REFORM

PRESCRIPTION FOR PREVENTION

A new model of primary care

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ABOUT REFORM

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Reimagining Health is one of the major work streams within this programme.

ABOUT REIMAGINING HEALTH

This paper is part of the *Reimagining Health* work stream.

'Reimagining Health' seeks to explore how to transform England's approach to health. It will consider how to move from a treatment-oriented model to one geared towards health creation, the changes necessary in healthcare to facilitate this, and how to build a fair and sustainable approach to funding. This paper is the second of several that seeks to fundamentally redesign the health and care system.

Reimagining Health Council

Reform is grateful to the expert members of the *Reimagining Health* Council who provide valuable insight and advise on the programme. Their involvement does not equal endorsement of every argument or recommendation put forward.

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Recommendations

Recommendation 1: In the short term, the Additional Roles Reimbursement Scheme should be amended to formally include Community Health Workers. In a model where budgets are pooled at a local level between health and other services, ICSs could choose to either create a similar reimbursement scheme for public health outreach roles, where CHWs can either be accountable to the PCN or contract them independently as a community service.

Recommendation 2: ICSs should conduct an exercise to determine the ideal estate strategy for their population, with the goal of creating modern premises that enable a more preventative model of primary care, closely integrated with other health-promoting services (for example, which facilitate co-located services and an expansion of ARRS roles).

It should be clear as a result of this exercise which existing premises:

- can facilitate a more preventative delivery model;
- which are currently unable to but could be modernised, including through expansion;
- and which premises are unsuitable for providing high-quality care and should be quickly discontinued.

ICSs should then map out the premises in their region which fall into these three categories.

Recommendation 3: The CQC should use its latent regulatory power to insist that all GPs currently occupying premises which are currently unfit for providing an appropriate standard of care should be vacated, as soon as possible, over the next parliament.

To compensate for this, NHS England should create a time-limited, ringfenced capital fund that can be accessed by ICSs to invest in building new primary care premises in their region, as an initial pull incentive.

GPs moving from unsuitable premises to these new estates should be heavily incentivised to continue practising with an offer of more affordable rent and support from the ICS to relocate. This rent could be shared between multiple general practice groups in cases where owner-occupiers are moving to more spacious premises.

Recommendation 4: ICSs should commit to upgrading all premises which are unable to facilitate a more preventative delivery model by 2035.

To incentivise greater private investment in estate regeneration, NHS England should provide a template for the scale and functionality required by these new premises in different geographies, to enable prevention-oriented care and better integration with local, health-promoting services. As with the New Hospitals Programme, this template should be used to facilitate a streamlined business case approval process for new construction projects – helping to crowd in private capital for estate development.

NHS England and ICBs responsible for primary care commissioning should then link the reimbursement of owner-occupier GPs to whether they occupy fit for purpose premises. Funds should be withheld from GPs who do not occupy these premises by 2035. The amount withheld should increase over time, to ensure that as many owner-occupiers as possible have moved to fit for purpose premises by this date.

Once NHSE's time-limited capital fund for estate regeneration has expired, per the model proposed by *Reform*'s paper *Close enough to care*, Combined Authorities would become responsible for estate investment and, where necessary to deliver a fit for purpose estate by 2035, should borrow from the Public Works Loan Body (PWLB) for this.

Recommendation 5: Practices should be supported in implementing systems by a 'SWAT' change management team employed by ICSs, who can be deployed across that specific locality to provide change management expertise required to successfully embed technological innovation across their local health system.

NHS England should introduce minimum standards for the design and content of GP websites. ICSs should then engage with PCN leaders on reviewing the usability of the GP websites within their PCN. Where they do not meet the set of agreed standards, the change management team can assist in upgrading them.

Recommendation 6: To incentivise investment in digitally enabled triage, and as outlined below in Recommendation 10, there should be a one-off admin automation fund made available by NHSE for ICSs and PCNs to bid into. To receive these funds, ICSs and PCNs should be required to submit a succinct plan for how the administrative improvements will lead to greater productivity in a particular network of practices. This should include digitally enabled triage as well as other administrative improvements.

Recommendation 7: ICSs, and in a future devolved model, regional government, must consider the ideal distribution of the nursing workforce for their locality, across the whole system: primary, community and secondary care. This should reflect changing and future demand, and the need to drive care upstream and out of costly, acute care.

Recommendation 8: ICSs should experiment with nursing incentives to develop the right nursing workforce for their particular locality – depending on the nature of demand, this could include stronger incentives to work in general practice, or creating stronger incentives to work in district nursing. These could include, but are not limited to, financial incentives, progression opportunities, or flexible working.

Recommendation 9: NHS England should conduct a national review into the scope of general practice to identify which clinical areas can be descoped with a view to enabling direct access to these specialisms. This should include data on workforce for those particular specialisms and the appropriate level of clinical expertise required for the majority of care within them (for example, whether a consultant dermatologist would need to review a rash).

Recommendation 10: The Additional Roles Reimbursement Scheme should be re-defined and re-scoped. It should be specifically targeted towards roles that help to manage demand better, including administrative staff such as receptionists, clerical officers, pharmacy assistants, practice managers, and nursing. In line with this, the ARRS cap for one practice nurse per PCN should be lifted.

There should also be a one-off admin automation fund made available by NHSE for ICSs and PCNs to bid into. To receive these funds, ICSs and PCNs should be required to submit a succinct plan for how the administrative improvements will lead to greater productivity in a particular network of practices.

Recommendation 11: Health and Wellbeing Coaches should be seen as a core part of the workforce. All new patients diagnosed with a long-term condition should be given access to a Health and Wellbeing Coach as a default part of their clinical care plan. Patients already diagnosed with one or more long-term conditions should be given access to a Health and Wellbeing Coach, initially prioritised based on the complexity of their condition and their confidence in managing it. ICSs should therefore determine the number of Health and Wellbeing Coaches needed for their locality based on their demographics and disease burden.

In a model where block contracts are still adopted, Health and Wellbeing Coaches should be hired under a community service contract rather than through the ARRS. Where ICSs contract community services using more innovative contracting, the use of Health and Wellbeing Coaches should be an expected part of any bid. Where ICSs contract community services using more innovative contracting, the use of Health and Wellbeing Coaches should be an expected part of any bid.

Recommendation 12: The National Institute for Care Excellence should expand their guidance base for invasive and sensor based remote monitoring: this should be explicitly based on an assessment of the most significant clinical needs in England (for example, COPD or arthritis), desired patient outcome and the technology solutions that can enable more technological self-management.

Recommendation 13: NHS England should develop basic data submission software that can be used across the NHS. This should relieve some of the logistical and/or technical burden from smaller NHS providers while ensuring uniformity and completeness in data submission.

Recommendation 14: NHS England should commission an annual Community Services Patient Survey, modelled off the GP Patient Survey, to understand patient experience and quality of care in community services.

1. Introduction

In *Reimagining Health: a framing paper*, *Reform* set out the case for a radical new approach to health. *Reform* argued that institutions designed for the post-war era, centred on the provision of acute, episodic treatment were ill-equipped to deal with the challenges of an ageing and multimorbid population. Such a one-size-fits-all model of health remains unsuited to the diverse and complex needs of England's communities, and multiple restructures of the healthcare system have failed to shift the dial on health outcomes.

Reform's recent paper, *Close enough to care,* responded to this goal by proposing the devolution of health and care to regional mayors, allowing the pooling of budgets between health and other (health boosting) public services. This paper takes these proposals forward by proposing wholesale reform to primary and community care.

To survive the challenges of the modern age, there is broad consensus that the health system must transition from a sickness service to a health creating service. The demand on the NHS should be reduced and diverted, not simply managed. Yet while the idea of shifting to a preventative model of care is not novel, the actualisation of this has proven consistently difficult and unsuccessful.

90 per cent of daily NHS activity happens in general practice and the community[1] – if the primary care model is no longer fit for purpose, it weakens the foundations of the entire system. More activity is being provided than ever before,[2] and yet patients continue to report declining satisfaction with the NHS.[3] The disconnect between higher activity and poorer satisfaction implies significant issues undermining our current model.

Demand on the primary care system is not only increasing in volume but in complexity. As the population ages, chronic illnesses – such as diabetes, hypertension and arthritis – have come to dominate healthcare use and expenditure.[4] Future demographic projections only cement the need to rethink the NHS model: if the system cannot cope with current demand, it will buckle under future demand.

The answer to this complicated demographic context cannot come from simply increasing the volume of general practice appointments available. The system can no longer default to a one-size-fits-all approach to meet the complex nature of patient demand: primary care needs to be able to treat different types of patients differently.

[1] Beccy Baird et al., *Making Care Closer to Home a Reality: Refocusing the System to Primary and Community Care* (King's Fund, 2024).
[2] *50 Million More GP Appointments Delivered by the NHS* (Department of Health & Social Care, 2023).
[3] Danielle Jefferies et al., *Public Satisfaction with the NHS and Social Care in 2023: Results from the British Social Attitudes Survey* (King's Fund, 2024).
[4] Department of Health, *Long Term Conditions Compendium of Information. Third Edition*, 2012.

This means rejecting a traditional model of care that focuses on what takes place within the four walls of a GP surgery. While it may seem logical to assume that the more complicated the case, the maximum clinical expertise required, for many long-term conditions this is not the case. Many of the patients in this category will interact primarily with alternative clinical specialists like community nurses and pharmacists, rather than general practitioners. The longstanding – and yet unachieved – ambition to shift care out of the hospital and into the community relies on these vital services, and so elevating their role within the primary care system is long overdue.

Primary care is uniquely positioned for early intervention as the first point of access in healthcare, but the system as designed is mostly reactive to clinical need when it arises, rather than stopping it in the first instance. This shift would also support growing calls for approaches that promote intervention on the wider determinants within a person's life that influence their long-term health outcomes, from diet to living conditions.

The primary care debate is often focused on increasing workforce supply.[5] But the imbalance between demand and supply in primary care should be seen as much about reducing and diverting demand as it is about increasing supply of the workforce. One of the most common capacity drains cited by interviewees was the administrative burden, rather than the clinical demand, of general practice. Indeed, straightforward yet understated interventions could enable substantial efficiencies in general practice, freeing up capacity.

Progress has of course been made in recent years: despite a global pandemic, more appointments than ever are being provided by a more diverse range of staff, the clinical expertise of pharmacies is increasingly being used, and digital capabilities have increased. There are also pockets of promising innovation in primary care across England. However while all this is welcome, systemic reform is needed if it is to be as effective as possible for patients and as efficient as possible for taxpayers.

A primary care system for the twenty first century needs to be able to intervene at the earliest possible point, deliver high-quality care when people need it, and empower patients to live independent, healthy lives.

In the following chapters, this paper will explore in detail how the primary care system can be fundamentally reimagined, aligned to three key principles: to intervene earlier, respond to clinical need faster and avoid preventable decline. This paper is supported by two supplementary papers on the funding model and technology that should underpin a reimagined primary care.

1.1 Defining primary care

Primary care is the first point of access in the health system, commonly known as the 'front door' of the NHS. It is the day-to-day healthcare available in every local area – such as general

[5] Stuart Hoddinott and Nick Davies, *Performance Tracker 2023: General Practice* (Institute for Government, 2023); Martin Marshall and Margaret Ikpoh, 'The Workforce Crisis in General Practice', *British Journal of General Practice* 72, no. 718 (May 2022); Kimberley Hackett, 'RCGP Calls on Government to Overhaul NHS Workforce Plan to Boost GP Numbers', 10 July 2024.

practice, community pharmacy and district nursing – and the place people turn to when they need health advice or treatment.

There is a general practitioner for every 1,700 people in England.[6] The vast majority of people also live within a 20 minute walk of a GP premises and even more people live within walking distance of a community pharmacy.[7]

General practice and primary care are often viewed synonymously, but this wrongly narrows the scope of what primary care can, and does, offer. In *Reform's* reconceptualised vision of the healthcare system, primary care encapsulates some public health responsibilities, general practice, and community services. The definitions of these are clearly outlined in their specific chapters.

While dentistry, optometry and mental health are considered an integral part of the typical primary care definition, these fall outside of the scope of this paper. As separate clinical domains with specific issues, they warrant individual policy analyses.

[6] *Trends in Patient to Staff Numbers at GP Practices in England: 2022* (Office for National Statistics, 2022).
[7] A. Todd et al., 'Access All Areas? An Area-Level Analysis of Accessibility to General Practice and Community Pharmacy Services in England by Urbanity and Social Deprivation', *BMJ Open* 5, no. 5 (May 2015).

2. The framework for a reimagined primary care system

The current crisis in primary care is driven by demand for services outstripping supply. Some estimations suggest, for example, that an additional 36.6 million consultations would have been required to meet the population need in 2019.[8] Despite impressive increases in appointment volumes since 2019, existing capacity is still not sufficient.

There are generally three solutions offered to counter this shortage: a larger workforce, working more productively or changing the nature of the demand.

Workforce supply is indisputably a problem in the English primary care system. England has less GPs per 1,000 people than most other European countries.[9] The consistent imbalance between the primary and secondary care workforce is also a concern: England has significantly fewer doctors in general practice than in other medical specialisms.[10] However, many roles performed by doctors and nurses in the OECD are performed by allied health professionals in the UK, making a direct comparison more difficult.[11] It is worth noting that the UK's total health and social care workforce is among the largest in the OECD.[12]

There are also several limitations to viewing primary care reform solely through the lens of supply. Supply-focused approaches generally seek to meet demand, rather than divert or reduce it. Addressing the increase in both volume and complexity in the most efficient way is also not solely dependent on GPs, but a multiplicity of practitioners. A larger workforce would certainly make managing demand easier, but it does not change the underlying system, which perpetuates a reactive approach to clinical demand rather than a preventative, proactive one.

Demand management is therefore also a problem in the English primary care system. Indeed, in any population, a relatively small number of patients account for a disproportionately large fraction of health care costs. In England for example, roughly half of all hospital bed days are attributable to five per cent of the population.[13]

It is commonplace in customer facing industries to segment the customer population into groups that are sufficiently similar to arrange commonly needed support and services.[14] Rather than meeting a minimum standard for all population segments, it enables the development of an offering that meets the needs of a specific customer segment.[15]

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[8] Steven Wyatt, *The Gap between Need and Supply of GP Practice Consultations* (The Strategy Unit, 2024).
[9] OECD.stat, 'Health, Physicians by Category, General Practitioners per 1000', Webpage, 22 April 2024.
[10] Ibid.
[11] NHS England, 'Allied Health Professionals', Webpage, 2022.
[12] OECD, *Health Care Resources: Total Health and Social Employment*, 2022.
[13] *Raising the Profile of Long-Term Conditions Care: A Compendium of Information* (Department of Health, 2008).
[14] *Whole Population Segmentation Models* (Outcomes Based Healthcare, 2021).
[15] Ibid.

But the segmentation of patient demand is not widely used to effectively *understand* patient demand and allocate appropriate resource in healthcare. The system still predominantly defines healthcare need based on disease status, unplanned health service use or by the provider whose services the patients are using at that moment, e.g. a nursing home population or a hospitalised population.[16] Crucially, primary care also has no systematic way of detecting pre-clinical need and minor health needs where people have not yet presented, undermining the system's ability to intervene early.

The result is a system largely formed around immediate clinical need rather than early intervention or long-term health prospects. This means resource and investment is heavily geared towards hospitals rather than primary care, and, within primary care, on general practice rather than community services. It also means care may be inconsistent or duplicative between different health services with little incentive for integration, which could otherwise result in savings across entire care pathways.[17]

If individuals could be identified early and offered more targeted support then it might be possible to improve their health outcomes, all the while making significant net savings for the health service as a whole from avoided hospital admissions 'downstream'.[18] The process is also not simply about reducing demand but shifting demand to underused services that are known to be cost effective.

Not only does a reimagined system need to be grounded in a detailed understanding of demand, but it also needs to translate this demand into a system that is geared towards early intervention, responds quickly to clinical need when it arises and empowers people to live healthy lives.

The ambition for health systems worldwide has long been to shift to a more preventative model of care that acknowledges the critical importance of wider health determinants, but few, if any, have achieved this transition. As has been discussed, the need for this shift will only grow more acute as clinical demand grows in both volume and complexity.

A reimagined model

The logical response should therefore be a primary care system designed explicitly around prevention rather than reaction. Across public service reform, prevention is typically grouped into three approaches.

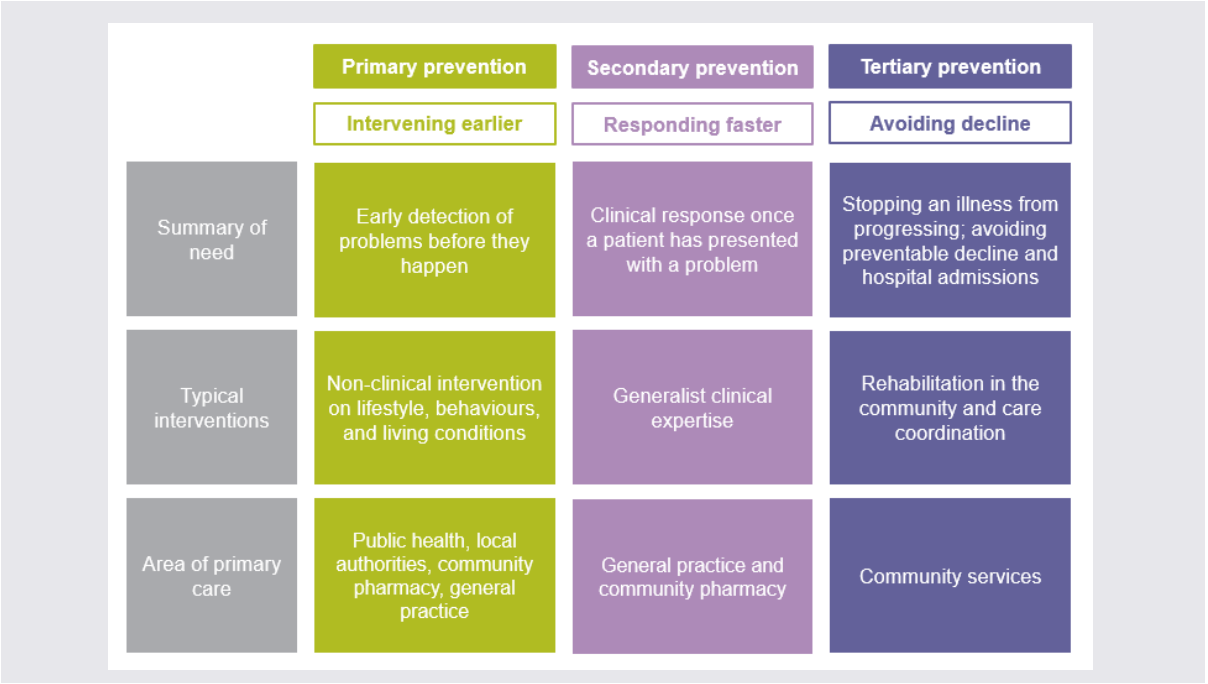
[16] Joanne Lynn et al., 'Using Population Segmentation to Provide Better Health Care for All: The "Bridges to Health" Model', *The Millbank Quarterly* 85, no. 2 (2007): 185–208.
[17] *Whole Population Segmentation Models*.
[18] NHS England, *Next Steps for Risk Stratification in the NHS*, 2015.

Figure 1: The three stages of prevention

Source: Institute for Work and Health[19]

The following chapters will explore primary care explicitly through these three lenses: namely how to intervene earlier, respond faster, and avoid decline.

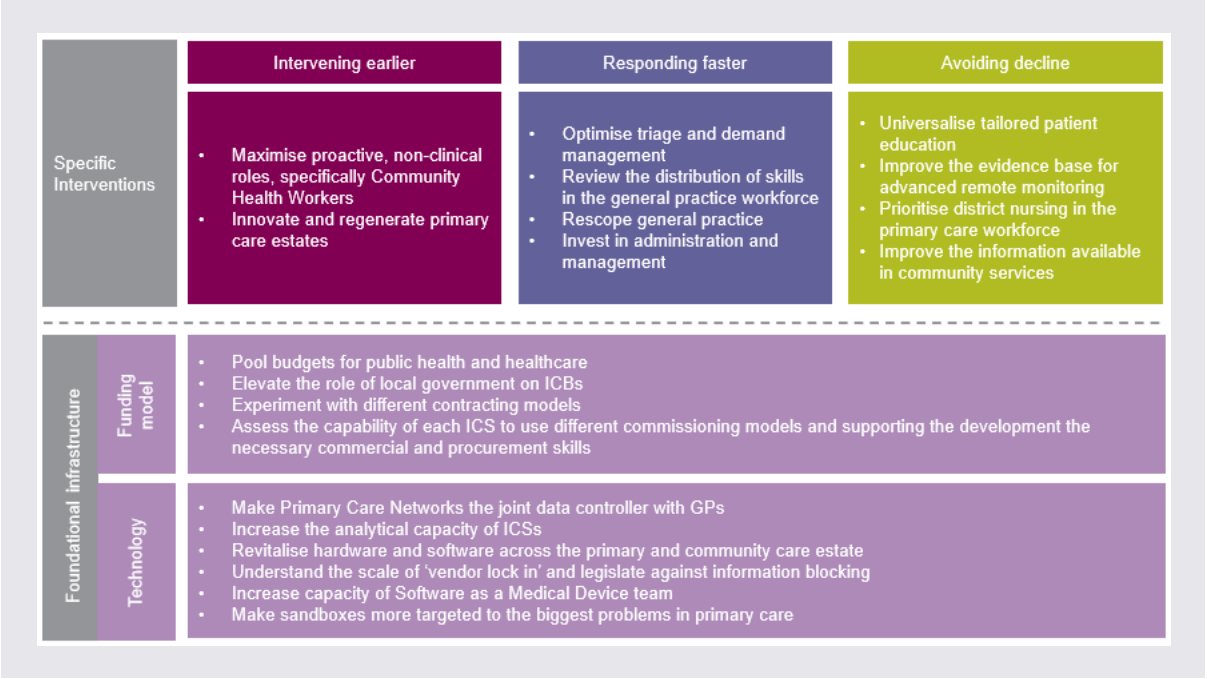
Figure 2: Reimagined pillars of primary care based on the three pillars of prevention



Translating these three pillars into a programme of reform requires both specific interventions for each pillar, and a set of interventions for the fundamental infrastructure that supports all three collectively.

[19] *Primary, Secondary and Tertiary Prevention* (Institute for Work and Health, 2015).

Figure 3: Programme of reform



As illustrated above, this paper is supplemented by two shorter papers that focus specifically on the funding model and technology infrastructure in primary care, as policy areas that cut across all three pillars.

Previous *Reform* work has proposed the devolution of healthcare to the regions via combined authorities, which would in turn render NHS England redundant. *Reform* is clear that this should be the long-term ambition – and this comes through in many of the proposals outlined in this report – but also recognises that reform must urgently be achieved in the current system. Several of the proposals included here refer to NHS England because, in the current model, it is one of the primary vehicles for driving change.

The first chapter will outline the scale of the current problem, chiefly the amount of unmet demand in the system and poor accessibility.

The following chapters will then explore how to intervene earlier, respond faster and avoid decline. Intervening earlier is primarily focused on the intersection between public health and primary care, with a particular deep dive into how to reform the primary care estate.

Responding faster focuses on general practice. The key objective of this chapter is to relieve capacity in the system to enable it to respond much faster when a patient presents with a clinical need.

Lastly, avoiding decline provides analysis on community services, one of the most underdiscussed parts of the health and care system. Community services are fundamental to the future sustainability of the NHS and social care as they are chiefly responsible for those with long-term conditions, in turn keeping them out of hospital. As the disease burden changes, this will only grow in importance.

Together, this programme of reform would help drive the essential shift towards prevention in the primary care system.

3. The scale of the problem

3.1 There is considerable unmet demand

General practice, the current focal point of our system of primary care, is struggling to meet demand, which has risen sharply in recent years. More patients than ever are waiting at least four weeks to see a GP and a significant amount of demand is thought to be going completely unmet.[20]

Compared to other countries, a much higher percentage of the population now have measurable levels of unmet need (4.5 per cent, compared to 2.8 per cent in France and only 0.3 per cent in Germany) – due to waiting times or travel distance.[21] Worryingly, a majority of people (51.4 per cent) report having avoided making a general practice appointment in the last year.[22] The most common reason for this was patients finding it "too difficult" (reported by 27.9 per cent), while 15.1 per cent said they were worried about the burden on the NHS.[23]

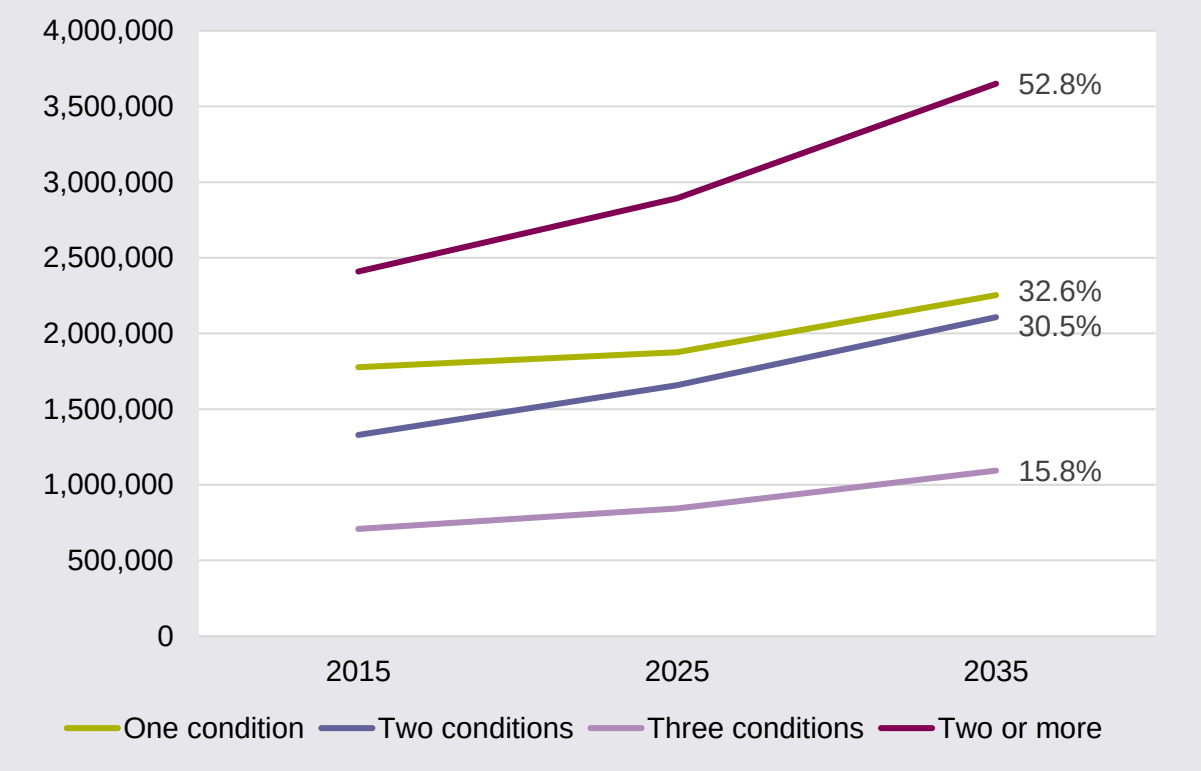
Beyond general practice and the number of annual appointments that take place, however, there is only limited understanding of the demand that exists on the primary care system.[24] This means, for example, that exactly how much latent demand goes unmet is not known. That clearly has a knock on effect on the system's ability to manage demand, and leads to 'seep through' to other parts of the health and care system, including urgent and emergency care services, often at a higher level of acuity than if it had been identified early. As the Academic Health Science Network for the West of England put it, "without knowing the level and characteristics of demand, it is hard to design effective interventions and evaluate this impact".[25]

This is particularly worrying given that in future the primary care system is set to face ever more complex demand as more patients live with multimorbid and long-term conditions that cannot be managed through short consultations in general practice alone (see Figure 4).

Indeed, as a report by NHS Providers argues, it is more often than not the "complexity and acuity of care needs" that is most challenging for services, rather than simply the volume of patients.[26] In the most recent GP Patient Survey, over half (56.1 per cent) of respondents reported a long-term physical or mental health condition, disability or illness – the highest level in over six years.

[20] Denis Campbell, 'One in 20 Patients in England Wait at Least Four Weeks to See GP, Figures Show', *The Guardian*, 22 January 2024.;
[21] European Observatory on Health Systems and Policies, *Sweden: Health System Summary 2023*, 2023.
[22] NHS, 'GP Patient Survey', Webpage, 2024.
[23] Ibid.
[24] West of England Academic Health Science Network, *Measuring Demand in General Practice*, 2015.
[25] Ibid.
[26] NHS Providers, *NHS Community Services: Taking Centre Stage*, 2018.

Figure 4: Prevalence of multimorbidity among 65-74 year olds

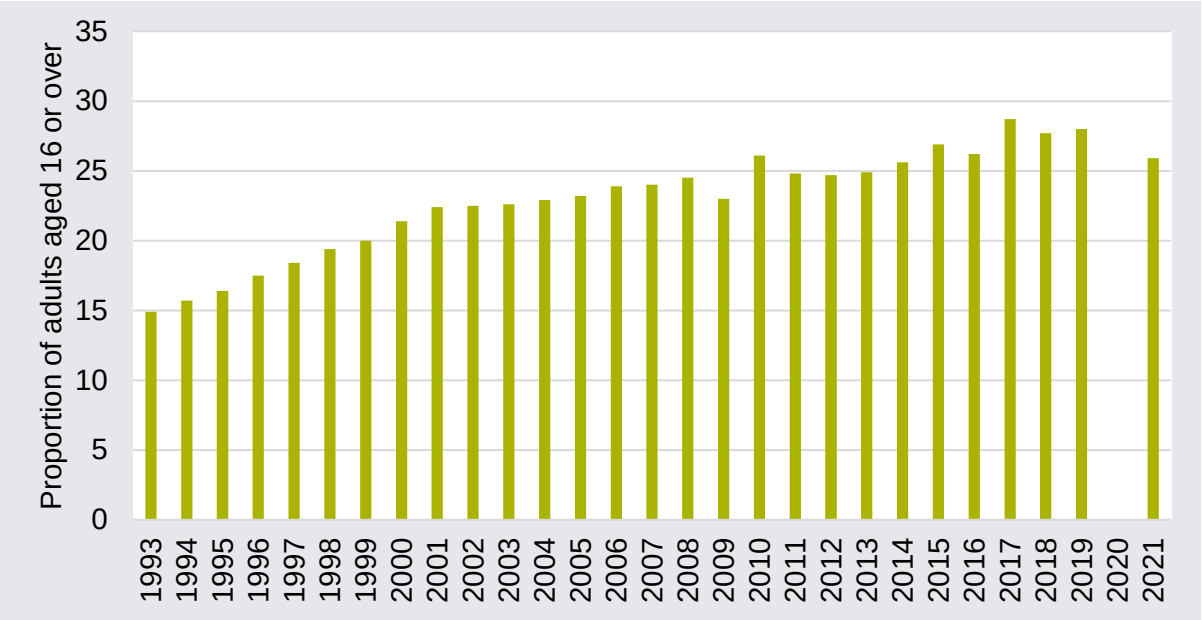


Source: Kingston et al., 'Projections of multi-morbidity in the older population in England to 2035', 2018.[27]

Projections from Cancer Research UK also estimate that more than 21 million UK adults will be obese by 2040, which equates to 36 per cent of the adult population, and if current trends continue, this could reach 71 per cent of the population.[28] This suggests that in addition to primary care facing greater demand due to an ageing population, the increasing prevalence of diseases such as obesity – which, in turn, is connected to numerous other preventable conditions – will simultaneously mean more complex, higher acuity health needs in the population at an earlier age.

[27] Andrew Kingston et al., 'Projections of Multi-Morbidity in the Older Population in England to 2035: Estimates from the Population Ageing and Care Simulation (PACSim) Model', *Age and Ageing* 47, no. 3 (May 2018).
[28] Jacob Smith, *New Analysis Estimates over 21 Million UK Adults Will Be Obese by 2040* (Cancer Research UK, 2022).

Figure 5: Percentage of adults who are obese



Source: Nuffield Trust, 'Obesity', 2023.[29]
Due to the impact of the COVID-19 pandemic, data was not collected in 2020 and no publication was released.

3.2 Access is poor

Growing demand on primary care – which represents 90 per cent of people's contacts with the NHS – and particularly on general practice, has led to notable efforts to increase the number of GP appointments carried out, to maintain access levels. For example, in 2019, an average of 25.2 million appointments took place in general practice each month. By February 2024, this had risen to 30 million appointments in a month.[30]

At the same time, waiting times for same day appointments have only mildly fluctuated in recent years. In 2019, 42 per cent (10.5 million appointments) took place on the same day as booking – and despite a 23 per cent increase in appointment volume by September 2023, 40 per cent still took place on the same day as booking (12.3 million appointments).[31]

Nevertheless, levels of access to primary care still compare unfavourably to other countries. In 2023, the UK ranked third worst out of 40 countries surveyed for appointments to see a GP within 24 hours.[32] Relatedly, appointment lengths are also lower in the UK than in comparable countries. Research suggests the average length of a GP appointment in the UK is 11 minutes, compared with a 19 minute average appointment for GP and primary care physicians in other

[29] *Obesity* (Nuffield Trust, 2023).
[30] *Appointments in General Practice, February 2024* (NHS England, 2024).
[31] *Access to GP Appointments and Services* (Nuffield Trust, 2023).
[32] Taz Ali, 'GP Waiting Times in UK Worse than Rwanda, China and Russia, Study Finds', *The Independent*, 21 November 2023.

countries.[33] According to the same research, UK GPs are also least satisfied with the length of time spent with patients: just one in four feel satisfied with this.[34]

Since general practice remains, for most people, the front door to the NHS, this has serious implications for the accessibility of the health system and for health inequalities. Diminished access to general practice limits people's ability to receive essential healthcare services and is associated with worse health outcomes in key areas, including higher rates of hospitalisation, premature death and lower life expectancy.[35]

Unfortunately, access to general practice varies considerably in England depending on where people live, and patterns of poor access often predictably correspond with other indicators of deprivation, such as the poverty and unemployment rate of a given area.[36] For example, in the South East, over three quarters of people (76 per cent) can access a GP appointment within a week of booking, whereas in the North East and Yorkshire only 67.7 per cent of people can, dropping to 64.8 per cent in the South West.[37] There is also significant variation in access to general practice between rural and urban areas. In rural areas, one in five people (20.6 per cent) wait more than a week for a GP appointment, compared to 16.9 per cent in urban areas.[38]

More generally, research finds that the 'inverse care law' – whereby resourcing and access are lower in the areas where health need is greatest – is a "persistent" feature of England's model of primary care.[39] Likely for these reasons, "improving access" continues to be identified as the biggest challenge facing general practice in the annual GP Patient Survey.[40] One of the main problems resulting from delayed access, or perceptions of delayed access, is that many people may ignore or delay doing anything about concerning symptoms because booking an appointment is too difficult. This means illness may grow more severe, making the eventual clinical solution more complex and resource intensive, as well as unpleasant for the patient.

[33] *UK GPs the Least Satisfied among High Income Countries with Amount of Time They Have with Patients* (Health Foundation, 2020).
[34] Ibid.
[35] Anna Gkiouleka et al., 'Reducing Health Inequalities through General Practice', *The Lancet Public Health* 8, no. 6 (June 2023).
[36] Victor Adebowale, 'Lord Victor Adebowale on Tackling Health Inequalities', Blog, NHS Confederation, 26 May 2023.
[37] NHS England, *Appointments in General Practice*, 2023.
[38] Eliza Parr, '"Patients in Rural Areas Face "Significantly Longer GP Waits"', *Pulse*, 25 September 2023.
[39] Rebecca Fisher, '"Levelling up" General Practice in England: What Should Government Prioritise?', The Health Foundation, 21 May 2021.
[40] *GP Patient Survey, National Report 2023* (NHS, 2023).

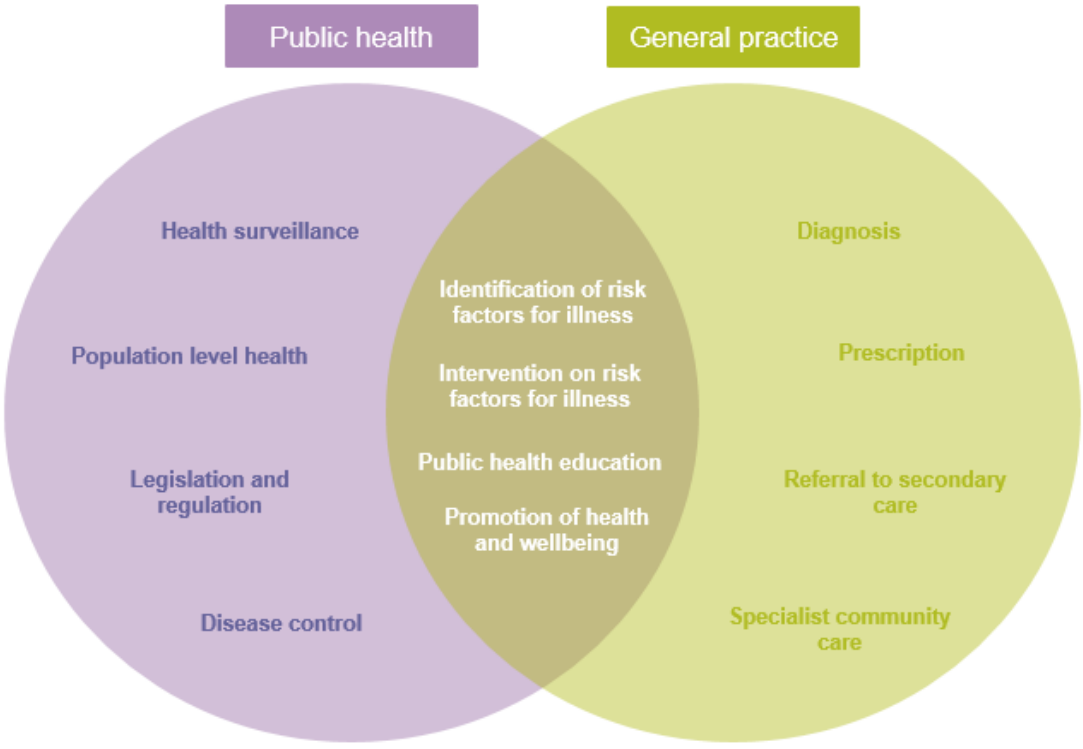
4. Intervening early

Primary prevention and early intervention is chiefly focused on the detection of risk factors to prevent an illness from developing. It commonly involves limiting risk exposure (e.g. poor living conditions) or increasing the immunity of individuals at risk of a disease (e.g. vaccination).

This is traditionally the remit of public health policy, a separate but complementary domain to primary care, as outlined in Figure 8. There is emerging consensus that a health system based on a strong primary care infrastructure and a strong public health sector is essential to maximise the health of the population.[41] Yet despite the fact public health and primary care are mutually reinforcing, they are organised and funded as two separate entities.

Given the expansive nature of public health policy, the complementary roles between public health and primary care must be carefully defined. The following section will explore the intersection between public health and primary care in a reimagined model. Currently, primary care relies too heavily on people correctly identifying they have a problem and presenting with it, rather seeking to stop that health problem from developing in the first instance.

Figure 8: Intersection between public health and primary care



[41] Jean-Frédéric Levesque et al., 'The Interaction of Public Health and Primary Care: Functional Roles and Organizational Models That Bridge Individual and Population Perspectives', *Public Health Reviews* 35, no. 1 (June 2013).

Bridging the gap between clinical care, behaviours, and wider health determinants is not always straightforward given the interdependencies inherent in poor health. While linkages between public health and primary care are essential for improved population health, it is also true that primary care practitioners cannot always intervene on structural factors and behaviour change in the way local authorities, businesses and communities can. This is one of the reasons why *Reform* has called for the devolution of the healthcare budget to local authorities who can then allocate funding to maximise health outcomes (not just *healthcare* outcomes).[42]

The following analysis is focused on 'intervening early' to ensure the early detection of illness. As a result, it focuses on strengthening integration with other public services that can help address the underlying structural factors in ill health.

In general, action will sit under two overarching approaches:

- Light touch clinical intervention *irrespective of any obvious clinical need* – such as proactive health visits.
- Intentional clinical intervention *targeting individuals susceptible to an illness* based on an assessment of need – such as population segmentation, explored in the supplementary paper, *Prescription for Prevention: A digitally enabled model of primary care*.

4.1 Current responsibility for early intervention

Despite multiple commitments to shift to a model of prevention made by successive governments over the last twenty years, the formal responsibility for prevention is ambiguous. Broadly, health prevention is split between local authorities and general practice.

4.1.1 Local authorities and public health

The commissioning and delivery of most public health functions sit with upper-tier local authorities. Local authorities are responsible for commissioning some sexual health services, public mental health services, physical activity, obesity services, drug and alcohol misuse services and nutrition programmes. These statutory duties are overseen by local Directors of Public Health (DsPH) who are chief officers in their local authority and principal advisers on all health matters to elected members and officers.

DsPH have a range of statutory responsibilities for health improvement, health protection, and public healthcare. They also commission a number of non-statutory duties, such as health visiting and school nursing, children's weight management and oral health and sit on independent safeguarding boards.[43]

4.1.2 General practice and primary prevention

[42] Rosie Beacon, *Close Enough to Care: A New Structure for the English Health and Care System* (Reform, 2024).
[43] Department of Health and Social Care, *Directors of Public Health in Local Government: Roles, Responsibilities and Context*, 2023.

The role of general practice in primary prevention is largely focused on vaccination and immunisation, rather than limiting risk exposure. Secondary prevention, rather than primary prevention, is more common in general practice. There are some pockets of innovation that deliver a much broader preventative model, such as Bromley by Bow,[44] but these tend to be exceptions.

More generally across the system, GPs have an expectation set by their professional bodies – notably the General Medical Council – to help people to "improve and maintain" their health. GPs are also required to offer "relevant health promotion advice" to their registered population under the General Medical Services contract.[45]

Evidence suggests the Quality and Outcomes Framework (QOF) – the pay for performance incentivisation scheme in general practice – has been effective in incentivising a more organised approach to chronic disease management and secondary prevention.[46] However, QOF provides no similar incentive for primary prevention.[47]

Aside from incentives, GP workloads understandably lead to a focus within, rather than outside, the practice. Even if general practices were better incentivised to pursue more primary prevention, GPs lack the time to engage in prevention activities outside of clinics.[48] It may also be a waste of their specific skill set and comparative advantage to other professionals.

4.2 The vision for a new model

Shifting to a model where early intervention is a formal part of the primary care ecosystem requires a transition from general practice to the community, from reactive care to proactive intervention, and from fragmentation in public health to integration with primary care, as outlined in Figure 9 below.

[44] Melanie Davis-Hall, 'The Bromley by Bow Centre: Harnessing the Power of Community', *British Journal of General Practice* 68, no. 672 (July 2018).
[45] Thomas Beaney and Luke Allen, *What Is the Role of General Practice in Addressing Population Health?* (King's Fund, 2019).
[46] David Buck, *Incentivising Public Health in Primary Care: Learning from the QOF* (King's Fund, 2011).
[47] Ibid.
[48] Beaney and Allen, *What Is the Role of General Practice in Addressing Population Health?*

Figure 9: A reimagined model of early intervention in primary care

Current approach	New approach
Public health co-ordinated in pockets by local government	Early intervention is a shared responsibility of local government and primary care practitioners
Waits for patients to present with a problem to identify non-clinical needs	Intervenes proactively and identifies problems before they become clinical problems
Fragmentation of clinical and non-clinical professionals	Clinical and non-clinical staff work in the same place in the same teams with straightforward access for patients
Incomplete understanding of individual patient need and background	Extensive understanding of wider health determinants in a patient's life and the risk this presents to their health

4.2.1 A model for patients

This model is designed to be responsive and tailored to patient need, and therefore would look very different for different patient profiles. Below are two illustrations of small but transformative interventions for two different patient contexts.

Patient example 1: Jamie

Jamie is 35, works full time, and has three children. His day-to-day routine consists of childcare, his 9-5 office job, and household chores. To socialise, he sometimes plays football with his friends, but more often he goes to the pub or relaxes with a takeaway. Jamie has recently started to put on weight.

Current model

Jamie continues to put on weight, and his eating habits are replicated within his family. Within ten years he has developed hypertension, and within 20, type 2 diabetes. His two children are overweight, and one is obese by his late teens, impacting his broader physical health and triggering depression.

Future model

Jamie and his family live in a relatively deprived area and the population segmentation model used by the ICS has identified a particularly high incidence of childhood obesity in that community. This is identified as a priority for the Community Health Workers (CHWs) responsible for that neighbourhood. Indeed having now seen Jamie and his family consistently over two years, the local CHW has started to notice his and his children's gradual weight gain.

She approaches the topic gently by asking them about their diet and exercise habits. It emerges that they struggle to cook healthy food as they don't know how to and worry it is too expensive. Jamie is also suffering from a residual knee injury that he has not been to the doctor's about which inhibits his ability to exercise. The CHW refers him to two appointments at the local primary care estate: one with a physio for his knee, and one with a dietitian (who does a weekly clinic) for dietary advice.

Patient example 2: Maryam

Maryam is six weeks old. She lives in an overcrowded household in an inner city social housing flat, with three other siblings. She is of Pakistani heritage and was born slightly underweight.

Current model

The health visitor visits every three weeks to check that Maryam is progressing well and putting on weight. It is a short but satisfactory appointment where all of the health visitor's individual priorities for Maryam are checked.

Future model

The CHW is due to arrive to check in on Maryam's family. She is aware that there is a particular problem in this locality with women from Pakistani heritage not seeking medical help and so is visiting more regularly. It emerged that Maryam's sibling hurt his arm playing recently, it has not improved and hasn't been checked. She helps them book an appointment with the GP two days later, who identifies a sprain and bandages his wrist. While Maryam is progressing well, the ongoing concern for the CHW is the living conditions of the family, where there has been a longstanding problem of black mould. The CHW escalates this with her contact in the housing department of the local authority and an appointment is arranged to check the mould and ascertain what action should be taken.

4.3 The building blocks

Developing a proactive, interventionist primary care system is predicated on improving visibility over the local population: both the traditionally 'healthy' and unwell. In addition to a more expansive data landscape and the integration of public health and primary care budgets (covered in supplementary papers published alongside this report), it requires more and different non-clinical roles and a revitalised primary care estate.

4.3.1 Maximise proactive, non-clinical roles

Light touch clinical intervention that is proactive rather than reactive has proven to be highly successful in identifying, and addressing, unmet need.

Despite the diversification of the primary care workforce through the Additional Roles Reimbursement Scheme (ARRS), there are few NHS roles that are explicitly designed around proactive intervention rather than waiting for a patient to present with a problem. The benefits of such interventions are extensive: as well as helping to identify health risks much earlier, it deepens local knowledge of the health needs in that community.

Community Health Workers (CHWs), for example, were a model developed in Brazil,[49] and are now replicated in a handful of localities in England. CHWs provide universal,

[49] Sebastian Rees, Patrick King, and Hashmath Hassan, *Looking Outward: International Lessons for Health System Reform* (Reform, 2023).

comprehensive and integrated health and social care support to all families in a hyper-local geographical area, usually around 200 households.

They are recruited from within these local areas, are paid full time and are members of the local primary care team. They are trained at a low technical level to support their households with a broad range of activities. CHWs differ to other community focused roles because they are:

- not referral dependent;
- proactive and comprehensive;
- geographically delineated, in that they cover a group of council blocks or streets; and
- address the health and wellbeing needs of anyone in a household.

This household-centred approach leads to substantial improvements in early intervention. This includes identifying suicidal residents or encouraging ethnic minority women to get a cervical cancer screening.[50] An early evaluation of the initiative in Westminster has found a 7 per cent drop in unscheduled GP visits in areas covered by CHWs. Other evidence shows that CHWs can reduce mortality for cardiovascular and cerebrovascular disease significantly. Areas with high coverage of this model (higher than 70 per cent) had 18 per cent lower mortality for stroke, and 21 per cent lower mortality for heart disease.[51] Anecdotal experience is similarly compelling. On a visit to the Westminster model, *Reform* learned that:

> "One person had been admitted to A&E after mixing different types of blood pressure medication. After realising why, a CHW helped them write down what they'd taken and set up alarms on their phone: something the resident hadn't thought or been told to do before. In less than five minutes, the CHW performed what countless visits by social services or GP appointments would likely have missed."

CHWs are also cost-efficient: the responsibilities of a CHW are similar to a healthcare assistant and so salaries can be estimated at a similar level, around Band 2 in the NHS pay guidelines (approximately £22,000 per annum). According to current job advertisements as of September 2024, their pay ranges from £24,000 to £26,000 per annum. The system return on the investment is high: recent experience in Westminster has shown additional uptakes of cancer screening and immunisation, reduced unscheduled hospital admissions, and lower stroke and cardiovascular mortality.[52] If every household in England had a CHW, it would cost around £2 billion a year.[53] But if it is targeted at the 20 per cent most deprived primary care networks, that figure shrinks to £300 million.[54] The ARRS, for context, will cost £1.4 billion in 2024-25.[55]

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[50] *Community Health Workers: The Eyes and Ears for Primary Health Care in the Community* (National Association of Primary Care, 2021).
[51] Matthew Harris, 'From Brazil to Westminster: Learning from a Community Health Worker Model', *Imperial Medicine Blog*, 7 April 2021.
[52] Matthew Harris and Cornelia Junghans Minton, *Changing the Front Door to the Health System: Westminster's Community Health Workers* (Reform, 2023).
[53] Ibid.
[54] Ibid.
[55] *Update to the GP Contract Agreements 2024/25: Financial Implications* (NHS England, 2024).

Recommendation 1: In the short term, the Additional Roles Reimbursement Scheme should be amended to formally include Community Health Workers.

In a model where budgets are pooled at a local level between health and other services, ICSs could choose to either create a similar reimbursement scheme for public health outreach roles, where CHWs can be accountable to either local government or the PCN depending on the model that the individual area is choosing, or contract them independently as a community service.

The ARRS has successfully enabled over 34,000 new patient facing staff in primary care. It was launched in 2019 as part of the Government's promise to improve access to general practice. The impact of this programme will be explored in the next chapter, but it is relevant to the funding of CHWs. Initially, Primary Care Networks (PCNs) could choose from five roles under ARRS, but over time the list has grown to 17, many of which had not previously been available within primary care. However, less technical, but more proactive roles that are considered a 'non-healthcare' role, such as CHWs, do not always qualify for ARRS funding.

The localities that have recruited CHWs have therefore had to work against the grain to employ them. In Westminster for example, CHWs are hired by the PCN using the ARRS money, which makes sense given the networked coverage of primary care at a local level. But they are then hosted by the Voluntary and Community Sector, who provide physical space, HR, and monitoring. Ultimately, local arrangements should be established which suit that local area, which could mean CHWs being hired by either local government or the NHS (or shared between them).

4.3.2 Innovate primary care estates

Some of the most successful primary care innovations in early intervention have taken a radical approach to estates.

The problem

The need to rethink estates is underlined by the fact that around 2,000 premises have been identified by GPs as not fit for purpose.[56] Indeed the current estates model is fraught with problems. A complete or comprehensive picture of the quality of the current primary care estate is not available, but 42 per cent of it is thought to be over 35 years old, and 62 per cent over 25 years old.[57]

This is complicated by the fact that very little of the primary care estate is owned by the NHS. Of the more than 6,000 GP practices in England, less than a quarter are owned by the NHS.[58] Hundreds of premises are owned by private, third-party developers, which are then leased

[56] Claire Fuller, *Next Steps for Integrating Primary Care: Fuller Stocktake Report* (NHS England and NHS Improvement, 2022).
[57] Sir Robert Naylor, *NHS Property and Estates*, 2017.
[58] Jessica Lubin, Christopher Smith, and Donal Sutton, 'Primary Care Estate: Delivering Value and Improving Care' (Good Governance Institute, Primary Health Properties, September 2020).

back to GPs. The systematic redevelopment of primary care estates is therefore difficult with multiple owners, who have competing interests.

Moving toward a new model

The convergence of a poor primary care estate with the urgent need to focus on population health presents an opportunity to fundamentally reset the approach. There are several pioneering examples of innovative estates, often defined as 'community health organisations', which have a strong population health orientation. These organisations sometimes comprise multiple GP practices in a network, and in other cases in a single building. They deliver comprehensive primary care through an interdisciplinary team, combining patient centredness with population health.[59]

Analysis by Citizen's Advice in 2015 found that GPs spent 19 per cent of their consultation time dealing with social issues.[60] Of these, 77 per cent of patients raised housing issues and 77 per cent raised work issues.[61] The survey found that such non-health demand is not only high, but it is also rising. Almost three quarters of GPs said non-health demand had risen since the previous year.[62] There is a clear logistical benefit to having representatives from these services – such as housing, social care services, or drug and alcohol services – situated within the same building.

To this end, community health organisations seek to develop an extended range of local health and social care services, which may include welfare rights advice, housing support, employment training, and parenting support, based on analysis of local needs. It sees its role as one of community development alongside, or even before, healthcare provision, providing an important community resource for often marginalised groups. Attention to the broader causes of illness like poverty or inadequate housing is integrated into their daily activities.[63]

Each community health organisation will take a different approach depending on its local community's needs. The internationally recognised Bromley-by-Bow centre, for example, is designed around a three acre community park, and offers holistic support to people by bringing together primary care, public health, social care and non-clinical services.[64]

Interviewees for this paper, however, also stressed that a revived primary care estate should not be a one-size-fits-all 'hub' approach – some practices, for example, need to be geographically dispersed to serve a more rural population or where the transport infrastructure is not well developed.[65] Other interviewees also emphasised that sometimes regeneration of primary care estates has led to unused space within a new building which was designed to be too large, and ill-suited to the needs of the local demographic.

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[59] Judith Smith et al., *Securing the Future of General Practice: New Models of Primary Care* (Nuffield Trust, 2013).
[60] Kathleen Caper and James Plunkett, *A Very General Practice: How Much Time Do GPs Spend on Issues Other than Health?* (Citizens Advice, 2015).
[61] Ibid.
[62] Ibid.
[63] *Community Health Centres* (TransForm Integrated Community Care, 2023).
[64] Durka Dougall, Matthew Lewis, and Shilpa Ross, *Transformational Change in Health and Care: Reports from the Field* (King's Fund, 2018).
[65] *Primary Care Networks: Critical Thinking in Developing an Estate Strategy* (Community Health Partnerships, National Association of Primary Care, 2019).

It should also be said that while co-location has been shown to improve inter-professional collaboration and minimise fragmentation among the various providers in the patient care pathway,[66] co-location is not evidenced to *automatically* lead to collaboration, and still relies on management and clinical leadership.

Nonetheless, the current system makes transitioning to more innovative estates that are tailored to evolving local needs difficult. Many independent GP practices lease their surgery premises, with the rent reimbursed in full by NHS England. However, this funding only covers 'general practice activity' for estates. GPs will only be reimbursed for the cost of the building that covers 'general practice', and the current guidance was written in 2011, long before the ARRS.[67]

Indeed a key challenge of the ARRS' implementation has been the lack of infrastructure to support additional staff. In May 2023, the Royal College of GPs reported that nine in ten practices did not have enough consultation rooms.[68] Although some employers are working creatively to introduce hot desking or hybrid working solutions, which allow staff to rotate through available space or work remotely,[69] this is not sufficient.

This issue is likely to be compounded in the medium-term, as additional GP trainees move into primary care. The NHS Long Term Workforce Plan committed to a 50 per cent expansion of training places by 2031 – requiring additional space to facilitate this training.[70]

Transitioning to a new model of primary care estate is further complicated by the fact that, in the current system, GPs have to take on a large amount of risk with their premises. Leases generally last 20 to 25 years, while mortgages for new GP partners are large. The prospect of being tied to a long, expensive leases or mortgages may not be attractive to newly qualified GPs who often want portfolio careers or fixed hours.[71]

The notional rent budgets for ICSs are also completely spent in most areas,[72] and ICSs often cannot take on new leases for privately financed premises due to limits on capital spending. Due to international accounting regulations, leases count towards capital, rather than revenue, spending.

There are some compelling options for enabling the much needed overhaul of the current system. These include three core financing mechanisms: public-private partnerships, borrowing to invest, and leasing from private developers. Financing is only one obstacle

[66] M. Bonciani et al., 'The Benefits of Co-Location in Primary Care Practices: The Perspectives of General Practitioners and Patients in 34 Countries', *BMC Health Services Research* 18, no. 1 (December 2018).
[67] *Health Building Note 11-01: Facilities for Primary and Community Care Services* (NHS England, 2011).
[68] Victoria MacConnachie, *Assessing the Impact and Success of the Additional Roles Reimbursement Scheme* (NHS Confederation, 2024).
[69] Ibid.
[70] NHS England, *NHS Long Term Workforce Plan*, 2023.
[71] Anna Colivicchi, 'Portfolio Careers Can Help with GP Recruitment and Retention, Says NHS England Director', *Pulse*, 20 October 2023.
[72] Mimi Launder and Zoe Tidman, *Untenable Stalemate Is Halting GP Practice Upgrades, Say ICBs*, 2024.

however, and transitioning away from the owner occupier estate and regulatory barriers must also be considered.

Financing mechanisms

Public-private partnerships

Previous examples of this include the Local Improvement Finance Trust (LIFT) Programme. LIFT was established in 2000 to support the transformation of primary care and increase community access to services across local areas.[73] This led to £2.5 billion worth of investment in the primary and community care estate having built 342 community-based healthcare facilities. Rather than private companies developing the estate and leasing it back to the NHS, LIFT was a Public-Private Partnership (PPP) with 40 per cent public and 60 per cent private ownership.[74]

Interviewees noted that pension funds and other private developers are increasingly expressing an interest in building new primary care premises, which can then be leased back to ICSs or GP partners. They also suggested that this option should be weighed against the cost of central government or local authorities simply borrowing more to invest in a new primary care estate.

Borrowing to invest

Although limits on capital expenditure for health make it difficult for ICSs to take full advantage of this avenue for investment, in the future model proposed by *Reform*, in which combined authorities are responsible for planning services, there would be significantly more flexibility.[75] For example, combined authorities could decide to borrow (at lower rates than the NHS)[76] from the Public Works Loan Body (PWLB) to fund new fit-for-purpose primary care estates, or enter into public-private partnerships with third party developers to jointly fund these projects.[77]

Leasing from private developers

Since local authorities are not bound by the same international accounting regulations (IFRS16) as ICSs and government departments, they could also lease new, fit-for-purpose private premises, built by private developers using revenue (rather than capital) spending, and then commission GPs to provide services within these new, local authority-maintained sites. Alternatively, government could set a higher capital expenditure limit (CDEL) for health, with funding ring-fenced for ICSs to use in the development of a new primary care estate: either by directly investing in new premises or leasing from private developers.

[73] Community Health Partnerships, *The NHS LIFT Programme: Transforming the Primary Healthcare and Community Estate*, 2016.
[74] Ibid.
[75] Beacon, *Close Enough to Care: A New Structure for the English Health and Care System*.
[76] Assura, *Written Evidence Submitted by Assura Plc (FGP0210)* (Health and Social Care Committee, 2022).
[77] Ibid.

In both of these options, as the 2017 Naylor Review of NHS property and estates identified, the development of new primary care premises would benefit from leveraging "substantial private sector investment".[78]

Obstacles to transition

Capital investment

There is a strong case for revisiting whether the ringfenced funding allocated to primary care estate regeneration is sufficient to accelerate progress towards a more preventative, primary and community-oriented model of healthcare delivery. The Estates and Technology Fund (ETTF), for example – which is used for investment in both infrastructure and technology – invested £800 million in the five years from 2016 to 2021.[79] Yet analysis shows that even the value of the owner-occupier estate (a large proportion of which is in desperate need of modernisation or replacement) is approximately £5 billion.[80]

A much larger ringfenced capital budget is available for the New Hospitals Programme (up to £18.5 billion from 2025-26 to 2030-31) in addition to the £3.7 billion allocated in the 2020 Spending Review.[81] While there are large parts of the hospital estate which are in need of repair and modernisation – contributing to a maintenance backlog of over £10 billion[82] – there is also a case for repurposing some of the funding which has not yet been allocated for investment in the primary care estate.

Given NHS England's stated ambition that healthcare should be delivered "where possible" in the community and primary care,[83] there could be an assessment of which types of activity (for example, certain diagnostics, minor injury and outpatient appointments) could be moved from hospitals to delivery in modern primary care premises coinciding with this.

Phasing out the owner-occupier estate

A key barrier to the creation of a modern primary care estate, also cited in the 2017 Naylor Review, is the fact that around half of GPs own their premises outright or hold mortgages.[84] This means that "active consideration" must be given to how GPs can be incentivised to move into new facilities.[85]

In Scotland, for example, as a possible precursor to this, government has committed to gradually purchasing the entire GP-owned primary care estate by 2043.[86] As Dr Peter Holden explained in evidence to the Health and Social Care Committee, the ownership of GP premises by Scottish Health Boards (equivalent to Integrated Care Systems), is intended to support recruitment and retention "particularly in rural and remote areas", and to counteract the "last person standing" effect – whereby all but one of the GP partners in a practice retire,

[78] Department of Health and Social Care, *NHS Property and Estates: Naylor Review*, 2017.
[79] Edward Argar, 'Health Services Repairs and Maintenance: Answer to Written Question' (UIN 77629, 21 July 2020).
[80] Policy Exchange, *At Your Service*, 2022.
[81] Esme Kirk-Wade, 'Hospital Building in England: Plans and Progress', House of Commons Library, 21 February 2024.
[82] Charlotte Wickens, 'The NHS Estate Continues to Deteriorate', 14 December 2023.
[83] NHS England, *The NHS Long Term Plan*, 2019.
[84] Policy Exchange, *At Your Service*.
[85] Department of Health and Social Care, *NHS Property and Estates: Naylor Review*.
[86] Health and Social Care Committee, *The Future of General Practice*, HC 113 (London: The Stationery Office, 2022).

leaving their colleague with the financial costs and other burdens associated with maintaining the premises.[87]

In the UK, the process of releasing the owner-occupier estate would also take time.[88] Though as the Naylor Review points out, commissioners and regulators have "considerable latent authority" to accelerate this transition, by insisting that the premises occupied by GPs are fit for purpose, and are able to fulfil the requirements of a new model of primary care – including by having space for additional GP trainees, ARRS roles and newly commissioned prevention-oriented services.[89]

ICSs, and in future combined authorities, could link GP reimbursement to clearly defined specifications for what their estates should be able to deliver. Strategic reviews could be conducted at a regional level to determine which estates in a particular area are adequate for the new model and to draft specifications and delivery plans for regeneration by a particular date.

Streamlining project approval

Finally, the creation of a new fit for purpose primary care estate could be accelerated by streamlining the NHS' decision-making processes for approving new construction projects. Interviewees explained that projects to build new premises are consistently delayed by the time it takes to move from an initial proposal being approved to a full business case being signed off – meaning that, as one interviewee put it, "even with a fair wind" premises development can take three to five years.

In the case of the New Hospitals Programme, interviewees told us that a standard design template for the functionality required by these hospitals (known as "Hospital 2.0") has helped to expedite approval of new projects.[90] The same principle should be applied to the regeneration of the primary care estate, to ensure a shorter business case process, and in turn much faster delivery.

Options for reform

This provides, in summary, three options for reform that together would significantly accelerate the development of a new primary care estate. ICS capital spending limits, bureaucratic approval processes and the ownership model of the current estate are the key barriers that need to be overcome before estates can be regenerated. These correspond with some of the main barriers to change identified by interviewees (see Figure 10 below).

[87] Ibid.
[88] Policy Exchange, *At Your Service*.
[89] Department of Health and Social Care, *NHS Property and Estates: Naylor Review*.
[90] Department of Health and Social Care, 'New Hospital Programme - Media Fact Sheet', Webpage, 25 May 2023.

Figure 10: Options for reforming the primary care estate

Barrier	Explanation	Policy option
Limits on ICS capital spending	• ICSs have very limited capital to invest in building new primary care premises, and due to international accounting regulations, leasing new premises from private developers would also count towards capital expenditure limits (CDEL). • Given other, urgent demands for capital investment in any given region, ICSs do not have a strong enough incentive to prioritise development of a new primary care estate.	• NHS England should create a time-limited, ringfenced capital fund that can be accessed by ICSs to invest in building new primary care premises in their region, as an initial pull incentive. • Thereafter, in the model proposed by *Reform*'s paper, *Close enough to care*, Combined Authorities would be responsible for investment and, where necessary to deliver a fit for purpose primary care estate by 2040, should borrow from the Public Works Loan Body (PWLB) for this investment.
Bureaucratic approval process for new estate projects	• A complex and slow approval process for constructing new primary care premises makes estate investment a much less attractive investment proposition for private developers. • In turn, government is missing out on the opportunity to crowd in substantial private capital.	• NHS England should provide a template for the scale and functionality required by new primary care premises in different geographies, to enable prevention-oriented care and integration with local, health-promoting services. • As with the New Hospitals Programme, this template should be used to facilitate a streamlined business case approval process for new construction projects – helping to crowd in private capital for estate development.
Lack of incentives for owner-occupiers to move to new premises	• More than half of the primary care estate is owned by GP partners ('owner-occupiers'). • A large proportion of this is completely unfit for delivering a more integrated, preventative model of primary care. • Yet these GPs have little incentive to move to new premises, that would either be much more expensive to lease, or require significant private investment by GPs themselves.	• NHS England and ICBs responsible for primary care commissioning should link the reimbursement of GP partners to whether they occupy premises which are sufficient for delivering the new, integrated and preventative model of primary care described in this paper. • Funds should be withheld from GPs who have not moved to fit for purpose premises by 2040. • The amount withheld should increase over time, to ensure that as many owner-occupiers as possible have moved to fit for purpose premises by this date. • Per the Naylor Review, the CQC should use its latent regulatory power to insist that all GP premises are fit for purpose by 2040.

Recommendation 2: ICSs should conduct an exercise to determine the ideal estate strategy for their population, with the goal of creating modern premises that enable a more preventative model of primary care, closely integrated with other health-promoting services (for example, which facilitate co-located services and an expansion of ARRS roles).

It should be clear as a result of this exercise which existing premises:

- can facilitate a more preventative delivery model;
- are currently unable to but could be modernised, including through expansion;
- are unsuitable for providing high-quality care and should be quickly discontinued.

ICSs should map out the premises in their region which fall into these three categories.

Recommendation 3: The CQC should use its latent regulatory power to insist that all GPs currently occupying premises which are currently unfit for providing an appropriate standard of care should be vacated, as soon as possible, over the next parliament.

To compensate for this, and support a managed transition towards a greater number of GPs becoming owner-occupiers, NHS England should create a time-limited, ringfenced capital fund that can be accessed by ICSs to invest in building new primary care premises in their region, as an initial pull incentive.

GPs moving from unsuitable premises to these new estates should be heavily incentivised to continue practising with an offer of more affordable rent and support from the ICS to relocate. This rent could be shared between multiple general practice groups in cases where owner-occupiers are moving to more spacious premises.

Recommendation 4: ICSs should commit to upgrading all premises which are unable to facilitate a more preventative delivery model by 2035.

To incentivise greater private investment in estate regeneration, NHS England should provide a template for the scale and functionality required by these new premises in different geographies, to enable prevention-oriented care and better integration with local, health-promoting services. As with the New Hospitals Programme, this template should be used to facilitate a streamlined business case approval process for new construction projects – helping to crowd in private capital for estate development.

NHS England and ICBs responsible for primary care commissioning should then link the reimbursement of owner-occupier GPs to whether they occupy fit for purpose premises. Funds should be withheld from GPs who do not occupy such premises by 2035. The amount withheld should increase over time, to ensure that as many owner-occupiers as possible have moved to modern premises by this date.

Once NHSE's time-limited capital fund for estate regeneration has expired, per the model proposed by *Reform*'s paper *Close enough to care*, Combined Authorities would become responsible for estate investment and, where necessary to deliver a fit for purpose estate by 2035, should borrow from the Public Works Loan Body (PWLB).

5. Responding faster

The management of 'secondary' demand is chiefly focused on the care required once a patient has presented with a clinical problem. This can include minor illnesses, medically unexplainable symptoms, or flare ups of established conditions.

This chapter will refer to 'secondary' demand – the demand associated with 'secondary' prevention. In this paper, this means the demand created when a person has decided they have a clinical need and goes to a GP.

5.1 What demand looks like

It is important when understanding the demand on primary and community care to understand it both through the lens of volume and complexity. Given that a large portion of the patients presenting with a problem are healthy, cost per patient is generally lower, but due to the high volume it likely accounts for the largest proportion of spend.

These patients require straightforward access to primary care services, support to manage unforeseen illness and return to health, and support to manage wellness.

Identifying what proportion of demand each group is responsible for is difficult due to a lack of comprehensive primary care data, and divergent needs in local areas which will mean each general practice will face a different demand mix. However, there are broadly four groups of clinical demand:[91]

- Patients with a minor illness effectively managed in one consultation
- Patients with ongoing illness and flare ups of established conditions
- Medically unexplained, undifferentiated symptoms
- Patients with enduring complex health needs or severe acute episodes

As this Chapter will outline, the assumption that each of these categories of patient must always be seen by a general practitioner is potentially misguided and an inefficient use of limited resource. This Chapter focuses on general practice reform through the lens of diversion and reduction of demand. It looks at how to relieve capacity in the system (administration, management, and the scope of general practice) and how to manage demand more effectively (digitally enabled, AI supported triage).

This demand is commonly managed through general practice, using a variety of clinical staff, such as nurses, and non-clinical staff, such as social prescribers. With the introduction of Pharmacy First, pharmacists can now also offer prescriptions for common illnesses.

Increasingly, this demand is met remotely but the majority (66 per cent) of GP appointments are still conducted face-to-face.[92]

[91] Rebecca Rosen, *Divided We Fall: Getting the Best out of General Practice* (Nuffield Trust, 2018); Joanne Reeve and Richard Byng, 'Realising the Full Potential of Primary Care: Uniting the "Two Faces" of Generalism', *British Journal of General Practice* 67, no. 660 (July 2017).
[92] *Appointments in General Practice, February 2024*.

5.1.1 Previous reform to general practice

Improving access to general practice has been a consistent policy ambition of governments for many years. At least since 1997, this has included:[93]

- Appointment innovations, such as using telehealth to expand the types of appointments offered to people or triage to optimise appointment allocation
- Giving patients direct access to services that remove the need to access general practice
- Increasing the number and range of professionals available to see patients within general practice
- Offering contacts outside of core hours, core settings and core services
- Supporting patient engagement, empowerment and education
- Supporting the internal and wider structures of general practice, such as integration with other local practices, including the formation of federations and primary care networks

Since 2019, there has been a particular focus on primary care reform to better meet increasing demand, largely centred around scaling primary care and diversifying the workforce.

Scaled models of primary care and multidisciplinary teams

The emergence of Primary Care Networks (PCNs) in July 2019 was significant for general practice. By May 2020, all except a handful of GP practices in England had come together in around 1,250 geographical networks covering populations of approximately 30-50,000 patients. While practices are not mandated to join a network, they would have lost out on significant extra funding if they did not join one.[94] The stated aims of PCNs were to stabilise general practice, to dissolve the historic divide between primary and community services, and to reduce health inequalities.

Despite the COVID-19 pandemic, PCNs have set up and are delivering additional services and have also expanded the primary care workforce through the Additional Roles Reimbursement Scheme (ARRS). However, this success has not immediately translated into achievement of their stated aims – they are a successful and responsive delivery model but have failed to bridge the divide between primary and community services and to stabilise general practice.[95]

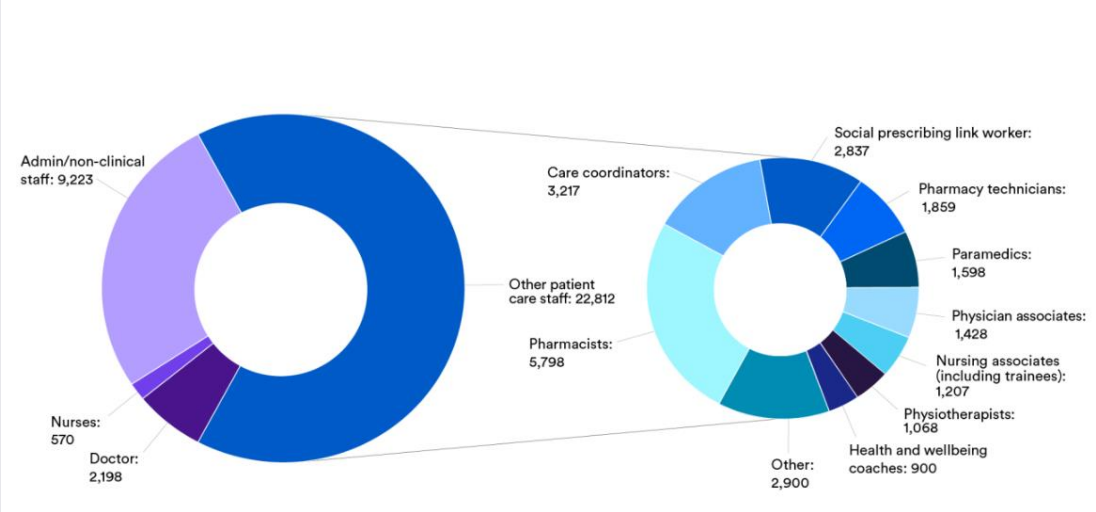
In 2019, in conjunction with PCNs, the ARRS was launched to improve access to general practice. The additional staff were intended to see patients who would otherwise have seen a GP but did not require a GP intervention. This funding could not previously be used to hire more GPs and only a limited number of nurses. However, in August 2024, the ARRS was rescoped to allow for the hiring of GPs specifically. The Government agreed to fund the ARRS with an extra £82 million to allow PCNs to hire GPs, which is expected to cover the cost of 1,000 extra GPs.[96]

[93] Rebecca Fisher et al., *Rethinking Access to General Practice: It's Not All about Supply* (Health Foundation, 2024).
[94] NHS England, 'Primary Care Networks', Webpage, 2019.
[95] Julia Swift, *Primary Care Networks: Three Years On* (NHS Confederation, 2022).
[96] Eliza Parr, 'What We Know (and Don't Know) about GPs Being Added to ARRS', *Pulse Today*, 9 August 2024.

While demand and pressure on general practice remain high, an additional 34,000 roles joining primary care has allowed providers to run additional appointments and extend existing services. By diversifying roles, there has also been an increase in first contact staff who can see patients without a GP referral.

However, these benefits are limited by both clinical and implementation challenges. As outlined in the previous section, more non-clinical roles in primary care are essential if the NHS is to move towards a model of prevention. With this said, demand is outstripping both clinical and non-clinical capacity, and the ARRS disproportionately focuses on the latter.[97]

Figure 11: Different roles hired in the ARRS, from March 2019 to June 2023



Source: Nuffield Trust, 'More staff in general practice, but is the emerging mix of roles what's needed', 2023.[98]

Analysis of PCNs and the ARRS also show that networks tend to lack a shared vision for how to integrate staff effectively into the day-to-day work of practices.[99] They work best when introduced with a clear purpose, with attention to the cultural change needed for multi-disciplinary working and with support for practices to redesign their services to accommodate the new roles.[100]

The ARRS can also exacerbate pre-existing health inequalities in access to care. Funding is only allocated once a person has been hired. This means that in an affluent area, where it is easy to recruit, extra staff are funded, enabling increased care capacity. In more deprived areas, recruitment can prove harder, meaning the funding and additional capacity is not secured.[101] The programme is also considered too prescriptive in terms of how many roles are

[97] Rebecca Rosen and Billy Palmer, *More Staff in General Practice, but Is the Emerging Mix of Roles What's Needed?* (Nuffield Trust, 2023).
[98] Ibid.
[99] Ibid.
[100] Ibid.
[101] Emma Bower, *ARRS Funding Sahould Be Weighted for Deprivation to Tackle Inequalities, MPs Told* (GP Online, 2022).

allowed per population size, and so limits the flexibility of local practices to respond to local needs.[102]

5.1.2 Expanded role for pharmacies

Community pharmacy has long been seen as an untapped resource and is progressively taking on a much broader clinically-focused role. Over the course of the next decade, community pharmacy will undergo significant transformation enabling patients to access further clinical services and becoming for many the first contact point for treatment.[103]

The Pharmacy First scheme already enables patients to be diagnosed and obtain a prescription for certain medicines, antibiotics and antivirals where clinically appropriate, in order to treat seven common conditions, without the need to visit a GP. The education and training of pharmacists is also changing so that from 2026, all pharmacists will qualify as independent prescribers, together with enhanced clinical, population health and consultation skills. This will enable them to deliver more direct patient care, significantly increasing primary care capacity.[104]

The overall ambition is for pharmacy to become the first port of call for many common ailments and some long-term condition management to reduce demand on general practice. For the large volume of patients who present with straightforward symptoms that can effectively be managed in one consultation this should deliver lower cost, more timely care.

5.2 The vision for a new model

These reforms indisputably represent progress. However they only go part of the way to achieving a future model of primary care that intervenes as early as possible, provides access to timely, high-quality care and empowers people to live independent lives.

Improving the ability of the primary care system to respond faster to clinical need requires greater innovation: it must be better at identifying the right practitioner for the right problem and in turn, managing demand more effectively. This also must be complemented with robust technological infrastructure – something primary care has consistently failed to secure (analysis of and recommendations for data and digital reform are contained in a complimentary paper published alongside this one, *Prescription for Prevention: A digitally enabled model of primary care*).

[102] *Health and Social Care Committee: Oral Evidence: The Future of General Practice, HC 892* (House of Commons Health and Social Care Committee, 2022). *Health and Social Care Committee: Oral Evidence: The Future of General Practice, HC 892*.
[103] Beccy Baird et al., *A Vision for Community Pharmacy* (Kings Fund, Nuffield Trust, 2023). Baird et al.
[104] Ibid.

Figure 12: A reimagined model of general practice

Current approach	New approach
Appointment offered with any available practitioner at a time that works for the practice	Right practitioner with the appropriate level of clinical expertise at the right time for the patient via the right modality
Clinician choice limited to general practitioner with limited ability to see someone the patient has seen before	Wide range of clinicians and non-clinicians available with the choice to see someone the patient has seen before
Difficult, lengthy booking process characterised by '8am rush'	Patient able to book an appointment instantaneously once triaged using direct online booking system
Incomplete visibility over content of patient record, particularly where the patient has interacted with a clinician outside the general practice	Care record connects with all relevant systems in general practice, community care, and secondary care

5.2.1 What this model would mean for patients

General practice naturally receives a wide variety of different patient profiles and should be able to respond with an approach that is both fast and personalised, in the most cost efficient way possible. Outlined below are two very different patient profiles and the potential pathway they would take in a reimagined system.

Patient example 3: Scarlett

Scarlett is an active 24 year-old with a busy social life working full time. She has no current health conditions. Throughout puberty she struggled with anxiety and depression but never sought help. Recently, she has been feeling unusually anxious, with associated physical symptoms including insomnia and heart palpitations.

Current model

Scarlett calls her GP at 8am, once through to a receptionist, she gets an appoint in two weeks' time. She is subsequently referred to the local mental health service, with an appointment in six weeks – two months after her initial call. During this time, her mental health has deteriorated and she is struggling with work.

Reimagined model

Scarlett logs onto her GP website and fills in her digital triage form for the GP. The triage connects with the population segmentation model for that locality, and identifies that since they have a particularly bad mental health problem among 18-24 year olds, Scarlett is considered higher risk. The practice offers her a phone call with one of their remote nurse practitioners later that day who works evenings. The nurse gives her a range of different options including medication or therapy.

Patient example 4: Eileen

Eileen is 72, widowed and lives in a small town just outside of Manchester in the large home where she raised her family. She lives off her State Pension. She has hypertension and rheumatoid arthritis, which has started to flare up in recent days. She has also recently developed an ambiguous rash on her stomach.

Current model

Eileen calls up her GP at 8am to try and get an appointment with her chosen GP, who she has seen for years before her arthritis diagnosis. She waits on hold for half an hour and the first appointment they can give her with her usual GP is one week from now, She waits on hold for half an hour and the first appointment they can give her with her usual GP is one week from now.

Future model

Eileen phones up her GP practice and she explains her symptoms to the clinician running triage. They ask for her NHS number and input the details into the online triage system. They advise she can go straight to a dermatologist who can review her rash, and find an appointment with the physiotherapist she usually sees for her arthritis flare ups. Both of these specialists are situated within the same primary care estate, and Eileen books consecutive appointments two days later.

5.3 The building blocks

Achieving this ambition requires a combination of new approaches to demand management and the composition of the general practice workforce. This should also be supported by a system-wide approach to technology in general practice, which is explored in our supplementary paper, *Prescription for Prevention: A digitally enabled model of primary care*.

5.3.1 Optimise triage and demand management

Achieving this model requires a combination of workforce reform and more effective demand management, including smarter approaches to identification and prioritisation according to risk (which should be based on a combination of symptom and patient information).

Indeed, prioritising appointments is unavoidable so long as demand continues to outstrip capacity. Triage is designed to respond to the increasing imbalance between patient demand and availability of appointments, by ensuring that the patients with the most urgent needs are dealt with first. Triage is also valuable for patients themselves, because it enables them to get the right appointment via the right modality at a time that works for them, rather than a one-size-fits-all approach to appointment allocation. It is valuable for clinicians by increasing consulting time without using additional capacity.

Interviewees told us that most practices triage their calls and the use of 'total triage' – where every patient has to provide some information on the reasons for contact – was expanded during the pandemic. But there is still significant variation depending on the practice, and government estimates that just 40 per cent of practices use *clinicians* to triage requests, and only 10 per cent receive most requests online.[105]

Triage could be anything from a relatively informal, non-standardised question from a receptionist to a systematic, standardised questionnaire conducted by a clinician. Most practices are moving to a telephone first system, some use standard receptionists, some trained care navigators, some nurses, and some doctors. Some also use online systems, which vary in their sophistication.

The opportunity cost of not using triage properly can be significant. Proper triage can improve patient care by ensuring that patients with the highest or most complex health needs are prioritised, and it frees up GP time to deal with more complex issues. Crucially, it can maximise workforce capacity by making the best use of the skills mix within the team and reduce overall GP pressure by delegating tasks across the practice.

Triage is generally more effective when undertaken by a clinician because it requires clinical decision-making, often based on undifferentiated symptoms. Interviewees emphasised that nurse-led triage is similarly effective, and that ultimately the more specialists are brought into the early decision making, the more efficient the management of demand would be.

There have been some experiments with triage in the UK which have had a positive impact on meeting demand without increasing capacity. The Esteem trial at 42 English practices demonstrates that telephone triage can be effective in producing a more efficient distribution of the general practice workload. It found that GP-led and nurse-led telephone triage of requests for same day GP appointments was associated with a 33 per cent increase for GP contacts per person, and 48 per cent increase in nurse contacts per person compared with usual care, but at equivalent costs.[106]

The triage process shifted workload from face-to-face consultations to telephone, and from GP to nurse.[107] As a 'unit' of cost, telephone consultations are considerably cheaper than in-person, so increasing this modality – where appropriate – is significantly more efficient.

A 2017 observational study of telephone-first systems in 147 English practices – where a patient cannot obtain a face-to-face appointment until they have spoken to a clinician on the phone – showed that it can have a major effect on the patterns of consultation. It reported a reduction in face-to-face consultations, suggesting that up to half of patients' problems could be dealt with on the phone. The substantial increase in telephone consultations led to an overall increase in GP consulting time.[108]

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[105] NHS England, *Delivery Plan for Recovering Access to Primary Care*, 2023.
[106] John L Campbell et al., 'Telephone Triage for Management of Same-Day Consultation Requests in General Practice (the ESTEEM Trial): A Cluster-Randomised Controlled Trial and Cost-Consequence Analysis', *The Lancet* 384, no. 9957 (November 2014).
[107] Campbell et al.; John L Campbell et al., 'The Effectiveness and Cost-Effectiveness of Telephone Triage of Patients Requesting Same Day Consultations in General Practice: Study Protocol for a Cluster Randomised Controlled Trial Comparing Nurse-Led and GP-Led Management Systems (ESTEEM)', *Trials* 14 (4 January 2013): 4.
[108] Jennifer Newbould et al., 'Evaluation of Telephone First Approach to Demand Management in English General Practice: Observational Study', *BMJ*, October 2017.

Online triage is still in its infancy, but when used effectively, offers substantively different benefits to telephone triage. It can provide both a more accessible platform for patients as well as allow unmet need to become visible and create a richer understanding of patient demand. Online triage also has unlimited capacity to capture – but not necessarily process – patient requests, whereas telephone triage is limited by the number of phone lines.[109] The range of patient requests that can be safely accommodated through an online triage platform is still unknown, but the ability to capture patient demand is an opportunity for continuous monitoring of demand that does not currently exist.

Figure 13: Example of AI supported triage, combined with population health management data

Brookside Group Practice has taken online triage one step further by consolidating their online triage system with their population segmentation model, powered by artificial intelligence (AI). Patients can access appointment booking in three ways: online, telephone or face-to-face, but online is best for the practice as it gives the highest level of detail.

Patients are asked the same questions on phone or in person. These requests are then processed by AI using a combination of background information provided by population segmentation where they have 11 categories, and clinical triage, to produce a combined risk score. The dashboard will subsequently organise them into a level of priority.

This process cuts out a significant burden on clinical time, and has allowed the practice to maximise the use of the ARRS staff, being able to assign people to, for example, a musculoskeletal practitioner where they present with a knee problem.

Some practices have found that online access to general practice lowers the threshold for patients to contact their GP, in turn increasing demand. This risks decreasing patient satisfaction if an appointment is not then given. However, in a model in which patients are directed elsewhere, for example to a pharmacist, or are given standardised, written advice, patients may feel more satisfied with the system.

Barriers to implementation of digitally enabled triage

During interviews, the most frequently cited implementation issue was the adoption of a new process into the pre-existing workflow and the change management this involved. Implementing an innovation involves time and temporarily reduced efficiency, particularly if it uses an unfamiliar online platform. Brookside Group Practice emphasised in interviews that it took a fair amount of work to get the triage system off the ground, and that the success of technological innovation relies heavily on how it is implemented.

GPs do not have the capacity to focus on process re-design and management. They may not also have the capability, as GP training does not include business and management training. For example, the process of implementation could include:[110]

[109] Daniela Rodrigues et al., 'Formalising Triage in General Practice towards a More Equitable, Safe, and Efficient Allocation of Resources', *BMJ*, May 2022.
[110] NHS Improvement, *Overview - Change Management - the Systems and Tools for Managing Change*, 2011.

- Assessing the scope of the change – how big the change is, who it affects, whether it is gradual or radical
- Redesigning the workflow – what roles need to be re-allocated, how does that change their working pattern, do those staff members need to be re-trained on something else, how does that impact staffing rotas, pay and operational costs
- Readiness of the organisation impacted by the change – how much change is already going on, what type of resistance can be expected

If not carefully designed, it can result in inefficiency and duplication, for example a telephone call followed by an in-person consultation. It can also bring stress for reception and clinical staff, as triage is an intense process for clinicians, requiring consistent, quick decision making with a sometimes incomplete picture.

It is also clear from the procurement of technology for other parts of primary care – particularly in the procurement of Electronic Health Records (EHRs) – that it can lead to 'vendor lock in' with systems that might be incompatible with other parts of the NHS. It is crucial that the triage software can connect to existing systems effectively – such as population health management databases – which will vary among practices. This interoperability between technological systems is essential but is currently suboptimal, and is explored extensively in our supplementary paper, *Prescription for Prevention: A digitally enabled model of primary care.*

Currently, digital triage is regulated as a medical device by the MHRA. Increasing the capacity of the team responsible for regulating and certifying these tools – enabling them to scale faster – is essential. This and the role of artificial intelligence in primary care is explored further in *Prescription for Prevention: A digitally enabled model of primary care.*

Poor GP website and form design can also be a barrier to accessing these services. In the 2024 GP patient survey, 37.1 per cent found it difficult to contact their GP practice using their website.[111]

In 2023, a report by Nexer Digital focused on the accessibility of UK GP surgery websites and found that the most common errors on websites were basic, including poor colour contrasting text, empty links, empty buttons and missing headings.[112] This, they suggested, makes it even more difficult for people with poor vision and/or those who use assistive technology to access the relevant systems on the websites. Failing to get the basics right undermines patients' ability to use technology, and therefore prevents surgeries from realising the full benefits of triage.

NHS England provide extensive guidance on how to design an accessible website, but as with the rollout of triage, it relies on the GP partners personally finding the time to implement or update a new website. Given the multiple, time-sensitive demands on their capacity, this can often be deprioritised.

[111] NHS, 'GP Patient Survey'.
[112] Nexer Digital, 'Given the Opportunity for Greater Online Engagement, How Accessible Are GP Websites?', 2023.

Recommendation 5: Practices should be supported in implementing systems by a 'SWAT' change management team employed by ICSs, who can be deployed across that specific locality to provide change management expertise required to successfully embed technological innovation across their local health system.

NHS England should introduce minimum standards for the design and content of GP websites. ICSs should then engage with PCN leaders on reviewing the usability of the GP websites within their PCN. Where they do not meet the set of agreed standards, the change management team can assist in upgrading them.

Recommendation 6: To incentivise investment in digitally enabled triage, and as outlined below in Recommendation 10, there should be a one-off admin automation fund made available by NHSE for ICSs and PCNs to bid into. To receive these funds, ICSs and PCNs should be required to submit a succinct plan for how the administrative improvements will lead to greater productivity in a particular network of practices. This should include digitally enabled triage as well as other administrative improvements.

5.3.2 The distribution of clinical skills

It is well established that there are numerous clinical roles involved in primary care that encompass many of the skills GPs have. Previous research has shown that 27 per cent of GP appointments were judged to have been avoidable, with the biggest reason being that the patient would have been better served had they been directed to someone else in the wider primary care team.[113]

Yet shifting patients to different clinicians has not been fully realised in practice, especially in meeting the more standardised, transactional need where much of the demand exists. While siphoning demand was theoretically the aim of the ARRS, there is little evidence to suggest the increase in non-clinical roles has been complemented with optimised demand management, nor a commensurate increase in the GP-adjacent workforce that can take on the more transactional clinical demand, such as nurse practitioners and pharmacists, which many ARRS roles cannot do.

The nature of clinical demand in general practice

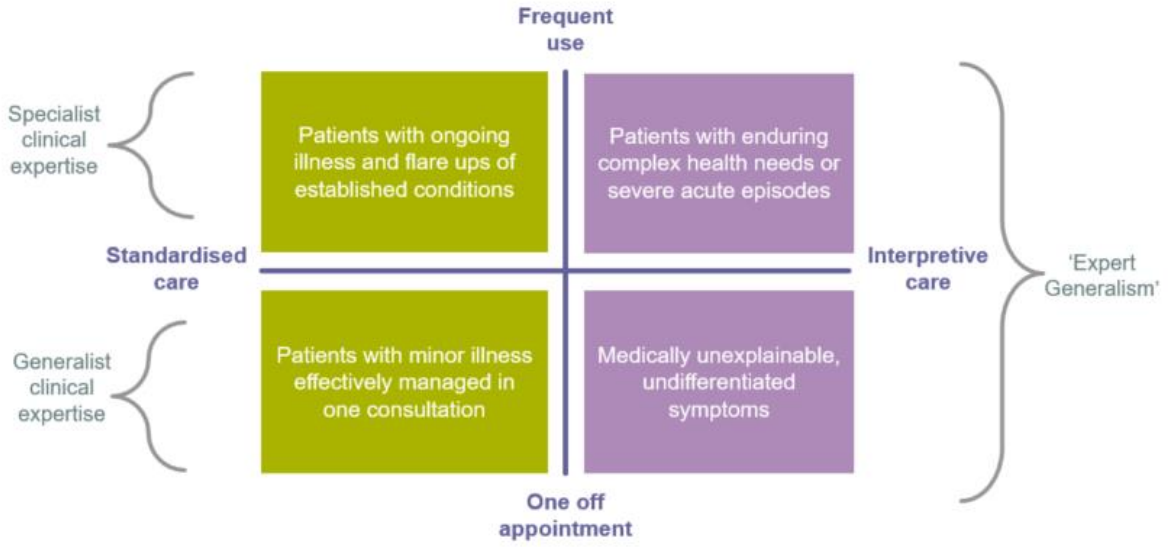
Figure 13 below illustrates the different types of care needed in general practice, comparing the standardisation of care versus the frequency of it. The increasingly complex patient profile can sometimes distract from the volume of patients in the bottom left quadrant. There is no specific estimation of how much demand this constitutes, but interviewees suggested it could be between 40 to 60 per cent of patient attendance, but this could vary extensively depending on the locality. A large part of this could be effectively managed by an alternative clinician – low intensity, accessible care at volume. Successfully shifting this demand to clinically qualified practitioners could have a substantial impact on demand diversion, and such a substitution of roles is a key part of the NHS Workforce Plan.[114]

[113] NHS Alliance, *Making Time in General Practice*, 2015.
[114] National Audit Office, *NHS England's Modelling for the Long Term Workforce Plan*, 2024.

It is true however, that defining the exact scope of the work delivered by nurses in general practice is challenging and GPs hold distinctive clinical skills – notably, their ability to manage clinical risk. The purpose of general practice training is to help GPs manage and hold the risk that a clinical decision could be wrong, not least because the strength of general practice is that not every illness is sent for investigation with specialists.[115]

The more interpretive the care – and therefore the more clinical risk involved – the more expertise is required. Patients with chronic complex care needs for example, especially those with diminished capacity to manage daily living, need both coordinated care and interpretive care and would therefore require specialist clinical expertise. This is explored more in the following chapter.

Figure 13: Stylised view of care required in general practice



Source: Adapted from Reeve and Byng, 'Realising the Full Potential of Primary Care', 2017. Note: Boxes do not represent the actual proportion of patients in the primary care system.

How clinical demand is met in general practice

Meeting the wide variety of clinical demand in general practice requires a multifaceted workforce. Yet despite the extremely diverse workforce within the primary and community care system, there continues to be a reliance on GPs as clinical decision-makers, leaving other clinical experts – such as nurses – underused.

It was this ambition that at least partially drove the introduction of the ARRS. While much of the narrative surrounding the ARRS is that it has enabled an increase in appointment volume, the reality is more nuanced. A larger proportion of appointments are indeed done by other staff, but it is not yet clear how well this is helping to meet the clinical, rather than non-clinical, demand on general practice. Particularly since some of the more clinically specialist roles, such as enhanced practice nurses are capped at one per PCN under the ARRS, or two where

[115] *Health and Social Care Committee: Oral Evidence: The Future of General Practice, HC 892*.

the PCN patient list is 100,000 or more.[116] This is largely because practice nurses are usually hired under the General Medical Services funding rather than the ARRS.

The NHS publishes data on the total number of ARRS staff employed in PCNs, but it does not collect data for the number of appointments carried out by all staff groups, which makes it difficult to evaluate the efficacy of the programme.

Based on the impact assessments available, the introduction of the ARRS roles appears not to be based on demand but rather availability of funding. The scope and design of roles appears to be largely unexamined. The roles have often been implemented to fill a deficit in already established roles (GPs and general practice nurses (GPNs)). Although as outlined below, it is not clear this has been successful, largely because evidence suggests they could most add value as new, additional roles offering a substantively different service rather than assisting with GP workload.[117]

Analysis has found that the ARRS roles contributed positively to distribution of work and clinical outcomes when used in the context of professional expertise, such as mental health nurses or dietitians offering an extra service not previously available.[118] When roles were used out of their normal context and jurisdiction, they impacted on the workload of GPNs as the ARRS professionals were seeking more advice, support, and leaving work incomplete.[119]

Indeed, where work or care previously provided by GPs or GPNs was shifted to ARRS colleagues, they could not complete it due to a lack of knowledge or skill, regulatory issues, or unfamiliarity with context.[120] This meant that care was left incomplete with GPNs having to perform rescue work, complete the episode of care or teach colleagues.

Recently, the ARRS was rescoped to allow for the hiring of GPs specifically. The Government agreed to fund the ARRS with an extra £82 million to allow PCNs to hire GPs, which is expected to cover the cost of 1,000 extra GPs.[121]

While extra funding for clinical staff that can directly target much of the demand coming into general practice is welcome, there is a consistent assumption that GPs are the main staff member that can meet the lion's share of demand in general practice.

Utilising alternative clinical expertise

One of the ways to shift demand to alternative clinicians in general practice is to increase the nurse workforce. The nurse workforce in primary care is expansive, and includes both nurses in general practice (practice nurses and Advanced Nurse Practitioners) and nurses in the community (district nurses and specialist nurses). There is growing evidence of the positive

[116] Megan Ford, *'Clarity Needed' over New ARRS 'Enhanced' Practice Nurse Role* (Nursing in Practice, 2024).
[117] Alison Leary and Geoff Punshon, *ARRS Workforce Impact Survey* (Queen's Nursing Institute, 2024).
[118] Ibid.
[119] Ibid.
[120] Ibid.
[121] Parr, 'What We Know (and Don't Know) about GPs Being Added to ARRS'.

impact Advanced Nurse Practitioners (ANPs) have on patient outcomes, particularly in improving access to care.[122]

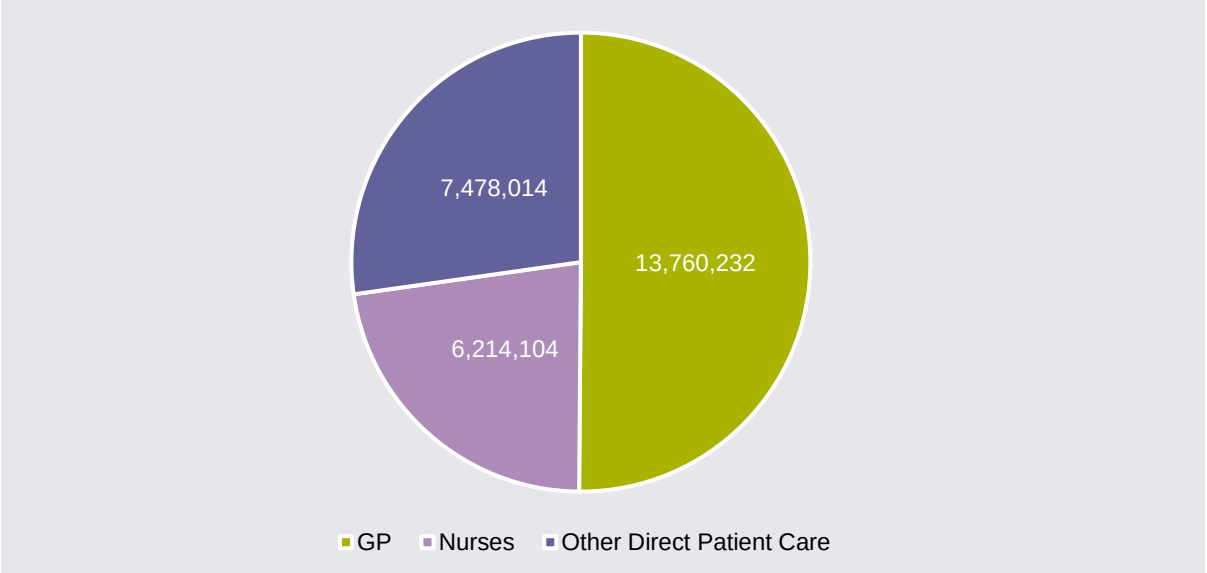
It is clear from the data available that nurses are not used as effectively as they could be. In terms of appointment volume, they currently provide less than half of the appointments GPs do.[123] Moreover, this data does not distinguish between the kind of appointments nurses are providing. Nurses often provide planned procedures – such as mole removal or wound management – rather than diagnostics and prescriptions (which some types of nurses are able to do).

Figure 14: Different professions within general practice

Role	Description	Covered by ARRS?
Physician associate	Healthcare generalists who support diagnosis and management of patients	Yes
Paramedic	Specialist in urgent care skills and clinical support for emergency situations	Yes
Physiotherapist	Joint and muscle specialist who helps to restore movement and function	Yes
Pharmacist	Specialist with advanced clinical training in safe and effective drug supply	Yes
District nurse	Nurse that conducts regular home visits to home bound patients	No
Enhanced practice nurse	Nurse with additional specialist training to provide specific types of care	Yes
Advanced Nurse Practitioner	Nurse with advanced clinical education and training	Yes
General practitioner	Doctors who treat all common medical conditions	Yes (as of August 2024)

[122] Maung Htay and Dean Whitehead, 'The Effectiveness of the Role of Advanced Nurse Practitioners Compared to Physician-Led or Usual Care: A Systematic Review', *International Journal of Nursing Studies Advances* 3 (November 2021); Davina Collins, 'Assessing the Effectiveness of Advanced Nurse Practitioners Undertaking Home Visits in an out of Hours Urgent Primary Care Service in England', *Journal of Nursing Management* 27, no. 2 (March 2019).
[123] 'NHS Digital Appointments in General Practice' (NHS England, March 2024). 'NHS Digital Appointments in General Practice'.

Figure 15: General practice appointments by role



Source: NHS England, 'Appointments in General Practice', 2024.[124]

Despite the need for practice nurses, the number of nurses working in primary care remains significantly lower in comparison to secondary care.[125] There are currently 23,000 nurses in general practice, and 405,000 in secondary care.[126] There are also significantly fewer nurses in general practice in comparison to GPs. There were 27,515 Full Time Equivalent (FTE) GPs in August 2022, and only 3,986 FTE Advanced Nurse Practitioners and 11,277 FTE practice nurses.[127] The current practice nurse workforce is ageing,[128] which is compounded by a shortage of newly qualified nurses and an increase in the workload of practice nursing staff.[129]

According to interviewees, the unbalanced nursing workforce between primary and secondary care can be partially explained by a perception that working in secondary care is a more dynamic environment, as well as providing more flexibility in shift options. In contrast, practice nursing is often a favoured career choice for experienced nurses.

This presents an opportunity. There is a substantial body of highly experienced nurses who could pursue a specialist qualification, such as a master's in Advanced Nurse Practice, and within one year move into general practice, boosting the workforce quickly and effectively. An ANP master's takes only one year, in contrast to the ten years it takes to train a GP.

This could, therefore, provide a relatively rapid increase in capacity for primary care, providing skilled resource to relieve GPs of some of their workload and freeing GPs to see more complex cases. The risk of incentivising nurses to move from secondary to primary care is that resource constraints in hospitals are exacerbated. Therefore, ICSs, and in a future devolved model,

[124] *Appointments in General Practice, February 2024*.
[125] Sarah Butler, 'Practice Nurse Workforce Numbers: Are We Heading towards a Problem?', *Practice Nursing*, April 2022.
[126] National Audit Office, *NHS England's Modelling for the Long Term Workforce Plan*. National Audit Office.
[127] *General Practice Workforce, 31 March 2024* (NHS England, 2024).
[128] Sarah Butler, 'Practice Nurse Workforce Numbers: Are We Heading towards a Problem?'
[129] Ibid.

regional government, must consider the ideal distribution of the nursing workforce for their locality across the whole system: primary, community and secondary care. This should reflect changing and future demand, and the need to drive care upstream and out of costly, acute care.

This is also in line with the NHS Long Term Workforce Plan which seeks to increase the nursing workforce over the next 15 years, committing to 170,000 more nurses by 2036-37. However, the plan does not detail how nursing staff numbers will be increased, whether the current distribution of the nursing workforce is the right one, and does not include any specific actions. An overall figure of an additional £2.4 billion is given, but the use for this funding is not specified.[130]

Once ICSs have identified the ideal distribution of their nursing workforce, there are a number of different levers they could pull to boost overall recruitment and to shift workforce to different parts of the system where demand is outstripping capacity. These include but are not limited to financial incentives, progression opportunities and flexibility.

Incentives for nurses to work in primary care

Financial incentives

Financial incentives can take a number of different forms. Most simply, this could be a 'golden hello', whereby new recruits into primary care get a one-off lump sum payment. There is precedence for this; Humber Teaching NHS Foundation Trust offered a £3,000 'golden hello' to all new Band 5 nurses who joined their trusts.[131] These financial incentives could be spread out over a number of months or years in order to ensure nurses are retained. The Royal College of Nursing warns that such golden hellos are not a long-term solution.[132] Nonetheless, they may help increase the appeal of working in primary care and therefore are a viable option for ICSs looking to shift the balance of nursing. Alternatively, ICSs could consider a one-off payment or grant to those studying nursing and/or pre-existing nurses who are completing additional qualifications.

Progression

Ensuring that there is visible career progression within primary care nursing could help to attract more nurses into primary care. This is particularly important given the 'perception' that primary care nursing is something to do later in life and career because of a more 'relaxed' work environment.

Offering a structured career path, outlining different career advancement opportunities both vertically and horizontally, might help to make primary care nursing more appealing and thus attract more nurses. Each ICS could create a nurse organogram for primary care nursing with clear metrics and milestones, marking what is needed to progress. Additionally, they could subsidise additional management courses for nurses who would like to take on a more managerial role.

[130] *NHS Workforce Plan: What Does It Mean for Nursing?* (Royal College of Nursing, 2023).
[131] Shanti Das and Jon Ungoed-Thomas, 'Nurses in England Offered "Golden Hellos" as Trusts Try to Ease Staff Crisis', *Guardian*, May 2023.
[132] Ibid.

Flexibility

Workplace flexibility can be an attractive feature which draws more people into the primary care nursing workforce. Employers who are flexible with their working arrangements tend to see improved engagement, and higher levels of job satisfaction, commitment and loyalty due to better work-life balance.[133] With the rise of online and telephone appointments, there is also more scope to offer virtual working in primary care. Offering primary care nurses this sort of flexibility could help ensure the sector can compete with other occupations and boost retention.

Flexible shift patterns already have a precedence in secondary care nursing, where nurses can typically choose whether they pick a night shift or a day shift. For primary care, flexible working arrangements can take a number of forms: compressed hours, average/annualised hours, and job shares. Midlands Partnership University NHS Foundation Trust successfully piloted an extended shift pattern scheme for community nurses, which has since been shared with other community teams.[134] With the rise of online and telephone triage and appointments, ICSs could also, where appropriate, advertise remote-only nursing vacancies – which may be particularly valuable in areas where recruitment is difficult.

Recommendation 7: ICSs, and in a future devolved model, regional government, must consider the ideal distribution of the nursing workforce for their locality, across the whole system: primary, community and secondary care. This should reflect changing and future demand, and the need to drive care upstream and out of costly, acute care.

Recommendation 8: ICSs should experiment with nursing incentives to develop the right nursing workforce for their particular locality – depending on the nature of demand, this could include stronger incentives to work in general practice, or creating stronger incentives to work in district nursing. These could include, but are not limited to, financial incentives, progression opportunities, or flexible working.

5.3.3 Rescope general practice

Providing direct access to specialists and, in turn, rescoping general practice is emerging as one way to reduce and divert primary care demand.

It is increasingly clear that if the model is to shift to prevention, some services need to be included where they previously were not, and others need to be descoped. In interviews for this paper, GPs have highlighted particular clinical domains that could be descoped and made into their own specialisms with direct referral, such as dermatology, ophthalmology, and ears, nose and throat.

[133] Kelliher C and Anderson D, 'Doing More with Less? Flexible Working Practices and the Intensification of Work', *Human Relations* 63, no. 1 (2010).
[134] NHS Employers, 'Flexible Shift Patterns in a Community District Nursing Team', May 2024.

Germany[135] and Sweden,[136] for example, do not have traditions of GPs acting as gatekeepers to the health system. In Sweden, the population has direct access to most specialists as well as GPs, and primary care has no formal gatekeeping function. Residents may choose to go directly to hospitals or to private specialists contracted by local councils. Patients can go directly to gynaecologists, paediatricians, and speech therapists. In rural areas where there are few or no specialists available, GPs are the main entry point for care and may refer the patients to specialists if necessary.

There is no personal doctor list system in Swedish primary care, and patients are always free to seek primary care and outpatient specialised care without geographical restrictions.[137] This is partially a result of having had multidisciplinary teams since the early 1970s, so formal choices for patients focus on the organisational unit rather than individual GPs.

Full self-referral, however, is not necessarily desirable: it is unlikely that specialists would be able to cope with a significant influx of patients unfiltered by primary care, in turn making it harder for high-need secondary care patients to get access. There is also the question of whether a patient would know which specialist to choose. GP gatekeeping is associated with lower healthcare use and expenditure, though also with lower patient satisfaction.[138] Survival rates for patients with cancer in gatekeeping schemes, for example, is significantly lower than for those in direct access models.[139]

There is nonetheless a strong case for enabling patients to self-refer to specialists they have seen before for an established condition, widening the specialists currently available for self-referral, or using technology to assist with diagnosis where appropriate.

Technology assisted triage can help patients go straight to specialists should they need to. This would enable direct access to specialists only for patients who meet tightly defined criteria. This could be complemented by AI-powered image recognition. Due to the nature of dermatology and ophthalmology, AI-aided diagnosis based on image recognition has become a focus of health innovation.[140]

[135] Simic D, Wilm S, and Redaelli M, 'Germany', in *Building Primary Care in a Changing Europe: Case Studies*, Dionne Kringos, Wienke Boerma, Allen Hutchinson, Richard Saltman and World Health Organization (World Health Organization. Regional Office for Europe, 2015).
[136] Hasvold T, 'Sweden', in *Building Primary Care in a Changing Europe: Case Studies*, Dionne Kringos, Wienke Boerma, Allen Hutchinson, Richard Saltman and World Health Organization (World Health Organization. Regional Office for Europe, 2015).
[137] Ibid.
[138] Poompong Sripa et al., 'Impact of GP Gatekeeping on Quality of Care, and Health Outcomes, Use, and Expenditure: A Systematic Review', *British Journal of General Practice* 69, no. 682 (May 2019): e294–303.
[139] Ibid.
[140] Zhouxiao Li et al., 'Artificial Intelligence in Dermatology Image Analysis: Current Developments and Future Trends', *Journal of Clinical Medicine* 11, no. 22 (November 2022).

Non-melanoma skin cancer is the most common cancer worldwide,[141] and AI can aid the early evaluation and diagnosis of skin cancer. Eye care is increasingly the front runner of the AI healthcare revolution because diagnosing eye conditions depends heavily on imaging. Many studies have shown that AI algorithms now equal or exceed expert diagnostic accuracy for many conditions, particularly when the diagnosis is based on image interpretation.[142] However, the application of these algorithms in clinical practice has not yet matured. There are some limitations concerning standardisation and potential overdiagnosis, but they have significant potential.

Recommendation 9: NHS England should conduct a national review into the scope of general practice to identify which clinical areas can be descoped with a view to enabling direct access to these specialisms. This should include data on workforce for those particular specialisms and the appropriate level of clinical expertise required for the majority of care within them (for example, whether a consultant dermatologist would need to review a rash).

5.3.4 Invest in administration and management

A significant amount of spare capacity could be unlocked if some of the administrative burden within general practice was streamlined.

The capacity benefits of better administration

Underinvestment in administrative and management support is a problem across the NHS. As previous *Reform* research has shown, this has had a substantial impact on hospital inefficiency, bed capacity and A&E waiting times,[143] and it is also a problem in primary care. In interviews for this paper, some GPs suggested that as much as 30 per cent of their time could be relieved if administration was dealt with more effectively – a potentially huge additional clinical capacity that can be unlocked.

Interviewees suggested that bolstering administrative staff could have a much more direct impact on GP capacity than some of the non-clinical roles in general practice funded by the ARRS. As outlined previously, ARRS staff tend to carry out tasks that GPs do not typically do themselves.[144] In addition, retention of administrative staff – especially receptionists – is poor.[145]

27 per cent of practice time is spent on activities relating to GPs "getting paid", which refers to tasks such as filling out reports and entering data into various information systems that report to other agencies.[146] Other areas include processing information from hospitals (26 per cent), keeping up to date with changes, reporting information, and supporting patients dealing with

[141] Li et al. Li et al.
[142] Catherine Jan et al., 'Diagnosing Glaucoma in Primary Eye Care and the Role of Artificial Intelligence Applications for Reducing the Prevalence of Undetected Glaucoma in Australia', March 2024.
[143] Sebastian Rees and Hashmath Hassan, *The A&E Crisis: What's Really Driving Poor Performance?* (Reform, 2023).
[144] Hoddinott and Davies, *Performance Tracker 2023: General Practice*.
[145] Ibid.
[146] Matt Willis et al., 'The Future of Healthcare: Computerisation, Automation and General Practice Services', 2020, https://doi.org/10.13140/RG.2.2.23586.45760.

the NHS.[147] 9,233 admin/non-clinical staff have been hired since 2019, which is significantly more than any other type of staffing group in general practice.[148] While it is true that this may still not be enough, it also suggests that just hiring more people may not be the only answer.

The work of primary care is made up of a variety of different tasks, some of which are difficult to automate, and others which have been automated in sectors outside healthcare for years. These tasks could include payroll and managing finances, checking and sorting post, printing letters, communicating with patients through texting, transcription, email account management, letter scanning, and checking for errors in paperwork.[149]

Significant gains could also be made by investing in technologies to support greater automation of these admin processes. The NHS Long Term Workforce Plan, for example, cites evidence that 44 per cent of all admin work in general practice could be "mostly or fully automated".[150] Some GP practices are already using speech recognition and other software to record patient notes in real-time and minimise manual record-keeping.[151] Others have used technology to automate payroll and bookkeeping, produce internal comms and certain forms of patient communication, and to automatically categorise emails, letters and other paperwork.[152]

How to implement more and better administration

To fully harness these benefits, however, requires dedicated investment – effectively targeted at improvements that will make the biggest difference to GP productivity. In the context of other cost and workload pressures in general practice, spending on new technologies and effectively managing their adoption is often, understandably, de-prioritised. The Estates and Technology Transformation Fund (ETTF), which existed in part for this purpose, made some difference – in practice many projects were focused either on estate or technology upgrades, not both – but there is much further to go.[153]

A one-off capital fund should be established specifically for admin automation, and distributed through competitive bids to ICSs and PCNs. Learning from the ETTF, which was delivered slowly and failed to reach all approved bids,[154] the eligibility criteria and application process for obtaining these funds should be as simple and unbureaucratic as possible.

An insufficient focus on practice management is also problematic. The ARRS does not cover additional costs such as training or supervision, or management resource required to change and manage services to effectively utilise new professionals.[155] Underinvestment in leadership, change management, HR and organisational development not only reduces productivity, but also risks undermining retention because the jobs recruited under the ARRS

147 Willis et al.
148 *General Practice Workforce, 31 March 2024*.
149 Matthew Willis et al., 'Qualitative and Quantitative Approach to Assess of the Potential for Automating Administrative Tasks in General Practice', *BMJ Open* 10, no. 6 (June 2020).
150 NHS England, *NHS Long Term Workforce Plan*.
151 Ibid.
152 Willis et al., 'Qualitative and Quantitative Approach to Assess of the Potential for Automating Administrative Tasks in General Practice'.
153 Lillie Wenzel and Harry Evans, *Clicks and Mortar: Technology and the NHS Estate*, 2019.
154 Pulse, 'Over Half of GP Practices Will Not Receive Promised Premises Funding, CCGs Warn', *24 May 2017*, n.d.
155 *Health and Social Care Committee: Oral Evidence: The Future of General Practice, HC 892*.

are not considered satisfying as “people get thrown into the deep end, it is fragmented, it does not work well and people get frustrated.”[156]

Interviewees highlighted to us that “what you need in general practice are corporate skills”, and that leadership development among clinicians is a problem in ensuring a productive practice. This may mean they do not prioritise change management or development of their employees, in turn undermining productivity and retention.

However, there are two further obstacles to implementing administrative automation. While much of the technology to automate administration already exists, there is still a lack of research in comparison to diagnostic AI. Research into machine learning for administrative tasks is either lacking or difficult to find, and is significantly lower in comparison to what is found in diagnostic care.[157] While numerous research efforts in AI exist to address these administrative tasks in other sectors, it is not clear the extent to which similar efforts have been made to solve them within general practice. Using regulatory sandboxes to encourage innovation in this area could potentially be highly impactful.

The second speaks to the two core problems which undermine innovation across the health service: poor data standardisation and poor interoperability. These, alongside sandboxes, are explored in our supplementary paper *Prescription for Prevention: A digitally enabled model of primary care.*

Recommendation 10: The Additional Roles Reimbursement Scheme should be re-defined and re-scoped. It should be specifically targeted towards roles that help to manage demand better, including administrative staff such as receptionists, clerical officers, pharmacy assistants, practice managers, and nursing. In line with this, the ARRS cap for one practice nurse per PCN should be lifted.

There should also be a one-off admin automation fund made available by NHSE for ICSs and PCNs to bid into. To receive these funds, ICSs and PCNs should be required to submit a succinct plan for how the administrative improvements will lead to greater productivity in a particular network of practices.

[156] Health and Social Care Committee, *The Future of General Practice*.
[157] Natasha Lee Sørensen et al., ‘Machine Learning in General Practice: Scoping Review of Administrative Task Support and Automation’, *BMC Primary Care* 24, no. 1 (14 January 2023): 14, https://doi.org/10.1186/s12875-023-01969-y.

6. Avoiding decline

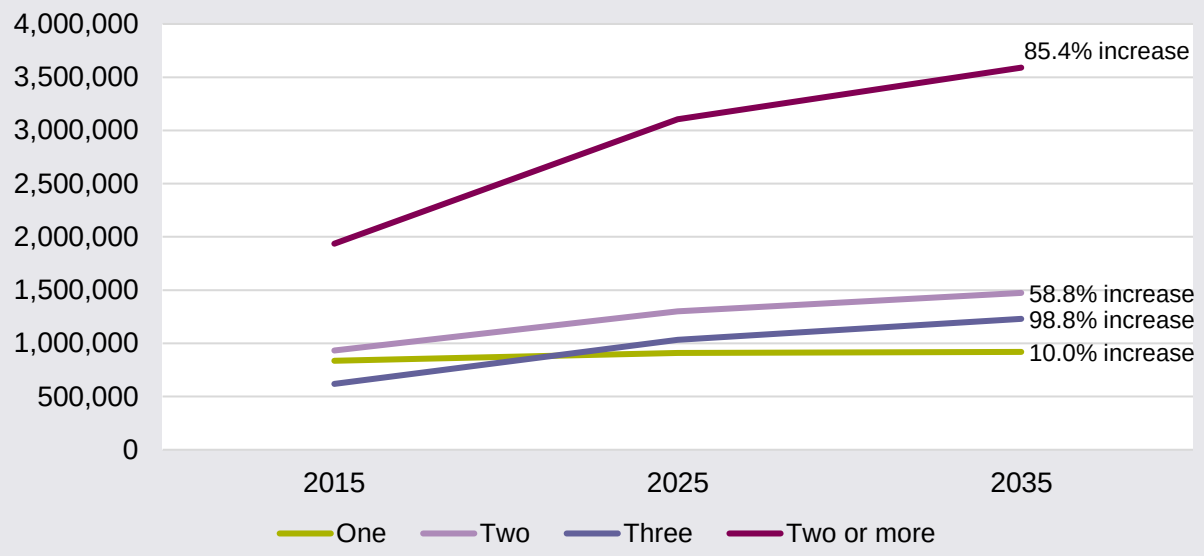
Demand within the 'tertiary prevention' bracket is chiefly focused on the care required once a patient has been diagnosed with a chronic illness, or multiple chronic illnesses (multimorbidity). Common examples include diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease, or arthritis (explained further in Figure 16 below).

The changing disease burden is one of the biggest concerns for the health system: multimorbidity increases the likelihood of hospital admission, length of stay, and readmission. This significantly raises the cost of healthcare and reduces an individual's quality of life.

Indeed, chronic conditions and multimorbidity dominate health service use and expenditure. When comprehensive data on long-term conditions and multimorbidity was last collected a decade ago, it was found that those living with long-term conditions account for 50 per cent of GP appointments, 64 per cent of outpatient appointments and 70 per cent of inpatient bed days.[158] These patients are the most likely to enter hospital care should they need specialist attention in a severe acute episode. 70 per cent of total health and care spend in England goes towards this group.[159]

The cost of providing care for those living with chronic conditions is likely to continue increasing. More than a quarter of adults in England, over 14 million people, already have two or more health conditions.[160] Importantly, given the close association between chronic conditions and ageing, we can expect this number to increase.

Figure 16: Prevalence of multimorbidity among 75-84 year olds



Source: Kingston et al., 'Projections of multi-morbidity in the older population in England to 2035', 2018.[161]

[158] Department of Health, *Long Term Conditions Compendium of Information. Third Edition*.
[159] Ibid.
[160] Mai Stafford et al., *Briefing: Understanding the Health Care Needs of People with Multiple Health Conditions* (The Health Foundation, 2018).
[161] Kingston et al., 'Projections of Multi-Morbidity in the Older Population in England to 2035: Estimates from the Population Ageing and Care Simulation (PACSim) Model'.

In mid-2020, there were 1.7 million people aged 85 years and over, making up 2.5 per cent of the UK population.[162] By mid-2045, this is projected to have nearly doubled to 3.1 million, representing 4.3 per cent of the population.[163] Multimorbidity is the norm in this age group. Some projections suggest the prevalence of four or more chronic conditions among people aged 75-84 years old is set to increase by 130 per cent by 2035.[164]

Effectively servicing this demand relies heavily on 'community services' alongside general practice. Community services are expansive and at times overlap with general practice, but the responsibility for these patients is generally split between district nurses, specialist nurses, care co-ordinators, pharmacists, physiotherapists, general practitioners, and occupational therapists.

6.1 What community services involve

Like public health, community services are highly complementary to general practice but are organised independently. This means they have a different model of contracting and commissioning to general practice and the staff are hired by different organisations to general practice.

Despite the fact community services are a crucial element of the system's architecture, the scope and breadth of community services is not well understood at a local or national level. This is partially because community services incorporate a heterogenous group of physical health and care services that are delivered in a variety of community settings, including clinics, community centres, schools and most importantly for multimorbid patients, in the home.[165]

The main types of services delivered in the community include, but are not limited to:

- adult community services – district nursing, intermediate care, end of life care
- specialist long-term condition nursing – heart failure, diabetes, cancer
- planned community services – podiatry, speech and language therapy, physiotherapy
- children's 0-19 services – health visitors and school nursing
- health and wellbeing services – sexual health, smoking cessation, weight management
- inpatient community services – inpatient services

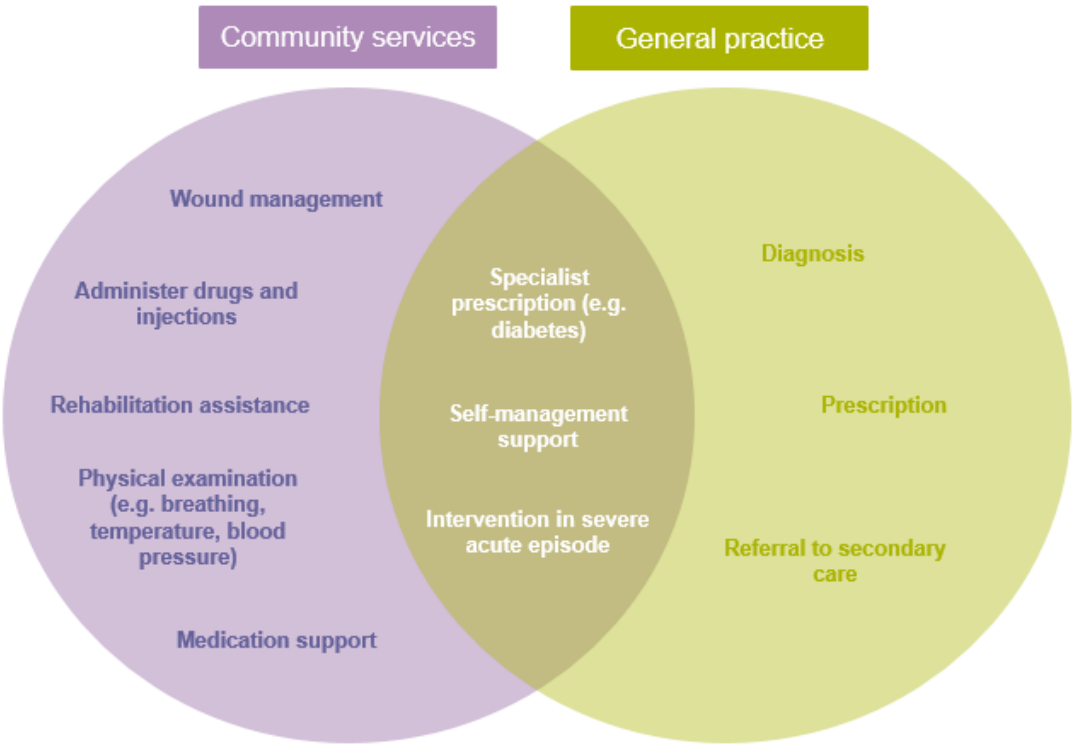
The analysis and recommendations in this Chapter will be most applicable to adult community services and specialist long-term condition nursing. Indeed the longstanding top level commitments to move care out of hospital into the community largely rely on these two key services. However some of the reforms proposed in our supplementary paper, *Prescription for Prevention: A new funding model for primary care*, particularly around contracting, will apply to all forms of community services.

Given the more specialist nature of care for multimorbid and ageing patients, there is inevitably overlap with general practice. A non-exhaustive list of clinical responsibilities is outlined below, but perhaps the most crucial distinction is the location of care. Community services are provided in the home rather than in general practice – an essential service for less mobile

[162] Office for National Statistics, 'National Population Projections: 2020-Based Interim' (Office for National Statistics, January 2022).
[163] Ibid.
[164] Kingston et al., 'Projections of Multi-Morbidity in the Older Population in England to 2035: Estimates from the Population Ageing and Care Simulation (PACSim) Model'.
[165] NHS Providers, 'State of the Provider Sector', May 2018.

patients. General practitioners are often the decision-makers for specialised diagnosis and treatment, while community nurses are the main executors of continuous care.[166]

Figure 17: The intersection between community services and general practice



6.1.1 Who is responsible for community services

How community services are provided, who provides them and how they are paid for is varied and complex.

Community services are a mixed economy of provider types covering a range of organisational forms and structures, and as a result, are more fragmented than any other part of the NHS. Non-NHS providers make up nearly half the value of contracts for community services. This can include community interest companies, social enterprises, and local authorities.[167]

The commissioning landscape is comprised of ICBs, local authorities and NHS England. However the large majority of adult community services and long-term condition nursing is commissioned through ICBs. Local authorities generally commission children's services and public health services whilst NHS England commission specialist services, such as dentistry and immunisation.

[166] Jinjin Ge et al., 'Community Nurses Are Important Providers of Continuity of Care for Patients With Chronic Diseases: A Qualitative Study', *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 60 (January 2023).
[167] NHS Providers, 'State of the Provider Sector'. NHS Providers.

Figure 18: Most common long-term conditions

Long-term condition	Explanation	Impact if not properly treated	Treatment and condition management	Factors that increase likelihood	More common in elderly people?
Hypertension	High blood pressure, heart has to work harder to pump blood	Increases risk of heart attack and stroke	Healthy lifestyle habits – not smoking, exercise, diet – and medication	Overweight, diet, smoking, stress, over 65, relative with high blood pressure, Black, African or Caribbean descent	Y
Type 2 Diabetes	Causes a person's blood sugar level to become too high, caused by problems with the insulin hormone	Kidney damage, eye damage, increased risk of heart disease and stroke, damaged nerves in feet, ulcers and infections in feet, foot amputations	Diet, exercise, medication, regular check ups	Obesity	Y
Coronary Heart Disease / Ischaemic Heart Disease / Coronary Artery Disease	The heart's blood supply is blocked or interrupted by a build up of fatty substances in the coronary arteries	Heart attack, angina (chest pain when blood flow to your heart is reduced)	Exercise, not smoking, medicines, angioplasty (balloons and stents used to treat narrow arteries), surgery	Smoking, alcohol, high cholesterol, high blood pressure, Diabetes	Y
Chronic Kidney Disease	Gradual loss of kidney function over time	Kidney failure and early cardiovascular disease	Lifestyle changes, medicine to control associated problems such as high blood pressure and high cholesterol, dialysis, kidney transplant	More common in Black people or South Asian origin, high blood pressure, Diabetes, high cholesterol, kidney infections, kidney stones	Y
Chronic Obstructive Pulmonary Disease (COPD)	Lungs become inflamed, damaged or narrowed leading to damage to the air sacs in the lungs or chronic bronchitis, which leads to long-term inflammation of the airways	The breathlessness brought on by COPD can mean people stop exercising, therefore more prone to other medical problems like high blood pressure, heart disease, obesity and Diabetes	Not smoking, inhalers or medicines, pulmonary rehabilitation	Smoking	Y
Atrial Fibrillation	Irregular and abnormally fast heart rate	Stroke – risk of blood clots forming if heart does not pump blood efficiently, heart failure	Medicines to reduce risk of stroke, medicine to control heartbeat, cardioversion, pacemaker	Age, high blood pressure, obesity, European ancestry, Diabetes, hyperthyroidism	Y

6.2 The vision for a new model

As the primary NHS carers for those with long-term conditions – and the fastest-growing driver of demand – community services are a fundamental component of the healthcare system.

Since 1974, governments have been promising to bring the health and care system out of the hospital and towards the community.[168] However, despite consistent aims and clear policy intent, the actualisation of this has proven to be both insufficient and unsuccessful.

It is difficult to over-emphasise how urgent the need for a more cohesive, robust community services sector is if the NHS is to avoid an unsustainable dependence on emergency care. However the community services model as it is currently designed will simply not be able to meet this growing, complex demand.

Figure 19: A reimagined model of community services

Current approach	New approach
The community nursing workforce is understaffed and overworked	District nursing workforce size is commensurate to the demand they face
Technology infrastructure underpinning community services are poorly connected to the rest of the primary care system	Technology seamlessly connects with all other primary and secondary care infrastructure providing an up to date, comprehensive view of the patient's needs
Poor understanding of chronic illness with limited training given to patient and informal caregivers	Each patient has a tailored, individualised management plan for their condition(s), with access to a coach specialising in behaviour change
Tools to assist with self-management exist on the margins rather than standard procedure	Technology assisted remote management is offered wherever appropriate
Poor understanding of community services and their impact on services within the wider NHS	Commissioners and policymakers have a comprehensive understanding of the volume and nature of work community services undertake

6.2.1 What would this model mean for patients

Outlined below are two very different patient profiles and the potential pathway they would take in a reimagined system of community services.

[168] Baird et al., *Making Care Closer to Home a Reality: Refocusing the System to Primary and Community Care*.

Patient example 5: Tom

Tom is 47 and works full time from home. While generally healthy most of his life, he has developed hypertension and type 2 diabetes in his late 50s, due to a genetic predisposition and modest weight gain. Tom notices his blood sugar levels are consistently high despite being diligent with his medication.

Current model

Tom is not scheduled to see the diabetes nurse for another month, so books an appointment at his GP surgery, which he manages to get after waiting on hold. The appointment is in a week.

Future model

As part of his care record Tom has a direct point of contact for his diabetes nurse. The same issue was flagged in his last appointment and so she proposes a moderate increase in his medication, and sends the prescription directly to his local pharmacy, which he picks up over lunch. She brings forward his next appointment to next week to better understand any underlying causes.

Patient example 6: Evelyn

Evelyn is 75 and has osteoporosis, osteoarthritis, type 2 diabetes, hypertension, and COPD. She has to take 12 different medications and follow 14 non-pharmacological recommendations daily. Recently her COPD has been flaring up and she has been more short of breath than she usually is.

Current model

Evelyn calls her GP and they try to find her an appointment as soon as possible with her named GP who is familiar with her complex clinical context. They can offer her a phone call with a different GP on the same day, but her now-concerned daughter thinks this won't be sufficient, and calls 111 instead who suggest Evelyn go to A&E.

Future model

Evelyn calls her care coordinator directly and explains her symptoms. Evelyn's care coordinator checks her remote monitoring data and can see her blood pressure is also high. Her care coordinator then organises for an emergency home visit from one of the available specialist community nurses to review Evelyn's self-management plan, and check whether she is using her remote monitoring tools properly to monitor her vital indicators and determine how well she is adhering to her medication. It turns out Evelyn is sometimes forgetting to take one of her medications and so the community nurse sets an alarm for that medication to remind her when to take it each day.

6.3 The building blocks for this model

Achieving this model requires a combination of empowering patients and reforming how the system operates around them. Patients need to understand how better to manage their conditions, but they also need to have access to specialist clinical expertise tailored to their individual needs if they need it.

6.3.1 Universalise tailored patient activation

Self-care is an integral part of avoiding preventable decline in the care of long-term conditions.

Self-management has been shown to reduce A&E attendance, in particular for adults with COPD and asthma.[169] Self-management support was associated with reductions in cost, a small, significant improvement in quality of life and significant reductions in healthcare utilisation.[170] It can also improve adherence to treatment and medication, particularly given the complexity of medication for multimorbidity.[171]

However, there has been a steady decline in the confidence of patients in managing their long-term conditions, with it currently at the lowest point in six years.[172] Over a third (34.9 per cent) also reported that they had not had enough support from local services to manage their condition – this is likely due to the fact that only 36.8 per cent of patients with one or more long-term conditions had a conversation with a healthcare professional to discuss what is important when managing those conditions.[173] Of this group that had a conversation with a healthcare professional, only 58.7 per cent had agreed a self-management plan.[174]

The success of self-care depends on a patient's level of activation – the knowledge, skills and confidence they have in managing their own health and care.[175] Effective patient activation and goal setting work best when they encompass a broader process, including negotiating, setting, planning and evaluating goals.[176] Programmes that aim to change patient behaviours are likely to be more successful than those that simply provide information.

Goal setting has emerged as a key element of self-management. The process of collaborative goal setting, where healthcare professionals and patients agree on a health-related goal, is mainly focused on medication, physical activity and diet. These goals are often directed at biomedical outcomes, such as 'lowering the level of HbA1c' for diabetic patients.[177] But

[169] Sarah Deeny, Ruth Thorlby, and Adam Steventon, *Reducing Emergency Admissions: Unlocking the Potential of People to Better Manage Their Long-Term Conditions* (Health Foundation, 2018).
[170] Maria Panagioti et al., 'Self-Management Support Interventions to Reduce Health Care Utilisation without Compromising Outcomes: A Systematic Review and Meta-Analysis', *BMC Health Serv Res*, August 2014.
[171] Nichapa Taibanguay et al., 'Effect of Patient Education on Medication Adherence of Patients with Rheumatoid Arthritis: A Randomized Controlled Trial', *Patient Preference and Adherence* Volume 13 (January 2019).
[172] *GP Patient Survey, National Report 2023*.
[173] Ibid.
[174] Ibid.
[175] Tina Janamian et al., 'Activating People to Partner in Health and Self-care: Use of the Patient Activation Measure', *Medical Journal of Australia*, June 2022.
[176] Stephanie A. Lenzen et al., 'Setting Goals in Chronic Care: Shared Decision Making as Self-Management Support by the Family Physician', *European Journal of General Practice*, December 2014.
[177] Ibid.

emotional and social management goals are also increasingly seen as essential to improve quality of life for those living with multimorbidity.[178] The use of technology can supplement these initiatives, as explored below, but it is most effective when it is closely tailored to the individualised needs of the patient.

It is not clear why self-management programmes are not more widely used than they currently are. In resource-constrained environments, particularly healthcare, it is common to limit responsibilities to specific tasks rather than understanding the patient holistically. However, implementing a self-management programme is not resource intensive, and has a potentially high pay off.

This task can be taken on by some of the non-clinical roles hired under the ARRS – as it directly falls under the remit of Health and Wellbeing Coaches. Health and Wellbeing Coaches are non-clinical, personalised care roles. They work specifically with people with physical and/or mental health conditions, people with long-term conditions and those at risk of developing them, to develop personalised goals, and early evidence of their impact on supported self-management is positive.[179]

Following the rollout of Health and Wellbeing Coaches in North East London, one coach articulated the effect their role was having:

> "One patient above 50, obese, hypertension (taking medication) was able to lose weight, started including exercise in her daily routine as well as healthier meals, and after 12 interventions her blood pressure was normal – not taking medication – and she decided to start studying to open doors for her professional life. Also, this patient was able to improve her mobility in the upper body, and her pains decreased"[180]

Health coaches tend to be experts in behaviour change in a way that is not too directive or prescriptive. Evaluations show that health coaching can produce positive effects on adoption of health behaviours, including improving physical activity, weight management, body mass index, blood glucose levels and dietary fat.[181]

But according to the data, Health and Wellbeing Coaches are only a small part of the recruitment wave from the ARRS: only 900 of these have been hired under the ARRS, and there are currently 6,311 general practices in operation in England[182] – though they may have been hired or commissioned as a community service rather than as part of general practice.

There are currently 26 million people in England with a long-term condition. To hire a coach for every single one of these patients would be an enormous recruitment wave. However, the main alternative is GPs managing their condition. As previously established, GPs are already operating beyond their capacity and as such they may not be able to find the time to create a self-management plan for more complex patients, the volume of which is continually increasing. This results in a poorer understanding of their condition and higher risk of hospital

[178] An De Sutter, Jan De Maeseneer, and Pauline Boeckxstaens, 'Empowering Patients to Determine Their Own Health Goals', *European Journal of General Practice* 19, no. 2 (June 2013).
[179] Richard Griffin, *'Making a Difference': An Evaluation of Health and Wellbeing Coaches in North East London* (King's Business School, 2022).
[180] Griffin.
[181] *Workforce Development Framework for Health and Wellbeing Coaches* (NHS England, 2023).
[182] Rosen and Palmer, *More Staff in General Practice, but Is the Emerging Mix of Roles What's Needed?*

admission. Both of these outcomes are less effective for the patient, and less cost efficient for the taxpayer, than hiring more Health and Wellbeing Coaches.

Interviewees did impress that patients often only need a one-off appointment, or a series of appointments with a Health and Wellbeing Coach and not necessarily a long-term relationship. The turnover of patients could therefore be reasonably high, reducing the need to hire a large volume of coaches. To avoid an outsized recruitment wave, it would also be worth ICSs understanding which long-term conditions both produce the most emergency admissions and where patients report the lowest confidence levels in self-management, in turn shaping the workforce supply around this demand.

Recommendation 11: Health and Wellbeing Coaches should be seen as a core part of the workforce. All new patients diagnosed with a long-term condition should be given access to a Health and Wellbeing Coach as a default part of their clinical care plan. Patients already diagnosed with one or more long-term conditions should be given access to a Health and Wellbeing Coach, initially prioritised based on the complexity of their condition and their confidence in managing it. ICSs should therefore determine the number of Health and Wellbeing Coaches needed for their locality based on their demographics and disease burden.

In a model where block contracts are still adopted, Health and Wellbeing Coaches should be hired under a community service contract rather than through the ARRS. Where ICSs contract community services using more innovative contracting, the use of Health and Wellbeing Coaches should be an expected part of any bid. Where ICSs contract community services using more innovative contracting, the use of Health and Wellbeing Coaches should be an expected part of any bid.

6.3.2 Improve the evidence base for remote monitoring

Enabling patients to precisely monitor their condition is foundational for a future model of community based care for chronic illnesses. It both empowers patients and reduces the demand on clinicians.

Remote monitoring involves patients sending data to a healthcare professional via wireless technology or text. Remote monitoring has had a positive impact on managing a range of chronic conditions, such as improving glycaemic control,[183] reducing blood pressure[184] and reducing the risk of mortality in heart failure patients.[185] A recent review showed that monitoring patients with heart failure can reduce heart failure-related hospitalisations by nearly 30 per cent.[186]

[183] Rashid L. Bashshur et al., 'The Empirical Evidence for the Telemedicine Intervention in Diabetes Management', *Telemedicine and E-Health* 21, no. 5 (May 2015).
[184] S. Omboni and A. Guarda, 'Impact of Home Blood Pressure Telemonitoring and Blood Pressure Control: A Meta-Analysis of Randomized Controlled Studies', *American Journal of Hypertension* 24, no. 9 (September 2011).
[185] Sally C Inglis et al., 'Structured Telephone Support or Non-Invasive Telemonitoring for Patients with Heart Failure', ed. Cochrane Heart Group, *Cochrane Database of Systematic Reviews* 2015, no. 10 (October 2015).
[186] Ibid.

Remote monitoring enables patients to monitor and understand their condition and for professionals to intervene proactively. This could include increasing their medication dose or, in the case of diabetes, changing meal choices, in turn reducing pressure on hospital and emergency services. It can also include giving personalised instructions to patients, such as when to take medication, and give them more visibility over their condition by collecting more data.

Before the advent of smartphones, this was often done over the telephone, which was still an efficiency gain – a home visit is four times the cost of a nurse phone call.[187] But with technological developments, there are now generally two approaches: invasive and non-invasive remote monitoring. Non-invasive can include the measurement of pre-specified parameters such as daily weight, blood pressure, pulse oximetry or medication adherence. Invasive monitoring for patients with heart failure for example, would include implanted devices measuring proxies such as left ventricular filling pressure.

Increasingly, more advanced technology using discreet sensors within the home has proven to successfully reduce demand and empower patients. For example, smart devices which monitor the patterns and behaviours – rather than clinical measurements – of individuals within their homes to identify subtle changes which might indicate a change in health status. These combine machine learning, behavioural data analytics and sensor technology to monitor how a vulnerable person is managing against a baseline activity level. The sensors monitor soft signs and behaviours that could potentially indicate a decline or an improvement in health and wellbeing, allowing care services to be tailored to personal need.

For example, *Lilli* is a smart device which monitors the patterns and behaviours of individuals to subsequently identify subtle changes which might indicate a change in health. Analysis estimated that using technology like *Lilli* could result in savings of £4,000 per person per annum. Extrapolating these savings, this suggests that for 1,000 units, £4 million could be saved, a number equivalent to 180,000 care hours or 120 carers.[188]

The efficiency gains of remote monitoring combined with self-management are high if it enables less frequent home visits without undermining the quality of care, and prevents hospital attendance and/or admission, whilst simultaneously empowering the patient.

However, while promising, the current system is not set up to enable widespread investment in remote, proactive monitoring. Non-invasive monitoring, due to its simplicity, is generally thought to be desirable given its relatively low costs, and is widely used. Effective remote monitoring is however contingent on providers having a care coordinator or specialist nurse in place as it requires a professional to review results and offer proactive interventions.[189]

Investment in invasive monitoring requires a strong evidence base to justify the expenditure, which is considerably higher than non-invasive monitoring. However, the evidence for the cost effectiveness of invasive monitoring is mixed, and clinical trials vary significantly in their design. Given that there is such a wide range of parameters and devices that can be used to

[187] Joanna Thorn et al., 'Cost-Effectiveness of a Patient-Centred Approach to Managing Multimorbidity in Primary Care: A Pragmatic Cluster Randomised Controlled Trial', *BMJ Open* 10, no. 1 (January 2020).2
[188] 'Digital Transformation in Social Care: How to Get It Right' (directors of adult social services, April 2022).
[189] Ibid.

monitor chronic illnesses, this leads to wide ranges in trial designs.[190] Evidence on cost effectiveness is also limited.

The National Institute for Health and Care Excellence (NICE) plays a role in developing the guidance for remote monitoring and advising NHS commissioners. NICE provides clinical advice to those working in the NHS, local authorities and the wider community to help them deliver high-quality health and social care. This can include clinical guidelines, as well as health technology guidance.

Assuming that such guidance is influential for commissioners in their spending decisions, this evidence base – on both efficacy and cost effectiveness – would need to be substantially expanded before resource constrained commissioners start experimenting with nascent innovations in invasive remote monitoring.

Recommendation 12: The National Institute for Care Excellence should expand their guidance base for invasive and sensor based remote monitoring: this should be explicitly based on an assessment of the most significant clinical needs in England (for example, COPD or arthritis), desired patient outcome and the technology solutions that can enable more technological self-management.

6.3.3 Prioritise district nursing

While effective community services, like the rest of primary care, rely equally on demand management and workforce supply, there are unique workforce issues within community services that must be addressed.

Nurses are often considered by patients to be the lynchpin connecting primary, secondary and social care. The nursing ecosystem in primary and community care is complex and varied. There are a wide range of different nurses, and the prevalence of each type will depend on commissioning decisions tailored to the demographic context of each locality. Indeed, in the recent Queen's Nursing Institute survey of district nurses, over 1,000 different job titles were given in response to the survey.[191]

The most common umbrella terms for nurses within the community, which this analysis will use, are district nurses and specialist nurses (these can refer to a subset of different nurses, such as diabetes nurses).

District nurses manage teams of community nurses and support workers, as well as visit housebound patients to provide advice and care, such as palliative care, wound management, catheter and continence care and medication support, particularly for people recently discharged from hospital or near end of life. District nurses are also able to prescribe medication to patients in a similar way to general practitioners.

[190] Sophie Castle-Clarke, Sarah Robinson, and Jessica Garner, *Beneficial Changes Network Case Study: Remote Monitoring* (Eastern AHSN, 2022).
[191] *District Nursing Today: The View of District Nurse Team Leaders in the UK* (Queen's Nursing Institute, 2019). *District Nursing Today: The View of District Nurse Team Leaders in the UK*.

The number of district nurses has fallen by almost half – 46.9 per cent – since 2009.[192] There are only some 4,000 district nurses in England, a ratio of one district nurse for every 14,000 people.[193] This compares with one GP for every 1,600 people. The NHS Long Term Workforce Plan aims to double the number of district nurses by 2028, and emphasises the need for significantly more qualified and experienced district nurses to meet changing healthcare needs.[194] The adoption of 'virtual wards' is just one of the policies that will place greater demands on district nursing services, as more complex care is delivered in the home.[195]

The district nursing workforce is undergoing a recruitment and retention crisis. The number of students enrolling for the District Nurse Specialist Practitioner Qualification (DNSPQ) is decreasing. 668 district nurses qualified in the 2021-22 academic year, a decrease of 6 per cent from the previous year, while there was a 9 per cent decrease in enrolments for new students in 2022-23.[196]

The district nursing workforce is also drawn from an ageing population. The majority of respondents to the QNI's survey of district nurses were aged over 45 years, with 46 per cent planning to either retire or leave in the next six years (25 per cent to retire, 21 per cent to leave).[197]

The reasons for the widespread dissatisfaction among the nursing workforce is largely down to low capacity (unpaid overtime, insufficient time to devote proper care to patients, unmanageable caseloads), poor progression and development, and poor administration (poor technology and no administrative support).[198] There is also significant regional variation in the pay band of district nurses holding the specialist practitioner qualification, but salary is relatively low down on the list of priorities for the district nursing workforce, far outstripped by staffing (50 per cent of respondents cited this as a concern) and IT (36 per cent).[199]

Given that low capacity in the district nursing workforce is not only undermining the goal of effectively shifting more care into the community, but also impacting retention of the current workforce, prioritisation of district nurses in a future model is essential. That means a focus on both the push and pull factors that influence recruitment.

As outlined in the previous Chapter, a major policy question for a future model of primary and community care is how to build a nursing workforce that meets the needs of modern society, thereby creating a more proportionate balance between the primary and secondary care nursing workforces. Even with increased investment into the primary and community care workforce through interventions like the ARRS, it has always been significantly smaller than secondary care, suggesting the latter has a much stronger pull factor for newly qualified

[192] *Nursing Numbers Plummet and Waiting Lists Soar While Government Delays Workforce Plan, Says RCN* (Royal College of Nursing, 2023).
[193] *Outstanding Models of District Nursing* (The Queen's Nursing Institute, 2019). *Outstanding Models of District Nursing*.
[194] National Audit Office, *NHS England's Modelling for the Long Term Workforce Plan*. National Audit Office.
[195] *Report on District Nurse Education in the United Kingdom, 2021-2022* (Queen's Nursing Institute, 2022).
[196] Ibid.
[197] *Outstanding Models of District Nursing*. *Outstanding Models of District Nursing*.
[198] *District Nursing Today: The View of District Nurse Team Leaders in the UK*.
[199] Ibid.

nurses. It is essential to understand why this is if the ambition is to create a more sustainable shift to primary and community care is to be achieved.

A focus on recruitment must be coupled with the implementation of less expensive, but potentially high-impact interventions to minimise the push factors that are leading to 21 per cent of district nurses saying they intend to leave the profession. Improving technology for example, is critical. IT was second on the priorities identified in the QNI's annual survey in response to the question: "What three priority areas would need to change to make a difference to your work?".

As with general practice, poor interoperability between systems across health and social care are a key problem. District nurses suggest that weaknesses in the current IT infrastructure frequently result in a delay in communication, frustration and potentially poorer patient outcomes.[200]

Ultimately, the interventions needed to improve the district nursing workforce are oriented around recruitment, understanding the incentives and disincentives to work in district nursing, and a concerted investment in technology. These are broadly aligned with the problems and solutions outlined in the previous Chapter in Section 5.3.2 (recommendations 7 and 8) and in our supplementary paper, *Prescription for Prevention: A digitally enabled model of primary care*.

6.3.4 Improve the visibility of community services

The data landscape in community services is woefully inadequate. Relatively little is known at a national level about the volume, nature and quality of care taking place in NHS community health services.

Community services include a wide range of different practitioners, and account for around 100 million patient contacts each year.[201] These contacts are provided by a wide range of provider organisations, including social enterprises, integrated care organisations, independent sector providers and local authorities.

NHS Digital, now part of NHS England, collects some data from individual providers and makes this available through the Community Services Data Set (CSDS).[202] However, the CSDS is mainly limited to the number of contacts with services. There is relatively little data on demand, patient and staff experience, patient outcomes and quality of care. This in turn means that commissioners can be led to use hospital sector data as a proxy for measuring the impact of community services, such as the number of delayed discharges or number of readmissions.[203] While these are important measures, they do not capture, for example, how many patients are being referred to community services, how this demand is being met and how long waiting times are for these services.

The fragmented landscape can be particularly difficult for commissioners, who may be making decisions on services in the absence of comprehensive data and managing numerous

[200] *Outstanding Models of District Nursing*. *Outstanding Models of District Nursing*.
[201] *Community Services: Improving Access to Clinical Information* (NHS Digital, n.d.).
[202] Josh Keith and Fiona Grimm, *How Better Use of Data Can Help Address Key Challenges Facing the NHS* (Health Foundation, 2022). Keith and Grimm.
[203] Baird et al., *Making Care Closer to Home a Reality: Refocusing the System to Primary and Community Care*.

contracts for closely related services, some of which contain relatively little detail and allow only limited oversight.[204]

It also has problems for political prioritisation because the lack of data perpetuates a "cycle of invisibility" in senior NHS leadership.[205] Senior leaders in the NHS often have career backgrounds working in hospitals, partly because of the high status of working in large teaching hospitals. Limited experience of primary and community care, compounded by limited data on those services, means that leaders' understanding of the issues is suboptimal.[206]

Aside from having insufficient scope, the completeness of CSDS data is poor: less than 40 per cent of contacts have a clinical coding showing the observation, procedure or finding, and less than 20 per cent have a primary diagnosis.[207] Workforce data is also poorly completed, with the staff group involved in treating the patient only 25 per cent complete.[208] The data is also collected in isolation, unlinked to other healthcare services a patient may be accessing, so it is difficult to properly evaluate the impact of community services on the whole pathway.[209]

This is in part because community service providers are not incentivised to submit high-quality returns in the same way that primary and acute services are, because payment is based on a block contract rather than by results (this is discussed in a complimentary paper published alongside this one, *Prescription for Prevention: A new funding model for primary care*).

Improving the quality of data collected can be done through a number of mechanisms. Financial incentives, for example, linking funding or bonus funding to completion and submission could be used. However, considering that data submission is a basic expectation across the rest of the NHS, and there are numerous other areas within community services that require investment, this may not be the most efficient use of funds, even if it would likely ensure the fastest upgrade in data quality.

Alternatively, standardising data collection and ensuring tools exist that guarantee the submission of complete, standardised data, could be effective and deliverable, with more cost efficiency than financial incentives. Tools could be built into data collection systems to ensure that users cannot complete the submission without completing all required fields.[210] However, the variation in data collection among different providers using different EHRs, might inhibit the collection of standardised data. This would therefore ideally be complemented by an audit of Electronic Health Record coverage among community service providers.

Recommendation 13: NHS England should develop basic data submission software that can be used across the NHS. This should relieve some of the logistical and/or technical burden from smaller NHS providers while ensuring uniformity and completeness in data submission.

[204] Anna Charles et al., *Reimagining Community Services: Making the Most of Our Assets* (King's Fund, 2018). Charles et al.
[205] Baird et al., *Making Care Closer to Home a Reality: Refocusing the System to Primary and Community Care*.
[206] Ibid.
[207] Feargus Murphy et al., *How Improved Community Data Unlocks NHS Efficiency* (Carnall Farrer, 2023).
[208] Ibid.
[209] Ibid.
[210] Ibid.

Recommendation 14: NHS England should commission an annual Community Services Patient Survey, modelled off the GP Patient Survey, to understand patient experience and quality of care in community services.

7. Conclusion

Primary care should be the jewel in the NHS crown, but to realise this, a fundamental reset is needed to ensure it is fit to meet the needs of both current and future populations. The aim of a reimagined primary care system should be to incentivise the earliest possible intervention, provide timely and high-quality care when needed and empower patients to live independent healthy lives. The recommendations outlined above are designed to address many of the major obstacles associated with building such a model.

The paper demonstrates that a substantial shift towards prevention can be achieved even outside the levers of major workforce reform. It is clear that some of the biggest levers to help deal with the future pressures on the healthcare system are found in the better deployment of technology and a much greater focus on community care, rather than fixating on the four walls of general practice (which in any case must be remodelled).

Realising the long-held ambition to focus our health system much more on preventing illness and addressing the social determinants of ill health must begin with primary care. In the short-term, there are crucial steps – from modernising the primary care estate to improving data join-up – that will mean the system is better placed to intervene as early as possible, and provide more integrated, patient-centred care.

In the longer-term, primary care will benefit from having excellent general practitioners who can spend more time with the patients who would benefit most from specialist medical advice. But also from having a workforce that can proactively reach into and support the wider health needs of diverse communities across the country.

Primary care has a critical, and much larger, role to play in intervening before illness occurs (primary prevention); detecting health needs early to reduce harm (secondary prevention); and stopping illnesses from deteriorating and requiring more acute treatments (tertiary prevention). To get there, we must reimagine the boundaries of primary care, how it is designed and delivered – and prioritise demand reduction and management, rather than having stretched services play catch-up with ever-greater and more complex levels of demand.

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