ROYAL COLLEGE OF GENERAL PRACTITIONERS

REV.1

	COUNCIL 22 NOVEMBER 2014 Outcome Based Commissioning for General Practice	REF: C/17	ITEM 21

CATEGORY

For DISCUSSION/ DECISION

SCOPE

UK-wide/

LEAD OFFICER(S)

Vice Chair External Affairs

LEAD DIRECTOR

DPT&D

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EXECUTIVE SUMMARY

General Practice is in a difficult place. The Put Patients First: Back General Practice campaign has highlighted the nature of the problem with an ever-expanding workload in the context of falling resources. The pressure we are under is clear for all to see. Many are taking early retirement and recruitment into the profession is at an all time low.

The 5 Year Forward View published in October 2014 recognises the central part that General Practice has to play in a successful sustainable NHS. Currently the funding mechanisms and the way that health care is commissioned are poorly aligned to assure a vibrant future for General Practice, essential for an effective future NHS. This paper begins to describe an alternative way of commissioning healthcare that has the potential not only to deliver outcomes that matter but to also secure the future viability of British General Practice.

PATIENT INVOLVEMENT / IMPLICATIONS

The Chair of the Patient & Carers Partnership Group is an observer member on Council and therefore able to comment and input directly to the discussion this issue.

RESOURCE IMPLICATIONS (Financial, Legal, Personnel, IT etc)

RECOMMENDATION

Council is asked :

1) To agree to further work to consider the case for, and potential benefits of, outcome based commissioning of healthcare services including general practice and primary care;
2) To agree exploring the potential for further work by the RCGP, potentially in collaboration with the Royal College of Physicians, to develop an approach to integrated outcome based commissioning.

Please use the attached link to access this report electronically:

ftp://rcgpftp.rcgp.org.uk

The Case for Outcome Based Commissioning

A discussion paper for Council

Overview

There is clearly a problem in the way that General Practice is resourced. The Put Patients First – Back General Practice campaign has articulated the challenges we face from decreasing resources at a time of increasing workload in General Practice and wider Primary Care. This is perhaps inevitable given the different funding mechanisms that are in place in the NHS. Much of the resource given to secondary care is activity based – the more that gets done the more that gets paid – and this drives certain types of activity ever upwards. Politicians champion this by declaring triumphantly that year on year the NHS does more and more. In General Practice the more we do, the same we get. General Practice is seen as a sponge that can soak up work, including work moved from hospitals into the community; but the sponge is now saturated and is leaking all over the floor. The consequences of these funding mechanisms being misaligned are not just inadequate funding for primary care but also fragmentation of care, over-specified commissioning, poor quality of care and waste.

Primary and secondary care funding needs to be aligned and needs to follow, not activity, but added value or outcomes. This paper begins to outline the need to move to a different funding mechanism based around outcomes that are virtuous not only for the individual but for primary care, the wider health care system and society itself. A move away from providing care in a transactional activity driven model would result in a better use of resources and is likely to decrease the overall environmental footprint of health care in the UK. This would result in commissioning for the “Triple Bottom Line” which includes the needs of individuals and society, the economy and finally the biosphere itself. There is of course a need to underpin any funding mechanism with a core offer in order to maintain the safety net of the provision of universal access to General Practice services. A move to this form of funding would enable General Practice to become locked into a funding mechanism that would help us to move to a system that is more sustainable, targeting resources towards keeping people well rather than paying when they become ill. It would also support the development of organisations with general practice at their heart that could support a sustainable future for primary care.

Introduction

The NHS, with general practice at its heart, is not just a health service, but an integral part of the fabric of British society. Uniquely among nations, Britain harnessed post-war determination to create a modern, fair society by introducing radical policies to tackle the five giants (squalor, want, disease, idleness and ignorance) that Beveridge identified as standing in the way of national reconstruction. A vision for a new national health service was at the heart of those giant-slaying policies – a health service that would provide universal access to comprehensive 'cradle to grave' health services, largely free at the point of delivery, funded, by central government from general taxation and national insurance, with resources allocated according to need and not ability to pay. From its inception, these principles and the NHS itself have commanded huge public affection and support.

Sixty six years later the principles and values on which the NHS was founded remain as relevant, important and as cherished by the British public as they were in 1948. For example, in 2013, a large Ipsos-Mori poll[i] found that the NHS is Britain's most popular institution, ranking ahead of the monarchy, the army and the GB Olympic team. Indeed, when asked what made them proud to be British[ii], 72% declared the NHS to be 'a symbol of what is great about Britain and we must do everything we can to maintain it".

For several decades, the NHS was often described as the envy of the world, but in recent years, this view has been increasingly challenged[iii]. Although, on many measures, the NHS does well compared to many other health care systems[iv] and the public remains proud of the principles on which the NHS was founded, it is sometimes hard to be proud of all that happens in the name of the NHS. This is not just because of the major scandals such as Mid-Staffordshire and Bristol, but there is also growing criticism of the NHS for its provision of fragmented and disjointed care of unpredictable and irregular quality, which is often wasteful, difficult to access and insensitive to the needs of individuals.

If the principles upon which the NHS is founded remain as fresh, relevant and as well supported as they were in 1948, much else has changed. In 1948, a baby boy's expectation of life at birth was 62 years; now – partly because of the success of the NHS – it is nearly 80 years. In 1948, health care was relatively simple and of limited effectiveness; now advances in science and technology make it hugely more complex and powerful. In 1948 most people were deferential towards authority and grateful that the NHS enabled them to be able to seek medical attention without having to worry about the financial consequences; now people regard ready access to the very best of health care tailored to their particular circumstance as their right not a privilege. In 1948 most care was reactive, responding to people who were ill or thought they were ill; now anticipatory care is a major part of the clinical workload, especially in general practice. Perhaps most importantly of all, in 1948 few people lived to extreme old age; but now the major client group of the NHS is the elderly with multiple co-existing physical, mental and social problems.

As health care increasingly comes to depend upon knowledge management the NHS must rise to the challenge to successfully provide access to decision support and the availability of a contemporaneous electronic clinical record in all clinical encounters. Despite the growth in complexity and volume of work, the basic model of health care delivery in the UK remains largely unchanged. As staff attempt to deal with new and growing demands using delivery mechanisms designed for a different era, they find themselves working ever harder and faster in an attempt to keep up. Burn out, demoralisation, and recruitment and retention problems are becoming increasingly common. This is particularly true of general practice.

For all these reasons there is a growing consensus that change is desperately needed - change that finds a new sustainable way of delivering the founding principles and values of the NHS to a 21st century population; change that works for staff as well as for those that use and pay for services; change that is affordable and sustainable.

GPs, as providers of the 90% of NHS care, have always been at the heart of NHS provision. Now, with the creation of Clinical Commissioning Groups, GPs are also responsible for more than 70% of the NHS commissioning budget. Following the 2012 Health and Social Care Act the commissioning of General Practice became the responsibility of NHS England's Local Area Teams. This has resulted in an inability to integrate the commissioning of primary and secondary care services. There is now a move to bring the commissioning of primary and secondary care together' described as"co-commissioning". This brings with it even greater opportunities for GPs and CCGs to orchestrate the delivery of care. We must however be mindful of, and respond to, the challenges that this will also bring in particular around conflicts of interest.

Key elements of RCGP Leadership

In exercising its role as the guardian of standards for family doctors in the UK, the RCGP will need to ensure that its leadership is grounded by its own strategic plan reflecting its core purpose of working to promote excellence in primary healthcare. Where it exists, valid and relevant evidence on the effective and efficient working of organisations and systems needs to be used, much of which can be drawn from disciplines beyond health care. The RCGP's own Clinical Innovation and Research Centre (CIRC) has a crucial part to play.

Being at the centre of both the delivery and commissioning of care gives general practice a unique opportunity and a great responsibility to shape the future of the NHS. Building on its values, summarized in its motto "*cum scientia caritas*' (knowledge with loving kindness), the RCGP is uniquely well placed to lead the development, promotion and implementation of policies that will safeguard the NHS and the values on which it was founded and, in doing so, to re-define the future of general practice. This in turn places a responsibility upon the RCGP to articulate how General Practice rises to the challenge of changing demography, patterns of illness and fiscal pressures whilst preserving NHS values. Continuing to develop an understanding of over diagnosis and over treatment is of crucial importance in order to be able to commission and provide services and care that have value for individuals.

In order to do this the system needs to move to a more outcome or value focused approach to delivering healthcare. It is often difficult to separate out the precise contribution of the different elements of a patient's journey along a pathway to the outcomes they derive from that pathway (and the UK is unusual in having such a clear demarcation between community based general practitioners and hospital based specialists). Commissioning for outcomes has the potential to be applied through co-commissioning of care across sectors, as set out in RCGP strategies and the more integrated form of service delivery espoused by the Royal College Physicians' Future Hospital Commission[5]

The Case for Outcome Based Commissioning.

Funding can be linked to activity (inputs), or achievement of targets (outputs). However, it can also be linked to outcomes for individuals and groups. The ultimate aim is to reward impact, but impact is usually the result of the work of many agencies – better quality of life may be influenced by health care, finance, education, environment etc. For the moment, moving to outcomes based commissioning is ambitious enough.

The case for outcome based commissioning has perhaps been best articulated over the past decade by Michael Porter of the Harvard Business School[v]. In a seminal paper published in the New England Journal of Medicine[vi] he wrote:

"In any field, improving performance and accountability depends on having a shared goal that unites the interests and activities of all stakeholders. In most fields, the preeminent goal is value. The concept of value refers to the output achieved relative to the cost incurred. Defining and measuring value is essential to understanding the performance of any organization and driving continuous improvement. In health care, value is defined as the patient health outcomes achieved per dollar spent. Value should be the preeminent goal in the health care system because it is what ultimately matters to patients and unites the interests of the system actors."

By re-focusing the health service on outcomes that matter to people and on the effectiveness of the wider system, outcome based commissioning will have profound implications for the delivery of care. We need to move away from a system that tends to reward activity and process and align the incentives of individuals, teams and organisations with the aims of the NHS and the needs of our wider society.

This table illustrates three potential types of commissioning stroke prevention in relation to hypertension

Inputs/activity	Outputs/targets	Outcomes
Number of patients treated for hypertension	Mean blood pressure achieved	Number of strokes prevented

A generalizable truth derived from the study of organisations and systems is that systems in which incentives for individuals, teams and organisations are aligned with system goals tend to achieve better outcomes and are less wasteful than systems in which incentives are misaligned and unrelated (or divergent from) system goals. [vii], [viii].

Planning in the NHS is blighted by short term planning cycles. These tend to be a result of the financial accounting cycle and the democratic political cycle both detracting from a sustained and consistent direction of health care policy and delivery. It is essential that the NHS develops a pattern of more strategic planning and objectives. We need to think, plan and invest in health in terms of many years and decades rather than months or a few years. In order to deliver this we need strong professional medical leadership to influence our politicians.

The NHS Sustainable Development Unit has explored the role of commissioning in health care provision[9]. The importance of commissioning for the whole system is promoted where the system extends beyond the traditional boundaries of the healthcare system to the wider environment. Commissioning with environmental sensitivity aims to minimize the negative effects of health care delivery. Metrics are in development to support this approach. One simple example would be for commissioners to require the ambulance service to take due account of the emissions from their vehicle fleet as well as their response times. This then has a virtuous contribution to the health of patients in their locality especially those with respiratory illnesses.

Incentives include, but are not confined to, financial incentives. They include prestige, peer and public recognition, opportunities for career progression, autonomy etc. If this is true, and the goal of the NHS is to achieve the greatest possible improvements in health from the resources made available to it, then this implies that the basic currency for commissioning health care needs to change from activity and block contracts to outcomes and (added) value (outcomes / £ spent). Outcomes and value should also become the basis for other incentives operating in the NHS, from career progression to whatever replaces clinical excellence awards and seniority payments.

The NHS needs to have high quality sustainable general practice at its heart.

Barbara Starfield's references[9,10,11,12,13,14,15,16] demonstrate that health care systems with strong population based primary care are more effective (i.e. produce better health outcomes), are more equitable (i.e. reduce differences in health outcomes) and are more efficient (i.e. both cheaper and of better value). This holds true both between and within countries. Even within countries, the

supply and availability of primary care doctors - but not specialists - is associated with lower mortality and better outcomes.

The key elements of primary care that underpin these observations are:

- **First contact care**, which requires accessibility and responsibility for reducing unnecessary specialist care,

- **Person-focused care over time** delivered by the patient's chosen physician, who assumes responsibility over long periods of time for all health care

- **Comprehensiveness of care** the availability in primary care of a wide range of services to meet common needs, and by demonstrating that care is, indeed, provided for a broad range of problems and needs.

- **Coordination of care** when people have to go elsewhere for problems outside the competence of the primary care practitioner.

Good primary care requires all four functions.

The implication of these findings is that if better outcomes and greater efficiency are to be achieved then sustainable high quality primary care capable of delivering the four key elements to the whole population to a high standard must be the heart of any solution.

The 2001 Institute of Medicine Report 'Crossing the Quality Chasm' [ix] suggests 10 relevant quality markers :

1. Care is based on continuous healing relationships
2. Care is customized according to patients' needs and values
3. The patient is the source of control
4. Knowledge is shared and information flows freely
5. Decision-making is evidence based
6. Safety is a system property
7. Transparency is necessary
8. Needs are anticipated
9. Waste is continuously decreased
10. Cooperation among clinicians is a priority

These 10 markers plus the 4 key elements described by Barbara Starfield should form the basis of the metrics used to move to outcome based commissioning of all health care, including that provided by general practitioners. From this would flow rewards to practices, or networks of practices, able to demonstrate high levels of continuity of care, value the informed decision making of individual patients and provide bespoke care to groups and individuals. The metrics also need to include those that require effective integration and co-operation across the traditional primary – secondary care divide.

There is a need to develop these specific metrics in conjunction with the wider NHS and beyond, for example through collaboration with the International Consortium for Health Outcome Measurement[*] (ICHOM) whose aim is to develop a core of outcome related metrics that can be used internationally. Whilst the purchaser provider split is at its most pronounced in England we believe that moving to systems that reward virtuous outcomes is appropriate and possible across the whole of the UK.

[*] ICHOM is a not-for-profit collaboration set up by the Harvard Business School, the Karolinska Institute, and the Boston Consulting Group to develop condition specific valid, relevant outcome measures . See www.ichom.org

The first three quality criteria espoused in the Institute of Medicine report require special attention. The inevitable conclusion, in terms of the commissioning of care, is the need to commission services for a patient at the individual level but also to assess the risk posed to the system by an individual's potential future needs and to act to mitigate these. Capitated multi-years of care contracts that reward the achievement of outcomes that matter would facilitate care. The patient group National Voices articulate the needs of the individual to be addressed by the system:

"*personalised care will only happen when statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.*

Multi-year capitated contracts that reward providers for delivering the outcomes that matter to patients can help deliver this ambition because they require providers to properly place the individual centre stage with a comprehensive anticipatory care plan, as described by the Coalition for Collaborative Care in their House of Care model. In this form of commissioning the provider function needs to include new functions including:

a) the ability to coordinate the care of individuals along pathways and across settings and

b) population health management. In other words, the provider must understand an individual's risks of future ill–health, future service use and expenditure and to design and deliver interventions to reduce those risks.

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

The outcome measures for such a contract could be a composite of those patients agreeing that an appropriate care plan is in place containing outcomes that matter and relevant population level indicators. The early emerging evidence (eg from Camden CCG is that when a health system focuses on improving outcomes that matter to people such as 'days spent at home' substantial changes in service outcomes e.g, A&E attendances and emergency admissions can improve dramatically)[x]. This approach to commissioning would work well with Integrated Personal Commissioning described in the NHSE 5 Year Forward View[19], as patients with complex conditions and their families would be at the centre of constructing their care plan, and managing an integrated health and social care budget.

There are many different models of care that are currently being proposed that have the potential to rise to the challenge of delivering capitated outcome based care. The RCGP believes that General Practice must be at the centre of the commissioning process and, at the centre of the provider function, integrating with others where appropriate, probably on a locality based approach. This would result in the development of natural health economies where the wellbeing of the individual and the population can be continually improved.

The NHSE 5 Year Forward View describes two approaches to integration: Multi- Specialty Providers (MCP), and Primary and Acute Care Systems (PACS).

The MCP has at its heart General Practice working with others to provide comprehensive locality based care which in time would have the ability to take on a delegated budget for their registered population. The RCGP sees this model fulfilling the core requirements set out above and able to be applicable across most of the system. These organisations can be seen as a natural evolution for GP networks or federations linking with specialists that can offer expertise beyond the four walls of a traditional hospital heralded by the RCP's Future Hospital Commission. In order to be effective

these organisations must be underpinned by a different funding mechanism with the characteristics set out above.

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

In either approach, networks of practices with extended functions, properly developed and managed, will result in organisations that have GPs at their centre, focusing on delivering outcomes that matter which bridge the traditional primary-secondary care divide. Such organisations would also add capacity for educational provision – the Pegasus network in Christchurch started with a co-ordinated CPD programme for all staff across the practice network, and now also hosts effective administrative training (for example expertise in human resources or financial governance. Even more importantly, additional teaching and training opportunities can be created for larger numbers of health care professionals at undergraduate and postgraduate level, through co-ordinating placement supervision and trainer support across a larger group of practices. Some Schools of Primary Care in England have seen educational initiatives as a first facilitating step towards federations, for example:

- an educational supervisor can work across more than one practice to allow small or inexperienced practices to start taking a few students at a time
- trainer or tutor absence does not leave the trainee without cover
- educational leads can draw on each other's expertise, for example to support trainees with difficulties
- there may be economies of scale for tutorials and specific learning opportunities
- there are likely to be improved opportunities for multidisciplinary training.

Contracting Approaches : Alliancing and Prime Provider / Contractor

The RCGP sees both strategic alliancing and project alliancing and also prime contracting (see below) as potential contributors to effective integration of health and care services.

There are several approaches by which multi-year outcome incentivized contracts can be let. The two leading approaches are

a) Alliance contracting

b) Prime provider / contractor

The Canterbury Clinical Network (CCN) in New Zealand[20] has recently attracted much attention as an exemplar of integrated care. Alliancing was originally pioneered and described in relation to the construction industry in New Zealand and has been adopted by the CCN. It is a mechanism that depends upon collaboration between organisations with shared goals. Alliances are thought to be best suited to, and typified by, the need to bring together expertise in order to manage complementing areas of great complexity. Such complexity is exemplified by the health care system.

Project alliancing was initially described by Hutchinson and Gallagher in 2003 and further developed by Ross[21]: "An integrated high performance team selected on a best person for the job basis; sharing all project risks with incentives to achieve game-breaking project objectives; within a framework of no fault, no blame and no dispute; characterised by uncompromising commitments to trust, collaboration, innovation and mutual support; all in order to achieve outstanding results."

This type of project alliance is different from a strategic alliance between organisations but the two can be seen as being complementary.

Early examples of multi-year capitated outcome incentivised contracts let in the UK have often used prime contractor rather than alliance contracts. In prime contractor contracts, commissioners let a contract single organisation, often formed from a new partnership of providers and hold it accountable and reward that contractor for delivering the desired outcomes. The prime contractor takes on responsibility for coordinating services. Examples of multi-year capitated prime contracts that have been awarded include the care of older people in Cambridgeshire, mental health services in Oxfordshire, musculoskeletal services in Bedfordshire, Sussex, Sheffield and Bexley, urgent care services in Herefordshire[21]. Others are in development elsewhere.

The RCGP recognises that these forms of contract also promote the effective integration of health and care services, a focus on outcomes and value. The principles outlined in this paper suggest that it is important that general practitioners should be involved at the centre of the partnerships responding to such contracts.

It is highly desirable to learn from the examples that are developing across the country and to encourage GP involvement (as it is essential that GPs are included) with a view to identifying the most effective arrangements prior to wider adoption. With appropriate financial and wider system support the RCGP would be willing to become a lead organization in the transformation of the way that care is commissioned, organised and delivered.

In conclusion:

The Put Patients First: Back General Practice Campaign has captured the attention of politicians and senior NHS policy makers. The NHS 5 Year Forward Plan describes the essential and pivotal role that General Practice has to play in enabling the NHS to face the enormous challenges that it faces. Aligning the funding mechanisms to the beneficial health outcomes that the evidence shows it is well placed to deliver has the potential to lock in a sustainable funding mechanism for a generation.

Council is asked to:

1) agree in principle that a move to the Outcome Based Commissioning of health care including that provided by General Practice and Primary Care is desirable.
2) approve further (appropriately externally funded) work by the RCGP to develop Outcome Based Commissioning
3) approve further work by the RCGP, potentially in collaboration with the Royal College of Physicians, to develop an approach to integrated outcome based commissioning.

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Conflicts of interest:
Dr Nicholas Hicks is a Co-founder and Chief Executive of COBIC Ltd (www.cobic.co.uk)