DOCTORS IN UNITE
PRIMARY CARE AND PUBLIC HEALTH VISION FOR REVITALISING PRIMARY CARE
A CHARTER FOR GENERAL PRACTICE

INTRODUCTION

This paper calls upon those who plan the National Health Service to recognise that unless we revitalise primary care and make it the centrepiece of the NHS, with General Practice as a fundamental part, we will fail to get the maximum benefit from our investment in the NHS. We call upon professional organisations, the public, and Trade Unions in particular, to campaign for the achievement of our Vision.

We approach the problem through an understanding of the social causes of ill health and the many players involved in primary care delivery.

Delivering health care is more than a series of tasks that can be marketed as though they were commodities. It requires relationships, and the possibility of continuity of care.

We believe it is possible to restructure the work of General Practice so that it can provide a system that meets people's health needs, reduces health inequalities, improves health outcomes and gives a satisfying working life to all those who work in the Primary Care Team, including General Practitioners.

It will be impossible to implement our vision with the current government's funding arrangements and attitude to privatisation.

EXECUTIVE SUMMARY

General practice workload is unsustainable. General practice is at a tipping point into irreversible decline, fuelled by an ever-increasing workload falling on fewer and fewer shoulders and with a shrinking proportion of funding going to general practice. There needs to be a radical programme of supported change to prevent demise.

A robust primary care system where the staff, including doctors, work as public servants for a public service is the foundation around which the NHS will be structured. Our emphasis in this Document is on the work of General Practitioners, since we are Doctors in Unite. However, other members of the primary health care team are no less integral to the delivery of high-quality general practice care.

The following problems require solutions most urgently. Morale, recruitment, and retention are at a historic low. There is inadequate funding for General Practice and Primary Care and conditions of work are poor, including poorly organised IT. We are losing continuity of care. There is an inadequate focus on Public Health, Health Creation and the social determinants of health.

A new GP Charter has to be part of wider change. Health and tackling health inequalities must be recognised as prime goals of government. There must be a new national care, support and independent living service free at the point of use, available to all in the United Kingdom. There must be a new national occupational health service. Community-based health research will need to be supported.

Spending on health and social care should increase considerably, with spending on Public Health, primary care and social care increasing by a greater proportion than spending on hospital services. Resource allocation must be such as to counter the Inverse Care Law, with extra resources going initially where there is greatest need.

Community Development and Health Creation must become business as usual across the NHS and Local Authorities. Health Creation is the process through which individuals and communities gain a sense of purpose, hope, mastery and control over their own lives and immediate environment; when this happens their health and wellbeing is enhanced. As Michael Marmot explains, it is key to tackling health inequalities. GPs will work with communities and share power with them.

Hospitals will need to support primary care with outreach and other mechanisms. They will need to deepen their links with the communities and the Local Authorities they serve, listening and responding to the needs of their local communities.

Local Authorities will work more closely with primary care, jointly setting the scene with communities and creating the conditions for community-strengthening.

We suggest adopting a 'Structure of Neighbourhood health communities' approach, (NHC) focussing on delivering for 25000 - 75000 population. The evolution to these structures would vary between the four nations with minimal organisational disruption. Within the NHCs there would be smaller practices covering up to 10,000 people that would include access to the wide "primary care" team around the patient. The NHCs would be directed by health professionals, community representatives and by local authority elected representatives. Community Development workers will also be employed, probably jointly funded and managed by the NHS and Local Authorities.

NHCs would be supported by district and regional level bodies covering populations from 250,000 upwards. These larger bodies would commission and oversee the provision of hospital-based services or less commonly needed services. These bodies would be accountable to representatives from the local authorities and NHCs within its footprint.

The contracts of primary health care staff would be held at Neighbourhood or District level. Line management would usually operate at either the practice or NHC level as appropriate. GPs' line managers will be clinicians or colleagues with significant experience of primary care, respectful of professional and public service values.

Premises will be rationalised, sometimes with the building of new community hubs. Services will be organised within wheelchair pushing distance as much as possible in urban areas.

There must be both a salaried and independent contractor option, but we must work towards a system where GPs will positively choose the salaried option. In the current commercialised and centralised NHS, we see the need to retain an independent contractor option and no longer

advocate universal salaried contracts, except in a future where the NHS has been reinstated as a fully publicly provided services or where circumstances make it work acceptably locally.

GPs will act within a team and a community. GPs do not have to lead the team they are part of. GPs will need to work closely with Local Authorities and Community Development workers and with members of the community itself. They will jointly be listening and responding to local people and contributing to the planning of local services.

Continuity of care will be supported and incentivised. The evidence for its benefits is strong. [i] [ii] [iii]

Improving GPs' working conditions is the key to better recruitment and retention. Making a GP's job desirable again, with career progression and an agreed finite working day, will help retain the current workforce. Expanding the primary care team, reducing the average practice size and increasing appropriate self-referral pathways will enable better use of GP consultation time. List sizes need, over time, to come down to 1,200 per whole time equivalent GP.

Mitigation of the effects of The Inverse Care Law We need to reverse the current situation in which there is an inverse relationship between access to quality clinical time and the need for it. We don't want equality of provision nor redistribution of existing workforce – we need equitable provision in line with need. Starting in areas with low life expectancy, we would prioritise those areas, building supportive networks and relationships, making the work more attractive.

Public Health will be comprehensively improved. There will be comprehensive analysis of population data obtained through the NHS within a legislative framework that generates trust and confidence and data sharing regulations that need to be practised and trusted. Population data should not be available for commercial exploitation. There should be neighbourhood Public Health leads with a joint primary care and Public Health background.

There will be individualised GP Job Plans, averaged over time, and determined by the needs of the Neighbourhood Health Community. The content and number of sessions will vary along the GP career path. Contracts will be available to Independent Contractors and those salaried to NHS bodies. GP contracts will be established that are attractive enough to mean that independent contractors increasingly choose to take them in preference to keeping independent contractor status. APMS Contracts will be abolished

The NHS will offer to purchase, at a fair price, or take an equity share in, the premises and equipment of practices who no longer wish to take on the burden of managing them or pay a fair rental for those that wish to remain owners, until their retirement from practice.

GP Remuneration will be at nationally agreed rates, following benchmarking principles, and including high quality pension provision that does not disincentivise GPs in their later career.

Training for the speciality of General Practice will be extended to 5 years, will include Public Health training and be adequate to take on independent practice. Some training will be shared with hospital speciality trainees and other primary care professionals.

Quality measures will relate to population health changes over at least 10 years. There will be professional monitoring/appraisal that will link with Public Health, patient experience and outcomes, professional compatibility and value for money. This will be professionally led and take place via the NHC and be accountable to them. Performance indicators that undermine good clinical practice and the building of clinical relationships will be rejected.

Terms and Conditions. GPs will not be responsible for employing other members of the primary health care team. GPs will have freedom of speech as advocates for their patients. GPs will have registered lists where continuity of care is enabled. GPs will work within a comprehensive primary care team.

Remote access consultations. GPs will have access to high quality, fit for purpose, well maintained IT systems to enable most appropriate use of face to face or remote consultations. Digital exclusion will be addressed to prevent a growing area of health inequality.

Data collection. Enhanced IT systems will enable the extensive use of data for clinical care, research and population health analysis whilst requiring specific consent for any commercial use, protecting the confidentiality of individual patient information, and maintaining security of data whilst it is in identifiable form.

Quality of General Practice care. The inequalities between the less good and the excellent need to be reduced by particularly improving the less good, whilst enabling the excellent to continue developing. The ability to provide continuity of care should be a significant part of how quality is judged. Patients must be assured of timely, adequate access to the health or care worker most appropriate to their need. Triage must facilitate this rather than being a barrier.

Funding. Our proposals will involve UK expenditure of about an extra £20bn per annum (2021 prices) in primary care revenue funding and a significant once off capital investment. This does not include the additional funding also required in social care.

A change of direction. Our vision requires movement away from policies of public sector cuts and preferential investment in the private sector. It will stop the expansion of a two tier service and give the population of all four nations of the UK the healthcare that they need.

PREAMBLE
The health service needs more money, but money alone is not enough. The World Health Organisation in the 1978 Alma-Ata Declaration (redeveloped as the Astana Declaration) sees health in terms of a whole individual, within a whole community. This vision cannot be delivered in a system that relies on commercialisation and fragmentation.

This document will state:

- the problems that need to be addressed,
- the prerequisites that must be fulfilled to achieve the vision for a future in which there is Health Creation not simply disease management,
- a description of this vision,
- a Charter specifically for General Practitioners of the future
- an action plan of how to proceed.
- appendices with further background thinking

CURRENT PROBLEMS WHICH OUR ACTION PLAN WILL ADDRESS
Excessive workload
This has become the key problem for general practice and primary care more widely. The causes are well known. The NHS requires a rolling, longer term workforce development programme without which no progress can be made. By increasing the number of GPs, by creating a community-centred approach, by reducing list sizes and by making working in a practice easier and more productive with better relationships, general practice will become more attractive and workloads will reduce.

Morale, recruitment, and retention at a historic low.
This is not related entirely to pay, but also to the profession losing its way, unsure what its role is, where it sits within the overall health and social care architecture and a fragmented workforce unable to meet demand. Patients are suffering as they struggle to get the care they need at the time they need it.
Qualified GPs are not being retained. Qualified GPs are not committing to permanent posts. The job satisfaction has reduced as there is so much that could potentially be done, but so little resource available. It has become much harder to achieve continuity of care even when that is considered to add value.

Inadequate funding for General Practice and Primary Care
The proportion of NHS funding going to GP is falling. There are too few GPs to manage the workload. The Inverse Care Law still operates, with particular problems in deprived areas including rural and coastal communities.

There is variability of provision of services between practices that is not based on any population or need differences.

Loss of continuity of care.
Continuity of care is good for practitioners, people and the Exchequer. With the loss of incentives to become a GP partner and the desire (by most citizens) for more flexible working, the current, more peripatetic, workforce is losing the continuous relationship with their patients and their practice – both features underpinning general practice.

Poor conditions of work.
Linked with loss of continuity, general practice has become more industrialised and transactional. Some of the key issues include:

- Contractual arrangements are unattractive to GPs

- Intolerable and unhealthy workload
- Imbalance between workload and resource
- Significant work done by GPs is effectively unremunerated
- GPs do not all wish to have employment responsibilities for other staff
- GPs do not all wish to have commitment to premises provision
- Current salaried options are inequitable
- Care shifting – hospitals placing increasing burdens on practices with no shifting of resources, including training and support.

An inadequate focus on Public Health, Health Creation and the social determinants of health
Health inequalities are not adequately addressed by the current systems.
There is too much victim blaming and inadequate action on the social causes of ill health
Public Health has been greatly weakened by cuts including cuts of resourcing given to local government.
There is a lack of comprehensive social care provision
There is a lack of democratic accountability

Poorly organised health IT
Although UK primary care is probably the most advanced primary care IT arrangement in the world, current provision still doesn't serve the needs of patients nor staff. There are:

- Minimal links to community provision including social care.
- Minimal links between hospital and primary care IT systems
- Inadequate standards and system guidance to ensure maximal coordination and effective use of integration
- Problems of data management between Public Health, Local Authorities and the NHS
- Inadequate harnessing of community assets via IT.
- Digital exclusion and lack of strategy around digital exclusion
- Inadequate broadband roll out nationally, particularly in rural areas

THE PREREQUISITES FOR A GP CHARTER

These are things beyond primary care that need to happen to make a primary care transformation work. A Charter has to be part of a holistic, bigger picture.

- Health must be recognised as a prime goal of government and there should be an understanding of the economic impact of a healthier population, especially a healthier senior population. The NHS must be reinstated as a publicly funded, publicly provided and comprehensive service, free at the point of use, available to all in the United Kingdom. The dangers of privatisation, where profit motives distort health care priorities and effectiveness must be understood.
- There must be a new national care, support and independent living service free at the point of use, available to all in the United Kingdom
- There must be a new national occupational health service (Appendix 3)
- Spending on health and social care should increase considerably, with allocations to Public Health, primary care and social care increasing by a greater proportion than spending on hospital services.
- Resource allocation must be such as to counter the Inverse Care Law[iv], which states "The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced". We need extra

resources going to areas of highest need and a planned service to mitigate the distorting effects of market forces. New resources should be focussed on areas with the lowest healthy life expectancy.

- Community Development and Health Creation must become business as usual across the NHS and Local Authorities.
- Hospitals need to:
    - support primary care with outreach and other mechanisms
    - deepen their links with the communities and the Local Authorities they serve, listening and responding to the needs of their local communities
- Local Authorities need to work more closely with primary care, jointly setting the scene with communities and creating the conditions for community-strengthening.
- Community-based health research must be supported

DIU'S VISION FOR PRIMARY CARE AND GENERAL PRACTICE

A manageable workload is the most basic requirement. All the other initiatives below contribute to that.

A **robust primary care system** where the staff, including doctors, work as public servants for a public service is the foundation around which the NHS will be structured. This is in keeping with the Astana Declaration of 2018 (Global Conference on Primary Health Care). Attaining the highest possible level of health is a crucial social goal, and this requires a comprehensive multidisciplinary team of skilled and adequately remunerated primary care workers. Training and career progression pathways will be available to all workers.

The infrastructure of Health Creation will be assembled. Health Creation is the process through which individuals and communities gain a sense of purpose, hope, mastery and control over their own lives and immediate environment; when this happens their health and wellbeing is enhanced. As Michael Marmot explains, strong communities can more easily tackle health inequalities, can improve health outcomes and help the statutory sector become more responsive.

GPs will work with communities and share power with them on the understanding that communities taking control improves health and helps tackle health inequalities. Health Creation and Community Development will play a significant role in making this happen. (Appendix 5)

The social determinants of ill health will be a government priority. Poverty, poor housing, poor air quality, poor environment, loneliness, work related ill health, poor diet, inadequate or unaffordable leisure, exercise, cultural and recreational opportunities, attention to spiritual needs, poor public transport and climate destruction will all be addressed. Primary care will have more levers to address these issues.

Support and supervision for GPs will be routine, as it is for many other professions. We all need support and insight to develop our roles and skills and to understand more clearly what we do and the impact we have.

Hospitals and specialist care will be deployed in support of primary care and will be organised at a scale appropriate to local needs. The primary care system will drive planning, management and allocation of resources, and will be accountable to its population. Its management will be adequately resourced. Primary care is the centrepiece of the NHS. Deficiencies in primary care inevitably lead to an increased demand on hospital services, whereas the improvements we propose will enable better use of such services.

Continuity of care
It is now well-established that continuity of care improves health outcomes at reduced cost. The transactional approach of most current general practice where the priority often seems to be to get through as many consultations as possible, regardless of who sees the patient, is at odds with continuity. We include horizontal continuity across the range of professional inputs as well as longitudinal continuing over the timespan of care provision

Structure
Neighbourhood health communities (NHC) will be developed for 25000 - 75000 population corresponding to natural communities. They would host the wide "primary care" team around the patient (including nurses, general practitioners, musculoskeletal therapists, physiotherapists, psychotherapists, community psychiatric nurses, family therapists, psychologists, occupational therapists, health visitors, midwives, elderly care nurses, pharmacists, dietitians, volunteer coordinators, optometrists, podiatrists, immunisers, school nurses, health care assistants, addiction workers, hospital specialists trained in community practice, social care workers, advice and advocacy workers, sexual health workers, dentists). This will not be about, as now, substituting less-comprehensively trained staff for GPs, but responding to the truth that good primary health care depends upon a range of skilled workers that must include GPs, but also many others.

Community Development workers will also be employed, probably jointly funded and managed by the NHS and Local Authorities.

Health professionals and community representatives would be joined by Local Authority elected representatives who would be integral to the governance of the neighbourhood primary health care system.

NHCs would be supported by district and regional level bodies covering populations from 250,000 upwards. These would commission and oversee the provision of hospital-based services or less commonly needed services. These bodies would be accountable to representatives from the local authorities and NHCs within its footprint.

The contracts of primary health care staff would be held at district or neighbourhood level but line management responsibilities would usually operate at either the practice or NHC level as appropriate

There would be smaller units (Practices) within the neighbourhood of the order of 5000 to 10,000 registered patients

Out of hours services would be developed at the level of the NHC, using the local knowledge of senior clinicians to deliver care most effectively.

Premises will be rationalised, sometimes with the building of new community hubs.

Services will be organised within wheelchair/pushchair pushing distance as much as possible in urban areas.

The contractual status of GPs
The innovation and commitment that the Independent Contractor model has, at its best, allowed to flourish are not dependent on the contractual model, but upon the organisational culture. Well-constructed job plans for GPs, designed around the needs of the Neighbourhood Communities, will ensure the headspace for creativity, and will enable this to be spread throughout all areas, with the associated benefits.

There must be both a salaried and independent contractor option, but we must work towards a system where GPs will want to choose the salaried option.

We also need remuneration to reflect the development of a GP's skills over time.

There are a growing number of directly managed practices where GPs are employees. Some have shown that an employment relationship can be compatible with proper professionalism. Others, to be blunt, have not and have merely reinforced the worst fears that GPs have traditionally had about remote, insensitive management. We have no wish to be employed by the private sector. Doctors in UNITE has always believed in a salaried contract. But first these doubts must be addressed and to ensure this there must be the option of a contract for services. In the current commercialised and centralised NHS, we no longer advocate universal salaried contracts, except in a future where the NHS has been reinstated as a fully publicly provided services or where circumstances make it work acceptably locally.

GPs within a team and a community
GPs do not have to be the team leaders.
GPs will need to work closely with Local Authorities and Community Development workers and with members of the community itself. They will be listening and responding to local people and contributing to the planning of local services.
The work done by GPs will vary at different stages of their careers

Continuity of care
Personal continuity of care is not essential for all consultations, especially when there is sufficient time and skill to establish a good relationship of trust in one consultation.
However, in many cases, continuity of care enables health outcomes at an individual level which would otherwise be impossible. The organisation of general practice must allow this to happen. This is why it must be organised around a specific population. Tools should be made available for practices to help them measure the continuity that they provide. New initiatives should always be judged for their potential impact on the scope of provision of continuity.

Access
There is not an infinite need for consultations. The biggest problem with access currently is the shortage of available workforce which deprives patients of timely quality access to the care most appropriate to their needs. The NHS needs more GPs. A new GP Charter will only help to the extent that it attracts more GPs who are adequately funded to do the necessary work. Making a GP's job desirable again, with career progression and an agreed finite working day, will help retain the current workforce and attract new recruits. Expanding the primary care team, community resources and appropriate self-referral pathways will make the most of GP consultation time. List size reduction is a key to improving access. Reducing the number of patients each GP has responsibility for will allow increased time for the consultation, with the potential to deal with problems more effectively. The GP fulfils a unique function in the primary care team, with particular skills in dealing

with undifferentiated problems and combinations of problems, and helping people decide on their own health care priorities.

Continued use and refinement of remote consultations (email, telephone, video) will enable choice of the most appropriate consultation medium but this will only help address inequalities if digital exclusion is addressed through maintaining alternative access pathways and providing staff to help with digital access.

Triage systems must not be designed as barriers to care, or as a means to stop people seeking advice. They should be the means by which patients are guided and facilitated to reach the most appropriate care provider or pathway. Triage systems need to be operable on a face-to-face basis as well as by telephone or digital means.

Data/Artificial Intelligence (AI) (see also Appendix 6)
The analysis of population data is important for a data led publicly owned, needs led prevention oriented national health system.

The NHS needs to develop a strategic vision about how AI is incorporated into GP systems to make constructive use of the opportunities to improve care.

Comprehensive data sharing regulations need to be adhered to and trusted. Population data obtained through the NHS should be available for research and analysis, but not available for commercial exploitation.

Public Health and joint primary care and Public Health leads (see also Appendix 2)
Our separate paper “Public Health and Primary Care" (see https//:doctorsinunite.com) envisages General Practice linked in to other vital support services to promote the health of our population and move towards the aim of the Alma Ata Declaration.

There should be neighbourhood Public Health leads with a joint primary care and Public Health background in each Neighbourhood Health Community.

Community Development (see also Appendix 4)
General practice must be firmly rooted in its communities, committed to understanding them and the diverse people who live in them, and supporting them in pursuing their own health. It is also potentially a significant local employer.

Community Development strengthens social networks; weak social networks are one of the major adverse determinants of health. It facilitates local community organisations to strengthen community spirit, provide mutual help and allow communities collectively to address the determinants of their health and articulate their needs.

Ultimately, there should be Community Development workers, with a budget for supporting community activity, in all neighbourhoods but they should first be deployed within the most deprived quintile.

Community Development workers are part of the team around the patient, and that team must recognise them as primary care colleagues, to help root the team in the local community and open valuable opportunities for mutual care.

Community Development has a bottom-up approach, helping communities articulate their needs and make their own decisions. This reinforces the advisory and advocacy role implicit in conventional Public Health practice. The neighbourhood Public Health lead and the Community Development worker should support each other – an empowered community will more productively use Public Health advice; listening to its responses helps target advice and balance it against other concerns.

The primary professional responsibility of Community Development workers must always be to the community they serve. Inevitably that community and the local NHS organisation will sometimes conflict so the organisation must commit in advance to prioritise the long-term benefits of the worker maintaining the confidence of the community over whatever short-term benefits may accrue from the worker acting in the organisation's interests. It will be difficult to remember this in the midst of conflict so they must include contractual clauses protecting the professional freedom of the worker.

Community Development workers should be employed by the regional/district level but could also be jointly funded between local authority and health services

Funding

Our proposals will involve UK expenditure of about an extra £20bn per annum (2021 prices) in primary care revenue funding and a significant once off capital investment. This does not include the additional funding also required in social care. Funding would build up to that level over a number of years in a planned way and there is the potential to reduce the additional cost by repurposing the use of funding in the 111 service.

About half of this sum would be spent on improving primary care generally and about half on our proposed neighbourhood Public Health system.

The UK is rich enough to invest more in the health of its people. Investment has valuable returns, and even in monetary terms the Keynesian multiplier is above the level at which it generates the economic development to pay for itself. Investing in our proposed Action Plan and GP Charter will cost more in the short term, but it will deliver a sustainable health care system that will deliver results of improved health care.

The plan we propose does require increased funding, but also represents a shift to a health service with a much stronger Public Health base, built on neighbourhood communities, and a much stronger primary care service.

Internationally, and in the UK, health services face longevity rising faster than healthy life expectancy, due to issues like mental health, diabetes, poverty and heart disease. Public Health spending (already inadequate) has been cut to raise money (itself inadequate) for the NHS, like stripping the lead off the roof to make buckets to catch the rain. It is time to mend the roof.

Current NHS policies acknowledge the problems of commercialisation and fragmentation but seek private sector solutions. It is important to restate that, even in market economics itself, there are good theoretical reasons for believing that markets do not work for goods and services which need risk-sharing to avoid catastrophic costs, which depend on the professional advice of providers, which are important contributors to equity, where there is scope for gaming important indicators of success, and which are consumed infrequently precluding the gaining of consumer experience. All five of these factors apply to healthcare. Markets in health care do not work. Addressing the problems of the NHS through markets is like attempting to save the Titanic by repeated attempts to

ground it on the iceberg.

During the "Lost Decade of Austerity" all our public services have suffered serious cutbacks damaging public and personal health and adding unacceptable pressures to the existing ones of demography, improved scope of care and the increased cost of technology.

The health and social care systems need more money. This is available. When the state spends money, it gets some back immediately in tax. When the recipient spends the money, this generates more tax. This is the Keynesian multiplier. For health (as for environmental improvement, education, public protection, relief of poverty, and community investment) it is greater than for other public spending. It is indeed above the level which generates more tax revenue than the spending (as indeed are many other public services, including education, welfare, public protection and environmental services).

The spending of this money also fits other objectives of Government including the levelling up of opportunities in deprived communities (especially if there is an adequate weighting for deprivation).

A NEW GP CHARTER

The GP Contract (see also Appendix 5)
GPs will have Contracts that, similar to hospital consultants, have defined sessional commitments. The sessional commitments will be defined in individualised job plans, averaged over time, and determined by the needs of the Neighbourhood Health Community.

The sessional commitments will cover direct clinical care, population-orientated Public Health work, commissioning, teaching, management, service development, advocacy, research, out of hours work, personal development and supervision.

The content and number of sessions will vary along the GP career path.

Contracts will be available to independent contractors and those salaried to NHS bodies.
GPs' line managers will be clinicians or colleagues with significant experience of primary care, respectful of professional and public service values.

GP contracts will be established attractive enough to mean that independent contractors increasingly choose to take them in preference to keeping independent contractor status.

Alternative Primary Medical Services (APMS) Contracts will be abolished since they do not fit in with the universal, public health focussed Neighbourhood Community concept.

Premises
The NHS will offer to purchase, or take an equity share, at a fair price, the premises and equipment of practices which no longer wish to take on the burden of managing them, or pay a fair rental for those that wish to remain owners, until their retirement from practice. These arrangements will need to flex to the needs and plans of the devolved nations.

Supervision
As part of their job, GPs should have regular supervision by professional peers. This would aid retention, avoiding burnout, retaining ideals and quality of working life.

Remuneration
Remuneration will be at nationally agreed rates, following benchmarking principles, and including high quality pension provision that does not disincentivise later career GPs. We also need remuneration to reflect the development of a GP's skills over time.

Training
Training for the speciality of general practice will be adequate to take on independent practice
It will include Public Health training.

Training will be extended to 5 years, but linked to career progression in a way that will enable trainees to settle in and commit to an area for the long term.

There will be training for doctors in general practice shared with hospital speciality trainees as well as primary and social care colleagues.

Established GPs should be entitled to sabbatical breaks to develop or enhance their professional skills.

Monitoring
Quality outcome measures, including patient experience, will relate to population health changes over at least 10 years.

Terms and Conditions
GPs will not be responsible for employing other members of the primary health care team
GPs will have freedom of speech as advocates for their patients
GPs will have registered lists where continuity of care is enabled
GPs will work within a comprehensive primary care team
GPs will not be required to own premises
GPs will have access to high quality, fit for purpose, well maintained IT systems

The Neighbourhood (see also Appendix 4)
There will be the development of Neighbourhood health communities and NHS bodies that will employ primary care staff, including doctors.

Neighbourhood health communities will have their own Public Health leads, who will be combining general practice/practice nursing work with Public Health work.

The primary care team will be constituted according to local needs assessment.

<u>ACTION PLAN FOR THE FIRST 2 YEARS OF A GOVERNMENT</u>

Transitioning from a Primary Care Network (or equivalent) to a Neighbourhood Community System

i) There will be a short-term rescue survival funding plan for each Primary Care Network, or locality in Scotland, Wales and Northern Ireland. This will determine what is

needed for its constituent practices. This will be devised with due regard to the realistic recruitment and potential retention situation in each area, until the implementation of the Neighbourhood Community System. Negotiations with Local Medical Committees will be fundamental to the process.

There is a significant part of the current GP workforce which is considering retiring from the profession, radically reducing hours of work, or changing career. Without a funded short term rescue plan the workforce and structures of present General Practice will not be available to develop the bright future we believe is possible.

ii) The Neighbourhood Community System will grow from the established Primary Care Networks in England, which would immediately receive increased investment to establish management and administration capacity sufficiently robust to become the bodies to which constituent practices are accountable. In Scotland, Wales and Northern Ireland there will be a different evolutionary path.

iii) Public Health led needs assessments would use information from Patient Participation Groups, the primary care workforce and currently existing social prescribing networks and community organisations

iv) There would be immediate investment in Community Development workers, with the funding at first concentrated on those areas with lowest healthy life expectancy and other indications of deprivation.

v) A workforce plan for each Neighbourhood Community would be drawn up, including medical staffing.

Creating the Borough based and Regional Structures

In England, these would transition from the Integrated Care Systems, stripping out any private sector influence. The Internal Market in the NHS would be abolished.

Further consultation is needed on whether contracts for Primary Care staff would be held at Borough level or Neighbourhood Community level, with appropriate investment in human resource capacity at the relevant level. The budget for staff would be set in response to the workforce plan from each of the Neighbourhood Communities in the Borough or equivalent area and would require substantial extra investment early in the transition to begin the process of restructuring towards a primary care led NHS. There needs to be the least possible re-disorganisation, with the new structures building on the pre-existing structures. The details will depend on what evolution of systems has occurred between this paper and possible implementation

Setting up Community Development and Health Creation

This needs to be funded from the start. It is important that existing Community Development be respected and built upon – it must not be disregarded. In addition, it is important that the system creates the conditions under which Community Development can thrive. That includes providing the funding, ensuring that Community Development is integrated into the local health and local authority processes so that issues raised by the community are clearly heard and clearly responded to and that any systematic process does not destroy the organic, responsive aspects of community action.

Democratisation

The need to develop local democratic control of primary care should be an early priority. There is no agreement about the best model of democratic control, no appetite for a another centrally-directed reorganisation and no confidence in Department of Health and Social Care or NHS England to carry out centrally-directed reorganisations without disruption. The aim should therefore be to lay down principles which will allow organic change and local experiment. The organisation of the democratic structures in the devolved nations will be necessarily different.

Investment in IT systems and data sharing (Appendix 6)
This has to include the staff to input into them and maintain and upgrade them, and training for system users. The linkage of primary care and Public Health data will begin. Links between primary care and hospitals will be extended.

Expansion of specified self-referral routes to NHS services where a GP intermediary may not be needed
The details of this will require further clinical input, but would be likely to include certain eye problems, hearing problems, musculoskeletal problems, breast problems, pigmented skin lesions, and some surgical and paediatric presentations, as well as an expansion of direct access psychology and counselling services and school-based child and adolescent mental health services. It is crucial that all of these pathways are linked to the main NHS and social care record.

Legal changes required to shift the balance towards a salaried service.
Terms and Conditions
The immediate need is to address demoralisation in general practice by shifting away from the current task-based over-directed model towards the kind of contract we advocate. The micromanagement of our professional contract creates a professional ethos of mindless compliance and cynicism. This leads to disillusioned and burnt out colleagues prematurely leaving the profession. Too much box ticking distracts from the expert generalist view of the whole patient. A very early priority is to negotiate a national salaried contract, to establish the bodies which we suggest are needed to employ salaried GPs in a way which would command confidence, and to provide arrangements for GPs to transfer staff (and premises where desired) to NHS primary care bodies.

- Radical change to GP contracts, both for Independent Contractors and new national salaried contract.
- GPs will not be responsible for employing other members of the primary health care team
- GPs will have freedom of speech as advocates for their patients
- GPs will have registered lists where continuity of care is enabled

Purchase of premises
The offer to purchase premises from those GPs who wish to sell is an essential part of GP retention.

Training places for GPs/Joint training in Public Health and General Practice/joint training with hospital speciality doctors along with primary and social care colleagues - workforce planning
The planned reduction in patients per GP and the additional Public Health roles proposed means that training places for general practice will need to steadily increase, as soon as practicable, with funding for extended training in addition.

The workforce training plan nationally will be based on the aggregate of workforce needs assessments for each Neighbourhood and requires secure funding for the permanent posts for which entrants to the expanded training programmes are being prepared.

These permanent post-training posts should be linked to the training programmes in such a way that Trainees will be able to commit to settle and work in an area knowing that they can continue to work there after the completion of training.

Realistic workforce planning needs to be looking at least 10 years into the future.

The team around the patient
We need to start a steady programme of expanding the team around the patient. Shortages of trained staff require us to put in place a concerted workforce development programme. In the past willingness to fund expansion has been out of synchrony with the availability of staff so that expansion programmes have lacked staff whilst expanded training programmes have often produced staff who cannot be employed. A new approach is needed in which funds are committed now to training and are also committed definitively into the future to expand teams as the training programmes produce their output. This requires funding plans beyond a single Parliament so cross-party planning would be helpful.

Funding
If there is a long-term commitment to the NHS and to gaining the health benefits that can follow a well resourced primary care system then the funding must be found, just like it was found for the Covid pandemic.

Reducing GP list sizes to an average of 1,200 (ranging from 1,000 in deprived areas to 1,400 in less deprived areas) will require an additional 20,000 GPs at a cost of around £3bn pa (including on costs and administrative support) and we would also propose to invest a further £7bn pa in expansion of primary health care teams and the management of Neighbourhood Health Communities.
Capital funding would be needed for premises and equipment.

2,500 half time Public Health consultants as neighbourhood Public Health leads will cost about £200 million including on costs and secretarial support. A budget of £6.5bn would allow an allocation of £100 per capita to fund local neighbourhood Public Health activities and initiatives. With a weighting for deprivation this would be an average figure – deprived neighbourhoods receiving more and affluent neighbourhoods less.

We would propose an increase of around £2.5bn pa in funding for screening services and behaviour change service to allow support for healthy living centres and about £0.5bn in Community Development workers.

Adding these together therefore we are seeking an investment of around an extra £20bn per annum in primary care revenue funding and a significant once off capital investment for the purchase and construction of premises and equipment including IT and telephony systems.

There is the potential to repurpose the use of some of the funding in the 111 service, with the Out of Hours service refocussing on Neighbourhood provision.

<u>Summary of DIU vision</u>
Primary Care needs to be the centrepiece of the NHS,

- **where most clinical contact, both reactive and preventive, takes place**
- **where GPs work as part of a well resourced multidisciplinary primary care team**
- **where GPs can provide continuity of care.**
- **where community health and social services make as much care as possible available within a push chair / wheelchair pushing distance with co-location where practical.**
- **where further specialist services required in support are identified.**
- **where GPs and their primary care colleagues can have happy and fulfilled careers.**
- **the place where communities are empowered, through community development to address their own health needs in collaboration with the statutory sector.**
- **where the determinants of health affecting the community are addressed through neighbourhood public health systems**

APPENDICES

APPENDIX 1- PRINCIPLES OF THE PRIMARY CARE SYSTEM

The primary care system depends on the 16 Cs:
Caring
Coverage – for all the population
Consistency – people should receive high quality care wherever they live
Community – Community Development and community empowerment in a system designed around defined communities.
Contact – rapid access to initial advice, and good and adequate accessibility to the first contact with professionals
Consultation – skilled interpersonal interactions as the basis for care
Commitment – to high quality personalised care
Coordination – various organisations, professions, workstreams and groups work together
Comprehensiveness – Community Development and empowerment, prevention, diagnosis, treatment, rehabilitation and care.
Continuity – programmes of care delivered seamlessly between different workers and organisations and with the ability to offer long term relationships
Collaboration – with NHS specialist services, residential and nursing home providers, local authority agencies and voluntary agencies so the appropriate body provides what primary care cannot provide itself.
Capacity – structured to meet needs
Cash – adequate resources
Creativity – enabling innovation and spread of best practice
Collegiality – where there is common searching for best practice, and support
Campaigning – so that the insights from primary care can be used for improvement to services

APPENDIX 2 - PUBLIC HEALTH AND PRIMARY CARE

The Context – Our Vision for Public Health
The NHS is a mechanism to pursue health as a social goal, not just a way of paying for health care.

Since a sharp bureaucratic divide now separates the NHS and local government, we often forget that one of the three wings of Bevan's NHS was run by local authorities and focused on prevention. In its

first quarter of a century the NHS, through this wing, cleared the slums, cleaned the air, eradicated polio and diphtheria, and dramatically reduced the incidence of TB enabling TB hospitals and TB wards to be closed or reused. These achievements of the early NHS show that the NHS did once emphasise prevention. But since reorganisation in 1974 it has lacked the means to do so. This could have changed in England when Public Health returned to local government in 2013 but instead a distinction was drawn between "the comprehensive health service" and the "NHS" which allowed the Government to cut funds for Public Health saying health visiting, school nursing, drug and alcohol services and NHS health checks were no longer part of the NHS! In the devolved nations Public Health remains part of the NHS but the need to link it also to local government remains a challenge. How to structure Public Health is a separate issue not dealt with in detail in this paper, but the principles are that it must work across local government and the NHS and be included within the concept of the NHS.

The cuts in Public Health services in the period of austerity have helped create the workload crisis which overwhelms general practice and hospitals. Obesity, alcohol-related diseases, mental illness and diabetes stoke this crisis. So does unhealthy ageing – if healthy life expectancy had kept up with life expectancy, longer lives would actually reduce demand as people lived longer before becoming heavy users of the health service. But instead an inequality emerged in which the poor not only die younger, but also spend longer in illness within their shorter lives (a factor neglected in NHS resource allocation formulae).

We need political action to address the environmental and commercial determinants of health. We need healthy housing, greenspace, healthy transport, good quality work. Asserting freedom to choose unhealthy lifestyles should not imply commercial companies are free to maximise their profits by persuading people to harm themselves.

Health is improved by resilient communities, mutually supportive and asserting control over the factors that affect their health. These political and environmental factors, including community empowerment, are central to the Public Health agenda. If we are to tackle the behaviours which cause, for example, obesity, diabetes, alcohol-related diseases, and if we are to achieve the kinds of changes in communities which are necessary to address climate change, we need to change behavioural norms and we need to address environments at a very local level. We need to move beyond ritualistic victim blaming of the ill. The achievement of these changes will be dramatically enhanced by active community involvement and neighbourhood Public Health.

All health professionals have a role in Public Health – advising how to live healthily and speaking out about the factors that make it difficult. Every contact with the health service should be an opportunity for prevention. But this opportunity is rarely available in a service based on "transactional" consultations or when there is inadequate time. In our document "Public Health and Primary Care" (see Doctors in Unite website) we discussed the contribution that every clinician can make to prevention under the headings:

- *Advocate for Change*
- *Social Prescribing*
- *Guiding Patients Through Their Health Journey*
- *Screening*
- *Risk Factors*

However, the Public Health professions have a particular role.

Public Health specialists, a medical speciality which also has a non-medical route of entry, are health professionals who treat a population, identifying the threats to its health and acting as change agents to improve it. Their role as change agents and advocates needs recognition and protection.

Health Visitors and Public Health nurses have an especial role in the health of children and families which is vital to creating healthy communities – both in neighbourhoods and in schools.

Health promoters and health campaigners have a key role in disseminating health information and health trainers in helping individuals make use of it.

Environmental health should be recognised again as a health profession and the enforcement of Public Health laws must again become part of our armament.

The Case for Dual Accreditation
We believe there is a need for training programmes which create doctors dually accredited in general practice and in Public Health and with the intention of practising both.
Healthcare Public Health and neighbourhood Public Health are two sub-specialties of Public Health which would particularly benefit from such dual roles.

We believe that it should be possible to arrange training for dual accreditation in less than the time it would take to complete both general practice and Public Health training independently by counting work relevant to both (such as epidemiological research or Public Health work in practices) towards the time required in each programme.

This would require the GMC to be prepared to recognise such dual accreditation programmes and Deaneries to be prepared to fund them.

We believe that doctors with dual accreditation could play a significant part in recruitment both to general practice and to Public Health.

Neighbourhood Public Health Leads
Each Neighbourhood needs a Public Health lead, dedicated to that Neighbourhood as its principal Public Health adviser. This individual would play the same role at neighbourhood level that the Director of Public Health plays at borough or county level.

The role would be to act as a health professional treating the population, to analyse its health needs, identify the measures to be taken to address those needs and to improve health, and to act as a professional change agent to bring about those measures.

The Public Health lead would become one of the professional members of the Neighbourhood Health Community.

An important part of the role of the Public Health lead would be to ensure the delivery of the Public Health offer described previously.

The Public Health lead would also ensure that the services provided by the neighbourhood were needs-led, population- oriented and outcome-focused, with a full grasp of the contribution prevention can make, rather than being directed from a thinking oriented around individual service silos.

Independent advocacy would be a core role of the Public Health leads who would write their own Annual Public Health Report and would engage with all issues affecting the health of their neighbourhood.

We believe that neighbourhood Public Health leads should have the full skill set of a consultant in Public Health. Ultimately all neighbourhood Public Health leads will be fully accredited Public Health specialists employed as part-time consultants (or part of the role of a consultant), under the direction of the Director of Public Health. However transitional arrangements will be needed for some time to come as the necessary body of trained individuals builds up.
Not all neighbourhood leads would be doctors. Individuals from the non-medical route of entry to Public Health might also work in this role and combine it with their own initial professional background as, say, a health visitor, researcher or Community Development worker. Public Health specialists from a Public Health nursing background, with their roots both in Public Health and in primary care, might particularly find the role attractive. There will also be those who will only wish to work part time and will find the role can be their only job.

Establishing Neighbourhood Public Health
There are three immediate priorities

- Appointing Community Development workers, initially to the most deprived quintile of neighbourhoods but then progressively expanding coverage
- Providing those Community Development workers with funding of £100 per capita to develop local community initiatives. Eventually this should be the average level of funding with deprived communities receiving more, so as the scheme is rolled out the funding of the initial schemes should increase
- Appointing half time neighbourhood public leads in neighbourhoods averaging 25,000 population. In our document "Public Health and Primary Care" we discussed the process of establishing neighbourhood Public Health leads. We pointed out that to have a half time neighbourhood Public Health lead for neighbourhoods averaging 25,000 population would require, if implemented across the whole of the UK, about 2,600 individuals (1,300 wte).

We might assume that about 40% of these roles will be taken by dually accredited doctors, about 40% by Public Health specialists from a health visiting or school nursing background and about 20% from other backgrounds. From calculations set out in the Doctors in Unite paper there is need for about 25 dual accreditation schemes each with an annual intake of 4 and, when it has built up to producing its first output, each with 24 people in training. There can also be an increase in the number of Public Health nurses who progress into training as Public Health specialists requiring additional Public Health training numbers to be created for individuals from this background who wish to work in neighbourhood Public Health. Training as a Public Health specialist should be recognised as one of the available career progressions for health visitors and school nurses, instead of, as at present, being seen as an abandonment of nursing.

Health visitors and school nurses who become fully qualified Public Health specialists would be one of the sources from which neighbourhood Public Health leads can be drawn.
In the 15 years that it would take to train enough dually accredited specialists various interim arrangements could be used, including recruiting doctors and nurses who have already undergone both trainings and a special programme of GP Public Health fellowships so that existing GPs can take on the role.

Whilst central organisation would be necessary in creating the new consultant posts and in making new money available, and this should be an immediate priority, it would be undesirable to set up the process simply by a centrally directed reorganisation scheme. It would be sensible for

Neighbourhood Health Communities to grow out of a process of Community Development and community action. For example, under the guidance of the neighbourhood Public Health lead, local practices might aim to develop patient participation groups and social prescribing whilst the local authority invests in community organisers and organisations and the local health system increasingly consults with the local community about the services it requires. Out of this process would arise the necessary commitment, both professionally and in community terms, that would allow a Neighbourhood Health Community to flourish and grow.

APPENDIX 3 – AN OCCUPATIONAL HEALTH SERVICE

A fully comprehensive NHS would also reach into the workplace – it was once thought occupational health might become the fourth wing of the NHS and there was even debate at the time the NHS was set up as to whether the Factories Inspectorate (now the Health and Safety Executive, HSE) should be part of it. The best evidence available (albeit that it is rather old) shows that about a third of the social local variation in ill health results from factors occurring in the workplace, which is not surprising as people spend that proportion of their adult waking time at work.

Over the last 40 years the proportion of the workforce benefiting from an occupational health service has declined dramatically. In 1979 about two thirds of the workforce had access to such a service and a third had access to a comprehensive service providing clinical services for emergencies and minor conditions, employment rehabilitation and support for sick and disabled workers to remain in work, health promotion, environmental surveillance, and biological monitoring. About a fifth of the workforce were served by an occupational health service carrying out epidemiology and research. Today less than a quarter have access to any service and comprehensive services (as defined in 1979) are rare.

We need a workplace occupational health service. DiU believes that this should be provided by (or, exceptionally, where a high-quality service already exists, licensed by) a public body. For especially hazardous industries this could be an industry-wide service operated by the Health and Safety Executive. For other workplaces it could be a dedicated service provided by an NHS body and located either within large workplaces or community hubs. It may be part funded by employers through a levy.

It would be democratically controlled locally by workers (preferably through their trade unions), the appropriate regulatory agency, consumer representatives and local communities and it would consider the environmental and cultural impact of the workplace on the community as well as on the workforce. It should be viewed as part of the NHS and the health and safety enforcement bodies should be viewed as part of the NHS in the same way that we advocate Public Health should be. Doctors in Unite has produced detailed policy proposals for an occupational health service which will address occupational health determinants but will also address the commercial determinants of health.

APPENDIX 4 - THE CONCEPT OF NEIGHBOURHOOD AND HEALTHY LIVING CENTRES

Neighbourhood is now emerging in official thinking in England, especially as a core part of the planning in many Integrated Care Systems. It draws practices together into geographical groupings of 30,000 to 50,000 people to arrange health and social care.
This differs from our concept in a number of ways

- It isn't always based on natural communities
- It does not build in local democracy, either for health workers or for residents

- It is still tied to the principle of commercial commissioning
- It devolves responsibility but not power. Power will still be centralised.
- It lacks the important Public Health element which is central to our vision
- It will lack resources and freedom to use them imaginatively to meet need

These elements need to be reintroduced into the concept. If it is possible to add these concepts back into the structure of neighbourhoods they could play a key role in reviving primary care and needs-led services. Without them they will just become the latest device by which the centre devolves onto others the blame for its decisions.

Healthy Living Centres
In our paper "Public Health and Primary Care" we describe the concept of a healthy living centre, combining the function of a health centre, community centre and leisure centre, similar to the Peckham experiment of the 1930s and 1940s.

Not all neighbourhoods will develop to have a physical building hosting a healthy living centre, although some will have centres which do co-locate a lot of components. The essential concept is that the Neighbourhood Health Community is inextricably linked with the wider community.

Community Development
Supporting people working together is central to a neighbourhood committed to improving the health of the people.

The role of neighbourhoods in Public Health should also address physical environments. People should work together to shape a greener environment focused on safe recreation and on attractive ambiences. Schemes like Incredible Edible in Todmorden, and similar schemes like the one in Gateshead, use small patches of land to grow healthy food and green the environment at the same time. There should be an aim that everybody can see greenery most of the time and is only a short walk from an opportunity to exercise in natural surroundings whether that be a park or a riverside path.

Community Development should build on local community assets.

Communities should focus on strengthening mutual support, recognising its value not only because of the help it delivers but also because of social networking. The strength of social networks is a proven major determinant of health.

We must recognise that there are limits on what can be expected immediately. Many people, particularly those in our most disadvantaged communities, are exhausted by the day to day struggle of survival. But the aim of Community Development is to raise people's capacity to work together to change the parameters of that struggle.

Most of the time, on most issues, most people do what they think is normal. Neighbourhoods should focus on creating healthy cultures. Supporting local initiatives like enabling a local lunch club to have hot rather than cold food, supporting a local fast food outlet to serve healthy food or reshaping streets to make walking and cycling easier are examples.

The following list (not exhaustive) is of important services which should be available within every community. Which setting they are provided from would be for the engaged local population to decide, based on the best fit for local need. This could be within the hubs or other community centres.

a. Child care services and nurseries.
b. Stay and play services for parents of young children.
c. Incorporated health visitors for advice
d. Youth clubs and youth advice services.
e. Clubs for social mixing and combating loneliness
f. Day centres for the disabled.
g. Cafes for informal meetings
h. Library services
i. Exercise opportunities
j. Skills for cooking and other domestic skills,
k. Gardening
l. Language skills
m. A host of other information services depending on the community
n. Advice services
o. Advocacy services
p. Somewhere for the community to come together to discuss any adverse events or threats to the community for example bad planning decisions, or to lobby for a better environment such as more greenspace, more provision for active transport, etc.
q. Surgeries for local Councillors and other public representatives
Q Community Development with funded local community activity

APPENDIX 5 - A JOB DESCRIPTION FOR GENERAL PRACTICE

Areas that can be legitimately included in a Job Description for Salaried GP Principals:

1. A salaried GP Principal's Job Description (JD) would set out the range and responsibilities of the post, both in terms of clinical work and work in non-clinical areas such as managing the practice, liaising with other agencies, particularly social care, and having a Public Health role.

2. The JD would lay down the contracted hours of work and be flexible so as to accommodate the shifting work-life balance that occurs during a working life. A range of possible duties for the employee doctor would be worked out on a local basis depending on the health and social care needs of the local population. It is a cliché but true that GPs are uniquely placed to understand local communities and their health and social care needs.

The priorities would include:

a) Clinical work with an emphasis on managing complex issues and undifferentiated presentations recognising the impact of the social determinants of health and relationships on medical needs. Clinicians (of all grades) will have protected time to discuss complex patients and their families and to do the administrative work arising from consultations.

b) An option of contributing to Out of Hours Care

c) Access to further training both clinical (mental and physical health) and non-clinical (managing services in small and larger organisations and Public Health)

d) Working directly with social care agencies so that patients/clients and their families receive services appropriate for their often-complex needs

e) Involvement with local organisations tasked with the re-alignment and development of services at a level higher than individual practices – a population approach to services. Such an approach would not only identify local reasons for inequalities of health and their causes, but also set up services to redress the adverse local and national factors.

f) A role in managing the practice and its services tailored to the local population needs.

g) Multi-disciplinary teaching and training of clinical and non -clinical staff, including GP trainees, hospital specialists in training and other health care students.

APPENDIX 6 - <u>HEALTH IT PRINCIPLES AND PRACTICALITIES</u>

We need a data driven NHS that makes maximum use of all patient data, including machine learning and Artificial Intelligence in order to:

- Prevent illnesses when it is possible through identification of those at higher risk of disease or where earlier diagnosis is helpful
- Empower patients with long term conditions in self-management
- Improve outcomes by personalising fine tuning or automating treatment
- Maintain the trustworthiness of the NHS in responsible and effective stewardship of patient data within the NHS
- Establish robust processes for the evaluation, regulation and continued oversight of patient data and data-driven technologies
- Actively partner with patients and the public

We want health tech to:

- *Enhance, not disrupt*

○ Enhance the NHS and social care
○ Enhance relationships between the patient and the NHS and social care, not replace or downgrade relationships or staff
○ Support people who find digital frightening or unusable and ensure that pre-digital systems exist and are not downgraded.
○ Support diversity
○ Enhance continuity, supporting relationship medicine, avoiding purely transactional processes.

- *Increase the power and control that people have over their own health and their healthcare.*

○ Ensure that people have read and write access to their own records
○ Ensure that everyone has their own Personal Health Record where they can record their own health data and be supported to stay as healthy as possible.
○ Ensure that the data is effectively co-owned by the patient and his/ her primary care advisors.

- *Automate the mundane*

○ Support the delivery of safe health and social care
○ Make boring tasks quick, safe and easy
○ Capture in real (or near real) time activities undertaken by the person and contribute to the person's health status.

- *Improve public trust*

○ If their data is used for research, people should be acknowledged through careful, appropriate information governance

○ New digital interventions must be thoroughly tested with continued oversight to ensure they are fully functional, improve outcomes and are user friendly.

○ AI processes must be ethically derived and ethically tested

○ Maintain the trustworthiness of the NHS in responsible and effective stewardship of patient data within the NHS

- *Boost research*

○ By and for the system

○ By individuals and groups of patients

- *Be Practical*

○ *Get the basics right* – hospitals, social care records need to be digital and there needs to be mutual inter-sectoral access with patient permissions.

○ *Don't re-invent health IT from scratch*. It will be necessary to work with existing and new providers, insisting on clear standards such as interoperability.

○ *Industry needs to work with NHS ideas* to find solutions to real, practical health and care problems.

○ *The NHS needs more people with relevant data/IT skills*

○ There needs to be a rolling training programme for all who use the NHS systems

Areas of work with significant benefits from e-health

Public Health – gathering data, supporting changing health behaviours, collective change, risk stratification. IT is very good at bringing people together to make change.

Identifying risk - preventing illnesses when it is possible through identification of those at higher risk of disease or where earlier diagnosis is helpful

Personalised empowered healthcare – supporting people with long-term conditions to stay as fit and well for as long as possible. For instance, advice to the patient with diabetes to help them look after themselves better and obtain better healthcare. Improve outcomes by personalising, fine tuning or automating treatment.

IT should provide informed and coordinated care around the patient – to include, for instance, hospital discharge, pharmacy, Health Visitors, dentists, optometrists, paramedics, care plans. All registered health and social care professionals directly involved in patient care have appropriate read and write access to a single health record to which the patient also has read and write access. It should enable patient initiated and intersectoral referrals.

NHS or the new National Care system can specify, procure, and install IT systems across health and care boundaries.

*Research***.** Gathering data from routine activity and from people's data (both in the NHS and elsewhere) to be used as the basis of research with suitable permissions and IG.

Developing a Personal Health Record, as a basis for supporting people's own health behaviours. This could accumulate data such as FitBit, home Peak Flow, home BP measurements. Relevant data could appear in the GP and/or hospital record.

Work on the social determinants of health and participatory democracy

- Social prescribing
- Community Development
- Bringing people together to collectively identify and challenge instances of social injustice and things that need to improve.

Risks to mitigate

Increasing inequalities

- 1.5 million more people are now online compared to 2020
- 14.9 million people still have very low digital engagement (may shop online, tend not to use email or online banking)
- 2.6 million people are completely offline, 39% of whom are under the age of 60.
- Rural internet provision is often poor
- In 2017, 56% of adult internet non-users were disabled
- The most common reason given for not having internet was that they didn't need it (64%)

25% of people used the internet to manage their mental health and 37% used the internet to manage their physical health (in 2020, 22% used the internet to manage their physical or mental health) 49% of people say the internet helps them manage and improve their physical and mental health 53% feel they might not have coped during lockdown without going online

Baking in prejudice, particularly through AI

The NHS needs to develop a strategic vision about how AI is incorporated into GP systems to make constructive use of the opportunities to improve care.

An emphasis on transactional processes which are easy to technify

Intrusively collecting data

Using data to oppress

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i Pereira Gray et al https://bmjopen.bmj.com/content/8/6/e021161

ii Sandvik et al. https://bjgp.org/content/72/715/e84

iii https://www.rcgp.org.uk/clinical-and-research/our-programmes/innovation/continuity-of-care.aspx

iv 50 years of the inverse care law - The Lancet

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