

Primary Care: Current Innovations

Introduction

'People are increasingly impatient with the inability of Health Services to deliver levels of national coverage that meets stated demands and changing needs, and with their failure to provide services in ways that correspond to expectations' (WHO 2008 p2).

This statement, drawn from the recently released WHO position on primary health care, highlights a challenge that presents itself to both developed and developing countries.

The importance of primary health care is reinforced by the World Health Organisation in this anniversary year of the original declaration from the Alma Ata conference of 1978. Many times during those last thirty years policy makers, clinicians, managers and members of the public have stressed the challenges posed by our accepted models of health care delivery. Research demonstrates that a strong primary care system makes a noticeable contribution to health outcomes and is significantly associated with reduced premature mortality (Mackinko et al 2003). There are opportunities to shift the established focus and increase the impact of primary care.

'Health care systems have evolved around the concept of infectious diseases, and they perform best when addressing patients' episodic and urgent concerns. However, the acute care paradigm is no longer adequate for changing health problems in today's world. Both high and low income countries spend billions of dollars on unnecessary hospital admissions, expensive technologies, and the collection of useless clinical information. As long as the acute care model dominates health care systems, health care expenditure will continue to escalate but improvements in populations' health status will not. (WHO 2002)

This report presents an overview of international developments at both macro (country wide) and micro (specific service)levels, describing some of the aims of the health policies of a range of countries in the developed world and providing examples of several current specific actions designed to meet the requirements expressed.

The examples must be read with the caveat that there are many different contextual factors between countries. Funding systems, legislation, structural arrangements and national cultures are some of the stark differences that will inform policies and local action. However there is still much to be learnt, and often inspiration to be drawn, from what happens elsewhere.

It is also important to note that the United Kingdom is often held up as an example to other countries and that our system and our services provide many examples of excellent care.

Structure of the Report

The report begins by outlining the similarities in the primary health care policies of all developed countries.

Given that context a number of particular examples of service shift are presented. These specific initiatives are described under the four headings used in the recent 'Evaluation of Care Closer to Home programmes' (2007). Many innovations could fit under more than one heading and the headings are a means of organising material, not giving a clear differentiation between intentions

Integration: Creating effective trusting relationships between contributors in the health and social care system, with an aim of enabling seamless, integrated care

Substitution; movement in location, skill, technology, clinical focus and organisation

Segmentation; grouping patients so that services can be designed around their needs

Simplification: keeping barriers to a minimum and ensuring that form follows function

However, it is acknowledged that the introduction of such innovative services is often difficult. The report ends with a discussion on the learning from various studies into how such changes are made.

Trends in Primary Care Policy

Central amongst what WHO (2008) describes as the current concerns of PHC reforms are:

- Dealing with the health of everyone in the community
- The promotion of healthier lifestyles
- Teams of health workers facilitating access to and appropriate use of technology and medicine
- Participation of society in policy dialogue
- Joint learning
- PHC as co-ordinator of a comprehensive response at all levels
- The recognition that PHC is not 'cheap' , but that it provides better value for money than its alternatives

A policy paper written in 2006 for the European Observatory on Health Systems and Policies notes that most developed countries are taking steps to transfer some types of care outside of hospitals for three key reasons:

- The challenge of delivering appropriate services to a diverse and dispersed population
- The belief that out of hospital care is more accessible, responsive and will increase patient choice
- Costs overall – whilst recognising that out of hospital care is not necessarily cheaper.

A scan of the current policy statements of several comparable countries demonstrates that all emphasise the need for a move away from current organisational silos; co-ordination and integration across primary and secondary care is seen to be essential. (Appendix 1 provides the headlines of trends within several countries)

Examples of Integration

Australia: GP Superclinics

The Australian Government has set out its intention to ensure that all Australians have access to affordable, high quality, comprehensive and integrated primary care services; the introduction of GP Superclinics are seen as one key mechanism for achieving this aim. There are 31 pilot sites around Australia, focussed on outer-metropolitan areas and rural areas where GP shortages are most acute. The Superclinics are to be new facilities that provide a base for GPs and other health providers to work together to deliver multidisciplinary care tailored to the needs of a local community. There is also a focus on providing teaching and educational facilities for students and new graduates.

Superclinics are expected to:

- provide patients with well integrated multidisciplinary and patient-centred care;
- take pressure off local public hospitals
- be responsive to local community needs and priorities, including those of Aboriginal and Torres Strait Islander people;
- provide accessible, culturally appropriate and affordable care for patients;
- provide support for preventive care, including promotion of healthy lifestyles;
- demonstrate efficient and effective use of IT;
- provide a working environment and conditions which attract and retain their workforce;
- be centres of high quality best practice care;
- operate with viable, sustainable and efficient business models;
- support the future PHC workforce through the provision of education and training opportunities; and

- integrate with local programmes and initiatives, demonstrating enhanced co-ordination with other health services and a partnership approach to local health service planning and co-ordination.

The DOHA is keen to emphasise that they do not intend to be prescriptive about models of Superclinic – whilst a co-located centre may be the solution in one place, they are also encouraging people to explore ‘hub and spoke’ service delivery models. In a hub and spoke model one site acts as principal base providing centralised support or activities to satellite sites. The hub and spokes have shared organisational systems (for patient records, appointments etc) and shared clinical governance arrangements.

The HealthOne programme in New South Wales is regarded as something of a prototype for Superclinics, as is GP Plus in South Australia. HealthOne is establishing integrated teams of GPs, nurses, midwives, community health workers and others who will focus on education, prevention, early diagnosis and intervention and better management of chronic conditions.

Finland, Germany, England, United States: Polyclinics

The Australian Superclinic is a specific variation of the polyclinic model which is already established in several countries (Imison 2008). The model can differ slightly; for instance a strong focus on prevention and community participation in Cuba; social care and health housed together in Northern Ireland, primary and social care centres in Finland, specialist dominated services in Germany and America.

In Finland health centres often have their own x-ray, in-patient beds, pharmacist and laboratory or they may purchase diagnostics and specialist services from hospitals. The models here have developed from the merger of small hospitals and health centres. One recent innovation is a system of e-consultation that allows GPs to receive advice from hospital based specialists within two days.

Polyclinics in Germany were developed to bring together disaggregated specialists. The Polikum model in Friednau, Berlin opened in 2005 with 16 physicians. The medical staff now total 14 GPs and 36 specialist physicians. The centre provides services for over 10,000 patients, is open for fourteen hours each day and continues to expand. Support services and diagnostics such as pharmacy, medical supplies and imaging are included. Electronic patient records and internet based guidelines for all staff provide a sound base for integrated working but the Centre also acknowledges the importance of spending time on team work and quality initiatives. The central ambition is to avoid hospital admissions and professional barriers are minimised to provide the most effective service for the patient.

The Westchester Medical Group (New York) brings together 123 physicians covering over 20 specialities. The Clinic is open in daytime hours during weekdays and at the weekend. On site laboratory and diagnostic services enable speedy responses, for instance routine laboratory test results are

available within 45 minutes. Additionally same day surgical and endoscopic procedures are offered.

Recent developments in England have stimulated an interest in the Polyclinic model – but the move is challenged by some. Dixon (2008) is clear that this proposal could work in England but warns that new developments must be in the hands of current GP practices and patients; that the end result must maintain the focus on personal and continuous care which is built on a registered list and that it is important not to deliver care in disease specific streams

Familiens Hus: Norway

Local communities can access a range of services for mothers, children and young people in the ‘familiens hus’ arrangements in Norway. These integrated centres house provide a community base for pre and post birth services, child welfare, a nursery school, family counsellor and other specific professionals such as child psychologist.

Improvement Foundation: Unique Care Programme

For almost five years the Improvement Foundation has been working with several PCTs (over 30 are now involved) in England to develop the Unique Care model. Developed from socio-medical models of care management from the US, Unique Care is based on an integrated health and social care team that works with the patient and family, providing a co-ordinated and individual approach. On referral to the team a full assessment is made and appropriate support is introduced; the patient is central to the process and is fully supported to self manage as much as possible. . If the patient is hospitalised the team provide an in-reach service to support discharge planning. Practice based registers of at risk patients are maintained.

The key features are:

- social care services are integral to the team and can quickly access care at all levels
- a validated risk tool (EARLI) is used to identify people at risk of crisis
- targeted open referral is possible
- an in reach system supports early discharge

A recent evaluation demonstrates that in all sites hospital bed days are dramatically reduced as are unplanned hospital admissions. Hospital costs are reduced but, because the resources used are those already in existence, primary care costs do not rise to match in patient savings.

Patients, families and professional staff all like the scheme; families understand care management and community matrons and GPs report increased job satisfaction.

Evaluations at several sites have demonstrated the impact on in-patient services. Unplanned hospital admission have reduced dramatically (50% in Ealing, 13% in Worthing, 24% in Barking and Dagenham); in –patient bed days are also reduced (70% in Ealing; 13% in Worthing and 11% in barking

and Dagenham). The figures given relate to all of the over 65 population in those areas, they are not restricted to those on the case management lists)

East Lincolnshire Chronic Obstructive Disease Service

The East Lincolnshire innovation is targeted at all patients registered with GP with mild/moderate and moderate to severe COPD. Screening and diagnosis of these patients is provided in primary care with follow up referrals from primary care to the aptly named 'Inspire' team. The team also take referrals from secondary care for patients requiring special support in the community. The system was introduced in phases across several years and is seen to save substantial amounts from decreased hospital admissions.

The range of services provided by the Inspire team include

- Training and support for primary care clinicians
- Case Management and co-ordination
- Acute respiratory assessment service
- Assisted service discharge
- Mental health support
- Palliative care service
- Oxygen assessment
- Triage of secondary care referrals
- Expert Patient groups

Integrating with the community: Court Thorn Surgery Cumbria

The Court Thorn Surgery in Cumbria emphasises the necessity to provide services that integrate into the local community and work with that community to ensure high quality provision. Exercise on prescription has been a feature for many years. Patients, first assessed at the surgery, can access weekly aerobic sessions in the village hall. Those not fit enough for aerobics can join the Walking for Health group. A patient trained as a Bowen Technique therapist offers a service to non-urgent cases such as back pain and frozen shoulder. To avoid long trips to the acute hospital one stop 'shops' are available for chronic conditions such as diabetes. For those who need to attend hospital a volunteer car service is provided.

Veterans Health Administration: United States

The Veterans Health Administration is the largest integrated health system in the United States. Until the mid 90s the system was largely hospital based and frequently criticised for being overly bureaucratic and inflexible. Through a strategic programme of change the system reinvented itself as a patient centred, high quality and high value service. A focus on quality supported by evidence based practice and the use of advanced medical and administrative technology were tools for change. Now programmes are community based, unified care is provided for those with multiple conditions and care co-ordinators use remote care systems such as HealtheVet to monitor patients in their own environments.

Evaluations demonstrate reductions in bed days, in emergency room usage and improvements in health related quality of life

The Green Gym: Telford

Telford's Green Gym offers half day conservation activities as alternatives to gym based activities aimed at benefitting people with chronic conditions or enduring physical or mental health conditions. The evaluation reports are very positive with people reporting weight loss, improved sleep patterns, reduced anxiety and a boost in confidence.

The Green Gym is a joint programme run by pooling resources from the British Trust for Conservation volunteers, Telford and Wrekin PCT and the Borough of Telford and Wrekin.

Similar programmes can be found in other areas including the 'Active for Life' programme, a local alliance between health professionals, care workers and volunteers in the Brighton and Hove area.

Examples of Substitution

The Expert Patient Programme

The Expert Patient Programme is an established self management course led by people who have personal experience of living with a long term condition. The programme was launched in the UK in 2002 and over 30,000 people have been through a course appropriate to their condition. The US and many other European countries run similar programmes. The aim is to enable participants to take more control over their illness and enhance their quality of life. Griffiths et al (2007) agree that evaluation studies have demonstrated the increase in patient confidence and the improvement in psychological health. However, they raise a note of caution about whether the programmes have reduced the use of health care resources and suggest that further studies may suggest how this outcome could be improved.

Telemedicine network: Ontario and Scotland

The ONT is funded by the Government of Ontario and was created in early 2006 from several smaller functioning units. Over 2000 health professionals deliver care via the network in over 500 sites. Many more professionals are linked in to educational and communication activities. The patient can attend their local primary care centre (Family Health Centre) and be seen by a specialist via a video-conferencing system and by the use of test-diagnosis instruments such as digital stethoscopes, high resolution patient examination cameras or endoscopic equipment.

Perth and Kinross Community Health Partnership are working with the Scottish Centre for Telehealth (SCT) to develop a service between three community hospitals that have minor injury/illness services and the out of

hours hub in Dundee. This service began in July 2008 and will be evaluated by the SCT.

Epsomedical: England

Epsomedical was opened in 2006 and is the first independent fully accredited treatment centre to open in England. Beginning its development as Epsom Downs Integrated Care Services the service was originally owned by sixteen GP practices serving 121,000 and the centre now provides a wide range of diagnostics and treatment for a number of conditions including cataracts, arthroscopy, hernia repair and skin cancer, GPs have been joined by Consultants, Anaesthetists and appropriately trained nurses.

Home monitoring systems: Western Australia

The remoteness of many Australian homes has driven moves to introduce home monitoring systems. The scheme introduced in Western Australia allows a GP and a cardiologist to work together – but at a distance – to care for patients in their own home. Daily monitoring measures of blood pressure, heart rate, lung volume, oxygen levels and weight are reviewed and allow action to be taken before problem occur.

Virtual wards: England

Substituting home for hospital is the ethos behind the virtual wards managed in Croydon. The programme, which was based on a Kaiser Permanente model of identifying and managing risk, began as a pilot in May 2006 and since then has saved £1million and has resulted in the local acute trust being able to close 100 beds.

Using a risk management tool, the Combined Predictive Model developed by the Kings Fund patients are assessed by a community matron to test out the suitability of maintaining them in their own homes. The degree of nursing input available is flexible and the nurse led team includes a GP or duty doctor, health visitors, pharmacist, AHP and social worker. The system uses all of the strengths of a hospital ward, there is a common set of notes for each patient, the team meets daily to discuss patients and a dedicated ward clerk provides administrative support. Each ward is embedded with a GP practice. To ensure 24 hour cover NHS Direct and the GP out of hours service receive an electronic list each evening of the patients on the virtual ward. When risk factors fall below an agreed threshold patients are discharged and are then monitored each quarter for a period of time.

Virtual wards carry a total of 100 beds. The most recent innovation has been the opening of a dedicated children's ward.

The significant role of nurses in primary care: Europe

Nurse led first access is common in the Netherlands and Sweden, in Swedish health centres patients are first assessed by nurses before being seen by the GP or accessing hospital treatment.

An innovative nurse consultant role has been introduced in primary care mental health services in County Durham as part of the New Ways of Working initiative. The nurse consultant aims to improve access to psychological therapies through training existing staff, enabling the introduction of computerised support and learning systems for patients and introducing new roles such as graduate and gateway health workers.

Anticoagulation services in primary care: Derbyshire

The community to which Erewash PCT in Derbyshire is responsible for has four acute hospitals within travelling distance. The numbers of people requiring long term anticoagulation treatment was growing and hospital clinics were becoming very overcrowded, people were experiencing long waiting times, minimal contact with specialist nurses and difficulties with parking. Additionally, as the policies for dealing with dosing requests varied in each hospital, there was evidence of disjointed and unsatisfactory care.

The PCT decided to ensure that all anticoagulation patients would be seen at a location near to their home, and that that location did not necessarily have to be their own GP. A nurse led Near-Patient Testing service was developed, providing three hour clinics each morning in three different locations, revolving around the thirteen general practices that are served. Sixty six patients are seen each session.

The service has developed by the nurses involved to include domiciliary visits for the disabled and to enable self testing for those assessed as competent to do so. The PCT provides this group of patients with monitoring equipment, education (part of the Expert Patient Programme) and support. Plans are being developed to move further into patient self- management.

Retail medicine: United States

Costello (2008) asks – ‘will retail clinics change the face of primary care in America?’ Over one thousand retail clinics have been set up in drugstores, grocery chains and airports across the United States and it is suggested that as many as 6,000 could be open in next four years.

The units are small and usually nurse led. The nurses are allowed to write some prescriptions and provide treatment for a range of conditions such as sinusitis and upper respiratory tract infections. As Wagner (2006) states one of their attractions might be to replace the gap left because of restricted ‘opening hours’ of physicians in many parts of the country. They are also popular because of the speed of access. Questions are raised about the quality of care but there is no data to support any claims of poor practice, indeed Costello reports on a recent study that emphasised that retail clinics

adhered to clinical guidance in 99.15% of patient visits by not prescribing unneeded antibiotics.

One interesting impact is that some doctors are responding by becoming more accessible, opening for longer hours and seeing patients virtually on the spot

Patient power and involvement: United States

Soubhi (2007) challenges what he sees as the traditional view of chronic care as a process of illness management that impacts on a system wider than the patient. He suggests that patients, health professionals and families can work together to create a learning community that can provide helpful outcomes for the whole system. That approach necessitates the development of several new techniques including the concept of the primary care team members working with the community as a 'village square' whose members will be focussed on taking roles in problem solving

Rheumatology, Orthopaedics and Chronic pain Service: Oldham

Several years ago Manchester SHA stimulated the development of Tier 2 services in primary care. These programmes were designed to triage referrals into secondary care. One such service in rheumatology in Oldham is now commissioned by the PCT to run a rheumatology, orthopaedics and chronic pain service. Managed by three partners, two GPs and a nurse consultant, the team now comprises GPs with a special interest, consultants, nurses, physiotherapists (including a consultant physiotherapist), podiatrists and administrative staff. Patients are booked in to any one of six local sites and will be managed under consultant led clinical pathways. Where possible patients are managed and treated within the service. Those who are referred into secondary care (now more than 30% less than previously referred) are fully investigated beforehand. Approximately 10,000 patients were seen by the service during last year.

The service also uses early discharge and self referral back into the service so the follow up ratio is low. Patients are encouraged to take an active part in managing their care and can fit treatment regimes into their other commitments Follow up appointments are also offered by telephone rather than face to face for extra convenience.

The savings of £500,000 gained for the PCT last year have been reinvested to develop a psychological service integrated into the team.

Ear, nose and throat: Rotherham

Research (Fall et al 1997) has demonstrated that nurses trained in ear care can save money by reducing ENT referrals and GP workload and can provide a timely, high quality and local service for patients. The Primary Ear Care Centre in Rotherham was set up over ten years ago and now carries out twelve clinics a week from four different locations. It also offers home visits for housebound patients. Most of the service is a basic primary care service for

eight GP practices but a Practitioner with Special Interest Service was launched in 2006 and sees more complex conditions and a recent innovation is the introduction of microsuction. Patients are usually seen within three weeks of referral, with urgent cases seen within a few days.

Patients can self refer and demand has grown to over 600 contacts each month. The staff also provide training programmes in ear care across the UK.

Dermatology: Leeds

An intermediate care dermatology service has been running in an area of Leeds since 2006. The service brings together consultant, GP and nursing expertise to enable the patient to be treated in community settings, eliminating outpatient referrals.

Patients are fast tracked into the specialist service with only a few weeks waiting time and can choose the date and time of their appointment. The specialist nursing team provide assessment, treatment and education and can refer into a co-consulting arrangement with a visiting consultant if necessary. Again this arrangement reduces the requirement for hospital visits. Patients have telephone access to the nurses and can call directly if they have any queries or concerns.

Electronic prescribing: United States

Over the last three years several successful pilot projects in electronic prescribing have been introduced in the United States. These programmes in states including Florida, Michigan and Massachusetts have demonstrated the benefits in improving patient safety, providing decision support, ensuring a clear audit trail, producing efficiency and reducing expenditure. The NHS is currently implementing an eprescribing programme and had announced a research programme that began in September 2008.

Examples of Segmentation

Diabetic patients: United States

A specific service for diabetic patients in identified communities has been piloted in the United States. The service employs Community Health Workers to provide support, practical assistance and knowledge. These individuals were frequently recruited from within their own communities and trained in a number of basic skills. They met people in community venues, clinics and in their own homes. Success depended on initial community involvement and buy-in as it is seen to be important that the worker is accepted in their role by the community. The employment of local people who were previously untrained led to other problems particularly as those appointed often found the training and the need for documentation was problematic.

Arthritis: Canada

One of the national primary care initiatives funded by the Canadian Government (2007) was designed to improve care for patients with arthritis. The project took a staged approach by conducting an initial survey to identify current resources, needs and blockages. Educational materials were developed, using that information collected and a number of interdisciplinary workshops were held to debate further action. Newsletters and videos communicated progress and provided further information. Patients and both secondary and primary care clinicians were involved throughout the programme and a follow up survey has reported a substantial and positive impact on self care and collaboration

Kaiser Permanente: Northern California

During the late 1990's Kaiser Permanente launched a chronic care management programme that focussed on tackling the care of patients with diabetes, chronic artery disease, asthma and chronic heart failure. Patients were divided into three levels. Level one patients were deemed to be those where the control of their disease was well managed and individuals could be well supported by primary care. Level three patients were those with complex multi-diagnosis who were frequently admitted to secondary care and who were often under the care of specialist nurses who could work across disease specialities. However it was the level two patients on whom the chronic care programme focussed. The diseases in these patients were deemed to be poorly managed.

The programme placed level two patients in the care of disease specific care managers who were usually attached to primary care teams. The managers worked intensively with the patients over a period of anything from six to fifteen months after which it was expected that patients could be regarded as level one. The care managers were mentored by disease specific physician champions and maintained a high level of training. An excellent information system was necessary to support the work.

Referrals to the emergency department reduced dramatically as did the frequency of acute events.

Simplification

After hours care: Netherlands and Denmark

The main reasons given by health systems for reorganising after hours care are:

- Increase in non-urgent demands leading to increase in workload
- Shortage of physicians
- Physician desire for better work/life balance

There are several models that can be used to simplify the system for patients and physician; one of the most popular in the UK, Netherlands and Denmark is the use of primary care cooperatives. In the Netherlands almost all

physicians now participate in large scale, after hours primary care cooperatives. There are approximately 120 such cooperatives with 40/120 physicians in each. Trained nurses do the triage and use national triage procedures and guidelines – frequently with computer based decisions support system. Chauffeured cars are available for doctors who make house calls- equipped with communication equipment, oxygen, infusion drips and automatic defibrillators. Chauffeurs are trained to assist the doctor and house calls are provided for patients seen to be urgent or moderately urgent (although this is difficult to maintain) However, survey evidence(Grol 2006) tells us that patients who receive only telephone contact are less satisfied than those who see the physician. Physician workloads have decreased and job satisfaction increased. The Netherlands favours a model in which hospital Emergency Departments and primary care cooperatives work together intensively and even integrate some services. Experience in Netherlands and Denmark of the combination of integrating telephone consultation, face to face consultation and house calls offer promising lessons.

GPs in Hospital setting

In New South Wales consumer access after hours is being improved by co-locating GPs in hospitals. The move is also designed to ease pressure on Emergency Departments. Ten new services were created in 2007 and as yet no evaluation is available

Email contact with GPs: United States and England

For several years Kaiser Permanente have offered patients alternative routes to brief consultations with primary care physicians. Most frequently used is a process whereby patients email into clinics to discuss symptoms and to arrange pre-consultation tests so that any necessary face to face consultations are short and well prepared. Excellent electronic patient records are required to ensure a service with minimal risk.

The Department of Health has recently announced the introduction of a similar pilot scheme in England beginning in April 2009; many GPs already offer this link to selected patients

A simpler, more personalised healthcare experience: United States

'A simpler, more personalised healthcare experience'. This is the definition that the Association of American Medical Colleges give to the concept of a medical home, an idea which is gaining momentum as an alternative to the impersonal and acute focussed American health system. The medical home model has a number of dimensions but is fundamentally a way of providing patients with a round the clock access to consultation and support to navigate through the system (a type of care management approach – but for everyone). The primary care physician would be central to the concept, highlighting a medical role that is not pivotal in the current system, and there would be a requirement for that physician to be the conduit for hospital and community based activity and to maintain a patient register.

It is interesting to note that France and Germany are also looking at measures to introduce some form of gatekeeper role and reduce direct access to specialists (Effelt et al 2006)

What supports success?

This report has briefly outlined a substantial number of initiatives that are taking place in developing countries in response to the understood need to significantly reshape the delivery of health services. As well as learning from the changing services adopted in other countries, it is also worth learning from the journey of change that they have travelled. Several studies highlight repetitive messages for those intending to look for innovation in primary care.

One of these messages is that it is not easy. In their study into inter-sectoral collaboration in primary care Thornhill et al (2008) produced substantial international evidence that collaborative working in primary care improves quality and safety for patients and can produce financial savings. However they recognise that there are several hurdles to overcome. In their discussion they cite the nervousness around taking responsibility for others, the barriers created by regulation and funding streams, the professional silos developed during professional education – but most importantly the different cultures in various parts of any system.

Work by Shortell et al (1998), Walaston and Kimberley (1997), Ham et al (2007), Rosenet et al (2007) and Russell (2008) draw attention to:

- Understanding receptive contexts at both policy and organisational level. This has long been a challenge for the NHS. Pettigrew's (1992) longitudinal study into change in the NHS provides a description of eight factors that can make the difference between receptive and non-receptive contexts.
- Developing a clear vision of what is intended and dedicated project management.
- Providing strong and effective clinical leadership, an issue that is increasingly recognised as pivotal in developing services. Enabling clinicians to take up the leadership role requires support and training as recognised in the recently published High Quality Care for All (2008)
- Training and support for all staff. The necessary developments may be in taking up new roles, in utilising procedures to bring about change or in understanding what other professions can bring to the situation.
- Building inter and intra organisational relationships. Cultural differences are still barriers to change and if relationships have not developed over time it may be that facilitated redesign workstreams will assist.

Tangible features such as clinical 'contracts' were found to help in some of the 'Care Closer to Home' sites.

- Ensuring information systems are efficient, efficacious and effective. Accurate information is frequently a lever for change, and is essential in measuring the impact of change. In many service shifts information is a vital feature in providing high quality care.
- Providing incentives to change. Most often those incentive are centred on improving quality for the patient and job satisfaction for the professional

Appendix one

Current policy trends

Australia

The development of a primary healthcare strategy is a focal point for the current Australian Government. The commitment dates back to an announcement by the then shadow Commonwealth Minister of Health in November 2007 at the Australian General Practice Network (AGPN) conference in Tasmania. The drivers for developing a new strategy included: a sense of inequity in Medicare provision across Australia; a strong interest in the role of nurses and allied health professionals on the part of the new government, concerns about the degree of bureaucracy highlighted in a review of the Medicare Benefits Schedule; and the recently introduced policy of developing better integrated primary health care services through initiatives such as the GP Superclinics programme.

New Zealand

In 2001 the New Zealand Government introduced a ten year Primary Health Care Strategy aiming to strengthen the role of Primary Care in improving the nations' health and reducing inequalities. The strategy included the need to develop the primary care workforce, co-ordinate care and continuously improve quality through the use of good information.

The New Zealand primary care strategy is expected to have significant implications for the number, mix, distribution and education of the primary health care workforce. The strategy acknowledges that the current mix and distribution of the primary health care workforce has been largely an unplanned response to demand and to various initiatives and incentives in the system. As a result the ratio of practitioners to patients is not closely matched to population need and numbers in many professions are showing signs of falling. In recognition of the need to increase the number of nurses the government have funded and evaluated several innovations aiming to develop new ways of working for nurse practitioners (Ministry of Health 2007).

Canada

In recognition of the importance of primary care within the system the Government of Canada set up an innovations fund to be accessed for projects that would run at both country and provincial level, some with a single geography focus, some to stimulate integration and some to prompt national action. All projects were evaluated and described in a comprehensive report issued in 2007. Much of the focus once again was on collaborative working, changing roles and public involvement.

Germany

The German health system is in the midst of some important changes. Recent reforms acknowledge the need to improve co-ordination across all services and include

- The introduction of disease management programmes that are focussed on certain conditions and that emphasise constituents such as patient education
- New models of integrated care
- Medical care centres providing a mix of primary and secondary ambulatory services; in Eastern Germany polyclinics were the norm- they are now being introduced in the western areas.

Norway

A recently published report (2008) in Norway describes the fundamental links between health and an effective and thriving society; 'Primary care must be improved' is a clear statement on the first page of the document. The aims of the Norwegian national strategy for health are described as ensuring services which:

- Are safe and secure
- Are effective
- Are co-ordinated and integrated
- Involve users and allow them to have influence
- Utilise resources effectively
- Are available and equally distributed

Sweden

Recent health policies in Sweden focus on the need for co-ordination of care, mainly driven by the requirement for cost containment and the desire to provide better services. The government is concerned about the increasing number of alcohol related problems, the impact of obesity and the rise in self reported mental health illness

England

Co-ordination, prevention, clinical leadership, public involvement and shifting care closer to home are all key features of recent NHS policy. The recent clinically led review of health services charged each SHA to set out plans for nine workstreams. These plans were developed in partnership with other agencies, emphasising the need for integration where appropriate. One workstream picked up the theme of prevention in its focus on 'staying healthy'. 'High Quality Care for All' (2008) provides a diagnosis of what is needed to lead the NHS into the next stage of reform.

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