

A 2014 Commonwealth Fund study of 11 developed countries' healthcare systems rated the UK's as the best.¹ The NHS, with general practice at its heart, is not just a health service, but also an integral part of the fabric of British society. Sixty-seven years after its foundation, the principles and values on which the NHS were founded remain as relevant, important, and as cherished by the British public as they were in 1948. For example, in 2013, a large Ipsos Mori poll² found that the NHS is Britain's most popular institution, ranking ahead of the monarchy, the army, and the GB Olympic team. Indeed, when asked what made them proud to be British,³ 72% declared the NHS to be 'a symbol of what is great about Britain and we must do everything we can to maintain it'.

GPs, as providers of 90% of NHS care, are central to NHS provision. In England following the Health and Social Care Act (2012) and the creation of clinical commissioning groups (CCGs) in 2013, GPs have become responsible for more than 70% of the NHS commissioning budget. Recent moves by NHS England are increasing the involvement of CCGs in the commissioning of primary care. This brings with it even greater opportunities for GPs and CCGs to orchestrate the delivery of care. Being at the centre of both the delivery and commissioning of care gives general practice unique opportunities and great responsibilities to shape the future of the NHS. How should GPs and CCGs make the most of these opportunities... and responsibilities?

A good place to start is to be clear about the purpose of a healthcare system. In a seminal paper in the *NEJM* Michael Porter of the Harvard Business School wrote:

*'In any field, improving performance and accountability depends on having a shared goal that unites the interests and activities of all stakeholders. In health care, value is defined as the patient health outcomes achieved per dollar spent. Value should be the preeminent goal in the health care system because it is what ultimately matters to patients and unites the interests of the system actors.'*⁴

If that is true, and we believe it is, then we need urgently to re-focus our health economies on delivering outcomes. The International Consortium for Health Outcomes Measurement defines outcomes very simply as 'the results that matter most

to patients'.⁵ If we are to identify the outcomes that matter most to patients we need to talk and listen to patients, their families, and communities. Experience shows that they are likely to describe outcomes in much more social and functional terms than professionals. For example, when older people in Cambridge were asked, they said they wanted the health and care system to help them stay independent for as long as possible, and, if they got sick, to recover their independence as much as possible. In thinking about the end of life, they said they wanted the system to relieve symptoms and to help them die in a place of their choice, cared for by their properly supported loved ones. And people with severe mental illnesses will tell you that an outcome of good care will be their ability to obtain and hold down meaningful employment. Dialogue with the community can add more population-oriented outcomes, such as reductions in inequalities in health to more individual-focused outcomes. Re-focusing the health system on delivering outcomes such as these would have profound and, we believe, beneficial consequences.

It also appears that a generalisable truth derived from the study of organisations and systems is that systems in which incentives for individuals, teams, and organisations are aligned with system goals tend to achieve better outcomes. They are also less wasteful than systems in which incentives are misaligned and unrelated to (or divergent from) system goals.^{6,7} So GPs, acting as commissioners, need to contribute to re-focusing the system on outcomes by replacing the current activity-based and block contracts with contracts that properly reward outcomes and value.

In addition, the NHS has been blighted by short-term planning and contracting cycles. The annual processes of negotiating contracts are wasteful and inefficient. More importantly, 1-year contracts do not give providers the security to invest in clinical services, including prevention, whose benefits may not be realised for several years.

GP commissioners can address both the misalignment of incentives and the blight of short-termism by replacing annual activity-based and block contracts with multi-year capitated contracts that reward improvements in outcomes that matter. These would apply to the whole system, including acute care, and not just primary and community services.

What would such a change in contracting mean for the delivery of general practice, particularly if some or all primary care budgets were included in these new outcome-based contracts? Although not without risk, it has the potential to catalyse much needed primary care reform in ways that will be good for the funding and provision of general practice. Starfield's work⁸ demonstrates that healthcare systems with strong population-based primary care are more effective (that is, produce better health outcomes), are more equitable⁹ (that is, reduce differences in health outcomes), and are more efficient (that is, are both cheaper and of better value). This holds true both between and within countries. Even within countries, the supply and availability of primary care doctors — but not specialists — is associated with lower mortality and better outcomes.¹⁰

The key elements of primary care that account for these observations are:¹¹

- *First-contact care.* Requires accessibility and responsibility for reducing unnecessary specialist care.
- *Person-focused care over time.* Delivered by the patient's chosen physician, who assumes responsibility over long periods of time for all health care (that is, continuity of holistic rather than disease-oriented care). Increasingly this will include proactive care and support planning.
- *Comprehensiveness of care.* The availability in primary care of a wide range of services to meet common needs, and by demonstrating that care is, indeed, provided for a broad range of problems and needs.
- *Coordination of care.* When people have to go elsewhere for problems outside the competence of the primary care practitioner.
- *Public Health Disease prevention services.* Such as immunisation and cervical screening.

Most GPs and the RCGP would recognise these as core elements of good general practice, and which need to be delivered well. Across the UK workload is rising, funding falling, technology and demography changing, recruitment and retention becoming more difficult, and public tolerance of unreliability in quality, safety, and access to care is reducing. As a consequence, general practice is becoming fatigued and is struggling.

The implication of Starfield's conclusions is that any provider or group of providers incentivised to deliver better outcomes and greater efficiency across a system by multi-year capitated outcome-incentivised contracts will need to ensure that sustainable high-quality primary care is at the heart of any solution. Patient safety needs to be of paramount importance and an important driver in any outcome-focused system of care. Adverse drug reactions account for approximately 6.5% of hospital admissions, resulting in a median bed occupancy of 8 days.¹² Importantly, this study demonstrated that this could be improved with appropriate educational interventions.

Multi-year capitated contracts could require providers to properly place patients in the centre with a comprehensive anticipatory care plan, as described by the Coalition for Collaborative Care in its House of Care model. Making a success of such contracts requires developing new capabilities including: the ability to coordinate the care of individuals along pathways and across settings; and population health management. Namely, the provider must understand individuals' risks of future ill-health, future service use and expenditure, and to design and deliver interventions to reduce those risks.

As general practice is the only element of the current provider architecture that deals with a registered rather than a referred population, it follows that general practice has to be central to any provider response to capitated outcome-incentivised contracts. It also follows that the leadership of any provider responding effectively to such contracts will require a good understanding of population-based general practice. It is essential, given the list-based nature of general practice, that a system designed to reward high-quality outcomes is also underpinned by a core offer to give a safety net to general practices and the communities that they serve.

The RCGP has long supported the notion that high-quality general practice can be promoted by more collective working across practices — whether as federations or more topically through the development of new models of care. The NHS Five Year Forward View describes several approaches to integration including Multispecialty Community Providers (MCP) and Primary and Acute Care Systems (PACS).

The MCP has at its heart general practice working with others to provide comprehensive locality-based care that in time would have the ability to take on a delegated budget for its registered population. The RCGP sees this model fulfilling the core requirements set out

above and able to be applicable across most of the system. These organisations can be seen as a natural evolution for GP networks or federations linking with specialists who can offer expertise beyond a traditional hospital, as recommended by the RCP's Future Hospital Commission.¹³ To be effective these organisations must be underpinned by a different funding mechanism with the characteristics set out before.

PACS are another organisational form that could deliver integrated care focused on outcomes. The RCGP believes that it would be perverse to pass the responsibility for the organisation and commissioning of extended primary care services to parts of the system that have no understanding of population-based primary care. If they are to be successful and to command confidence they too will need leadership that understands population-based primary care drawn from general practice.

In either approach, networks of practices with extended functions, properly developed and managed, will result in organisations that have GPs at their centre, focusing on delivering outcomes that matter, which bridge the traditional primary-secondary care divide. The evidence from New Zealand is that networks of practices focusing on quality and outcomes not only improve outcomes for patients but also have tangible benefits for previously struggling practices.¹⁴ Such organisations also add capacity for educational provision — the Pegasus network in Christchurch started with a coordinated continuing professional development (CPD) programme for all staff across the practice network, and now also hosts effective administrative training (for example, expertise in human resources or financial governance). Even more importantly, additional teaching and training opportunities can be created for larger numbers of healthcare professionals at undergraduate and postgraduate level, through coordinating placement supervision and trainer support across a larger group of practices. Some schools of primary care in England have seen educational initiatives as a first facilitating step towards federations:

- an educational supervisor can work across more than one practice to allow small or inexperienced practices to start taking a few students at a time;
- trainer or tutor absence does not leave the trainee without cover;
- educational leads can draw on each other's expertise, for example, to support trainees with difficulties;

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- there may be economies of scale for tutorials and specific learning opportunities; and
- there are likely to be improved opportunities for multidisciplinary training.

Properly designed, these new organisations have the potential to ensure the public will continue to receive the best elements of primary care and that GPs and their teams have rewarding careers for decades to come. The successful creation of such organisations and services will need significant GP input from the beginning. The challenge will be to free up enough time for GPs, as providers, to contribute effectively.

So, GPs, as commissioners, by insisting on the development and letting of multi-year capitated outcome-incentivised contracts and, as providers, by working with colleagues to design new ways of supporting primary care, can achieve the triple victory of improving outcomes, getting better value, and securing sustainable high-quality general practice for future generations.

Macaskill-Smith, who was instrumental in setting up effective primary care networks in New Zealand, advised English GPs 'don't wait for an invite'.¹⁵ We agree. This is a party GPs need to gatecrash or — better still — host.

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Nicholas Hicks is Co-Founder and Chief Executive of COBIC Ltd (<http://www.cobic.co.uk>), an organisation that provides advice to commissioners and others about outcome-based commissioning.

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