

Who cares? The future of general practice

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Reform

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Executive summary

The core delivery model for general practice has remained largely unchanged since the creation of the National Health Service (NHS) in 1948. General practices are independent businesses, contracted by the state to provide defined health services to a registered list of patients. Practices are owned and run by one or more ‘partners’ – general practitioners (GPs) who hold contracts and share the profits their practice delivers. In theory, this incentivises the most effective care for all patients – from a young, healthy person requiring one-off treatment to an elderly patient with a variety of long-term conditions.

Today’s consumers of care are very different to those for whom the 1948 model was built. People expect to interact with services through technology, outside of core operating hours. People’s needs have also changed – increasingly requiring care for long-term conditions. These patients account for 50 per cent of GP appointments.¹ Across the system, care for people with long-term conditions is thought to consume 70 per cent of health and social care spending.² This is set to continue. By 2018, the number of people with multiple long-term health conditions will rise to 2.9 million – an increase of 1 million since 2008.³ Today’s elderly and chronically ill patients need integrated, accessible and extended care in the community. Instead, general practice providers remain small, care is episodic rather than coordinated and technology is not exploited. For taxpayers, this creates huge financial inefficiencies, as GPs handle appointments regardless of need, care is not delivered in the most cost-efficient place and economies of scale are not leveraged.

Recent moves to change this approach offer an alternative future. In England, the Coalition Government backed a range of new models of care, offering a variety of extended services and increased opening hours, underpinned by a workforce designed to meet the needs of patients effectively. These ‘vanguard’ providers can offer such services by operating at significant scale. International providers offer further evidence of tomorrow’s healthcare model. Many providers go beyond focusing on reactive care, by proactively monitoring and tending to the needs of all people under their care. Such a ‘population-health’ approach goes beyond traditional health and care services, to focus on wider determinants of people’s wellbeing. It therefore emphasises prevention for the healthy majority of patients, and joined-up care for those who need it.⁴

With its registered list of patients, and position as the defined first point of call for any patient entering the healthcare system, general practice is perfectly placed to lead a population-health approach. An increased focus on prevention for healthy patients, and self-management of long-term conditions, could save up to £1.9 billion by 2020-21. In addition, large providers can offer a range of extended services – including diagnostics, minor surgery and urgent care centres. Lakeside Healthcare in Northamptonshire offers an urgent care model to approximately 200,000 people at one third the price of an equivalent A&E visit.⁵ Applied across England, this could deliver savings in the region of £1.1 billion a year.

To deliver these services most effectively, providers will need to operate at much larger scale. Providers offering best practice in England and elsewhere hold patient lists at least ten times larger than today’s average list size of 7,400 patients; many aspire to operate at multiples of that. This affords providers the size to invest in front-end change and exploit back-end efficiencies, including making the most of technology. Online triaging, for example, has the potential to direct patients to self-care, rather than booking

1 Department of Health, *Long Term Conditions Compendium of Information. Third Edition*, 2012, 3; British Medical Association, *General Practice in the UK*, 2014, 2.

2 Department of Health, *Long Term Conditions Compendium of Information. Third Edition*, 3.

3 British Medical Association, *General Practice in the UK*, 2.

4 David Kindig and Greg Stoddart, ‘What Is Population Health?’, *American Journal of Public Health* 93, no. 3 (March 2003): 380–83.

5 This information was kindly supplied by a representative of Lakeside Healthcare and has been used with their permission.

appointments. If the proportion of people using such triaging services matched the number of people who use the internet each day, savings could be in the region of £274 million a year. Underpinning this with a multidisciplinary workforce also offers the potential for more efficient care. A number of experts interviewed for this paper explained that GPs could pass 50 per cent of appointments they currently conduct to other professionals. A more diverse workforce could, for instance, see pharmacists or nurses administering the estimated 57 million appointments (15 per cent of the total number of appointments) consumed by common conditions and medicines-related problems each year.⁶ This alone could deliver up to £727 million of savings per year.

This new approach to care from population-health providers can only materialise within a healthcare system that acts as one. Today's fragmented approach to care is driven by a funding stream that fails to incentivise integration. The commissioning of services is split between NHS England, clinical commissioning groups, and local authorities, which fund services such as public health, social care and primary care separately. Contracts also undermine incentives to provide more prevention, self-management and care in general practice. GPs receive set funds per registered patient, but secondary care is funded based on activity. This misaligns incentives for primary-care providers: with a fixed income regardless of activity, GPs are motivated to reduce care and secondary providers are incentivised to increase it.

Instead, contracts should cover the whole care needs of defined populations. Integrated commissioning bodies should replace today's fragmented commissioners. Whole-population-care contracts should be capitated, with commissioners able to attach bonus payments to incentivise improved care in specific areas. Contracts must also be time-limited and the appropriate size to incentivise competition between providers. Patient choice of provider must be upheld.

Ultimately, general practice is one part of a patient's journey and cannot be viewed in isolation from the rest of the system. General practice should, however, play a much expanded role in a new healthcare model. This report presents a radical blueprint for change. Designing a system that acts as one, with an increased amount of care delivered within general practice, will improve outcomes for patients at a lower cost to the taxpayer.

⁶ Reform calculations. NHS Alliance, *Making Time in General Practice*, 2015, 54.

Summary of recommendations

1. The Government should abandon its target to employ 5,000 more GPs. NHS England should conduct an audit of general practice appointments and work with providers and representative bodies to understand how consultations can be delivered more efficiently by other clinicians. NHS England should build a recruitment and training plan based on this information.
2. Current funding streams should be replaced with contracts that commission services covering the whole care needs of defined groups of people.
3. Contracts should focus on outcomes that matter to patients, rather than outputs or process. Commissioners, providers and patients should work together to determine these outcomes.
4. Commissioners should fund services from an integrated budget. The Government should investigate the optimum size of commissioning bodies and work with NHS England, clinical commissioning groups and local authorities to understand how these bodies should be constructed.
5. The Government should develop a long-term plan to collect data from general practice and across the NHS to be used to design contracts. The Government should satisfy itself that the care.data programme is best-placed to achieve its aims, clarify providers' legal obligations and ensure that people are adequately informed of their right to opt out.
6. Commissioners should nurture nascent markets through risk-sharing agreements. The nature of these agreements should vary by market maturity, but be designed for providers ultimately to assume full financial responsibility for patient care.
7. Future contracts must be fixed-term to encourage competition and the best services for patients. Exact durations will depend on market maturity, but best practice suggests between five and 15 years are optimal lengths.
8. Commissioners should uphold patient choice throughout the care system. Funding should follow the patient to incentivise providers to deliver the best care for all users.

1 Introduction

GPs themselves say that in many parts of the country the corner shop model of primary care is past its use-by date. So we need to tear-up the design flaw in the 1948 NHS model where family doctors were organised entirely separately from hospital specialists, and where patients with chronic health conditions are increasingly passed from pillar to post between different bits of the health and social services.

Simon Stevens, Chief Executive of NHS England,
October 2014⁷

General practice is widely seen as the jewel in the crown of the NHS.⁸ It is the first point of call for patients and staffed by generalists, tasked with managing the whole healthcare needs of defined groups. Since 1948, this has been delivered through a familiar model: small-scale, independent practices, owned and staffed by general practitioners (GPs), who are contracted to provide specific services for a registered list of patients. Care has long been delivered in 10-minute, face-to-face appointments with a GP – who provides care and assistance for some and diverts others through the system to secondary-care providers, such as hospitals, which offer specialist care.

As Simon Stevens has identified, however, this model has become outdated as demand has changed. People expect to interact with services through technology, outside of core operating hours. People's needs have also changed, as they increasingly require care for long-term conditions. These patients account for 50 per cent of GP appointments.⁹ Across the system, care for people with long-term conditions is thought to consume 70 per cent of health and social care spending.¹⁰ This is set to continue. By 2018, the number of people with multiple long-term health conditions will rise to 2.9 million – an increase of 1 million since 2008.¹¹

Today's elderly and chronically ill patients need integrated, accessible and extended care in the community. Instead, general practice providers remain small, care is episodic rather than coordinated and technology is not exploited. For taxpayers, this creates huge financial inefficiencies, as GPs handle appointments regardless of need, care is not delivered in the most cost-efficient place and economies of scale are not leveraged. Addressing these inefficiencies may go some way to helping NHS England find the £22 billion savings it has targeted across the healthcare system by 2020-21.

General practice should be at the forefront of delivering low-cost, high-quality care. Healthcare systems oriented towards primary care are more likely to deliver better health outcomes, including lower mortality rates, fewer premature deaths, higher satisfaction with the healthcare system and a decrease in utilisation of hospitals and emergency departments.¹² The highest-quality primary care systems deliver lower overall healthcare costs.¹³

It is therefore crucial to revolutionise the way general practice operates in England.¹⁴ Care should be delivered by larger providers, capable of offering a range of extended services, such as diagnostics, urgent care or minor surgery, seven days a week. This entails a more diverse workforce, with less of an emphasis on the GP, and a greater use of technology, particularly for the interaction between patients and clinicians. Patient self-management and a more sophisticated approach to offering non-biomedical care will also improve

7 Neil Durham, 'GPs Should Be Able to Expand Practices to Employ Hospital Consultants, Says NHS England', *GPonline*, 3 October 2014.

8 Jeremy Hunt, 'New Deal for General Practice', 19 June 2015.

9 Department of Health, *Long Term Conditions Compendium of Information. Third Edition*, 3; British Medical Association, *General Practice in the UK*, 2.

10 Department of Health, *Long Term Conditions Compendium of Information. Third Edition*, 3.

11 British Medical Association, *General Practice in the UK*, 2.

12 James Macinko, Barbara Starfield, and Leiyu Shi, 'The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970–1998', *Health Services Research* 38, no. 3 (June 2003): 1970–1998.

13 *Ibid.*

14 Since 1999, health policy in the UK has been devolved. The four national healthcare systems retain many similarities for historical reasons but the policy frameworks are diverging. This paper focuses on England. Some international analyses continue to treat the UK as a single healthcare system. In places, therefore, we use data applying to the UK.

outcomes and deliver savings for the NHS. This approach represents a paradigm shift in the delivery of primary care: a system based around the needs of the patient, rather than the GP.

Scaled systems with some of these characteristics exist in pockets of England. However, there is an emerging consensus, including amongst the expert stakeholders interviewed for this paper, that a sustainable system capable of incentivising radical long-term change does not exist. Funding streams across primary care and between primary and secondary care are fragmented: they fail to encourage integrated care.

To borrow Simon Stevens' words, this necessitates a tearing-up of the contractual framework. New contracts should be designed to make providers accountable for the whole care needs of a defined population group. These can be awarded to single providers, or groups. To incentivise the integration of care and emphasis on prevention of ill health and self-management of chronic conditions, these contracts should be commissioned by integrated commissioners, which replace the current split between NHS England, clinical commissioning groups and local authorities. To exploit the growing market of providers, commissioners should design contracts to stoke competition within local health economies, through the regular retendering of contracts, which are designed through scrupulous data collection. Patients must be empowered to choose providers they feel best meet their needs.

This is an ambitious vision. It affects not only general practice as it stands today, but the provision of wider primary, community and secondary care. The prize is great: better, more accessible care at a lower cost to taxpayers.

2

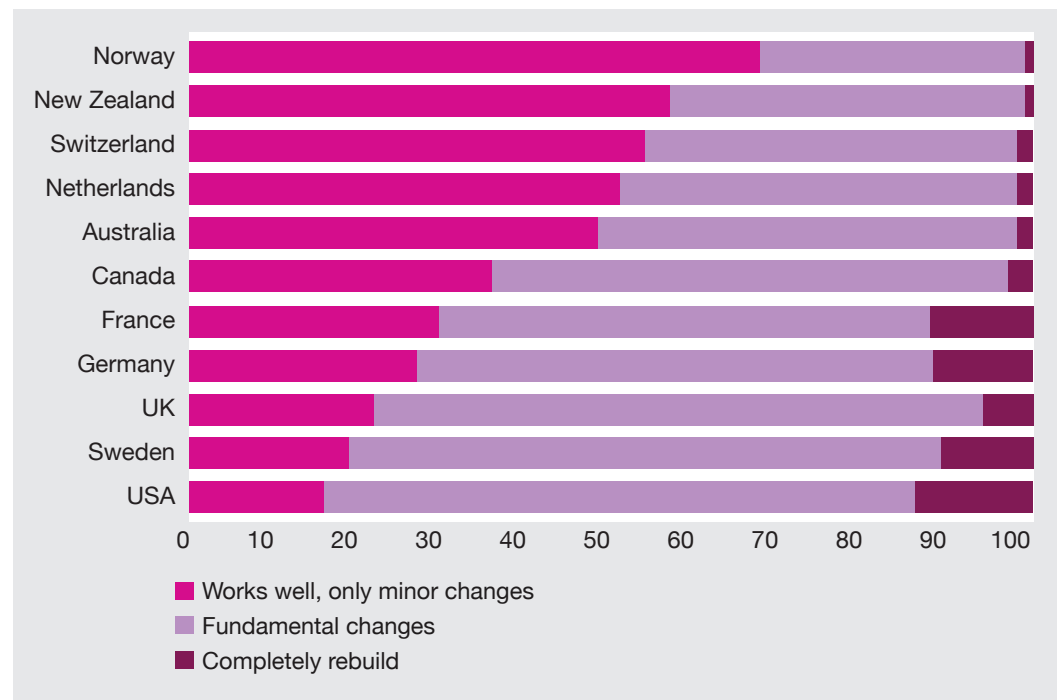
Primary care: fit for the past

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General practice is out of date. The model, built for 1948, must address the ever-more complex needs of a growing, ageing and more technologically sophisticated population. It cannot do so in its current state, which affects outcomes for patients and puts significant cost pressures on the system as a whole.

For these reasons a number of experts interviewed for this paper described general practice as being in “crisis” – a concern reflected in the literature.¹⁵ The Commonwealth Fund found 70 per cent of GPs believe the system needs “fundamental change” – an abnormally high proportion by international standards (see Figure 1).

Figure 1: Change needed in primary care according to primary-care physicians



Source: The Commonwealth Fund, ‘Primary Care Physicians in Ten Countries Report Challenges Caring for Patients with Complex Health Needs’, 12 July 2015.

2.1 Fragmented

2.1.1 Small, isolated practices

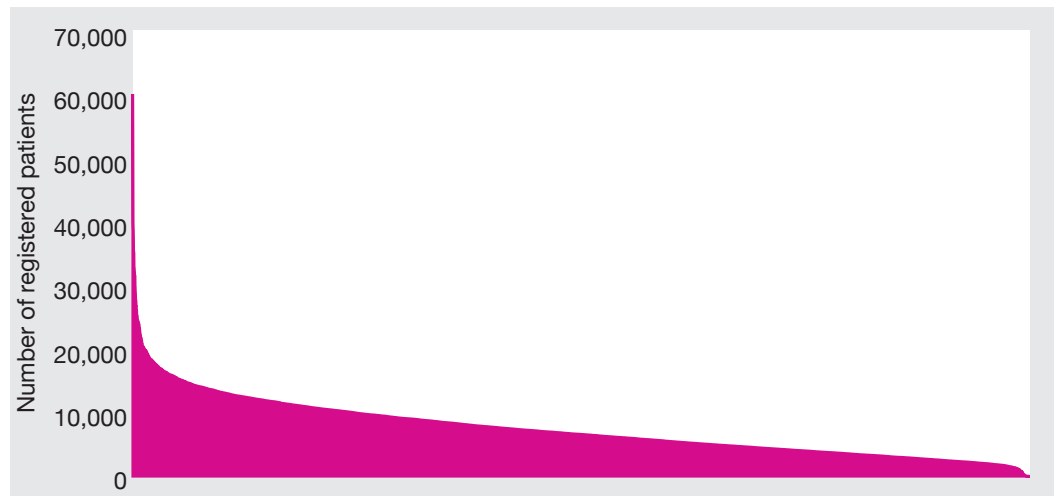
Since 1948, general practice has retained its core model of small-scale, independent businesses (run by partners), commissioned to provide services for a local population. Today, there are approximately 7,875 general practice surgeries in England.¹⁶ They have an average registered list size of 7,461 patients, but this varies considerably: 41 practices list more than 25,000 patients, while 90 have fewer than 1,000 (see Figure 2). The small scale is also reflected in personnel: 61 per cent of practices have fewer than four partners and only 6 per cent have 10 or more.¹⁷

¹⁵ Mark Dayan et al., *Is General Practice in Crisis?* (Nuffield Trust, 2014).

¹⁶ Reform calculations. National Audit Office, *Stocktake of Access to General Practice in England*, 2015, 4.; Health and Social Care Information Centre, ‘Numbers of Patients Registered at a GP Practice – Jan 2016’, 19 January 2016.

¹⁷ Reform analysis of Health and Social Care Information Centre, ‘General and Personal Medical Services in England 2004-2014: General Practice Bulletin Tables 2004–2014’, 2015.

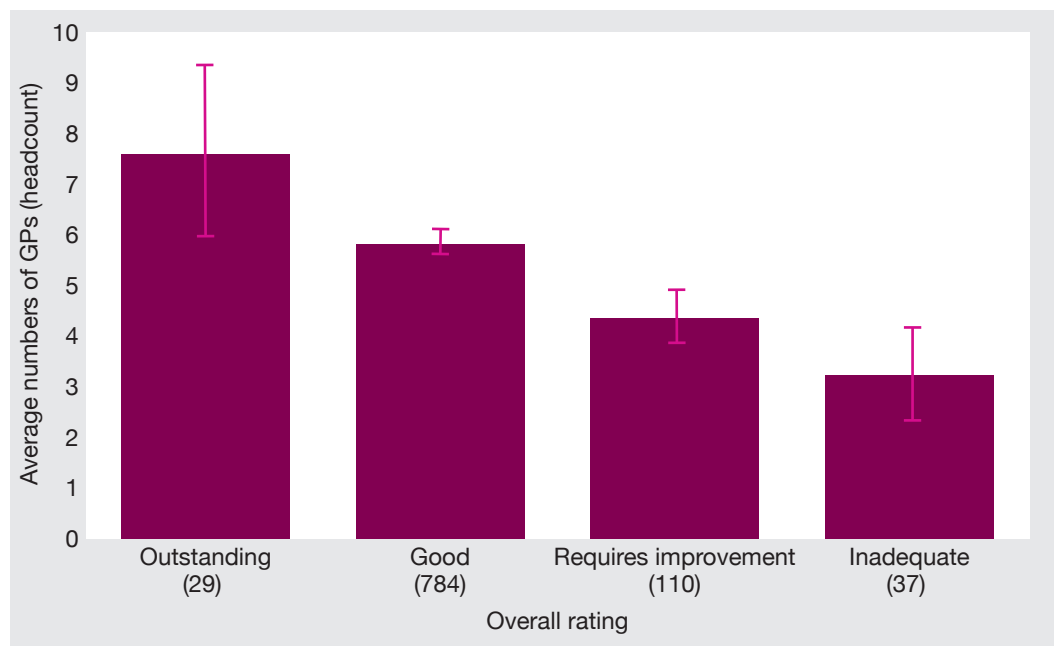
Figure 2: Distribution of practices by number of registered patients, January 2016



Source: Health and Social Care Information Centre, ‘Numbers of Patients Registered at a GP Practice – Jan 2016.’

Small scale is a problem for patients. The Care Quality Commission (CQC), which regulates health and care services, highlights a clear correlation between size and quality (see Figure 3).¹⁸ Similarly, research by the Institute for Fiscal Studies has demonstrated a positive relationship between the number of clinicians and outcomes scores, as measured by the Quality and Outcomes Framework (QOF).¹⁹ It also found a negative correlation between the number of clinicians and emergency inpatient admissions for ambulatory care-sensitive conditions, for which community care and case management can prevent hospital admissions.²⁰

Figure 3: Size and quality in general practice



Source: Care Quality Commission, *The State of Health Care and Adult Social Care in England 2014/15*, 2015.

18 Care Quality Commission, *The State of Health Care and Adult Social Care in England 2014/15*, 2015, 94.

19 Elaine Kelly and George Stoye, *Does GP Practice Size Matter? GP Practice Size and the Quality of Primary Care* (Institute for Fiscal Studies, 2014), 24–31.

20 Ibid.

Remaining small in size deprives practices of the ability to deliver the extended services needed to address the complicated needs of today's population.²¹ The failure to provide extended diagnostic services in general practice, for example, has been identified as driving unnecessary traffic into secondary care.²² Professor Steve Field, Chief Inspector of General Practice at the CQC, has drawn the link between scale, the ability to offer multi-professional teams and quality.²³

Care is also largely isolated and delivered in siloes, despite integration being the aim of successive governments.²⁴ This undermines the ability to provide patients with timely access to a range of services, as well as creating inefficiencies within the system.²⁵ As The King's Fund and Nuffield Trust have explained, "[w]ithout integration, all aspects of care can suffer. Patients can get lost in the system, needed services fail to be delivered or are delayed or duplicated, the quality of the care experience declines, and the potential for cost-effectiveness diminishes."²⁶ For example, before integrating services, fragmented care in Torbay and Blackburn meant it was "commonplace" for multiple assessments of older people to take place.²⁷ Integrated providers have delivered positive results: in Wales, the integration of chronic care across primary, secondary and social care reduced costs across three Local Health Boards, the regional administrative units for NHS Wales, by £2.2 million over three years.²⁸

Inefficiencies between primary and secondary care have also been found. NHS Alliance has shown that processing hospital bookings and dealing with hospital referrals were seen by GPs as unnecessarily consuming 4.5 per cent of appointments in general practice.²⁹ Patients are also bemused by the complexity of the healthcare system: supporting patients navigating the NHS was the fifth most burdensome area of bureaucracy for clinicians surveyed by NHS Alliance.³⁰

In response to concerns that small and isolated practices are unable to expand services and increase access, GPs have begun to group together to form 'federations'. These are formal collaborations between multiple practices to share best practice and extend services. One recent survey counted 5,750 practices as part of some form of federation, covering 75 per cent of England's population.³¹ Interviewees for this paper explained, however, that federations are largely seen as defensive measures to gain efficiencies, without providing innovation. One described it as "like putting old wine in new bottles" because federations "tinker round the edges" by providing small economies of scale, but retaining the same core services. This is borne out by a recent British Medical Association (BMA) survey, which found that bidding for primary-care contracts was the most common explanation (43 per cent) for GPs working in federations.³² A survey by the *Health Service Journal* concluded that half of federations shared no single function across GP groups.³³ Mike Bewick, former National Deputy Medical Director at NHS England, stated that this showed a "lack of ambition and clear priorities".³⁴

21 Judith Smith et al., *Securing the Future of General Practice: New Models of Primary Care*, 2013, 7.

22 Paul Corrigan, *Size Matters – Making GP Services Fit for Purpose* (New Health Network, 2004), 19.

23 House of Commons Health Select Committee, *Oral Evidence: Primary Care*, 2015.

24 Deloitte, *Primary Care: Today and Tomorrow Improving General Practice by Working Differently*, 2012, 17–18.

25 Nick Goodwin et al., *Integrated Care for Patients and Populations: Improving Outcomes by Working Together* (The King's Fund and Nuffield Trust, 2012).

26 *Ibid.*, 4. This was echoed by the House of Commons Health Select Committee in 2012, which found that fragmented services across primary and secondary care "are inefficient and lead to poorer outcomes for older people." House of Commons Health Select Committee, *Social Care, Fourteenth Report of Session 2010–12. Volume I*, 2012, 3.

27 House of Commons Health Select Committee, *Social Care*, 7.

28 Goodwin et al., *Integrated Care for Patients and Populations: Improving Outcomes by Working Together*, 5.

29 NHS Alliance, *Making Time in General Practice*, 6.

30 *Ibid.*

31 Nick Renaud-Komiya, 'Exclusive: GP Groups Cover Most of England but "lack Ambition and Priorities"', *Health Service Journal*, 1 June 2015.

32 British Medical Association, *The Future of General Practice: Full Report*, 2015, 5.

33 Renaud-Komiya, 'Exclusive: GP Groups Cover Most of England but "lack Ambition and Priorities"'.

34 *Ibid.*

To improve and integrate services, NHS England has outlined a range of ‘new care models’ (see box below). The *Five Year Forward View* explained the advantages of better use of technology, extended services within general practice and the integration of primary, secondary and social care.³⁵ To support this change, NHS England unveiled a package to help drive “radical innovation” and share best practice,³⁶ and provided ‘vanguard’ sites access to a £200 million transformation fund.³⁷

Selected new care models

Multispecialty community providers (MCPs): Multidisciplinary teams (working in federations or single organisations) able to provide a wider range of services within a primary-care environment – including diagnostics, social care and other services, such as dialysis and chemotherapy.

Primary and acute care systems (PACS): Integrated single organisations which provide GP, hospital, mental health and community services. These could evolve in different ways – such as a hospital opening a GP surgery or an MCP taking over a hospital – but would share the aim of becoming accountable for the whole health needs of a population.

Urgent and emergency care networks: Integrated systems which reduce pressure on emergency departments by directing urgent and emergency demand to the most appropriate place, which could be primary care, community mental health teams, pharmacies or urgent care centres.

Source: NHS England, *Five Year Forward View*, 2014.

2.1.2 Fragmented funding

Today’s lack of integration is driven by a fragmented funding system. General practices are independent care-providers, contracted by public-sector bodies to deliver defined services. The fragmentation operates at two levels: between the bodies that commission services, and within the contracts that fund the delivery of care.

As it stands, health and care services are contracted by three different bodies – or ‘commissioners’ – which drive a siloed approach to healthcare (see Figure 4). Since 2012, GP-led clinical commissioning groups (CCGs) – of which there are now 209 – have commissioned secondary-care services – a remit that, since 2015, can be extended to commission primary-care services. General practice, however, remains separately commissioned from public health, which complicates the ability of GPs to focus on prevention.³⁸ Likewise, social care funding is separate from healthcare funding, undermining the integration of these services.³⁹ When asked to list the barriers to dealing with financial problems, the conflicting priorities of different national bodies was the most commonly cited response from CCG leaders.⁴⁰

35 NHS England, *Five Year Forward View*, 2014, 16–17.

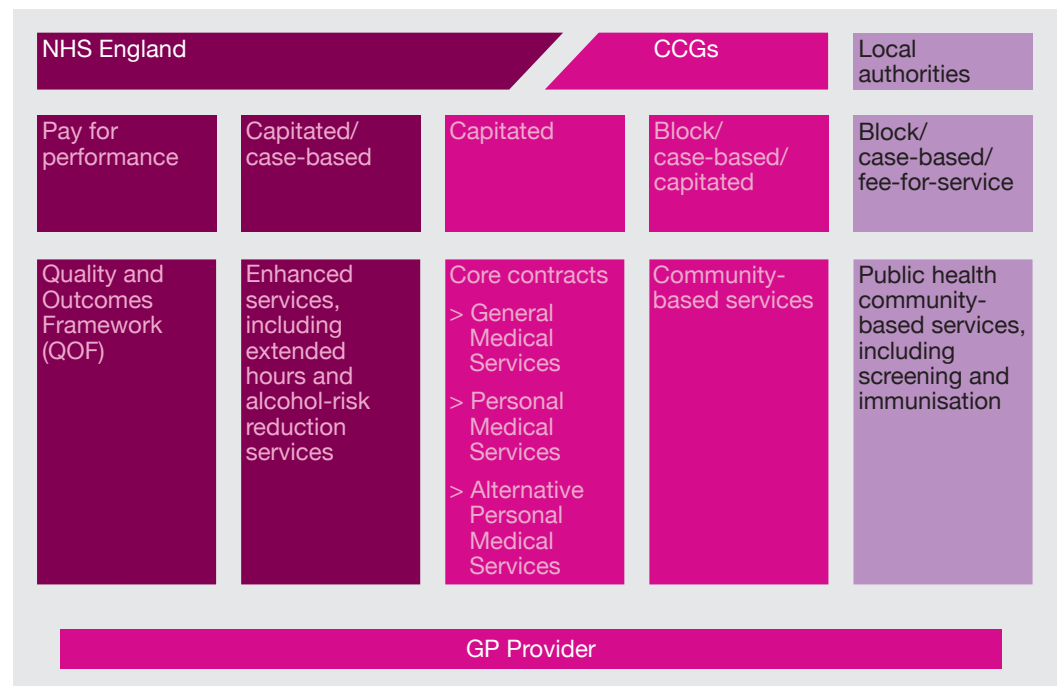
36 NHS England, *The Forward View into Action: New Care Models: Support for the Vanguard*, 2015, 8.

37 NHS Confederation, ‘Details of Vanguard Support and Funding Published’, 31 July 2015.

38 Chris Ham and Rachael Addicott, *Commissioning and Funding General Practice: Making the Case for Family Care Networks* (The King’s Fund, 2014), 24.

39 House of Commons Health Select Committee, *Social Care*, 6–9.

40 Rebecca Thomas, ‘CCG Barometer: “Worrying” Lack of Confidence in Dealing with Deficits’, *Health Service Journal*, 6 November 2015.

Figure 4: Primary-care commissioning

Funding is primarily provided by one of three core contracts (see Figure 4). The General Medical Services (GMS) contract came into force in 2004 and is negotiated between NHS England and the BMA; Personal Medical Services (PMS) contracts are negotiated between NHS England and practices.⁴¹ Alternative Provider Medical Services (APMS) contracts, introduced in 2004 and revised in 2013, are fixed-term contracts, commissioned locally and designed for private providers, such as Virgin Healthcare.⁴² Around 96 per cent of providers hold a GMS or PMS contract.⁴³ These are capitated – providing funding per registered patient, with the amount received per patient varying by characteristics such as age and gender. GP partners, who take earnings from profits made, should therefore be incentivised to provide care at the most cost-effective moment – thereby motivating prevention of ill health, self-management of long-term conditions, and appropriate care in the most cost-efficient setting.⁴⁴

This is undermined, however, by the separate funding for secondary care.⁴⁵ Around two-thirds of hospital activity is covered by activity-based funding.⁴⁶ Emergency admissions are paid on a payment-by-results tariff.⁴⁷ This misaligns incentives for primary-care providers: with a fixed income regardless of activity, GPs are incentivised to reduce care and secondary providers are incentivised to increase it. Keith Willett, National Director for Acute Episodes of Care, has called this set-up “completely illogical.”⁴⁸ One practitioner interviewed for this paper labelled it a “disaster” because it results in inconsistency of care: knee replacements, it was explained, are based on the whims of the practitioner not a cost-benefit analysis of the treatment for the patient and system. Monitor (now part of NHS Improvement, which oversees care providers, foundation trusts and NHS trusts) has raised concerns that funding streams “tend to fragment care and are inconsistent with the delivery of integrated care.”⁴⁹ Funding fails to incentivise providers to

41 Thomas Powell and Elizabeth Blow, *General Practice in England* (House of Commons Library, 2015), 5–7.

42 Monitor, *Improving GP Services: Commissioners and Patient Choice*, 2015, 15.

43 *Ibid.*, 14.

44 Monitor, *Capitation: A Potential New Payment Model to Enable Integrated Care*, 2014, 7.

45 Louise Marshall, Anita Charlesworth, and Jeremy Hurst, *The NHS Payment System: Evolving Policy and Emerging Evidence* (Nuffield Trust, 2014).

46 *Ibid.*, 20.

47 Nigel Hawkes, ‘NHS Payment System in England Is “completely Illogical,” Says National Director’, *BMJ*, 19 November 2014.

48 *Ibid.*

49 Monitor, *Capitation: A Potential New Payment Model to Enable Integrated Care*, 5.

consider the most cost-effective point to provide care.

Current contracts also fail to incentivise change. One practitioner described a contract which mandated 72 appointments per 1,000 patients, 75 per cent of which had to be seen by GPs. Such contracts, it was explained, leave little space for practices to act independently to achieve outcomes for the patients they serve. This, the practitioner argued, suggested that commissioners “have no clue how to drive change”.

There are also concerns that the mechanism underpinning the capitation calculation leads to an unequal distribution of funding. GMS’s ‘Carr-Hill’ formula – used to determine the allocation of core funding – has been identified as not taking into account many health inequalities affecting the need for treatment. One study estimated that Tower Hamlets, in east London, is underfunded by 33 per cent because of Carr-Hill’s failure to recognise how deprivation increases demand and therefore workload.⁵⁰ It is thus welcome that NHS England has committed to amend the formula to reflect this for a new contract in 2016.⁵¹

2.2 Out of date

2.2.1 Reactive care

Healthcare has long been seen as too reactive – responding to the needs of patients who are unwell, instead of preventing them from falling ill.⁵² Policymakers have aimed to incentivise prevention via contractual changes. In the 1990s, bonus payments for achieving immunisation targets were introduced. More recently, QOF sought to improve public health and reduce diseases.⁵³ In some areas, these incentives did change behaviour: the 1990 contract increased GP enquiries into behaviour such as tobacco use and exercise,⁵⁴ and QOF focused attention on prevention.⁵⁵

In many critical areas of public health, however, issues persist. Smoking levels have declined, but one in five adults smoke – with smoking estimated to cost the taxpayer £5.2 billion a year.⁵⁶ Concerns have been raised that QOF bonus payments have focused more on identifying people with smoking-related disorders than increasing cessation advice.⁵⁷ Levels of obesity are rising, with almost two-thirds of adults overweight or obese, costing the NHS £5 billion, and the UK economy £15.8 billion, annually.⁵⁸

With ever more demand from people with long-term conditions, self-management is critical to reduce GP workloads and alleviate cost pressures on the system.⁵⁹ Yet, as GPs have explained, practitioners “tend to think self-care is all very well in theory, but they do not have the time to implement it.”⁶⁰ The dislocation of funding between primary and secondary care and the fragmentation of health and public-health commissioning underpins this. The result is that almost 30 per cent of patients felt poorly engaged in making decisions about their own health in 2009-10.⁶¹ Poor self-management has serious implications for patients and the healthcare system. The total cost of direct care for patients with diabetes, for example, was £9.8 billion across the UK in 2010-11. However

50 Kambiz Boomla and John Robson, ‘GP Funding Formula Masks Major Inequalities for Practices in Deprived Areas’, *BMJ*, 12 June 2014.

51 Neil Roberts, ‘Exclusive: Carr-Hill Formula to Weight GP Pay for Deprivation from 2016/17’, *GPonline*, 1 September 2015.

52 Julian Tudor-Hart, ‘Two Paths for Medical Practice’, *Socialist Health Association*, 9 April 1992.

53 Tammy Boyce et al., *A pro-Active Approach. Health Promotion and Ill-Health Prevention* (The King’s Fund, 2010), 8–9.

54 B. R. McAvoy et al., ‘Our Healthier Nation: Are General Practitioners Willing and Able to Deliver? A Survey of Attitudes to and Involvement in Health Promotion and Lifestyle Counselling’, *The British Journal of General Practice: The Journal of the Royal College of General Practitioners* 49, no. 440 (March 1999): 187–90.

55 Boyce et al., *A pro-Active Approach. Health Promotion and Ill-Health Prevention*, 9.

56 Cathy Corrie and Amy Finch, *Expert Patients (Reform)*, 2015), 15.

57 Boyce et al., *A pro-Active Approach. Health Promotion and Ill-Health Prevention*, 9.

58 Department of Health, ‘News Release: Reducing Obesity and Improving Diet’, 25 March 2013; Public Health England, ‘New Release: Obesity and Health’, 2014.

59 NHS England and Public Health England, *Sustainable, Resilient, Healthy People & Places A Sustainable Development Strategy for the NHS, Public Health and Social Care System*, 2014.

60 Beth McCarron-Nash, ‘Self Care: Part One – Why GPs Must Invest in Self Care’, *GPonline*, 28 March 2014.

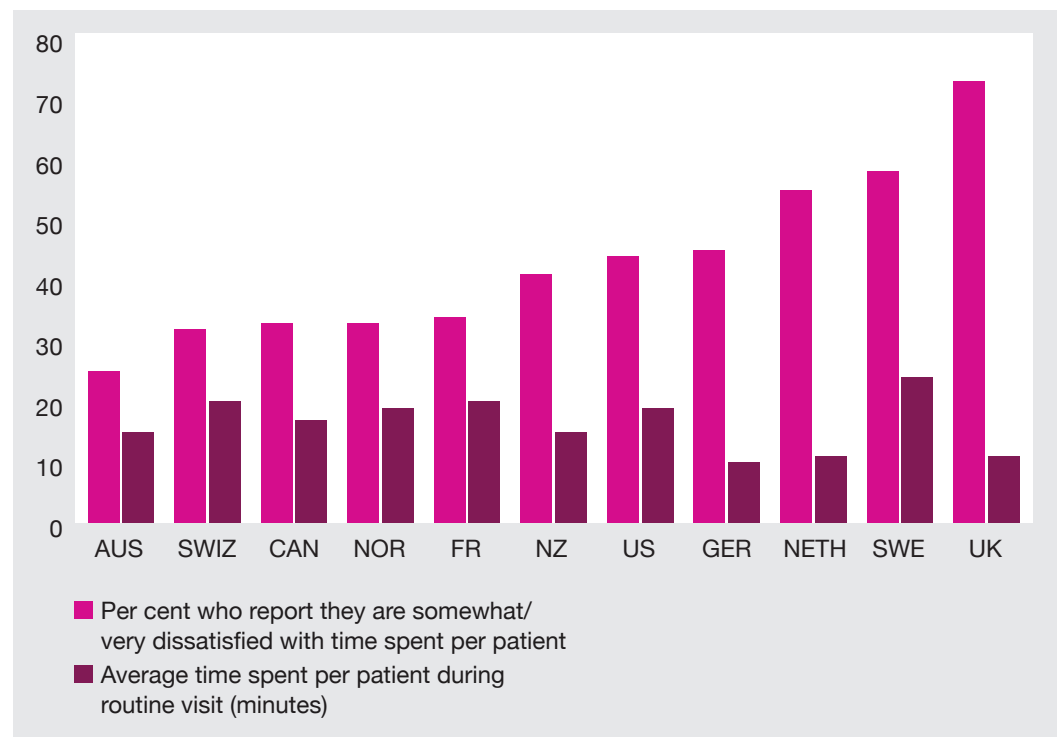
61 Corrie and Finch, *Expert Patients*, 16; S. Allender et al., ‘The Burden of Smoking-Related Ill Health in the UK’, *Tobacco Control* 18, no. 4 (1 August 2009): 262–67.

“indirect costs”, such as treating potentially avoidable complications, are significantly greater at £13.9 billion.⁶² This care is currently delivered across the NHS, but general practice has a key role in monitoring the health of these patients.⁶³

2.2.2 Rigid appointment times

General practice has also failed to keep pace with the needs of a changing population. Overwhelmingly, care is delivered through 10-minute face-to-face consultations.⁶⁴ This is a cause for concern. Short appointments do not allow GPs adequate time to address the complex and multifaceted needs of people with long-term conditions, which can result in patients returning to receive further care.⁶⁵ In other instances, GPs interviewed for this paper explained that 10 minutes might be too long: greater use of technology, such as telephone or online interactions, can enable clinicians to tend to the needs of several people within one slot. UK physicians have the highest dissatisfaction levels with time spent per patient amongst 10 OECD countries surveyed by The Commonwealth Fund (see Figure 5).

Figure 5: Physician dissatisfaction with consultation length



Source: The Commonwealth Fund, ‘Primary Care Physicians in Ten Countries Report Challenges Caring for Patients with Complex Health Needs,’ 12 July 2015.

2.2.3 Rigid opening hours

Problems with rigid appointment times are compounded by falling satisfaction with opening hours (see Figure 6). Sixty-nine per cent of patients also rate their experience with out-of-hours services (between 6.30pm and 8am) as convenient, falling to 60 per cent for full-time workers. Current contractual arrangements do not incentivise longer

⁶² N. Hex et al., ‘Estimating the Current and Future Costs of Type 1 and Type 2 Diabetes in the UK, Including Direct Health Costs and Indirect Societal and Productivity Costs’, *Diabetic Medicine: A Journal of the British Diabetic Association* 29, no. 7 (July 2012): 855–62.

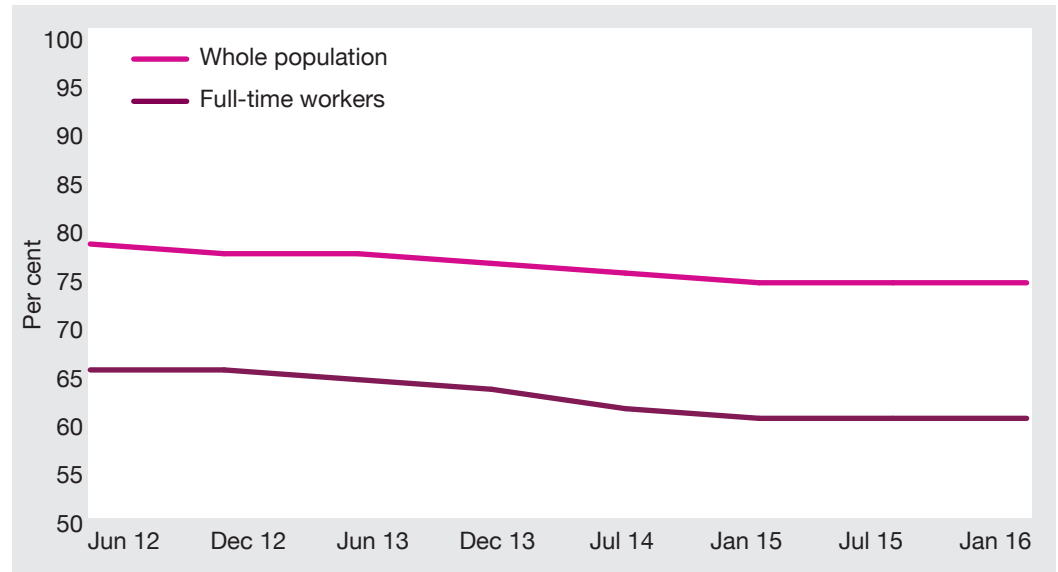
⁶³ Paul Corrigan, John Grumitt, and Suzanne Lucas, *Integrated GP Led Diabetes Care in Bexley. The Role of ‘an Active Integrator’ in Developing Integration in NHS Services*, 2012.

⁶⁴ This is despite the 10-minute-minimum rule being removed from QOF’s payment criteria. Caroline Parkinson, ‘GP 10-Minute Appointment Rule Axed’, *BBC News*, 15 November 2013.

⁶⁵ House of Commons Health Select Committee, *Managing the Care of People with Long-term Conditions. Volume 1*, 2014, 3.; Sofia Lind, ‘Half-Hour GP Appointments “Should Be the Norm”, Says RCGP’, *Pulse Today*, 16 August 2015.

opening times: since 2004, the GMS contract has allowed practices to opt out of providing extended opening hours. An estimated 90 per cent of providers have done so.⁶⁶ The Government has responded by committing to create a new contract, which extends opening hours to 8am to 8pm, seven days a week, by 2020 to improve access and care for patients.⁶⁷ This follows two ‘waves’ of pilot sites, currently trialling seven-day services, via the Prime Minister’s GP Access Fund.⁶⁸

Figure 6: Convenience of GP opening hours, June 2012 – January 2016



Source: NHS England, *GP Patient Survey – National Summary Report, 2016*.

Inconvenient opening hours put unnecessary pressure on the wider system. In 2013-14, the National Audit Office (NAO) estimated that 5.8 million cases were handled by out-of-hours GP services, at an average cost of approximately £68 per appointment.⁶⁹ This compares to an average cost of £21 per consultation in general practice during core hours.⁷⁰ The NAO queried the value for money delivered by out-of-hours services, with variable cost and performance across the country.⁷¹ Concerns have been raised by the NAO and others about access to out-of-hours surgeries.⁷² Waiting times in excess of 12 hours in the east of England were described as “clinically unsafe” in 2015.⁷³

2.2.4 Lack of technology

Access to care is also impaired by the lack of technology used in general practice. This is despite the NHS’s long-standing aim of harnessing technology to improve patient experience and health outcomes. Within primary care, this has resulted in a variety of ideas – including access to electronic health records (EHRs) and online booking services (see Figure 7).⁷⁴

⁶⁶ National Audit Office, *Out-of-Hours GP Services in England*, 2014, 4.

⁶⁷ Prime Minister’s Office, ‘Prime Minister Pledges to Deliver 7-Day GP Services by 2020’, 10 April 2015. Nigel Praities, ‘Seven-Day Access to GPs for All Patients, Promises PM’, *Pulse Today*, 30 September 2014.

⁶⁸ NHS England, ‘Prime Minister’s GP Access Fund’, n.d., accessed 28 March 2016.

⁶⁹ National Audit Office, *Out-of-Hours GP Services in England*, 6.

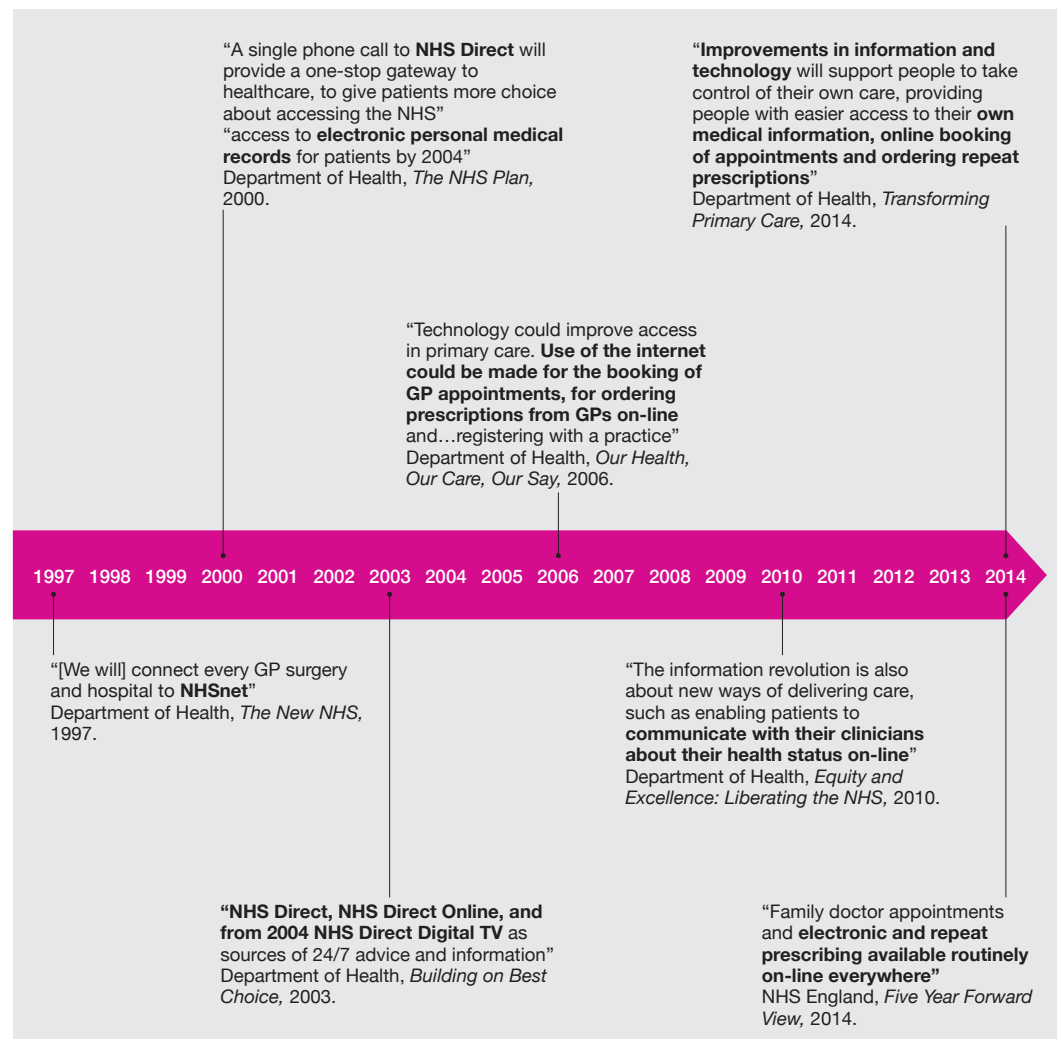
⁷⁰ National Audit Office, *Stocktake of Access to General Practice in England*, 6.

⁷¹ National Audit Office, *Out-of-Hours GP Services in England*, 9.

⁷² *Ibid.*, 20.

⁷³ Mariam Issimdar, ‘NHS out-of-Hours GP Service 12-Hour Wait “Clinically Unsafe”’, *BBC News*, 15 January 2016.

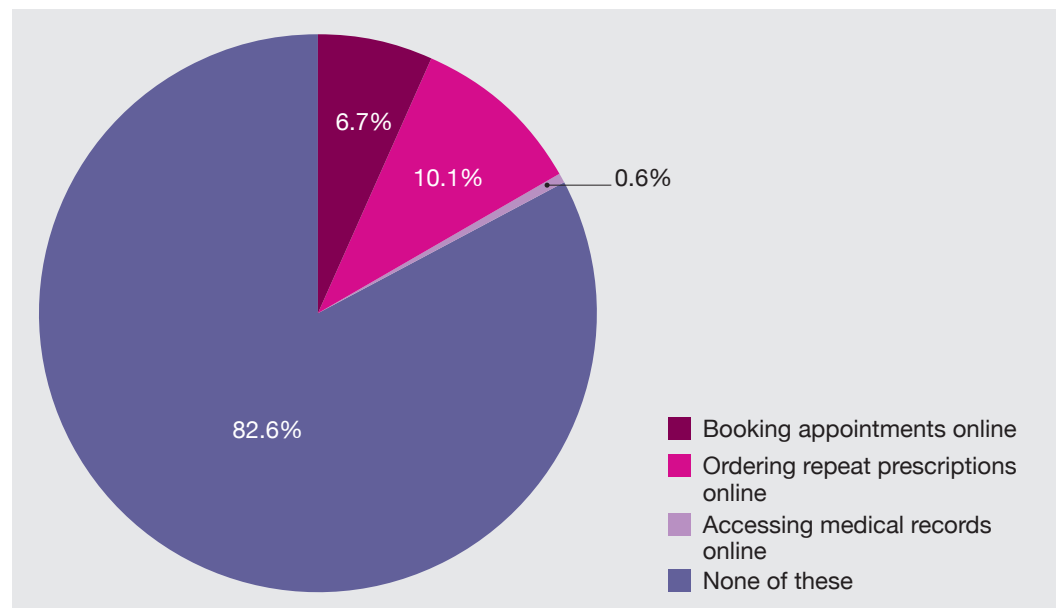
⁷⁴ See, for example, NHS England, *Five Year Forward View*, 2, 4, 6, 7, 12, 20, 31–34.

Figure 7: Timeline of government policy on the use of technology in primary care

This technology, however, has not been widely embraced. While 98 per cent of practices offer access to online booking⁷⁵ – since it is mandated by core contracts – only 7 per cent of patients report using it. Indeed, eight in 10 people report using no online GP services, despite 75 per cent of the population going online for health information (see Figure 8).⁷⁶

75 Tracey Grainger, ‘Reform: NHS as a Social Movement – the Role of Technology’, 1 December 2015.

76 Ibid.

Figure 8: Patients' use of online services provided by general practices

Source: NHS England, *GP Patient Survey – National Summary Report, 2016*.

A key barrier to implementation is that many GPs have yet to be convinced of the benefits of this technology. Practices are worried that online services do not provide good value for money, with some reporting that the services require extra staff to administer.⁷⁷ The Royal College of General Practitioners (RCGP) has also expressed concerns that online booking systems create inefficiencies by only allowing patients to book 10-minute appointments – which may be too long or too short.⁷⁸ Another problem, raised by Citizens Advice, is that functionality of online services inhibits take-up – with some requiring patients to register in person.⁷⁹ Although in practice these problems have not materialised for providers using this technology (see Chapter 3).

The uptake of EHRs has been equally slow. The Coalition Government set 2015 as the year by which patients would be able to access their EHRs online.⁸⁰ The aim was to enable better decision-making, a more personalised approach to healthcare and improved outcomes.⁸¹ Figure 8 shows, however, that fewer than 1 per cent of people in England report accessing their medical records online. The roll-out of EHR has been set back by providers failing to meet contractual obligations in part because commissioners and providers underestimated the technically ambitious nature of the project.⁸² GPs are also yet to be won over: in 2013, fewer than 30 per cent of doctors believed patient access to EHR was a good idea, largely because of concerns for the security of online medical records.⁸³ One official interviewed for this paper, however, suggested GPs are reluctant to relinquish control over patients' care and this has contributed to slow uptake.

77 Jonathan Ware and Rachel Mawby, *Patient Access to General Practice: Ideas and Challenges from the Front Line* (Royal College of General Practitioners, 2015), 4.

78 Ibid.

79 Citizens Advice, *Understanding Patient Access to Online GP Services*, 2015, 6.

80 BBC News Online, 'Patients Promised Online GP Booking by 2015', *BBC News*, 21 May 2012.

81 Department of Health, *The Mandate: A Mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*, 2013, 9.

82 National Audit Office, *The National Programme for IT in the NHS: An Update on the Delivery of Detailed Care Records Systems*, 2011, 6.

83 Michael Woodhead, 'Less than a Third of Doctors Think Online Access to Records Is a Good Idea', *Pulse Today*, 15 February 2013.

2.3 Unsustainable

2.3.1 Supply and demand

Demand for general practice is unprecedented, with an estimated 372 million consultations taking place in 2014-15.⁸⁴ This demand, however, is being met inefficiently by a workforce built around the GP rather than the patient. Despite recent government calls to address this poor balance,⁸⁵ the emphasis on the GP remains the default setting: since 2015, the GMS contract has provided all patients with a named GP.⁸⁶ The composition of the clinical workforce has also shifted towards the GP in recent years: between 2004 and 2014, the number of GPs increased at a faster rate (by 15 per cent) than the number of practice nurses (by 11 per cent).⁸⁷ This trend will continue: the Government has committed to expanding the primary-care workforce by 10,000 by 2020, including 5,000 more GPs, funded by £750 million of investment.⁸⁸

This is an inefficient allocation of NHS resource. Research, based on a survey of general practice staff, suggests 27 per cent of GP appointments could be undertaken by another professional.⁸⁹ This is likely to be a conservative figure: survey respondents' estimates varied from 0 per cent to 73 per cent, depending on their understanding of the range of alternatives.⁹⁰ GPs and other expert stakeholders interviewed for this paper explained that the true figure is likely to be closer to 50 per cent. Across England, these figures represent a misallocation of GP resource of between £2 billion and £4.6 billion in 2014-15 (see Figure 9). These figures vary depending on what proportion of consultations GPs currently conduct themselves, which, without centrally collected data, is not clear.

Figure 9: Misallocation of GP consultations (£)

Percentage of GP consultations which could be undertaken by another clinician	Proportion of all GP surgery consultations estimated to be delivered by GPs themselves	
	62 per cent ⁹¹	75 per cent ⁹²
27 per cent	£2.0 billion	£2.5 billion
50 per cent	£3.8 billion	£4.6 billion

Calculations are based on unit costs of £33 per consultation lasting 11.7 minutes. This excludes direct care staff costs, qualification costs and travel and so may be a conservative estimate.⁹³

Sources: *Reform* calculations. NHS Alliance, *Making Time in General Practice*, 2015; QResearch and The Health and Social Care Information Centre, *Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch database*, 2009; NHS England, *GP Patient Survey – National Summary Report*, 2016.

84 National Audit Office, *Stocktake of Access to General Practice in England*, 4.

85 See, for example, Department for Health, *The NHS Plan: A Plan for Investment, A Plan for Reform*, 2000, 43.

86 British Medical Association, 'General Practice Contract 2015-2016', n.d.

87 *Reform* calculations. Health and Social Care Information Centre, 'General and Personal Medical Services in England 2004-2014: General Practice Bulletin Tables 2004-2014', 2004-2014.

88 HM Treasury, 'Unprecedented Investment in the NHS', 24 November 2015.

89 NHS Alliance, *Making Time in General Practice*, 7.

90 *Ibid.*, 24.

91 This is the proportion of consultations delivered by GPs in 2008-09, the last time data was collected. QResearch and The Health and Social Care Information Centre, *Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch Database*, 2009, 18.

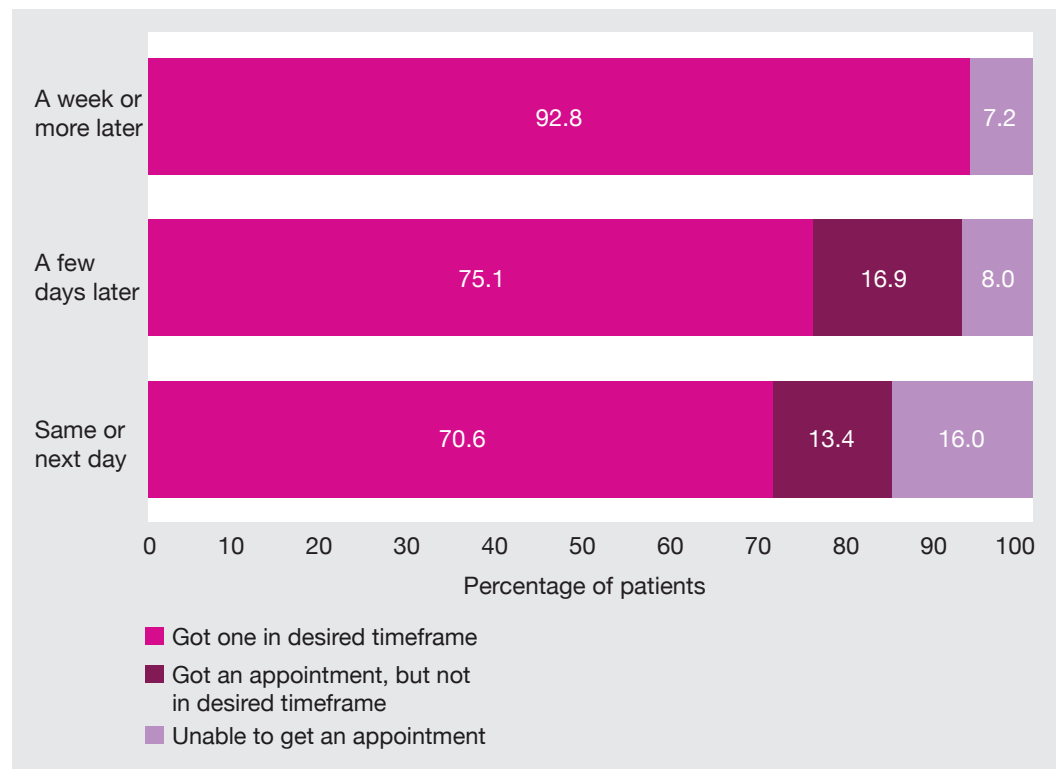
92 This was the percentage of people in the GP Patient Survey who answered "...to see a GP at my surgery" in answer to the question "What type of appointment did you [last] get? I got an appointment..." NHS England, *GP Patient Survey – National Summary Report*, 2016, 26.

93 Lesley Curtis and Amanda Burns, *Unit Costs of Health and Social Care 2015* (PSSRU, 2015), 177.

2.3.2 The cost of poor access

This poor workforce balance, coupled with a lack of technology and rigid opening hours, affects access to general practice. One in six people cannot get an appointment for the same or next day (see Figure 10). Moreover, GPs expect the situation to deteriorate: average waiting times, some suggest, will reach two weeks by May 2016.⁹⁴

Figure 10: Waiting times for GP appointment (preferred and actual)



Source: National Audit Office, *Stocktake of access to general practice in England, 2015*.

This causes two major problems. First, unmet demand – whereby patients forego healthcare advice they feel they need. On average, 11 per cent of people were unable to get an appointment in 2014-15,⁹⁵ up from 9 per cent in 2011-12.⁹⁶ Second, poor access pushes patients to use more expensive (and less convenient) parts of the healthcare system. In 2012-13, an estimated 5.8 million A&E appointments were used after patients were unable to get a GP consultation.⁹⁷ Hospitals are paid £124 for a visit to A&E – six times the cost of a general practice consultation (see Figure 11).⁹⁸ Compared to the cost of GP appointments, this, plus the use of out-of-hours GP services, represent £869 million of extra expenditure.

⁹⁴ Jaimie Kaffash, 'Average GP Appointment Waiting Times to Hit Two Weeks by next Year', *Pulse Today*, 5 June 2015.

⁹⁵ National Audit Office, *Stocktake of Access to General Practice in England*, 31.

⁹⁶ Natasha Curry, 'Fact or Fiction? Demand for GP Appointments Is Driving the "crisis" in General Practice', *Nuffield Trust*, 3 March 2015.

⁹⁷ Thomas E. Cowling et al., 'Access to General Practice and Visits to Accident and Emergency Departments in England: Cross-Sectional Analysis of a National Patient Survey', *British Journal of General Practice* 64, no. 624 (1 July 2014): 434-39.

⁹⁸ National Audit Office, *Stocktake of Access to General Practice in England*, 16.

Figure 11: Cost of care

Type of appointment	Number of appointments	Cost per appointment (2014-15)
GP	372 million (2014-15)	£21*
Extended hours GP (Prime Minister's GP Access Fund, Wave One sites)	0.4 million (2014-15)	£30 – £50**
Out-of-hours GP	5.8 million (2013-14)	£68
A&E (after failing to get a GP consultation)	5.8 million (2012-13)	£124

*This is the average cost of a consultation in general practice, covering appointments with GPs, practice nurses and any other members of staff, delivered in the surgery, by telephone or at home.⁹⁹

**The independent evaluation of the pilot sites explains that the higher cost of extended access is “to be expected for a pilot scheme with economies of scale only taking effect over a longer period.”¹⁰⁰

Sources: National Audit Office, *Stocktake of Access to General Practice in England, 2015*; National Audit Office, *Out-of-Hours GP Services in England, 2014*; Mott MacDonald, *Prime Minister's Challenge Fund: Improving Access to General Practice First Evaluation Report: October 2015, 2015*.

2.3.3 Paying for poor practice

Another inefficient expense is QOF. This was introduced in 2004 to provide additional funding based on quality of care. Since 2005-06, QOF has paid out £1 billion each year to GPs.¹⁰¹ This comprises approximately 13 per cent of a practice's income.¹⁰² Participation in QOF is voluntary, but around 99.8 per cent of practices have signed up.¹⁰³

QOF is laudable in principle, and it has been praised for changing GP behaviour by making better use of practice nurses and incentivising data collection.¹⁰⁴ QOF's aims, however, are belied by its application. Its scoring system has been widely criticised as a box-ticking exercise which focuses on process more than outcomes: one study found that QOF procedures “dictated the talk and actions” of appointments with patients with long-term conditions, causing GPs to miss non-biomedical issues affecting patients' health.¹⁰⁵

While the difference in QOF scores between practices in the least and most deprived areas has narrowed over time, it has been argued that “no evidence shows that this has led to a reduction in health inequalities.”¹⁰⁶ Average QOF scores are remarkably high: 95 per cent between 2010-11 and 2014-15 – well above the 75 per cent expected by the Department of Health when QOF was introduced.¹⁰⁷ For some health issues, the average score was 100 per cent during this period. This was the case for obesity, despite it being a significant public-health problem (see Figure 12). For cancer, the average was 96.5 per

99 Ibid., 6.

100 Mott MacDonald, *Prime Minister's Challenge Fund: Improving Access to General Practice First Evaluation Report: October 2015, 2015*, vi.

101 Ibid.

102 Martin McShane and Edward Mitchell, ‘Person Centred Coordinated Care: Where Does the QOF Point Us To?’, *BMJ*, 11 June 2015.

103 Deloitte, *Primary Care, 22*.

104 Ibid., 23.

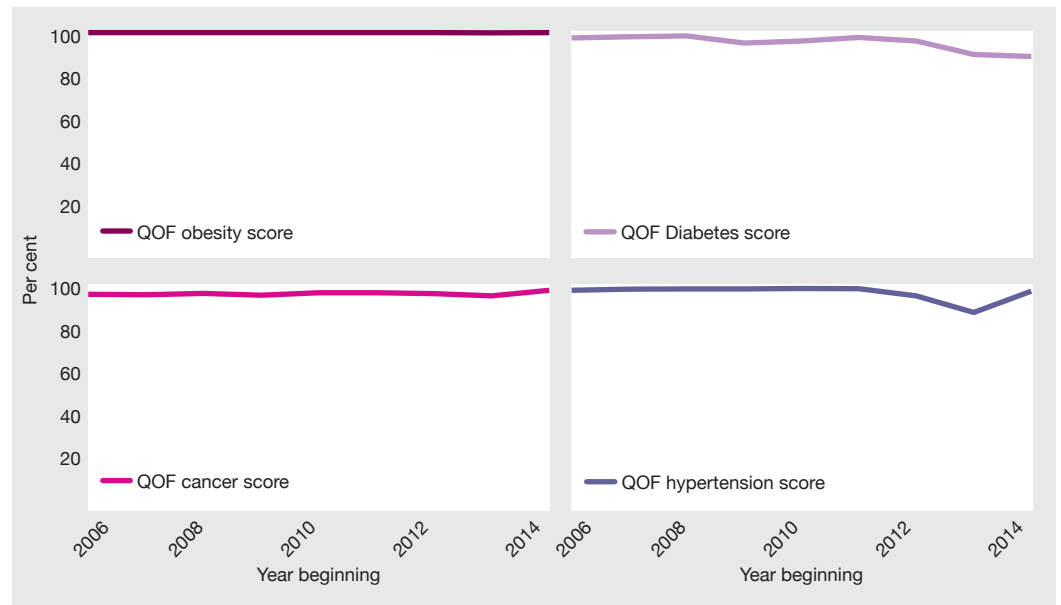
105 Carolyn A. Chew-Graham et al., ‘How QOF Is Shaping Primary Care Review Consultations: A Longitudinal Qualitative Study’, *BMC Family Practice* 14 (2013): 103.

106 McShane and Mitchell, ‘Person Centred Coordinated Care: Where Does the QOF Point Us To?’

107 Reform calculations. Health and Social Care Information Centre, *QOF Results: 2010-11, 2011*; Health and Social Care Information Centre, *QOF Results: 2011-12, 2012*; Health and Social Care Information Centre, *QOF Results: 2012-13, 2013*; Health and Social Care Information Centre, *QOF Results: 2013-14, 2014*; Health and Social Care Information Centre, *QOF Results: 2014-15, 2015*.

cent. This is despite cancer survival rates in England lagging behind comparable European countries, with late diagnosis being “one of the major reasons explaining our poorer outcomes”.¹⁰⁸ Faster diagnosis and better prevention are key to improving outcomes, but with spending on cancer expected to increase from £6.7 billion in 2012-13 to £13 billion in 2020-21,¹⁰⁹ QOF is in part rewarding poor outcomes, which then have to be paid for in secondary care.¹¹⁰

Figure 12: QOF scores by condition



Sources: Health and Social Care Information Centre, *QOF Results: 2006-07 to 2014-15*; Health and Social Care Information Centre, *Health Survey for England – 2013, Trend tables, 2014*.

¹⁰⁸ Independent Cancer Taskforce, *Achieving World-Class Cancer Outcomes: A Strategy for England, 2015-2020*, 2015, 27.

¹⁰⁹ *Ibid.*, 6.

¹¹⁰ A problem QOF recognises Health & Social Care Information Centre, *Quality and Outcomes Framework – Prevalence, Achievements and Exceptions Report. England, 2014-15*, 2015, 29; The King’s Fund, *Improving the Quality of Care in General Practice*, 2011, 129.

3

The future of primary care

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It is essential that NHS England and the Government articulate a vision of a healthcare system that acts as one. Much of this vision involves secondary care, and therefore goes beyond the scope of this paper. Best practice from across the globe, however, shows the benefits of a larger role for primary care.¹¹¹ In England, general practice is uniquely placed to lead this approach:

- > It is the long-established first point of call for patients, with the average person visiting their GP practice six times each year.¹¹²
- > GPs are generalists, with a responsibility to care for the whole needs of patients, and the wider population.¹¹³ Close and frequent contact allows clinicians to clearly understand the needs of patients.
- > General practice holds a registered list of patients, who reside in a similar geographical location. This is the “basic tool” of providing proactive, preventative services, as it allows providers to identify and address patient needs most effectively.¹¹⁴

Best practice from across the globe also highlights how primary-care providers can deliver higher-quality healthcare at a lower cost to users. A variety of different approaches have been taken, but common features include: emphasising prevention and the self-management of long-term conditions; providing extended services hitherto delivered in hospitals; and improving access through longer opening hours, for example. To offer these services, providers have embarked on significant structural change. They act at scale, embrace technology and restructure the workforce around the patient to improve access to high-quality care. Doing this in England could save billions of pounds for taxpayers, while improving healthcare outcomes for patients.

To bring about this approach, financial incentives must be aligned across the whole healthcare system. This requires a new contractual model, outlined in Chapter 4, in which providers become responsible for the care of all patients within a defined area. Providers could act singularly, or as part of a consortium to deliver this care.

3.1 A new approach to care

There is a mounting body of evidence to show that healthcare systems that address the whole care needs of defined population groups are able to provide higher-quality care at a lower cost.¹¹⁵ This ‘population-health’ approach includes, and goes beyond, traditional health and care services, to focus on wider determinants of people’s health, including lifestyle, local environment and conditions in which people are born, live and work. It therefore emphasises prevention for the healthy majority of patients, and joined-up care for those who need it.¹¹⁶

3.1.1 Prevention

The importance of the wider determinants of people’s health is well-recognised,¹¹⁷ with many chronic conditions linked to lifestyle.¹¹⁸ Unhealthy behaviours such as smoking and associated complications such as high blood pressure and obesity accounted for around

111 Macinko, Starfield, and Shi, ‘The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970–1998’, 1970–1998.

112 Jaimie Kaffash, ‘Average GP Practice Receives £136 per Patient Annually – Less than a Sky TV Subscription’, *Pulse Today*, 2 December 2015.

113 Amanda Howe, *Medical Generalism: Why Expertise in Whole Person Medicine Matters* (Royal College of General Practice, 2012).

114 John Ashton, ‘Developing a Community-Oriented Health and Well-Being Service for Cumbria, through Clinical Commissioning: Personal Reflections’, *London Journal of Primary Care* 4, no. 2 (2012): 93–95.

115 Ruth Thorlby, *Reclaiming a Population Health Perspective: Future Challenges for Primary Care* (Nuffield Trust, 2013); Hugh Alderwick, Chris Ham, and David Buck, *Population Health Systems Going beyond Integrated Care*, 2015.

116 Kindig and Stoddart, ‘What Is Population Health?’

117 Alderwick, Ham, and Buck, *Population Health Systems Going beyond Integrated Care*, 5.

118 Séverine Sabia et al., ‘Influence of Individual and Combined Healthy Behaviours on Successful Aging’, *Canadian Medical Association Journal* 184, no. 18 (11 December 2012): 1985–92.

30 per cent of all years of life lost to disability in the UK in 2010.¹¹⁹

Pioneering providers have aimed to address these problems early. Kaiser Permanente, the largest not-for-profit, integrated-care system in the United States of America, has encouraged smoking cessation through providing patients with access to a personal counsellor, classes and support groups. This primary-care-led approach helped reduce smoking among Kaiser Permanente members by 25 per cent between 2002 and 2005.¹²⁰ Another approach is offered by the Vitality programme, which operates in South Africa, the USA and the UK. It uses behavioural economics and health promotion to incentivise healthy choices.¹²¹ Members earn ‘points’ for good behaviour, such as going to the gym, enrolling in smoking-cessation programmes and buying healthy foods.¹²²

In England, Liverpool City Council’s Healthy Homes Programme, launched in 2009, involved ‘health proofing’ homes: keeping them insulated and removing hazards to reduce accidents. This contributed to a 57 per cent reduction in excess winter deaths in 2013, with Public Health England estimating potential cost savings over a 10-year period of £55 million.¹²³ The Bromley by Bow Centre, in east London, goes beyond biomedical prescribing by providing GPs with the tools to refer people to a range of services to address issues affecting people’s wellbeing. It runs 100 projects, delivered by specialist teams, with links to over 1,100 voluntary organisations, including legal advice, skills and employment programmes, money management services and healthy lifestyle programmes. Another study estimated that the returns on integrating health, housing and social-care services could save the NHS up to £2.65 for every £1 spent through early intervention.¹²⁴

3.1.2 Self-management

Motivating those with long-term conditions to self-care is critical for the NHS. Around 15 million people in England have one or more long-term condition.¹²⁵ These patients account for 50 per cent of GP appointments, 64 per cent of outpatient appointments and 70 per cent of inpatient bed days – and this trend is set to grow.¹²⁶

There is widespread agreement that the self-management of complex conditions improves clinical outcomes for patients and reduces the burden on the care system.¹²⁷ For example, a study of asthma patients suggested that encouraging self-care can reduce GP visits by up to 69 per cent while another study of people who had previously suffered from heart failure reported a halving of hospital admissions.¹²⁸ Diabetes UK estimates that 95 per cent of diabetes care is self-managed.¹²⁹

As with prevention, self-management must be encouraged by providers. Diabetes UK, for example, has favoured a ‘Care Planning House’, which outlines the ingredients needed for self-care, including healthcare professionals who have the skills to encourage self-management.¹³⁰ Implementing such an approach requires a shift in culture. Currently, the traditional attitude of “doctor knows best” prevails: GPs fail to see patient preference as an important aspect of their work,¹³¹ or argue they cannot “make time” to engage patients in shared decision-making.¹³² Training programmes could empower clinicians to offer

119 Catherine Foot et al., *People in Control of Their Own Health and Care* (The King’s Fund, 2014), 16.

120 Alderwick, Ham, and Buck, *Population Health Systems Going beyond Integrated Care*, 12.

121 AIA Australia, *The Case for Incentivising Health: Using Behavioural Economics to Improve Health and Wellness*, 2014, 12–20.

122 Corrie and Finch, *Expert Patients*.

123 Public Health England, *Health and Care Integration Making the Case from a Public Health Perspective*, 2013, 11.

124 Turning Point, *Benefits Realisation: Assessing the Evidence for the Cost Benefit and Cost Effectiveness of Integrated Health and Social Care*, 2010, 9.

125 The King’s Fund, ‘Active Support for Self Management’, n.d.

126 Department of Health, *Long Term Conditions Compendium of Information. Third Edition*, 3; British Medical Association, *General Practice in the UK*, 2.

127 Department of Health, *Research Evidence on the Effectiveness of Self Care Support*, 2007, 13–24.

128 Ibid.

129 House of Commons Health Select Committee, *Managing the Care of People with Long-term Conditions*, 35.

130 Diabetes UK, *Year of Care: Report of Findings from the Pilot Programme*, 2011, 32.

131 Al Mulley, Chris Trimble, and Glyn Elwyn, *Patients’ Preferences Matter: Stop the Silent Misdiagnosis* (The King’s Fund, 2012).

132 A Coulter, *Implementing Shared Decision Making in the UK* (The Health Foundation, 2009).

advice on the options open to patients.¹³³ The *Shape of Training Review* has suggested that patients could be involved in the training and assessment of clinicians to help professionals gain a patient perspective.¹³⁴ Providers concerned that this is not happening could include patient self-care in the performance-management criteria of job descriptions. For patients, education courses, such as DESMOND, for type-2 diabetes, and more general self-management courses, such as those provided by the Expert Patients Programme, could also enable better self-care.¹³⁵

Implementing this approach to prevention and self-management would not only achieve better outcomes for patients, but also deliver significant savings for taxpayers. These savings will depend on the level of patient engagement, as detailed by the Wanless Review in 2002.¹³⁶ Previous *Reform* research found that the Review's "fully engaged" scenario – which assumes greater self-care for those with long-term conditions, above-target progress in smoking reduction and obesity resulting in fewer hospital admissions, GP visits and prescriptions¹³⁷ – could save the NHS £1.9 billion by 2020-21.¹³⁸

3.1.3 Treatment

Despite an emphasis on prevention and self-care, people will still require care for a whole host of issues. Much of the care currently provided in hospitals, can be delivered within primary care. This could result in better outcomes, at a lower cost to the taxpayer.

3.1.3.1 Triaging

To achieve this, patients must be diverted to the most appropriate clinician, which requires general practice to improve its use of triage. Currently, triage is seen as a source of "substantial extra demand", in the words of Dr Richard Vautrey, Deputy Chair of the BMA.¹³⁹ This need not be the case. Telephone triage has been shown to result in the handling of one third of demand over the telephone.¹⁴⁰ Another study concluded it reduced emergency admissions by 20 per cent.¹⁴¹ Experts have also estimated that 17 per cent of GP time is consumed by the "worried well".¹⁴²

Recently, providers have used emerging technology to triage patients effectively. WebGP, designed by the London-based GP network, the Hurley Group, is a pioneering e-consultation and triaging service – through which patients can submit questions, book appointments and find self-care advice. A six-month trial across 20 practices, covering roughly 130,000 patients, reduced demand for services, resulting in a return on investment of £11,000 per practice and the equivalent of £414,000 per CCG of 250,000 patients due to fewer emergency admissions. If these savings could be replicated nationally, the returns would be in excess of £170 million for the NHS.¹⁴³

The pilot shows, however, that greater benefits could be realised from triaging alone. Across the 130,000-patient list, the website received 27,000 unique visits across 18 months.¹⁴⁴ Eighteen per cent of patients planning to visit the surgery followed signposting to avoid booking an appointment – but only one in four visitors used the signposting function.¹⁴⁵ Clearly if the benefits of this system were to be realised, practitioners would need to move more demand online. Citizens Advice reports that 34 per cent of patients would like to use

133 Corrie and Finch, *Expert Patients*, 37.

134 David Greenaway, *Securing the Future of Excellent Patient Care*, 2013.

135 Angela Coulter, Sue Roberts, and Anna Dixon, *Delivering Better Services for People with Long-Term Conditions: Building the House of Care* (The King's Fund, 2013), 11.

136 Derek Wanless, *Securing Our Future Health: Taking a Long-Term View* (HM Treasury, 2002).

137 For further information, see: Corrie and Finch, *Expert Patients*, Annex.

138 *Ibid.*, 4.

139 Caroline Price, 'Telephone Triage Increases Demand on GP Practices', *Pulse Today*, 4 August 2014.

140 John L Campbell et al., 'The Effectiveness and Cost-Effectiveness of Telephone Triage of Patients Requesting Same Day Consultations in General Practice: Study Protocol for a Cluster Randomised Controlled Trial Comparing Nurse-Led and GP-Led Management Systems (ESTEEM)', *Trials* 14 (4 January 2013): 4.

141 GP Access, 'A&E Effects', n.d., accessed 25 March 2016.

142 Gareth Iacobucci, 'Fifth of Appointments Wasted on "Worried Well", Leading GPs Warn', *Pulse*, 16 March 2010.

143 webGP, *webGP: The Virtual General Practice: Pilot Report*, 2014, 13.

144 *Ibid.*, 6.

145 *Ibid.*

online services.¹⁴⁶ Applying this modest figure to WebGP's findings could save £120 million in GPs' time across England.¹⁴⁷ If the number of people using online health services matched the proportion who use the internet each day, savings could reach £274 million.¹⁴⁸

Even more impressive results have been seen elsewhere. An online consultation portal developed by the Mayo Clinic in the USA reported that office visits were unnecessary in 40 per cent of cases.¹⁴⁹ Another triaging system, askmyGP, has returned similar results: a pilot study in a practice in north London resulted in one-third of people being called into to see a GP, one-third telephoned by the GP and one-third contacted by another clinician.¹⁵⁰ These examples hint at significant efficiency savings for the NHS.

3.1.3.2 Flexible consultations

Triaging services could also be used in conjunction with more flexible consultations to ensure that patients get the most appropriate care. This can avoid care being boxed into 10-minute face-to-face appointments. Instead consultations should be flexible: longer for those with multiple complex conditions, and shorter, or remote, for those capable of managing their health. The average consultation time of a phone or Skype appointment is around seven minutes because patients are more likely to use these to make quick and simple queries – regarding self-management, for instance.¹⁵¹ This could free up time to provide longer appointments for those requiring more attention.

Patients with complex needs should be offered longer consultations. Increasing consultation lengths can enhance the patient's ability to understand and cope with their health issues;¹⁵² longer consultations may improve a GP's ability to accurately diagnose patients with psychological problems.¹⁵³ Evidence from the Year of Care programme – which aimed to improve outcomes for people with long-term conditions by encouraging self-management and a more personalised approach to care – has shown that longer consultations can be implemented without increasing costs.¹⁵⁴ The programme found that 20 minutes was often sufficient for patients with long-term conditions.¹⁵⁵ The RCGP has stated that “longer consultations, of at least 15 minutes, need to become the norm, with flexibility for changing patient needs”.¹⁵⁶

Another approach is to move away from traditional one-on-one GP-patient consultations. Group consultations enable large groups of 10 or 20 people with similar issues, including family carers, to spend an hour or more with a GP or nurse.¹⁵⁷ In Smethwick, support groups for people with long-term conditions, such as diabetes and hypertension, were identified as potentially delivering £2.5 million of savings and significant improvements in participants' key health indicators: body mass index and blood pressure.¹⁵⁸

3.1.3.3 Extended services

Providers can also offer a wide range of extra services within a primary-care setting. Pioneers across England and the globe offer insights into what can be achieved through this approach.

146 Citizens Advice, *Understanding Patient Access to Online GP Services*, 3.

147 Reform calculations, assuming the NAO's estimate of £21 per appointment, based on one in four using signposting services.

148 Reform calculations, based on 78 per cent of adults accessing the internet every day, or almost every day. Office for National Statistics, 'Internet Access – Households and Individuals', 8 June 2015.

149 Steven C. Adamson and John W. Bachman, 'Pilot Study of Providing Online Care in a Primary Care Setting', *Mayo Clinic Proceedings* 85, no. 8 (August 2010): 704–10.

150 Daloni Carlisle, 'Remote Consultations: Are They Safe, Effective and Efficient?', *NHS Alliance*, n.d.

151 Davie McGirr, 'Really? I Can See the Doctor Now?', *Digital Life Sciences*, 16 April 2015.

152 S Mercer et al., 'More Time for Complex Consultations in a High-Deprivation Practice in Associated with Increased Patient Enablement', *British Journal of General Practice* 57, no. 545 (2007): 960–69.

153 Catherine Hutton and Jane Gunn, 'Do Longer Consultations Improve the Management of Psychological Problems in General Practice? A Systematic Literature Review', *BMC Health Services Research* 7 (2007): 71.

154 Diabetes UK, *Year of Care: Report of Findings from the Pilot Programme*.

155 Coulter, Roberts, and Dixon, *Delivering Better Services for People with Long-Term Conditions: Building the House of Care*, 9.

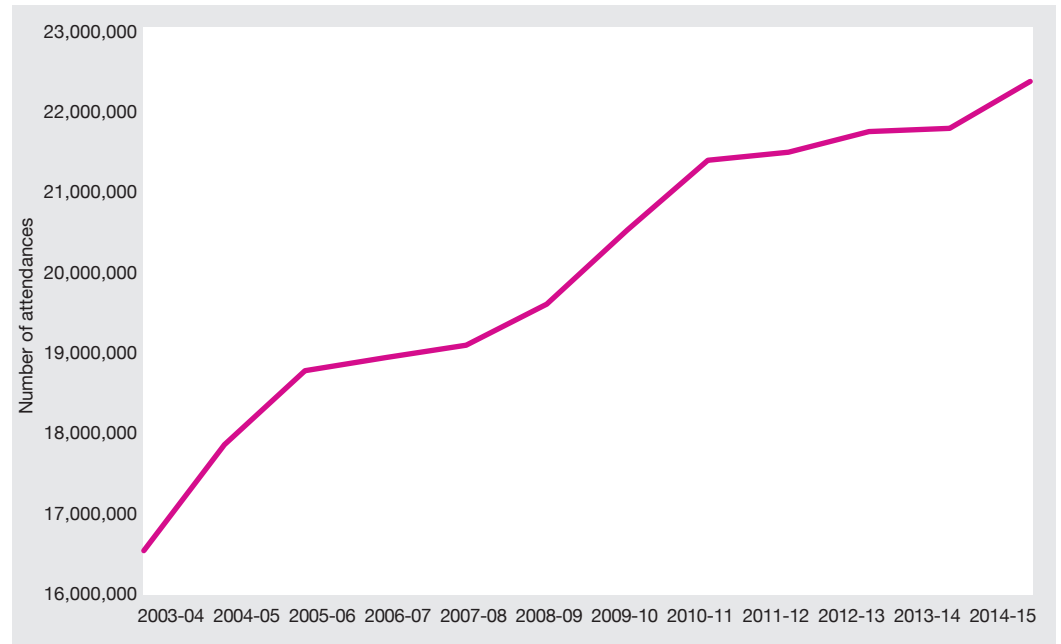
156 Royal College of General Practitioners, *The 2022 GP: Compendium of Evidence*, 2013, 28.

157 Georgina Craig, 'Group Consultations: A Way to Spend More Time with Patients', *NHS Alliance*, n.d.

158 NHS Alliance, *Making Time in General Practice*.

Urgent and emergency admissions are a huge source of demand on the healthcare system. Currently, urgent care is split between primary (same-day GP appointments, for example) and secondary care (A&E, for instance). This fragmentation is widely perceived as generating confusion amongst patients,¹⁵⁹ as well as failures of care, through poor data sharing, for example.¹⁶⁰ Furthermore, rising A&E attendances and emergency admissions (see Figure 13) are adding significant costs to the NHS.¹⁶¹

Figure 13: A&E attendances and emergency admissions, 2003-04 – 2014-15



Source: NHS England, 'A&E Attendances and Emergency Admissions', 2016.

This demand could be addressed by primary-care providers developing urgent care centres. The benefits of this approach are demonstrated by Lakeside Healthcare, based in Northamptonshire, which offers an acclaimed Urgent Care Model ('CorbyCare') to its own practice list of 100,000 patients and to a total catchment area of approximately 200,000. CorbyCare is open seven days per week, from 8am until 8pm. It currently provides around 250 urgent appointments each day, each costing less than a third of the price of an equivalent A&E visit.¹⁶² It has a very low conversion rate (percentage of patients presenting compared to the percentage of patients admitted to a bed) of 1 per cent, compared to a district general hospital (DGH) average of 34 per cent and has reduced overnight stays in local A&E units by between 30 and 50 per cent.¹⁶³ To achieve this level of service and cost reduction, the unit is led by senior GPs with special skills – all senior doctors and nurses being Advanced Life Support trained.

Lakeside's reduction of A&E traffic also corresponds to other estimates. The College of Emergency Medicine has suggested that 37 per cent of A&E attendances could be managed by GPs.¹⁶⁴ Others have called this figure "too low", pointing to six GP-led urgent care centres in London which consistently handle over 60 per cent of A&E activity.¹⁶⁵

159 V. Lattimer et al., 'The Impact of Changing Workforce Patterns in Emergency and Urgent Out-Of-Hours Care on Patient Experience, Staff Practice and Health System Performance', *National Institute for Health Service Delivery and Organisation Programme*, 2010.

160 Tejal K. Gandhi, 'Fumbled Handoffs: One Dropped Ball after Another', *Annals of Internal Medicine* 142, no. 5 (3 January 2005): 352–58.

161 National Audit Office, *Emergency Admissions to Hospital: Managing the Demand*, 2013, 4.

162 This information was kindly supplied by a representative of Lakeside Healthcare and has been used with their permission.

163 Alisdair Stirling, 'GP-Led Urgent Care Centre Cuts A&E Admissions "by Half"', *Pulse Today*, 23 January 2014.

164 Clifford Mann and Michelle Tempest, 'Beyond the Official Data: A Different Picture of A&E Attendances', *Health Service Journal*, 22 May 2014.

165 Sam Benghiat, 'Time to Recognise the Real Impact GP Led Urgent Care Has on A&Es', *Health Service Journal*, 17 July 2014.

Applied nationally, this would be the equivalent of 13.4 million A&E appointments. Delivered at a third of the price of an A&E appointment, it could save the NHS £1.1 billion a year.¹⁶⁶

Limited access to diagnostic services also negatively affects patient care – causing long delays and inappropriate referrals.¹⁶⁷ It is also inefficient for the wider system: somewhere in the region of 33 per cent of referrals to secondary care are for tests GPs cannot order.¹⁶⁸ GPs with direct access to diagnostics have delivered a more efficient use of hospital resource.¹⁶⁹ In the Netherlands, for instance, chest x-ray services across 78 general practices resulted in changes in care management for 60 per cent of patients, including fewer referrals to a medical specialist (from 26 per cent to 12 per cent).¹⁷⁰

Other practices have gone further. In Croydon, a GP federation improved access to diagnostics by installing ultrasound, MRI and echocardiography services. These services, it was claimed, improved care quality, increased patient satisfaction and saved £1.6 million from the reduction of follow-up appointments across the federation between February 2010 and January 2011.¹⁷¹ They also reduce clinical time elsewhere in the system: direct access to echocardiography reduces the need for the patient to see a cardiologist.¹⁷² For the patient, treatment times also improved – with diagnosis and treatment of musculoskeletal problems taking three weeks instead of a three-month wait for a test.¹⁷³

Primary-care physicians express a preference for a greater array of tests to streamline diagnoses.¹⁷⁴ Interviewees did, however, highlight the need for a critical mass to accommodate extra services – particularly large machinery. Modality, a ‘super-practice’ with 70,000 registered patients based in Birmingham, uses its scale to offer advanced diagnostics such as x-rays.¹⁷⁵ Lakeside’s approach to emergency care is underpinned by extensive equipment, including DGH standard x-ray, ultrasound and pathology lab (where blood and gas results are returned to clinicians in 10-15 minutes).¹⁷⁶ Clinicians may also require training to operate specific services. Practices in Croydon successfully did this by training healthcare assistants to administer a range of services.¹⁷⁷

Primary care could also provide other services that are currently delivered in hospitals. A group of 20 GP practices in Kent provide minor surgery and care for minor injuries, with improved results reported.¹⁷⁸ As part of its focus on elderly patients (73 per cent of whom have five or more chronic conditions),¹⁷⁹ ChenMed, in the USA, provides 86 per cent of specialist consultations in primary-care centres.¹⁸⁰ This has contributed to its reduced hospitalisation rate and overall cost savings. Elsewhere, New Zealand’s Canterbury District Health Board, which provides health services across the whole district of over half a million people, frontloads care in general practice by providing, for example, services to

166 This is based on an A&E appointment costing £124 and GP appointments costing £21 (see Figure 11). The cost of A&E appointments is an average across the three types of A&E attendances for which NHS England provides data. This data covers the total number of attendances for all A&E types, including minor injury units and walk-in centres. There is no official breakdown of these costs, so we have applied the average cost across these consultations. To get a clearer picture of how much this approach would save, the Government should be clear on the costs of specific A&E, walk-in-centre and minor-injury appointments. NHS England, ‘A&E Attendances and Emergency Admissions’, 2016.

167 Margaret O’Riordan, Claire Collins, and Gillian Doran, *Access to Diagnostics – A Key Enabler for a Primary Care Led Health Service* (The Irish College of General Practitioners, 2013); Candace Imison and Chris Naylor, *Referral Management: Lessons for Success* (The King’s Fund, 2010).

168 Catherine Foot, Chris Naylor, and Candace Imison, *The Quality of GP Diagnosis and Referral* (The King’s Fund, 2010), 33.

169 Bonnie Sibbald, ‘Direct Access to Diagnostic Services’, *The British Journal of General Practice* 59, no. 562 (1 May 2009): 144–45.

170 Anouk M Speets et al., ‘Chest Radiography in General Practice: Indications, Diagnostic Yield and Consequences for Patient Management’, *The British Journal of General Practice* 56, no. 529 (8 January 2006): 574–78.

171 Agnelo Fernandes, ‘Providing Rapid-Access Diagnostics in Primary Care’, *Pulse Today*, 26 April 2011.

172 Ibid.

173 Ibid.

174 Jeremy Howick et al., ‘Current and Future Use of Point-of-Care Tests in Primary Care: An International Survey in Australia, Belgium, The Netherlands, the UK and the USA’, *BMJ Open* 4, no. 8 (1 August 2014).

175 Modality Partnership, ‘About Us’, accessed 17 November 2015, <https://www.modalitypartnership.nhs.uk/about-us>.

176 This information was kindly supplied by a representative of Lakeside Healthcare and has been used with their permission.

177 Fernandes, ‘Providing Rapid-Access Diagnostics in Primary Care’.

178 NHS England, *Five Year Forward View*, 17.

179 Brandon Glenn, ‘How One Primary Care Practice Innovated to Improve Outcomes for High-Risk Medicare Patients’, *Medical Economics eConsult*, 6 November 2013.

180 Dorest CCG, ‘Clinical Services Review’, 17 December 2014, 9.

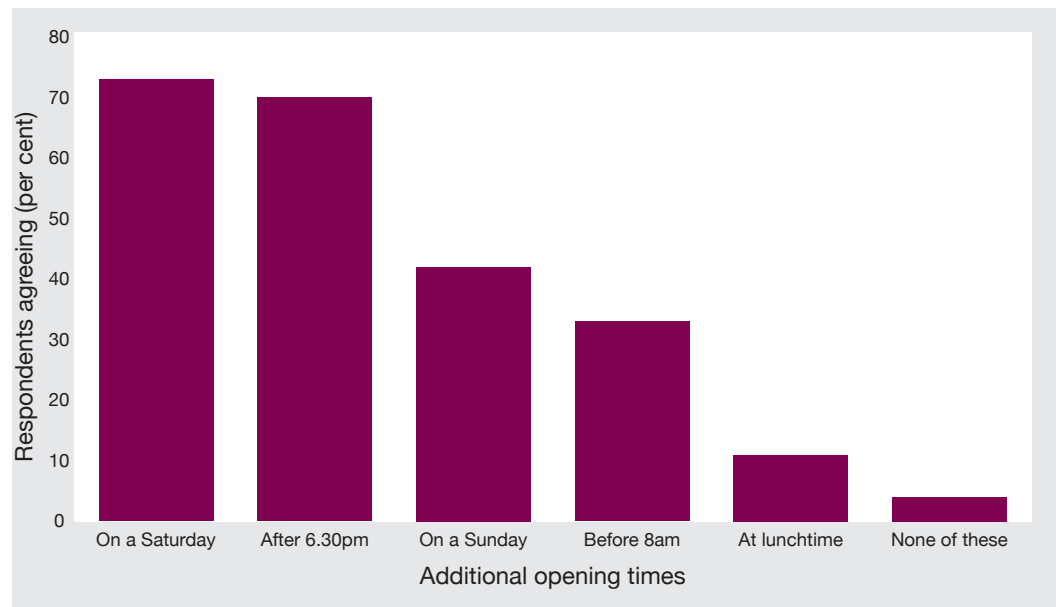
remove skin lesions – in a country with a high incidence of skin cancer.¹⁸¹ This has reportedly contributed to saving patients more than one million days waiting over four clinical areas.¹⁸²

These examples are far from exhaustive. Providers are clearly best-placed to decide where care is delivered most effectively and so the number of extended services offered in primary care will vary. This is the lesson of the development of integrated primary care providers in New Zealand, following the purchaser-provider split in the early 1990s: bottom-up change was engendered through GP autonomy.¹⁸³

3.1.3.4 Longer opening hours

A critical aspect of delivering improved care and cost efficiencies is through longer opening hours, including evenings and weekends. This is most convenient for patients (see Figure 14) and avoids costly redirections of appointments to A&E.

Figure 14: Additional opening times that would make it easier to see or speak to someone



Source: NHS England, *GP Patient Survey – National Summary Report, 2016*.

Base: The 26.4 per cent of patients who do not feel their GP surgery is currently open at times that are convenient for them or who don't know and answered question.

Two 'waves' of pilot sites, so-called Prime Minister's GP Access Fund sites, have begun providing extended opening hours. Early indications suggest that the first wave of 20 sites returned efficiencies in certain areas: 13 sites saw a collective reduction of 34,000 minor A&E attendances, which if continued over a year, would generate savings of £3.2 million.¹⁸⁴ Convenience of opening times (90 per cent) was higher than the national average (74 per cent).¹⁸⁵ Despite concerns about early demand for weekend services,¹⁸⁶ some pilot providers, such as Taurus Healthcare, a federation serving 185,000 patients in Herefordshire, are reporting a steady increase in booking GP appointments at weekends (see Figure 15).

181 Nicholas Timmins and Chris Ham, *The Quest for Integrated Health and Social Care A Case Study in Canterbury, New Zealand* (The King's Fund, 2013), 4.

182 Ibid.

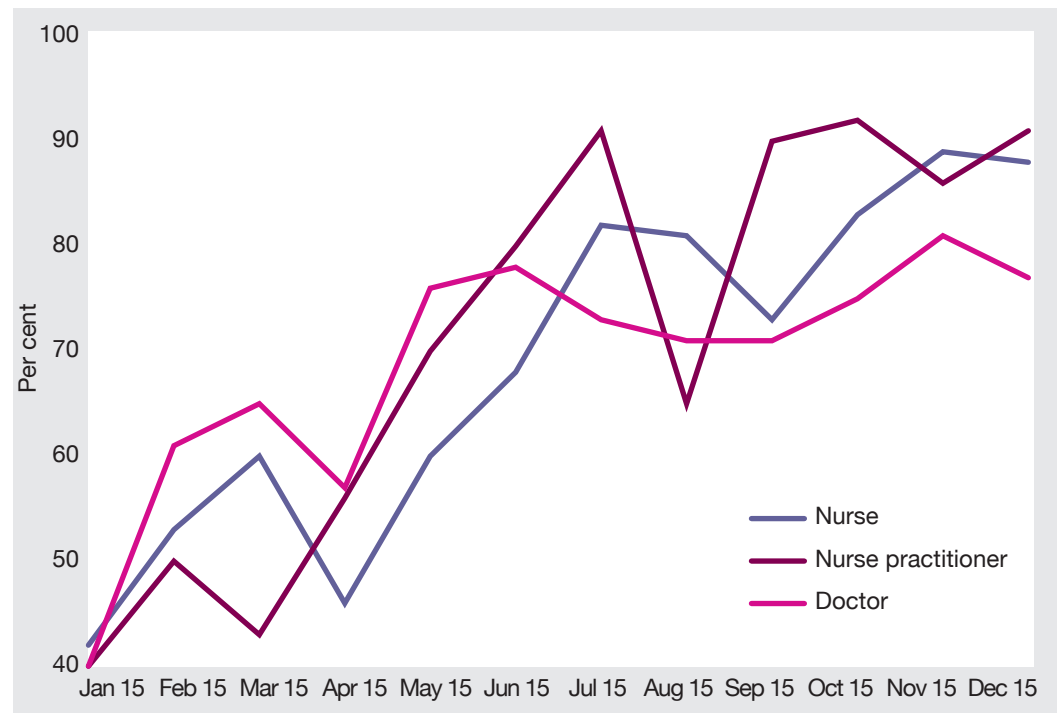
183 Ruth Thorlby et al., *Primary Care for the 21st Century* (Nuffield Trust, 2012), 30.

184 Mott MacDonald, *Prime Minister's Challenge Fund: Improving Access to General Practice First Evaluation Report: October 2015*, 5.

185 Ibid., iii.

186 BBC News, 'Sunday GP Appointments "Not in Demand", Research Says', 6 November 2015.

Figure 15: Proportion of weekend appointments utilised at Taurus Healthcare (by practitioner)



Source: Kindly provided by a representative of Taurus Healthcare.

The extent to which patients value out-of-hours care in a general practice environment is perhaps best illustrated by Pegasus Healthcare's 24-hour, seven-day GP care facility. Based in Canterbury, New Zealand, this is receiving increasingly complex cases and takes more patients out of hours and at weekends than the local emergency department – in spite of each visit costing patients \$75.¹⁸⁷ Visiting despite this price tag has been explained in part because of the more pleasant environment provided by primary care, compared to emergency departments.¹⁸⁸ Although New Zealanders are used to paying for a GP appointment, which may affect decision making.

Practitioners interviewed for this paper explained that out-of-hours care is best provided by larger organisations, which are able to distribute resources across a large estate. For example, Taurus Healthcare collects data on expected demand to open practices in a cost-efficient manner. Such an approach works in line with the Government's recommendation that not "every GP practice should have to open seven days a week, still less that every GP should have to work on a seven-day basis."¹⁸⁹

3.2 Population-health providers

Delivering this approach to care requires significant structural change. As the above examples show, providers will need to operate at a much larger scale than present. At the front end, larger primary-care centres will be better-placed to accommodate extended services. Larger providers also hold the capacity to develop a more diverse workforce to offer this care more efficiently. At the back end, large-scale providers are better-placed to invest in digital technology and develop tools to understand the risk levels of their registered list of patients.

¹⁸⁷ Timmins and Ham, *The Quest for Integrated Health and Social Care A Case Study in Canterbury, New Zealand*, 28.

¹⁸⁸ Ibid.

¹⁸⁹ Alistair Burt, *HSC Inquiry on Primary Care*, 2016, 3.

Patient lists will therefore need to grow considerably. Exactly how this will look is not clear, but empirical evidence suggests these will be at least one order of magnitude greater than present. Modality lists 70,000 patients, and plans to expand.¹⁹⁰ Lakeside Healthcare hopes to cover 300,000 patients.¹⁹¹ One interviewee explained that we should not be surprised to see one-million-patient providers; another hypothesised that in 10 years' time only 10 providers would deliver extended primary care across England.

3.2.1 Size matters

A number of large-scale, population-health providers exist across the globe (see Figure 16). Ribera Salud, a private provider contracted to deliver services in Valencia, encapsulates the attitude of a population-health approach, explaining that “the main goals of the whole system are to keep the entire population as healthy as possible and achieve the best value for money and use of the hospital.”¹⁹² This incentivises Ribera Salud to intervene at the most effective moment. This was a market-driven development: the organisation was originally contracted to provide secondary care, but soon extended the contract to primary care for financial reasons.¹⁹³ Overall, Ribera Salud has delivered care improvements at 26 per cent lower cost than providers in the wider region of Valencia.¹⁹⁴

Figure 16: Population-health providers

Organisation	Facilities	Number of patients
Kaiser Permanente, USA	38 hospitals; 619 medical/ outpatient facilities	10,200,000
Ribera Salud, Spain	Six hospitals; over 100 primary-care centres	720,000
Counties Manukau, New Zealand	Four hospitals; over 90 primary-care, community-care and outpatient facilities	500,000
Jönköping County Council, Sweden	Three hospitals; 34 primary-care centres	340,000
Southcentral Foundation, Alaska	Six primary/community-care facilities	60,000

Sources: Kaiser Permanente, ‘Fast Facts about Kaiser Permanente’, *Kaiser Permanente Share*, 18 March 2016; NHS Confederation, *The Search for Low-Cost Integrated Healthcare: The Alzira Model – from the Region of Valencia*; Andrea Thoumi et al., *Reinventing Chronic Care Management for the Elderly* (Centre of Health Policy at Brookings, 2015); Counties Manukau Health, ‘Localities’, n.d; Hugh Alderwick, Chris Ham, and David Buck, *Population Health Systems: Going Beyond Integrated Care* (The King’s Fund, 2015).

At the front end, only large providers are able to offer the infrastructure necessary to deliver the extended services outlined. Pioneering providers in England have invested heavily in buildings: Lakeside Healthcare provides a large primary-care centre, with observation bays and beds alongside its urgent care centre. Investment in technology is seen by some smaller practices as prohibitively expensive, despite the longer-term value delivered.¹⁹⁵ Larger providers, who stand to gain greater efficiencies, see technology as a critical part of their operating model – and have invested heavily by developing their own systems in the cases of Modality and the Hurley Group.

190 Nick Renaud-Komiya, ‘Exclusive: Vanguard GP “super Partnership” in Talks to Expand across England’, *Health Service Journal*, 2 January 2016.

191 Sofia Lind, ‘Largest GP Practice in the Country Set to Cover 100,000 Patients’, *Pulse Today*, 9 November 2015.

192 Andrea Thoumi et al., *Reinventing Chronic Care Management for the Elderly* (Centre of Health Policy at Brookings, 2015), 4.

193 NHS Confederation, *The Search for Low-Cost Integrated Healthcare: The Alzira Model – from the Region of Valencia*, 2014, 6.

194 *Ibid.*, 8.

195 Carlisle, ‘Remote Consultations: Are They Safe, Effective and Efficient?’

But infrastructural change in itself, interviewees explained, will not deliver change without a leadership with the space to design and deliver a long-term approach to improving care. Smaller practices have been reported to leave GPs feeling like they were on a “treadmill”, with little space to develop strategic planning.¹⁹⁶ With bespoke leadership roles, often filled by non-clinicians with business backgrounds, larger providers are well-placed to map out a medium to long-term vision.¹⁹⁷

Larger providers are also better-placed to exploit economies of scale. Centralisation of functions such as IT and HR have been cited as drivers of cost efficiencies.¹⁹⁸ Salford Health Matters, a federation of GPs, set up a central business unit to coordinate back-office functions, including HR, IT and finance staffed by an administrative team. This is reported to provide benefits in terms of economies of scale and monitoring contract performance.¹⁹⁹ Scaled providers are able to develop administrative teams are able to organise staff training, workforce planning and IT development.²⁰⁰

Data has also been utilised by larger providers. One practitioner interviewed for this paper explained that it is a “massive force for change”, which enabled them to provide the highest take-up of childhood vaccinations in the area through collecting data on the previous year’s rate, covering upfront costs and rewarding improvements. Such dashboards drive competition between clinicians by monitoring practice-by-practice performance, identifying underperforming GPs and sharing strategy from top performers during board meetings. One practitioner interviewed for this paper explained this method led to improved outcomes in stroke deaths, heart failure and diabetes complications across a group of practices.

To achieve this scale, providers can act singularly, or as part of consortia. Smaller organisations can form the latter (see Figure 17). Individual GP practices, community pharmacies, physiotherapists, urgent care services, mental health services, employment charities and skills services, could win alliance contracts or, under a single umbrella organisation, joint venture contracts to provide services across care pathways. These are appealing to small organisations because they share business risk between providers, who can then divide care most effectively between themselves.²⁰¹ Alliance contracts have found favour in New Zealand and Australia to integrate care.²⁰² Large, individual providers, able to manage the care for large populations, will be able to take on contracts themselves and subcontract services where necessary. Monitor has highlighted that larger providers are better able to mitigate risk of random overspend when covering whole care pathways.²⁰³

196 Smith et al., *Securing the Future of General Practice: New Models of Primary Care*, 48.

197 David Greenaway, *Securing the Future of Excellent Patient Care: Final Report of the Independent Review*, 2013, 52.

198 Smith et al., *Securing the Future of General Practice: New Models of Primary Care*, 7.

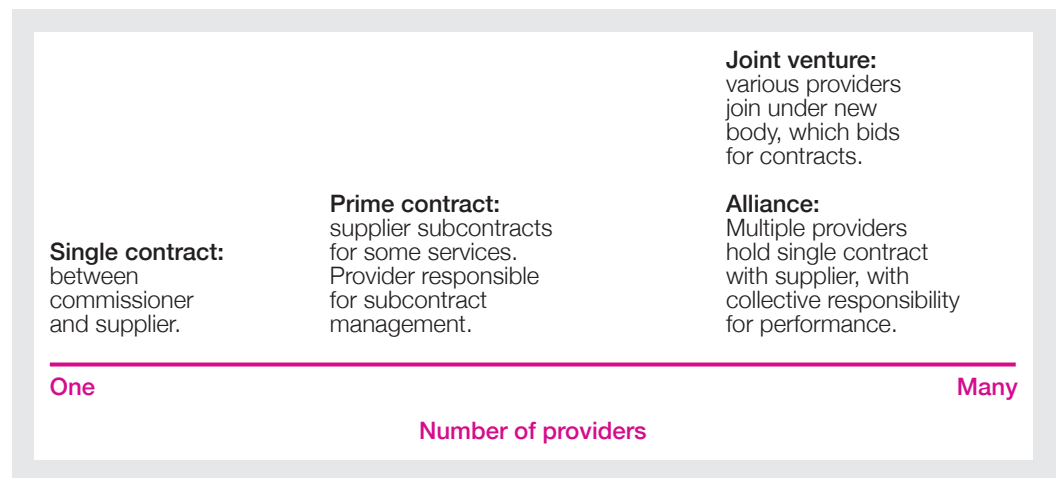
199 Candace Imison et al., *Toolkit to Support the Development of Primary Care Federations* (The King’s Fund, 2010), 72.

200 Smith et al., *Securing the Future of General Practice: New Models of Primary Care*, 52–3.

201 Grafton Group, *Clinical Contracting Considerations*, 2013, 11.

202 Timmins and Ham, *The Quest for Integrated Health and Social Care A Case Study in Canterbury, New Zealand*, 19–20.; Acevo, *Alliance Contracting: Building New Collaborations to Deliver Better Healthcare*, 2015, 11.

203 Monitor, *Capitation: A Potential New Payment Model to Enable Integrated Care*, 15.

Figure 17: Contractual models

Source: Grafton Group, *Clinical Contracting Considerations*, 2013.

3.2.2 Understanding demand

To best serve patient needs, providers will need to understand demand. Broadly speaking, there are three categories of patients:²⁰⁴

- > Healthy people who visit the GP sporadically for minor health issues.
- > Healthy people who are at risk of chronic health problems because of age or lifestyle.
- > People with one or more chronic condition.

Understanding people's needs at a granular level can enable providers to deliver tailored care that meets the needs of the people for whom the provider is responsible.²⁰⁵ The lack of empirical evidence means the exact potential of risk segmentation is unclear – and NHS England has warned of the difficulty of making significant efficiencies from a small number of high-risk patients.²⁰⁶ Early evidence, however, suggests that opportunities do exist. In Devon, risk profiling was 87 per cent accurate in predicting unscheduled admissions for the top 200 high-risk patients – allowing providers to take a proactive approach to care management.²⁰⁷ Practitioners interviewed for this paper also explained that understanding future demand allowed them to provide a longer-term, proactive approach to delivering care. Providers should therefore investigate how such an approach might benefit their patients.

Yet barriers to implementation exist. Data between primary care, community health, mental health, secondary care, social care and ambulance services is siloed, with few clinicians and commissioners having access to the same, matched data sets.²⁰⁸ Extracting data for the purposes of risk-stratification requires a “concerted effort” from providers and commissioners – including the skills to analyse and synthesise data into comprehensible reports.²⁰⁹ To overcome siloes, the Inner North West London Integrated Care Pilot, a group of providers covering 890,000 patients, created a working group to construct a common framework to enable the smooth use and sharing of data and privacy protection.²¹⁰ Interviewees explained that organisations operating at scale were

²⁰⁴ Thorlby, *Reclaiming a Population Health Perspective: Future Challenges for Primary Care*, 13.

²⁰⁵ Oleg Bestsenny, Tom Kibasi, and Ben Richardson, *Understanding Patients' Needs and Risk: A Key to a Better NHS*, 2013, 4.

²⁰⁶ NHS England, *Using Case Finding and Risk Stratification: A Key Service Component for Personalised Care and Support Planning*, 2015, 21.

²⁰⁷ Ibid.

²⁰⁸ Bestsenny, Kibasi, and Richardson, *Understanding Patients' Needs and Risk: A Key to a Better NHS*, 16.

²⁰⁹ Ibid.

²¹⁰ Ibid.

better placed to invest in and manage such an approach. Clearly, organisations must also reach a critical mass of patients to effectively segment groups of people.²¹¹

Without this capacity, providers could procure population-health mapping software to segment risk and benchmark key performance indicators from publicly available data.²¹² Such tools, however, will require upfront investment, including implementation fees, capitated annual subscription fees and training in the order of tens of thousands a year, depending on practice size.²¹³

3.2.3 A team-based approach

Understanding demand and operating at scale can allow providers to design teams around patient needs.²¹⁴ A better use of a variety of clinicians would allow the Government to scrap its commitment to employing 4,000 new GPs and retaining 1,000 GPs by 2020.

Interviewees for this paper explained that the current emphasis on GPs – as embodied by the right to a named GP – is misplaced. Other clinicians may take many of these duties. As The King’s Fund has explained, patients with long-term conditions will need ongoing management, but: “General practitioners themselves may not need to take on this role – practice nurses or community matrons may be more appropriate”.²¹⁵

Southcentral, in Alaska, has pioneered this approach for its 60,000 patients. It employs a multidisciplinary model to deliver extended services in primary care (see Figure 18).²¹⁶ Each primary-care team is responsible for 1,400 patients. Patients are triaged to the most appropriate person by the nurse case manager. GPs are primarily responsible for initial diagnoses of problems, but other team members may fulfil this function. For those with chronic conditions, the nurse case manager develops care plans, monitors conditions and provides information. Administration staff work alongside nurse case managers on prevention and population health. A medical assistant undertakes tests and screenings and builds relationships with patients. Teams share an office to encourage collaboration. There are numerous teams within each practice, who take it in turn to run a Saturday clinic.²¹⁷

Primary-care teams are supported by integrated-care teams. This team aims to ensure the delivery of the most cost-effective care. Behavioural health consultants, for example, provide psychological assistance to improve the wellbeing of the population.²¹⁸

211 Geraint Lewis, Natasha Curry, and Martin Bardsley, *Choosing a Predictive Risk Model: A Guide for Commissioners in England*, 2011, 15.

212 Mark Davies and Paul Molyneux, ‘Population Health Management’, 24 November 2015.

213 MedeAnalytics, ‘Mede/Population Health Service Pricing Document’, n.d., 1.

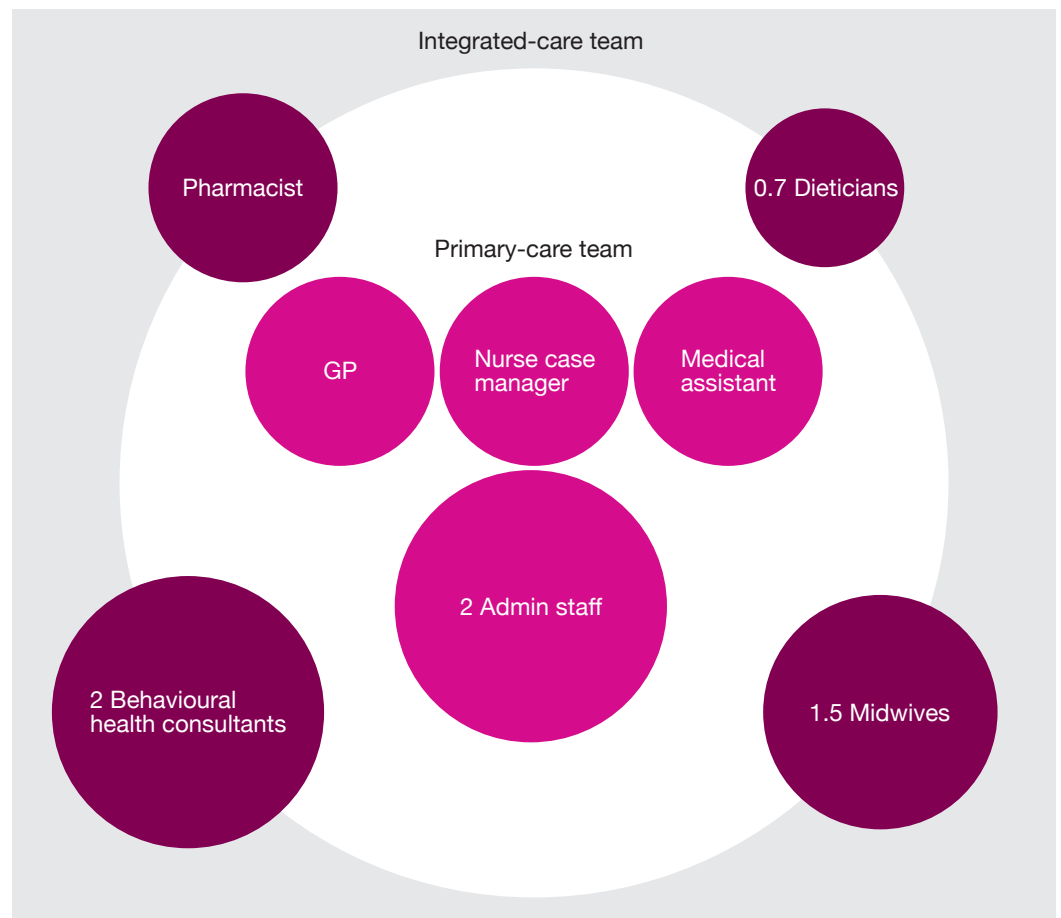
214 Michael Porter, Erika Pabo, and Thomas Lee, ‘Redesigning Primary Care: A Strategic Vision To Improve Value By Organizing Around Patients’ Needs’, *Health Affairs* 32, no. 3 (2013): 523.

215 Nick Goodwin et al., *Managing People with Long-Term Conditions* (The King’s Fund, 2010), 58.

216 Ben Collins, *Intentional Whole Health System Redesign: Southcentral Foundation’s ‘Nuka’ System of Care* (The King’s Fund, 2015), 32.

217 *Ibid.*, 34–37.

218 *Ibid.*, 37.

Figure 18: Southcentral primary-care team

Source: Ben Collins, *Intentional Whole Health System Redesign: Southcentral Foundation's 'Nuka' System of Care* (The King's Fund, 2015).

Southcentral's team-based approach has delivered improvements in access, outcomes and efficiency:

- > direct access to the appropriate clinician has removed the GP as the 'bottleneck' in the system and reduced waiting times from four weeks to the same day;
- > face-to-face GP appointments have fallen by 35 per cent;
- > referrals are faster; and
- > the relationships between patients and their team are better developed.²¹⁹

A team-based approach to providing care could be developed within the NHS. One practitioner interviewed for this paper explained that building such teams was their vision. Understanding how this might look is difficult because data on precisely how appointments are administered is scant. It will also vary across the country. Nevertheless indicative estimates have been made (see Figure 19).

219 Ibid., 33–37.

Figure 19: Estimated GP appointments (by type)

Long-term conditions	Musculoskeletal	Common conditions/ medicines-related problems	Mental health and wellbeing
50 per cent	Up to 30 per cent	Up to 15 per cent	Up to 33 per cent

Sources: *Reform* calculations. Department of Health, *Long Term Conditions Compendium of Information. Third Edition, 2012*; Chartered Society of Physiotherapy, 'Physiotherapy Works: Self-Referral', n.d., accessed 17 February 2016; NHS Alliance, *Making Time in General Practice, 2015*; Royal College of Psychiatrists, 'Talking to Your GP about a Mental Health Problem', 2016.

Many of these appointments (mental health issues and long-term conditions, for example) overlap. Nevertheless, Figure 19 provides an insight into how primary care in England might employ a more diverse workforce.

Long-term conditions require a range of interventions, from reviewing medication to intense care. Pharmacists and nurses could meet much of the care management needs. For example, pharmacists could deliver annual reviews, develop care plans and monitor medication for asthma patients – a group which has been identified as under-engaging with GP services but which frequently visits pharmacists for prescriptions.²²⁰ A small-scale pilot study found that pharmacist-led management resulted in 32 per cent fewer GP appointments and 40 per cent fewer hospital admissions.²²¹ Elsewhere, nurses have been shown to provide the same levels of care for diabetic patients as GPs,²²² with higher patient satisfaction.²²³ One interviewee for this paper estimated that 90 per cent of transactions for diabetics could be conducted by nurses. Analysis by King's College London explains that larger practices are more likely to employ nurses with postgraduate qualifications in diabetes care.²²⁴

For musculoskeletal problems, the Chartered Society of Physiotherapy has argued that over 100 million appointments could be freed up each year through patient self-referral.²²⁵ Such appointments would, it is argued, cut costs by £33 per patient on top of unquantified savings through fewer appointments, such as scans and x-rays.²²⁶ It also can cut waiting times and improve patient satisfaction.²²⁷ In Scotland, self-referral is underpinned by a telephone triaging system.²²⁸

For other common conditions or medicines-related problems, pharmacists and practice nurses could offer care.²²⁹ Evidence from abroad shows that nurse-led primary care can have a positive effect on patient satisfaction, hospital admission and mortality.²³⁰ GPs interviewed for this paper argued that cutting such appointments from their workload would improve job satisfaction by allowing GPs to focus on solving complex medical problems. Delivering appointments at between approximately £10 and £19 less cost than a GP, nurses and pharmacists meeting demand for these issues could offer cost savings of between £402 million and £727 million per year for the NHS.²³¹

220 Royal Pharmaceutical Society, *Pharmacist-Led Care of People with Long Term Conditions, 2014, 2–3.*

221 *Ibid.*, 3.

222 Trevor Murrells et al., *Managing Diabetes in Primary Care: How Does the Configuration of the Workforce Affect Quality of Care?* (King's College London, 2013).

223 Sue Horrocks, Elizabeth Anderson, and Chris Salisbury, 'Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors', *BMJ* 324, no. 7341 (4 June 2002): 819–23.

224 Murrells et al., *Managing Diabetes in Primary Care: How Does the Configuration of the Workforce Affect Quality of Care?*, 5.

225 Chartered Society of Physiotherapy, 'Physiotherapy Works: Self-Referral', n.d., accessed 17 February 2016.

226 *Ibid.*

227 *Ibid.*

228 *Ibid.*

229 NHS Alliance, *Making Time in General Practice, 53.*

230 Nahara Martinez-Gonzalez et al., 'Substitution of Physicians by Nurses in Primary Care: Review and Meta-Analysis', *BMC Health Services Research* 14, no. 1 (2014): 214.

231 *Reform* calculations based on nurses or pharmacists taking on all of the 62 per cent of these appointments GPs currently conduct. Costings extrapolated from hourly direct clinical patient time of pharmacists and GP practice nurses provided by the Personal Social Services Research Unit. This assumes appointments hold constant at 372 million. Curtis and Burns, *Unit Costs of Health and Social Care 2015, 174, 222.*

The Government has, however, committed to enlarging the GP headcount by 10 per cent.²³² Evidence here suggests that other clinicians could more effectively manage demand. Providers, along with the Government, should therefore work towards a blueprint for a more efficient healthcare workforce, with less of an emphasis on GPs.

Implementing such a diverse workforce would require a cultural shift amongst practitioners. As NHS Alliance explains, many GPs are unaware of what services other clinicians can cover.²³³ Interviewees for this paper argued that some may be reticent to move away from GP-centred care. Southcentral found that a quarter of employees were opposed to workforce changes. To address this, the provider invested heavily in communicating changes, training staff and helping them adapt to the new model – a process which took six months in some cases.²³⁴ Such an approach may need to be taken in England, particularly as successful models spread. Providers should therefore be careful to avoid these tensions, but vanguards employing more diverse workforces appear to be managing the transition.

To understand precisely how the workforce could best meet the needs of today's patients in the most cost-effective manner, NHS England should conduct an audit of consultations within general practice. This should aim to gain a detailed understanding of what appointments are conducted by whom. Following this, NHS England should work with professional bodies and providers to understand what proportion of appointments can be conducted by different clinicians. This should include an appraisal of whether capacity exists for clinicians to fulfil these roles – or whether clinicians require training to fulfil different roles. Pharmacists and nurses have indicated that they might require extra training to fulfil more of the functions outlined above.²³⁵ NHS England should build a recruitment and training plan based on a new understanding of clinician roles within general practice – which may involve shifting funding across clinician training.

Recommendation 1

The Government should abandon its target to employ 5,000 more GPs. NHS England should conduct an audit of general practice appointments and work with providers and representative bodies to understand how consultations can be delivered more efficiently by other clinicians. NHS England should build a recruitment and training plan based on this information.

3.2.4 Disruptive technology

Further efficiency savings and improvements in care quality can be delivered through increased use of technology within primary care.

3.2.4.1 E-consultations

The Government has aimed to increase the use of video consultations for many years.²³⁶ These services are being pioneered in the private sector by companies such as Babylon Health (see box below).

²³² BBC News, 'Jeremy Hunt: "10% More GPs for Seven-Day Week Work Load"', 19 June 2015.

²³³ NHS Alliance, *Making Time in General Practice*, 24.

²³⁴ Collins, *Intentional Whole Health System Redesign: Southcentral Foundation's 'Nuka' System of Care*, 34.

²³⁵ Royal Pharmaceutical Society, *Pharmacist-Led Care of People with Long Term Conditions*, 3.

²³⁶ Department for Health, *The NHS Plan: A Plan for Investment, A Plan for Reform*, 19; Department of Health, *Our Health, Our Care, Our Say: A New Direction for Community Services*, 2006, 119; Department of Health and NHS England, *Transforming Primary Care: Safe, Proactive, Personalised Care for Those Who Need It Most*, 2014, 39.

Babylon Health

Babylon Health is a digital-healthcare company which offers a range of e-consultations via computers and smartphones. These include:

- > Video consultations with GPs, and specialist consultants following referral.
- > 'Ask' function, through which GPs and nurses respond to text and photo-based health queries.
- > Prescription ordering.
- > Dashboard of healthcare statistics which can be linked to wearable apps and healthcare kits.

The system currently has 250,000 registered users and has been praised for increasing access to GP appointments. Babylon is currently at an early stage of partnering with the NHS.

Sources: Madhumita Murgia, "'Robot Doctor' App Raises \$25m to Predict Future of Your Health', *Telegraph*, 14 January 2016; Pippa Stephens, 'AI, Robots, Pocket Doctors: Patient-Centred Health Tech', *BBC News*, 23 September 2014.

The potential savings for the NHS of this system are not clear, with a two-year pilot yet to be completed.²³⁷ However, video consultations have proved beneficial elsewhere. A trial for diabetes patients at Newham Hospital in London resulted in a reduction of missed appointments by between 14 and 34 percentage points, improved control of the condition and fewer A&E attendances.²³⁸ The programme was estimated to save £27 per consultation in clinician time.²³⁹

Similar technology has also been used elsewhere. The Mayo Clinic in Minnesota has designed an online care site. Patients enter concerns online, which are generally reviewed by a clinician within 24 hours.²⁴⁰ Different patient groups use the system differently: many 'e-visits' were for minor issues, such as coughs or headaches. People with long-term conditions, such as hypertension and diabetes, used the system to contact physicians about concerns, as well as view laboratory results, which stopped unnecessary visits.²⁴¹

Technology can also be employed to streamline communication between health professionals. In Bradford, GPs have been using e-consultations to share the EHRs of patients with chronic kidney disease with renal specialists, who then decide whether patients need to be referred to a clinic or can instead undergo interventions in primary care.²⁴² The programme improved patient safety because on average e-consultations were seven times faster in producing a response.²⁴³ Given the high cost of clinic appointments, each e-consultation was calculated to save around £100 per appointment.²⁴⁴

3.2.4.2 Artificial intelligence

Technology is developing at a rapid pace, taking on many of the functions currently undertaken by clinicians. Babylon plans to launch an artificial intelligence (AI) version of its app, which understands symptoms and prevents illnesses through tracking a person's daily habits and cross referencing them against other key data such as medical records and diet. It can respond to basic medical questions and suggest a course of action.²⁴⁵ Another example is provided by the California Health Care Foundation (CHCF), which is working with data scientists to produce algorithms capable of diagnosing diabetic

²³⁷ Healthwatch Southend, *Babylon: GP Consultations via a Smartphone App*, 2015.

²³⁸ Trisha Greenhalgh et al., 'Virtual Online Consultations: Advantages and Limitations (VOCAL) Study', *British Medical Journal* 6, no. 1 (1 January 2016).

²³⁹ NHS England, 'Newham Diabetes Skype Pilot Success Increases Young People's Clinic Attendance', 19 January 2015.

²⁴⁰ Adamson and Bachman, 'Pilot Study of Providing Online Care in a Primary Care Setting'.

²⁴¹ *Ibid.*

²⁴² Bradford Teaching Hospitals NHS Foundation Trust, *Electronic Consultation: Chronic Kidney Disease*, 2012.

²⁴³ *Ibid.*

²⁴⁴ *Ibid.*

²⁴⁵ Madhumita Murgia, "'Robot Doctor' App Raises \$25m to Predict Future of Your Health', *Telegraph*, 14 January 2016.

retinopathy.²⁴⁶ At present, CHCF's algorithm concurs with a doctor's opinion in 85 percent of cases – equivalent to the concurrence between two doctors.²⁴⁷ Entilic, another California-based company, is developing image recognition which would allow machines to analyse x-rays and MRI scans with more accuracy than the human eye.²⁴⁸

To capture these benefits for primary care in England, providers must operate at scale. Detailed data analysis require providers to have sufficient list sizes and considerable expertise to extract and manage data.²⁴⁹ The larger the patient list, the greater the benefits for providers. Technological advances such as data analytics, remote consultations and AI have the potential to change how healthcare functions – this would bring considerable benefits to providers and patients alike.

²⁴⁶ The Economist, 'Now There's an App for That', 17 September 2015.

²⁴⁷ Ibid.

²⁴⁸ The Economist, 'Rise of the Machines', 6 May 2015.

²⁴⁹ Bestsenny, Kibasi, and Richardson, *Understanding Patients' Needs and Risk: A Key to a Better NHS*, 16.

4

Healthy markets

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Scaled primary care, built around the needs of the whole population is a compelling vision – one that is widely shared. The Government has signalled its support for integrated, scaled practices through NHS England’s new-care-models programme. The previous chapter outlined how this vision can be expanded to deliver a population health approach.

To achieve this vision, the Government must align funding across the whole healthcare system. Integrated commissioning bodies should replace today’s fragmented funding system, currently shared – to different degrees across the country – between NHS England, CCGs and local authorities. Integrated commissioners will be best-placed to design and commission contracts which hold providers responsible for the whole care needs of defined populations. The Government has an excellent opportunity to do this: it has committed to creating a new contract for general practice at scale.²⁵⁰ However, such contracts must replace the current framework – not simply act alongside it. Contracts must also incentivise competition between providers and encourage patient choice of providers that best meet their needs.

Such a commissioning framework is starkly different to today’s landscape. International best practice reveals what can be achieved through contracts covering whole care pathways. This approach also treats providers with maturity – as the independent, profit-making organisations they have been since 1948.

4.1 Aligning incentives with patient needs

4.1.1 Population-health contracts

Achieving the integration of care, efficiency savings and improved outcomes for patients outlined in Chapter 3 requires that the current contractual model be replaced. The negative effects of capitated versus activity-based funding were outlined in Chapter 2. Funding across primary, secondary and community care should be aligned; contracts should cover the whole care needs of a defined population. Depending on the scale of individual providers, these could range from alliance to prime contracts – as set out in Figure 17. Where appropriate, commissioners might also use performance incentives to improve care in strategic areas. To incentivise a population-health approach, the Government could take heed from a number of successful contractual models from across the globe (see Figure 20).

Figure 20: Contracts for whole care pathways

Type of contract	Description	Key example	Outcomes
Capitated	Per-patient budget for care given to a defined population, with ability for provider to keep efficiency savings.	Valencia, Spain (Ribera Salud).	28 per cent fewer hospital admissions (2012-14); high patient satisfaction; 26 per cent lower cost.
Capitation and pay for performance	Capitated budget and performance bonus.	Massachusetts, USA (Alternative Quality Contract, AQC): 10 per cent of contract value is performance bonus.	Improved quality; spending reduced by 6.8 per cent (2009-12).

Sources: Thoumi et al., *Reinventing Chronic Care Management for the Elderly* (Centre of Health Policy at Brookings, 2015); The Health Foundation, *Need to Nurture: Outcomes-Based Commissioning in the NHS*, 2015; Zirui Song et al., ‘Changes in Health Care Spending and Quality 4 Years into Global Payment’, *New England Journal of Medicine* 371, no. 18 (30 October 2014).

²⁵⁰ Prime Minister’s Office, ‘Prime Minister Pledges to Deliver 7-Day GP Services by 2020’.

Integrated contracts for the treatment of specific conditions across the care pathway have been successfully used, in England and abroad.²⁵¹ In Bedfordshire, a prime contract for musculoskeletal care was designed to reduce fragmentation and improve value for money for the CCG.²⁵² Stockholm County Council in Sweden designed a contract for hip and knee arthroplasty, with an outcomes payment worth 3.2 per cent of the contract value to integrate care.²⁵³ This resulted in 20 per cent fewer complications and revisions between 2009 and 2011 and cost per patient falling 17 per cent between 2008 and 2011.²⁵⁴

Such contracts incentivise improved and integrated care, at lower costs, but they remain siloed – and thus unable to address the whole healthcare needs of many individuals.²⁵⁵ Capitated budgets for the whole care needs of a defined population group should incentivise providers to deliver the most cost-efficient care for patients, with the whole system in mind. Providers can then keep, as GPs currently do, the savings made. As Monitor has recognised:

*Allowing providers to share in any such gain gives them an added incentive to identify risks, intervene early and arrange the right treatments, at the right place and the right time in order to aid patients' recovery, continued wellness and better management of their long term conditions.*²⁵⁶

Such an approach would align the NHS with best practice elsewhere. In New Zealand, Canterbury District Health Board moved from unconnected, sometimes fee-for-service, contracts to alliance contracts to integrate services under a 'one system, one budget approach'.²⁵⁷ This proved successful: in 2011-12, Canterbury was the only District Health Board to receive a "very good" grading from the New Zealand Auditor,²⁵⁸ a rating it again achieved in 2012-13.²⁵⁹ Jönköping County Council, in Sweden, takes a population-based commissioning focus, targeting four key groups: children and young people, people with mental health conditions, people with drug and alcohol problems, and elderly people.²⁶⁰ Services are based around these needs, rather than provider boundaries, resulting in positive outcomes in key health indicators, including life expectancy,²⁶¹ subjective health status²⁶² and psychological wellbeing.²⁶³

Payment bonuses may also incentivise improved outcomes in specific areas. This approach was taken by the AQC, with positive results (see Figure 20).²⁶⁴ This was the aim of QOF – but, as Chapter 2 highlighted, QOF fails to provide value for money for taxpayers. A better approach would be to allow commissioners the freedom to address the specific needs of distinct populations by rolling outcomes payments into population-health contracts. A small number of pioneering CCGs, with the Government's support, have already replaced QOF with local outcomes-based contracts.²⁶⁵ Early qualitative data suggests clinicians felt better-placed to offer 'whole-person' care and patients were more involved in the decision-making process.²⁶⁶

251 The Health Foundation, *Need to Nurture: Outcomes-Based Commissioning in the NHS*, 2015, 22–23.

252 Rachael Addicott, *Commissioning and Contracting for Integrated Care* (The King's Fund, 2014), 9.

253 Jennifer Clawson et al., 'Competing on Outcomes: Winning Strategies for Value-Based Health Care', *Bcg.perspectives*, 16 January 2014.

254 The savings came from lower volume (40 per cent) and lower-cost providers (60 percent). *Ibid.*

255 Addicott, *Commissioning and Contracting for Integrated Care*, 19.

256 Monitor, *Capitation: A Potential New Payment Model to Enable Integrated Care*, 7.

257 Timmins and Ham, *The Quest for Integrated Health and Social Care A Case Study in Canterbury, New Zealand*, 17–19.

258 Controller and Auditor-General, *Health Sector: Results of the 2011/12 Audits*, 2013, 25.

259 Controller and Auditor-General, *Health Sector: Results of the 2012/13 Audits*, 2014, 29.

260 The King's Fund, 'Jönköping County Council, Sweden', n.d.

261 Socialstyrelsen, *Öppna Jämförelser 2014 – Folkhälsa*, 2014, 24.

262 *Ibid.*, 28.

263 *Ibid.*, 50.

264 Blue Cross Blue Shield of Massachusetts, *The Alternative QUALITY Contract*, 2010, 7.

265 Caroline Price, 'Bye Bye QOF? Framework to Be First Casualty of Co-Commissioning Drive', *Pulse Today*, 23 December 2014.

266 South West Academic Health Science Network, *An Evaluation of the Somerset Practice Quality Scheme (SPQS)*, 2015.

Recommendation 2

Current funding streams should be replaced with contracts that commission services covering the whole care needs of defined groups of people.

4.1.1.1 Outcomes that matter to patients

Commissioners must ensure that these contracts motivate providers to address outcomes that matter for patients. An important criticism of QOF, for instance, is that it focuses on narrow measurements and fails to incentivise outcomes that matter most to patients.²⁶⁷ In diabetes care, for example, QOF measures blood pressure, HbA1c and cholesterol measurements,²⁶⁸ but not “what really matters”, according to Michael Porter and Thomas Lee: loss of vision, heart attacks, strokes or amputations.²⁶⁹ Porter and Lee suggest a hierarchy of outcomes that matter to patients (including health status achieved or retained and recovery process after incident).²⁷⁰ In England, a group of organisations in Cornwall redefined outcomes based on what patients wanted (see box below).

Cornwall and the Isles of Scilly outcomes measurements

In Cornwall and the Isles of Scilly, a number of organisations, including a CCG, Foundation Trusts, local authorities and voluntary organisations, have designed and implemented an outcomes framework focusing on healthcare goals patients deem most important. This includes: improved health and wellbeing (life expectancy, improved quality of life), improved experience of care and support (improved experience of people, improved quality of service) as well as reduced cost of care and support (reduced per capita and whole-system cost). Integrating care, focusing on high-risk people and focusing on patient-centred outcomes have led to impressive early results: between 2013 and 2014, self-reported wellbeing improved by 23 per cent and non-elective emergency admissions for those with long-term conditions fell by 40 per cent.

Sources: Monitor, *Capitation: A Potential New Payment Model to Enable Integrated Care*, Appendix 2; Tracey Roose, *Living Well: Pioneer for Cornwall and the Isles of Scilly. A Report to The House of Commons Health Select Committee*, 2014.

Porter and Lee have argued that monitoring a full set of outcomes is “one of the most powerful vehicles for lowering health care costs.”²⁷¹ This, the authors state, is exemplified by a German study which found that one-year follow-up costs were 15 per cent lower in hospitals with above-average outcomes when compared to hospitals with below-average outcomes.²⁷² According to Göran Henriks of Jönköping County Council, in Sweden, a key outcome of the Esther Project, which reduced hospital admissions for elderly people through delivering more coordinated care, was its cultural lessons, including the importance of “[c]oncentrat[ing] on what patients value, not on what professionals value.”²⁷³ Other studies have shown that simply making outcomes publicly available improves clinical results.²⁷⁴

Recommendation 3

Contracts should focus on outcomes that matter to patients, rather than outputs or process. Commissioners, providers and patients should work together to determine these outcomes.

267 Rebecca Rosen, *Transforming General Practice: What Are the Levers for Change?* (Nuffield Trust, 2015), 9–10.

268 The National Institute for Health and Care Excellence, ‘Quality and Outcomes Framework Indicators’, n.d.

269 Michael Porter and Thomas Lee, ‘The Strategy That Will Fix Health Care’, *Harvard Business Review*, October 2013.

270 *Ibid.*

271 *Ibid.*

272 *Ibid.*

273 Institute for Healthcare Improvement, ‘Charting the Way to Greater Success: Pursuing Perfection in Sweden’, n.d.

274 Judith H. Hibbard, Jean Stockard, and Martin Tusler, ‘Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?’, *Health Affairs (Project Hope)* 22, no. 2 (April 2003): 84–94; Porter and Lee, ‘The Strategy That Will Fix Health Care’.

4.2 Commissioning

4.2.1 Integrated commissioning

As Chapter 2 outlined, a key reason for contracts failing to align incentives throughout care pathways is that different organisations provide the funding for different segments of care. To deliver a population-health approach, commissioning bodies must be able to procure care across the pathway by controlling pooled budgets.

On one level, this is the direction of travel within the NHS. The introduction of co-commissioning between CCGs and NHS England will give CCGs increasing responsibility to commission primary-care services.²⁷⁵ The Government has pledged to integrate health and social care services by 2020,²⁷⁶ with local commissioners tasked with developing plans to achieve this.²⁷⁷ In Manchester, CCGs and councils began to pool their budgets in April 2016 to “ensure that joined up commissioning of health, social care and wellbeing services is undertaken, through the whole pathway from asset based early intervention to acute hospital care.”²⁷⁸

In their current composition, however, CCGs may not be best-placed to fulfil the role of integrated commissioners for larger providers. Some providers are starting to outgrow their CCG: in 2015, Lakeside attempted to move from Corby CCG to Nene CCG, but was denied because the move would have made Corby unviable as Lakeside cared for two-thirds of its patients.²⁷⁹ To procure larger contracts, CCGs have also felt it necessary to merge.²⁸⁰ In Staffordshire, three CCGs, with a £600 million budget, covering 500,000 people, are planning to merge to manage financial risk.²⁸¹ In other places – such as Sheffield, Southend, Devon and Plymouth – budgets held by CCGs, local authorities and NHS England are being pooled.²⁸²

It has therefore been suggested that commissioners could cover larger populations. Larger organisations may be better-placed to purchase integrated care by, for example, covering larger homogenous health groups than the current 209 CCGs. Monitor has mapped out 37 local health and care economies, in which common patients and funding flows between CCGs and providers.²⁸³ Bodies commissioning the care of these populations would be starkly different from current commissioners (see Figure 21).

275 In January 2016, Simon Stevens anticipated 55 per cent of CCGs would take on full delegated responsibility by April 2016, with a further third co-commissioning alongside NHS England. Public Accounts Committee, *Oral Evidence: Access to General Practice in England: HC 673*, 2016, 17.

276 HM Treasury, *Spending Review and Autumn Statement 2015*, 2015, 2.

277 NHS England, *People Helping People: Year Two of the Pioneer Programme*, 2016, 19.

278 12 Team Bury, *Bury Locality Plan: 'Bolder, Braver Bury – Towards GM Devolution' 2016-2021*, 2015.

279 Nick Renaud-Komiya, 'Exclusive: Vanguard "Super Practice" Bid to Switch CCG Rejected', *Health Service Journal*, 11 March 2015.

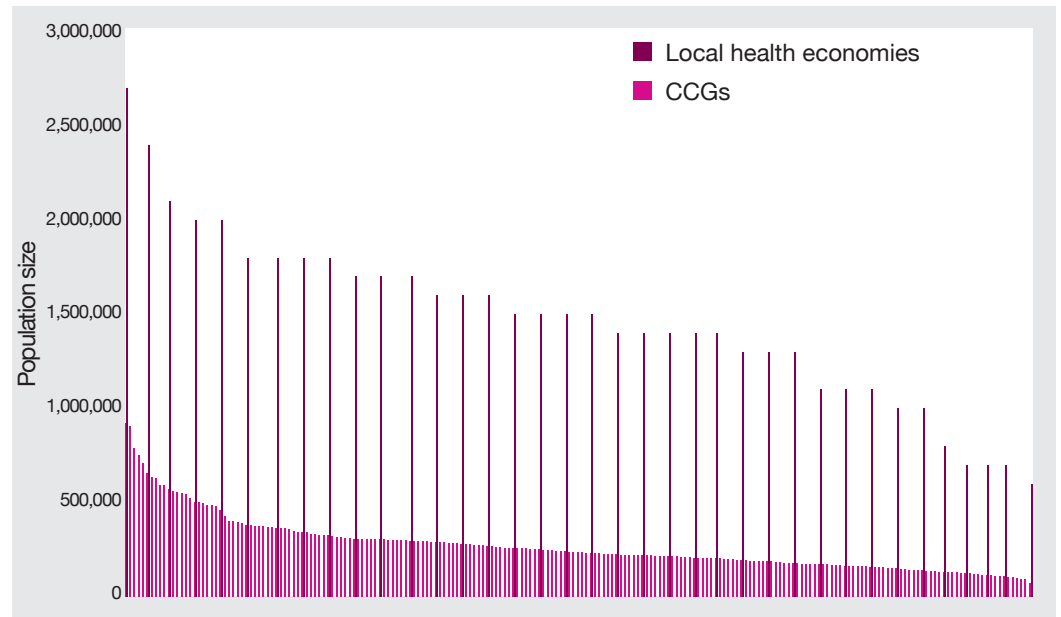
280 Furthermore, the Grafton Group comprises nine CCGs across the country, who have joined to share knowledge about patient-centred commissioning. Grafton Group, *Clinical Contracting Considerations*, 7.

281 Nick Renaud-Komiya, 'Staffordshire CCGs Anticipate "Virtual" Merger', *Health Service Journal*, 16 February 2016.

282 Richard Humphries and Lillie Wenzel, *Options for Integrated Commissioning: Beyond Barker* (The King's Fund, 2015), 39.

283 That is to say, these are areas in which over 75 per cent of CCG spending and over 75 per cent of local provider clinical income is spent. Monitor, *Considerations for Determining Local Health and Care Economies*, 2015, 14.

Figure 21: Clinical commissioning groups and local health economies by population size (2015-16)



Sources: NHS England, 'Technical Guide to Clinical Commissioning Group and Area Team allocations 2014-15 and 2015-16', 27 March 2014; Monitor, *Considerations for Determining Local Health and Care Economies*, 2015.

Recommendation 4

Commissioners should fund services from an integrated budget. The Government should investigate the optimum size of commissioning bodies and work with NHS England, clinical commissioning groups and local authorities to understand how these bodies should be constructed.

4.2.2 Data-driven commissioning

Contracts must also be data-driven to understand patient needs and provider capabilities. Procurement theory dictates that commissioners who understand current spending and provider capabilities are best-placed to design innovative and competitive contracts capable of incentivising improved services.²⁸⁴ Understanding patients' care needs and use of services, outcomes of current services and best practice are crucial to designing contracts capable of delivering improved outcomes.

The lack of data in the NHS is well-recognised – the number of appointments has not been collected since 2008, for instance. Monitor has described the recording of data for community services as "poor".²⁸⁵ General practice has historically collected data through four separate IT systems, which has made extraction difficult for commissioners.²⁸⁶ The Government attempted to address this in 2007 through the General Practice Extraction Service (GPES) – but procurement and IT failures mean the service is yet to be fully implemented.²⁸⁷ Moving forward, the NAO notes that while "its data is critical for determining payments to GPs [for NHS England]...there is unlikely to be a long-term future for all or part of the GPES."²⁸⁸ This raises questions about the ability of commissioners to collect crucial information for designing contracts.

²⁸⁴ Alexander Hitchcock and William Mosseri-Marlio, *Cloud 9: The Future of Public Procurement (Reform, 2016)*, 38.

²⁸⁵ Monitor, *Improving GP Services: Commissioners and Patient Choice*, 6.

²⁸⁶ National Audit Office, *General Practice Extraction Service – Investigation*, 2015, 8.

²⁸⁷ *Ibid.*

²⁸⁸ Helen Atherton, 'Use of Email for Consulting with Patients in General Practice', *British Journal of General Practice* 63, no. 608 (2013): 9.

The Government has also attempted to collect and standardise data between general practice and hospital care through its care.data programme. This involves the Health and Social Care Information Centre collecting (and anonymising) information such as referrals, NHS prescriptions, family history, vaccinations, blood test results, body mass index and smoking and alcohol habits. Data is intended to be collected on an opt-out basis. This information can be used to plan services to prevent disease, identify risk, highlight inefficiencies in care pathways and identify which groups might be more or less likely to benefit from a treatment.²⁸⁹ The Major Projects Authority has, however, questioned the achievability of the project.²⁹⁰ The roll-out of the programme has been hindered by concerns about the privacy of patient data, and worries about the inadequate explanation of patients' ability to opt out of the scheme.²⁹¹ It also revealed confusion over legal responsibilities from GPs regarding the extent to which they need to inform patients about data extractions.²⁹²

In lieu of robust centrally collected data, commissioners in other areas of the NHS have devised novel ways of collecting outcomes information: in Staffordshire, CCGs and Macmillan Cancer Support have committed to spending the first two years of a 10-year contract working with the prime provider to develop the data to define the appropriate outcomes. These will then form the basis of incentive payments from the third year of the contract.²⁹³ International experts have expressed a preference for a small number of standardised metrics.²⁹⁴

Recommendation 5

The Government should develop a long-term plan to collect data from general practice and across the NHS to be used to design contracts. The Government should satisfy itself that the care.data programme is best-placed to achieve its aims, clarify providers' legal obligations and ensure that people are adequately informed of their right to opt out.

4.3 Competition and choice

Commissioners with control over health budgets for a defined population should be best-placed to cultivate a functioning marketplace and get the best value from providers.²⁹⁵ *Reform* has previously argued the benefits of competition in healthcare.²⁹⁶ Evidence from the OECD, International Monetary Fund and others suggests that competition can be used "effectively to create a system that's responsive and to incentivise high quality and efficient care."²⁹⁷ In practice, international evidence of the effects of competition is

289 NHS England, 'The Benefits of Care.data', n.d., accessed 24 March 2016.

290 Cabinet Office, *Major Projects Authority Annual Report 2014-15*, 2015, 2014-15.

291 Colin Marrs, 'Care.data – An In-Depth Check-up on NHS England's Controversial Bid to Join up Health Data', *Civil Service World*, 18 September 2015.

292 Ibid.

293 The Health Foundation, *Need to Nurture: Outcomes-Based Commissioning in the NHS*, 14.

294 Josh Seidman and Nelly Ganesan, *Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract*, 2015, 14.

295 Typically, competition in primary care is understood in terms of patient choice, rather than a range of provider competing for services. The vision of the future of primary care articulated here, however, requires a focus on competitive procurement of services from a range of providers. Expert Panel on Effective Ways of Investing in Health, *Competition among Health Care Providers in the European Union: Investigating Policy Options* (European Commission, 2015), 39.

296 Cathy Corrie and Leo Ewbank, *How to Run a Country: Health and Social Care (Reform)*, 2015), 4.

297 Isabelle Jourard, Christophe Andre, and Chantal Nicq, 'Health Care Systems: Efficiency and Institutions' (OECD, 2010); Carlo Cottarelli, 'Macro-Fiscal Implications of Health Care Reform in Advanced and Emerging Economies' (International Monetary Fund, 2010); Will Hazell, 'Monitor: Role for Competition in New Provider Landscape', *Health Service Journal*, 2014.

positive.²⁹⁸ In England, competition between GP practices has been associated with quality.²⁹⁹ In Derby, for example, a private provider commissioned to provide primary-care services in 2007 improved access and performance.³⁰⁰ The spectre of competition may also have increased the performance of nearby practices.³⁰¹ Similar results have been reported for hospital care in Australia.³⁰²

4.3.1 Nurturing nascent markets

In nascent markets, where providers not in a position to assume full financial risk, commissioners may need to work with organisations to share the risk of moving to large, integrated bodies.³⁰³ The AQC in the USA distributes risk between insurer and providers: savings and losses on the capitated budget are shared, with proportions dependent on the size of provider, degree of care integration and ability for the provider to assume risk for variation in care.³⁰⁴ Monitor have outlined the potential of gain or loss-sharing agreements to aid the development of new models of care by mitigating financial risks and allowing the share of efficiency savings.³⁰⁵ Clearly, risk-sharing agreements will vary by market size and maturity and so commissioners will need to be dynamic in their agreements.³⁰⁶

Recommendation 6

Commissioners should nurture nascent markets through risk-sharing agreements. The nature of these agreements should vary by market maturity, but be designed for providers ultimately to assume full financial responsibility for patient care.

The move from small-scale practices to larger multi-purpose ones may, in certain instances, require investment in new infrastructure. Hitherto, governments have used public money in the form of investment funds, such as the Primary Care Transformation Fund (worth £1 billion over four years), to accelerate change.³⁰⁷ All too often, however, these funds are used to balance finances before driving operational change – as is the case with NHS hospitals' Sustainability and Transformation Fund.³⁰⁸

Instead of relying on new taxpayer money to invest in infrastructure that will pay dividends to independent organisations, future providers should look to private capital markets. There is an estimated £6 billion ready to invest in primary-care infrastructure from the private sector.³⁰⁹ For this investment to materialise, the British Property Federation has called for the movement of many secondary care services to primary care and the related acceleration of infrastructure change to be made a clear ministerial priority.³¹⁰ With this in place, commissioners could also investigate the extent to which they have capacity to back private-sector loans to lower the cost of borrowing for smaller providers.

298 US Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition*, 2010; Gary Jarrett, 'An Analysis of International Health Care Logistics: The Benefits and Implications of Implementing Just-in-Time Systems in the Health Care Industry', *International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services* 19, no. 1 (2006): i – x; D. Wholey, R. Feldman, and J. B. Christianson, 'The Effect of Market Structure on HMO Premiums', *Journal of Health Economics* 14, no. 1 (May 1995): 81–105; Dennis P Scanlon et al., 'Does Competition Improve Health Care Quality?', *Health Services Research* 43, no. 6 (December 2008): 1931–51; J. Zwanziger and G. A. Melnick, 'Can Managed Care Plans Control Health Care Costs?', *Health Affairs (Project Hope)* 15, no. 2 (1996): 185–99.

299 Chris Pike, *An Empirical Analysis of the Effects of GP Competition*, 2010.

300 Penelope Dash and David Meredith, 'When and How Provider Competition Can Improve Health Care Delivery', *McKinsey & Company*, November 2010.

301 Ibid.

302 Ibid.

303 The Health Foundation, *Need to Nurture: Outcomes-Based Commissioning in the NHS*.

304 Blue Cross Blue Shield of Massachusetts, *The Alternative QUALITY Contract*.

305 Monitor, *Multilateral Gain/Loss Sharing: A Financial Mechanism to Support Collaborative Service Reform*, 2015, 5.

306 Monitor and NHS England's advice is alert to this and sets out a range of variables that should be considered by commissioners. Ibid., 13–30.

307 NHS England, 'Primary Care Transformation Fund Promises Major Upgrades to GP Premises', 29 October 2015.

308 Sally Gainsbury, 'Transformation Fund' or Deficit Mop-up? Time for an Honest Conversation', *Nuffield Trust*, 20 January 2016.

309 British Property Federation, *Unlocking Investment in Primary Care Infrastructure*, 2014, 2.

310 Ibid., 5.

4.3.2 Healthy competition

The real prize, therefore, is to create healthcare markets that continuously improve and innovate.³¹¹ This requires careful market stewardship: commissioners must skillfully manage risk while incentivising competition for contracts.³¹² For instance, the type of contract – whether prime or alliance, for example – used will be important: commissioners must engage with providers to decide which contract will be best suited to the providers operating within a local health economy.

Another crucial factor is contract length. GMS contracts have no end date; PMS contracts are subject to negotiation, but in practice have no end date or are renegotiated periodically.³¹³ This is self-evidently uncompetitive. Precise length of contracts will need to be determined by commissioners based on the sturdiness of markets. Current practice can hint at appropriate lengths. For example, current outcomes-based contracts in England are between three and 10 years in length.³¹⁴ The AQC is a three-to-five-year contract, which is considered long term enough to incentivise provider investment and give providers time to “experiment” with solutions.³¹⁵ The current Ribera Salud contract runs for 15 years with the option to extend the provision of specific services for an extra five years.³¹⁶

Commissioners must draw a balance between reiterating contracts regularly enough to maximise competition (including using data to benchmark performance and more competitively construct new contracts) and allowing providers to invest in new models of care, including infrastructure and relationships with other care providers. Market entry is critical to improving services: in private markets, at least half of productivity increases over a 10-year period is due to the replacement of less productive organisations with more productive ones.³¹⁷

Vanguard providers are keen to expand services. Modality, it has been reported, hopes to move beyond Birmingham into London.³¹⁸ The AQC model is considered replicable.³¹⁹ Growing numbers of large providers, in the UK and abroad, are providing an increasingly large pool of viable providers to compete for contracts. This is on top of large private providers, such as Virgin Healthcare, which currently provides 30 primary-care facilities, and continues to win other NHS contracts.³²⁰

Recommendation 7

Future contracts must be fixed-term to encourage competition and the best services for patients. Exact durations will depend on market maturity, but best practice suggests between five and 15 years are optimal lengths.

A range of other options could also be explored. One stakeholder interviewed for this paper explained that hostile bids for other providers would spread best practice. As McKinsey has argued, appropriately rewarding contracts should incentivise organisations to buy poorly functioning providers.³²¹ With careful management from commissioners to guarantee patient safety, manage risk and uphold competition, this could support the extension of best practice.

311 Tom Latkovic, *The Trillion Dollar Prize* (McKinsey & Company, 2013), 9.

312 Tom Gash et al., *Making Public Service Markets Work* (Institute for Government, 2013).

313 Monitor, *Improving GP Services: Commissioners and Patient Choice*, 15.

314 The Health Foundation, *Need to Nurture: Outcomes-Based Commissioning in the NHS*, 22–23.

315 Seidman and Ganesan, *Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract*, 4.

316 NHS Confederation, *The Search for Low-Cost Integrated Healthcare: The Alzira Model – from the Region of Valencia*, 7.

317 Office of Fair Trading, *Choice and Competition in Public Services: A Guide for Policy Makers*, 2010, 57.

318 Renaud-Komiya, ‘Exclusive: Vanguard GP “super Partnership” in Talks to Expand across England’.

319 Seidman and Ganesan, *Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract*, 13.

320 BBC News, ‘Private Company Virgin to Run North Kent Community Hospitals’, 14 January 2016. The 30 primary-care services includes 19 GP practices.

321 Dash and Meredith, ‘When and How Provider Competition Can Improve Health Care Delivery’.

4.3.3 Meaningful choice for patients

Choice of primary-care services must remain central for patients – as it has since 1948. The *Five Year Forward View* and NHS Constitution commit to upholding patients' ability to choose when and how they receive care.³²² Choice of provider has been shown, in the UK and abroad, to enhance patient wellbeing.³²³ As Monitor has recognised: "Patients can therefore benefit from choosing the practice that best meets their specific needs and preferences."³²⁴ It is also what people want: 93 per cent believe it is important to be able to choose their GP.³²⁵

Yet it is not frequently exercised: only 3 per cent of people have switched GP provider because they were dissatisfied with their practice.³²⁶ One barrier is awareness: almost a third of people think they do not have alternative GP practices from which to choose.³²⁷ One limiting factor to patient awareness of services, according to Monitor, is that some GPs believe they are prevented from publishing comparative information about the quality of their services – which is not the case.³²⁸ Higher quality may also drive choice: one study found that, to some extent, patients have been more likely to register with practices that return better QOF results.³²⁹ An innovative market, with providers offering different ranges services, can offer patients meaningful choice. Patients exercising this choice can drive other providers to adapt services to meet users' needs.³³⁰

Providers should also be responsible for patients who travel to receive care from another organisation. This is the case in Valencia, where Ribera Salud must pay other public providers for patients care costs at the regionally set price.³³¹ This system, in which money follows the patient, creates financial incentives for providers to take on new patients and provide the best care for all registered patients.

Recommendation 8

Commissioners should uphold patient choice throughout the care system. Funding should follow the patient to incentivise providers to deliver the best care for all users.

322 Department of Health, *The NHS Constitution: The NHS Belongs to Us All* (Department of Health, 2013), 8–9, NHS England, *Five Year Forward View*, 12–13.

323 Valentina Zigante, *Consumer Choice, Competition and Privatisation in European Health and Long-Term Care Systems: Subjective Well-Being Effects and Equity Implications* (PhD Thesis, The London School of Economics and Political Science (LSE), 2013).

324 Monitor, *Improving GP Services: Commissioners and Patient Choice*, 27.

325 *Ibid.*, 26.

326 Maria Booker, *Which? Response to Monitor's Call for Evidence on General Practice Services Sector in England*, 2013.

327 Corrie and Ewbank, *How to Run a Country: Health and Social Care*, 4.

328 Monitor, *Improving GP Services: Commissioners and Patient Choice*, 36, 57.

329 Rita Santos, Hugh Gravelle, and Carol Propper, *Does Quality Affect Patients' Choice of Doctor? Evidence from the UK* (University of York, 2013).

330 Corrie and Ewbank, *How to Run a Country: Health and Social Care*, 4.

331 Thoumi et al., *Reinventing Chronic Care Management for the Elderly*, 5.

Appendix: list of interviewees

The research for this paper was informed by 22 semi-structured interviews, lasting approximately one hour each. The interviews were conducted under the Chatham House Rule. The full list of interviewees is as follows:

- > Senior manager, Accenture
- > Executive, Babylon Health
- > Senior official, British Medical Association
- > Director, OneMedicalGroup
- > Director, Digital Life Sciences
- > Director, GP Access
- > Senior official, Hackney London Borough Council
- > Partner, The Hurley Group
- > Professor, Imperial College London
- > Professor, Imperial College London
- > Partner, KPMG
- > Partner, Lakeside Healthcare Group
- > Director, McKinsey & Company
- > Former Health Minister
- > Executive, Modality Partnership
- > Senior official, Monitor
- > Senior official, NHS Crawley Clinical Commissioning Group
- > Senior official, NHS East of England
- > Senior official, NHS Tower Hamlets Clinical Commissioning Group
- > Senior fellow, Nuffield Trust
- > Senior official, Public Health England
- > Partner, Taurus Healthcare

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