SQUARING THE CIRCLE –

The place of personal care and small practices in the new NHS

EXECUTIVE SUMMARY

What do patients want from the NHS? When people are asked this question, their key priority is their relationship with their doctor, nurse or other health professional. This document considers how the NHS can preserve this therapeutic alliance at the same time that primary care is facing far-reaching change. How can we ensure that reform protects and promotes strong and long-lasting relationships between patients and health professionals?

Relational continuity is seen most clearly in small practices. The evidence shows that many patients prefer small practices. They value the long-term relationships built between GPs, their fellow health professionals and patients. All demographic groups value this relational continuity but the preference is even stronger amongst those who are more vulnerable through age or long-term conditions. Yet the number of small practices is in decline. This puts the survival of personal doctoring at risk. Small practice is the barometer of the health of relational continuity in primary care.

The balance of evidence suggests that small practices overall deliver clinical medicine to the same standard as those of larger size. There is increasing evidence to suggest that their key strength, relational continuity, results in more cost-efficient use of resources, including diagnostics, referral to secondary care, and improved health of the relevant population.

The future

There are many paths to excellence. The evidence shows that small practice is one of these paths. As general practice organisation and service delivery becomes ever more complex the survival of this path will depend upon co-operative working. This document suggests two models for the future survival of small practice in the modernised NHS: 'nested' small practices working as a

purpose built super-surgery on one site; and the small practice virtual super-surgery. Different models suit different circumstances. The organic development of partnerships that meet the needs of local patients and the wishes of patient participation groups should be encouraged.

These partnerships, working from one site or from many, should increase both choice and contestability in primary care. Patients will have a wider range of choice in terms of treatment and health professional within these new units, which will provide a broader range of services and professionals than at present. Patients will have a choice over which practice they register at within in these partnerships. Practice associations, whether purpose built or virtual, will need to have credible patient participation groups, which can guide their commissioning and providing roles. These, together with peer pressure from professionals within such an association, can ensure that services are of sufficient quality and that patients can choose between different services. A new dimension of competition and contestability in primary care will open up at the interface between these associations, acting as practice-based commissioners. Patients will choose to register with an association depending upon commissioning skills as well as quality of clinical care, personal care and continuity. This will clearly be a long-term development.

Immediate priorities

NHS Alliance and the Small Practices Association believe that in the short term, Primary Care Trusts and the forthcoming White Paper should value, maintain and extend relational continuity in primary care, while extending the range of services available and the number of points of access. Primary Care and PCT commissioners must now assess the degree to which they are able to offer personal care and relational continuity in both small and large practices. Our aim is to highlight those aspects of primary care in the UK that have made it the envy of the world, while making them fit for a greatly extended role in the 21st century.

Chapter 1 – The Evidence for Small Practices and Relational Continuity

Our definition of small practice is those consisting of up to three GPs and 6,000 patients. These GPs and their patients have chosen this format in the face of decades of pressure to expand. From 1966 to 1990 GPs were financially incentivised to work in groups of three or more. Practice size has continued to grow since 1990 – the median size of practice today is five whole-time equivalents.

This increase in practice size has inevitably reduced the numbers of practices, effectively reducing the choice available to patients who wish to register with a new surgery. In some areas practice expansion has reached its logical conclusion – one single practice has established a monopoly, completely removing choice.

For choice to become the driver of increasing quality, differentiation between services provided is necessary. There is a spectrum of differentiation with relational continuity at one end and breadth of service at the other. With the loss of small practices in many parts of the country patients are denied an important choice. Those practices that remain should be preserved if contestability is to have any meaning.

The research into the pros and cons of small practice size has been consistent over time. Patients prefer small practice for its accessibility and human scale. If small practices are special in some way, it is because they deliver a high level of continuity of care to their patients.[1] [1a][1b][1c][1d][1e]

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[1] Cartwright A. Patients and their doctors. 1967; *London*; Routledge, Kegan and Paul.
[1a] Cartwright A, Anderson R. General Practice revisited: a second study of patients and their doctors 1981 *London;* Routledge, Kegan and Paul.
[1b] Rights and responsibilities in health care. Institute for Public Policy Research 1998.
[1c] What type of practice do patients prefer? Baker R. & Streatfield J. *BJGP* 1995; **45**: 654-659.
[1d] Hjortdahl P, Laerum E. Continuity of care in general practice: effect on patient satisfaction *BMJ* 1992; **304**: 1287-90.
[1e] Wensing M, Hjortdahl P, Grol R. Patient Satisfaction with availability of general practice: an international comparison *International Journal for Quality in Healthcare* 2002; **14**: 111-116

The concepts of small practice and continuity are closely linked. The three most pragmatic definitions of continuity of care are:

- **Informational continuity**: The use of information about past events and personal circumstances to make care appropriate for each individual.
- **Management continuity**: A consistent approach to the management of a health condition that is responsive to a patients changing needs.
- **Relational continuity**: An ongoing therapeutic relationship between a patient and those who care for him or her. Also known as a therapeutic alliance. [2]

Patients assume that informational continuity and management continuity are a given in the NHS. The weight of evidence is overwhelmingly that, when patients are asked what they want, their paramount concern is being able to talk to a doctor or nurse who is committed to them as a person.[3] In other words, they want relational continuity. However managers, and clinicians, have different outlooks. This document considers the evidence from all three perspectives.

It is worth noting that negative attitudes to small practice within the NHS have been based on flawed evidence. Much of the research comparing single-handed practice with those of other sizes has not compared like-for-like populations of GPs. The Small Practice Association's (SPA's) best estimate is that about half of the single-handed practitioners in city and urban areas are originally from overseas. It is a remarkable testimony to the resilience of these GPs and the single-handed practice structure that despite their enforced lack of GP training, and the damaging effects of acknowledged institutional racism, their practices have delivered clinical medicine of comparable quality to practices of larger size, when statistically combined with those of non-overseas single-handers.[4]

The managers' view

[2] Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of Care: a multidisciplinary review. 2005 *BMJ*; **327**: 1219-1221
[3] What patients want from primary care, National Primary Care Research and Development Centre, August 2005,
[4] Hippersley-Cox J, Pringle M, et al. Do single handed practices offer poorer care? *BMJ* 2001; **323**: 320-323

In business small units are structurally more fragile than large. General practice is no exception. If the practice nurse is off sick, the care of long-term conditions may be affected. A GP scheduled to retire is a big worry.

In almost any measurement of practice function single-handed (and to a lesser extent small) practices seem the worst performers, which is embarrassing for them. And at the same time the best, which is curious. In fact this is partly straightforward mathematics – smaller practices have fewer GPs and therefore greater variation from the mean in terms of performance.

Among the disadvantages of small practice, isolation is a key concern. At its most extreme end lies the nightmare of potentially harbouring another Dr Shipman. Dame Janet Smith in reviewing evidence for the Shipman enquiry concluded: 'It seems to me that the policy of the Department of Health and of PCTs should be to focus on the resolution of the problems inherent in single-handed or small practices rather than to try to reduce the numbers of them in existence. I know that the Department of Health says that it has no such policy but I have the clear impression that such a policy exists in the regions, if not in Whitehall. It is typified by the attitude that single-handed practices are a problem and that the NHS will be better off without them.'[5]

Small practices inevitably have higher structural costs. The additional costs are, on average, 10 per cent more for staffing, 20 per cent more for computerisation and 30 per cent more for buildings.

Small practices are thought to be 'not developed'[6] – they have fewer ancillary staff, a smaller range of services within the practice and fewer of them are training registrars. However this lack of developed structure does not prevent small practices from making primary care services available or delivering access to these services.[7] LIFT will not operate for small practice units due to the

[5] *Independent public inquiry into the issues arising from the case of Harold Shipman*, Fifth Report, p387-406 2004. www.the-shipman-inquiry.org.uk
[6] Baker R. General practice in Gloucestershire, Avon and Somerset: explaining variations in standards. BJOGP 1992 **42**, 415 - 418
[7] Population need and the provision of Primary Health Care in Southern Derbyshire Hann M, Baker D,

diseconomies of small scale. It is more difficult for a small practice to get their premises updated than for their larger neighbours.

However, what is not usually taken into account is that smaller practices have benefits as well, including cost benefits. They have tighter control of prescribing costs.[8] There is also a small but growing body of evidence that suggests the continuity provided by small practices delivers lower inpatient, outpatient and total costs. [9][10][11] Studies in the US and UK show that continuity results in fewer referrals and A&E/Emergency Room visits[12]. Even more striking results emerge from recent research in the US and Europe, demonstrating that continuity also results in lower total costs.[13][14][15] There may also be savings in the costs of referrals and inpatient care. Total costs will be open to investigation with the advent of the national tariff and fair share budgets. Small practices also have other advantages; they appear to be able to work more as a team, for instance.[16]

The GP and primary care clinicians' view

Though the small practice environment is more challenging it is also more rewarding for those who choose it. In an SPA survey of single-handed GPs in London, half had initially been in partnership. Of those less than 5 per cent would prefer to return to partnership.[17] Outside the capital, GPs feel less stressed in single-handed practice.[18] A small SPA survey suggests that single-handers

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[8] Wilson RPH et al. Influences of practice characteristics on prescribing in fundholding and non-fundholding practices; an observational study. *BMJ* 1996; **B313**: 595-599
[9] Alppert JJ, Robertson LS, Kosa J, et al. Delivery of healthcare for children: report of an experiment. *Pediatrics* 1976; **57**: 917-930
[10] Wasson JM, Sauvigne AE, Modigniki RP. Continuity of outpatient care in elderly men. *JAMA* 1984; **252**: 2413-2417
[11] Starfield BH. Elements of Primary Care *Oxford University Press USA* 1992 page 53
[12] Sweeney KG, Pereira Gray D. Patients who do not receive continuity of care from their general practitioner – are they a vulnerable group? BJGP 199; **45**: 133-5
[13] Christiakis DA et al. Association of lower continuity of care with greater risk of Emergency Department use and hospitalisation in children *Pediatrics*; 2001; **103**: 524-528
[14] De Maesneer JM, De Prins L, Gosset C, Heyerick J. Provider continuity in family medicine: does it make a difference for total health care costs? *Annals of Family Medicine* 2003; **1**: 144-148
[15] Freeman G, et al. Continuity of Care: report of a scoping exercise for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D. Summer 2000.
[16] Poulton B, West MA, Jenner D. The determinants of effectiveness in primary health care teams. *J of Interprofessional Care* 1999.**13**: 7-17
[17] SPA survey
[18] *Occasional paper 71* RCGP London

choose to retire slightly later than partnerships of two GPs. In turn, GPs in partnerships of two retire later than those in groups of three GPs. About 50 per cent of GPs from small practices surveyed wish to return to part-time work after retirement.

Small practice is also an environment where GPs are more likely to have a relationship with their patients based on an understanding the holistic significance and impact of disease on each individual. [19] The patient is seen as more than a fragmented list of symptoms, diseases or body parts and this can have a major impact on the success of treatment, the well being of the patient, and the costs of primary care.

A key benefit of small practice is the clear identification of responsibility for an individual patient's healthcare and ownership of any health problem. A patient who sees several different GPs may find each works on one isolated instance of care, and none takes overall responsibility (dilution of responsibility). Or a patient's care may fall between specialist and GP with neither taking full ownership of the issue at stake (collusion of anonymity). There is less dilution of responsibility and collusion of anonymity the smaller the practice. Single-handed practice in particular is transparent in such matters. There are clear benefits to patient care.

Knowledge about the patient is known to be helpful in consultations and can result in more time-efficient consulting. [20] [21][22] This is more of benefit in management rather than diagnosis.[23] In amassing such psychosocial information clinicians become more committed to their patients.[24]

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[19] Mainous AG, Baker R, Love M, et al. Continuity of care and trust in one's physician: evidence from primary care in the United States and the United Kingdom *Fam. Med.* 2001; **33**: 22-27

[20] Gulbrandsen P, Hjortdahl P, Fugelli P. General Practitioners' knowledge of their patients' psychosocial problems. *BMJ* **314**: 1014-1018

[21] Simon GE, et al An International Study of the relation between somatic symptoms and depression. *NEJM* 1999; **341**: 1329-1334

[22] Hjortdahl P, Borchgrevenink CF Continuity of Care: influence of general practitioners' knowledge about their patients on use of resources in consultations *BMJ* 1991; **303**: 1181-4

[23] From scoping study

[24] See ref. 22

General practice is increasingly complex. Young doctors, especially those who have never experienced small practice, would not consider single-handed practice in the first instance, and would be concerned about the responsibility of being a principal in a small practice. This is compounded by the fact that though small practices deliver more than 20 per cent of the GP component of primary healthcare they provide less than two per cent of the training.

The patients' view

Given a choice, patients prefer small practice. This was known in 1968 and remains true today. [25] [26] The reasons include accessibility and continuity of care. An international study, which compared five leading Western healthcare systems, rated the NHS bottom of the league for accessibility and diminished continuity of care. Both access and continuity are known to be greater in small than large practices. [27 ,28, 29]

A Consumers' Association (*Which?* magazine) study demonstrated an interesting and important dissonance between the desires of patients and what the doctor thought the patient wanted. Doctors thought that patients wanted multiple services on one site and that patients wanted them to be up to date in their knowledge. This latter quality patients took for granted. What in fact patients required was a known doctor who took the time to listen to the patient.[30]

All groups of patients prefer continuity. A recent study demonstrates that patients and carers have clear views on when they need personal continuity.[31] They want it for more serious problems or those that have a bigger impact. Such care is valued more by those who are particularly vulnerable: the elderly and

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[25] See ref 1 Cartwright et al. and ref 1e Wensing et al.
[26] The Future Patient.In Progress, The Institute for Public Policy Research Spring 2000
[27] Commonwealth Fund (2201) International Heath Policy Survey Report 2002
[28] Campbell JL The reported availability of general practitioners and the influence of practice list size. *BJGP* 1996; **46**: 456-468
[29] Roland M, Mayor V, Morris R. Factors associated with achieving continuity of care in general practice. *JRCGP* 1986; **36**: 102-104
[30] What makes a good GP? *Which?* 1995; June :18
[31] Freeman GK et al. Continuity in primary care: a stated preference discrete choice experiment. *Society for Academic Primary Care; abstract for parallel session* July 2005

patients with long-term conditions, severe or terminal illness. [32]'Knowing the GP enables the patient to cope better with the illness and life itself. Such enablement is greatest in single-handed practice."[33]

Another important pan-European study demonstrated that UK GP services were bottom of the league, by some considerable distance, when judged by those aspects of quality open to patient judgement. Lack of relational continuity is very clear to patients.[34]

In a very recent publication the Department of Health (DH) recognises the great importance of a 'therapeutic alliance' between clients with drug or alcohol abuse problems and their health professionals.[35] The DH encourages providers and commissioners to develop services featuring this therapeutic alliance for these vulnerable clients. Similar encouragement must be given to commissioners of services to equally vulnerable patients such as those with long-term conditions.

These studies and others were triggers to the current government's determination to reform primary health care services as part of wider NHS reform. The DH has rightly focused on the issue of access. So far it has targeted fast and same day access to any practitioner but the debate is rapidly moving on to the question of how practices can provide convenient, scheduled access to a clinician of the patient's choice. On balance the evidence is that more provider continuity is associated with greater patient satisfaction and lower costs.[36]

It would be regrettable if, at the same time that the NHS is learning from the strengths of the US health care systems, we were to neglect our own successes. The US has rediscovered the importance of continuity of care from the UK system.

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[32] Shers H, Webster S, van den Hoogen H, Avery A, Grol R, van den Bosch w. Continuity of care in general practice: a survey of patients' views. BJGP 2002; **52**: 459-62. Also Kearley KE, Freeman GK, Heath A. An exploration of the value of the personal doctor-patient relationship in general practice. *BMJ* 1988; **297**: 528-30

[33] Howie JGR, Freeman GK, et. Al. Quality at general practice consultations: cross sectional survey. *BMJ* 1999; **319**: 738-743

[34] See ref. 3

[35] Retaining clients in drug treatment *NHS* June 2005

[36] See refs 7, 8, 9, 10, 11, 12

Chapter 2 – Challenges to Small Practices in the Modern NHS

The creation of the modern NHS has led to a number of changes, which have often posed particular challenges for small practices.

The issues

- **Primary care is doing more** than it did ten years ago with practices often requiring more space, staff and resources with expanding primary care teams. Childhood asthma, for example, is now almost entirely treated in primary care.

- **Changing skill mix** has helped to meet this increasing demand. GPs undertake work that was previously carried out by specialists. Nurse practitioners treat minor illnesses/injuries and long term disease that was previously largely the responsibility of GPs. Healthcare assistants take on aspects of nursing such as blood-taking.

- **Increased practice infrastructure** has been needed to meet this increasing clinical workload and staff development, requiring improved IT and more sophisticated practice management.

- **GPs are more accountable** and their clinical practice is more standardised than ever following the introduction of NICE, the NSFs, the Healthcare Commission and the Quality Framework of the new GP contract. Single-handed practices have been particularly under the microscope.

- **Rapid access has improved** but this has sometimes been at the expense of planned access. The 24/48 hour target has been achieved but maintaining planned access through pre-booked appointments is still a challenge. Sufficient time in the consultation appears to be an even bigger issue and personal care and continuity are now emerging as public priorities. [37][38]

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[37] I s the NHS getting better or worse? An in-depth look at the views of nearly a million patients between 1998 and 2004. Picker Institute Europe. 18 April 2005

[38] CFEP UK Surveys What do patients think of their health professionals and their practices? July 2005

- **GPs are now doing more work outside traditional surgery** in roles such as GPs with a special interest, practice based commissioning (PBC) and primary care trust work. This, together with an increasingly part-time workforce and changes in out-of-hours arrangements, have put a strain on the ability of many GPs to provide personal and continuous care.

The modernisation of general practice has proceeded with only a modest increase in GPs. The average annual increase over the past twenty years has been around 0.8 per cent. Over the same period consultant numbers increased at *seven times* the rate of GPs. For those at the frontline of primary care, it has often seemed the case of trying to fit a quart into a pint pot – too often the work moves to primary care but the resources stay in secondary care. The current programme of change will address this but also provide new challenges for smaller practices.

The change agenda

With foundation trusts and payment by results (PBR), there is now a mechanism for resourcing increased work in primary care and a vastly expanded role for GPs in commissioning improved/new services, monitoring the use of secondary care services and rationalising the use of referrals and diagnostics. Within primary care, choice and contestability will challenge traditional general practice especially when it is unable and unwilling to provide services required by the PCT commissioner; where their services are poor or inaccessible; or where patients simply prefer an alternative provider for those services. The current policy focus on long-term conditions will see a huge expansion of work into primary care. GPs need to decide if they want to grasp a lead role in both local provision and commissioning.

Changing primary care

Primary care teams will continue to enlarge to meet this increasing workload (e.g. with the introduction of modern matrons). There will be an expansion of local diagnostic facilities such as ultrasound, and intermediate treatment such as locality clinics available to GP generalists. The traditional GMS practice, especially in areas where patients find it difficult to register, will give way to a range of

different kinds of generalist provider – PMS, APMS and SPMS. The devolution of directly-provided PCT services over the next two years will offer major opportunities and challenges.

Changing practices

The survival of any given general practice, or indeed general practice as a whole, will depend upon meeting the needs of the population. This will include squaring the circle of providing fast access for those who need and want it and future access by appointment, where patients can see their doctor without facing a lengthy wait. Practices may have to make themselves more available with the likely return of Saturday morning and late evening surgeries. Smaller practices will be challenged by larger ones, who can offer more services under one roof. Increasingly practices will be judged not only for what they can provide in-house but also for the services that they are able to commission for their patients. Patient participation groups for individual practices and/or practices working and commissioning together will become the norm to ensure that practices are providing and commissioning what their patients want.

Changing practitioners

The trend towards an increasing number of GPs working part-time is likely to continue as will the increasing availability of leadership roles outside the consultation room (particularly in PBC). Post-Shipman, quality control will be ever tighter through appraisal, revalidation and other means. Work-life balance will continue to be an issue as will whether general practice is a vocation or simply a job. Research showing that those in control of their destiny are healthier and that achieving perfect work/life balance may not lead to better care [CHECK *Michael – can you reference from our telephone call?*] may encourage GPs to take on currently available leadership roles, which may not be on offer for ever.

Changing people/patients

Patients want their doctor now – the question is whether 'now' or 'their doctor' matters most. There is little to suggest that either informational or management

continuity can replace personal continuity, however good the IT system, although where a GP works closely with an individual practice nurse or partner GP, there can be an element of 'team continuity'. IT and the electronic medical record will contain only cold information, not knowledge of the person and their therapeutic needs and history. As patients continue to become more demanding, wise practices will involve their patients in making decisions about provision and commissioning. Patients will also be involved in roles such as personal and community health improvement, communication, extending self-help, raising money and so on. Ideally, then, the future shape of each local practices should be decided by its own population, which will lead to very different models in different areas.

The solution

The modernised NHS has many implications for small practices. None of this need challenge their existence or ethos but isolation is not an option. The survival of the small practice depends upon developing relationships with other local practices in a number of areas.

Working together

Not every practice will have the capacity for PBC, in terms of clinician or manager time or skills. Some practices may have resources and skills in particular clinical areas, which could reduce the need for secondary care for both their patients and the patients of other practices. As practice-based commissioners and the providers of a wide range of services, small practices can only lead, coordinate and deliver improved local health and services by forming alliances.

Sharing resources

Practices will face an increasing demand for skilled people to deliver the modernised NHS such as strategic managers, IT support and specialist nurses in long term conditions. Small practices will only be able to afford these by sharing with each other.

Learning together

Issues of clinical governance, accountability and quality control will lead to closer working between smaller practices as a means of both reducing and sharing clinical risk.

Planning together

Practices are poised to take on a much stronger leadership role than ever before. This might go beyond commissioning services to taking on a much fuller role in the development of local health in partnership with local authorities. This might include:

- communication of health news and messages
- contact with the media
- encouraging/kitemarking health initiatives in local public or private services
- a much stronger working relationship with social services.

Such work might seem anathema to some GPs and small practices. But planning collectively in this way, with one or two interested managers and clinicians, will give each small practice far greater potential to improve local health and services for their community.

Contestability and choice

Closer relationships between practices will lead to pooling of resources and budgets. These practice associations will offer more comprehensive care. This should offer the patient a wider choice of practitioners and treatment closer to home. While greater partnership offers greater choice in this sense, there is a danger of a lack of contestability, when practices within a PBC scheme have a virtual monopoly on commissioning/providing services for their population. Safeguards against complacency (both in providing and commissioning roles) will be provided by the patient forum for such an association, by the PCT and PEC, who will need to assure themselves that other providers could not do better, and

by peer pressure between practitioners and practices, who will not want to be tarred with the brush of under performance. Nevertheless, the individual patient will need redress through contestability within such a system. They will still have two options. If discontented with the provider role of their GP, they can leave and register with another within the association. If unhappy with the services commissioned or provided overall by the association of practices then they might want to register with a practice within a different association. This would not present problems for patients who lived on the geographical borders of such a practice association. The defection of a few might well encourage the providers/commissioners to do better.

If many patients at the centre of such a geographically-based patient association were to change associations then there would be the problem of whether there was a one-to-one relation between the association and its geographical area in terms of being able to fulfil its health commitment to the overall population. It depends whether the health of the local population or contestability in terms of health services provided are the priority. There would be a case for saying that patients within a practice association could move between practices but individual patients could not move between practice associations. The whole association or PBC scheme would also have the option to join a geographical neighbour if patients (and to some extent practitioners and practices) felt this was desirable. Research suggests that competition between commissioners is more likely to improve standards than competition between providers, where gaming may not benefit the patient.

Chapter 3: The Future of Small Practices

Relational continuity is easier to deliver in small units, breadth of services in large. Relational continuity in primary care is most fully developed in small practices. These small practices are the barometers of the NHS, indicating the health of relational continuity, or the therapeutic alliance, within primary care. So how will small practices fit into the future NHS structure, delivering more services while maintaining this continuity?

Challenges to relational continuity

There is an important distinction between the erosion and the dilution of relational continuity.

If increased services within primary care reduce the frequency and/or detract from the quality of a relationship between a GP and a patient, that is erosion. If increased services do not reduce or detract from that relationship that is dilution.

If a patient sees his or her GP four times a year and this frequency is reduced by a new service that is erosion. The delegation by GPs of out-of-hours responsibility marginally erodes relational continuity. Pooling lists of patients very significantly erodes relational continuity.

If the introduction of a new service has no impact on the frequency or quality of contact that is dilution. NHS Direct and Walk-in Centres dilute relational continuity.

Erosion harms relational continuity – dilution does not.

The new NHS structures

The forthcoming White Paper will be focussed on primary care but some aspects of future policy can already be assumed.

- There is no DH agenda to eradicate single-handed and small practices. Individual PCTs may have such an agenda.[39]
- Primary care will become increasingly complex, as will secondary care.
- Change will accelerate so learning is at a premium.
- Cost efficiency and value for money will remain an important component of quality.
- Patient choice will be bolstered in the attempt to improve quality of health care.
- Payment by results should help to move work from secondary to primary cares.
- PBC will shape primary, intermediate, and secondary care.
- There will be closer liaison between health and social services.

The spectrum of illness is changing. Co-morbidity, mental ill-health, genetics and the impact of social change are the most pressing factors. Accordingly adaptability will be at a premium. There is some suggestion that small teams can adapt quicker than large ones.

The stakeholders

1. The Department of Health

Though the White Paper is not yet written there are known major determinants of the direction of travel.

- Patient choice will be a driver of quality improvement.
- There will need to be alternative providers, including private providers, in all areas of service delivery.
- General practice will be just one way that citizens can satisfy their health needs.
- Resources will continue to increase markedly until 2008.
- More of secondary care will be delivered in a primary care setting as this is both more convenient to patients and cost effective.
- There will be national tariffs for most elective and emergency secondary care procedures and, in time, for services provided to primary care.

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[39] Contained in the submission to the Shipman Inquiry by Sir Nigel Crisp, NHS Chief Executive, 2004

- There will remain pressure to make services accessible and convenient.
- There will be greater co-operation and co-ordination between health and social service provision.
- There will be a comprehensive system of IT linking all areas of the NHS and able to deliver the patient record to any NHS site.
- It is intended that PBC should become universal during 2006.
- PCT provider functions will be devolved.

2. The patient

It has proven very difficult for patients to become involved in discussion about the way services are provided to them because involvement was sought in making technical decisions, often at strategic level, rather than those of direct concern to patients. The patients' representative was either in a position of relative ignorance or was unrepresentative of citizens as a body.

With patients' new ability to make choices around their individual health needs, patterns of use and need will be easier to recognise. Data collection at practice and or at PCT level will enable these patterns to be used to shape services. When this data is fed back to patients they in turn will choose in a more informed and rational way. A full turn of this virtuous cycle of knowledge could take as little as two years. Patient choice may then prove to be an uncomfortable driver. Some friction or dynamic tension between commissioners, contractors and providers is inevitable and surely welcome.

The increasing use of questionnaires will give a whole new dimension to audit. Those areas of quality where patients are competent to judge will become increasing clear. This will ultimately involve the entire health care system.

The voices of communities, whether in villages or in cities, will be heard as never before. Politicians and the media locally will add an important health dimension to their work, informed by knowledge from the feedback information. Such community movers and shakers will then also be able to help in the delivery of health promotion and illness prevention.

3. The clinician and manager

Clinicians and managers will have to focus on a shared agenda if PBC is to act as one of the keys that unlocks the potential of the NHS as a great public service.

Clinicians in primary care are the group with the best understanding of patients' desires and needs. This knowledge will increase and be made both more certain and more available by the feedback from patients.

GPs in particular will have the new role of navigator, in helping individual patients make their individual choices. From the changing sum of these choices clinicians and managers will be able to adapt current services to present need. Later we can prepare for future need, rather than contract for services to meet needs that are already several years out of date. Research suggests that most patients want to make their choices in discussion with their preferred GP.

Management skills will be challenged in reshaping service delivery, as this will include disinvestment, traditionally difficult and neglected.

The trust that patients invest in their GPs will be given greater currency as, together with managers; they shape those community services that deliver community health protection and health promotion.

The Vision – Squaring the Circle

Different communities will have different health needs. Different groups of providers will find different answers to similar problems. What will be shared is the same commitment to quality and the same central concepts of clinical governance.

There is however a trend to move towards larger units. This must be recognised by smaller practices. It is driven by the imperative of increasing the range of services in one location and the need to garner the more obvious structural cost efficiencies of larger size. There will be a series of adaptations by small practices

to the new world. The extreme ends of the new spectrum of small practice will be the nested small practice and the virtual super-surgery. All practices along the spectrum will offer the small practice benefit of personalised, continuous medical care together with the new services of the modernised NHS.

Model A: The nested small practice

This concept is of small practices based within a purpose-built primary care centre (which could be described as a super-surgery).

Such a centre could be funded in a variety of ways from LIFT to PFI or self-funded. Premises development will clearly take time.

At the most fully developed stage, the centre could house all primary care services, secondary care practitioners, walk in centres, NHS Direct and unscheduled care, as well as social services. There could even be complementary health services and private providers even such as hairdressers or beauticians.

Patients would still be registered with their individual GPs (if single-handed) and identify with them and their teams. More detail is available in Appendix A.

Model B: The small practice virtual super-surgery

At the other end of the spectrum lies the linked small practice or virtual super-surgery. This will be based on the hub and spoke model.

Here small practices will remain in their present location. Some will also take on extra roles (GUM clinic, substance abuse disorder services, respiratory clinic etc.) depending upon the skills and desires of the individual practitioners and their staff. Consideration will of course be given to the facilities available. Managers will be sympathetic to the use of efficiency savings to develop premises for some additional use unless this detracts significantly from the strategic plan.

Small practices will act within a confederation covering a geographical area. This need not preclude practices of larger size. Such confederations will pool skills and

facilities so that patients within that confederation can be offered those additional services either within different practices or at a central diagnostic and treatment centre (DTC). More detail on this model is given in Appendix B.

Conclusion

In reality, small practice virtual super surgeries will fall somewhere on a spectrum between the two models above, depending upon available local premises, local expertise, culture, history and the views of local patients and professionals. The hub and spoke model of local DTCs attached to small practices many be easiest to coordinate, while the concept of practices acting as collective using only current practice premises (albeit extended and developed) will require considerable expertise in terms of planning and developing working partnerships. The principle, whatever system is adopted, will be to work towards some of the aspirations illustrated in Model A but without everyone needing to be housed in a central, purpose-built primary care centre.

Whatever model evolves locally will be an organic development from patient choice. Patients individually will decide which practice they want to register with (whether small or large). Collectively, within practice patient groups, they will help clinicians decide what range of services and choice need to be offered within the nest of practice groups or virtual super surgery. Where individual patients or practices are unhappy with the commissioning arrangements of such a practice association then they may choose to join a neighbouring association. Where such friction does not lead to improvement within a given association, this will lead to a crisis. This could result in a neighbouring association taking on the commissioning role of the failing association. The fact that this might happen should create sufficient contestability within the system to avoid proficient provider or commissioner complacency. The dissolution of nested or virtual super-surgeries should be a rarity.

Appendix A

Model A: The nested small practice in detail

The purpose-built, small practice super-surgery will attract practices within a given area to work under one roof, offering a wide variety of services to all local patients including treatment closer to home. It will act as a one-stop shop. Sometimes these super-surgeries will be part of a community hospital or adapt a former community hospital building. Services provided on site might include:

- Traditional hospital outpatient services – providing locality clinics staffed by primary care professionals with a special interest and specialists. Much of the current secondary care workload could be transferred to the new super-surgery.

- Diagnostic facilities such as x-ray, ultrasound and MRI scans, either on-site or with regular visits from a mobile unit.

- All traditional primary care services such as midwifery, health visiting, district nursing, physiotherapy and chiropody

- New services such as re-ablement teams and modern matrons.

- Social services – allowing integration between health and social care.

- Immediate access services - such as walk in clinics, NHS Direct and out-of-hours services, which may be staffed and coordinated by the small practices collectively themselves or form part of a parallel service.

- Coordinated voluntary services.

- Complementary and other health related services.

- A single patient participation group. This would direct internal services and commissioning decisions.

There would be an element of parallel access to other primary care practitioners (chronic disease nurses/nurse practitioners/physiotherapists) but the principle of primary care referring to secondary care would remain even if secondary care were to be housed in the same building.

The small practice ethos would be nested within a unified management structure, which can plan, commission, lead, manage and staff many of the initiatives within such a centre This structure would ensure good strategic management. In some localities, small practices might choose simply to co-exist as discrete entities within such a complex; in others they may act as a strongly integrated collective.

Practices would work within a combined PBC scheme designed to ensure that more services were provided within primary care. Other clinicians including those from secondary care could well be sub-contracted or employed when and where appropriate.

Secondary care work carried out by GPs would be additional to, not instead of, their core work as a holistic family doctor, who can act as independent advocate and commissioner for both the individual patient and for the whole population.

The single patient participation group would liaise with the local politicians and the media, and might fundraise for disadvantaged groups. Patient advocacy and navigation functions could also be included. These patient groups would be encouraged to be responsible for gathering and organising the data from the variety of patient contacts with the health and social services, as PCTs and GPs will have potential conflicts of interest.

Those aspects of services that do not require personal care (e.g. monitoring of blood pressure/diabetes) could be carried out by the patient group, relying on clear information and targets, monitoring themselves and seeing practitioners only when things are going wrong. Properly organised this would leave individual GPs with more time to provide a personal relationship for those individuals and groups that value it most.

Advantages

- All services under one roof – one stop shop.
- Easier for practices to share resources – e.g. waiting room/staff/management
- Greater opportunities for professional/educational interaction and the coordination of plans and health services.

Disadvantages

- Surgery is further from the patient's home and may be more difficult to access.
- Collective working in a large building may make the provision of personal and continuity of care more difficult.
- The widespread development of such premises will require money and time.

Appendix B

Model B: The Small Practice virtual Super-surgery

The small practice virtual super-surgery recognises many of the advantages of model A, while accepting that practices will remain geographically dispersed among the community.

There are two possible models at either end of the spectrum

1. Individual small practices continue exactly as they are with a central locality diagnostic and treatment centre fulfilling all the other functions listed in Model A. In many cases the DTC will act as the hub of collegiate activity, and as the base for the patient participation group described in model A. The DTC will afford better diagnostic access and clinical interfaces for traditional outpatient services, GPwSIs, nurses and allied health professionals. The centre will act as a beacon for local health activities, some offered on-site, some kite-marked out in the community settings. The DTC will also be a meeting place for the PBC organisation and shared educational activity and can provide opportunities for structural economies of scale.

2. All the services listed in Model A are dispersed among the surgeries themselves. The largest surgery (possibly attached to a community hospital) might offer many of the services in Model A, while other surgeries might take on some aspects of the model. One surgery could have nurses providing chronic disease management, another offering premises for consultants and primary care practitioners with a special interest and a third offering complementary health services.

Whether there is central DTC, either purpose-built or based within a cottage hospital, or whether these various facilities are attached to individual surgeries within the collaborative, will all depend upon local geography and resources.

Advantages

- Small practices remain visibly small and close to the patients.
- Most of the aspirations of the super-surgery can be met in terms of patients getting diagnosis and treatment provided locally.
- Practices will have to work hard to make a virtual super-surgery effective and this could lead to better mutual understanding, support and joint working than within usual joint premises where these things are taken for granted.

Disadvantages

- It will be more difficult to practice one-stop shop medicine as patients may need to access services at the individual small practice, another practice offering added services or the locality diagnostic and treatment centre.
- Adapting the working patterns and premises of a large number of practices is likely to be more complex and challenging than when all services and practices are housed within one building.
- Some practices are bound to offer more added facilities than others, which may make them more attractive to patients previously registered with other surgeries, when they come into contact with them.

The small practice virtual super-surgery is a compromise between competition between practices wanting individual patients to register with them and cooperation between practices aiming to maximise the services provided locally. It is an organic experiment designed to see what patients and the market really want. If patients start registering with practices that have more facilities and deregister from those that don't, then the system will naturally converge towards Model A. In some cases, this may lead to just one large practice rather than several small practices. The large practice will need to look at how it can preserve the small practice ethos of personal care and continuity, where patients can still identify with particular GPs and members of staff.

Alternatively, the concept of a small practice virtual super-surgery may prove to be sustainable, where patients want to continue to be registered with their current practice and also want to access other services either centrally within the locality or from other practices. If and where this happens, then the small practice virtual super-surgery may prove to be the best balance between

providing local leadership and coordination of a comprehensive range of services, while maintaining the individual and personal services currently provided by small practices. Patients and, to some extent, the market will determine the model that is right for their particular locality and this is likely to vary from place to place.