

Size matters

making GP services fit for purpose

Professor Paul Corrigan

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The New Health Network is an independent not-for-profit organisation that promotes sustainable health service modernisation that benefits all patients and the public health.

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The New Health Network
Lafone House, The Leathermarket
Weston Street, London, SE1 3ER
020 7407 1618
coordinator@newhealthnetwork.co.uk
www.newhealthnetwork.co.uk

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Foreword

by Dr Tom Coffey GP, Chair of The New Health Network

The New Health Network is publishing this pamphlet with the aim of stimulating debate on why, despite clear intentions from consecutive governments over many decades, the so-called shift from secondary to primary care seems so difficult to achieve. In his commentary, Paul Corrigan suggests that organisational size is the stumbling block and includes four solutions from expert commentators outlining how larger organisations can be developed to improve services for patients.

Some of the most entrepreneurial GPs have been expanding their practices, over many years, to provide more services outside hospital including some minor surgery and diagnostics. However, most Practices and Primary Care Trusts (PCTs) have yet to grasp the opportunities that will allow primary care to fulfil its potential.

As a partner in a practice with a list of 18,000 patients, situated on two sites with 13 GPs (six partners and seven salaried), I believe we are still too small to develop all the services our patients need. We have struggled to improve access to diagnostics, acquire premises that would allow the transfer of care from hospital to the practice and receive a fair slice of the local public health resource. The four models outlined in this book would allow our practice to grow and overcome these barriers.

In addition, practice based budgets under practice based commissioning (PBC) would provide the revenue vehicle to allow the funding required to support capital investments in the community. For too long, the inability to access secondary care funding has been the strait-jacket that has held back entrepreneurial GPs.

Models of primary care provision that allow the transfer of care from the hospital to the community, with increased access to diagnostics and dedicated action to address health inequalities will inevitably produce larger organisations. Yet the most popular GPs are those who work in single-handed or small practices. Furthermore, the present small business model of General Practice has not spawned a thriving private practice for GPs (unlike almost all other public services) – an indicator of its popularity. Therefore, the acid-test of newer larger

About the Author

Paul Corrigan gained his first degree in social policy from the LSE in 1969, his PhD at Durham in 1974 and has been appointed visiting professor of public policy at the University of North London since 1995. For the first 12 years of his working life he taught at Warwick University and the Polytechnic of North London – he was Head of Department of applied social studies in the latter. He taught, researched and wrote about inner city social policy and community development.

In 1985 he left academic life and for the next 12 years he worked in local government – mainly in London but also as a member of staff in the local government unit of the Labour party. In 1997 he started to work for himself as a local government consultant working on issues of modernisation and in 1999 started to work for the Office for Public Management. That year through Kogan Page he published *Shakespeare on Management*. From July 2001 to May 2005 he worked as a special adviser to the Secretary of State for Health.

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models of primary care provision will be their ability to combine the much needed shifts in healthcare with continuity of care and a personal service.

Finally, the ability of patients to make a real choice about their GP will only occur when wider registration becomes a reality and new providers enter the market. I would not be surprised if most of the new entrants are GP entrepreneurs, expanding their practices and taking advantage of new models of provision.

Introduction

In arguing for new forms of primary care provision, this pamphlet brings together three strands of thinking historically kept separate.

First, there is an interest in creating organisational forms that are fit for purpose. Some of this debate takes place in the Financial Times and on the business pages, where questions are raised about whether small or large businesses are the right size to develop different parts of the economy. Sometimes, these debates enter the mainstream media and provoke great general interest – such as the contemporary debate about the retail trade. Is it better that our food is sold to us through very small businesses like the corner shop or through large supermarkets? For most people the hope is for both to service our needs.

A similar debate on organisational form takes place in the politics pages of newspapers. The knee-jerk reaction to any challenge to the state form of public service provision is the charge of “privatisation”. In fact a range of different public organisations are being put forward alongside private business ones; some small and some large.

However, this debate has not often included the organisational structure of the NHS.

At the moment throughout England there are some 9,000 GP practices all trading independently. This model of primary care has served the country and patients well but it is becoming increasingly clear that it cannot continue to be the only organisational model for the future. This pamphlet argues for a radical move in General Practice away from the small scale private business model towards larger organisations – some large single organisations – some networked smaller organisations – some public and some private.

The second strand of thinking concerns the relationship between primary and secondary care within the NHS. For many decades, the NHS has aimed to move some secondary activity into the primary sector. Not only has this intention failed to become a reality, but the reverse has happened with too many primary care episodes involving hospitals. Current policy is even more ambitious. If the NHS

cannot succeed in moving millions of care episodes outside of hospital, the NHS is in trouble.

The third strand of thinking is the goal of reducing health inequalities. Major government policy documents of the last few years have increasingly stressed the intention to reduce health inequalities. Whilst no policy expects that general practice will be able to overturn health inequalities on its own, it is expected to play a significant role in doing so. Here also, GPs organised through the small business model do not have the necessary infrastructure.

This pamphlet braids these three strands of thinking into a single argument for the development of new, larger, public and private organisations to deliver General Practice in this country. It does not argue that the small private business model has no place in service delivery; instead it argues that we need larger alternatives to work alongside the current private model.

Chapter 1

Why is primary care still provided by small businesses?

Small businesses can achieve much, but on their own they cannot achieve everything that larger organisations are capable of. It is crucial to ask therefore, why most primary care in this country is still provided by small businesses called General Practices?

For a number of reasons, many of them correct for the Britain of 1948, the NHS outsourced most primary care from its inception. GPs were not salaried employees in a nationalised primary care service. The favoured model for delivery was the small business providing a very local service. So GP surgeries continued to be set up as small businesses gathering state paid-for clients. In reality, as in the TV myth of Dr Findlay, there were owners (the Partners) who employed staff (the famous Janet) and paid for premises (a big house in the village) and held out to junior GPs the option of becoming an owner.

This is undoubtedly a strong model; the combination of being a professional and of running your own business provides a double reason for high status and has remained the cornerstone of NHS primary care delivery for over 50 years.

However, not all doctors have been employed in this way. The NHS has chosen to develop its secondary care through large organisations called hospitals where the doctors are salaried employees. Indeed, in many places the hospital is the single biggest employer in a locality. The contrast is clear; in primary care the model has been based on that of the privately owned small business, while in secondary care the model has been that of state owned large organisations. In addition doctors can also work for themselves in private practice.

In some areas of the country, the existing model of primary care has provided the population with the quality care that they have needed. In particular, GP practices have often successfully developed a close relationship of trust between a high status local professional and the people they serve. People feel safe with their doctor and trust their ability, not only to provide health services but to also act as a gatekeeper for secondary hospital care. It is likely that these relationships

would not have been built up if services had been provided through a large organisation. Locality and smallness have been, and continue to be, important parts of building a beneficial relationship – a strength that no-one is suggesting should be scrapped.

What this pamphlet argues, however, is that the small business model for General Practice is not sufficient for some of the tasks we now expect primary care to take on; and in some areas of the country it does not work at all.

The ‘small business model’ is not sustainable

The failure to move activity from secondary to primary care, despite its constant restatement as a policy intent is one of the greatest puzzles of health policy over the last few decades.

Much outpatient work, including most diagnostics (for example pathology tests and routine x-rays and scans) could be carried out away from the hospital setting, in or nearer to the primary care setting. Most of the care of patients living with long-term conditions could also be carried out in primary care. Patients with diabetes, for instance, should be able to manage their condition with the full support of a primary care team of specialist nurses and doctors, podiatrists, ophthalmologists, pharmacists and others – never needing to step inside an acute hospital.

For most patients primary care should offer the complete pathway of care. We should be aiming for a national health service where primary care is more than just the start of a patient’s journey that will end in secondary care. Yet despite good intentions, the reverse happens. More activity in more patient pathways involves moving into and out of the hospital sector. In particular, as diagnostic tests become more sophisticated and an increasingly integral part of healthcare, the GP in her room with the patient seems able to complete fewer and fewer care pathways.

Much of the reason for this lies in the difference in the scale of the organisational structure between primary and secondary care. A small organisation with few assets is unlikely to put its entire future at risk by investing in, for instance, a new diagnostics capacity. For small businesses, precisely because they are small, the risk entailed in making the decisions about investing in new diagnostic equipment can be too high.

However, for a large organisation such as a hospital, the same decision to invest in the same process is a very different one, simply because of its size. The risk of success and failure may be the same but the impact of it for a large organisation

is much smaller. This does not mean that no small business primary care provider will develop new diagnostic capacity, but it means that the size of the organisational form militates against it.

As new medical activity has developed, there has been no incentive for primary care to develop new services, instead it has been cumulatively easier for secondary care to make the decision to include it within its business plan.

For this reason most new diagnostic activity is developed in secondary care institutions and most primary care has increasingly referred people for that part of their pathway to the hospital. In this way, the relative scale of primary and secondary care organisations has continually meant that, despite the best endeavours of policy, more activity has inappropriately developed within the secondary sector.

New challenges for primary care

The tasks that NHS health policy has laid upon primary care for the next few years are enormous. We can claim with some justification that if primary care fails to carry out these tasks, the NHS itself will fail as hospitals become overwhelmed with demand that should be dealt with in more appropriate primary care settings.

The tasks expected of primary care over the next five years are at the very least:

1. Developing more effective health improvement for individuals and communities
2. Creating clear frameworks for the management of long-term conditions
3. Delivering primary care in a closer relationship with social care
4. Providing much of the diagnostic and outpatient services currently carried out in secondary care
5. Providing most minor surgery.

These are dramatic and necessary changes; around five million tests and interactions that now take place in secondary care will have to take place in primary care. The question is whether the existing organisation of most primary care services, the small business model, is the best organisational structure to deal with these issues.

1. Developing more effective health improvement

“The aim is to put in place a reliable, effective and accessible infrastructure for health improvement and prevention services that matches the infrastructure for high quality treatment services that we all expect.”

Choosing Health¹

Whilst hospital care will have some part to play in this, it is obvious that primary care will account for most of the NHS role in developing ‘a reliable, effective and accessible infrastructure’. If services are to be more convenient and more accessible for patients, then they must be genuinely provided much closer to where people work, live and play. This involves NHS services going out into the very different communities that exist in our society. If one aim is, for example, to target the unhealthy outcomes of behaviour of young men and women, then it will be necessary to do that much closer to where they live their lives. Health improvement will have to be “out there” in our very diverse communities, not inside traditional NHS institutions.

“For general practice the new primary care medical care contracting arrangements offer enormous potential to develop new ways to meet a growing demand for health, with more flexible services; greater choice; increased specialist activity; an improved range of quality of services and services tailored to local needs.”

op cit²

Obviously some of these services will be provided by others outside of the NHS – by local government and community organisations. Explicitly, however, primary care is expected to play a strong role:

“We will foster and expand a comprehensive range of community health improvement services that includes specialist practitioners who know how to:

Help people develop their understanding and skills to improve their own health;

Strengthen community action for health to tackle inequalities, and;

Work with communities, offering training advice and support to a broad range of health professionals.”

op cit³

Since its inception, the NHS has wanted to have a much greater impact in improving the health of the nation. This is not to suggest that primary care has failed to act in the area of health improvement in the past, but the latest public

health White Paper⁴ emphasises the very considerable task facing primary care in its core health improvement role.

2. Better management of long-term conditions

“Long-term conditions affect older people more than younger people and people in lower socio-economic groups are also more likely to be diagnosed with one or more condition... The impact on individual patients and the NHS is enormous:

About 60% of adults report some form of long-term or chronic health problem;

People with long-term problems are significantly more likely to see their GP (accounting for 80% of GP consultations) to be admitted as an inpatient (on average about twice as likely given a particular problem and stay in hospital much longer;

Use of the NHS increases with the number of problems reported (the 15% of people with three or more problems accounts for almost 30% of inpatient days).”

NHS Improvement Plan⁵

There is broad consensus among commentators and professionals in the NHS that developing better patient pathways for patients with long-term conditions is essential. Whilst these conditions – such as diabetes, asthma, depression or arthritis – have been a part of people’s lives for decades, advances in medical treatment now mean that it is possible for people to live with one of more of these conditions for much longer periods. Indeed recent medical progress has meant that some diseases pattern such as coronary heart disease and some cancers are now experienced as chronic diseases over decades rather than acute episodes.

These are enormous numbers of people (literally millions), treatments (literally tens of millions) and emergency admissions (a high percentage of all emergency admissions). Obviously much of this already takes place within primary care, but the whole drive of policy is to capture more and more of this activity within primary care provision. The direction is clear:

“Patients generally prefer to be at home rather than in hospital, provided that they are properly supported.”

op cit⁶

So primary care will be expected to better organise and manage the care and support of the 17 and a half million people living with long-term conditions.

3. A closer relationship with social care

“Social care commissioning and provision will be further integrated with health care to deliver a better experience for the individual and ensure the most efficient use of available resources. Patients and their families should not have to take the trouble to communicate between different services. That is the job of the local NHS and the local authority process... There will be a greater role for preventative services to help people avoid hospitalisation. Social care is critical to that work.”

*op cit*⁷

People with long-term conditions frequently need social care packages to be closely linked with their health care. This is one of the reasons why the Government White Paper on primary care due out at the beginning of 2006 will incorporate as a single document the planned White Paper on Social Care. However the relationship between social and health care has not been a happy one. Organised with a different set of founding principles (health care is free at the point of need, social care is means tested) and organised within very different governance arrangements (social care being commissioned from a local government base and primary care from within the NHS), there are radical differences between these two sets of care. They must work better together. Whilst hospitalisation will often require a period of social care, most of the development of a better relationship between health and social care will have to be worked out between local government and primary care.

4. Providing most diagnostic and outpatient services

“Our aim is to transform diagnostic services by expanding capacity and making the best use of the resources we already have. Increasingly, the NHS will provide diagnostic services closer to the patient’s home or work.... Investment in and procurement of improved diagnostic services from both public and private providers will be an increasingly important feature of the new system. Patients will be offered greater choice in where, when and how they access diagnostics services. Where appropriate, GPs will also be able to refer patients direct to a diagnostic facility, cutting out patient waits associated with going to diagnostics services via a consultant.”

*op cit*⁸

It is in the area of diagnostics where the intention of health policy has been most at odds with what has actually happened. As medical science has developed rapidly, both in the type of diagnostic test and in the range of diseases that can

be better diagnosed, much has moved from the GP consulting room into the hospital. Too many patients have to travel to hospitals, often at inconvenient times, for diagnostic tests, only to have to go back to the GP for the result and then be referred back to the hospital to see a specialist. For primary care to be able to deal with more patients within its services it is going to have to move substantially into that activity.

This is ambitious, but absolutely necessary if patients are not to become more frustrated at a seemingly inefficient system and our hospitals are not to be clogged up with people having one off appointments. But it will require strong capital-intensive development of services outside of those hospitals.

5. Providing most minor surgery in primary care

“We now have around 1,300 GPs with a special interest providing 700,000 procedures in the community previously done only in hospital...An independent evaluation of GPs with a special interest in ear, nose and throat (ENT) showed that a GP could see 30 to 40% of ENT patients referred to secondary care. GPs with a special interest in ENT lead to significantly shorter waits and high levels of patient satisfaction.”

*op cit*⁹

Increasingly more GPs have been carrying out minor surgery that had until recently been carried out within the hospital sector.

Better technology and much better drug treatments mean that a range of surgery that up until five years ago could only be carried out in hospital can now be carried out in primary care. In some areas, all vasectomies are now carried out in primary care and in most places few cataract operations now involve an overnight stay. With advances in technology and patient safety, over the next ten years an increasing number of these activities will be best carried out within primary care settings.

Taken together, these five policy themes are incredibly ambitious. They demonstrate a commitment to primary care which is historically unparalleled. The question is whether small businesses alone can successfully take on such a wide range of interactions.

The challenge from global health inequalities for primary care

Aside from the policy demands placed on primary care, many GP practices also face the additional burden of responding to global health inequalities.

The inverse care law – where poor people get poor services – is clearest in terms of the location of primary care. In secondary care the position is more complex, with some of the best hospitals, the new NHS Foundation Trusts, being in the poorest parts of the country. Primary care, however, is recognised by the government to be ‘weak’ in deprived areas¹⁰.

The recent White Paper on Public Health recognises that in future “*We also need to tackle health inequalities head on ensuring that the NHS provides people in disadvantaged areas and groups with services designed around their needs so that they want to use them*”¹¹. This new policy also recognises that “*unemployed people and individuals with low income and poor educational qualifications use health services less relative to need than the employed, the rich and the better educated*”¹². These are powerful long-term inequalities that will not be easily overcome, but the NHS principle of equal access does not allow us to simply accept the status quo, instead it argues for change.

Moreover, many disadvantaged areas of the country are experiencing not just inequalities of health in this country but the impact of global inequalities. People leave home in Africa, the Far East and Eastern Europe and they come, with their particular health background, to English cities. For most of them their second contact with the state – the first being immigration and asylum services – will be the NHS. And most of those contacts are in primary care.

In many English cities, the world walks into the GP surgery with all the complexity that worldwide diversity in health background brings. Some people will have been living unequal and difficult lives in another country, which will have had an impact upon their health chances. Therefore in some inner city areas in this country, primary care is faced with health outcomes that are the result of large scale population movement caused by globalisation with the concomitant complexities of different diseases, different cultures, different languages and different inequalities.

At the moment, those of us committed to reducing health inequalities expect a small business to not only cope with this but to solve it. The small business primary care model of the past cannot solve the health inequalities that are experienced by globalisation and it is ridiculous to pretend that it can.

Let us look at a concrete example. A GP in an inner city area is concerned to diminish the inequality of infant mortality that exists between different ethnic groups and knows that, for example, infant mortality is higher for mothers who were born in Pakistan. Concerned that such mothers get early antenatal care, the Practice may run a clinic with women from the community to foster earlier

antenatal care. However, despite best intentions, much of the infant mortality inequality rate amongst the mothers will have been set 20 years ago with diet and health conditions experienced thousands of miles away. It is not that the antenatal clinic is irrelevant but that the GP cannot take on the inequalities of the world.

Globalisation and locality

The relationship between globalisation and locality is vital here. At the moment primary care is solely organised around small localities. The strength of that model has been based upon the longstanding idea that locality provides continuity. If a GP provides services to families who continue to live in one small area there will be continuity of care over generations. And that GP will know through their practice, and not necessarily statistics, about their patients and their morbidity.

In some localities continuity is still the norm. But in others globalisation and mobilisation have blurred concepts of locality. In some localities, in some cities, half of the patients in a particular practice could change in a year and be replaced by entirely different people. Not only does the GP not know the patients’ parents or grandparents, but they know nothing about the society the patient comes from.

The experience or sense of ‘locality’ that has been a strength for continuity over centuries can, given global movement, become the biggest example of discontinuity. This is not just a change in the dynamics of locality, but a reversal. Services based around continuity in those areas, now have to be based around discontinuity. It is not that it is impossible to provide care, but it is very different, and localities cannot ‘defend’ their continuity against the changes and intrusions of globalisation.

This question of rapid population change is not just an issue of globalisation, though it is at its most stark there. We also expect the small business model GP practice to be able to overturn the internal inequalities of British society whether in an urban setting or a rural one.

In his brilliant book about a rural GP, *A Fortunate Man*, John Berger elegantly describes the high status and values driven work of a GP; his sense of mission and deep care.¹³ But Berger also underlines the despair, not only at the sense of failure caused by people’s morbidity and mortality, but the inequalities of our society. The GP could not solve the rural housing crisis that had people with TB living in damp accommodation and could not increase the finances that people needed to live on. Daily he confronted those issues and much of his feeling of

failure to improve people’s health was caused by a feeling of failure to intervene and improve people’s conditions of life.

In the concluding essay in the book John Berger sums up the contradiction in the life of a popular man:

“The doctor is a popular hero: you have only to consider how frequently and easily he is presented as such on television. If his training were not so long and expensive, every mother would be happy for her son to become a doctor. It is the most idealised of all professions. Yet it is idealised abstractly. Some of the young who decide to become doctors are at first influenced by this ideal. But I would suggest that one of the fundamental reasons why so many doctors become cynical and disillusioned is precisely because when abstract idealism has worn thin, they are uncertain about the value of the actual lives of the patients they are treating. This is not because they are callous or personally inhuman; it is because they live in and accept a society which is incapable of knowing what a human life is worth”.¹⁴

30 years later in a very different place – Hackney – David Widgery wrote movingly about his work as a GP.¹⁵ The experiences of inequality that were a part of the genesis of much of the morbidity that he came across were different to those in a rural area, but the feelings of a GP, operating as they both were – on their own – were very similar.

“When I came here in that fateful taxi down the Hackney Road, I didn't know what the bruised face of a heroin addict was like, or how children could be locked up without food, four in a room, by a drunken father as punishment, or what happens to a jaw when it is broken in a domestic fight and concealed. And now I do. I know what decomposed bodies of alcoholics smell like after two weeks, and the noises made when dying in pain, and what happens to a woman's face when she is told her breast cancer has spread. And I think I wish I didn't”.¹⁶

John Berger’s ‘fortunate’ GP committed suicide and David Widgery died at the age of 45.

I am not claiming that most GPs get up every morning and dedicate their work to removing the inequalities of our society and feel a failure when they do not. But I am claiming that many of them confront daily the conditions of ill health that are in part caused by global experiences of inequality. The organisational structure that they work within is too small to give them much assistance in this difficult struggle.

Chapter 2

Why larger primary care organisations are needed

I have described three reasons why the small business model, on its own, cannot succeed in the development of modern primary care.

- »»» It has proved too small to develop services, such as diagnostics, and has therefore accelerated the drift of activity from primary care to the larger organisations of secondary care.
- »»» It cannot meet the five large policy tasks that the NHS is requiring primary care to complete in the next five years through the provision of new services.
- »»» It cannot adequately support GPs in tackling the experiences of global health inequalities.

Whilst Government policy has not highlighted this question of size per se, major policy documents have called for new forms and methods of delivery:

“Developing new, innovative models of care and pursuing opportunities for sustained action as well as quick wins will be particularly important in tackling inequalities.”
*Choosing Health*¹⁷

And even more explicitly:

“Patients will also have more choice from a wider range of services in primary care, helping people to get access to more personalised healthcare. In addition to developing traditional primary care services such as GP practices and pharmacies, the NHS will be increasingly working with innovative new providers. These will be particularly important in deprived areas where primary care is most needed ...”
*NHS Improvement Plan*¹⁸

Creating new organisations is hard detailed work. Over recent years GPs and organisations with different backgrounds, all with a track record for innovation, have put hard work into the business of thinking through new organisational models. Below are four examples of larger primary care models from four such organisations:

The NHS Alliance has consistently looked to ways in which entrepreneurial GPs can provide better primary care for patients.

General Healthcare Group, an experienced provider of private acute services, recognised that the creation of the new Independent Sector Treatment Centres would challenge its core business. It has begun to look at the possibility of providing NHS GP services on a scale larger than the small business.

Mutuo is driven by a long term commitment to the revival of co-operative organisations in the UK and recognises that primary care, with its relationship to local people, provides a classic opportunity for that development.

Colleagues from MPP have had a long term interest in the development of organisational forms that are both business-like and in the public sector. Their championing of the public benefit corporation as a way of providing networked services to small GP practices is an imaginative way of developing this form.

Large GP-led provider organisations

Dr Michael Dixon GP, Chair of the NHS Alliance

General Practice is conventionally regarded as the gateway to the NHS, rooted within the local population. For much of the public, primary care means General Practice, which, given the right incentives, has shown itself to be able to deliver fast and effectively. The new world of choice and contestability is well suited to GPs, who have a strong track record as innovative and entrepreneurial small businessmen.

Leading local GPs (possibly with other health professionals and managers) could develop a comprehensive provider organisation offering a full range of primary care services plus services traditionally provided in secondary care and those commissioned by social services. It could also provide an umbrella organisation for private sub-contractors, voluntary and other services.

This could be initiated by a very large practice or a group of practices operating from a large site such as a primary care centre. Alternatively, it might be a virtual network of practices developing their scope of provision through a central primary care provision unit which could provide services for a number of practices.

In business terms, the GP practices could continue as conventional GMS/PMS (General Medical Services/ Personal Medical Services) practices side by side with this extended primary care provider organisation. The latter might either

be a registered company or possibly a not-for-profit organisation led by a small group of GPs and possibly others such as nurses, specialists, pharmacists or managers. These could be owned through shares by GPs within the practices, who wished to be so involved. In other cases the GPs may want to extend shares and ownership of the company to other primary care professionals and/or secondary care professionals who work within the provider organisation. The model would include potential ownership by all primary care clinicians and managers working within the provider unit or by just some.

The premises may be joint-owned by the GPs and the provider company. In others the capital of both the traditional GP and extended provider services may be part or entirely owned by a Private Finance Initiative provider and rented to the GPs and the private provider company.

What would be provided?

The strength of any bid for providing services would depend upon offering a cost effective, quality, comprehensive and integrated service. This might include some or all of these:

- services currently provided in secondary care such as advanced diagnostics/specialist outpatients/ GPs, nurses and allied professionals with a special interest – all reducing the payment by results cost of secondary services from the acute sector
- in-patient services, where a community hospital existed locally or in a nursing home
- all traditional primary care services – including district nursing, health visiting, midwifery, physiotherapy and chiropody
- appropriate community mental health services such as community psychiatric nursing, counselling and cognitive behavioural therapy
- walk-in and out-of-hours services
- some social services such as healthcare assistants and advocacy for patient budgets
- pharmacy, dentistry and optometry
- local health information/initiatives and health trainers
- other services such as complementary medicine
- plus other services housed within the provider organisation extending its remit and effectiveness – for example voluntary services and Citizens Advice Bureau.

Services could either be directly provided by the company or sub contracted from others (eg diagnostic services or nursing home beds).

The potential benefits

Above all it would provide a comprehensive local service which integrated services under the management of one provider. This organisation would be owned and led by frontline clinicians.

The clinicians who owned and run it would have good local knowledge, a traditional NHS ethos and personal investment in the community. Such an organisation would encourage co-operative working with agreed protocols and care pathways and improved skill mix. All clinicians would have a vested interest in cost effective working practices.

Providing this range of services through a single organisation would avoid fragmentation of an individual patient's care and unnecessary duplication of services with resulting expensive unused capacity. It would offer choice within the system and parallel access for patients.

Ensuring quality of care

The system would encourage better patient care because there would be the external safeguards through a Primary Care Trust (PCT) commissioner to ensure value for money, quality and safety, supported by watchdogs such as the Healthcare Commission.

There would also be internal safeguards, with high quality clinical governance. In addition, practices and providers would be required to have patient participation groups with payment being conditional on showing that the patients are being effectively listened to.

Patients would still be free to register with the practice of choice within the local consortium and free to move their registration to another practice in another area using a different provider consortium, if they think that the primary care services provided might be better.

Co-terminosity with practice based commissioning (PBC)

There would be nothing to stop one practice setting up a provider organisation for several others, but in practice there would be greatest advantages where one PBC organisation could bring several local practices together as a cluster on one purpose built site or operating from several sites. Indeed it is likely that these provider organisations will evolve from successful PBC practices working together as a unit and finding that they can provide services better themselves. Advantages of the PBC consortium involving the same practices and patients as the integrated provider organisation include:

- An increased impetus for local practices to devolve appropriate services from the local acute trust to the primary care provider organisation.
- A counterbalance to profiteering by a private provider by the need of practices and GPs, as commissioners, to balance budgets and maximise local health.
- Better service redesign as PBC practices will be able to ensure that re-configured services use or develop all local talents available and that the services commissioned are properly organised and integrated.
- Building upon the advantages of professional engagement and partnerships between practices achieved in PBC.

www.nhsalliance.org

NHS primary care provision through a large private company *General Health Care Group*

People want more effective health advice; out-of-hours access to GPs, more services available in the community; and better coordination between social care and health care. And older people want help to stay active longer – not only having services in their home but activities to get them out and about to exercise and socialise.

These reforms require a different type of organisation to that which has been traditional in primary care. A new model has to be one that is based on the “company” model, one that delivers a mechanism that is responsive to people’s needs, that allocates investment resources against these needs, and one that can deploy sophisticated management talent. This requires:

- 1) Larger Health Centres to give the economies of scale and scope required to:
 - Organise the critical mass of GPs (at least 10 per centre) that will allow for rotas, which in turn will allow near-24 hour operation.
 - Consolidate demand to justify a greater mass of equipment (including diagnostic scans in major centres) and services (community activities, such as “activity groups”).
 - Allow better integration of health and social services.
- 2) GP practices with more professional management that can act on customer needs, and design efficient work practices. An important function of better management will be to market services better.

Some misunderstanding surrounds the words “consumerism” and “marketing” in the public sector. “Consumerism” is not some sort of mechanical and rather shady practice, and marketing does not mean advertising. These words describe processes that seek to understand what customers want and need, to design services that meet those wants and needs, and seek to provide information that allows consumers to access those services.

Marketing services better is particularly important in designing a patient and public led health service. Lack of information (for patients, the public and health professionals) is a major current complaint – and probably an important driver of health inequalities in that the better off seek out, find and use information better than the worse off. Designing information in ways that are accessible to, and useable by, consumers (instead of being a dump of “public information”) is a vital part of good management.

Finally, the function of professional management will be to manage efficiency so that more services can be offered to the public at lower cost to the taxpayer. In addition all managerial and administrative resources should be working as close as possible to the point where services are delivered to patients.

In summary, a “company” model is the most appropriate mechanism for reforming a primary healthcare system that is no longer delivering what patients want. This type of industrial organisation will move the system from one characterised by:

- Separation of health and social care to one that offers an integrated service.
- A centralised bureaucracy to one in which the State provides the overall regulatory and standards context, and the structure of a commissioning function separated from a provider function.
- A supply-driven emphasis on the NHS institution to one that listens to the voice of the citizen.

The “company” model, which exists first and foremost to understand the needs of its consumers and to deliver against those needs (the cost of failure being liquidation), is the most appropriate mechanism for building a truly “patient-led NHS”.

www.generalhealthcare.co.uk

Developing mutual providers of NHS primary care

Peter Hunt, Director of Mutuo

There are now over 31 NHS Foundation Trusts, with many more in the pipeline and a membership already exceeding 400,000. In addition there are 20 new GP out-of-hours mutuals; 110 football supporter trusts; a continued growth in leisure service mutuals; the prospect of large social housing mutuals and new mutuals in child care. In all, there are more than half a million citizen members of new mutuals – a real growth of co-operative organisations and membership.

What makes them special is that their members are entrusted with the social ownership of these bodies. Staff, users, and local specialists have more of an input in deciding how standards could be improved and the particular needs of local communities met. This is achieved by making management accountable to an elected board, comprising stakeholder representatives.

The potential benefits of mutual structures

Mutuals can take a variety of forms. They might be producer dominated, in the case of GP co-operatives, worker co-operatives or leisure trusts, or they may be consumer dominated in the case of consumer co-ops, building societies, foundation hospitals or football supporter trusts. In each case, the members will behave differently, and the culture of the organisation will reflect the relative balance of the different stakeholders, as well as its overall aims and objectives.

Mutual governance structures are designed to build stakeholder participation in the business, theoretically bringing a range of benefits. GP co-operatives, which are producer-dominated mutuals, identified four success factors that were related to their mutual governance arrangements¹⁹:

- They are expert (in that the frontline healthcare providers also plan the care).
- They are innovative and entrepreneurial.
- They are flexible and responsive to local health needs.
- They have used the inherent self interested mutuality to build strong, cohesive organisations.

Many mutuals go further by building-in participation from and accountability to their customers and achieve the benefit of having inclusive decision making structures.

The mutual opportunity in Primary Care

The mutual model builds on the ethos that is at the core of the NHS. And because a mutual provider is overtly established with the clinicians and staff at the centre of the membership, and because it is established with the objective of serving the local community, the model allows doctors to determine how they should best serve their community, with any surplus generated being fed back to the benefits of the community and staff. It allows them to do this with organisations that are bigger than the existing small business model.

This delivers real alternatives for GPs, staff and patients to access locally responsive, high quality primary care services. It is a supplement rather than a replacement to existing GP services and would work in either GP led, or PCT led environments. They will promote best clinical practice in a supportive, professionally led, locally accountable environment, at the delivery end of primary care.

Primary Care Mutuals ensure that good young doctors are attracted to primary care because they facilitate the desire of doctors to work under a salaried arrangement, rather than being required to invest in a practice with the associated long-term commitment; plus career and practice development opportunities in a supportive environment.

They provide an alternative structure to manage the increasing complexity of patient care, including the commissioning of secondary care by establishing a structured approach across practices to chronic disease management involving both primary and secondary care.

Mutuals are large enough to enjoy some economies of scale and to share administrative and clinical staff in a way that allows for efficiency and specialisation. They continue to operate locally and be responsive to local needs and offer support in a way that is seen by clinicians to be helpful to them in delivering patient care.

They allow the clinician to control the clinical environment, ways of working and treatment paths in a way that allows them to assure appropriate treatment for each patient and promote an environment in which the teams of specialists and generalists can operate together to provide mutual support to each other. This encourages the sharing of best practice to raise the standard in all aspects of their operating model and they will provide a supportive and developmental employment environment consistent with the expectation of a modern workforce.

These new Mutual primary healthcare providers are likely to spring from, for example:

- A number of GP practices that recognise that an umbrella mutual structure will allow them to enjoy the benefits of economies of scale, standardised support processes, more advantageous purchasing and commissioning leverage etc. whilst still allowing appropriate local control of the clinical environment and responsiveness to the local patient needs.
- One GP practice where there is no clear and obvious succession plan and where the mutual model provides a vehicle whereby doctors can work under a salaried arrangement without the requirement to make the longer term personal commitments of capital and development of the ‘business’.
- A PCT (perhaps that has a number of practices where it has been unable to attract GPs under the traditional practice model) for which the establishment of a mutual organisation enables them to provide an attractive proposition to GPs to work as salaried staff within a supportive organisation whilst allowing the PCT to focus on the commissioning of services rather than as a provider.
- An out-of-hours provider, perhaps that began as a co-operative but which has increasingly found itself recruiting salaried staff to meet its out-of-hours obligations and which then is able to move into the provision of in-hours care through establishing a new structure.

A mutual approach to primary care aims first and foremost to establish a sustainable basis for the ownership and delivery of primary care services that retains and builds on the strengths of UK general practice.

It seeks to establish locally owned and controlled bodies, each of which provides a framework for a number of existing GP practices to operate together with shared services, thereby achieving more effective professional development and support, consistency of clinical practice with resulting improvements in quality of outcomes, a supported working environment and increased efficiency.

www.mutuo.co.uk

Building multi-practice partnerships

Laurie McMahon and Gerald McLean, MPP

MPP have worked with a number of GP and practice manager groups about how they envision the new world of primary care. The conclusion is that it will be much harder for smallish practices to act independently of each other as separate organisations. This will lead to pressure for larger groupings of GPs to work together to create economies of scale in relation to the increasingly heavy management load and to give practices sufficient leverage as commissioners. There are a number of ways that larger operating units for primary care – different forms of practice collaboration or integration – could be created.

Our proposals allow GPs to preserve the integrity and independence of their practices whilst at the same time overcoming the disadvantages of relatively small-scale operations. When we talked to groups of practices up and down the country the answer that began to emerge was about creating solid managerial ‘platforms’ that allow like-minded practices to come together in locally-run ‘collaboratives’ that could offer the benefits of a much larger organisation.

These Collaborative Platform Organisations (or CPOs) allow major economies of scale and give GPs more purchasing clout as procurers and commissioners – without compromising the status of practices as independently owned and operated businesses. This is akin to franchising but without the full standardisation of the end service. Though unglamorous, perhaps the best analogy would be providing a ‘Spar-service’ of management services to independently owned local shops.

We drew heavily on our knowledge of running a large GP Multi-Fund for over 250,000 patients but we also ran a pilot ‘practice collaborative’ project involving all 35 practices in a single PCT. From this we learnt that for the GPs to gain sufficient confidence to link their businesses into formal collaboratives an incremental approach is required. We also know that given GPs’ need for independence they need to have ownership of the platform organisation. So we have now developed a model in which the member practices own the CPO outright, and because of public sensitivity about profiteering from illness, we advise establishing the CPO as a not-for-profit ‘public benefit’ company. This means that although having complete autonomy to develop its business the CPO will not distribute dividends and will be held to account by its non-executives to ensure that operating surpluses are spent for public benefit.

Building the business

The candidate management and commissioning services that our GPs identified include: handling the contract; driving PBC; contract negotiation/management; finance (payroll; accounts); business financing; human resources (HR); procurement; health and safety; estates and facilities; planning; compliance, standards and audit; technology management; transport; service development; and marketing.

Although there will be a core management and commissioning package supplied as part of the basic membership of the CPO, additional services can be purchased as options by individual practices. The costs of the management services and commissioning will be met through the practice budget agreed with the PCT and through the money allocated to each practice by the PCT to run practice based commissioning. We are now undertaking an ‘integration audit’ with six groups of ‘like minded practices’ across the country as the first stage in building their platform.

Developing the services

Once the platforms are running, the second stage is to work with the practice members to produce a CPO Commissioning Plan. This involves looking at the needs of the combined practice populations and looking at how those needs could best be met – aligning with whatever strategic guidance is offered by the PCT. We are working with a major independent provider to help establish how the practices might offer patients ‘surgery side’ facilities to provide a wider range of higher quality services closer to peoples’ homes and to decrease the flow of patients into in-patient hospitals. This process will determine the level of clinical services that will be provided within the CPO’s ‘domain’ as well as the NHS (practice-based) Commissioning Plan for services not available within the domain. On behalf of practices the CPO would first secure the endorsement of the PCT for the Commissioning Plan and then negotiate with providers for the patient services that need to be purchased from other providers.

It is early days and there is a way to go before we can demonstrate the full advantages of the model to patients, practices and the new PCTs but the strength of interest in a GP owned, not-for-profit, collaborative organisation of like-minded practices suggests that CPOs may well become a familiar feature of the NHS landscape in the future.

mpp_@btconnect.com

Chapter 3

The benefits of emerging models

Several themes emerge from the four examples above (pages 20-30). Their solutions all provide direct, comprehensive and robust support for the frontline member of staff providing the service. And either because of the size of the organisation or of the networks that provide managed services, they encourage the direct use of specialist back-up within the primary care organisation.

All four examples, to a greater or lesser extent, facilitate the move of diagnostic services and minor surgery away from acute hospitals; the means to tackle health inequalities; and the support to develop primary care organisations.

1. Diagnostic services and minor surgery closer to home

All of these models, because they could be developed up to any size, offer the possibility of providing a wide range of diagnostic and day case surgery within primary care. They would give many more patients the opportunity to complete their care pathway within primary care.

A mutual that organises 70 GP surgeries could afford to buy-in a very wide range of diagnostic services for that many patients. It would probably have within it a wide range of different clinics – several antenatal clinics, several clinics working with patients with diabetes, asthma and other long-term conditions. A large private company developing a primary practice offer for NHS patients would be able to include a wide range of different day case operations as well as diagnostics.

Such a service would transform the public’s experience of primary care. Patients would be able to complete many more of their packages of care without having to go to a hospital. They would become used to expecting their GP to be able to complete such an experience within their primary care practice.

2. Giving GPs the tools to tackle health inequalities

There are a number of different services that a larger organisation can provide to confront inequality.

First, better primary care services for the poorest areas. Larger organisations can bring the full range of primary care services to poor areas. At the moment it is these areas where primary care services are at their weakest because it continues to be difficult for PCTs to persuade GPs to set up businesses in the poorest areas of the country.

Being part of a bigger organisation means that GPs can spend a part of their career within the same organisational structure working in an inner city area. At different times in their career, they can move within the organisation to work in different locations.

Second, international real time databases can be provided directly into the consulting room. The component parts of this are already available on the web, but at the moment a busy GP needs to construct their own search. A larger networked organisation would easily create and up-date a database containing a range of information that exists about the health background and lives of people, and make it available to frontline GPs. Wherever a patient comes from a good networked database can provide the GP with direct information about that location and its disease pattern.

We have already seen the very significant impact the smart use of information can have on diabetes services, for instance in Slough. The national informatics organisation *Dr Foster* provided both information and assistance in using that information and ensured that in a poor area with very high numbers of people from the the south Indian subcontinent, who are genetically more likely to have diabetes, they could target diagnostic resources²⁰.

This is just the beginning of what informatics could provide to assist primary care in confronting inequality.

Thirdly, linguistic services. Very small localities can have over 100 languages spoken within them. This list can sometimes be supplemented without warning by people who speak a new language needing primary care services. Larger or networked organisations can provide comprehensive linguistic back-up with staff qualified in both the values of confidentiality and the translation of the specific language. At the moment this too often takes place through relatives and guess work.

Fourthly, ensuring poor patients get a better public service. John Berger's "fortunate man" failed most days because on his own he could not, for example, improve the housing conditions of the poorer people in his community. All over the country GPs try to improve the lives of their patients by becoming experts in the local labour market, housing allocation policies and welfare benefits policy. At

best they become gifted amateurs, but given the complexity of these issues, it is hard for small practices to provide patients with the best advice and action. A networked or large organisation could employ full time staff to work for local people, either in the surgery or at the end of a multilingual telephone. A patient's case would be followed up by the GP through expert welfare rights practitioners, who can act for the patient in maximising their income, their opportunities for work and their other choices within modern public services.

3. Management services and business development

Many GPs enjoy the business of running a business, in which case these new structures are not necessarily for them. But for others the development of a small business is not why they wanted to be a doctor. They are not interested in developing an HR policy for practice nurses or in spending time with their bank manager discussing a business plan. Within these models this second group will have a choice. They can choose to be salaried GPs working for a co-operative, a growing small business or a large private business. Under these circumstances, as a salaried member of staff they would expect to be provided by the employer with the very best HR services and would negotiate their terms and conditions of service.

Others may want to remain as an owner but without having to worry about the plumbing of the surgery or the National Insurance contributions of the staff. In which case, they could remain as a small GP practice but pay for managed services from a public benefit corporation.

If they wanted to remain as owners they would have a further choice. They could maintain their ownership of their small business but choose to change the organisational form of that ownership into a mutual, or maintain their ownership and also become part-owners of a mutual or public benefit corporation that provides them with managed services.

Hundreds of GP practices could be networked in this way, backed up with high class services or buying them in from the best network on the market; or they could play a role in developing and running the public benefit corporation or mutual that provided their services.

For those commentators that call the development of new providers 'privatisation', the greater number of staff involved in owning their organisation will be one of the methods of demonstrating the absurdity of the charge. For them this transfer of ownership from a small private enterprise model to a mutual is a change from private to public organisation not the other way around.

For other staff, these models create choices that rarely exist at the moment. A practice nurse or manager is most likely to be an employee in the doctor's small business. Within these models, they can retain that role as employee but within a wider range of different organisations. They can also play a role in owning and/or managing these emerging models, so there will be many more non-doctors owning primary care organisations.

Chapter 4

Next steps

The government policy direction is clear – they want new providers in primary care. But the wish itself will not bring them into existence; to do that, members of the public have to have the opportunity of creating that demand.

At the moment the demand for primary care services is largely determined by the existing providers of primary care services, most of whom tend to think that the only way of providing services is the way in which they currently deliver them. If the people who are providing the service are allowed to determine the way in which that service develops, it is likely that the ways of the past will dominate the ways of the future. New forms of provision in primary care will not emerge unless members of the public themselves have the capacity to register that demand.

This, of course, is the idea behind our individual right to register with our choice of GP. Legally, my primary care registration is mine – my choice – my right to move and my right to register with something different. But in reality that right is heavily circumscribed. I can choose to register with a GP practice within a very small locality. If all the practices in my locality offer similar services and are similarly organised, then there is in reality no choice. For new organisational forms of primary care to start to offer services, members of the public have to really own their right to register and have to be able to locate that registration with one of a range of organisations that are agreed to be safe and effective by the Healthcare Commission.

As this pamphlet has demonstrated, if the demand for primary care is freed up there are a number of different organisational forms waiting to be brought into primary care alongside the small business model. These are not merely theoretical methods of provision worked out in Whitehall; they are real possibilities that have been developed with people who actually deliver primary care services now. The Government, in looking for the innovative providers that the NHS Improvement Plan wants, must simply free up the way in which demand for the full range of primary care services is organised. These new forms of provision are ready to come into play to meet this demand at the earliest opportunity.

Conclusions

In our country, small businesses are a vital part of our society and service provision. But they exist alongside other organisations. Most other services have developed different organisational forms organically. Smaller organisations have developed into larger ones while new generations of smaller organisations have developed. As a nation we seem to be happy with that as a model for social and economic improvement.

Within primary care however, this has not been allowed to happen. The small business model has continued to dominate with very little competition from other larger organisations.

It is important to reiterate at this point that my argument is not that there should be no small businesses providing GP services in England. In many circumstances, this model provides excellent care. But we live in a very diverse society where people live very different lives that demand very different primary care models. To be effective, primary care needs to be organised in different ways. And as a nation and an NHS we cannot afford for primary care to continue to be as weak as it is in some areas of the country.

Moreover, provision will never be moved from secondary to primary care if it continues to be organised only in the way it is, and primary care will never be able to confront the health issues fuelled by globalisation if it continues to be organised only in this way.

There will be some who deliberately smear this argument with the charge of privatisation. For some all public service reform, irrespective of what it is actually achieving, is labelled as privatisation. But for that charge to have any weight in the real world there would have to be a considerable increase in the amount of activity that takes place through private enterprise. It would either be the case that more patients receive their care from organisations developed through private enterprise or more patients have to privately pay for their care.

This is not the case here. First, most GP practices are already organised through the private enterprise model of the small business. It is simply not possible to privatise private enterprises. In reality these reforms will lead to some private organisations transferring into the public sector of the co-operative movement and the public benefit corporation.

Second, within the models outlined here, not a single patient has to reach into their pockets to pay for anything. And as importantly, these larger models have a much better chance of providing more equal access to care than they do at the moment.

This pamphlet has suggested some different organisational methods of providing GP services. Some of these new organisations are public sector and some are private sector but all the care will be provided free at the point of need within NHS values.

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Why, despite clear intentions from consecutive governments over many decades, does the so-called shift from secondary to primary care seem so difficult to achieve?

In this discussion paper, Paul Corrigan argues that the current “small business” model for general practice is part of the problem, in that small GP practices have neither the incentive nor the capacity to invest in surgical and diagnostic services, let alone face the challenges of health inequalities and globalisation. Without radical change, he suggests, primary care will not be able to deliver the improvements in access and services that patients require.

The pamphlet also includes four contributions from experts involved in developing new models of primary care; they describe how larger organisations, including co-operatives, public benefit corporations and private providers can, working alongside smaller GP practices, revolutionise healthcare in this country and help ensure that primary care is fit for purpose.

The New Health Network

Lafone House, The Leathermarket, Weston Street, London SE1 3ER

Tel: 020 7407 1618

email: coordinator@newhealthnetwork.co.uk

www.newhealthnetwork.co.uk