

# Commissioning and funding general practice

Making the case for family  
care networks

Authors

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**Chris Ham**

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Chris was a governor and then a non-executive director of the Heart of England NHS Foundation Trust between 2007 and 2010. He has also served as a governor of the Canadian Health Services Research Foundation and the Health Foundation.

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# Foreword

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General practice is becoming ever more complex as we tackle the challenges of an ageing population, a baby boom, and more people with mental health problems.

Much will need to change if we are to continue to give patients the care they need and deserve, today and in the future.

It's now nearly a decade since the College published its roadmap on the future of general practice, which first described the concept of GP 'federations' – whereby different GP practices pool resources and expertise to improve patient care.

In the intervening years, it has been fascinating to see how thinking has progressed and federations in many areas of the United Kingdom have developed into professionally led and professionally driven solutions to local problems.

This report from The King's Fund is a good opportunity to take stock and reflect on how we can make the most of these developments for the benefit of the wider NHS. In particular, it poses questions on whether federations can flourish with current contractual models or whether new systems should emerge.

Like everything, there are risks and opportunities in what is being suggested and there will be differences of opinion. But we feel it will be good to have this debate, particularly when it might, in itself, generate new ways of working for practices and federations.

Whatever the outcome, it must work for patients and ensure that GPs can continue to act in their patients' best interests. We look forward to being part of the discussions that will now ensue.

Dr Maureen Baker  
Chair  
Royal College of General Practitioners

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# Summary

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General practice is widely recognised to be the foundation on which NHS care is based. International studies have shown general practice in the United Kingdom in a positive light and most patients report high levels of satisfaction with the services they receive from general practitioners (GPs). There is also evidence of variations in the quality of general practice, and increasing recognition that primary care will have to change to meet the needs of the population now and in the future.

This paper describes the current system of commissioning and funding general practice and how this is being used in four areas of England to develop innovative models of primary care provision. The current system contains a range of freedoms and flexibilities and these are enabling general practices to provide a wider range of services and to raise standards of care. This is leading to greater collaboration between practices and the emergence of federations and networks operating on a larger scale than has traditionally been the case.

Notwithstanding these innovations in commissioning and provision, the current system is complex with the details and technicalities of contracting often imperfectly understood. There is therefore a case for a new approach that brings together funding for general practice with funding for many other services in order to develop the models of care required to meet the needs of an ageing population and a changing disease burden (Ham *et al* 2012; NHS England 2013d). The aim of this approach would be to accelerate the provision of primary care-centred integrated services, resulting over time in greater emphasis on joined-up care in the community.

General practice has a central role in the provision of such care alongside services provided by NHS staff working in the community and colleagues in social care. Also essential is closer integration of services provided out of hospital, available 24/7, and co-ordinated with specialist expertise in hospitals, among mental health providers and in related forms of care. Increasing attention needs to be given to care that is preventive and proactive with the aim of supporting people to remain independent for as long as possible and avoid the inappropriate use of hospitals and care homes.

The approach we propose would centre on contracting with providers to deliver these services using a population-based capitated contract that includes funding for the services provided by GPs themselves. In most cases, providers would be led by GPs because of the importance of the registered list and they would have freedom to use the funding contained in the contract to decide how to deliver the outcomes specified by those commissioning care from them. This would include the freedom to provide services directly or alternatively to arrange for them to be provided by others. The scope of services included in the contract is likely to vary between areas depending on local needs and capabilities.

GPs would not be compelled to take part in this approach, which would be both optional and voluntary. One of its attractions would be to liberate GPs to enable them to innovate in how care is delivered. This would result from avoiding over-specification of service models and allowing scope for different approaches to be developed in different areas. This approach also has the potential to reverse the decline in the share of the budget allocated to general practice in recent years by releasing resources currently spent on other services, at a time when the prospects for the foreseeable future are of no real-terms growth in NHS funding. This could be achieved by GPs using the budgets they are allocated to invest more in general practice and related services in agreement with those commissioning care from them.

New forms of commissioning would help to stimulate practices to make further progress in the development of federations and networks. The aim of this would be to work at the scale needed to provide extended services out of hospital with general practice at the heart of these services. This would build on the examples described in this paper and would establish a platform on which practices could collaborate with each other and with other providers to deliver a wider range of care to the populations they serve. Over time, it is possible to envisage the emergence of what we are calling ‘family care networks’, which would be able to provide most forms of care other than those requiring specialist expertise best provided in hospitals.

For the public and patients, family care networks would have the potential to offer accessible and responsive services that extend well beyond what is currently available in general practices. These services would have general practice at their core, with practices working hand-in-hand with a range of other services that people need to access from time to time. GPs would help people navigate through these services and would retain a key role in co-ordinating care in different settings. The evolution of family care networks through the changes to commissioning and funding outlined here could transform general practice and form the foundations on which a health and care system fit for the future could be built.

The ideas discussed in this paper have been articulated by The King’s Fund and others in previous work, most recently in our report with the Nuffield Trust commissioned by NHS England Midlands and East (Smith *et al* 2013). We have returned to them now because of the debate that is taking place on the future of general practice led by the Royal College of General Practitioners (RCGP), the British Medical Association (BMA), NHS England and others. This debate creates a once-in-a-generation opportunity to provide the freedoms needed to empower innovative GPs and their colleagues so that they can be at the forefront of the service provision transformation that we have called for elsewhere (Ham *et al* 2012). Practices willing and able to embrace new ways of working would be empowered to take greater responsibility for budgets and services through federations with the scope of responsibility increasing over time and extending to other areas of England as the benefits become apparent.



The approach we propose includes the following elements:

- commissioners negotiate a population-based capitated contract with providers
- the contract focuses on outcomes and not inputs
- providers demonstrate that they have the capabilities to manage the contract
- providers create new organisations to manage the contract
- providers work at a scale sufficient to manage the contract without being so big that incentives for member practices are attenuated
- providers take ‘make-or-buy’ decisions
- providers develop sophisticated means for contracting and incentivising ‘within network’
- GPs find ways of collaborating with hospital-based specialists
- commissioners work together to support implementation
- conflicts of interest are managed effectively
- market regulators support rather than inhibit testing of the new contract.

There is now a real urgency to take forward these ideas as a consequence of the unprecedented financial pressures facing the NHS and social care, the evidence of current and future workload shortages in primary care, and the increasing demands arising from the ageing population and changing disease burden. Simply doing more of the same will not be sufficient and it is for this reason that we argue for a new approach based on innovative ways of commissioning and providing services. The need now is to move beyond pockets of innovation and implement new models of care at the scale and pace required by the urgency of the current position.

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# Introduction: the context of change

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England's population is both expanding and ageing. The combined impact of these two demographic changes has been to increase the pressures on the NHS in general and on primary care in particular. These pressures are compounded by the increasing prevalence of long-term conditions in the population and the impact of risk factors like cigarette smoking, alcohol misuse, obesity and being overweight, which tend to cluster in certain communities (Buck and Frosini 2012). Rising public expectations are adding to the workload of hard-pressed frontline staff.

Of particular importance is the increasing number of people with more than one long-term condition and especially those with several. The challenge of multi-morbidity lies behind the increasing needs of frail older people. Its existence underlines the importance of services being well co-ordinated in order to provide timely and high-quality care for people who are in contact with many health and social care professionals. Increased prevalence of dementia in the population highlights the need for mental health services to be at the heart of such care.

General practice is well placed to develop new ways of responding to rising demands. This is because of the existence of the registered list of patients and the opportunity this creates for practices to use their knowledge of patients on the list both to prevent illnesses and deliver appropriate treatments. The challenge for general practice is to realise the potential of the registered list by paying greater attention to population health to ensure a focus on all those on the list, not just those patients who seek advice and support. General practice must also develop proactive care to anticipate needs before they become crises, thereby enabling earlier and more effective interventions (Thorlby 2013).

The shift to population health management and proactive care is often difficult to achieve in general practice today due to the demands of patients requiring a rapid response to their needs, and the limited resources in primary care, both financial and workforce. *It is for this reason that general practice cannot be expected to meet the challenge of an ageing, expanding population on its own.* Critically important is to ensure that practices work hand-in-hand with other services in the community, including those provided by nurses, health visitors and allied health professionals, and that different funding streams are used more flexibly.

Equally important is to engage social care in developing well co-ordinated services. This form of care plays a key role in supporting people with complex needs to remain independent and to facilitate their re-ablement when they return home from hospital. A strong case can also be made for practices to work more closely with some hospital-based specialists and their teams, especially specialists in the care of older people and other specialists whose work is enhanced by closer integration with out-of-hospital services. By making use of the full range of skills and resources in the community, there is an opportunity to improve the way care is delivered even at a time of constrained resources with community services wrapped around primary care (Edwards 2014).

The King's Fund has summarised elsewhere evidence that demonstrates the benefits of integrated care and has showcased examples of communities and organisations that have started to realise these benefits (Curry and Ham 2010; Goodwin *et al* 2012; Ham *et al* 2013; Ham and Walsh 2013; Timmins and Ham 2013). The challenge for the future is to build on these examples and support general practice to play a leading role in their development. As we argued in our report on quality in general practice, this requires moving away from the current model of small, independently minded practices towards new forms of organisation that enable practices to work together and with other providers to put in place the networks of care that are required (Goodwin *et al* 2011).

The Royal College of General Practitioners (RCGP) has led the argument for federations of practices to be established, able to work on the scale needed to ensure effective co-ordination of services in the community and to establish a platform on which to build stronger links between practices and other services (RCGP 2007). The argument for federations is based partly on the need for practices to be able to access the resources and expertise required in future, whether these resources are staff, technology, premises or equipment. Practices also need access to a level of management and clinical expertise that is rarely available today, for example to stratify the risks of the populations served and to develop proactive service interventions.

By working at scale, practices should also be better equipped to support patients to manage their own health and well-being, for example by offering self-management programmes that may be difficult to provide in practices of the size typically found in the NHS today. Self-management support is particularly important for patients with long-term conditions who now represent a major part of the workload of practices. Federations of practices are also well placed to invest in technology to enable patients to obtain information and advice and to keep in contact with providers without the need for face-to-face consultations.

Important as these arguments are, they pale by comparison with the need to make out-of-hospital services available 24/7 where appropriate to halt the increasing use of hospitals and to make care closer to home a reality. Practices are usually too small and atomised to be able to do this on a sufficient scale to make a tangible difference to patterns of service use in hospitals. A fundamental shift is therefore needed to support practices to collaborate with each other and to work closely with out-of-hospital services. This in turn will enable patients to access help in the community for urgent needs that do not require hospital treatment and care. It also means making better use of the skills of all staff working in the community, including arranging their work to ensure that patients can obtain advice and support outside normal working hours.

Among other things, collaboration between practices would help to ensure that out-of-hours services are provided to a high standard. Investment in intermediate care would allow rapid response services from community nurses and their colleagues to be made available to patients at risk of being admitted to hospital or a care home. This would also involve ambulance services where paramedics and emergency care practitioners have a key role in providing expertise alongside GPs and their teams and other services in the community. A further potential benefit would be to enable care at the end of life to be provided in people's own homes where appropriate by integrating this care more effectively with the work of practices and other services provided out of hospital.

Our vision is of practices forming the core of what we call ‘family care networks’ that provide people with access to all but the most specialised and complex forms of care. These networks would integrate the expertise of GPs, nurses, pharmacists, allied health professionals, paramedics, social workers and some hospital-based specialists to provide high-quality, responsive services. GPs would continue to have a key role in providing care with their teams and co-ordinating the contribution of other professionals but they would do so by drawing on expertise from a range of sources. In these networks, people would be able to access services 24/7 where appropriate, as care closer to home becomes a reality after years of debate and discussion.

In making these points we are highlighting the need for general practice to work differently to meet the needs of a growing and ageing population in which multi-morbidity will be a major driver of demand in the future. The challenge is how to do this when organisational and financial barriers between services inhibit innovations in care. Professional divisions between different groups of health and social care staff and the lack of resources to fund new forms of service delivery reinforce these barriers. Nevertheless, as the examples described in this report show, change is possible and it has often occurred where GP leaders, with the support of managers, have used flexibilities in the current options for commissioning and funding general practice to move in the direction set out here.

We now go on to outline the nature of these flexibilities before reviewing how they are being applied in four areas of England. This leads into an analysis of the emerging lessons from these areas and an outline of what a new contracting framework designed to accelerate the development of family care networks might entail.

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# 1 The GP contract

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The work of GPs has evolved during the lifetime of the NHS with family doctors working increasingly as part of primary care teams and delivering a wider range of care to patients. Changes to the GP contract have stimulated these developments and have also been associated with the emergence of new organisational forms such as federations of practices and 'super partnerships'. General practice in the United Kingdom has been widely studied and is often cited as an example for other countries to learn from and adapt (Starfield *et al* 2005).

Notwithstanding the changes that have occurred, general practice is still delivered mainly through a 'cottage industry' model in which practices of varying sizes provide a limited range of first-contact care to their patients. While the services provided by GPs are often highly valued by patients, this model of provision can be difficult to access at the time it is most needed and is vulnerable to variations in the quality of care delivered (Goodwin *et al* 2011). These factors, together with growing workload pressures on GPs and reductions in the share of the NHS budget allocated to general practice, have raised fundamental questions about the model of care needed in the future (RCGP 2007; BMA 2013; NHS England 2013d; Smith *et al* 2013).

The core purpose of general practice, as stipulated in the national contract, is very broadly described as the services that GPs must provide to manage their registered list of patients when they are ill (the national contract then includes various specifications on this core purpose). These services involve direct consultation and examination, and/or making available further investigation as appropriate, including referral to specialists (*The National Health Service (General Medical Services Contracts) Regulations 2004*). GPs usually deliver services in partnership with other GPs, leading a number of nurses and other support staff who all together comprise the primary care team.

In addition to this core function, GPs play a crucial role in the provision of extended primary care services, such as prevention, screening, vaccinations and immunisations, and some diagnostic services. Part of this role is to help patients navigate through the wider health care system and access care appropriate to their needs. GPs also help to ensure effective co-ordination of care for their patients, including social care and services outside the NHS.

GPs have typically worked as independent contractors under the terms of a national contract since the inception of the NHS, reflecting the deal struck between the British Medical Association (BMA) and the post-war Labour government under which GPs should not become salaried employees of the state. However, in the past 15 years there has been a substantial growth in the number of GPs employed on a salaried basis, usually by fellow GPs who as independent contractors are partners who own their practices. Around 9,000 GPs in England are now salaried, comprising one quarter of all GPs and representing a seven-fold increase since 2002 (Health and Social Care Information Centre 2013).

As the owners of their practices, GP partners share practice profits with other partners. Salaried GPs are not eligible to share in practice profits. This has given rise to the emergence of GPs with different financial stakes and benefits in primary care, leading to concern in some quarters at the lack of opportunities for younger doctors to become partners. However, some GPs prefer to be salaried rather than take on partnerships as this means they are not obliged to take responsibility for the management of the practice as a small business or purchase equity in it.

NHS England has recently launched a ‘call to action’ on the future development of primary care. The aim is to consult GPs, other providers and wider stakeholders regarding the direction of primary care services, to enable GPs to play a stronger role in ‘integrated out-of-hospital services that deliver better health outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources’. NHS England is seeking input on how it can most appropriately support GPs and primary care providers in the development of services and new ways of working, particularly in relation to national contracting frameworks (see [NHS England 2013c](#)).

There are several ways that GP practices currently receive payment for delivering services – through their core GP contract for the delivery of essential services and through enhanced or extended service contracts, agreed both nationally and locally. An important innovation in 2004 was the Quality and Outcomes Framework under which a proportion of pay is linked to the quality of care they deliver to patients. In addition to these contracts, GPs are eligible to tender for locally commissioned services procured by the clinical commissioning group (CCG) – either independently or in partnership with other providers.

We will briefly describe these different contracting mechanisms.

## A brief history of the GP contract

The core GP contract is developed through negotiation between the government and the British Medical Association (BMA), and is renegotiated from time to time in response to changing needs. When the NHS was established, GPs were paid mainly on the basis of capitation payments for each patient on the registered list. Capitation payments meant that the income of GPs reflected the number of patients registered with them with the size of payments varying according to the age of patients. These payments remain an important component of most GPs’ pay but successive changes to the contract have provided funding to cover practice costs, fees for providing specified services, incentives for health promotion activities, and most recently pay for performance under the Quality and Outcomes Framework. The result is a complex and varied system of remuneration that defies simple characterisation.

The first major change in the contract occurred in 1966 when a basic practice allowance was added together with funds and incentives for GPs to work with nurses and to come together in groups in improved premises. These changes were made in response to concerns about low pay and declining morale – a recurring theme in the history of general practice in the NHS. They had the effect of reducing reliance on capitation payments. The 1966 contract was widely seen as a watershed in the development of general practice within the NHS and led to the growth of primary health care teams working from modern buildings and increasingly in partnership with other GPs. The contract also resulted in substantial pay increases for GPs. All of these measures led some observers to see the period immediately after 1966 as a golden age for general practice.

The next major change occurred in 1990 when the government acted to increase the proportion of GPs' income that derived from capitation payments and commensurately reduced the proportion that derived from the basic practice allowance. Incentive payments were introduced for GPs to undertake health promotion among their patients, including health checks on new patients, regular checks on the over-75s, and the provision of advice on smoking cessation and other issues. As in 1966, this led to increases in pay for GPs. Oversight of the performance of GPs was strengthened through the newly created Family Health Services Authorities and steps were taken to control prescribing costs through the use of indicative drugs budgets. These measures were an indication of the rise of managerialism and the challenge to medical autonomy.

The most recent major change occurred in 2004 when the government negotiated revisions to the contract with three major effects. First, the Quality and Outcomes Framework enabled practices to earn extra income if they improved the quality of care as measured by performance against a range of metrics related mainly to the management of patients with long-term conditions. Second, the contract enabled GPs to opt out of delivering out-of-hours services and to accept a reduction in income for so doing. Many chose this option and where this happened, out-of-hours care was taken on by other providers, bringing an end to GPs' traditional 24/7 responsibility for the patients on their lists. In fact, well before this date, in recognition of the difficulty faced by smaller practices in providing evening and weekend care, GPs were leading the way in deputising services and out-of-hours co-operatives, with the effect of significantly eroding the personal continuity that GPs were traditionally able to offer their patients. Third, GPs' pay increased largely as a result of the incentives contained in the Quality and Outcomes Framework.

Changes to the contract have recently been agreed to take effect from April 2014, albeit on a much smaller scale than those introduced in 1966, 1990 and 2004. These changes attempt to address concerns around out-of-hours services, where the core contract will stipulate that GPs who have opted out of out-of-hours services have a duty to monitor and report on quality and support greater integrated care. Additionally, people aged 75 years and over will have a named, accountable GP. There will also be a reduction in the number of indicators in the Quality and Outcomes Framework, and GPs will have a greater role in reducing avoidable emergency admissions (NHS England 2013b).

Successive changes to the GP contract have resulted in GPs working in partnership with other GPs in small groups rather than in the single or two-person practices that predominated until 1966. GPs have also come to work in primary care teams with the support of practice nurses, managers and receptionists, together with other staff in larger groups. The funding for these staff provided in the 1966 contract stimulated this development. Practice premises have been improved through investment in both publicly and especially privately owned buildings, supported by incentives provided by the state that cover most of the costs of these buildings. Vocational and continuing education have helped to maintain and raise standards of care. With financial support from the government, GPs have been at the forefront of the development and use of information technology in the NHS and the development of electronic medical records.

Figure 1 (p 12) illustrates the flow of funding in general practice today.

## Variations on the contract

There are currently three main types of core contract: General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS). GMS is the contract agreed nationally and stipulates essential services to be provided. These essential services are set in legislation (managed in practice through the contract), and specify that the general practice must provide services (during core hours) to manage their registered list of patients and temporary residents, who are: ill with conditions from which recovery is generally expected; terminally ill; or suffering from chronic disease. These services involve direct consultation and examination, and/or making available further investigation as appropriate (including referral) (*The National Health Service (General Medical Services Contracts) Regulations 2004*). GMS funding is made up of the global sum (capitated payments) based on the age and gender of patients and other factors, and lump sum allowances, for example, for premises and IT.

PMS is the contract negotiated locally and allows greater flexibility than GMS to respond to the variations in need between areas. PMS Plus may include a wider range of services than GMS, for example some community services and services that would usually be provided in hospitals. The APMS contract allows the organisations responsible for commissioning primary medical care services to contract with a wide range of providers including those in the independent sector. It has been used to encourage innovative models of care as well as new providers to enter the general practice market. Like PMS, the APMS contract is more flexible than GMS, allowing commissioners to tailor services to local needs (*see Table 1 below*).

**Table 1: Overview of essential service contracts\***

General Medical Services (GMS)	Personal Medical Services (PMS)**	Alternative Provider Medical Services (APMS)
Nationally negotiated between the BMA and Department of Health	Locally negotiated	Locally negotiated. Can be held by the widest group of 'alternative' or independent providers
Stipulates essential services	Stipulates essential services	No requirement for essential services
Contract managed by area team of NHS England (previously primary care trusts - PCTs)	Contract managed by LAT (previously PCTs)	Contract managed by LAT (previously PCTs)
Held by 55% of practices in 2012	Held by 40% of practices in 2012	Held by 2.2% of practices in 2012

Sources: [Health and Social Care Information Centre \(2013\)](#), Gravelle and Hann (2006, cited in Moris *et al* 2011)

\* In addition, Specialist Personal Medical Services (SPMS) contracts are identical to PMS contracts, but do not include core services and are usually used to serve the needs of particular populations: homeless, refugees, teenage contraception, home-based palliative care, etc.

\*\* A variant of the PMS contract is PMS Plus, which enables further service developments in the practice. Critically, the key difference is that PMS Plus contracts include additional budgets for community services, prescribing or secondary care services.

## Contracting for additional services

### Enhanced services

Payments through enhanced services contracts are made in addition to payment for the essential services set out in the core contract. The terminology used to describe these contracts and their scope has changed over the years and there are currently two main kinds: Enhanced Services (formerly Directed Enhanced Services (DES)) and Community-Based Services (formerly Local Enhanced Services (LES)). At the time we undertook fieldwork, DES and LES were in use and for this reason we rely mainly on this terminology.



NHS England (like PCTs before it) is legally required to commission Enhanced Services provision. Current contracts include out-of-hours provision, minor surgery and essential services to individuals struck off registered lists for acts or threats of violence. The opportunity to provide these services must be offered to GMS and PMS contract-holders in the first instance. Alternative providers can then be sought if the service is not commissioned. The total spend on these services in 2011/12 was almost £367 million (Health and Social Care Information Centre 2012).

LES contracts are those that have been locally agreed between PCTs (now NHS England) and GP practices to reflect particular needs and priorities. These contracts cover a broad range of locally agreed priority functions including sexual health screening, smoking cessation programmes, blood pressure monitoring and weight management. The total spend on LES contracts in 2011/12 was almost £270 million (Health and Social Care Information Centre 2012).

From April 2013, CCGs were delegated responsibility for managing LES contracts on behalf of NHS England and these are now known as community-based services. Guidance from NHS England indicates that CCGs can commission any services considered necessary to meet the needs of their local population, including primary care that is outside of the terms of the core GP contract. NHS England further suggests that CCGs will need to consider guidance on managing the potential conflict of interest that arises with GPs as both providers and commissioners of care (NHS England 2013a).

### Quality and Outcomes Framework

The Quality and Outcomes Framework was introduced as part of the revised GMS contract in 2004 and is a voluntary incentive scheme for GP practices, providing financial rewards if various indicators are met. The total spend on the Quality and Outcomes Framework in 2011/12 was just over £1.1 billion (Health and Social Care Information Centre 2012). Most practices on GMS contracts, as well as many on PMS contracts, take part in the Quality and Outcomes Framework. It was quite a significant payment and incentive programme when introduced, and remains so because of the amount of money attached to it.

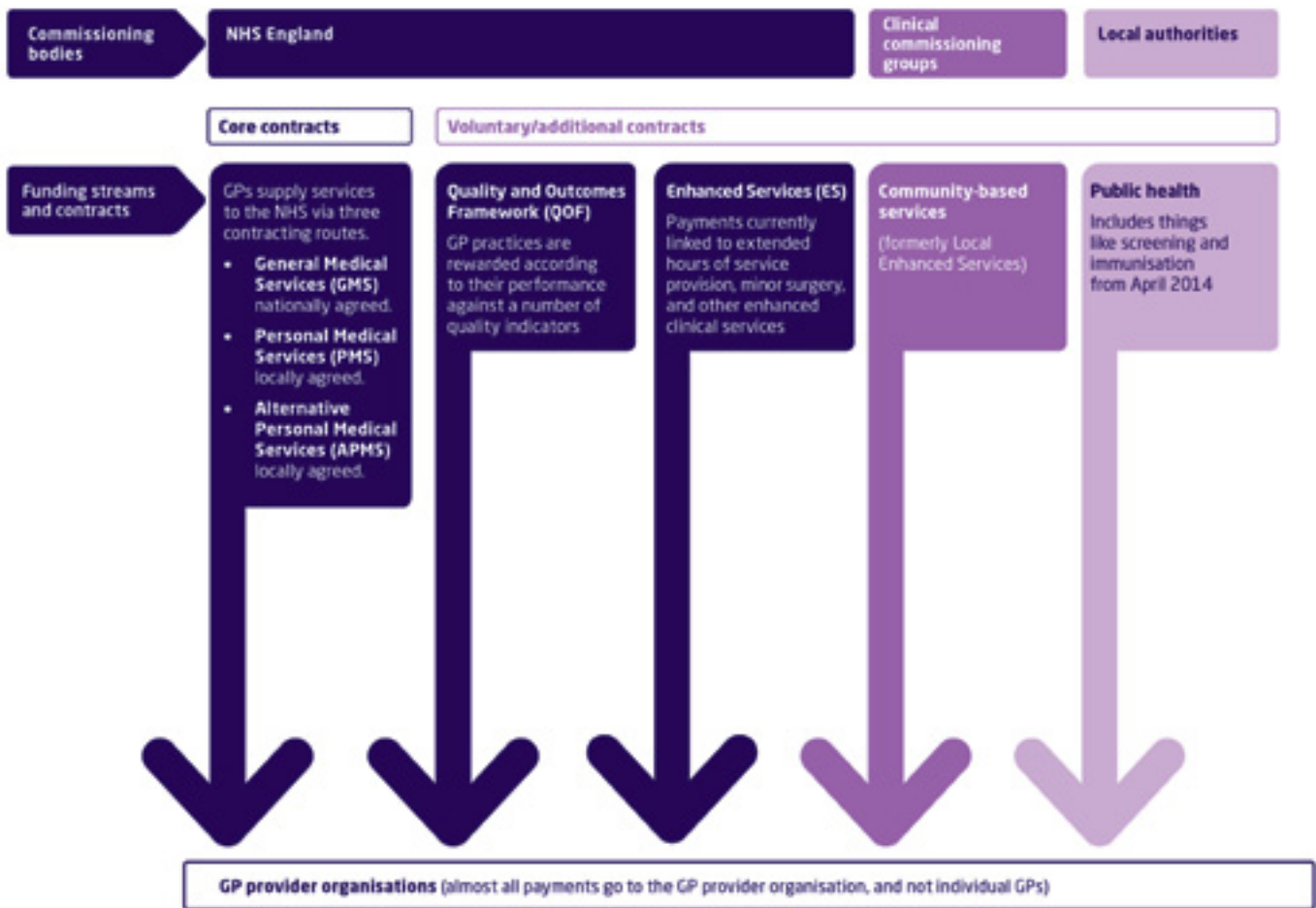
### Summary

This section has highlighted the complex contracting and payment system in which GPs are operating. What scope then is there within this system to create the services required by demographic shifts and the changing disease burden? Is it possible to use the flexibilities contained within existing contractual options to build on the undoubted strengths of general practice? In particular, is it possible to use these flexibilities to enable a wider range of services to be provided by GPs working with other providers in the integrated models of service delivery that are needed?

To answer these questions, we undertook interviews with expert and national stakeholders, as well as researching four detailed case studies of areas of England known to be attempting to integrate GP services and/or reconfigure the way general practice is organised at scale. These case studies are not intended to be representative of developments in England as a whole. Rather, they were purposively chosen to illustrate novel organisational delivery and change where stakeholders could reflect on the contracting system and other issues associated with their reform efforts.

Across the entire study, 49 interviews were conducted – 23 within the case study sites (GPs and CCG managers), 16 among national and expert stakeholders, and 10 with GPs and strategic leaders from other localities identified as using contracting mechanisms in innovative ways that were not captured within our case studies. We will now describe providers' responses to the existing contractual framework, along with their future aspirations for integrated primary care.

**Figure 1** Flow of funding and contracting in general practice under current system



## 2 Case studies of innovative models of primary care

To understand how the current system of contracting for general practice is being used in England, we identified four sites where PCTs and now CCGs are working with GPs to develop innovative models of primary care provision.

**Table 2: Overview of case study sites**

	Town and country	Northern city	Inner city	Rural county
<b>Demographics</b>	Semi-rural area	Large urban area	Inner-city area with ethnically mixed population	Large rural area
<b>Number of practices (and groupings)</b>	41 practices (single federation)	94 practices, 18 neighbourhoods, 3 localities	36 practices, 8 federated networks	82 practices, 6 localities
<b>Patient population</b>	285,000	492,000	282,000	515,000
<b>Co-terminosity with CCGs</b>	Co-terminous with 2 CCGs	Co-terminous with 1 CCG	Co-terminous with 1 CCG	Co-terminous with 1 CCG
<b>Main contract type</b>	15 GMS, 23 PMS (3 PMS Plus), 3 APMS	60 GMS, 22 PMS, 12 APMS	21 GMS, 6 PMS, 8 APMS, 1 interim management	72 GMS, 9 PMS, 1 APMS
<b>Motivation for change</b>	To consider income streams in addition to the core GP contract  Scale adds strength to tenders	To address inequity in investment and ensure consistency in the quality of care across all practices	To address under-investment in primary care and improve health outcomes  40% of contract value based on network outcomes	To tackle inequity in investment and disconnected service provision
<b>Focus of collaboration</b>	Dementia, frail older people, GPs in A&E, acute visiting service and outreach consultants	Access and prevention	Diabetes, immunisations and long-term conditions	Closer relationships with community and secondary care
<b>Major ambition</b>	Federation bids for services outside core contracts, investing income into primary care provision and sharing resources	Every patient to have access to consistently high-quality primary care from every practice	To standardise and improve overall quality of primary care for long-term conditions	To move towards more proactive care management
<b>Achievements</b>	<ul style="list-style-type: none"> <li>■ Reduction in spending</li> <li>■ Dementia care - earlier identification and support</li> <li>■ Locality-based extended hours with a common web-based clinical system</li> <li>■ Increased collaboration with agencies including local voluntary and community groups</li> </ul>	<ul style="list-style-type: none"> <li>■ Increased childhood and flu vaccination rates above national trends</li> <li>■ Reduction in prescribing rates and spending</li> <li>■ 16,000 additional people identified on disease registers</li> <li>■ Reduction in A&amp;E attendances</li> <li>■ Reduction in unplanned admissions</li> </ul>	<ul style="list-style-type: none"> <li>■ Improved clinical outcomes across a range of long-term conditions - eg, blood pressure and cholesterol control for people with diabetes; increased childhood immunisation rates</li> <li>■ Stronger relationships between GPs and commissioners, community services and social care</li> </ul>	<ul style="list-style-type: none"> <li>■ Specialists increasingly working alongside GPs in the community</li> <li>■ Improved relationships with community providers in some localities</li> <li>■ Development of shared electronic care record in some services</li> </ul>

The case study sites were selected to include different parts of the country, including urban and rural settings. A common characteristic in all sites was the use of contracting to stimulate practices into collaborating in order to offer an extended range of services and to raise standards of care. These aims had resulted in practices establishing federations and other forms of organisation to deliver primary care-centred integrated services on a bigger scale than is possible in the established model of general practice.

Information was gathered through visits and interviews with GPs and managers involved in developing innovative models of primary care provision in each site. These visits were supplemented with interviews in other areas doing similar work and with a small number of national stakeholders. The results were shared with the four sites to ensure accuracy and completeness and were discussed within The King's Fund with other colleagues working on primary care and integrated care. The proposal for a new approach to contracting for general practice set out in the final section of this paper was tested with a number of experts at a seminar early in 2014.

In each of the case studies, developments were led by a small group of GP leaders, with support from managers and often commissioners. GP leaders saw their main ambition as improving quality of patient care. To achieve this goal, leaders reported that they had to 'win over hearts and minds' among GPs and other local providers, relying on goodwill and informal mechanisms of influence. Leaders saw this local, clinical ownership as a key driver of successful change. Effective and regular communication through this process was considered fundamental to its successful implementation.

Each site had a different focus for collaboration, which was then reflected in how they assessed their achievements. The town and country site initially prioritised improving dementia, care for frail older people, GPs in accident and emergency (A&E), acute visiting service and outreach consultants, and it was monitoring progress on particular measures in these areas. The northern city site had a wide-ranging focus for its programme and was measuring achievements on immunisation, access, avoidable admissions and prescribing rates. The inner city site focused on outcomes and was particularly attentive to bringing about improvements in diabetes care and immunisation rates in an area of high need. The rural county site concentrated on strengthening primary care provision, improving IT systems and communication flows, and building closer integration with community and some specialist services.

Given this variation in focus, the self-reported achievements for each site were quite different and wide-ranging. The reported achievements were largely focused on reduced spending (town and country, northern city), increased vaccination rates (northern city), better management of long-term conditions (town and country, northern city, inner city), reduced unplanned admissions and A&E attendances (northern city) and improved working relationships with other providers across health and social care (town and country, inner city, rural county).

## Organisational structures

The town and country site has established a formal provider partnership, legally structured as a limited liability company. Each practice holds a single share in the overarching company. The partners evolved into a federated structure over time, considering it a transparent approach with clear governance. The limited liability company structure gave GPs more flexibility over recruitment and the terms and conditions of employment. It was also seen as a stronger model, in defending their contracts from ‘outside predation’. Despite the formal structure, the federation has what it considers to be ‘light touch’ governance, relying on quarterly meetings.

*This is about getting a structure together to allow people to work legally and safely, so they’ve got to be able to interact with each other and they need a structure to do that.*  
(GP, town and country)

The northern city site has not established a legal structure to support its collaboration but has built a governance structure to support service improvement, share best practice and pool resources as appropriate. This site has 94 GP practices, grouped into 18 neighbourhoods, which are then organised into 3 localities. The CCG (formally the PCT) has worked with practices, neighbourhoods and localities to articulate their purpose and core function at each level and to provide funding and incentives to improve care.

Dedicated managers at the CCG support neighbourhoods and localities, helping them to improve quality. Nominated GPs represent each of the neighbourhoods at locality meetings, and in discussions with the CCG. The grouping of these localities was originally based on geography as well as on historical relationships. In 2011, two of the localities merged to create a configuration that was considered to best reflect groups of ‘like-minded’ practices, rather than geography.

*There is no defined geography for the [name] locality, but there is a lot of commonality in terms of the way they work. They’ve been together for a number of years now, so they’ve obviously got a bit like-minded in the way they behave and the way they move forward.*  
(CCG manager, northern city)

Some practices within this site were at an embryonic stage of federating. The neighbourhood structure was seen as a forum for strengthening relationships less formally, where the CCG developed service specifications and contracting frameworks to ‘make it [federating] almost the natural thing to do’ (senior CCG manager, northern city).

The inner city site similarly relied on an approach that grouped its 36 practices into 8 networks. Unlike the northern city site, performance was monitored at the network level by the PCT and now by the CCG. Each network has a formal governance structure and leadership. Clinical leaders head up each network, supported by a manager and co-ordinator. Network boards meet monthly to plan and review performance measures against contract objectives.

Some of the networks have established legal partnerships, through community interest companies. There was a general reliance on pre-existing relationships; the inner city site had more recently grouped some practices together and likened these less ‘organic’ local partnerships to an ‘arranged marriage’. Commissioners had designed the overarching network configurations and acknowledged that they needed to be somewhat prescriptive to ensure the boundaries were sensibly configured and co-terminous with local authority borders. They suggested that allowing practices to move around too much would be destabilising.

*So we ended up developing the care package that described the who, the what and the how. But actually how practices – and then how networks – then formulated, that was really up to them within that framework.*  
(CCG manager, inner city)

The rural county site has also divided into 6 localities (across 82 practices) and each operates as a 'clinical directorate', with a nominated clinical director. There are no legal structures to support these localities. Under the PCT, each locality held a commissioning budget for what was described as 'common stuff', working with community services, social care and local authorities to deliver this care in the community. Transforming community services was reported to have caused a 'fairly quick excruciating death' of ambitions to achieve closer integration of community services and the work of general practices. The resulting instability eroded many established relationships and associated enthusiasm.

More recent policy reforms provided a continually unstable platform on which to rebuild these structures – 'and the reason is not because anybody is deliberately making it difficult; it's because nobody quite knows who does what in this system, who has responsibility for what' (CCG manager, rural county). This site is only now beginning to re-establish effective relationships across provider groups. Localities are the platform for learning collaboratives, and the area is considering how it can rebuild on their previous ambitions to manage a budget and work with other providers. Governance structures had been established but these were less formal than the other cases described here.

*...the community services got ripped out of it, and the practices were struggling to see what they were setting up and what they were going to become. So they pulled back from that, and I think it's taken us probably about two to three years to get back... well, we aren't anywhere near that position yet – but we are starting to line things up.*  
(GP with CCG role, rural county)

For the rural county site, forming a federation felt like a 'step too far' at the moment, although there was some local interest and enthusiasm. One of the smaller localities within the area is considering a staged approach to federating – firstly through sharing premises and back-office functions. If the practices then realise the benefits of working together, they will move to become an incorporated body. However, this process is based on the practices moving at their own pace, when they are ready for the next stage of collaboration.

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# 3 The primary care contracting framework in practice

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Earlier parts of this paper described the national contracting framework, and the different types of core GP contract. This section describes interviewees' reflections on the contracting frameworks within which they are operating.

## Contracting for essential services: the core GP contract

Within each case study, individual practices held different types of contract – GMS, PMS or APMS. It was through discussions of these contracts where there was the greatest variation in feedback.

Many GPs expressed dissatisfaction with the current contract, particularly regarding workload requirements, income pressures, variable funding across practices and inflexibilities for innovation.

*Under the very old contract, the more you wanted, the more staff you wanted, the more funding you got, etc. And then it was completely screwed down in the last version of the contract.*

(GP with CCG role, rural county)

Despite dissatisfaction with the contract, there was little optimism regarding a new agreement. Alongside workload and income concerns, GPs feared that a new contract would be more rigid and uniform, offering less flexibility at a local level. GPs found potential standardisation and uniformity to be de-motivating, with fears of a tightened budget, more box-ticking and less personalised contractual alternatives.

Some GP leaders had used this pessimism to their advantage to establish unity across local GPs and build a critical mass for greater influence over contract development and negotiation. A GP in the town and country site confessed that anxieties around the current and potential future GP contract had made it possible to engage other GPs.

*The new GP contract is a bad bit of legislation, a bad bit of contracting by the Department of Health for GPs but it's actually driven them all into my fold. They, therefore, need to come in order to keep their practices stable because we can't operate in debt.*

(GP, town and country)

There were various criticisms of the current contract – mostly that it does not allow for sufficient innovation, is bureaucratic (particularly GMS) and has undergone frequent renegotiations (PMS). In addition, any plans to innovate in a substantive way on the deliverables of the core GP contract now need to be negotiated with the relevant local area team (now known as area team) – the regional representative body of NHS England.

Practices reported variable experiences of managing this relationship. Some area teams were flexible and supportive of general practice ambitions, while others were seen to be uncertain about delegating freedoms to primary care providers given their own nascent responsibilities. The rural county site reported that the remoteness (geographically and managerially) of their area team was responsible for stifling innovation in their local area.

One practice in the town and country site described their desire to deliver services 'over and above the standard GP contract' as the motivation for holding a PMS Plus contract. This practice believed that PMS Plus would provide more flexibility, involve less bureaucracy and offer greater possibilities for integration. They were able to set local priorities and standards. The PMS Plus contract has helped the practice to establish closer working relationships with community services, enabling it to contract directly with community services. Community nurses are seconded to the practice. This arrangement is reported to be more efficient, cost-effective, and provide better patient outcomes while still supporting community nurses to be part of the primary care team.

Despite the flexibilities of PMS Plus, leaders in the town and country site reported that current contract options had inherent limits, prompting them to develop alternatives. The value of the GP contract is falling, and GPs reported that the creation of the federation (and its infrastructure) opened up the opportunity to be an affordable and credible bidder for additional community service contracts.

*The work that we're doing as a federation is completely and utterly separate to what we do under GMS or PMS – and there's nothing really within that which helps us or provides anything in terms of anything beneficial, or negative. It's just completely separate.*  
(GP, town and country)

The rural county site also reported that the GP contract was not aligned with improving patient experience and quality of care because it supports the delivery of 'widgets' of work rather than promoting new ways of delivering care across a local population:

*I don't think the GP contract is helping us to change the conversation. I think it's not necessarily going to stop us, but it doesn't enable us – because it's very much geared towards financial recompense.*  
(CCG manager, rural county)

Interviewees from this site further acknowledged that it is difficult to understand or interact with the technicalities of the GP contract.

*I tended to think that a GP contract is a GP contract – but there is a difference between PMS and APMS which I still can't fully get my head around. And even where there is a core GMS contract, the fact that some practices seem to get more resources than others for it, is all weird and wonderful.*  
(CCG manager, rural county)

Notwithstanding these concerns, many providers and national stakeholders interviewed from outside the case study sites (from NHS England, legal firms, provider representative bodies and other primary care providers) spoke of the potential flexibilities of the GP contract to support innovation and integration. These stakeholders were generally more positive about the current GP contract than interviewees in the case study sites, acknowledging that there had been some dissatisfaction with its terms, but suggesting that many of the apparent restrictions that were troubling GPs were less constraining than they believed them to be. These respondents felt there was considerable integration and innovation that could be achieved within the current contractual framework – but what was missing was a willingness to innovate.



This view was echoed by the experience of the chief executive of a GP federation that holds an APMS contract (outside the case study localities) who described the contract as ‘liberating’ rather than constraining in any way. The suggestion was that perceived restrictions arose due to poor understanding of the contract – she herself admitted that she had until recently not actually read the contract in depth. Her advice was to read carefully and understand the contract, which would potentially alleviate some of the concerns regarding its limitations. As this comment shows, there is often an inadequate local understanding of the detail or technicalities of the contract and what is possible within the current system.

Leaders in the rural county site reported that they could make a lot of progress ‘under the radar’ as long as they were meeting their Quality and Outcomes Framework obligations and reporting on the required measures. However, it was acknowledged that there was only so much that GPs could achieve through this approach.

This suggests that greater flexibilities are needed to encourage innovative approaches to commissioning and contracting that are not dependent on leaders finding ways around contracts and then having to beg forgiveness if they are discovered to be breaking the rules.

## Contracting for additional services

Discussions around contracting for additional services fell into two categories: enhanced services through LES and DES contracts, and tendering for further local services directly commissioned by the CCG. Delivering enhanced services was a tangible way that GPs could see themselves establishing collaborations across practices and improving the quality and consistency of care across a locality. In many cases, LES contracts were relatively routine (eg, screening and immunisations) and efforts were under way locally to consider the most effective means of delivering these contracts. Uptake of LES and DES contracts is voluntary, and was thus variable within and across case study areas.

### Enhanced services

Commissioners from the northern city site used LES contract to address variations in funding and performance across practices. Commissioners worked with providers to develop a specification of what services and impact were expected at a practice, locality and neighbourhood level. The expectations outlined in this specification ultimately formed 13 key performance indicators (KPIs), such as A&E attendances, vaccination rates for vulnerable groups and children, alcohol interventions and prescribing rates.

These KPIs were all encapsulated within a single LES contract. Commissioners spent considerable time working collaboratively with clinicians to develop the terms of the LES contract, encouraging buy-in across all 94 practices in the locality. All but one of the 94 practices ultimately signed up to the LES contract (with the other practice agreeing to meet the targets for the KPIs, but not through a formal contract mechanism). Crucially, each practice was awarded variable funding through this LES contract to equalise investment across the entire locality at £90 per patient.

For some practices this represented a marginal amount of money, while for others it brought a considerable investment. The overriding emphasis was on improving and standardising quality, rather than on making money at a practice level. Nevertheless, the additional investment was at risk – that is, commissioners made the upfront investment to enable practices to finance local service improvements, but would ‘claw back’ the money from the practices if they did not achieve the KPIs, or at least demonstrate efforts to do so.

*I think overall, wherever you go in the city, most doctors are very much in favour of it [the LES] because they’ve actually been able to improve the quality of the care that they offer patients.*

(GP, northern city)

Other case study sites were instead seeing the challenges of delivering the requirements of the more standard LES and DES contracts in isolation from concerns to improve quality of care. Taking on these contracts provided a stimulus to practices in some areas to collaborate, although this was not always easy to achieve. One GP described attempts to collaborate to deliver on LES contracts as like ‘a flotilla of little boats, going in different directions.’

*On Monday I signed, how many did I sign? Ten separate [LES contracts], and that's not all of them. So I just signed ten and we said ‘Oh yes, we'll carry on doing all these’, and one of them, the public health one, had three or four consumed within that one signature. We just ticked which boxes we were going to do and then signed, so it was one signature but it actually covered potentially six.*

(GP with CCG role, rural county)

By contrast, the town and country site reported that only a third of its practices were taking up enhanced service contracts. Practices signed up for various LES contracts if they believed there to be patient benefit and if they could afford to deliver it. Some practices would have to employ more staff to deliver the service, and they were reluctant to do this given the short duration of some LES contracts.

Larger practices, with more solid infrastructure, generally had greater capacity to enter into these contracts. Smaller practices were typically not in such a strong position to provide enhanced services in isolation – but they had great concerns about other providers (particularly private sector providers) delivering these services instead for their patient population. These practices were increasingly working in partnership to resist the entry of alternative providers into this market. In this sense, collaboration between practices and the emergence of a federation was in part a defensive strategy.

The town and country site reported that variable uptake of LES and DES contracts across practices was creating a two-tier system for patients, with inequitable access to enhanced services across the area. The rural county site described a series of disjointed services, with no coherent or strategic plan for delivery. Enhanced service contracts were described as a ‘sweetie shop’, where GP practices signed up for everything and then ‘stick their hand out [for payment]’. Interviewees in the rural county site felt that some GPs saw LES and DES contracts (and the accompanying additional income) as an entitlement, rather than something that is earned through delivering extended services.

More positively, LES and DES contracts were increasingly seen as a stimulus for general practices to work together. The town and country site saw this collaboration as an opportunity to involve smaller practices in the delivery of enhanced services. In this site, the federation provided a platform for collaboration and enabled ‘the strong to support the weak’. It also provided an infrastructure to allow these services to be delivered and managed in a more equitable way across the locality.

The rural county site saw co-operation as a necessary approach to manage cohesion across the locality:

*...the brighter ones amongst them start to work out: ‘Well if we do it all together it'll be much better, we've got far more chance of hitting our own individual outcomes if we work with the others and work out how to do it together.’*

(GP, rural county)

The northern city site provided the most explicit example of how LES contracts can be used constructively to improve and standardise quality and outcomes across a locality as described above. Commissioners have largely driven this approach, but provider engagement was instrumental to the successes of the approach. The majority of practices have achieved the KPIs, with very few being asked to return any of the initial investment in 2012.

In the light of the evolving provider and commissioning landscape, this site was revising the KPIs by which practices will be held to account. As mentioned previously, responsibility for administration of LES contracts is transferring to NHS England in 2014, which in turn, can delegate responsibilities to CCGs. In practice, the LAT covering the northern city site will be responsible for ‘approving’ the terms of the new contracts currently being developed by the CCG.

### Additional and tendered services

In addition to the contracts detailed above, GPs were bidding to provide other locally commissioned services. These services were typically tendered by the CCG for the delivery of care for a disease or condition like dementia or for a client group like frail older people. It is in this area where the most activity around collaborative contract development could be seen between GPs and other providers.

One of the concerns associated with GPs bidding for locally tendered services was the apparent conflict of interest generated by GPs acting as both commissioners and providers of care. Some interviewees expressed dissatisfaction with how the evolution of recent health reforms had produced this conflict. GPs felt that the original reforms articulated in the White Paper matched their ambitions to give GPs greater control over the organisation and delivery of health care for their local population. However, the eventual legislation as defined in the Health and Social Care Act 2012 placed greater emphasis on GPs as commissioners, and could limit their role in delivery because of concerns around conflict and competition.

Some GPs and commissioners expressed anxieties regarding the broad range of services that must be opened up to tender from any qualified provider. In some cases, it is possible that the service areas previously covered by LES contracts (which must initially be offered to general practices) could instead be procured through an open tender. This is starting to happen in parts of the NHS. For many services, the onus was on commissioners to demonstrate that general practice is the only, or most appropriate, provider to deliver the service within the broader range of providers.

Some interviewees suggested that this competitive environment generated anxieties across general practice, particularly where service provision and investment was less stable.

*By default any commissioning is AQP [any qualified provider]. The case we have to build is the registered list – so, why is it that it’s only the registered list holder, or that the best option is for the registered list holder to be commissioned to deliver these services?*  
(Senior CCG manager, northern city)

Some sites meanwhile were beginning to consider how they might use innovative contractual mechanisms to meet their objectives as providers. To work around potential conflict, GPs were establishing new contractual mechanisms and working with other providers outside general practice to establish and deliver these contracts – particularly through a prime provider model.

The prime provider model places a contract with a lead or prime contractor to deliver care for patients with a specific clinical condition (such as dementia) or for a defined patient population (eg, frail older people). The prime provider holds a contract with commissioners and agrees to work under an agreed budget, and potentially to an agreed set of outcome (or other) measures. The prime provider then subcontracts to other local providers to deliver particular parts of the care pathway. The town and country site had the most explicit contractual approach to deliver tendered services through multiple prime provider contracts.

*So all we need to do contractually is to make sure that the terms of that contract are replicated all the way through. It doesn't really matter what it is, it doesn't matter whether you're making chocolate Easter eggs or furniture. As long as everybody knows what it looks like, what the materials are, what the targets and the outcomes should be, as long as we ensure that those are replicated all the way through – we know that we're okay, and we do that through a legal contract that is drawn up to match each of our subcontracts.*  
(GP with CCG role, town and country)

Through the model described by this site, a single organisation bids for contracts from the CCG and then subcontracts particular aspects to other providers, including the federation. The town and country site is part of a prime provider model for dementia services, where the mental health trust is the prime provider and subcontracts with the federation to deliver part of that service. The site plans to tender for trauma and orthopaedic services in the future, with the acute trust as the prime provider. This approach seeks to work around any conflict of interest in the tendering process, as GPs would not be directly commissioning themselves.

GPs in this site – and those from other case study sites – were in agreement that the apparent conflict does not need to be a barrier to participating in a prime provider model for delivery of additional services. Rather, GPs in this site suggested that the CCG first needs to demonstrate clearly that what they are tendering for is beyond the requirements of the core GP contract. Second, GPs should declare their interest at the tendering stage, and remove themselves from the decision-making process. This transparency, alongside clear CCG governance arrangements, should be sufficient for ensuring GPs are not able to unfairly favour a particular practice in this tendering process.

The prime provider model brings with it an explicit mechanism to support integration between GPs and other providers. The risk is that the model could create new silos for specific conditions and diseases, and also generates a potentially complex contractual arrangement, with various subcontracts in place. This shifts responsibility for designing local provision away from the CCG and on to the prime provider. This provider is then ultimately responsible for the co-ordination and performance of all those with whom it subcontracts, requiring a sophisticated accountability framework and performance monitoring matrix.

Designing a delivery pathway, negotiating subcontracts with other providers, and developing an accountability framework might be beyond the current capability of many local providers including general practices. Some questioned whether the model might be deliberately employed by commissioners to shift co-ordination and governance responsibilities onto providers. To manage this risk, the prime provider is likely to build in additional costs to the original contract – and it could therefore be expensive to the commissioner.

## Risk-sharing and accountability for outcomes

Much of the development in delivery has been driven by a greater focus on outcomes, shifting responsibility for achieving these outcomes onto GPs, and then sharing responsibility (or risk) across individuals, practices and wider provider organisations. The intention has been that providers should have a clear stake, meaning part of their income will be dependent on successful collaboration.

Interviewees saw opportunities for CCGs and local providers to work together to negotiate outcomes, and then for providers to consider how they might work in partnership to achieve these outcomes. Outcomes-based contracts could help in incentivising greater collaboration across GPs and across different providers in health and social care. The outcomes under discussion largely focused on intermediate quality and/or process measures, such as reducing unnecessary admissions, increasing immunisation rates, and diabetes or blood pressure control. There was no discussion of longer-term outcomes, such as mortality or morbidity.

The northern city site provides an example where general practices individually have a proportion of their income at risk through a LES contract that is based on achievement of (or at least demonstrating efforts to achieve) a series of KPIs. The risk is built into the start of the contract agreement. Rather than receiving a bonus for achieving a particular standard, practices receive additional upfront funding to invest in appropriate service improvements (an action plan is agreed with the commissioner). If practices cannot demonstrate that they have achieved the KPIs, or used the investment to fund service improvement, then it must be returned to commissioners.

The inner city site was using outcomes-focused performance measures in innovative ways to promote greater partnership working across practices. Initially 70 per cent of the Quality and Outcomes Framework payment was given to practices up front to invest in infrastructure costs and care delivery (now reduced to 60 per cent – increasing the proportion of the payment that is at risk across practices, as the networks have become more stable). The remainder is held back, payable on achieving the required standard on the outcome measures. All practices in the entire network must achieve the target for the payments to be released.

*In reality what that meant was if you collectively hit your targets you got the payment, but if, as a consequence of someone else in your network dragging your average down, none of you got a payment.*

(CCG manager, inner city)

The intention is that shared risk motivates GPs to work collaboratively to improve performance across the entire network. The objective is to stimulate providers to develop novel and effective ways of working across the locality to meet performance targets. GPs who do not meet required standards are subject to greater peer pressure to perform through this approach. Providers within the network share data, so performance is transparent and comparable. This transparency in itself was considered to be a motivator for triggering behaviour change, where low-performing practices would be ‘shamed’ into achieving outcome targets. This stimulus was considered to be even stronger when there is money attached, and where poor performance impacts on the income of another practice.

Leaders in the inner city site feel they have a solid platform of primary care delivery – with the core GP contract and the local approach to sharing risk to achieve improved outcomes. As in the northern city site, these initiatives have largely been driven on the commissioning side, setting out innovative processes, agreeing outcomes and calling on providers to design a system that will deliver them. Commissioners have made efforts to trust and grant freedoms to providers, whom they consider better able to see the gaps in service specifications.

Collaborative models of delivery are central to this model.

*Having the expertise over more than one practice is quite an attractive solution for a commissioner if you're working to a wider contract, because you've got a combined wealth of knowledge, risk, clinical delivery opportunities of four or five combined practices as opposed to putting all your eggs in one basket.*

(CCG manager, inner city)

Despite existing experiments with risk allocation – through a prime provider model (town and country), LES contracts (northern city) and pooling outcome payments (inner city) – there was variable appetite for taking on any substantial shared risk across practices, or in collaboration with other providers. One interviewee from the rural county site suggested that such risk-sharing required a ‘leap of faith’ – for both GPs as providers and the area team to support this approach. This leap of faith might be too great for some GPs at the present time.

*...the most challenging aspect of doing what we're doing is not the medicine, it's the finances. Because people don't want to lose the resource, they're not even keen on sharing the resources. And obviously there's no new resource anywhere, so we're all dealing with the same pot of money. So without a doubt, the most challenging thing that we're dealing with is when it comes to discussing finance.*

(GP, town and country)

Different methods of paying providers in general practice, community services and hospitals create a potential barrier to sharing risk across practices and with different provider groups. Risk-based contracting requires significant support to ensure providers and commissioners hold the necessary capabilities. If providers possess these capabilities, there is potential for improvements in clinical delivery and increased financial efficiencies.

## Challenges to general practice provider development

A number of challenges stand in the way of practices' ability to make significant progress in developing innovative models of care. They include structural instability, shifting accountabilities, provider engagement and payment models.

### Structural instability

Interviewees reported that national and regional restructuring has had a negative impact on attempts to strengthen primary care services and develop partnerships with other providers. One example was the Transforming Community Services agenda that required PCTs to divest from their provider arm, and caused substantial upheaval and uncertainty. As described by the rural county site in particular, this transition had the impact of stalling – and potentially damaging – efforts to integrate the work of general practices with that of community services:

*We've ended up with where we are, and what we lost was a significant programme of integration that we were developing, that was beginning to show some significant benefits. And suddenly integration became a dirty word. It was like it wasn't on anybody's lips, it was all about having clear blue water between GPs and commissioning, and community services have to go. Yes, it wasn't in keeping with our ambition or the direction of travel we were going in, but we had no choice, or it certainly felt like that at the time.*

(GP with CCG role, rural county)

More recent reforms through the Health and Social Care Act 2012 have generated further instability, with different accountabilities and funding streams through central government, local authorities and CCGs. Some of these funding streams are under considerable financial pressure. Further, GPs felt that primary care is now quite removed from public health (the responsibility of local authorities), which could have a significant impact on attempts to organise and deliver services with a population-health focus.

Interviewees in the northern city site were anxious that some KPIs in their existing LES contract are now the responsibility of local authorities rather than CCGs. KPIs with a public-health focus (eg, vaccinations) would no longer be funded by CCGs, and as such could not easily be compiled within a single LES contract and funding stream. There were concerns that part of the overall package of improvement might unravel given variable and emergent payment responsibilities. In this case (and in other sites across the country) the CCG had an embryonic relationship with their associated local authority, which is itself coming to terms with its new commissioning responsibilities.

### Shifting accountabilities

Since many of the structural reforms were embedded in April 2013, some GPs reported a distant relationship with their area team – geographically and in terms of transparency, expertise and communication. These regional representative bodies of NHS England do not necessarily hold the primary care capabilities to assure GPs and CCGs of their credibility. There were some concerns expressed that a number of area teams do not have a comprehensive understanding of primary care or ambitions around integration. When accompanied with geographical remoteness, interviewees questioned the ability of the area team adequately to understand or represent their interests. In the northern city site, there were concerns that the area team might question the content or ambition of developing a new LES contract.

Area teams, as emergent and unstable organisations themselves, were seen to be currently unable to manage the flexibility and innovation necessary for primary care to evolve – with their nervousness instead supporting a micro-managed or ‘one size fits all model’ that limits innovation and responsiveness. Some GPs felt that they might have more local control if they were able to relate directly to NHS England nationally.

*... ideally you need to be given permission or dispensation to just get on and do some stuff and be given a framework within it to work and then somebody that you check it out with. And I would prefer that it was somebody nationally, that had some big brains on it, that understood primary care and general practice. Rather than you're at the whim of a small area team with people struggling to manage contracts for I don't know how many hundreds of practices they've got.*

(GP with CCG role, rural county)

In the northern city site, having continuity of clinical personnel from the PCT's professional executive committee into the area team allowed for a more constructive and informed relationship. In other sites, however, the pre-existing relationships and organisational memory was predominantly held within the CCG rather than the area team. New relationships were taking time to develop, generating uncertainty and instability. National and other expert stakeholder interviews highlighted more constructive relationships between GPs and area teams where there was greater flow of personnel from strategic health authorities or PCTs into the area teams.

There was some feeling across the case study sites that when CCGs were in shadow form, there had been greater freedom and capacity for ‘blue-sky thinking’ among GPs as they took on their emerging commissioning role – looking at care pathways and delivery systems in innovative ways. This supports the findings from Naylor *et al* (2013), who found considerable enthusiasm across CCGs in the lead-up to their full roll-out. However, since CCGs have had statutory responsibilities from April 2013, some interviewees felt that an element of this enthusiasm has waned and processes have become more bureaucratic.

*It is very noticeable – the style and the enthusiasm and the ability to take a calculated amount of risk seems to have vanished because everybody is worried now that they're statutorily responsible for this and their head will be on the block if they don't deliver.*  
(CCG manager, town and country)

Other GP providers felt that CCGs offered a positive and more innovative partnership, whereas PCTs had been fixed in established ways of working. In either case, these different responses indicate that there remains considerable variation in local relationships between providers, commissioners and area teams, which has destabilised provision during recent reform implementation.

### Provider engagement

There have been ongoing challenges to engaging providers, including GPs, in efforts to integrate and organise services in different ways. The town and country site reported that there were continual tensions between a risk-averse commissioning and provider environment, and the aspirations of more forward-thinking leaders.

*Herding GPs is not an easy task, it's not for the faint-hearted. But once you've got it, then you've got the possibility of taking money that's required to develop the community care in a safe way, with the legal entities of contracts, subcontracts and all the other things.*  
(GP, town and country)

New models of care are established through innovative leadership and an investment of time, resources and money. The concern is whether other practices across the country have the time and resources needed to support a more collaborative structure, in addition to existing day-to-day clinical work.

*When we have spoken to other areas where they want to federate, one of the questions they will ask is 'who paid for your time? How did you get that resourced?' and when you tell them 'we didn't, we've just done it in our own time' they're not interested.*  
(GP with CCG role, town and country)

Difficulties in engaging providers may not necessarily be a result of deliberate reluctance or sensitivity to financial implications. Rather, the well-documented pressures on GPs demonstrate the difficulties in finding the space to develop new relationships, undertake preparatory work, and then manage the implementation process. Despite potential long-term benefits of operating at scale and in collaboration, the initial investment of time and resources may be prohibitive for many practices across the country.

Interviewees suggested that some GP providers did not see the need to work in different ways or in partnership, or were more risk-averse – particularly in response to recent financial challenges. Barriers or inflexibilities in the current GP contract were then often presented as excuses for inertia. The right people need to be around the table, designing the configuration of local services and negotiating contract development – providers and commissioners who can work together, drawing on a complementary skills set. Innovative practices will need to have a vision beyond the current contract and a commitment to take on more risk.

The northern city site was adamant that clinical engagement was essential to the success of its LES model. Providers needed to know that this was not something being 'done to' them, but rather that they were co-designers of the approach and its content. Engagement and collaboration in this context requires not only commitment across providers, but also from commissioners and area teams. The inner city site also referred to positive local relationships between managers, commissioners and providers. The previous PCT had a 'partnership ethos' where they simply facilitated discussions, and where clinicians worked through the arguments and arrived at the answers independently.



### Payment models

As noted above, variable payment models across different parts of the health and social care systems potentially stand in the way of more radical shifts in delivery or more formal collaborations across provider groups. Bundled tariffs make it difficult to extrapolate a portion to be allocated to subcontracted providers. Block contracts may discourage innovation. Social care is means-tested while health care is free at the point of delivery, which continues to reinforce a divide between access to different types of care. Incentivising outcomes through both enhanced service contracts and the Quality and Outcomes Framework could mean that providers are paid twice for achieving the same outcomes without proper accountability and oversight by commissioners.

Innovations based on shifting care into the community present a challenge to acute providers and others who are reimbursed through activity-based payments. One interviewee described current attempts to engage hospitals in integration as ‘a bit like turkeys voting for Christmas’. Hospitals (and commissioners) will need to reconsider fundamentally their business model for sustainable integration to occur. One interviewee in the rural county site suggested that the current payment model has extremes – payment by results in the acute setting which encourages activity and block contracts for community services ‘which don’t encourage anything’.

*So, in the hospital sector we have a system that encourages activity and sucks into hospital, then in the community we have a block contract that really says ‘well, whatever you do you’ll get the cash’ – so both of those things are encouraging things in the wrong direction.*  
(GP with CCG role, rural county)

Until payment models are aligned with this population-based perspective, a barrier stands in the way of progress. Mindsets and accountabilities need to shift so providers and commissioners are not preoccupied with organisational self-protection, but instead focus on collaborating to meet the needs of the population.

Funding into general practice currently flows from at least four different directions – local authorities (public health), area teams (enhanced services), NHS England (national contract) and CCGs (locally commissioned services). Restricted social care budgets are reportedly prompting local authorities to change and restrict criteria regarding access to services at a time when the emphasis needs to be on prevention and early intervention. One interviewee likened this arrangement to a ‘dog’s dinner’.

Interviewees were overwhelmingly supportive of capitation and taking a greater role in managing a population-based budget. Capitation would bring together all of the costs for a defined population over a specified time period, calculated as an average amount for each person within that population. In many cases, providers would be able to retain any savings, to use either for re-investment or personal profit. The intention is that providers will be incentivised to give greater consideration to the costs of care, and to developing more efficient methods for achieving outcomes or other specified performance metrics. In the final section of this paper we discuss how a population-based capitated contract might be developed with the aim of accelerating the development of new models of primary care-centred integrated services.

### Sources of support and guidance

The complex commissioning environment (tendering processes and financial risk) could preclude many GPs from developing services or operating in formal partnerships. Taking part in interdependent relationships with external providers is potentially even riskier. Some interviewees feared this preclusion may mean tenders are awarded to providers simply on the basis of price or to large companies that are able to bear a greater degree of financial risk, rather than consideration of local provider mix.

*So actually – just like out-of-hours [services] – what happens? You get the consequences of it. You get the cheapest, you get very few people in the market, you drive out the co-ops and the quality in your process.*

(GP, inner city)

As such, there is a need for support and guidance to enable smaller and less experienced practices to adapt to the evolving commissioning and contractual environment and compete with alternative providers. Many GPs were considering where they could get good advice without ‘spending millions of pounds on management consultancies’. For instance, all of the practices involved in the town and country site have pooled a sum of money for the federation to purchase legal and accountancy support. To support neighbouring localities with equally limited resources, they are now helping other practices that are considering a federated model. GPs saw the federation model as an opportunity for smaller and less confident providers to come together to share risks and expertise. The federation enables GPs to build capacity as a credible network to bid for services outside the core contract.

GPs and commissioners were looking to various sources of support regarding the organisation of primary care, and different contractual options. Some spoke of drawing together a ‘jigsaw’ of ideas from other areas and industries that were then adapted to meet local needs. Some looked to examples from the United States, such as Kaiser Permanente, Accountable Care Organizations and the Alternative Quality Contract for inspiration regarding mechanisms for collaboration, risk-sharing and outcomes-based contracting.

Other interviewees suggested that many of those involved in the organisation and design of health care systems are too quick to look to international examples, while ignoring innovations already under way in England. There is much that can be learned from local developments in the NHS. There were some forums – learning collaboratives, email networks and other mediums – emerging across the case study sites where primary care providers and commissioners shared experiences and brought back learning to their local community.

GPs in these case study sites did not routinely refer to area teams or Commissioning Support Units for support or advice. Organisational models and new contracting alternatives were emergent and there was not much technical advice available. Instead, design is being driven more from the ground up – from GPs and CCGs, who are drawing on knowledge from a range of sources.

Nevertheless, there is scope for additional support regarding the technicalities of contract development and organisational arrangements in particular. These areas present a significant gap in provider knowledge, potentially precluding many from considering innovative ways of developing provision and working in partnership across boundaries. This lack of knowledge and competence is even more strongly felt in attempts to establish formal partnerships or contracts across different provider groups.

### Summary

This section of the paper has described how four areas of England are using the freedoms and flexibilities contained within current contracting frameworks for general practice. The picture that emerges is one of considerable innovation but also of complexity and instability. The details and technicalities of contracting for general practice are imperfectly understood and this in itself may be inhibiting more widespread and effective use of the flexibilities that exist. This is compounded by organisational changes and the associated loss of experienced leaders and organisational memory in some places.

As our research shows, additional services beyond those required to be delivered through the core GP contract can be commissioned through DES and LES (and the contracts that will replace them) alongside the opportunities that exist for local contract negotiation through PMS and APMS. One of the effects has been to stimulate greater collaboration between practices through federations and networks, creating a platform on which more services can be delivered out of hospital and where greater integration of the work of practices with each other and with other services can be supported. A number of improvements in care have been made as a consequence as innovative GPs and managers have exploited the options available to them.

The experience reported here shows that the use of tendering for services and the desire to open up the market to new providers is a double-edged sword. On the one hand it is creating stronger incentives in some areas for practices to collaborate both as a defensive strategy and to be able to compete on equal terms in the emerging market of care. On the other hand, it requires practices to be able to access expertise that they may not possess in order to survive and grow at a time when resources in the NHS are under huge pressure. Whether practices as small businesses are ready to take the 'leap of faith' referred to by one of our interviewees and share risks and rewards with other practices with whom they have a relationship that is at times competitive and at times collaborative, is a question we return to in the final section of this paper.

All of these developments are being played out in a context in which increased attention is being paid to variations in the quality of general practice. There have also been moves by the providers of some acute hospitals to establish a foothold in the primary care market, with indications that others are considering following their lead. There is ongoing debate about new models of out-of-hospital care with innovative community and acute providers seeing themselves as having a more significant role in future. This might include employing GPs directly and/or collaborating with federations and networks to deliver more integrated services in the community.

Notwithstanding the innovations described in this report, it is clear that there are limitations in the current contracting framework both in the scope for commissioning practices to provide additional services and in the division of responsibilities between CCGs and NHS England. Equally important are limitations in the business model used by practices which continues to be based on small providers who are inevitably constrained in their ability to contribute to the development of the models of care required in future. It is for these reasons that a new approach to commissioning and funding is needed in order to stimulate practices to federate and to work with other providers in developing the integrated services needed.

It is against this background that the final section of this paper makes the case for the use of a population-based capitated contract under which federations would take on much greater responsibility for budgets and services with the ability to use budgets much more flexibly than under current contracting arrangements.

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# 4 A new approach

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The new approach to commissioning and funding general practice that we now go on to describe builds on previous work by the authors and The King's Fund, including work undertaken with colleagues at the Nuffield Trust (Ham 2007; Ham 2008; Smith *et al* 2009; Curry and Ham 2010; Goodwin *et al* 2011; Smith *et al* 2013). Underpinning this approach is the recognition that GPs are both providers of care and commissioners, and that their role as providers is the more important of the two. From this perspective, the reforms put in place by the coalition government since 2010 have focused far too much on the involvement of GPs in commissioning through the establishment of CCGs, and far too little on how the role of GPs as providers can be strengthened. This paper seeks to put the role of GPs as providers at the forefront of debate about the future of general practice.

As we argued at the beginning of this paper, the ageing population, changing disease burden and rising public expectations, alongside the impact of risk factors like cigarette smoking, alcohol misuse, obesity and being overweight, create an urgent need to develop new models of service provision. These models should build on the importance of the registered list in general practice and give greater attention to population health and proactive care. Practices need to work in collaboration with each other and with a wide range of services in the community and elsewhere to meet the challenges of the future.

In our view, this requires a radical shift from the current model of general practice to the use of federations and networks of practices able to work at the scale needed to ensure effective integration of services. Federations and networks also offer the possibility of practices accessing the resources needed, be these staff, technology, premises or equipment. Practices need new skills too in areas such as risk stratification of the population, quality improvement and collaborative working with other providers. The approach we outline will also demand much higher levels of capability than practices have traditionally had in managing financial and clinical risks.

Before describing in more detail how this might work, it is important to emphasise that a new approach to contracting for general practice is a means of delivering improved outcomes for populations and patients – and is not an end in itself. Improving outcomes depends on using increasingly scarce resources for health and social care more effectively with greater priority given to prevention, early intervention, and support to enable people to live independently in their own homes for as long as appropriate. Our Time to Think Differently programme has set out in detail the case for change and has outlined the future shape of services required to meet changing population needs (Ham *et al* 2012).

This paper focuses on the means of making this happen. Without changes to commissioning and funding arrangements, the argument for new models of care will remain theoretical. Changes are needed in all areas of care in order to realise the policy ambition set out by the government for developing more integrated services closer to home that are better equipped to meet the needs of older people and those with complex needs. In the case of general practice, the priority should be to focus on the physiology rather than the anatomy of primary care to stimulate GP leaders, managers and others to innovate at scale and pace.

Designed in the right way, changes to commissioning and funding arrangements have the potential to create a permissive and enabling environment in which innovations in care can be implemented bottom up rather than top down. They may also enable the decline in the share of the NHS budget allocated to general practice to be reversed by allowing more flexibility in how resources are used and releasing resources for re-investment. Specifically, the approach we describe will break down barriers between different funding streams and allow providers to use savings in one area of care to be re-invested in other areas.

Such an approach would be optional rather than compulsory and would need to be tested and evaluated to establish whether the potential benefits outweigh the risks. Practices would still be able to work under the current contract including being able to provide enhanced services. However, practices able and willing to do more would have the opportunity to take on a budget with which they would form federations to deliver care and integrate with other services. The scope of budgets and services commissioned and provided in this way might vary depending on the readiness of federations to assume greater responsibilities, and is likely to increase in the light of experience. The result would be an NHS version of the 'variable geometry' under which different countries chose different degrees of integration and power sharing within the EU.

For the public and patients, there is the potential to put in place services that offer accessible and responsive care that extends well beyond what is currently available in general practices. These services might be thought of as a family care network with general practice at its core, working hand-in-hand with a range of other services that people need to access from time to time. GPs would help people navigate through these services and retain a key role in co-ordinating care in different settings. The evolution of family care networks through the changes to commissioning and funding outlined here could transform general practice and form the foundations on which a health and care system fit for the future could be built.

Changes to commissioning and funding are not without risk. As we emphasise, practices will need much greater capabilities than at present to take on a bigger role in providing services and to put in place the models of care that are needed. There is no certainty that these changes will succeed, nor indeed that the appetite for working under a new contract is sufficiently strong to motivate more than a minority of GP leaders to volunteer to take part. This is one of the reasons why we propose that NHS trusts should be encouraged to work with practices and support them to realise the potential of the approach we now describe. This approach would have the following features.

#### **A population-based capitated contract**

The contract would cover a defined population made up of patients on the registered lists of the practices involved. It would be funded on a capitation basis with the size of capitation payments determined by a combination of population need and the range of responsibilities included in it. Funding for primary medical care would be incorporated with funding for other services covered by the contract. A variety of risk-sharing arrangements are possible, ranging from the provider accepting full risk to the provider sharing risk with the commissioner.

Practices working in this way might comprise all those based in the same locality or alternatively they might be like-minded practices who choose to work with each other irrespective of geography. The major advantage of retaining a geographical focus is the opportunity it creates to develop population health interventions that are often impossible to implement in the current model of general practice. The advantage of creating federations on the basis of like-minded practices is the opportunity to develop organisations in which the members are motivated to work with each other to succeed. Experience of other countries like the United States and New Zealand points to the importance of voluntary participation in medical groups, meaning that serious consideration should be given to this option.

One of the benefits of federations based on like-minded practices is that it creates the potential for choice and competition between federations in the same areas. This might stimulate the emergence of innovative approaches in different federations as well as creating incentives beyond the outcomes contained in the contract for providers to be responsive to the needs of patients and efficient in the use of resources. The potential for competition between federations is clearly much greater in urban areas than in more rural and remote communities.

**The contract would focus on outcomes and not inputs**

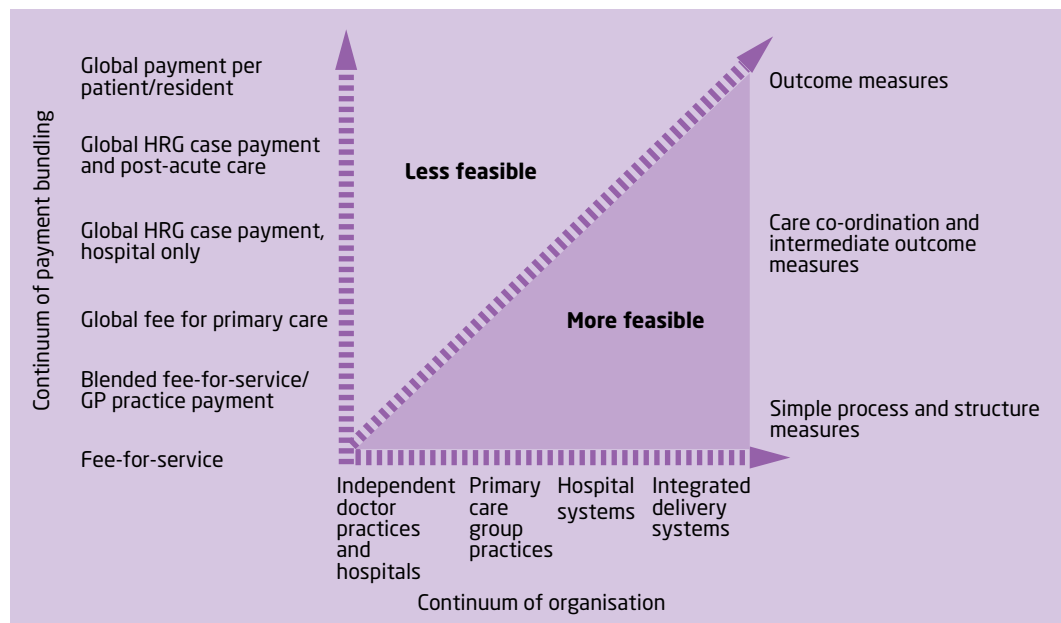
In place of the complexities of the current GP contract, this approach would focus on the principal outcomes that providers would be expected to deliver. These outcomes would encompass a number of dimensions including population health, patient experience, access to care, continuity of care, the quality of clinical care, service utilisation and financial performance. As in the case studies considered here, the contract could include incentive payments under which providers would be rewarded for delivering these outcomes and penalised for failing to do so.

In emphasising outcomes, our intent is to focus discussion on what providers are expected to deliver and to avoid a descent into argument about how services and budgets should be used. This is important in making the new contract an attractive option for practices as it would give them freedom to innovate and provide services in the way that best delivers the results that matter to those commissioning care from them. Decisions on whether to adopt models of primary care specifically designed to meet the needs of frail older people, such as ChenMed and CareMore in the United States, would be a matter for providers working under the contract rather than commissioners.

**Providers would need to demonstrate that they have the capabilities to manage the contract**

The experience of the United States in the 1980s and 1990s when medical groups took on capitated budgets at risk under contract with health insurers contains a number of lessons and warnings for the NHS. One of the most important is the need for providers to demonstrate that they have the capabilities to manage the contract and deliver the expected outcomes. The capabilities required increase as payment systems move from fee-for-service to global capitation, as illustrated in Figure 2 below.

**Figure 2 Organisation and payment methods**



Source: Adapted from Commonwealth Fund (2009)

The approach proposed here falls short of global capitation but still requires providers to be able to access expertise of various kinds: contract negotiation and management, financial management, utilisation management, and the management of clinical quality. Also important is well-developed clinical leadership and access to real-time information to enable leaders to keep within budget while also achieving the outcomes included in the contract. *The underlying point is that innovations in payment systems if used wisely have the potential to stimulate innovations in service provision and in how providers are organised.*

Failure to recognise this insight risks repeating what happened in the United States where many medical groups went bankrupt because they lacked the capabilities to take on the responsibilities they were offered. This was particularly but not exclusively a challenge for independent practice associations (IPAs), described by Casalino in his analysis as:

*...loosely structured organisations that lacked strong physician leadership; drastically under-invested in management and infrastructure; and failed to gain physicians' cooperation (physicians' loyalty was to their practice, not to the IPA network of practices). They lacked adequate data systems, experienced executives and financial reserves. They never developed the many capabilities needed to succeed in risk contracting. They were unable to: create adequate incentives for their physicians to cooperate with the IPA programmes; track and manage utilisation of physician, hospital and ancillary services; calculate accurately the actuarial risk for their population of capitated patients; pay claims (when they assumed that responsibility); negotiate contracts with other providers; or create effective care management programmes (for example the use of nurse case managers to coordinate care for patients with chronic illnesses).*  
(Casalino 2011, pp 15–16)

As we go on to discuss, if the approach advocated here is to avoid repeating these mistakes then federations of practices will have to acquire rapidly a range of capabilities they have not needed under the current model of general practice.

#### **Providers would need to create new organisations to manage the contract**

The case studies summarised in this paper illustrate the way in which practices are already establishing new organisations as they take on greater responsibility for budgets and services. In one of the case study sites this involved setting up a limited liability company in which practices had shares in order to borrow money and create more flexible employment arrangements. Other areas preferred to use social enterprises and community interest companies as these were seen to be better suited to a commitment to working in partnership and achieving high levels of engagement among practices.

Beyond our case studies, some areas are establishing super partnerships as GP leaders with the support of managers explore ways of working at the scale needed in future. Super partnerships may include specialists as well as GPs, and in some cases nurses and managers. If the new approach to commissioning and funding advocated here finds favour, it is likely that these and other organisational forms will become more common to enable practices to manage budgets and contracts effectively.

This will require greater formality than found in some of our case studies, particularly if federations take on budgets for a wide range of services. Informal collaboration may be sufficient to support innovations that make use of current freedoms and flexibilities, but the much more ambitious approach we have described will need to be based on firmer foundations. This is to ensure robust governance of funding and services linked to explicit accountability for performance both within family care networks and between networks and commissioners of care. The current business model found in most practices will therefore be superseded by these new arrangements.

**Providers would need to work at a scale sufficient to manage the contract without being so big that incentives for member practices were attenuated**

Clinical and financial risk management is related to the size of population served. Evidence indicates that population coverage in the range of 25,000 to 100,000 people is needed to enable federations and networks to function effectively (Ham 2010). The actual size will depend on the scope of the services covered by the contract and the extent of risk-sharing between providers and commissioners. The use of stop-loss insurance can also enable smaller provider networks to work under these arrangements.

In making these points, it is important to be sensitive to the danger that larger organisations may find it more difficult than smaller ones to engage member practices and create a sense of common ownership and purpose. If this were to happen, it would attenuate the incentives for practices to play their part in delivering the organisation's objectives and sharing in its success. Experience in the United States is that large groupings of doctors of the kind found in Kaiser Permanente, for example, have avoided this danger by developing a strong culture and incentive system that binds doctors together.

This has taken many years to develop and it would be unrealistic to expect emergent federations in the NHS to be able to do the same in short order. Our case studies offer encouragement in demonstrating what is possible within the current system of commissioning and funding general practice, particularly in showing the willingness of practices to collaborate to provide extended services and raise standards. The step change we have described will only succeed if other areas are willing to follow suit and build the relationships and systems on which family care networks will depend.

**Providers would be able to take 'make-or-buy' decisions**

The funding provided under the new contract would include a number of out-of-hospital services beyond those provided directly by practices such as community services, social care and out-of-hours primary medical care. This has the potential to stimulate the emergence of different provider organisations, ranging from those that choose to provide most services directly to those that establish networks of providers in which the federation is the prime provider subcontracting with other providers. Under the prime provider model, the federation may choose to work with other providers in a close-knit virtual network, or alternatively it may prefer to test the market on a regular basis through tendering for services not delivered directly by practices. A combination of these two approaches is also possible.

In working in this way, federations would be able to take 'make-or-buy' decisions, using their expertise first and foremost as providers to deliver services directly and to commission services from other providers where this was appropriate. This would entail a deliberate blurring of the commissioner/provider split to enable GPs to use their control over budgets to strengthen the provision of care, including care in their own practices. There is considerable potential to release resources currently used in acute hospitals by reducing A&E attendances and emergency admissions, cutting lengths of stay, and redesigning outpatient services. There is also evidence that services integrated across hospitals, the community and social care enable hospitals to be used more appropriately, particularly for older people (Imison *et al* 2012).

Planning guidance for the NHS issued in December 2013 underlines the urgency of addressing these issues with its requirement for a 15 per cent reduction in emergency activity to enable the NHS to adjust to the transfer of £2 billion to the Better Care Fund in 2015/16 (NHS England 2013c). Experience from the United States indicates that medical groups operating under capitated contracts were able to make savings by identifying people most at risk of hospital admission and by making use of case managers and related interventions. The most effective medical groups and IPAs reduced hospital days per 1,000 patients per year by as much as two-thirds (Ham 2010). Achieving reductions on this scale



may not be feasible in England but there is undoubtedly scope to cut spending on acute hospital care through proactive care supported by investment in community services.

### **Providers would need to develop sophisticated means for contracting and incentivising ‘within network’**

A major challenge to making these arrangements work is developing contracts and incentives ‘within network’ to deliver the outcomes required. Among other things, this encompasses how GPs are paid – by salary or other means – and how subcontractors are incentivised. The judgement here is how to calibrate the optimum balance between offering certainty to GPs to entice them to enter the network, and crafting incentives to motivate GPs to develop innovations in care that will deliver the changes in service provision that are sought.

Differentiation between GPs working as partners and GPs working on a salaried basis in the current system is likely to continue to increase in future. Some GPs may wish to take a lead role in developing new organisations to deliver services under the new contract as managing partners. Others may prefer to concentrate on their role as primary care providers either as partners sharing in the profits of the new organisations or being employed on a salary. Where GPs are salaried, incentives payments are likely to be needed to ensure delivery of high standards of care. The attitude to risk and work of GPs at different stages of their careers will shape how these arrangements evolve. The new contract also offers opportunities for innovations in the roles of nurses and other members of the primary care team, freeing up GPs to use their skills on patients with more complex needs.

Equally important is how to engage subcontractors and reward them for contributing to the delivery of contract outcomes. A variety of incentives and approaches to payment are likely to be needed, and will take time to evolve in larger and more complex federations. Providers taking on the new contract will need to be skilful as commissioners in order to put in place the requisite arrangements with subcontractors.

In part this is a technical challenge related to the design of ‘internal’ contracts and rewards, and in part it is a cultural challenge related to the role of leaders and the development of behaviours, relationships and trust between partners in the contract. Experience in other sectors where supply chains link prime providers and subcontractors may hold lessons for the NHS as these new means of contracting and incentivising are brought into operation. Alliance contracting and related approaches may also have a part to play.

### **The new contract could stimulate GPs to work more closely with specialists**

In making the case for integrated care to be given higher priority, we have consistently argued that the benefits of integration occur when clinical teams and services are well co-ordinated, not when organisations merge (Curry and Ham 2010). This includes primary care teams working more closely with hospital-based specialists and their teams, particularly in those services and specialties where there is scope for more care to be provided in the community in order to reduce pressures on hospitals. Innovations in care in a number of areas are exploring how specialists can work alongside primary care teams to make a reality of clinical integration, including in the care of children, older people and people needing to access the skills of diabetologists, rheumatologists, respiratory physicians and other ‘office-based’ specialists.

We have previously set out the arguments for integrated clinical partnerships and clinically integrated groups in which specialists and GPs work together in multi-specialty groups that could bridge the historic division in British medicine that inhibits the delivery of integrated care (Ham 2007; Ham 2008). The desirability of this happening is underlined by experience in the United States where groups of primary care physicians who took on budgets that put them at risk for hospital services needed to work in co-operation with specialists to be able to manage these budgets successfully (Ham 2010). Collaboration with specialists is particularly important in enabling federations to reduce

use of hospital services by having access to diagnostic and treatment expertise in the community, and to reach into hospitals when patients are admitted.

Multi-specialty medical practice holds out the prospect of substantial savings in the costs of hospital care because of the opportunity it creates to provide proactive care, rapid responses to crises and delivery of some services out of hospital. This includes use of risk stratification and case management to support the small proportion of people who account for a high proportion of service use and cost. Again this underlines the need for practices to work on a sufficient scale to enable closer integration with specialists to occur because it would not be efficient or feasible to seek to build multi-specialty medical practice for small populations (Ham 2008). Emerging evidence from one of our sites (town and country) indicates that proactive care for frail older people is saving considerably more in reduced use of hospitals than it is costing.

### **Integrated commissioning would be needed to implement the new contract**

Responsibility for commissioning NHS services has been seriously fragmented under the coalition government's reforms with the population-based budgets previously controlled by PCTs divided between NHS England, CCGs, local authorities and Public Health England. These organisations will need to work together to implement the new contract, which is likely to draw on resources from different sources.

NHS England, through area teams, has the lead responsibility for commissioning primary medical care. We have noted already the views of interviewees in the four case study sites about the challenges this has created and the lack of capabilities in these teams in some regions. A strong case can be made for area teams to work closely with CCGs in taking forward the new contract, in the process drawing on CCGs' understanding of the performance of practices in their areas and how they can be supported to develop integrated services. In many areas it will also be important to involve local authorities too in view of their responsibility for commissioning public health services and social care.

For all of these reasons, integrated commissioning would be needed to implement the new contract, reversing the fragmentation brought about by the Health and Social Care Act 2012. Over time, subject to uptake of the new contract among practices, area teams may take on the current commissioning responsibilities of CCGs, reinforcing the role of GPs primarily as providers rather than commissioners. This would have the advantage of streamlining a complex set of commissioning arrangements, thereby reducing transaction costs and focusing scarce commissioning expertise in fewer organisations. However, area teams would need to address concerns about their capabilities identified in our case studies in order to have the credibility to take on this role.

### **Conflicts of interest would need to be managed**

If family care networks are given freedom to use budgets flexibly and to increase spending on primary medical care where appropriate, there is the risk that GPs will be perceived to be gaining financially and inappropriately in the absence of proper governance and accountability. Accordingly, practices involved in bidding to provide services under the terms of the new contract would be excluded from the process of commissioning these services. Providers delivering services under the contract would be held to account for their use of funds both through established auditing procedures and by reporting annually and transparently on their performance under the contract.

The governance of provider organisations such as federations should include membership beyond that of the practices directly involved to provide further assurance that potential conflicts were being managed. This might entail senior independent non-executive directors from outside the NHS and experienced lay membership on provider boards. One option that should actively be encouraged is to involve people served by family care networks to play a prominent role in their governance to anticipate and avoid any possible concerns about provider dominance.

### **Market regulation would need to support rather than inhibit testing of the new contract**

The Health and Social Care Act 2012 has had the effect of strengthening considerably the role of market regulators with the Office of Fair Trading and the Competition Commission having powers under the Act to review proposed mergers and investigate if features of the health care market are suspected of preventing, restricting or distorting competition. This gives rise to a risk that these regulators and Monitor will inhibit new forms of commissioning and funding general practice if commissioners place contracts with established providers willing to work in this way without using competitive tendering to test the market. Our case studies and wider experience in the NHS highlight the costs and complexities involved in tendering and the risk that contracts will be awarded on the basis of cost rather than quality.

For these reasons, we would propose that commissioners engage with providers to put in place the new contract and to test and evaluate its impact ahead of widespread roll-out. Instead of this being done through a conventional competitive tendering route, commissioners would use their knowledge of the market to work with providers known to be interested in negotiating the scope of the contract, risk-sharing arrangements and other aspects. As we go on to discuss, various organisations might become prime providers of care, and there would be a deliberate emphasis on discovering which approaches worked best rather than seeking to design how the new contract will work at the outset. Monitor could play a constructive role in ensuring that regulation of the new contract was proportionate.

Similar arguments apply to the more limited question of how CCGs decide to commission care under the new version of LES known as community-based services. In some areas CCGs are going out to tender for these services using the ‘any qualified provider’ route, raising concerns that practices will be at a disadvantage in bidding for these contracts compared with private companies with experience of going through tendering exercises. If these concerns are well founded, it may make it difficult for practices to lead the development of primary care-centred integrated services. NHS England and Monitor have a role in providing guidance on procurement to avoid this risk while ensuring compliance with competition rules.

### **Related issues**

If the new approach we have outlined is to be developed, then a number of related issues will need to be considered. These include:

#### **The role of NHS providers**

We have argued throughout this paper that the registered list means that practices are uniquely well positioned to take the lead in developing innovative models of care under the new contract. The question that arises is whether the contract might also be available to other providers such as NHS trusts providing community services and acute services. Another option would be to invite third sector and private sector providers to enter the market to compete with established practices and other providers.

Our bias is to start testing the new contract with federations or networks of practices in those areas where GP leaders and others are enthusiastic about the opportunities it offers. The risk in such an approach is that it might accentuate variations in care by enabling practices already performing well to improve further while doing little for practices whose performance is not as good. These practices are often to be found in areas of greatest need consistent with the inverse care law adumbrated by Julian Tudor Hart in the 1970s (Hart 1971).

A case can therefore be made for other NHS providers such as trusts providing community services and acute services to be given the opportunity to test out the new contract in those areas of the country where standards of primary care need to be improved and where leadership and enthusiasm from within the GP community may be lacking. To avoid the risk of NHS providers 'asset-stripping' practices and diverting resources into their own services, one of the conditions of participation would be to require them to deliver the contract in partnership with practices. This would have the added advantage of practices bringing their registered lists into the partnership.

The benefit of testing this option is that it could help to accelerate improvements in primary care provision and the emergence of integrated models of care in areas where the need for this to happen is greatest. It might also galvanise the GP community to take action itself in the knowledge that other providers could enter the market if practices themselves decide not to take up the option of the new contract. At a time when the need for innovation in the NHS has never been greater, encouraging a variety of approaches to be tested and evaluated has obvious merit, not least in unfreezing ways of working which increasingly appear anachronistic.

### **Leadership and organisational capabilities**

Implicit in the direction we have indicated is a critical need to build leadership and organisational capabilities to support change. The shift from cottage industry general practice to post-industrial care (Swensen *et al* 2010) depends on supporting GPs, managers and others currently working in the NHS to imagine a different future and to work together to make this a reality. This will need active support from professional bodies like the Royal College of General Practitioners (RCGP) as well as from NHS England.

It will also require exceptional skill and commitment on the part of leaders to manage the transition to the new approaches to commissioning and funding we have described. A significant investment in leadership and organisational development in primary care will therefore be needed to develop appropriate capabilities. Federations will additionally need to forge partnerships with organisations that have the skills not usually found in practices to be able to manage contracts and budgets successfully.

Critically, at a time of major and growing pressures on frontline primary care teams, this approach would require finding the resources to enable the members of these teams as well as leaders in the GP and management communities to take time from their current responsibilities to plan a way forward. Optimism can be seen in the examples described in this report where this is already happening and fragments of a different future are becoming visible. The challenge is to move beyond the fragments to make a reality of new models of care and the commissioning and funding changes needed to bring them into being. The new contract may represent a leap of faith for the NHS but there is much relevant experience in countries like New Zealand (Thorlby *et al* 2012) and the United States on which to draw, including the Alternative Quality Contract in Massachusetts (Ham and Zollinger-Read 2011) (*see* Box opposite).

## The Alternative Quality Contract (AQC)

Blue Cross Blue Shield of Massachusetts introduced the AQC in 2009. It allocates a capitated budget to medical groups to cover the costs of care and an allowance for administrative expenses. The budget is based on historic spending on health care by groups and includes performance incentives based on 64 measures of quality, safety and outcomes, divided equally between primary and secondary care. Early results showed improvements in quality coupled with a slowdown in cost increases. In some cases the contract is held by a medical group and in others it is held by a medical group and one or more hospitals. A key lesson is the importance of primary care physicians being at the centre of the organisations that take on the contract.

The major unanswered question is whether sufficient GPs will have the courage and the will to embrace the opportunities offered by the new contract. To ask practices to work in collaboration and to share financial and clinical risks is a major step whatever the concerns of GPs about existing contractual options and funding pressures. If GPs lack affinity with colleagues in other practices with whom they are expected to collaborate, this may make it impossible to gain sufficient commitment to sharing financial and clinical risks in federations. This is another reason why careful thought needs to be given to whether federations are formed on the basis of geography or through like-minded practices choosing to work together.

### **A long-term commitment**

This relates directly to the final point we wish to emphasise, namely the need to allow sufficient time for the new contract to be implemented and evaluated. The recent history of NHS reform is littered with examples of innovations that have been lauded on their introduction only to be superseded before they have been given time to bed in – or even worse to be declared a failure when in reality it was too soon to tell. Changes of the magnitude we have outlined will not work smoothly from the outset and it will most likely require several years before a proper assessment of costs and benefits can be made.

Policy-makers should therefore start from the position that at least five years will be needed to implement, modify and adapt the new contract and should avoid rushing to premature judgements. This means being willing to accept, in Harford's words, that success always starts with failure, and that taking calculated risks is not only unavoidable but also positively desirable in the pursuit of worthwhile innovations (Harford 2011). The approach described here is most likely to deliver benefits through early testing with federations able and willing to assume greater responsibility for budgets and services with the scope of responsibility increasing over time and extending to other areas as more practices see the benefits of this way of working.

### **Where next?**

The ideas set out here offer a framework for debating how a new approach to commissioning and funding general practice could lead to the emergence of the models of care that are required to meet the needs of an ageing population and changing disease burden. The challenge is to use commissioning and funding levers to accelerate innovations in care and to put in place the primary care-centred integrated services that are needed in future. This is most likely to be achieved by creating a permissive environment that breaks down barriers between different funding streams and enables medical leaders and managers to implement care closer to home.

Family care networks have the potential to be at the forefront of innovations in care. This will only happen if the pivotal role of GPs as providers is properly recognised and if practices are supported to work together and with other providers to put in place the services that will better meet changing population needs. Population-based capitated contracts tied to the delivery of outcomes could see the emergence of a variety of integrated care organisations that both provide and commission these services on the requisite scale.

This holds out the prospect of the current model of general practice being superseded by new forms of delivery that build on the real strengths of general practice, providing it with the resources needed to respond effectively to rising demands. The alternative is to persist in the belief that current ways of commissioning and funding general practice are sufficient and will enable the innovations in organisation and service delivery reported here to be developed and extended in other areas. A period of experimentation is in reality the only way of testing these alternatives.

We have outlined the principal components of a new approach without seeking to specify in detail a route map from the current position to an alternative future. This is deliberate, because outlining a blueprint is more likely to stifle than encourage the innovations now needed. There may well be other and better ideas than the ones set out here on how to support the NHS to make a reality of new models of care, and we hope this report will stimulate a wider debate on these issues. If, as we have argued, current contracts and flexibilities have important limitations, then now is the time for all options to be put on the table.

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