultation Service (CPCS) in which calls to practice are directed to pharmacies for referral and case handling. This runs in conjunction with the NHS111 CPCS version, and presents a major channel shift, easing pressure in other parts of the system.

• The advent of general practice-based pharmacy, accelerated by the Additional Roles Reimbursement Scheme, has forged new collaborative links between general practice and pharmacy, as has the development of 1259 Community Pharmacy PCN Leads acting as local community pharmacy network “ambassadors”.

• Optimising medicines - for instance, care around medicines at point of patient hospital discharge: the new Discharge Medicines Service is a key NHS initiative underpinned by the rise of the Integrating Pharmacy and Medicines Optimisation construct with ICS development.

However, no meaningful evaluation of improved outcomes has been undertaken and there remains much to be done, particularly around developing technology and platforms that offer interoperability, a single-view-of-patient, and pathways and processes that optimise the patient experience.

Despite these challenges, there can be no doubting the enthusiasm and willingness of those in the pharmacy sector to play a significant role in a collaborative approach to delivering healthcare. The profession appears well positioned to support the move towards localisation and population health.
The why as well as the how

That said, for real integration to happen, the pharmacy sector must be open to a radical change of structures and mindsets.

It’s important for the pharmacy sector to have a unified vision for the future. That vision, or roadmap, should be based on a clear definition of the role of pharmacy, and should reflect an understanding of (although not be constricted by) what is acceptable to patients and providers.

That vision is then created and decided by the sector, as opposed to having change imposed on it.

Mixed economy, mixed message

Pharmacy has always been part of a mixed NHS / private funded economy. The fact that pharmacies offer over the counter, as well as prescription medicines, confers benefits to patients and the NHS alike. In fact, it means the sector subsidises the NHS.

Further, as an easily accessible first port of call, pharmacy plays a key role in reducing the burden within wider primary care and releasing capacity. However, this duality is not always fully appreciated by the public or by the service itself.

Given the benefits, why should there be any issue about pharmacies being able to offer
some products and services to those who are happy to pay as is done for spectacles or non-NHS dentistry?

For example, during the pandemic, services such as ear wax removal or contraception, which are normally provided by GPs, ceased. Pharmacies can offer these services to those able and willing to pay.

The whole system can benefit from satisfying a need in a consumer-driven market and operating a commercially-driven service. Further, commercial drive often promotes innovation, the national flu programme started out as a local, commercial pharmacy-provided service which has now been adopted nationally.

Reducing the option for people to pay for services would lead to unintended consequences and both pharmacy and the population must learn to live comfortably with this duality.

A case for national standards?

While the direction of travel for provision of health services is towards localisation, there are questions as to whether localisation is guaranteed to improve outcomes. Having multiple iterations and local variations of pharmacy services can produce inefficiencies, and could ultimately cause un-optimised care. There is a strong case for pharmacy to define a set of standardised services for use nationally, in much the same way as the optical sector has done.

While services could still be commissioned at a local level, having an optimum national service specification set on which the pharmacy sector is unified, would end complex local negotiation and unnecessary variation. This approach would also offer more consistent services to the benefit of the population and health economy.

An example is the recent Covid-19 vaccination programme. This was a nationally agreed service but was commissioned locally. Where local commissioners wished to enhance the specification, for example to offer extra vaccination buses or centres, the national framework helped make this a more straightforward process than if the process had been developed in locality.

However, an over reliance on national frameworks can threaten to stifle innovation. As such, the spec will need to be reviewed regularly, and an environment created in which local innovations are shared and quickly adopted to a national level. Perhaps through an innovation hub system, which would cease unnecessary and wasteful duplication.

The changing role of digital

IT isolation for pharmacy is a reality in many areas currently, but is the universal delivery of live ICS based Local Healthcare Record systems that incorporate access for pharmacy the answer?

This isolation is largely down to information governance (IG) protocols being imposed which limit true integration and the widespread use of unified electronic patient records (EPR). Currently, any pharmacy located close to several geographical borders has to comply with each ICS’s IG protocols, all of which are different.

The pharmacy panel raised the issue that in many cases, IG protocols that purport to safeguard patient data are counter intuitive. It is possible that a non-clinical person working in a GP practice will have more access to patient data than a clinical professional such as a pharmacist.

IG barriers must be broken down to enable pharmacy to fully play its part in a collaborative system.
Different relationships – building trust

There are longstanding areas of misunderstanding and mistrust within - and of - the pharmacy sector. There may always be traditional contractually related tensions between pharmacy and NHS England. Communication between general practice and pharmacy is in many cases unnecessarily unsatisfactory. Too many conversations, when they happen, focus on operational issues instead of those relating to clinical care.

These are not merely related to contractual issues but to issues such as management of prescription processes.

These are largely down to a lack of the right sort of conversation - put another way, having the right conversations with other professionals inevitably leads to mutual understanding and a better outcomes for patients. Conversations between practices and pharmacists need to be at a higher level than at present.

Drivers of transformation are not driven solely by contractual alterations or financial reward. The more powerful drivers are around job satisfaction, work-life balance and self-esteem. Changing contracts is not the ideal starting point for initiating change. As with the other primary care providers, there is a clear need for different conversations between the professions, but especially between general practitioners and pharmacists.
Around 19 million sight tests take place every year. NHS sight tests account for around 70 per cent of these with the remaining 30 per cent being self-funded. Cataract procedures are the most common intervention, commonly picked up by community optometrists. Acute eye problems account for 2.6 million GP appointments and 270,000 A&E admissions. The number of people with sight loss is estimated to rise to 2.7 million by 2030.

The cost to the UK economy of sight loss in adults is estimated at £28 billion. Eye conditions, particularly those that are long-term, can adversely impact on other long-term conditions, and can also exacerbate loneliness, dependence, depression and cognitive impairment.

Much like pharmacies, opticians are often located in central locations such as in neighbourhood centres and in the heart of the most deprived communities. Many are open when other healthcare professionals are unavailable. There are different types and sizes of opticians, ranging from the large chains with premises on every high street, or in edge of town supermarkets, to independents in small communities, in the suburbs and often in deprived areas or rural settings.

The link between eye health and general health is well established. Eye disease for example is a direct consequence of diabetes, hypertension and smoking. Poor diet and obesity also contribute. However, the majority of vision
correction and sight loss can be treated with early identification via primary care optical practice working in patient communities.

Sight loss is more prevalent in older age – 61 per cent of people aged 70+ suffer from an eye condition, an issue set to grow further given the anticipated proportion of older people in a relatively short time.

Sight testing is the core business for optometric practice, but many offer additional services such as low vision, audiology and specialist contact lens services. Optometry can also deliver extended primary care services where they are commissioned. Typically, these deliver first contact care for urgent eye conditions and enhanced case finding provision, allowing for further diagnostics beyond the sight test, and often avoiding the need for secondary care services.

General ophthalmic services (GOS) are provided by around 6,000 independent contractors in England, primarily in the high street, yet under the current system, the potential for optometry practices isn’t being realised: the most significant reason being the inconsistency of local commissioning. Based on these numbers, the average PCN should incorporate between 4 and 5 community optician practices, who should become intrinsic parts of a co-ordinated first contact provision of care.

While there are many ways in which people can access eye care, there are issues around communication which have led to variable understanding of the service. Although this has improved slightly from a low base, the situation remains that the public has very limited knowledge about what optical practices actually offer.

As a result, and possibly linked to the perception that an optometrist is a fee-paying alternative, most people will go straight to their GP or A&E with an eye complaint. But, even if people are aware that optometry should be their first port of call, if extended (non-GOS) services are not commissioned locally to deliver that care, it can then only be accessed if the patient pays.

The fact is, there is significant potential for community-based eye care services to provide diagnostic and preventative treatment which may currently be provided in hospitals. But it isn’t yet possible to communicate a universal message about this because historically, there has also been a lack of understanding about the sector among some local commissioners.

With a new focus on clinical collaboration and prevention, the optical sector is well-placed to make its contribution to PCaS.
PRIMARY DENTAL CARE

Proposals for any change should be seen in the context of the post-Covid environment of ‘build back better’. This environment presents a unique opportunity for the sector to increase preventative, as much as restorative, dental care.

There is considerable, chronic unmet need for dentistry, and a backlog in demand which has been exacerbated by the pressures of Covid-19. This is particularly acute in the “heavy metal community” – older people whose teeth were treated with metal fillings, many of which now need review and replacement. The service has a desire to improve access for those who do not utilise dental services and to ‘build back fairer’, but this will require a considerable review of available NHS funding to the sector. Many of the drivers of poor oral health such as poor diet, obesity and diabetes could be addressed using dentistry within a broader multi-disciplinary workforce.

However, there are workforce recruitment and retention issues across the whole sector that include technicians and dental nurses. This has been exacerbated by the new cadre of graduates who do not consider NHS work as attractive as private services.

There is a lingering distrust among the dental workforce towards successive governments who are perceived as having consistently under-invested in dental and oral health. Dentistry
spend is now greater in the private sector than in the NHS (NHS spending having fallen over the past decade) and there are a growing number of corporate structures that now hold NHS dental contracts.

To negate the need for the current level of private provision and to improve access to NHS dental care, it is estimated that an extra £4 billion investment would be needed to entirely replace private provision with NHS services.

Dentistry is different to the other primary care contractor services in a number of respects: First, it is able to demonstrate substantial improvements in oral health based on existing data on disease levels and treatments. Second, the majority of people accessing dental care do so without symptoms. Dental diseases remain a public health problem with significant consequences for health economies. For example, the most common reason for a child to have a general anaesthetic is for the removal of decayed teeth, a condition which is entirely preventable. The cost of this care comes from the general medical budget highlighting an opportunity of how both crafts can work together.

People are increasingly being driven to seek medical, rather than dental treatments, for oral health problems, largely down to the charges that apply in the dental sector. However, the dental practitioner is the most appropriate and skilled clinician for many, if not most, oral health problems.

Dental health can be an early indicator of more general health and social problems. For example, neglect and safeguarding issues can be identified through dental attendance as well as signs of more generic health problems. Closer working relationships between dental and other primary care providers provide opportunities to improve a patient's health and experience as well as outcomes. There are also efficiency gains to be made with care provided in the right setting, a reduction in medication use and broader support of public health programmes.

Current contractual arrangements tend to mitigate against true integration within PCNs – historic non-existence of registration, use of co-payments and the size of the non-NHS sector, are potential barriers. There are, however, opportunities arising from more specialised contract holders to work collaboratively at scale to tackle social determinants of health.

For example, one model may be based on the size of a PCN and the allocation of a dentist for approximately every 2,000 people. An alternative model could be based on the nature and scale of need within a PCN. This would mean close collaboration between local professional committees to meet local needs. Funding for such a model might be found from efficiencies in lower pharmaceutical or hospital-based treatments (where low complex procedures attract much higher costs).

Achieving and maintaining good oral health is a major part of the prevention agenda for general good health and wellbeing and the Stronger Together looks at how by taking a flexible approach to contracts and commissioning, dentistry can play its part in providing PCAs.
We have not only been encouraged by the willingness of the four primary care contractor organisations to participate in the production of this report but by the openness to change and closer collaboration. Our work together has convinced us that primary care at scale is not only a real possibility but a necessary progression.

Developing a culture of co-production will take time and inspired leadership – and, we are pleased to have identified some areas and issues that will help expedite that process.
References

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