The Primary Care Home

Introduction and summary

It is an imperative that clinicians have a leadership role in commissioning. A role that is defined as one of the three key priorities of the government's plans to reform and modernise the NHS[1] General Medical Practitioners have been given a specific leadership role in commissioning NHS services for a variety of reasons, but the prime reason is they are the only group of practising clinicians who have a clearly defined population responsibility. General practice is list based.

It is increasingly clear that all providers need to define a population responsibility if they are to be a more influential and proactive organisation. This is of particular import to improve the care of people who have a long term condition. Future care will inevitably be more integrated and overtly accountable, much more based in community settings and optimally delivered if chiefly responsible for a defined population.

Hence the concept of the Primary Care Home, a community based, integrated, accountable home for population care where the needs of the individual and of the community can be met. Served by an holistic budget that enables a 'make or buy' approach to care delivery and commissioned by the statutory commissioner(s)

What could be the attributes of a primary care home?

From a strictly NHS focus commissioners must be about ensuring good provision of care.

Key 'design principles' essential to improve health and healthcare are

- integrate care, in its widest sense, including social services and the voluntary sector.

- level up general practices to reduce 'unwarranted' variation

- redesign pathways so that care is delivered 'closer to home', reducing the system's current dependence on hospital in and out-patients.

- put in place targeted prevention programmes that addresses the needs of the population

The 'primary care home' as a provider can deliver on all the above as it is predicated on extending the vision and scope of the existing 'GP home'.

A home not only for general medical practitioners and their teams but for all primary care independent contractors and their staff (Pharmacists, Dentists, Optometrists), community health service and social care professionals. And potentially a home for many currently working in hospitals in particular those who have a responsibility for long term conditions care, for rehabilitation and re-ablement and for the surgeons who in particular specialise in 'office based' procedures. With modern technology such procedures are on the increase.

The 'Primary Care Home' offers one model of integrated financially responsible provider organisations. Commissioners enabling, supporting and contracting for such transparently accountable organisations will call into question the scale, functions and indeed the size of commissioning itself. Whilst it inappropriate to prescribe local structures, herein lies an opportunity to radically re-shape NHS organisations to lessen unnecessary or duplicative administrative and managerial functions. Providers can and must take on many functions currently undertaken by commissioners within a transparently accountable system.

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[1] 'Equity and Excellence. Liberating the NHS'. *Department of Health.2010*.

Background

In the USA over many years has seen a focus by some health care leaders to fashion a system for co-ordination of care out of their country's non- system approach to health care delivery. The concept of the 'Medical Home' is such an approach discussed for some thirty years. Of course some notable USA 'meso'-organisations have developed outstanding system approaches; Kaiser Permanente, the Veterans Health Administration and so on. President Obama with his reform programme is attempting in an often hostile environment to bring some national system approaches to bear on the wider USA health care service through new organisational models. The National Protection and Affordable Health Act[2] includes the concept of Accountable Care Organisations.

So what of England? Where is our 'Medical Home'? And our 'Accountable Care Organisation'? To me even if not universally acclaimed as such, it already exists - it is list based general practice where primary care workers combine one to one personal care with the potential of population care. The list or as my father's generation knew it-the panel- dates its origins to at least 1911, the time of the epoch breaking Lloyd George National Insurance Act. The even more epoch breaking NHS Act of 1946 reinforced the panel/list of general medical practice. The success of general practice in the UK is based on continuity of care serving a practice population. Good general practitioners have the on-going trusting relationship with and a responsibility for their patients even when those self-same patients are not 'in front of them'. Commentators and academics have described UK general practice well; 'soul of a proper, community orientated, health-preserving care system'[3]. "The well known but underappreciated secret of the value of primary care is its person and population, rather than disease, focus"[4] . And yet also at the individual patient level "the ability to organise the chaos of the first presentation ...'. Paul Freeling late emeritus Professor of General Practice.

In summary, Starfield describes the merits of a first contact primary care system as; "That aspect of a health service that assures person focussed care over time to a defined population, accessibility to facilitate receipt of care when it is first needed, comprehensiveness of care in the sense that only rare or unusual manifestations of Ill health are referred elsewhere, and coordination of care such that all facets of care (wherever received) are integrated.[5] Bringing the following benefits; Higher patient satisfaction with health services, lower overall health service expenditure, better population health indicators, fewer drugs prescribed per head of population, the higher the number of family physicians the lower the hospitalisation rate.

And 'We identify three areas in which British general practice performs well, leading both international policy analysts and the public to their favourable conclusions: Equity, Quality,

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[2] National Protection and Affordable Health Act ((Pub.L. 111–152, 124 Stat. 1029. 2010)

[3] Berwick DM. A transatlantic review of the NHS at 60. BMJ 2008;337:a838.

[4] Starfield B, Shi L, Macinko J. Contribution of primary health care to health systems ... quality of care in England. N Engl J Med. 2009; 361(4): 368–78.,

[5] Starfield, B. J Epidemiology and Community Health 2001; 55:452-4.

Efficiency. And three important characteristics that contribute to its success: Coordination, Continuity and Comprehensiveness'.[6]

It is these unique attributes of the GP system that has lent itself well to being the central plank of post 1990 English NHS reform. GP Fundholding where budgets could be allocated to a GP practice population and not tied to a specific disease or care group. Allowing an opportunity for a more imaginative use of the monies to provide better care for their patients.[7] The Quality and Outcomes Framework (QOF-which is UK wide)) which is the largest pay for performance system for clinicians world-wide and can only be successfully delivered to a defined population. And of course in 2013 the General Practice led Clinical Commissioning Groups that will replace the current Primary Care Trust managerially led commissioners. The Groups will receive their monies based on aggregated practice list based allocations and where every general practice must be a member of a consortium.

The latter is one of the key structural and leadership components of the current government's reform and modernising of England's NHS. The White Paper of 2010, "Equity and Excellence: Liberating the NHS" sets out plans for reform focused around three key purposes:

- First, to put patients first – for every patient to genuinely feel that there is '*no decision made about me, without me*';
- Second, to focus not on inputs and processes, but on outcomes. Thereby Injecting a spirit of innovation and entrepreneurship into a Health Service that is properly accountable to the people it serves;
- And, third, in order to deliver the best care, we must empower the NHS staff whose responsibility it is to give that care. Decisions should be made as close to patients as possible. Wherever possible, they should be made jointly with patients. General practice is ideally placed to combine clinical decision-making with deciding the best use of resources.''

There are also reforms to the Public Health System where Local Authorities will quite rightly have the lead role locally for improving the health of their population. Rightly as their services and influence have far more impact on the social determinants of health than the NHS is able to. But the local NHS General Practice led Clinical Commissioning Groups will be a member of the local Health and Well Being Board and account to but not be accountable to the Public Health System. There are many facets of improving the public's heath that the NHS will lead, for instance-vaccination and immunisation, cervical screening and improving the health of those who have a long term condition. Services in which general medical practice has already achieved much. The responsibility for a population is essential

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[6] Wilson T, Roland M, Ham C. The contribution of general practice and the general practitioner to NHS patients, J R Soc Med 2006; 99:24–28.

[7] Julian Le Grand, Nicholas Mays, and Jo Mulligan (1998) (eds) *Learning from the Internal Market: a Review of the Evidence*. London, Kings Fund.

to having an important role in improving the public's health. The huge impact that long term conditions have on health inequalities needs to be addressed with some urgency.

Discussion.

England's NHS has had a purchaser/provider split since 1991. The 'primary care home' is predicated on extending the vision and scope of the existing 'GP home' and being an integrated population based provider organisation that can also be formally commissioned to undertake some commissioning responsibility on the 'make or buy' principle.

Of course there are purists who rigidly state that commissioning and provision must be separate. If that is the case, those that in reality actually 'spend the money'-the practising clinicians-could never influence commissioning let alone lead it. A purity of opinion that brings to mind those that describe an academic as 'someone who takes what works in practice and shows it cannot work in theory'. Commissioning takes place at various levels and by different bodies, including the very large-scale (for specialist services) but also at a much more local level. Of course providers can commission and at individual clinician level do so every working day by the act of referral of patients to other services. So no need for rigid rules of separation but a transparent accountability and governance.

There are many forms of integration with mixed evidence that integration can produce better care.[8] The chief potential downside of integrated organisations is the strong possibility of 'provider capture' that will lessen choice and responsiveness for their citizens. At the very least such organisations must offer their public and patients choice outside of and within their services and constituent practices. That offer must be overtly transparent.

And which population do they serve? All of the services offered of such an organisation must be left to local choice so an organisation could be actual or 'virtual'. Similarly with their defined population. The most straightforward approach is for it to be based on the GP practice population as its building block. It is a population or 'list' recognised over many years by patients and professionals alike. For that reason it was chosen as the population base for the Integrated Care Pilots of the Primary and Community Care Strategy of the NHS[9] and even more fundamentally as the building block of the soon to be General Practice led Clinical Commissioning Groups. However local agreed choice of this and other aspects must prevail. Local ownership of new approaches is essential.

What could be the attributes of the primary care home?

- Population community based care where the needs of the individual and of the community can be met
- A home not only for general medical practitioners and their teams but for all primary care independent contractors and their staff (Pharmacists, Dentists, Optometrists) and community health service and social care professionals.
- And potentially a home for many currently working in hospitals in particular those who have a responsibility for long term conditions care, for rehabilitation and re-

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[8] Ramsay, A., Fulop, N. and Edwards, N. Journal of Integrated Care 2009, vol 17(2): 3-12.

[9] 'Next Stage Review'. Department of Health. 2008

ablement and for the surgeons who in particular specialise in 'office based' procedures. With modern technology such procedures are on the increase.

With a focus on delivering;

- Improved service quality and responsiveness to patients' individual requirements
- All Long Term Condition care excluding emergencies
- Care closer to the patient's home and the 'home' as a venue for the extended skills that can appropriately provide the growing number of care currently still delivered in many hospitals. Examples are diagnostics, outpatient and day care, admission avoidance particularly for those with long term conditions and a home for patients who should have shorter lengths of hospital stay. Such approaches build on existing innovative work around the virtual ward the concept developed in Croydon Primary Care Trust, South London[10]
- Service redesign which promotes clinical innovation and excellence particularly around integrated appropriate care with a lessening of unwarranted variation, clinical interventions of low value and duplicative services- a reduction in unnecessary or inappropriate care leading to better value for money as clinicians prioritise to keep overall health expenditure within budget aided by joint combined budgets. In fact by aligning internal incentives

  And for the broader public's health.
- A population responsibility allows for the setting of holistic budgets that enable virement between budget headings in response to local priorities.
- Where a bio-clinical focus and addressing the social determinants of health can be the responsibility of one provider organisation emphasising the importance of a relationship with local government and third sector organisations – hopefully often with combined budgetary responsibility .

Such community based organisations would be commissioned by the statutory NHS commissioner or indeed statutory commissioners. The NHS and Local Authority working together whether for healthcare alone or preferably also for social care. Indeed for the broader public health aspects of the whole local authority.

Accountable to their commissioner but transparently working with and accounting to their population. That being the bulwark against provider capture.

Charged with budgetary control and the ability to 'make or buy'.

From formal integration of organisations as part of a spectrum that enables integration through such as joint ventures through to virtual organisations - but fundamentally with a clarity of governance and accountability. Where patient care depends on various forms of networking/partnerships, clarity of where accountability and responsibility lies is paramount.

And for providers, having a population focus can break the 'shackles' of too rigid a split that currently occurs between the commissioner and provider. Enabling more 'liberation' of all providers to be truly partners of commissioners. Enabled community based accountable population based providers that can take over some of the tasks currently undertaken by commissioners. Only actual contract setting needs to be separated in the commissioning cycle

Commissioners may need choices of integrated organisations from which to choose which does imply at least some overlapping boundaries of providers.

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[10] Society Guardian, Friday 12 October 2007

Many other professionals feel they and not only GPs need to lead and/or influence commissioning. And they are right. Many then seek formal representation on a board or some such structure. That to me is a formulaic model that seeks a totemic presence to influence. All I can say, given the many failures of NHS organisations, what value alone has the formulaic board added? And board membership can be a bureaucratic time consuming process. From initially refreshingly being given flexibility as long as the board details were in the public domain, the government after much NHS pressure is now prescribing commissioners board membership in more detail. There seem to be many confusing and conflicting issues. It must be clear that the responsibility of the board is about the governance of an organisation. This is quite a separate responsibility to engaging local clinicians and others in service design and review. It seems that the two separate responsibilities have often been unhelpfully conflated and that board membership is seen as conferring some sort of generic status on the members.

But good commissioners need good providers and vice versa. One of the best options to impact on commissioners and play to professional's strengths is to provide high quality, extended scope, accountable services. The extra dimension that will create more meaningful partnerships and an influence with commissioners is when the provider also serves a defined population. Population responsibility has too long with the exception of general medical practice, been the preserve of commissioners. And a population responsibility does not preclude the opportunity to serve the public who do not live within that population. The added strength of a population approach is to be a proactive service to those of the public who are 'not in front of you'

And therein lies the nub of this concept. All primary care contractors apart from some of the 'corporates' however large within their professional ambit are small in NHS terms. The Royal College of General Practitioners promoting of GP Federations offers the opportunity for primary care professionals and their staff to remain local and retain the uniqueness of their current organisations. Yet concomitantly have an overarching organisation for activities that require a more centralised headquarters like function.[11]

But the Primary Care Home offers more. A chance for professionals to integrate when that is necessary to increase their range of activities. And also to be part of an organisation real or virtual that can deliver on the potential of community based professionals by being an holistic resource for their community.

The Primary Care Home will not succeed if this is perceived as a GP takeover. All professional skills are required if we are to improve on the often disappointing outcomes that the NHS currently provides. Chris Ham an academic who has long cogently supported integration states "Primarily integration is about relationships between people. These relationships are not informal friendships. They have to be worked on and built professionally if clinical integration is to be meaningful and sustained through good and bad times.[12]

And given the zeitgeist of the current reforms, not for commissioners to micro manage providers but instead to hold them rigorously to account for outcomes many of which need to be locally defined. Defined by public, patients, providers and all forms of commissioners alike. Outcomes for the NHS and for the public's health. The primary care home to extend the person and population rather than disease focus to even more be the 'soul of a proper, community orientated, health-preserving care system'. With clear involvement of the local population on a spectrum from transparent, information to a membership model.

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11 *BMJ* 335 : 585 doi: 10.1136/bmj.39342.589294.DB (Published 20 September 2007)

12 Competition and integration in the English National Health Service BMJ 2008;336:805

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