

Joining up services in the community

GPs leading the way

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General practice is widely recognised as the foundation of the NHS. It is viewed positively in international studies, and most patients report high levels of satisfaction with the services they receive from general practitioners (GPs).

However, practices are under increasing pressure to respond to the demands of an ageing population, many of whom have long-term conditions, at a time when their share of NHS resources is declining. We therefore have to consider how general practice is organised and funded, and in particular how it connects with the wider health and social care system.

We have produced this briefing, based on a paper – Commissioning and funding general practice: making the case for family care networks – in which we argue that GPs should take the lead in developing care out of hospital by taking responsibility not only for their own services but for many other services used by patients in the community.

We believe that the existence of registered lists of patients offers practices an opportunity to use their knowledge of these patients both to work proactively, anticipating needs before they become crises, and to develop appropriate treatments. The registered list also offers a challenge to practices to focus on all people on the list, not just patients who seek advice and support.

The shift to population health management and proactive care is often difficult to achieve in general practice today. It is for this reason that we propose a move away from the current model of small, independently minded practices towards new forms of organisation that enable practices to work together and with other providers to put in place the integrated services that are required. We believe that different funding streams should be used more flexibly to enable this to happen, creating the possibility of practices receiving more resources as funds are released from other areas of care such as hospitals.

The ideas set out in this briefing go well beyond debates about changes to the current GP contract to describe the more fundamental reforms required to ensure general practice is able to meet the needs of the population in future. These reforms would offer GPs who are willing an opportunity to test out a radically different way of delivering care to patients allowing other GPs to retain their existing contracts.

What would this mean?

The approach we propose starts from the premise that GPs are both providers and commissioners and that their role as providers is the more important. Strengthening the role of GPs as providers requires a new approach to commissioning and funding care based on federations and networks of practices able to provide care on the scale needed in future. Other providers, including NHS trusts, should also have the opportunity to work with practices in developing this approach.

In putting forward these ideas, our aim is to promote an environment that breaks down the barriers between funding streams and services and enables GPs and managers to make a reality of integrated services in the community. Innovations in the commissioning and funding of general practice have the potential to drive changes in how services are provided. The approach we argue for would have the following characteristics.

Commissioners negotiate a population-based, capitated contract with providers

Federations of practices would take on a population-based capitated contract to provide care to patients on their registered lists. The funding in the contract would be based on the numbers of patients served and the range of responsibilities included in it. Funding for general practices themselves would be incorporated into funding for other services covered by the contract. A variety of risk-sharing arrangements are possible, ranging from providers accepting full risk to providers sharing risk with commissioners. Federations might be formed from practices working in the same area or from like-minded practices that choose to work together irrespective of geography.

The contract focuses on outcomes and not inputs

Under the contract, federations would be required to deliver outcomes agreed with commissioners. These outcomes would encompass a number of dimensions including improvements in population health, patient experience, access, continuity, the quality of clinical care, service utilisation and financial performance. The contract would include incentive payments to reward providers for delivering these outcomes and penalise them for failing to do so. The focus of the contract would therefore be on what providers are expected to deliver rather than how they should do so, giving practices the freedom to innovate and provide services in the way that best delivers the required outcomes.

Providers demonstrate that they have the capabilities to manage the contract

Federations and networks would need a range of capabilities to manage the contract successfully, including expertise in contract negotiation and management, financial management, utilisation management, and the management of clinical quality. They will also need well-developed clinical leadership and access to real-time information to enable them to keep within budget while also achieving the required outcomes. Medical groups in the United States that took on capitated contracts in the 1980s and 1990s often failed because they lacked these capabilities. The contract should only be offered to providers with the expertise needed.

Providers create new organisations to manage the contract

The wider range of responsibilities and funding included in the contract will require more than informal collaborations between practices. It will need new organisations to be created to manage the contract, drawing on the experience of the innovations in primary care described in our report. Robust governance of services and budgets linked to explicit accountability for performance will be essential. These organisations might include limited liability companies, community interest companies and social enterprises, and super partnerships.

Providers work at sufficient scale to manage the contract without being so big that incentives for member practices are attenuated

In order to manage the clinical and financial risks effectively, federations would need to cover populations in the range of 25,000 to 100,000 people. The actual size would depend on the scope of services covered by the contract and the extent of risk-sharing between commissioners and providers. The use of stop-loss insurance would enable smaller provider networks to work under these arrangements. There is a risk that larger organisations may find it more difficult than smaller ones to engage member practices and create a common sense of ownership and purpose.

Providers take 'make or buy' decisions

Federations and networks should be able to use their budgets to commission services from other providers where appropriate. They would take 'make or buy' decisions, providing services in house or subcontracting to other providers in virtual networks, which might be either close-knit arrangements or looser alliances. A variety of forms of primary-care centred, integrated services would emerge depending on geography and also on how far GP leaders wished to extend their role as service providers.

Providers develop sophisticated means for contracting and incentivising 'within network'

A major challenge in making this approach work is in how to develop contracts and incentives 'within network' to deliver the outcomes required, encompassing, for example, how GPs are paid – by salary or other means – and how subcontractors are incentivised. Some GPs may wish to take a lead role in developing federations as managing partners, others may prefer to concentrate on their role as providers either as partners or on a salary. Where GPs are salaried, incentive payments are likely to be needed to ensure delivery of high standards of care. Lessons could be learnt from the experience in other sectors in which supply chains link prime providers and subcontractors.

GPs find ways of collaborating with hospital-based specialists

Federations and networks will need to work closely with hospital-based specialists to manage budgets successfully. The new models of care required in future will involve treating fewer patients in hospitals and more care being delivered closer to home. GPs can play their part in this process working closely with community nurses and other services provided in the community but they will also need the support of specialists in the care of older people, paediatricians and various 'office-based specialists'. Multispecialty medical practice offers opportunities to provide proactive care, rapid responses to crises, and specialist care in community settings that in the past has usually only been available in hospitals and that may generate substantial cost savings.

Commissioners work together to support implementation

Responsibility for commissioning has been seriously fragmented under the coalition government's reforms, with the population-based budgets previously controlled by PCTs divided between NHS England, CCGs, local authorities and Public Health England. These organisations will need to work together to implement the new contract, particularly NHS England's area teams and CCGs, but also including local authorities in view of their responsibilities for both public health and social care. Our research shows that area teams must rapidly address concerns about their capabilities if they are to be able to commission and fund general practices to deliver the new models of care we advocate.

Conflicts of interest are managed effectively

Practices involved in bidding to provide services under the terms of the new contract would be excluded from the process of commissioning these services. Providers would be held to account for their use of funds both through established auditing procedures and by reporting annually and transparently on their performance under the contract. To provide further assurance that potential conflicts are being managed, federations should be governed by boards with members beyond the provider practices, including having patient representatives and lay members of their boards.

Market regulators support rather than inhibit testing of the new contract

The approach proposed here is a radical departure for the NHS and needs to be tested and evaluated ahead of widespread roll-out. Instead of taking a conventional competitive tendering route, commissioners should use their knowledge of the market to work with interested providers to negotiate the scope of the contract, risk-sharing arrangements and other aspects. Various organisations, including NHS trusts, might become prime providers of care, and there would be a deliberate emphasis on discovering which approaches work best rather than designing the approach at the outset. Monitor should ensure that regulation of the new contract is proportionate and that the rules on market regulation are interpreted accordingly.

What are the next steps?

We believe that in most areas general practices are best placed to take forward the approach we have described. Where practices are unwilling or unable to do so, then NHS trusts should be offered the opportunity to take the lead. At a time when the need for innovation in the NHS has never been greater, encouraging a variety of approaches has obvious merit, not least by changing ways of working that are no longer fit for purpose.

Practices will need support to enable them to work differently. Significant investment will be needed in leadership and organisational development. Federations will also need to forge partnerships with organisations that have skills to help them to manage contracts and budgets successfully. This will require finding resources to enable GPs and colleagues to take time out from their current responsibilities to plan a way forward.

Sufficient time will be needed to implement and evaluate the new contract. Policy-makers should assume that at least five years will be required to assess whether the approach proposed here is delivering the expected benefits. There are advantages in starting with enthusiastic practices and extending the scope of the contract to additional services and other practices over time.

The demographic and financial pressures the system is now facing mean that doing more of the same is not an option. There is an urgent need to move beyond localised pockets of innovation by taking radical action. What we have suggested here is a starting point for discussion and a contribution to the current debate on the future of primary care. For more of our work on this subject please go to www.kingsfund.org.uk/gp

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