AN INQUIRY INTO

PATIENT CENTRED CARE IN THE 21ST CENTURY

Implications for general practice and primary care

Report of an independent inquiry commissioned by the Royal College of General Practitioners
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In a world of limited resources and rising demand for healthcare, the effectiveness of primary care – and the role that patients play in interacting with it – is hugely important. In the UK we have one of the world’s greatest primary care systems, based on the solid foundation of comprehensive list-based general practice. Our primary care service lies at the very heart of our health system and, arguably, is why the NHS has historically dominated international league tables comparing the effectiveness, efficiency and fairness of different healthcare systems.

Yet, there is broad consensus that our health system must change in order to meet the needs of a population that is ageing, experiencing more chronic disease and expecting more from its healthcare. At the same time, we need to find ways of working that are sustainable, as unprecedented budget and workforce pressures make it impossible simply to deliver more of the same.

These imperatives are not unique to the UK. Many countries are now seeking to develop innovative approaches to health and care with the triple aim of better health, higher quality care and financial sustainability. In doing so, a number of new approaches have emerged. Some of these are structural, such as the interest in developing loosely termed ‘population health management organisations’ – examples include Accountable Care Organisations in the USA or the Alzira system in Spain. Some are cultural, such as the desire to change the relationship that citizens have with their own health and their consequent use of health and care services. Others are commercial, as major technology companies – Apple, Google and Samsung to name but a few – provide direct to consumer information and diagnostic capability that is inextricably changing the relationship between the patient and the professional.

At the heart of the success of all of these approaches lies the concept of ‘patient centred care’. This describes a new type of health system where empowered citizens are able to identify and manage health risk factors, receive individualised and holistic care, and are demonstrably equal partners in managing their health.

Critically, however, patient centred care also means that the varying needs, capabilities and preferences of individual patients and their carers must be met on an individual basis. For example, some want more involvement in their care, some are happy with a strong professional lead; some are very capable of drawing on new technologies, some less. For the NHS this means it will need to personalise its offer according to individual circumstances and recognise the importance of delivering outcomes that are defined by each of us and reflect what matters specifically to us.

This report is the product of several months of evidence gathering and lively discussion by the independent inquiry into patient centred care in the 21st century. We have sought to define patient centred care, identify why it is so important, and consider its implications for patients, carers, and health and care professionals. We conclude that the NHS has a huge opportunity to tackle the rise in multimorbidity and develop a more effective approach to population health management. This would be built on the foundations of our current system of a registered list and deliver patient centred care routinely to all.

However, we also conclude that in order to achieve this, our model of general practice must change, including at its most profound level – the relationship between the professional and the patient. We believe that if this is to be delivered at pace and scale, general practice must be incentivised and supported to make it happen. It is heartening, therefore, that this inquiry was commissioned and hosted by the Royal College of General Practitioners, which has recognised a need and a desire for change.

There is no magic bullet. Instead, we take inspiration from the British Olympic cycling team, whose brilliant success was underpinned by the concept of the aggregation of marginal gains. We set out a number of manageable changes that, when combined, would help to ensure that a truly patient centred approach is at the heart of our health and care system.

We recognise that many of these ideas are not new. We understand, however, that the journey from rhetoric to reality is often fraught with difficulty, so our emphasis is on steps to practical progress. Finally, we believe that these ideas are entirely consistent with the vision set out in the NHS England Five Year Forward View and, if implemented at pace and scale, would provide the practical means by which its ambitions could be achieved in primary care and general practice.

Mike Farrar
Chair, Independent Inquiry into Patient Centred Care in the 21st Century
The inquiry into patient centred care in the 21st century was commissioned by the RCGP to identify cost effective solutions to the medical, social and financial challenges posed by rising levels of multimorbidity in England. Our terms of reference asked us to focus specifically on general practice, in the context of the broader range of primary, community and social care services.

This report draws on over 80 written evidence submissions and discussions with more than 50 individuals from a broad range of health, care and patient organisations. It sets out to define what a ‘patient centred’ approach to care means and identify why it is important – to all patients, but particularly to those with multimorbidity. Finally, it considers what changes are needed to deliver patient centred care in the community – and how general practice must evolve to help make this happen.

Executive summary

What is patient centred care?

Individual preferences, capabilities, support networks and expectations of care vary enormously. However, we have identified three core, interrelated elements of patient centred care:

1. A holistic – or ‘whole person’ – approach to patient care, that considers an individual’s needs as a whole rather than treating medical problems in isolation. This approach recognises that an increasing proportion of healthcare users have several long term health problems – often including both physical and mental health conditions.

2. Flexible care that tailors support according to an individual’s personal priorities, needs and individually defined outcomes. This means going beyond a narrow focus on treatment of medical problems, to an understanding of people’s lives, their environment, their personal values and their goals.

3. The need for a collaborative relationship between patients and the professionals involved in caring for them, through which patients are empowered to be equal partners in their own care.

Put simply, care that is ‘patient centred’ means care that is holistic, empowering and that tailors support according to the individual’s priorities and needs. What this represents for patients is usefully expressed by the National Voices narrative for person centred coordinated care.

“I can plan my care with people who work together to understand me and my care(s), allow me control, and bring together services to achieve the outcomes important to me.”

(National Voices 2013)

Key findings

• The UK’s health system is facing some fundamental challenges. People with long term conditions – rather than diseases that can be cured – are now the main users of healthcare in England and the number of people with multiple long term conditions is predicted to grow considerably. More people wish to be informed about and involved in managing their health, and innovations in technology and treatments offer opportunities to change the way in which care is delivered. At the same time, the NHS is under increasing financial pressure. As NHS England’s Five Year Forward View makes clear, to sustain a comprehensive high quality NHS, new models of care are needed to manage demand and improve efficiency.

• The NHS performs well when compared to other similar health systems on measures of continuity, communication and patient engagement – an achievement that should be celebrated. But evidence suggests that the health service is failing to deliver patient centred care consistently – both in the context of general practice and the wider health and care system. All too often, care is poorly coordinated, hindered by artificial barriers between services, and structured around the treatment of single diseases – rather than the needs of the individual. As a result, some patients are pushed into interventions that they do not want, while they are denied other forms of support that they need.

• There is broad consensus that our health and care system must change in order to better meet our population’s needs and preferences. Care that is holistic, empowering and that recognises the individual’s priorities and needs is important to all patients, but it is particularly vital to those with long term conditions and other complex needs. Our review of the evidence suggests that re-orientating the health and care system around a patient centred approach has the potential not only to improve health outcomes and quality of life for patients, but also to reduce avoidable demand for health and care services – and thereby help place the NHS on a sustainable financial footing.

• In order to achieve such a shift, it will be vital to encourage and enable health professionals to provide holistic and personalised care, and to support patients to play an active role in managing their own health. This requires professionals to work with patients in a very different way, demanding new skills, knowledge, and ways of thinking about the dynamics of power between professionals and patients. It also requires that clinical guidelines, regulatory requirements and payment mechanisms recognise the importance of patient empowerment and personalised care – so that the system rewards practices that ensure patients’ needs and preferences underpin decisions about their care.

• In parallel to a shift in attitudes and behaviours (by both patients and professionals), new models of care are needed that can deliver coordinated community-based services and proactive population health management. For this to happen, a range of health and care professionals – including GPs, nurses, allied health professionals, medical specialists, mental health professionals, pharmacists and social workers – will need to work together collaboratively, breaking down the old barriers between primary and secondary, health and social care.

• General practice, with its registered list of patients and generalist approach to care, is a key strength of the current system and has significant potential to play a more active role in both improving population health and providing personalised, ongoing care to people with long term conditions. As a result, we believe that general practice should be at the core of new models of service provision in the community, working alongside a range of other services.

1 National Voices is a national coalition of health and care charities in England.
Making patient centred care happen

We believe that the development of patient centred services in the community, based around general practice, can be achieved through the aggregation of a number of manageable changes:

1. Empowering patients, carers and communities – including through:
   - improving health literacy
   - support for self management
   - personalised care planning
   - patient access to health records
   - embracing new means of accessing care and technologies
   - more transparent data on general practice and primary care
   - strengthening the patient voice in primary care.

2. Supporting patient centred professional practice – including through:
   - ensuring that training and education is aligned to the delivery of patient centred care
   - re-orientating and diversifying the nature of the consultation process

3. Enabling service providers to change – including through:
   - encouraging collaboration between practices
   - horizontal integration across health and social care
   - vertical integration between primary, community and secondary care
   - improving out of hours care
   - closer collaboration with the third and commercial sectors.

4. Improving commissioning – including through:
   - co-commissioning and reintegration of fragmented budgets
   - patient held budgets
   - reform of primary care and general practice contracts, with an emphasis on population health management and rewarding improved outcomes.

5. Creating the right operational and policy infrastructure – including through:
   - training more people from primary care backgrounds to take up leadership roles; not just GPs, but also professionals from other groups such as community nursing and the allied health professions, as well as patient representatives
   - developing clinical guidelines that reinforce patient centred care and enable professionals to deliver personalised care, including to people with multiple long term conditions
   - ensuring regulatory bodies look for evidence of the effective delivery of patient centred care, including auditing the quality of advice and clinical decision making processes, and the existence of mechanisms for soliciting and acting upon patient feedback
   - increasing the proportion of growth money spent on collaborative models of community-based care at a faster rate annually than spending on hospital-based care until a more equitable balance has been reached
   - recruiting more medical students into general practice and increasing the supply of the wider primary care and community clinical workforce, including community and primary care nursing staff
   - prioritising the development of information systems and digital technology to enable the sharing of information across organisational and professional boundaries, and to support patients to access services and engage in self care.
Introduction

In June 2014 the Royal College of General Practitioners commissioned an independent panel to lead an inquiry into patient-centred care in the 21st century, with the aim of identifying cost-effective solutions to the medical, social and financial challenges posed by rising levels of multimorbidity. The panel was asked to focus specifically on general practice in England, in the context of the broader range of primary, community and social care services. In particular, it was asked to consider:

- how models of NHS care need to change to deliver better outcomes, as cost-effectively as possible, for the growing number of people living with multiple long-term conditions
- what this means for the way in which NHS resources are deployed in a financially constrained environment
- how the role of general practice can best be developed in order to support the new models of care required and what policy levers and financial mechanisms should be put in place to deliver these at the scale and pace needed.

This report draws together the results of the inquiry’s discussions and evidence gathering process. Chapter 1 defines what a ‘patient-centred’ approach to care means and outlines the scope of the inquiry. We then go on to consider why our health system needs to change and why a patient-centred approach is important – to all patients, but particularly to those with multimorbidity (Chapter 2). In Chapter 3, we describe barriers to change within the current health system, as well as a number of as yet unrealised opportunities. We then consider what changes are needed to deliver patient-centred care in the community – and how general practice must evolve to help make this happen (Chapter 4). Finally, in Chapter 5, we set out what we think the core components of patient-centred primary care should look like.

About the inquiry

The inquiry ran for five months (June to October 2014). During this time the panel gathered and evaluated evidence from a broad range of individuals and organisations from across health and care, including patient representatives and general practice professionals.

The panel’s deliberations were focused around three seminars:

- patient-centred care – the patient view
- designing care around those with multiple long-term conditions
- realigning NHS resources to meet the needs of patients with multiple long-term conditions.

More than 50 expert witnesses gave oral evidence, both at these seminars and separate evidence sessions. In addition, over 80 written responses were submitted to the inquiry’s online call for evidence between June and July 2014.

The panel was asked to focus on the NHS in England, although many of its findings will be relevant to the devolved nations of the UK.

The inquiry was supported by staff from the RCGP, but its conclusions and recommendations remain independent.

Chapter 1: What is patient-centred care?

Few would disagree that patient-centred care is a good thing. It is harder, however, to define what it means in practice. From the start, it was a priority for the inquiry to ensure that its definition reflected what patients themselves understand to be patient-centred care. We therefore took considerable amounts of evidence from patient organisations and representatives.

Experiences and expectations of patient-centred care vary according to context. However, we have identified three core, interrelated elements of patient-centred care:

1. A holistic – or ‘whole person’ – approach to care that considers an individual’s needs as a whole rather than treating medical problems in isolation. This approach recognises that an increasing proportion of healthcare users have several long-term health problems – often including both physical and mental health conditions. It appreciates that these conditions, and the medical interventions to treat them, may interact in complex ways and provides a coordinated, long-term response to health, care and support needs that transcends professional and organisational boundaries.

2. Flexible care that tailors support according to an individual’s personal priorities, needs and individually defined outcomes. This means going beyond a narrow focus on treatment of medical problems, to an understanding of people’s lives, their environment, their personal values and their goals.

3. The need for a collaborative relationship between patients and the professionals involved in caring for them, through which patients are empowered to be equal partners in their own care. For this to happen, patients require reliable information about the risks and benefits of their lifestyles, and when appropriate, the treatment options open to them. We believe that citizens and patients should be better supported to make decisions about their care (often in the face of competing priorities), to engage in their own self-care, and to make behavioural changes that benefit their health.

![A whole person, rather than disease specific, approach](image)

Put simply, care that is ‘patient-centred’ means care that is holistic, empowering and that tailors support according to the individual’s priorities and needs. What this represents for patients is usefully expressed by the National Voices narrative for person centred coordinated care:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

(National Voices 2013)

![A whole person, rather than disease specific, approach](image)
Scope of the inquiry

Our terms of reference (Appendix 1) asked us to look at the role of general practice – within the broader context of primary, community and social care services – in delivering new models of care in England. We have therefore focused our inquiry on the challenges and opportunities of securing the delivery of patient centred care in general practice.

Nevertheless, it is clear to us that effective patient centred care should not be restricted by organisational barriers. Many respondents have told us that the way in which people access care is changing. General practice is now only one of a variety of access points to primary and community care. We have therefore sought to describe how the skills and expertise of general practice can best meet the needs of healthcare users in the context of widening access to health, care and support services.

Patient centred or person centred?

The terms of reference of the inquiry asked us to reflect on ‘patient centred’ care in the 21st century. We considered in some detail whether the term ‘person centred’ would provide a more appropriate description of the individualised, whole person approach to care that our inquiry describes in this report. We acknowledged that the term ‘patient’ may, in some contexts, suggest a traditional, asymmetrical doctor-patient relationship, where the doctor holds all of the knowledge and tells the patient what is best for him or her. This relationship is, needless to say, at odds with our vision of patient centred care.

However, we recognised that the term ‘patient’ is still commonly used across the health service, and is easily understood by both professionals and the public. We also felt that it was necessary to challenge any negative associations that the word patient may suggest in today’s NHS. We therefore decided to maintain the term ‘patient centred’ for the purposes of our inquiry. We would, nevertheless, like to make it clear that we see considerable merits in the term ‘person centred’ and would endorse its use to describe the vision of individualised, whole person care that we describe in this report.

The UK’s health system is facing some fundamental challenges. Our population is expanding, ageing and experiencing more chronic disease. More people wish to be informed about and involved in managing their health, and innovations in technology and treatments offer opportunities to change the way in which care is delivered. At the same time, the NHS is under increasing financial pressure. NHS England’s Five Year Forward View makes it clear that, to sustain a comprehensive high quality NHS, new models of care are needed to manage demand and improve efficiency (NHS England 2014).

In considering how best to develop our health system to meet these challenges – and thereby better serve our population’s needs and preferences – a patient centred approach to care has never been more important.

Changing needs and expectations

As a society, our health needs and expectations are changing. More than 15 million people in England – or just under a third of the population – have at least one long term condition, such as hypertension, diabetes, coronary heart disease, depression, or other medical condition that cannot be cured (Department of Health 2012a). These individuals are now our main users of healthcare, accounting for around 50 per cent of all GP appointments, 70 per cent of all inpatient bed days, and 70 per cent of the total spent on health and care (Department of Health 2012a). Many of these conditions are preventable or could be delayed, but are brought on or exacerbated by risk factors such as excessive drinking, being overweight, smoking and stress.

Increasingly, people live with multiple health conditions – often a combination of physical and mental problems. Recent analysis of patient data from Scotland found that most people with a common long term condition had at least two, and frequently more, other disorders (Barnett et al 2012; see also Figure 1). It also found that, although most people aged over 65 had multimorbidity, the onset of multimorbidity occurred 10 to 15 years earlier among those living in the most deprived areas and, in absolute terms, more people under 65 had multimorbidity than older age groups.

FIGURE 1 Number of conditions experienced by patients with common, important diseases (Source: Barnett et al 2012). Reprinted with permission from Elsevier.
Around 30 per cent of people with a long term physical condition also have a mental health problem (Naylor et al 2012), emphasising the need to address an individual’s mental and physical health needs at the same time. This relationship appears to be two-way: people with long term physical conditions are more likely than the rest of the population to develop mental health problems, while those with mental health problems are more likely to develop physical conditions (Naylor et al 2012). There is also a strong correlation between socioeconomic status, long term physical conditions and mental health disorders, meaning that people from deprived areas are more likely to live with both a physical and a mental health disorder (Barnett et al 2012).

In parallel with changes in patients’ needs, people’s expectations of healthcare are also evolving. More people wish to be informed and involved in decisions about their health, and increasingly they expect to use technology to interact with services.

Patients told the inquiry that they want greater freedom to make informed decisions on what treatment options are right for them, based on their own individual circumstances and priorities. This message is reiterated in previous research. Patients say that they want to work with clinicians who listen, explain clearly, are open to discussion, and involve them in decision making (Ridd et al 2009). Most surveys suggest that, while not everyone wants an active role, a majority do (Flynn et al 2006). People also say that they want better coordination of care, so that services and professionals work together to meet their needs as a whole (National Voices 2012).

Meanwhile, the internet and related digital technologies, such as smart phones, are becoming increasingly essential to many people’s day to day lives – and offer significant potential to change the way in which people interact with health services. At least 38 million adults in Great Britain – or 76 per cent of the population – now access the internet every day (21 million more than in 2006, when directly comparable records began) (Office for National Statistics 2014). The market for direct-to-consumer health and fitness technologies is also growing rapidly, as leading technology companies produce apps and ‘wearables’ (such as blood pressure, heart rate and motion trackers) to analyse health data. In the US, around one in five people say that they own a wearable technology, and 75 per cent of consumers say that they would like to use wearables to collect and track medical information (PricewaterhouseCoopers 2014). Yet the NHS has been slow to realise the potential of new digital technologies to improve patient care. Only four per cent of patients, for example, report booking their GP appointments online, the use of health apps to enable self care is far from widespread, online access to patient health records remains the exception, and we are yet to achieve fully interoperable electronic health records across the NHS.

System change is needed

There is broad consensus that our health and care system must change in order to better meet our population’s needs and preferences and deliver outcomes that matter to service users. Few would disagree that care should be integrated around the patient, delivered in the community (rather than hospital) where appropriate, and should empower individuals to live healthier and more independent lives. Patient centred care is central to the successful delivery of this vision.

The call for a more patient centred approach is not new and has been taken up by numerous patient organisations, health leaders, advisory and advocacy groups. NHS England’s Five Year Forward View, for example, argues for a more engaged relationship with patients, carers and citizens in order to promote wellbeing and prevent ill-health (NHS England 2014). This echoes the government’s Mandate to NHS England, which requires it to ‘ensure the NHS becomes dramatically better at involving patients and their carers, and empowering them to manage and make decisions about their own care and treatment’ (Department of Health 2013). Earlier this year, the Commission on Whole Person Care, chaired by Sir John Oldham, put forward a compelling case for a shift towards coordinated, person centred care, which it argues cannot be achieved within the existing fragmented system (Independent Commission on Whole Person Care 2014). National Voices, a coalition of health and social care charities in England, has subsequently called on the government to set an urgent ambition to achieve genuinely person centred care by 2020 (National Voices 2014).

A 2014 survey by the Commonwealth Fund, a US research foundation, suggests that the NHS performs well when compared to other similar health systems on the delivery of person centred care, which it evaluated using 11 measures of continuity, communication and patient engagement (Davis et al 2014; see also Appendix 2). The UK’s strong comparative performance, although based on a narrow set of indicators, should be celebrated as testament to the strengths of the NHS as a system and the commitment of its staff. However, it must also be tempered by the Commonwealth Fund’s conclusion that all countries could improve substantially in the delivery of patient centred care.

This is consistent with the picture that emerged from the inquiry’s evidence gathering process. While we heard that there are many good examples of patient centred approaches, evidence suggests that the NHS is failing to deliver patient centred care consistently – both in the context of general practice and the wider health and care system.

All too often for patients with complex ongoing needs, such as the frail elderly and those with long term conditions, care is poorly coordinated, hindered by artificial barriers between services, and structured around the treatment of single diseases and acute problems – rather than the ongoing needs of the individual. As a result, people with multiple long term conditions experience less continuity of care (Salisbury et al 2011), are at greater risk of unplanned admission to hospital – including admissions that are potentially preventable (Payne et al 2013), and tend to have poorer quality of life and worse health outcomes than the rest of the population (cited by Barnett et al 2012). Wasteful duplication of care is also common for people with multimorbidity – characterised by multiple appointments and tests, poor continuity, and polypharmacy (the use of multiple medications).
Evidence also suggests that, despite increasing demand for health information, the NHS is yet to harness the potential of patient empowerment to improve health. Between 25 and 40 per cent of the population have a low level of health ‘activation’ – meaning that they lack the knowledge, skills and confidence to play an active role in managing their health (Hibbard and Cunningham 2008). As a result, they are more likely to attend accident and emergency departments, to be hospitalised or to be re-admitted to hospital after being discharged (Hibbard and Gilburt 2014). A survey by Self Management UK suggested that as many as 48 per cent of patients with long term conditions wait longer than five years between being diagnosed and being offered a place on a self management course (Self Management UK 2013). Meanwhile, only three per cent of general practice patients say that they have a written care plan and, of these, over a quarter (27 per cent) say that their plan is not reviewed regularly (Ipsos MORI 2014).

The evidence base for patient centred care

Care that is holistic, empowering and that recognises the individual’s priorities and needs is important to all patients, but it is particularly vital to those with long term conditions and other complex needs. Our review of the evidence suggests that re-orientating the health and care system around a patient centred approach has the potential not only to improve health outcomes and quality of life for patients, but also to reduce avoidable demand for health and care services – and thereby help place the NHS on a sustainable financial footing.

Robust evidence underscores the importance of effective patient engagement and empowerment. The World Health Organization’s ‘road map’ for improving healthcare to meet the needs of chronic conditions stresses the need to focus on the role of the patient, support self management, and enable behaviour that prevents or delays the onset of chronic conditions (World Health Organization 2002). We know that people with high levels of health activation (that is, who have the knowledge, skills, and confidence to manage their health) are more likely to adopt healthy behaviour, to have better clinical outcomes and lower rates of hospitalisation (and therefore lower overall healthcare costs), and to report higher levels of satisfaction with services (Hibbard and Gilburt 2014). Moreover, evidence suggests that people’s activation levels can be increased through targeted interventions to build their skills and confidence – often resulting in associated improvements in health (Hibbard and Gilburt 2014). Similarly, including patients in decision making and treatment planning makes the delivery of care for chronic conditions more effective and more efficient (Holman and Lorig 2000).

The value of proactive care and disease prevention is underlined by the fact that most chronic conditions are preventable or can be delayed – as can most complications of conditions that have already developed (see, for example, World Health Organization 2002). The necessity of engaging people to take ownership of their health, and thus prevent avoidable diseases, was emphasised in 2002 by Derek Wanless’ review of long term trends affecting the NHS (Wanless 2002), and is at the heart of NHS England’s Five Year Forward View (which acknowledges that Derek Wanless’ advice has not been heeded) (NHS England 2014). Previous research has underlined the untapped potential of general practice, with its registered list of patients, to engage in a more proactive approach to improving the health and wellbeing of the local population (see, for example, Thorby 2013).

The importance of providing care that considers the context in which people live – including factors such as work, loneliness, and housing – is backed by evidence of the role of non medical factors in determining people’s health and well-being. A 2002 study, for example, suggested that only 15 per cent of the impact on population health outcomes is attributable to healthcare, compared to 40 per cent for health behaviour patterns and 45 per cent for social circumstances and environmental exposure (McGinnis et al 2002).

In summary, we believe that there is an emerging consensus that a new, more patient centred approach to care is required to meet our population’s changing needs and preferences, and to prevent ill health. Patients repeatedly say that they want well coordinated, personalised and holistic care that offers continuity over time. They also want to be involved in decisions about their care. This approach makes sense — for patients, for professionals, and for the health and care system as a whole.
Chapter 3: Delivering patient centred care – barriers and opportunities within the current system

The need to move towards a patient centred approach to care is widely recognised and underpinned by solid evidence (see also Chapter 2. The case for change). However, a number of systemic barriers mitigate against the effective and consistent delivery of patient centred care in today’s NHS. Our current health and care system remains too focused on acute care rather than chronic conditions, treatment rather than prevention, hospital rather than community-based care, organisations rather than patients. In this chapter we explore barriers to change within the current system, as well as a number of as yet unrealised opportunities.

Underinvestment in primary and community care

The health service is facing an unprecedented mismatch between resources and patient needs. Recent projections by NHS England, Monitor and the Nuffield Trust suggest that, if spending remains broadly flat in real terms, trends in demand continue and no further productivity gains are made, the NHS in England will face a funding gap of around £30 billion a year by 2023 (NHS England 2014; Monitor 2013; Roberts et al 2012). Even if funding increases in line with economic growth (GDP), the annual funding gap would remain at around £12 to £14 billion a year (Roberts et al 2012). This means that curbing rising demand and improving productivity will be key to sustaining a high quality NHS.

Long term conditions are a major driver of health service utilisation. Improvements in the way in which they are managed – both through increased prevention and the timely delivery of appropriate care in the right settings – will therefore be key to meeting the financial challenge the NHS faces. For example, over 78 per cent (£7.7 billion) of the amount spent in England on diabetes in 2010/11 was on treating complications, of which £5.5 billion was in secondary care (Hex et al 2012). According to the Nuffield Trust, if acute sector activity for chronic conditions is managed so that the probability of receiving inpatient care for these conditions remains at 2009/10 levels, this would lead to a £6 billion reduction in the level of the funding gap in England by 2021/22 (Roberts et al 2012).

However, while there is widespread recognition of the need to shift care out of hospital and into new models of community provision, efforts to make this happen have been impeded by an enduring lack of investment in primary and community services. Even though healthcare spending rose by 22 per cent between 2006 and 2012, most of this growth was absorbed by hospital services. Indeed, over the same period the proportion of the total healthcare budget directed to primary care services shrank from 27 per cent in 2006/07 to 23 per cent in 2012/13 (Dayan et al 2014). Given the imperative to provide more proactive and joined-up out-of-hospital care, with primary care and specialists working together to deliver more care in community settings, these trends are going in the wrong direction (see also ‘Pressures on general practice’ below).

Organisational barriers

In order to deliver patient centred care effectively – and thereby better serve the needs of people with ongoing complex needs – services will need to be integrated around the people using them. Currently, patient centred care is often hindered by the traditional division of services between different sectors and organisations, each with its own systems, performance measures, funding approaches, commissioners and cultures. Where boundaries between organisations exist, opportunities abound for patients to fall through the gaps. Frequently patients and carers have to coordinate between services themselves, often due to a failure of communication between the different organisations and professionals involved.

The inquiry heard from a number of sources that the old division between primary and secondary care is a particular barrier, hindering a joined-up approach to the redesign of services and leading to problems when patients move between the two. We also received robust evidence about the need to achieve better integration between health and social care – a task made all the more challenging because of the different funding regimes that apply – and between primary care and community health services. Finally, many stressed the enormous opportunities that could be realised through building better links between the voluntary sector and statutory health and social care services, at both national and local levels.

Payment by results

The payment by results system is now widely acknowledged to mitigate against the development of new integrated models of out-of-hospital care. By paying for each episode of care, it reinforces a disease focused approach, while doing nothing to incentivise providers to prevent or delay the onset of illness or to find alternatives to hospital admissions. In addition, the system inhibits collaboration between providers, encouraging organisational behaviours and responses that are driven by the desire to maximise income and minimise costs, rather than to work collaboratively to deliver patient centred care.
Slow progress on information systems

Effective information systems are fundamental to the delivery of coordinated, patient centred and evidence-based care (Independent Commission on Whole Person Care 2014; World Health Organization 2002). However, the NHS has been slow to capitalise on the opportunities presented by innovations in information and digital technology. The absence of a robust shared electronic patient record, that can be used by all those involved in the care of a particular individual (including across different organisations and by the individual themselves), is frequently cited as a major barrier and make use of data about patient needs, different organisations and by the individual the care of a particular individual (including across different organisations) – what has been described as a ‘cottage industry’ (The King’s Fund 2011). The move to a federated way of working would require a seismic shift for many practices, and is restricted in part by a lack of management and leadership capacity, not only among GPs but also practice managers and other primary care professionals.

Pressures on general practice

General practice lies at the heart of care delivery in the NHS and is well placed to deliver more proactive patient centred care and population health management. It is the first and most commonly used point of access to healthcare in England for most people (The King’s Fund 2011), and it also plays a crucial role in providing care for people with long term conditions, who account for at least half of all GP appointments in England (Department of Health 2012a).

At the same time, the development of new models of care is constrained by resource and workforce shortages in general practice. While general practice activity has increased substantially over the last decade, spending on general practice has not kept pace with the rest of the health service. Since 2005, the share of the NHS budget that goes to general practice in England has been declining steadily, from 10.95 per cent in 2005/6 to 8.50 per cent in 2011/12 (Deloitte 2014). Meanwhile, the general practice workforce is under increasing pressure; the Centre for Workforce Intelligence has concluded that, without a significant increase in size, the GP workforce will be insufficient to meet expected patient demand adequately (Centre for Workforce Intelligence 2014). As a result, many general practice professionals report that they lack the time and resources needed to plan, develop and implement new ways of working.

The shift to delivering more proactive and patient centred care within general practice is also, in some instances, being held back by traditional attitudes and behaviours in regard to care delivery. The traditional, face-to-face GP consultation remains the main unit of activity in general practice. This is by and large a reactive model of care, which treats people when they become ill, and is based around the assumption that the clinician – rather than the patient – is the main decision maker. While there are many and increasing examples of the provision of proactive, collaborative and innovative care in general practice, the challenge of changing professional attitudes and behaviours should not be underestimated.

Finally, we received evidence that policy initiatives that have prioritised speed of access to general practice – for example, through the 48-hour access target – have in fact made it more difficult for practices to provide patient centred care, as it has become harder to ensure that patients are able to see their preferred general practice professional. This is a worrying trend, particularly given that people with complex ongoing needs, such as multimorbidity, often have the most to gain from relationship continuity (see, for example, Nutting et al 2003).

A lack of clinical guidelines for managing multimorbidity within general practice

Increasing attention is rightly being paid to variations in clinical practice within general practice, and the extent to which this results in differences in standards of patient care. One response to this has been the introduction of clinical protocols and guidelines, which aim to standardise clinical practice in line with evidence of best practice.

However, while clinical best practice guidance undoubtedly has a role to play in improving care, the inquiry received evidence that the rigid application of guidelines may in fact stand in the way of patient centred care, particularly for people with multiple conditions. At the moment, most guidelines are designed for use with people with single conditions, rather than managing patients with multimorbidity. In particular, there is a lack of evidence to guide decisions about medicine use in patients with multiple conditions, including information on the effect of stopping treatment and comparing the risks and benefits of different treatments.
Furthermore, for care to be truly patient centred, clinicians must be able to apply clinical protocols flexibly, so as to take into account what will have the greatest positive impact on the individual’s quality of life, in the context of their lives, values and priorities. As such, there is a need to distinguish between unwarranted variation in care, and warranted variation that is a result of taking a patient centred approach to care (see box).

**Warranted and unwarranted variation in general practice**

There are many guidelines in use in general practice that encourage GPs to recommend a particular intervention or medicine to patients with a specific condition. In order to check whether the treatment is indeed offered, patients with a particular condition are audited for compliance. For GPs, who use computerised disease registers, variation in clinical practice becomes an easily verified figure.

Patient variation in acceptance of treatment has become important in audited figures. These figures may be linked to general practice income and are published, leading to a reputational risk for the GP. In some cases, high levels of compliance have become a requirement of the regulator. In these circumstances the GP is under considerable pressure to persuade a patient to accept a certain medicine or intervention.

Yet patients vary greatly in their desire for, and tolerance of, treatment. Variation may occur because the doctor has not understood or been organised enough to implement the recommended guideline (unwarranted variation). Alternatively, however, the doctor may have had a full discussion with the patient and the patient may have made an informed choice that they did not want the intervention – for example as the side effects or difficulty of taking multiple medications outweighed the potential benefits (warranted variation).

Furthermore, the evidence of benefits associated with a particular intervention is often derived from studies of people with a single condition – and not people with multimorbidity. There may be good reason to suppose that, in some cases, following the single disease protocol may be of very little benefit or even harm to patients with multiple conditions. In such instances, the GP’s decision not to follow the guideline may in fact represent good patient centred care (warranted variation).

In order to distinguish between warranted and unwarranted variation and allow the patient to exercise power over the treatments given, audit processes need to change from auditing how many patients are given a certain medicine, to evaluating the quality of the advice given and decision made (through mechanisms such as peer review and patient feedback). Meanwhile, clinical guidelines need to be developed to support clinicians to manage care for patients with multimorbidity.

**Introduction**

At its heart, patient centred care is about changes in behaviour – the behaviour of professionals towards patients and each other, and the engagement of patients with their own health and the health and social care system. The ability to make patient centred care a reality, therefore, lies ultimately in the hands of the professionals who deliver care and the patients and communities they serve. Critical to this will be embracing the change in the balance of power and responsibility between professionals and patients required by patient centred care.

At the same time, the structures, systems and processes that form the context for care provision can make an important difference to the delivery of patient centred care, by creating an environment in which it is most likely to flourish. Increasingly, politicians and policy makers are recognising the need to refocus the health and social care system to encourage, support and enable the kind of behaviours on which patient centred care depends, and to ensure that patients are involved at every level. The development of primary and community-based care is central to this.

In this chapter, we examine how the different actors within the health and social care system can help drive a decisive shift towards the delivery of patient centred care within the community setting, and the measures required to empower and equip them to do so. We look at the respective roles of patients, carers and communities (Section A), health and care professionals (Section B), provider organisations (Section C), and commissioners (Section D). We then consider the supporting infrastructure required to allow system wide change to happen (Section E).

Some of our recommendations are intended for national level policymakers and professional bodies, while others are more relevant at a local level and will apply directly to professionals, providers and commissioners. There is no single magic bullet action, but rather a series of aligned measures that, if made, would change individual, organisational and system wide culture and behaviours. It is the aggregation of these changes that offers the potential to usher in a new world of patient centred care.

**A. Empowering patients, carers and communities**

We believe that a fundamental shift in attitudes is required so that patients, carers and communities are viewed as bringing assets as well as needs, as part of the solution not part of the problem, and that their active engagement should be welcomed as leading to better, swifter and more sustainable health outcomes.

There are tangible means by which this approach could be routinely operationalised in primary care and general practice – these are described below. But if change is to be genuinely embraced and understood, health professionals will also need to redress the power imbalance present in many current interactions with patients and/or their carers.

We believe that any transaction in primary care that is truly patient centred should be understood to be ‘a meeting of experts’ – the patient with expertise in themselves, their lives and their capabilities, and the professional an expert in the prevention, diagnosis and treatment of illness. This attitude has become much more prevalent amongst health professionals in recent years, but it is by no means universal. Without comprehensive adoption of this attitude in all settings, we believe it will not be possible for us to deliver patient centred care as the bedrock of UK general practice.
Improving what we know about our own health and health and care services

We believe that there is enormous potential to improve what citizens know about their health and about health and care services. GPs are a trusted source of health information (Department of Health 2011) and the RCGP has recently highlighted the important role that general practice can play in helping to tackle low health literacy (RCGP 2014). Measures that should be taken include:

- supporting patients to develop health literacy skills, both in understanding and using health information, and in understanding their rights to clear, accessible information tailored not only to their clinical needs but also to their health literacy;
- providing information on:
  - lifestyle choices and management to maintain good health and well-being
  - when and how to seek professional help
  - information on managing diagnosed conditions, including materials relevant to those with multimorbidity
  - performance data (see also Transparency of data on general practice and primary care below)
  - the costs of care and treatment.

Information on costs is rarely available to patients but we believe that, as part of a patient-centred approach, this should be shared as a means of facilitating engagement with the resource issues that dominate the sustainability of healthcare in the NHS. We believe this must be handled sensitively and proactively by publishing information on treatment costs widely and not in an individual patient setting, where patients may feel pressurised on choice of treatment options. By creating greater understanding of the relative costs of care, we believe there would be an enhanced opportunity to promote healthy lifestyles and also avoid wasteful use of services.

CASE STUDY: Bromley by Bow Health Partnerships – empowering parents to manage their children’s health

Bromley By Bow Health Partnership, in Tower Hamlets CCG, has introduced a co-productive, “DIY” initiative to improve local parents’ knowledge and skills in looking after their children’s health.

The Bromley By Bow Health Partnership includes three local general practices, one of which is the award winning Bromley By Bow Centre. The Partnership is an excellent model of how community co-production can work to improve people’s health literacy, supporting them to look after their own health and their family’s health.

The DIY initiative was created with the aim of empowering parents to manage their children’s health. It began after one of the practices, St Andrews Health Centre, identified parents of under-fives as being frequent attendees at the practice. Parents would visit the surgery largely for support and reassurance in managing their children’s common ailments. These repeat visits led to the realisation that health professionals need to work better with parents and carers to help them understand when children’s symptoms can be managed at home, and when there is a real need to seek intervention from a health professional – whether this is the pharmacist, the nurse or the doctor.

Recommendations:

- Resources should be commissioned to aid clinicians in communicating with patients of different levels of health literacy.
- Greater public awareness of the costs of treatment and the appropriate use of healthcare services should be promoted, through increased communication by politicians and NHS leaders and improved access to cost data.

Support for self management

We believe that, in general, people wish to manage their health issues as far as possible without recourse to professional healthcare interventions. This may be to avoid unnecessary utilisation of NHS resources, to maintain their ability to work and manage their daily life without disruption and, in more acute cases, to reduce the risk of losing their independence. Even for those patients who are the heaviest users of healthcare, the proportion of their time that they spend in contact with services will usually be relatively small, and 83 per cent of patients with long term conditions say that they play an active role in managing their health all or most of the time (Department of Health 2011).

A growing body of evidence suggests that interventions to equip patients and carers with the skills and confidence to manage their long term conditions deliver better outcomes and reduced healthcare utilisation costs. For example, evaluation of the Expert Patients Programme – a self management programme for people who are living with a long term condition – found that 45 per cent of participants felt more confident that their symptoms would not interfere with their lives. The programme was also associated with a seven per cent reduction in GP consultations and a 10 per cent reduction in A&E attendances (as cited in Leatherman and Sutherland 2007).

Over 90 per cent of people with long term conditions are interested in being more active self managers (Department of Health 2005). We believe that better access is needed to more and different forms of support for individuals, their carers and communities – not just from professionals working in the health system, but also from the voluntary sector, community groups and from other patients and carers. General practice has a central role in achieving this, both through the direct provision of self management support and the signposting of other support opportunities locally, as does the pharmacy sector. Forms of support could include:

- structured education in self management
- patient and carer support groups
- patient coaching
- better access to community activities and resources that support health and well-being (these vary from community to community, but could include exercise and social clubs, or groups engaged in arts, music and sport)
- funding low level social and domiciliary support
- respite support for carers.
To be most effective, support for self-management should be tailored to the activation levels of the individual concerned and must also be appropriate to their personal circumstances. There is growing interest in the use of patient activation measures as a tool to identify to what extent patients have the knowledge, skills and confidence to manage their health, and to use this information to shape the provision of support in order to optimise patient outcomes. Whilst the logistics of measuring patient activation on a routine basis could prove challenging, we believe the benefits could be great, and ways of achieving this within primary care should be trialled as a matter of urgency.

Substantial potential also exists to make better use of technology to support patients to manage their health. There is a major commercial move towards supplying products that enable citizens to: assess and avoid health risks; diagnose early symptoms of health problems; offer information and techniques to help manage long term conditions; capture vital signs to track and predict potential problems; maintain a self care plan for the management of a diagnosed long term condition; and deliver care and treatments with minimal ongoing recourse to health professionals.

This market is growing rapidly and has the potential to enhance the ability of citizens, patients and carers to manage health problems independently. In some cases in the USA, such programmes or products are seen as the first line of support and are mandated by insurers. We believe that the uptake of such products will increase and that it is therefore vital to educate both professionals and patients about this new environment and its implications for their respective roles. However, while innovations in technology, information provision and approaches to self care present a huge opportunity, it is important to recognise that some patients will struggle more than others to engage in their own care. It is vital, therefore, to reach out and tailor support to groups that may otherwise be at risk of being left behind, in order to avoid differential levels of patient awareness and activation becoming a driver of increased health inequalities.

**CASE STUDY:**
**Bradford Telecoaching for patients with long term conditions**

Bradford Telecoaching is a self management support service for patients with at least one physical long term condition, including individuals with multimorbidity and/or co-morbid mental health issues. Its ‘self management coaches’ help patients to understand and better manage their condition(s) at home, with the aim of: supporting healthy lifestyle changes; increasing motivation, confidence and well-being; and giving patients the tools to become active partners in designing and managing their care.

The service seeks to work on a shared care basis with referring GPs, who receive individual patient summary reports and regular updates on the development and performance of the service. It is delivered by a partnership between Local Care Direct (a community-owned healthcare provider) and Turning Point (a social enterprise focused on health and social care) on behalf of Bradford City and Bradford District Clinical Commissioning Groups.

**Recommendations:**

- CCGs should invest in commissioning an enhanced range of options to support self care, accessible via and integrated with general practice, pharmacy and other primary healthcare services.
- NHS England should work with CCGs to trial the routine collection and use of patient activation data in primary care.
- Resources should be developed to assist professionals and patients to navigate the range of self management and support aids available, both commercially and from the statutory and not for profit sectors, and to use these to the best possible advantage in the context of the patient-professional relationship.

**Personalised care planning**

The process of personalised care planning can play a key role in the delivery of patient centred care for those with long term conditions and complex needs. As The King’s Fund describes it: “Collaborative personalised care planning aims to ensure that individuals’ values and concerns shape the way in which they are supported to live with and self-manage their long-term condition(s). Instead of focusing on a standard set of disease management processes, this approach encourages people with long-term conditions to work with clinicians to determine their specific needs and express informed preferences for treatment, lifestyle change and self-management support. Then, using a decision coaching process, they agree goals and action plans for implementing them, as well as a timetable for reviewing progress.” (Coulter et al 2013).

Care planning requires general practice to work with patients in a very different way – shifting from the traditional, reactive, treatment-focused model of consultations to a proactive system that supports people to stay well. Recent changes to the GP contract have sought to promote the production of personalised care plans for patients most at risk of hospitalisation. However, experience suggests that to embed care planning meaningfully can be challenging (Kennedy et al 2013), and there is a danger that attempts to implement it on a large scale may result in an inflexible tick box exercise that does not truly respond to patients’ priorities.

Whilst policy makers’ attention has tended to focus on the cohort of individuals at highest risk of hospital admission, the greatest gains from care planning may come from those who are at an earlier stage of their condition, where there is greatest scope for prevention of deterioration (Roland and Abel 2012). However, GPs’ capacity to deliver care planning remains constrained and it is clear that if a care planning approach is to be properly implemented for all those patients who would benefit from it, we will require more primary care based clinical professionals with the time, resources and skills to deliver this. Specifically, there is a need for:

- measures to inform patients about care planning and self care
- sufficient time for professionals, such as the GP,
to spend with the patient to enable care planning and review – this will require significantly longer consultation times on a regular basis

- training for professionals involved in care planning
- for very complex patients, the ability to provide coordination across a range of services will also be key and may need to be supported through different health and care professionals (e.g. pharmacists) working in tandem with the GP.

Recommendation:

- Practices should follow a personalised care planning approach for all those patients in need of proactive care, with particular focus on at risk groups such as those with learning disabilities and patients with multiple conditions.

Patient access to health records

It is difficult to imagine a package of measures to enhance the delivery of patient-centred care that did not involve action to improve patients’ ability to access and have input into their health records. Equally vital, however, is to ensure that this is coupled with measures to support patient understanding of this information – for example, by making the record easy to navigate, presenting the data in a way that can be easily understood by patients, and providing links to supporting information.

Patients already have the ability to access their paper records, but this is not widely known and the process can be cumbersome. The Department of Health’s original goal was for all NHS patients to be able to access their records online by 2015 (Department of Health 2012b), but this target was scaled back in the 2015/16 GP contract to providing online access – where requested by patients – to all information that is held in a coded form within their health record, but not to free text entries. We therefore welcome the recent national level political commitment to enable full online access to patient records – including, where appropriate, to free text entries – together with the aspiration to deliver this set out in NHS England’s Five Year Forward View (NHS England 2014).

Looking ahead, there is an opportunity to expand online access to include read/write access for patients to some areas of their record. For example, patients could be prompted to create a personal profile, with details about their circumstances and priorities, and add comments to existing entries. It may also be appropriate for some patients to input the results of tests which they administer or arrange themselves, so that these can be reviewed remotely by healthcare professionals involved in their care. Needless to say, it would be important to ensure that read/write access did not compromise the integrity of the record or allow individuals to delete data (not least as it is a medico-legal requirement to keep records for 10 years).

Alongside these measures, a national push is needed to educate citizens about their rights to access their records, and to support patient understanding of the information provided therein. It must also be acknowledged that the provision of full records access, in a format that the patient can understand, will be extremely time consuming for practices – as records will need to be checked and, where appropriate, redacted, to ensure that third party or harmful information is not revealed. The cost for practices in undertaking this work needs to be reflected in allocations and contracts if it is to be achieved at pace.

CASE STUDY: Online record access at Haughton Thornley Medical Centres

Dr Amir Hannan’s GP practice in Greater Manchester was one of the first in the UK to offer its patients online access to their GP health record. More than 3,245 (28 per cent) of patients at Haughton Thornley Medical Centres now access their records online via the practice’s web portal.

Patients log in using secure access codes and can see their full electronic health record, including details of consultations, test results and correspondence with other providers. Crucially, the information is presented in a format that is easy to navigate and is accompanied by links to further resources that support the patient’s understanding of the data – such as leaflets on different conditions, medicine and self care information, and local support groups.

The practice reports that online records access – supported by a sustained effort by the practice and its clinicians to ensure that patients are able to understand the information provided – has empowered patients to become more actively involved in decisions about their healthcare. It has also freed up appointments and reduced call volumes, as patients are able to go online to access both their test results and the information they need to understand what these mean.

Recommendations:

- Practices should be resourced to undertake the work necessary to make rapid progress towards full online access.
- NHS England should work with the profession and with GP software providers to develop the technological functionality and safeguards necessary to introduce read/write access for patients to their GP health record.

Enabling new means of accessing care

Patients should be able to routinely choose the point and manner in which they access primary care and health information – including through a variety of health professionals and services, and by telephone and online.

In order to broaden access to care, we believe that further practical support is needed to enable practices to develop their online offer, including the resource required to ensure that this does not lead to a knock-on deterioration in face-to-face access for those who need or choose it. At the same time, policy makers and professionals should consider carefully how they can design new and different points of access to the healthcare system that meet a range of patient needs and preferences, whilst avoiding the danger of generating supply induced demand.

It is also clear that patients are not simply passive recipients of a standard or revised NHS offer, but are actively pursuing other routes to secure health advice, care interventions and treatment options.
In such circumstances, four things are essential. Firstly, traditional service provision, with the emphasis on the patient fitting in with the professional organisational model, will have to change. Secondly, there is an increasingly important role for health and care professionals to help citizens and patients navigate this new world, and where asked, to help to interpret and guide them in appropriate courses of action. Thirdly, traditional and non traditional providers must work together constructively to avoid fragmentation of care and to facilitate the best possible patient outcomes. Finally, health professionals may need to consider how these changes affect their sense of their professional identity and morale. We believe that the role of being a ‘significant other’ in the lives of patients is an essential and rewarding one, which can evolve from the traditional perception of the professional as the sole expert.

Put simply, we believe that the NHS and social care system must align with those other aspects of people’s lives, where they have choice, transparency and diverse options for accessing advice, support and services that are much more closely attuned to their personal needs.

**CASE STUDY: LloydsPharmacy Online Doctor**

LloydsPharmacy Online Doctor (formerly Dr Thom) is an online private GP service used by almost 1,000,000 patients across the UK, which offers commonly used prescription treatments over the internet. It was founded in 2002 by a doctor specialising in sexual health, to help treat patients who felt embarrassed or uncomfortable about speaking to their GP, or who did not have the time. In 2006, it became the first online organisation to register with the Care Quality Commission. Its London-based team of doctors provides a range of medical services and treatments, including contraception, sexual health testing kits, erectile dysfunction and hair loss treatments, asthma inhalers, and travel health.

In order to request a product or service, patients firstly fill in an online questionnaire, which is described as “an online version of the chat you would have face to face with your GP”. This is assessed by one of the team’s doctors, who are available every day from 9am to 6pm (including weekends) and aim to respond within one hour during weekday working hours. The patient is notified of the doctor’s decision, as well as any test results, through their online patient record. If the doctor requires further information before proceeding, he or she may communicate with the patient online via the Patient Record or book a telephone conversation. Medicines are supplied by LloydsPharmacy and are delivered to the patient’s home or available for same day pick up in store.

**Recommendations:**

- More research should be commissioned on designing new routes of patient access, both within general practice and across primary care, with a view to incentivising appropriate service usage and avoiding fragmentation of care.
- NHS England should commission a range of practical resources and advice that practices can use to improve their online offer.

**Facilitating access for excluded and isolated groups**

There are notable examples of practices that have made considerable effort to identify and secure routes of access for excluded groups. The reasons for exclusion may be manifold and relate to prejudice, fear or cultural issues. However, patient centred care requires that general practice offers access for all groups.

We are aware of the exclusion of specific individuals and problems from mainstream general medical care where these particular problems are deemed outside the scope of or lower priority areas for care. For example, concerns were voiced to the inquiry about the failure of some practices to provide the support required to enable patients with specific needs to access their services, such as easy read information and interpreters. In addition, we received evidence of the relatively low priority given to supporting patients with learning disabilities and their families, and more generally the lack of attention to co-morbidity between mental and physical health problems (which has been shown to reduce life expectancy for those with serious mental illness). We believe that such barriers and exclusions are an anathema to the high standards expected of general practice and should be addressed through professional guidance and development, backed up where necessary by regulatory challenge and targeted resourcing.

One particular area in which problems can occur relates to the acceptance of patients onto, and their removal from, GP lists. It is essential that barriers do not exist that make it more difficult for vulnerable or excluded groups, such as the homeless, to register. GMC guidance states that doctors may end a professional relationship if there has been a breakdown of trust that means they are no longer able to provide clinical care, and in such circumstances practices may apply to NHS England to have a patient removed from their list. However, removal from a practice list should always be a last resort, and should never be used as a tool through which to exercise power over a patient concerning the way in which their care is provided.
Recommendations:
- The RCGP should update its guidance on the removal of patients from GPs’ lists, and should work with patient organisations, NHS England and others to review what further action could be taken to ensure high standards in this area and prevent the inappropriate exclusion of patients from GP lists.
- NHS England and CCGs should work with primary care services at a local level to audit whether the specific needs of excluded and vulnerable patients are being adequately met and should put in place robust plans to tackle any deficiencies that emerge.

Transparency of data on general practice and primary care

There is considerable evidence that making data available on performance in secondary care has helped to empower patients and their carers, whilst also enabling clinical staff to understand and pursue their desire to offer the highest standards of care (McKinsey 2011).

We see no reason why general practice should be exempt from this move to make information available to the patients and the registered populations it serves. However, we also believe that considerable thought and sensitivity is required to produce valid, accurate and meaningful metrics for general practice. It is important to recognise that there is enormous variation in the contexts in which general practice operates, and to take this into account in any comparisons. Factors that can have a significant impact in determining general practice outcomes include: socio-demographic and other differences between patient populations; distance from hospitals; and other local health services available.

We support the principle that there should be greater transparency around variation of practice and outcomes in general practice. Whilst we acknowledge the importance of understanding the reasons behind variation in the way in which disease is treated and managed, we believe that the range of indicators should be broadened to place more emphasis on measures of patient centred care. This should build on data sets such as the GP Patient Survey, and the existing work that has already been done to develop tools for the measurement of patient centred care and patient activation (Health Foundation 2014; Hibbard and Gilburt 2014).

In order to introduce such a system of transparency we believe it is essential to avoid a climate of fear and reward excellence, rather than penalise poorer performance in its early stages. Coupled with this we would wish to see educational opportunities to support individual clinicians, and research to understand the factors that inhibit the delivery of patient centred care.

Over time, failure to improve would incur sanctions, but only after remedial support had been offered.

Recommendations:
- More data on primary care should be collected and published to improve understanding of variations in performance and outcomes and of the factors that might lie behind these.
- Performance indicators used should be designed in collaboration with primary care professionals, and broadened to place a greater degree of emphasis on measures of patient centred care.

Strengthening the patient voice in primary care

It is clear that, as part of a drive to empower patients, there is an opportunity to develop the strength of the patient voice in primary care, as a means to encourage and embed patient centred care.

A key mechanism for strengthening the patient voice within general practice is the work of Patient Participation Groups. These operate with different constitutional roles and functions across different GP practices, but share the potential to act as a powerful force in redefining the traditional relationship between patients and professionals and in promoting patient centred care. For example, PPGs can play an important role in helping to improve the health literacy of practice populations, and in working with practices to support self care and champion the effective use of services.

From April 2015, it will be a contractual requirement for all practices in England to have a PPG, to engage with their PPGs to obtain patient feedback and to act on agreed suggestions for improvement. We endorse these expectations, and wish to see PPGs playing a greater role in service development and in the governance and scrutiny of practices. In order to enable PPGs to carry out their functions effectively, it will be important to ensure that they have access to advice and resources to support them in their development. A key source for this is the National Association for Patient Participation, which, in addition to the tools and guidance it already offers, is currently working with NHS England to produce a quality framework for PPGs.
Local Healthwatches and CCG patient reference groups also have an important part to play in scrutinising and shaping community-based services, and can help to provide a broader perspective that extends across the full range of providers within a given locality. A number of local Healthwatches and CCG Patient Reference Groups are forging links with PPGs in their areas, and we urge the further development of such networks as a means of sharing expertise and engendering a deeper understanding of issues such as variations in care.

**Recommendations:**

- NHS England and CCGs should make available resources and learning opportunities to equip PPGs with the skills and capabilities to be as effective as possible.
- As part of its inspection process for general practice, the CQC should look at how the practice supports the role of its PPG, evidence of collaborative working, and how it has responded to any feedback or suggestions made by the PPG.

**B. Supporting patient centred professional practice**

In recent years we believe that the role of professionalism, dedication to great care and a strong desire amongst primary care professionals to be the best they can be for patients has been insufficiently recognised in the policy landscape. We continue to believe that this is the most powerful means to ensure care that is both safe and patient centred.

Indeed, whilst it is understandable following high profile service failures that searching questions are asked about the presence of core professional standards and motivation, the case for assuming either that these have been lost or that they are only present in response to external regulation and inspection is a false one. Increased transparency, sensible inspection, good regulation and proportionate sanctions all play an important part. Ultimately, however, it is the professionalism of clinicians and staff minute by minute, day in day out, 365 days a year that will secure excellent health outcomes, patient experience and patient centred care.

We therefore believe that great strides forward in delivering patient centred care can be made through supporting and improving the systems, standards and processes influencing professional practice and behaviour.

We believe that these improvements are deliverable through the following routes:

- aligning training and education with the delivery of patient centred care
- reorientating and diversifying the nature of the consultation process
- encouraging greater multiprofessional teamwork
- establishing clarity of the role of the GP within the new primary care landscape in order to ensure the population get the best from general practitioners and in doing so, that general practice is seen and felt to be an important, popular and rewarding place to work.

**Aligning training and education with the delivery of patient centred care**

There is a great deal of evidence to demonstrate that the nature and content of basic training influences not only the competence, legitimacy and priorities applied by professionals to work in practice, but also the behaviours, attitudes and mindsets they adopt in doing so (see, for example, Howe 2002). It is particularly important, therefore, to align education and training – across all professional groups and at all stages of professional development – with ways of working that can deliver the best outcomes.

We strongly believe that more can be done to educate and train professionals about the benefits of patient centred care and the skills required to deliver it, particularly within community settings. Central to this objective is the involvement of patients themselves in all aspects of the education and training process.

Key elements of patient centred care that should feature within the education and training that professionals receive include:

- the management of health in relation to physical, mental and social need
- the adoption of appropriate power relationships between patients and professionals
- the effective care of patients with multimorbidity
- the ability to promote shared decision making and to tailor care to reflect varying levels of health literacy, patient expectation and support needs
- the role of the professional in enabling patients to navigate the range of information and services now available to them in a digital age.

The RCGP has developed a detailed case for the delivery of enhanced and extended four year training for GPs, and the need for longer GP training was reflected in the findings of the subsequent Shape of Training Review. The proposed new curriculum is designed to support many of the key components of a patient centred approach to care – including more active health promotion and prevention, improved care management and coordination for people with long term conditions (such as managing multimorbidity and enabling self care), and increased understanding of the health needs of the local community. As such, we believe that the Department of Health should implement extended and enhanced GP training as a matter of urgency.

While we recognise that many of the professionals in current practice are well equipped to deliver patient centred care, this is by no means the case universally and we would wish to see the RCGP, RCN, RCM and RPS, for example, create opportunities to highlight the findings of this inquiry and establish appropriate continuing professional development for those who have already qualified.

We received evidence from the RCN, NHS Confederation and National Association of Primary Care that suggested that not only is it important to align education and training, but also that we should consider the development of new roles and better use of skill mix to focus specifically on improving care for those with multimorbidity. For example, we are conscious that the development of community psychiatric nursing as a discipline was strongly associated with the transformation of the mental health service model from long stay hospitals to community care, and we believe that parallels could be drawn in this context.
We therefore endorse the need to explore these options, and would ask HEE, NHS Employers and other relevant stakeholders to do this as a matter of urgency, given the time taken to institute, train and recruit to new roles.

### Recommendations:

- The Government should fund and mandate the delivery of enhanced four year GP training as a matter of urgency.
- HEE should assess the existing curricula for the training of professionals operating in primary and community care to ensure that they sufficiently support the delivery of patient centred care, including the effective management of multimorbidity.

### Reorientating and diversifying the nature of the consultation process

The process of shared decision making is an essential element of patient centred care. It involves clinicians and patients working together as partners to select tests, treatments, management or support packages, based on clinical evidence and the patient’s informed preferences (Coulter and Collins 2011).

NHS England wants to embed shared decision making in NHS care (NHS England 2013a) – a goal that we strongly support. However, while we heard many positive example of shared decision making in practice, we believe that there is still much to be done to make it the norm across primary care. This should include an enhanced focus on the quality of shared decision making as part of audit and improvement processes, and the development and use of decision aids that enable patients and clinicians both to understand the clinical evidence and to place this in the context of the patient’s goals, values and lived experience (Greenhalgh et al 2014).

For many years the modus operandi for general practice has been the standard consultation, lasting on average a little more than ten minutes. Recently there has been significant debate about whether this is still appropriate as a standard model, particularly given imperatives for more in-depth proactive management of the symptoms associated with long term conditions. The need to offer longer consultations to some patients, in the context of a limited GP workforce, has stimulated a variety of strategies for more segmented access to care – for example through triaging systems, by separating access for urgent and chronic presentations, or through the definition of distinct patient sub-groups (Porter et al 2014). These invariably lead to flexibility in appointment times and types (e.g. online, telephone, face-to-face) that are more attuned to the needs and lives of patients.

We received evidence of the effectiveness of practice-based anticipatory care approaches for high risk patient groups in ensuring earlier diagnosis, and reducing the need for residential and hospital care (Beales 2013). In addition, we are aware of a number of academic trials currently underway that involve offering proactive identification, longer consultation times and improved continuity and care planning to patients with multimorbidity. One such is trial Bristol University’s 3D study, in which comprehensive person centred assessments are undertaken every six months, structured around the three dimensions of health, medication and depression.

Relationship continuity is highly valued by patients with long term and complex needs and should form an essential part of strategies to ensure person centred care for these groups. The RCGP’s continuity of care toolkit sets out a range of practical strategies that practices can employ in order to maximise continuity of care (RCGP 2014). One model that is receiving increasing attention is the formation within practices of smaller teams of GPs who can see each other’s patients when one of them is unavailable, drawing on experience in the Netherlands where part time GPs are required to pair up to offer patients continuity (RCGP 2011; RCGP 2013).

### Recommendations:

- Practices should routinely audit the quality of shared decision making that takes place in the context of the GP consultation.
- NHS England should work with practices to promote the adoption of new consultation processes to enable them to provide better and more proactive care for those with complex needs.

Encouraging greater multidisciplinary team work

There has been significant progress in recent years towards the establishment of effective multidisciplinary team working in the NHS and social care system. However, we believe that much more could be done to enhance the support and services available in the community setting to patients with long term conditions and to ensure that they receive joined-up care. This will require closer collaboration between professionals, patients and their carers and far better sharing of information between health and care professionals.

General practice is well placed to act as the ‘medical home’ of the patient in the community. As expert medical generalists, GPs are equipped to provide whole person diagnosis and care management, and to support patients with broad health needs to make decisions about their medical care. It is clear, however, that general practice cannot meet the needs of our ageing and more chronically ill population on its own. For this reason it is vital that general practice works much more closely with other services that people need in the community – including those provided by nurses, allied health professionals, medical specialists, mental health professionals, social workers and third sector organisations.

The value of expert medical generalists – including those practicing in acute medicine, general practice and geriatric medicine – is increasingly being recognised (for example by the recent Shape of Training review). However, many patients, and particularly those with complex long term conditions, will also require coordinated specialist medical help at some point.
The Royal College of Physicians’ Future Hospital Programme has underlined the potential to develop collaborative working between hospital specialists – such as teams working in paediatrics, palliative care, and respiratory and diabetic medicine – and professionals traditionally based in the community. As part of this, specialist medical teams would spend more time working in the community – usually with patients with complex long term conditions – while primary and community care teams would be better able to reach into hospitals when patients are admitted (Future Hospital Commission 2013). This would include developing new ways of working that avoid admitting patients to hospital if they can be supported in the community, such as through increased use of ‘day case’ ambulatory care and ‘acute’ outpatient clinics.

Improved collaboration between specialist medical teams, GPs and other primary care professionals can help ensure swift access to diagnostic and treatment expertise and appropriate ongoing specialist support where it is needed. For example, a number of emerging models of community-based care involve the provision of better access for GPs, nurses and other health professionals to better diagnose and treat patients in primary care or make improved referrals (Robertson et al 2014). In addition, we heard that, for patients with complex needs, there is a greater opportunity to agree diagnosis and treatment options with input from a range of disciplines, as well as from the patient and their family/carers themselves. Time set aside for this purpose is likely to ensure better use of resources in the medium to long term and so should be better recognised through the current financial and contractual incentives.

 Whilst multidisciplinary working is crucial, it is important that systems are put in place to ensure that this is coordinated and does not inadvertently lead to a loss of continuity of care. To avoid this, there must be clear lines of responsibility and accountability, coupled with effective information sharing. In particular, it is important to ensure that collaborative working is supported by the use of shared electronic medical records across different health and care settings (see also ‘Information systems and digital technology’ below), together with appropriate training in the use and potential of the care record for professionals working as part of the multidisciplinary team.

Under the GP contract, practices are required to allocate patients over 75 with a named accountable GP, who will work with relevant associated health and social care professionals to deliver a multidisciplinary care package that meets the needs of patients, and by March 2016 all patients will be allocated a named GP. We welcome this development as having the potential to support multidisciplinary working and ensure that there is an assigned GP in the patient’s practice with the ability to provide continuity and a generalist medical perspective. In addition, we believe that patients with high levels of need for care and support should be assigned a single care coordinator, whose role it is to act as a point of contact between the patient and the multidisciplinary team and to facilitate the delivery of integrated care.

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**Recommendations:**

- The RCGP, the RCP and other Royal Colleges should work together to identify and evaluate new models of interdisciplinary working to deliver complex care to patients in the community.
- Patients with high levels of care and support need should be assigned a single care coordinator to act as a point of contact for the patient and to facilitate integrated working.

**Establishing the role of general practice in the primary care landscape**

As models of care evolve to embrace a patient centred approach, it is important to recognise the consequent change that this will entail for the role of the GP. Over recent decades GPs have already seen their professional position within the NHS and, arguably, their personal position within communities, change considerably.

The shift in pay towards a relatively equal position with hospital consultants has been welcome, as has, for the most part, their growing influence over resource deployment through clinical commissioning.

On the other hand, the last decade has seen a comparative reduction in resources for primary care relative to secondary care, an average reduction in practice income over the last seven years, and a sharp growth in demand for GP services as our population has aged and become more chronically ill. These factors have all contributed to a reported decline in morale, a lessening of the attractiveness of general practice as a career, and questions being raised about the sustainability of the current independent contractor status.

We heard evidence to suggest that the opportunity to deliver patient centred care more consistently, if embraced, could improve both GP morale and workload management. But we were told that this would need to be coupled with greater clarity about the new role for GPs in the overall system. Since 2000, various attempts have been made to describe the GP’s role but there remains a pressing need to recognise and deploy the expertise, competence and capability of GPs to maximum effect.

We believe that patient centred models of care can and should enhance the historic value of general practice. GPs, as the natural vanguard of a new approach and potential leaders of a population health management system, have much to contribute to the future sustainability of a modern NHS. This should be acknowledged politically, rewarded fairly and properly, and advertised to those who aspire to a career in primary care and general practice. It is also crucial, given general practice’s orientation towards population health, that GPs are prominent in any thinking about integrated care organisations.
Recommendation:
- NHS England should implement the ‘new deal’ for general practice outlined in the Five Year Forward View, recognising the value of general practice to the NHS and its patients and committing to build on its strengths. New policies should reinforce the importance of the key factors that are central to the success of the general practice model, particularly an easily accessible, local single point of access; provision of comprehensive services from a generalist clinician; continuity of care; and the registered list, with a clear contractual relationship between individual patients and doctors.

C. Enabling provider organisations to change

The way in which service providers are organised plays a key role in creating the right environment for delivering patient-centred care. As a result, we believe that models of service provision need to evolve in order to meet citizens’ changing needs and preferences. In this section we consider developments in:

- collaboration between practices (such as federations)

Collaboration between practices

There is increasing recognition that the delivery of joined-up, patient-centred care in the community will require new models of care provision. We believe that general practice has a key role to play in meeting the challenge of providing pro-active and preventative care for an ageing, more chronically ill population. However, for this to happen, general practice will have to work differently.

There is significant potential for practices to work together as networked or federated organisations to expand the scale and scope of the services that they provide. The concept of a primary care federation was first described by the RCGP in 2007 (RCGP 2007), and there are now a significant number of innovative examples of federated or networked practices around the UK. Such models are already allowing organisations to share back office functions (and therefore reduce unit costs), increase overall capacity, broaden their skill-mix, and offer patients access to a wider range of clinical and community services. Equally, working at scale also allows improvements to ensure high quality out of hours care, achieve better integration with other services, and ensure consistent quality standards across multiple practices.

Other possible models of inter-practice development include super-partnerships – large scale single practices operating across multiple sides within a local community – and regional and national multi-practice organisations, which are similar to super-partnerships but have sites that are dispersed across a larger regional or national area.

NHS England’s Five Year Forward View proposes developing federated structures into Multispeciality Community Providers in order to provide integrated out-of-hospital care. We see this as an exciting new opportunity to build new population health management organisations based on the strengths of connection that practices enjoy with their patients and their local communities, and that these strengths must not be diluted as a result of the drive to upscale. It is therefore essential that emerging models preserve the local small-scale points of access to care that many patients value.

We believe that stronger levers are required to enable progress towards new models of general practice to be realised faster and on a more universal basis. This should include consistent access to support for practices as they federate, to enable identification of best practice and shortcut the learning process, as well as flexible commissioning and funding arrangements. As the Nuffield Trust observed in its analysis of new models of primary care: “Practices and their teams struggle to find the time and space to take stock and plan, and experience from existing models of scaled-up primary care suggests that such planning is vital...Such radical change needs support, incentives and permission to test out new approaches to the delivery and organisation of care.” (Smith et al 2013).
of UK general practice. Whilst it is too early to assess the relationship between these new models and better outcomes we are very positive about their potential benefits, and believe that they could facilitate patient centred care in community settings.

Recommendation:
- NHS England should accelerate the adoption of new forms of inter-practice collaboration such as federations, by providing practices with protected time and resources to support at scale development, and by launching a pilot programme for the establishment of Multispeciality Community Providers.

Horizontal integration between health and social care

Much has been made of the responsibilities created by the Health and Social Care Act 2012 to ensure greater integration of care, and the announcement of the integrated care pioneer sites was welcomed in the NHS. Key to this is achieving better horizontal integration across health and social care services in the community. On this basis, any approach to integration that solely brings together community health and community social care service provision but excludes primary medical care is not sustainable.

We believe that no models of care provision would be truly integrated without general medical services at their heart, as general practice remains the central point for cradle to grave care and has responsibility for the registered list of patients. Logistically, however, connecting services to general practice has been challenging and various models of joint working with community health and social services have been tried with varying degrees of success.

Recent reorganisations have arguably weakened relationships between general practice and community health and care services. However, in a number of locations there is now growing interest in orientating community health services more closely around general practice. A similar opportunity also exists for mental health services, given the large number of patients with mental health needs that are managed in general practice.

This suggests the importance of developing models of provider collaboration across a range of different disciplines and organisations, bringing together services such as general practice, pharmacy, mental health, social care and physiotherapy, as well as specialist and hospital-based services. These models should focus on ensuring a smoother continuum for patients, including people with multiple and complex conditions who need management and coordination of care, specialist intervention from physical or mental health teams, and specialised support services to enable them to live independently. General practice federations or Multispeciality Community Providers could provide possible organisational models that provide the basis for such collaboration.

In summary, we are clear that integrating health and social care structures can do much to enhance the delivery of patient centred care, especially in addressing health and social care needs as part of the same service package. However, more work is needed to build on the lessons of the integrated care pioneers and tackle contractual barriers that could prevent general practice from being at the heart of integrated care.

Recommendation:
- The Department of Health should review the current financial and regulatory environment to ensure it supports the development of organisational models that bring together general practice with community health, social care and mental health services.

Vertical integration between primary, community and secondary care

One of the most consistent strategies being deployed across the world to deliver high value care is the drive to create vertically integrated healthcare organisations, which move the focus from clinical services delivery to population health management. Accountable Care Organisations in the USA are the most prominent of these, but many countries already have small scale examples of such approaches.

In the NHS we have seen a small movement towards vertical integration of services, as a number of acute hospital trusts now provide both hospital and community services. The RCP’s Future Hospital Commission described how its concept of a single unified Medical Division can act as a coordinating point for hospital-initiated care, both within the hospital setting and also reaching out into the community (Future Hospital Commission 2013). NHS England has subsequently set out a new care delivery option, the Primary and Acute Care System, which captures these intentions and creates a new opportunity for the NHS to try such innovations (NHS England 2014).

However, across the world we have yet to see the engagement at scale of vertically integrated care that emanates from general practice rather than hospitals. Although we recognise the logistical challenges entailed, this model should be further explored as the potential basis for a Primary and Acute Care system. This could be achieved either through a single leap between hospital and primary care or as a development of the Multispeciality Community Provider Organisation.

From our consideration of how the NHS might facilitate this shift, we believe the success of such organisations would require six elements:

1. The adoption of a population health outlook. This would underpin the design and delivery of services, with clinical services viewed as one aspect of a broader spectrum of services.
2. The offer of a longer term outcomes-focused contract.
3. Flexibility within the organisation to operate local contractual arrangements with staff.

4. The adoption of a culture of patient centred care that engages patients as equal partners in their care, and populations in their own health.

5. Primary care services that work formally at scale, including bringing registered lists together.

6. Stronger connections between health services and the wider community services planned and delivered through local government, whose statutory duties include the wellbeing of their population.

All of these elements would, in our view, point to the value of exploring new models of vertically integrated care that take a primary care perspective as their starting point. This is not to suggest that such models can be delivered by general practice alone; indeed it is clear that the leadership for such radical change would need to draw on local hospital trusts and wider local government, alongside professionals from primary, community and social care. It is simply that the key components of a population health approach are more fundamentally enshrined in primary care and general practice than any other part of the system. For example, screening, vaccination, and chronic disease registers are all features of existing practice and form the bedrock of population health.

We believe there would be considerable merit in developing and learning from this concept – alongside other models of integrated care – in a number of health economies in England. However, it is crucial that the way in which these new models are resourced and held accountable reflects the central role of primary care and general practice in achieving the delivery of proactive, patient centred care in the community, in parallel with harnessing leadership, expertise and resources that reside within secondary care.

CASE STUDY: Mayo Clinic: a multispeciality Accountable Care Organisation

Accountable Care Organisations (ACO) developed in the United States in response to the need for more accountable and integrated forms of delivering health services. ACOs take many forms, but the basic concept is that a group of providers agrees to take responsibility for providing all care for a given population for a defined period of time under a contractual arrangement with a commissioner. Providers are held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target (Shortell et al 2014).

The USA’s Mayo Clinic is an integrated, multispecialty group practice ACO (subsequent case study details sourced from McCarthy et al 2009). It specialises in the diagnosis and treatment of complex patient illness in an environment in which physicians from every medical specialty work collaboratively to meet individual patient needs, often during the same patient visit. This is underpinned by the use of a shared electronic medical record across inpatient and outpatient settings.

Every Mayo patient is assigned a coordinating physician whose job is to ensure that the patient has an appropriate plan of care, that all ancillary services and consultations are scheduled in a timely fashion to meet the patient’s needs, and that the patient receives clear communication throughout and at the conclusion of a visit.

The organisation is physician-led at all levels and operates through physician committees and a shared governance philosophy in which physician leaders work with administrative partners in a horizontal, consensus-driven structure. Salary-based compensation and shared system resources help remove barriers to teamwork that tend to exist in other reimbursement models. Resources are held centrally rather than by individual sites or departments, thus helping to reduce competition or infighting among departments or disciplines.

Improving out of hours care

We received evidence concerning the need for access to primary and community health services out of hours, to prevent patients from remaining in hospital when they could be transferred into the community, and to ensure access to the support necessary to avoid the need for hospital admissions.

We believe that personalised out-of-hospital care should be available to patients who need it 24/7, including seven day support from services in the community to enable patients to leave hospital. It is critically important to ensure that out of hours services maximise continuity of care, with systems in place to facilitate the sharing of patient information and ensure smooth and timely handover of care.

This will require innovative ways of providing coordinated care in the community. For example, networks of general practices – working closely with the wider primary and community care team – could take responsibility for providing out of hours services to patients on their registered list. However, there should be no ‘one size fits all’ model for the provision of out of hours services. Providers and commissioners must have the ability to develop models to reflect the context for service delivery and the needs and priorities of their populations.

Recommendation:

- NHS England should pilot and evaluate the establishment of vertically integrated healthcare organisations that reflect the central role of primary care in the delivery of a population-based health approach.

Recommendation:

- CCGs should work with general practice and other primary care, community health and social care professionals to develop new models of collaborative working to ensure delivery of personalised out of hours care for patients in the community.

The need to provide better, more joined-up out of hours care should be balanced against the need to ensure that the workforce – including the primary care workforce – has the capacity to deliver this effectively. Solutions need to be developed that provide good access to primary care for patients without creating unmanageable workloads. This will require a system wide approach. We believe it is perfectly possible to achieve both aims by establishing an appropriate balance of advice, care and support for patients from a range of services and professionals – making sure that the right advice and professional intervention is available, and that patients’ social as well as medical needs are met.

Consideration should also be given to how out of hours models will relate to other services within the local area. For example, there is a risk that the development of services such as walk in centres and minor injury units may lead to the emergence of new supply-induced demand, without necessarily leading to a reduction in pressures elsewhere in the healthcare system. We welcome the description of the new model of Urgent and Emergency Care Networks, set out in the Five Year Forward View, and recognise its potential to deliver greater coordination and cohesion of out of hours care.
The value for money argument of investing in this sector is, in our view, proven and the development of this sector could hold the key to a sustainable health and care system in the UK. We also believe that capitalising on this opportunity could be the greatest single factor in the drive to establish patient centred care in the medium term.

In addition, we believe that primary care and other community-based NHS providers will increasingly need to build partnerships with commercial sector organisations, including high street pharmacy chains and suppliers of direct-to-consumer digital technologies. This move will, in our view, be driven by health service users, who will increasingly access health and wellbeing services offered by the commercial sector both online and in the high street – such as home test kits and wearable technologies that collect and track health information.

It is important that statutory providers accept – and welcome – these new routes to accessing healthcare resources and information, and find ways to work collaboratively with commercial stakeholders to maximise benefits for patients, as well as to minimise any risks. Information sharing will be key to this – for example, by providing the means to upload data obtained from the commercial sector to the patient’s health record, subject to the individual’s consent and with necessary safeguards. Equally, statutory providers will inevitably play an important role in guiding and advising patients on how to make best use of the services available from the commercial sector.

### Collaboration with third and commercial sector organisations

If care is to be truly patient centred then it is essential to understand and support the role that patient and community led third sector organisations can play in delivering a range of care services. Countless examples are present up and down the country: some constituted formally and part of major national charitable organisations; others intensely local, based on informal networks; and many virtual, as online communities. Such groups play a vital role in enabling patient centred care and often provide the bulk of patient contact, even where long term conditions are multiple and complex. Enlightened local health systems place such groups at the heart of their planning and resource them accordingly, but too often these groups are at the edge of NHS thinking and are subject to the uncertainties of annual funding cycles and bids.

Given the creation of social value and the development of social capital that many of these organisations offer, we would wish to see a greater commitment to establishing longer term contracts, and to unlocking funding for new preventative services through mechanisms such as social impact bonds (see glossary). There is also scope for the delivery of more innovative national funding. For example, a long term strategic framework funded through the national lottery has enabled the UK to create a world class sporting infrastructure in the last decade, and we believe it would be possible to replicate this for a world class third sector health and social care system now.

### CASE STUDY: Age UK’s integrated care programme

Age UK’s Integrated Care Programme operates across England and brings together voluntary organisations and health and social care services in local areas to provide an innovative combination of medical and non-medical support for older people. Age UK staff and volunteers become members of primary care led multidisciplinary teams, providing care in the local community for older people with multiple long term conditions who are at risk of recurrent hospital admission.

Age UK works with local health and social care services to draw up shared care management plans for the older people on the programme, based on guided conversations with them about their goals and social needs. The older person receives support from a volunteer to help them carry out the activities highlighted in their plan, and wrap-around support services are provided by the voluntary sector. Regular multidisciplinary team meetings are held involving GPs, community nurses, social care and the local Age UK office to review the support needs of the older people receiving the service.

One example of the programme is the Newquay Pathfinder, which was established in 2012 and is one of the Government’s integration pioneers. During the first year, there was a 30 per cent reduction in non-elective hospital admissions among the 100 older people helped, and it has been calculated that the programme could have potentially saved up to £4 within the health and social care system for every pound spent.

### Recommendation:

- Funding structures should be developed that encourage providers of community-based care, including general practice, to develop joint services and links with the voluntary sector.

### D. Improving commissioning

We have received evidence and have a strongly held view that, despite policy rhetoric about the importance of patient centred care, many of the financial, contractual and commissioning processes currently operating in the health and social care system are insufficiently aligned to achieve this outcome. As a result it is harder on the ground for health and social care professionals, informal and formal carers, voluntary groups, and professional organisations to provide patient centred care without financial penalty or risk.

As an illustration of this point, practices that excel in providing patient centred care to patients with complex needs and that invest in providing a broader range of support services, are unlikely to be financially rewarded for doing so, and may well be worse off. Taking the time to engage with patients, improve health literacy, and support community orientated patient and volunteer groups can all contribute to improved health outcomes and lower overall health and social care costs – for example, by increasing independence and reducing referrals...
and emergency admissions. However, the financial benefits of doing so often accrue to other parts of the system, rather than to practices themselves.

Key to commissioning patient centred care will be developing improved metrics to measure its delivery. Although significant progress has been made in recent years (see, for example, Hibbard and Giburt 2014; Collins 2014), this remains challenging, not least given the inherently individualised nature of patient centred care and the relative paucity of comparative data across many areas of community services.

In this section we identify a number of areas that would help to improve the commissioning of services in order to deliver patient centred care. These cover:

- co-commissioning and reintegration of fragmented budgets
- patient held personal budgets
- population health management and new forms of contracting.

Co-commissioning and reintegration of fragmented budgets

Co-commissioning can take a variety of forms and contractual routes, but at its heart is the recognition that resources relevant to meeting the needs of patients, especially those with multimorbidity, rarely sit within one budget. In a world where physical, mental and social needs all make a significant contribution to people’s wellbeing and health outcomes, the need to align budgets and consequently financial incentives is imperative.

Commissioning of medical services in general practice has largely been undertaken through the framework of a national (general medical services), or a local contract (personal medical services, and alternative personal medical services variations). Currently, the budgets and accountability for contracting primary care services rest with NHS England, and are separate from the respective responsibilities that CCGs and local authorities have for commissioning hospital and community services, and health promotion and social care services.

At a general level, we believe strongly that this fragmentation of budgets makes it harder to incentivise and reward integrated care that is centred on the patient (and their carers). As a result, we welcome recent moves by NHS England to create opportunities for re-integrating budgets through co-commissioning. We believe it is possible to protect against any undue or inappropriate influence on primary care spending by GPs, who have vested interests in their independent businesses, through processes of good governance and transparency.

Bringing budgets together and allowing a primary care based commissioning perspective to influence service delivery and design would help to ensure that pathways of care and deployment of resources support patient centred care. Delivery of these goals could be further enhanced by enabling patients themselves and the full range of formal and informal primary care providers (including pharmacists, voluntary and community groups) to play a greater role in the commissioning process.

One area in which we see particular potential for co-commissioning is in the relationship between pharmacy and general practice. By encouraging more effective arrangements for collaboration, co-commissioning of pharmacy and general practice services could help drive increased uptake of support for self care, and enable improved management of medication for patients with multimorbidity. There are also a range of other areas – such as children’s services, sexual health services, and learning disabilities services – where co-commissioning could have a significant impact on enabling better outcomes and patient experience, given the high degree of fragmentation of commissioning responsibilities that currently affects them.

If there are benefits from integrating fragmented health budgets, this is equally true across health and social care. The establishment of the Better Care Fund represents an important step in this direction, whilst also illustrating the complexities involved in agreeing risk sharing arrangements, particularly in a cash-constrained environment.

The ultimate application of the principle of co-commissioning would be the introduction of a single integrated budget that recognises the interrelationship of the physical, mental and social needs of service users and their families. We strongly support this approach, which we believe should focus on agreed patient centred outcomes, with a particular emphasis on those with multimorbidity. We expect that, over time, this would lead to a gradual shift of resource towards increased provision of proactive and preventative health and social care in community settings.

Case Study: Earls Court Health and Wellbeing Centre

Earls Court Health and Wellbeing Centre, in London, is an example of innovative commissioning that brings together general practice, dentistry, sexual health, and wellbeing services under one roof. The service, which is jointly funded by the NHS and the local authority, integrates a range of services with a commitment to delivering care that addresses physical, mental and social wellbeing. As part of its wellbeing services, the centre offers wellbeing coaches and peer mentors, as well as a range of healthy living activities and employment workshops in its communal space. Volunteers, known as “Centre Champions”, help ensure that people are able to access the health or social care services they need.

The Centre’s design was informed by Turning Point’s model of Connected Care, in which local people are empowered to shape the way services are commissioned to better meet the needs of those they are intended to serve.
PatIent centred cAre In the 21st century

Co-commissioning should be developed in a way that allows maximum flexibility for integration between general practice and other primary, social and secondary care budgets, so as to facilitate the delivery of patient-centred care in the community. Particular attention should be paid to the opportunities for co-commissioning to enable better integration between pharmacy and general practice, and to meet the needs of people with multimorbidity.

Co-commissioners should take steps to ensure that both patients and the full range of community-based primary care providers (both formal and informal), are able to input into, and help shape, the development of local commissioning plans.

Recommendations:

- Co-commissioning should be developed in a way that allows maximum flexibility for integration between general practice and other primary, social and secondary care budgets.

- Co-commissioners should take steps to ensure that both patients and the full range of community-based primary care providers (both formal and informal), are able to input into, and help shape, the development of local commissioning plans.

Patient held budgets

Following the introduction of personally held social care budgets from the 1990s onwards, the NHS piloted, and then rolled out on a national basis, personally held budgets as a means of creating more patient-centred commissioning of treatments and care. Building on this, NHS England has recently set out proposals for a new integrated personal commissioning programme, based on the principles of person-centred care. These are targeted at people with complex needs, and will involve the option of a joint personal health and social care budget and a ‘year of care’ capitated payment model.

Personal health budgets can allow patients to exercise greater choice over how and by whom their care is provided, for instance by employing their own personal assistants. In addition, they can offer patients greater flexibility to access support tailored to their needs, which may fall outside the boundaries of traditional services.

We welcome the move to extend opportunities for personal budgets and believe this can contribute substantially to the delivery of patient-centred care. Equally, we believe there are not a panacea for all patients in all circumstances, and that, in line with the principle of patient-centred care, their use should remain voluntary for patients.

The NHS Confederation has identified a series of criteria that, if met, indicate that a service area is more likely to be amenable to personal health budgets (NHS Confederation 2009). These are: the existence of a clearly defined pathway of care; easily quantifiable units of activity; patients with stable, predictable needs; regular contact with a health professional; and, non-specialist interventions.

It is vital that personal health budgets are underpinned by a strong collaborative relationship between patients and professionals, in which they work together to set patient-centred goals, review outcomes, and plan care on an ongoing basis. GPs are central to this process, and the RCGP has produced a guide for GPs on their role in facilitating the appropriate use of personal health budgets (RCGP 2012b). Patients must be fully informed of the potential risks and benefits of the different treatment options that they might be considering accessing via their personal health budget, and commissioners must ensure that patients receive the support they need to manage their budgets and purchase care.

Recommendation:

- Patient held budgets should be underpinned by arrangements to ensure strong collaborative working between patients and professionals, with recognition given to the central role of GPs in supporting their appropriate use.

Population health management and new forms of contracting

The current contractual structures within general practice, and the incentives they produce, focus strongly on disease rather than health promotion, and on specific treatments rather than the whole person. They remain a huge improvement on the bureaucratic, fee for service system in operation under the previous GP contract but are insufficiently aligned to reward the delivery of patient-centred care.

Within the existing contract structure, we are supportive of the Quality and Outcomes Framework, which is enshrined in all GMS and most PMS contracts. However, we believe that it is necessary for the QOF to change to reflect our evolving understanding of the clinical evidence and the design of effective payment systems.

A number of options have been mooted during our inquiry that may all be worthy of exploration. One size almost certainly does not fit all. Whilst there is a need for evidence-based incentives (and, in some cases, greater standardisation of clinical processes) local ownership and design of contracting approaches should be encouraged, combined with patient and public involvement through greater transparency of procurement.

1) Evolution within the current QOF structure

There is a strong case to enhance the QOF in its current form to ensure it relates better to delivering holistic care and improving patient experience. These areas are not suitably covered by the current metrics and we need to find better ways to measure whether patients genuinely regard their care to be tailored to their needs.

One important aspect of this is the under-recognition of mental health disorders and learning disabilities relative to their prevalence in general practice consultations and their co-morbidity with physical health problems. We believe that a new iteration of the QOF should place greater emphasis on interventions to support people living with mental health disorders and learning disabilities. This would be an important step towards holistic care and improved health outcomes, including closing the life expectancy gap for people in these groups.

2) A national core QOF with scope for local elements to be introduced

As an alternative to a single standardised national QOF, we believe that there could be a variation under which the core elements of the current QOF would be maintained, but with the addition of some key elements geared towards the delivery of patient-centred care as defined at a local level (subject to clear evidence of their contribution to achieving specific local outcomes and goals). This hybrid would be a way of recognising, for example, the work that many practices undertake at the heart of their communities to create community groups or informal care networks. It would also have the benefit of allowing experimentation with new criteria, standards and measurement.

3) A shift to shared population health management approaches

The third route to improve contracting would be the most radical and would reflect the fact that the science of population health management is developing rapidly. Evidence from Valencia’s Aitza model, for example, highlights the benefits of this approach (see case study below and also NHS Confederation 2011). Given the existence in the NHS of a single registered list of patients, the NHS should have a significant advantage in implementing this approach.
CASE STUDY: The Alzira model

The Alzira model in Valencia, Spain, has operated since 2003 and has employed different mechanisms with the objective of providing integrated and efficient health services. The model has utilised both capitation and outcomes-based mechanisms in support of this objective.

Key to the model’s success has been the adoption of a primary care orientation as part of the integration of primary and secondary care. A single provider is responsible for all healthcare provided to the population of the region, receiving a fixed annual capitated budget.

The model has delivered the following outcomes:

- improved clinical outcomes and high patient satisfaction, facilitated by closer integration of services and pathways;
- emergency waiting times in an acute setting of 60 minutes – versus a wider regional average of 131 minutes;
- the costs of providing health services to the commissioner have been reduced by 25 per cent, with costs far lower than regionally and nationally.

In such cases there would be a contract let for the management of the health of a given population, that may include parties other than existing GP practices (such as wider community health and social care services, local pharmacy services or, as in the case of the Spain’s Alzira model, the local hospital service provider). Contracting models associated with a population health management approach may vary from prime contracting, through a lead service provider who would subcontract with others, to an alliance contracting model where all contracted parties would work to shared incentives and goals.

CASE STUDY: Alliance contracting in Canterbury, New Zealand

“The first thing we do when there is a problem, and because this is an alliance, is ask ‘How can we help?’ You are not performing. What’s the problem? Can anyone else in the alliance help?’ And we put resources in. Because the idea of an alliance is that nobody fails. We either all fail or all succeed.” – Carolyn Gullery, Canterbury Health Board. (Cited by Timmins and Ham 2013)

The Canterbury health authorities in New Zealand have radically changed their approach to contracting as part of a strategy to relieve pressure on hospital care and meet the needs of a growing, ageing population.

Instead of input defined, competitive and often fee-for-item-of-service contracts with penalties for under-performance, Canterbury has moved towards a form of ‘alliance’ contracting for a wide range of services across the health system. As The King’s Fund observes, the idea is to create a ‘high trust, low bureaucracy’ approach to contracting that encourages innovation over the means of delivery because it is the broad outcome – ‘What is best for the patient? What is best for the system?’ – that is the overarching goal (Timmins and Ham 2013).

Alliance contracting is one element of a broader approach to delivering more integrated care in Canterbury. The results of this include:

- a shift in resources from acute hospital care towards community care and elective hospital services;
- decreased acute admissions, readmissions and length of stay;
- more care is delivered by services outside the hospital – such as community-based radiology, spirometry tests, and more minor surgery performed in the community;
- fewer patients are entering care homes as more are supported in the community;
- a lack of gridlock and less acute strain on the hospital have allowed elective surgical activity to rise, with waiting times for elective surgery down.

Should a population health management model be adopted – and we believe that a number of Multispeciality Community Providers and Primary and Acute Care Systems will emerge in the UK on the back of NHS England’s Five Year Forward View – then we would envisage that current primary care contracts would be subsumed into a single larger contract. This would need to have considerably more longevity (contracts in Spain have ranged from 15 to 25 years) if they are to be attractive to service providers. In addition, contracts could build in shorter term quality metrics measuring patient centred care, given the key role of this in delivering improved outcomes at a lower cost.

Allowing local flexibility of contracts would not require forced changes to remove independent contractor status and make all GPs salaried. Prime or alliance contracting, for example, can easily accommodate both independent and salaried options, with the choice left to individual GPs and other clinical staff.

Recommendations:

Options for reforming the GP contract should be explored as a matter of urgency. As part of this:

- QOF should be realigned to better recognise multimorbidity, mental health interventions, learning disabilities and patient empowerment;
- NHS England should work with CCGs to encourage uptake of new population health management approaches, such as Multispeciality Community Providers and Primary and Acute Care Systems, that build on the primary care platform;
- NHS England should work with CCGs to encourage alliance contracting models.

E. Creating the right infrastructure for patient centred care

In this section we consider the key actions that are needed to ensure that the supporting infrastructure components are in place to support patients, professionals, providers and commissioners to deliver patient centred care. These relate to:

- leadership and governance
- clinical guidelines
- regulation
- resources
- workforce planning and commissioning
- technology.

Leadership and governance

In order to achieve the vision set out in this report, the NHS will need leaders that understand primary care and are committed to breaking down professional silos and organisational barriers. Changes must be made to decision-making structures to give a stronger voice to professionals working in primary care at all levels of the NHS. This will necessitate attracting and equipping more people from primary care backgrounds to take up leadership roles; not only GPs, but also professionals from other groups, such as community nursing and the allied health professions.

Previous leadership initiatives have tended to focus on secondary rather than primary care; the NHS Leadership Academy should work with the relevant professional bodies to ensure that this is not perpetuated. GPs have been key to establishing CCGs, and are critical to successful provider-led reform – including the development of general practice federations. It is therefore important to ensure that there is a sufficient pool of GP leaders for the future. As the professional body for GPs,
the RCGP clearly has a vital role in supporting this. In addition, there is a need to tackle the practical barriers that can hold individuals back from taking on leadership roles, such as the need to provide backfill for time spent away from the direct provision of clinical care.

We are very supportive of the growing numbers of patient leaders who are able to bring a strong patient perspective into the heart of health and care decision-making, and commend those places that have begun to operate in this way. However, we believe that in order to embed the patient voice consistently across the NHS, there is a pressing need to encourage and equip patients to take up more leadership and governance roles – including through the provision of leadership development opportunities.

Recommendations:
- GPs and other primary healthcare professionals should be encouraged and trained to take on system leadership roles.
- Development opportunities should be provided to patients to take up leadership roles.

Clinical guidelines
Clinical guidelines, and the way in which they are used, should reinforce patient centred care. NICE has recently announced its intention to develop guidelines to help manage multimorbidity, and these should be progressed as quickly as possible, together with the decision aids and information needed to enable clinicians to discuss the issues appropriately with patients. Financial and professional frameworks must recognise that guidelines are a tool to be used in the context of a patient’s goals and circumstances, and where there is a clinical need to diverge from them in the interests of patient centred care, clinicians must not feel that this will lead to professional censure or financial penalty.

To support the development of clinical guidelines, greater research is needed into improving the clinical outcomes and quality of life of those with multimorbidity. Backed up by better access to research funding. Future studies of interventions should not exclude patients with co-morbidities, and should explicitly describe the risks and benefits of the intervention for patients with different combinations of co-morbidities. In particular, there should be more research into effective approaches to addressing the risks of polypharmacy (the use of multiple medications to treat a patient).

Recommendations:
- NICE should prioritise the development of guidelines to help manage multimorbidity.
- Information and tools should be produced to enable clinicians to explain to patients the benefits and risks of treatments and how these vary depending on personal circumstance, for instance according to the number of long term conditions a person has.
- More research should be undertaken into effective treatments for those with multimorbidity, and research funding bodies should support this by increasing the proportion of resources that they devote to this area.

Regulation
We believe that the power of professional ethos is the most sustainable way of achieving changes in practice, and recognise the dangers of externalising responsibility for ensuring the provision of patient centred care. Indeed, depending on the metrics and standards used, there is a risk that inspection can skew the nature of practice activity in ways that do not reflect patient priorities. It is therefore important that inspection regimes are designed in a way that reinforces the need for patient centred care, for example by including patient activation scores.

We received evidence from the Care Quality Commission regarding the new framework it is introducing for inspecting GP practices, under which practices will need to be able to demonstrate that they take a person centred approach. The inspections will include an examination of care of those with long term conditions, including to what extent the practice provides: care tailored to reflect individual needs, values and choices; regular patient care reviews, involving patients and carers; and support to patients and carers to ensure the provision of coordinated, multidisciplinary care.

Vital to creating an environment that is conductive to patient centred care is the process of soliciting, evaluating and acting upon patient feedback. We therefore recommend that, as part of its inspections, the Care Quality Commission looks for evidence that this is taking place, both at an individual and organisational level. Where patient centred care is demonstrated to be present this should be explicitly recognised and rewarded, while where services are found not to be sufficiently patient centred, it is important that the underlying causes are understood and tangible ways in which improvement can be achieved are identified.

Recommendations:
- As part of its general practice inspection process, the CQC should look for evidence of mechanisms for soliciting and acting upon patient feedback.

Resources
We believe that the delivery of effective patient centred care in community settings will be crucial to addressing the funding pressures that the NHS is facing. Indeed, there is a growing consensus among policymakers that, in order to meet the needs of an ageing population in a time of financial constraint, the NHS must deliver more care in community settings to promote independent living for longer and focus more on preventing ill health rather than simply treating it. In order to make this happen, it is critical to invest in good primary care, which not only delivers better health outcomes but also lower overall healthcare costs (Starfield et al 2005; World Health Organization 2008).

We feel strongly that NHS England and the Government must take immediate action to increase investment in community-based care, including general practice. However, we recognise the pressure on hospital-based acute care in the interim, and so recommend a phased approach to ensure that these essential services remain viable. Taking account of this, we recommend that investment in care delivered in the community increases at a proportionately faster rate annually than spending on hospital-based care. This should include investment in new models of care that promote the transition from services traditionally provided in hospital settings to more collaborative models, involving specialists and generalists working together in the community.
Additionally, we believe that there is an opportunity to allocate a proportion of this investment to a new ‘primary and community care transformation fund’ that would be used to support the delivery of patient centred care in community settings. Such a fund should be accessible to all agencies and organisations – whether they are statutory, non-statutory, community or hospital-based – subject to their ability to demonstrate greater value for patients, families, carers and taxpayers in community settings.

Recommendations:
- From 2015 onwards, NHS England should increase spending on collaborative models of community-based care at a faster rate annually than spending on hospital-based care until a more equitable balance has been reached.
- NHS England should allocate a proportion of additional investment in community-based care to a primary and community care transformation fund to support the delivery of patient centred care in community settings.

Workforce planning

In order to deliver effective patient centred care, the NHS will require a workforce that is trained to respond to the complex and broad needs of patients with multimorbidity. The inquiry therefore welcomes the recommendation of the Shape of Training report that young doctors should undertake a broad-based curriculum before making a final career choice.

It is vital that our healthcare professionals are taught the principles of managing long term conditions, including how different diseases interact (particularly physical and mental health disorders), and how to empower patients to self manage, make decisions about their care, and change behaviour that is harmful to their health. We heard that GPs’ skills as ‘expert generalists’ mean they are well placed to provide this type of personalised and continuous care to people living with multiple long term conditions. However, the potential for general practice to meet this challenge is being undermined by a lack of workforce capacity.

The Centre for Workforce Intelligence has found that current GP workforce levels are not sustainable and, without a significant increase in size, the GP workforce will be insufficient to adequately meet expected patient needs (Centre for Workforce Intelligence 2014). Yet despite steadily rising demand for GPs, the GP workforce has grown more slowly over the past decade than other areas of the health service.

We welcome the Government’s target for 50 per cent of specialty trainees to choose to enter GP specialty training by 2016, as set out in its mandate to Health Education England (Department of Health 2014), thereby increasing the number of GP trainees to 3,250 per year. However, it appears increasingly unlikely that these targets will be hit. The number of GP training vacancies in England averaged only around 2,700 per year between 2009 and 2012, rising slightly to 2,850 vacancies in 2013, of which only 2,744 were filled — significantly below the Government’s target increase by 2016.

Urgent action is therefore needed to recruit more medical students into general practice. This will require a shift in the undergraduate medical curriculum, with more positive exposure to general practice as part of the teaching programme, coupled with an increase in the number of academic GPs. Furthermore, in order to help address the recruitment problems faced by under-doctored areas (which broadly tend to be more deprived), incentives should be introduced to attract trainees into these areas.

GPs are only one component of the primary care and general practice team. The CfWI has found that the practice nurse and advanced nurse practitioner workforce also have the potential to significantly expand in size (Centre for Workforce Intelligence 2014). For this to happen, however, there is a pressing need to develop both national training standards and clear career pathways for practice nurses. This may involve thinking in different ways about how practice nurses are employed — for example, smaller practices may come together and employ nurses as a group in order to offer career progression.

As part of a strategy to attract more nurses into general practice, and primary and community care, all undergraduates should undergo placements in primary and/or community care as part of their undergraduate training. HEE should work with the Nursing and Midwifery Council to develop both national training standards and clear career pathways for practice nurses and to ensure that all undergraduate nurses undergo placements in primary and/or community care as part of their core training.

Recommendations:
- The GMC should increase pressure on medical schools to promote the importance and potential of general practice, to increase the proportion of the curriculum taught in general practice settings, and to shift the balance of medical academics with more academic GPs (particularly in positions of leadership).
- HEE should deliver a substantial and sustained increase in GP training numbers, including incentives to attract trainees into under-doctored areas and measures to increase short term supply, such as retainers and return-to-practice schemes.
- HEE should take action to increase the number of staff entering the wider primary care and community health workforce, including community and primary care nursing staff.
- HEE should work with the Nursing and Midwifery Council to develop both national training standards and clear career pathways for practice nurses and to ensure that all undergraduate nurses undergo placements in primary and/or community care as part of their core training.
Access to accurate and timely information is a prerequisite for the delivery of coordinated, patient centred and evidence-based care. As such, effective digital information systems that systematically gather, link and analyse data about service users – including their needs, preferences and experiences of care – will be fundamental to driving outcomes that matter to patients (see also ‘Transparency of data on general practice and primary care above’).

It is absolutely crucial that the NHS develops interoperable systems that allow comprehensive electronic patient records to be shared across all care settings (including with patients and between health and social care), with the option for patients to opt out if they wish. Despite broad recognition of the importance of achieving this, progress towards shared electronic records has been slow, and some secondary care providers still rely on paper records. As a result, we welcome NHS England’s renewed commitment to achieving fully interoperable electronic records in its Five Year Forward View and support its intention to focus on developing key systems that will enable different parts of the health service to work together, while providing nationally specified interoperability and data standards that local systems must meet (NHS England 2014). We strongly believe that the use of shared electronic records must be treated as core to health and care services – rather than a ‘nice to have’ addition – and recommend that support and funding is targeted at organisations most lacking in digital capacity.

We are only beginning to understand the potential of new digital technologies – such as smart phone apps and wearable technology – to transform care delivery. We believe that it is vital that NHS England offers national leadership and support for the development and adoption of new digital technologies, working with key third sector and commercial stakeholders. As part of this, there is a need for clear and concise documentation of the advantages and disadvantages associated with the use of new technologies, for example through pilot programmes, to support other organisations to implement them efficiently and at scale.

General practice IT systems have pioneered the use of digital records in the NHS, but there is still huge potential to make better use of digital technology in primary care. We welcome the contractual imperative for all practices to offer online appointment and prescription booking by March 2015, but we are concerned that many practices are still some way from providing online booking to all patients. At the same time, further incentives and support should be offered to practices to use technology to improve access to services – including through online, telephone and skype/voip consultations – and should build on learning from the Prime Minister’s Challenge Fund pilot sites (NHS England 2013b).

Recommendations:

- NHS England should work as a matter of priority to implement common standards of interoperability between electronic patient record systems, to enable the real-time sharing of patient information, with the patient’s consent, across care settings and between members of the multidisciplinary team.
- Financial incentives and support should be offered to practices to implement and evaluate new technologies to improve patient access and care.

We describe here what we think the core components of patient centred primary care might look like. This vision is not exhaustive, and nor is it intended to be prescriptive. As we outlined in Chapter 4, we believe that change of this kind is possible but is likely to require different approaches in different parts of the country. Crucially, it will only happen if those people delivering care are afforded freedom to innovate.

Empowering, holistic and personalised care

- Primary care has shifted from an emphasis on reactive care (treating people when they are ill) to a proactive model that aims to help people to remain independent and well for as long as possible.
- A personalised, ‘whole person’ approach underpins all primary care consultations. Primary care professionals start by listening to what their patients want to achieve and take account of their physical health, mental health, and the context in which they live.
- The goal of empowering patients to be equal partners in their own care is embedded as an essential part of care provision. The relationship between the patient and the professional has shifted from a traditional ‘top-down’ approach to a collaborative partnership. Professionals support and motivate patients to play an active role in determining their own care and support, and work with patients to help them to make lifestyle changes that benefit their health and wellbeing.

For patients with long term conditions (physical and/or mental), personalised care planning is the norm. Patients are involved in reviewing and planning all aspects of their care, with input sought from a range of professionals and services as appropriate, and priority is given to the patient’s own needs and preferences. General practice services have the flexibility (and capacity) to offer longer consultations to those who need them, and agree regular, systematic follow-up to maintain progress.

Patients and, where appropriate, their carers are given the support they need to live with and self-manage their long term condition(s), including access to reliable information, decision aids and community support services, and specialist advice and support. Each patient with complex needs is assigned a single care coordinator – such as their nurse, social worker, GP or a third sector professional – whose job is to support them to navigate through the system and ensure that their care plan is implemented.

Primary care services work collaboratively with commercial sector organisations to support patients who wish to use direct-to-consumer products and digital technologies – such as home test kits and wearable technologies that collect and track health information. Primary care professionals play an important role in guiding and advising patients on how to make best use of these services, and patients have the option to upload data obtained from the commercial sector to their online health record.
Services organised around the patient

- Health and care provision is organised around the needs of the patient, rather than traditional organisational boundaries. New models of primary care have developed to provide patient-centred services in the community, with the aim of achieving the outcomes that matter most to those receiving them.

- General practice is at the core of these new models of service provision, working alongside a range of other services that people need in the community – including those provided by nurses, allied health professionals, medical specialists, mental health professionals, social workers and third sector organisations.

- By coming together to form federations or networks, practices are able to work at the scale necessary to deliver a wider range of care, integrate with other services, and provide high quality out of hours care. These models are underpinned by flexible commissioning and funding arrangements that break down barriers between providers and allow practices to work at scale.

- Multidisciplinary working is routine, particularly to coordinate care around people with multiple conditions. Primary care teams work much more closely with specialists across both hospital and community settings and have access to diagnostic and treatment expertise. As part of this, increasing numbers of specialist medical teams work in the community. Collaborative working is supported by the use of shared electronic medical records across different health and care settings, and underpinned by generalist and multidisciplinary training programmes for health and care professionals.

- Patients are able to access primary care services when and how they need them – including by telephone and online – and providers are afforded flexibility to respond to the access needs of the populations they serve. The importance of continuity, particularly for people with complex needs, is recognised and patients are given the choice to see their preferred GP, or other primary care professional, wherever possible.

- Outcomes are focused on what matters to patients and are shared by partners working across all sections of the health and social care economy, driving collaborative working.

Care rooted in the community

- Primary care services are rooted in and accountable to the communities they serve. General practice makes use of its registered list to deliver proactive population health management – such as outreach to individuals not making regular visits, and risk stratification and proactive case management to anticipate needs before they become crises.

- Services are designed to deliver the outcomes that matter most to the people who use them, underpinned by transparent data on patient reported experience and outcomes. Patient partnership groups are essential to this process, and play an active role in scrutinising and improving quality in general practice and primary care services.

Summary of recommendations

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<td>Resources should be commissioned to aid clinicians in communicating with patients of different levels of health literacy.</td>
<td>Department of Health, NHS England</td>
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<td>Greater public awareness of the costs of treatment and the appropriate use of healthcare services should be promoted, through increased communication by politicians and NHS leaders and improved access to cost data.</td>
<td>CCGs</td>
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<td>CCGs should invest in commissioning an enhanced range of options to support self care, accessible via and integrated with general practice, pharmacy and other primary healthcare services.</td>
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<td>NHS England should work with CCGs to trial the routine collection and use of patient activation data in primary care.</td>
<td>NHS England, CCGs</td>
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<td>Resources should be developed to assist professionals and patients to navigate the range of self management and support aids available, both commercially and from the statutory and not for profit sectors, and to use these to the best possible advantage in the context of the patient-professional relationship.</td>
<td>NHS England</td>
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<td>Practices should follow a personalised care planning approach for all those patients in need of proactive care, with particular focus on at risk groups such as those with learning disabilities and patients with multiple conditions.</td>
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<td>Practices should be resourced to undertake the work necessary to make rapid progress towards full online access.</td>
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### Recommendation

- **NHS England should work with the profession and with GP software providers to develop the technological functionality and safeguards necessary to introduce read/write access for patients to their GP health record.**
  - **Who should act:** NHS England

- **More research should be commissioned on designing new routes of patient access, both within general practice and across primary care, with a view to incentivising appropriate service usage and avoiding fragmentation of care.**
  - **Who should act:** NHS England

- **NHS England should commission a range of practical resources and advice that practices can use to improve their online offer.**
  - **Who should act:** NHS England

- **The RCGP should update its guidance on the removal of patients from GPs’ lists, and should work with patient organisations, NHS England and others to review what further action could be taken to ensure high standards in this area and prevent the inappropriate exclusion of patients from GP lists.**
  - **Who should act:** RCGP, NHS England

- **NHS England and CCGs should work with primary care services at a local level to audit whether the specific needs of excluded and vulnerable patients are being adequately met and should put in place robust plans to tackle any deficiencies that emerge.**
  - **Who should act:** CCGs, NHS England

- **More data on primary care should be collected and published to improve understanding of variations in performance and outcomes and of the factors that might lie behind these.**
  - **Who should act:** Health and Social Care Information Centre, NHS England

- **Performance indicators used should be designed in collaboration with primary care professionals, and broadened to place a greater degree of emphasis on measures of patient centred care.**
  - **Who should act:** NHS England, CQC

- **NHS England and CCGs should make available resources and learning opportunities to equip PPGs with the skills and capabilities to be as effective as possible.**
  - **Who should act:** CCGs, NHS England

- **As part of its inspection process for general practice, the CQC should look at how the practice supports the role of its PPG, evidence of collaborative working, and how it has responded to any feedback or suggestions made by the PPG.**
  - **Who should act:** CQC

### Recommendation

**Supporting patient centred professional practice**

- **The Government should fund and mandate the delivery of enhanced four year GP training as a matter of urgency.**
  - **Who should act:** Department of Health

- **HEE should assess the existing curricula for the training of professionals operating in primary and community care to ensure that they sufficiently support the delivery of patient centred care, including the effective management of multimorbidity.**
  - **Who should act:** HEE

- **Practices should routinely audit the quality of shared decision making that takes place in the context of the GP consultation.**
  - **Who should act:** GP practices, CCGs

- **NHS England should work with practices to promote the adoption of new consultation processes to enable them to provide better and more proactive care for those with complex needs.**
  - **Who should act:** NHS England, Local Area Teams

- **The RCGP, the RCP and other Royal Colleges should work together to identify and evaluate new models of interdisciplinary working to deliver complex care to patients in the community.**
  - **Who should act:** Royal Colleges

- **Patients with high levels of care and support need should be assigned a single care coordinator to act as a point of contact for the patient and to facilitate integrated working.**
  - **Who should act:** NHS England, CCGs, Local Authorities

- **NHS England should implement the ‘new deal’ for general practice outlined in the Five Year Forward View, recognising the value of general practice to the NHS and its patients and committing to build on its strengths. New policies should reinforce the importance of the key factors that are central to the success of the general practice model, particularly an easily accessible, local, single point of access; provision of comprehensive services from a generalist clinician; continuity of care; and the registered list, with a clear contractual relationship between individual patients and doctors.**
  - **Who should act:** NHS England
### Enabling provider organisations to change

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Who should act</th>
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</thead>
<tbody>
<tr>
<td>NHS England should accelerate the adoption of new forms of inter-practice collaboration such as federations, by providing practices with protected time and resources to support at scale development, and by launching a pilot programme for the establishment of Multispeciality Community Providers.</td>
<td>NHS England</td>
</tr>
<tr>
<td>The Department of Health should review the current financial and regulatory environment to ensure it supports the development of organisational models that bring together general practice with community health, social care and mental health services.</td>
<td>Department of Health</td>
</tr>
<tr>
<td>NHS England should pilot and evaluate the establishment of vertically integrated healthcare organisations that reflect the central role of primary care in the delivery of a population based health approach.</td>
<td>NHS England, CCGs</td>
</tr>
<tr>
<td>CCGs should work with general practice and other primary care, community health and social care professionals to develop new models of collaborative working to ensure delivery of personalised out of hours care for patients in the community.</td>
<td>CCGs, Local Area Teams, NHS England</td>
</tr>
<tr>
<td>Funding structures should be developed that encourage providers of community-based care, including general practice, to develop joint services and links with the voluntary sector.</td>
<td>NHS England, Department of Health</td>
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</table>

### Improving commissioning

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Who should act</th>
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<tbody>
<tr>
<td>Co-commissioning should be developed in a way that allows maximum flexibility for integration between general practice and other primary, social and secondary care budgets, so as to facilitate the delivery of patient centred care in the community. Particular attention should be paid to the opportunities for co-commissioning to enable better integration between pharmacy and general practice, and to meet the needs of people with multimorbidity.</td>
<td>NHS England</td>
</tr>
<tr>
<td>Co-commissioners should take steps to ensure that both patients and the full range of community based primary care providers (both formal and informal), are able to input into, and help shape, the development of local commissioning plans.</td>
<td>CCGs, Local Area Teams, Local Authorities, NHS England</td>
</tr>
<tr>
<td>Patient held budgets should be underpinned by arrangements to ensure strong collaborative working between patients and professionals, with recognition given to the central role of GPs in supporting their appropriate use.</td>
<td>NHS England, CCGs</td>
</tr>
<tr>
<td>Options for reforming the GP contract should be explored as a matter of urgency. As part of this:</td>
<td>CCGs, Department of Health, NHS England</td>
</tr>
<tr>
<td>● QOF should be realigned to better recognise multimorbidity, mental health interventions, learning disabilities and patient empowerment</td>
<td></td>
</tr>
<tr>
<td>● NHS England should work with CCGs to encourage uptake of new population health management approaches, such as Multispeciality Community Providers and Primary and Acute Care Systems, that build on the primary care platform</td>
<td></td>
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<tr>
<td>● NHS England should work with CCGs to encourage alliance contracting models.</td>
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## Recommendation

<table>
<thead>
<tr>
<th>Creating the right infrastructure for patient centred care</th>
<th>Who should act</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs and other primary healthcare professionals should be encouraged and trained to take on system leadership roles.</td>
<td>NHS Leadership Academy, NHS England, RCGP</td>
</tr>
<tr>
<td>Development opportunities should be provided to patients to take up leadership roles.</td>
<td>NHS England, Healthwatch</td>
</tr>
<tr>
<td>NICE should prioritise the development of guidelines to help manage multimorbidity.</td>
<td>NICE</td>
</tr>
<tr>
<td>Information and tools should be produced to enable clinicians to explain to patients the benefits and risks of treatments and how these vary depending on personal circumstance, for instance according to the number of long term conditions a person has.</td>
<td>NHS England, NICE</td>
</tr>
<tr>
<td>More research should be undertaken into effective treatments for those with multimorbidity, and research funding bodies should support this by increasing the proportion of resources that they devote to this area.</td>
<td>National Institute for Health Research, Medical Research Council</td>
</tr>
<tr>
<td>As part of its general practice inspection process, the CQC should look for evidence of mechanisms for soliciting and acting upon patient feedback.</td>
<td>CQC</td>
</tr>
<tr>
<td>From 2015 onwards, NHS England should increase spending on collaborative models of community-based care at a faster rate annually than spending on hospital-based care until a more equitable balance has been reached.</td>
<td>NHS England, CCGs, Department of Health</td>
</tr>
<tr>
<td>NHS England should allocate a proportion of additional investment in community-based care to a primary and community care transformation fund to support the delivery of patient centred care in community settings.</td>
<td>NHS England</td>
</tr>
</tbody>
</table>

## Recommendation

<table>
<thead>
<tr>
<th>Who should act</th>
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<tbody>
<tr>
<td>GMC</td>
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<tr>
<td>HEE</td>
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<tr>
<td>HEE</td>
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<tr>
<td>HEE, Nursing and Midwifery Council</td>
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<tr>
<td>NHS England</td>
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<tr>
<td>NHS England</td>
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### Appendix One

**Terms of reference:**

The objective of the inquiry is to identify cost effective solutions to the medical, social and financial challenges posed by rising levels of multimorbidity, with a specific focus on general practice in the context of the broader range of primary, community and social care services. In particular the inquiry will consider:

- How do models of NHS care need to change to deliver better outcomes, as cost effectively as possible, for the growing number of people living with multiple long term conditions?

- What does this mean for the way in which NHS resources are deployed in a financially constrained environment?

- How can the role of general practice best be developed in order to support the new models of care required and what policy levers and financial mechanisms should be put in place to deliver these at the scale and pace needed?

The inquiry will be undertaken by a panel chaired by Mike Farrar. The RCGP has agreed the inquiry’s terms of reference and will act as its secretariat, but it will be for the panel members themselves to determine how to proceed with its work and the inquiry’s recommendations will be independent of the College.

### Appendix Two

**Commonwealth Fund measures of patient centred care**

**Source:** Davis et al 2014

<table>
<thead>
<tr>
<th>Patient centred care measures</th>
<th>Raw UK score</th>
<th>UK ranking out of 11 countries (Overall ranking = 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients reporting always or often getting telephone answer from doctor the same day (base: have a regular doctor and tried to contact by phone)</td>
<td>75</td>
<td>8</td>
</tr>
<tr>
<td>Doctor always or often explains things in a way that is easy to understand.</td>
<td>94</td>
<td>1</td>
</tr>
<tr>
<td>Received clear instructions about symptoms to watch for and when to seek further care after surgery or when leaving the hospital (base: those who had surgery or been hospitalised)</td>
<td>88</td>
<td>2</td>
</tr>
<tr>
<td><strong>Continuity and feedback</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the same doctor 5 years or more</td>
<td>59</td>
<td>9</td>
</tr>
<tr>
<td>Doctor routinely receives and reviews data on patient satisfaction and experiences with care</td>
<td>84</td>
<td>2</td>
</tr>
<tr>
<td>Regular doctor always or often knows important information about patient’s medical history</td>
<td>94</td>
<td>2</td>
</tr>
<tr>
<td><strong>Engagement and patient preferences</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist always or often involves patient as much as they want in decisions about care and treatment (base: saw or needed to see specialist in past 2 years)</td>
<td>87</td>
<td>1</td>
</tr>
<tr>
<td>Doctor or healthcare professional discussed patient's main goals or priorities in caring for condition (base: has chronic condition)</td>
<td>78</td>
<td>2</td>
</tr>
<tr>
<td>Specialist always or often tells you about treatment choices (base: saw or needed to see specialist in past 2 years)</td>
<td>85</td>
<td>2</td>
</tr>
<tr>
<td>Regular doctor always or often encouraged you to ask questions</td>
<td>80</td>
<td>1</td>
</tr>
<tr>
<td>Doctor or healthcare professional gives clear instructions about symptoms, when to seek further care (base: has chronic condition)</td>
<td>80</td>
<td>2</td>
</tr>
</tbody>
</table>

**Rationale for choosing this measure:**

- **Communication:**
  - **Patients reporting always or often getting telephone answer from doctor the same day:** Measures the promptness of telephone access, which is crucial for patients with urgent needs. The ranking highlights the need for improvements in this area.
  - **Doctor always or often explains things in a way that is easy to understand:** Assesses the clarity of doctor communication, essential for patient understanding and compliance. The high ranking underscores the importance of clear communication.
  - **Received clear instructions about symptoms to watch for and when to seek further care:** Evaluates the effectiveness of post-discharge care, crucial for patient safety and healthcare efficiency. The ranking indicates areas for improvement.

- **Continuity and feedback:**
  - **With the same doctor 5 years or more:** Reflects the importance of long-term doctor-patient relationships, which improve patient satisfaction and adherence. The relatively high ranking shows room for enhancement.
  - **Doctor routinely receives and reviews data on patient satisfaction and experiences with care:** Measures the feedback loop in care delivery, critical for quality improvement. The ranking reflects the challenge of integrating patient feedback into care.
  - **Regular doctor always or often knows important information about patient’s medical history:** Assesses the completeness of patient information, facilitating informed decision-making. The ranking highlights the need for robust information sharing.

- **Engagement and patient preferences:**
  - **Specialist always or often involves patient as much as they want in decisions about care and treatment:** Evaluates the patient’s involvement in care planning, important for shared decision-making. The ranking suggests areas for improvement.
  - **Doctor or healthcare professional discussed patient's main goals or priorities in caring for condition:** Measures the alignment of care with patient priorities, essential for patient-centered care. The ranking highlights the importance of patient-focused care planning.
  - **Specialist always or often tells you about treatment choices:** Assesses the patient’s role in treatment decisions, crucial for informed consent. The ranking indicates the need for more patient involvement.
  - **Regular doctor always or often encouraged you to ask questions:** Evaluates the patient’s empowerment, critical for active participation in care. The ranking suggests the need for enhanced patient engagement.

**Patient centred care measures**

- **Communication:**
  - **Doctor always or often explains things in a way that is easy to understand.**
  - **Received clear instructions about symptoms, when to seek further care (base: has chronic condition).**

- **Continuity and feedback:**
  - **Regular doctor always or often knows important information about patient’s medical history.**

- **Engagement and patient preferences:**
  - **Specialist always or often involves patient as much as they want in decisions about care and treatment (base: saw or needed to see specialist in past 2 years).**
  - **Doctor or healthcare professional discussed patient's main goals or priorities in caring for condition (base: has chronic condition).**

**Commonwealth Fund measures of patient centred care**

- **Doctor always or often explains things in a way that is easy to understand.**
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- **Regular doctor always or often encouraged you to ask questions.**
- **Doctor or healthcare professional gives clear instructions about symptoms, when to seek further care (base: has chronic condition).**
**Glossary**

**Alliance contracting:** An alliance contract is a contractual arrangement between the commissioner(s) and an alliance of parties who deliver the project or service. There is a risk share across all parties and collective ownership of opportunities and responsibilities associated with delivery of the whole project or service. Any ‘gain’ or ‘pain’ is linked with good or poor performance overall and not to the performance of individual parties.

**Co-commissioning:** When two or more commissioners come together to commission healthcare services, for example NHS England might work with clinical commissioning groups to commission primary care services. This can take a variety of forms and contractual routes.

**Co-morbidity:** The presence of one or more additional disease or disorder co-occurring with a primary disease or disorder.

**Continuity of care:** The degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient’s medical needs and personal context (Haggerty et al 2003).

Three types of continuity exist in all settings:
- Informational continuity — the use of information on past events and personal circumstances to make current care appropriate for each individual.
- Management continuity — a consistent and coherent approach to the management of a health condition that is responsive to a patient’s changing needs.
- Relational continuity — an ongoing therapeutic relationship between a patient and one or more providers.

**Lead provider contracting:** An arrangement where the commissioners issues a contract for a care pathway to a single lead provider, and the lead provider is then responsible for either providing, or subcontracting, the care specified.

**Long term condition:** A medical condition that cannot, at present, be cured but is controlled by medication and/or other therapies. Also known as a chronic condition.

**Medical generalism:** Medical generalism is an approach to the delivery of healthcare that routinely applies a broad and holistic perspective to the patient’s problems. The ability to practise as a generalist depends on one’s training, and on the routine use of skills that helps people to understand and live with their illnesses and disabilities, as well as helping them to get the best out of the healthcare options that are available and appropriate for their needs (RCGP 2012a).

**Multimorbidity:** The coexistence of two or more physical or mental long term conditions, including at least one physical condition.

**Multispecialty Community Provider (MCP):** A new model of care described in NHS England’s Five Year Forward View (NHS England 2014) that will make it possible for extended group GP practices to form – either as federations, networks or single organisations. These providers would become the focal point for a far wider range of care needed by their registered patients, with the aim of shifting the majority of outpatient consultations and ambulatory care out of hospital settings. MCPs could employ consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff. MCPs may also take over the running of local community hospitals and, in time, take on delegated responsibility for managing the health service budget for their registered patients.

**Patient activation:** Describes the knowledge, skills and confidence a person has in managing his or her own health and healthcare.

**Personalised care planning:** Personalised care planning aims to ensure that individuals’ values and concerns shape the way in which they are supported to live with and self manage their long term condition(s). Instead of focusing on a standard set of disease management processes, this approach encourages people with long term conditions to work with clinicians to determine their specific needs and express informed preferences for treatment, lifestyle change and self management support. Then, using a decision coaching process, they agree goals and action plans for implementing them, as well as a timetable for reviewing progress. It is a continuous or cyclical process, rather than a one off event (Coulter et al 2013).

**Personal health budget:** A personal health budget is an amount of money that is allocated to an individual to allow them to meet their health and well-being needs, as agreed between the individual and their NHS team (such as their GP) as part of their personalised care plan. The aim is to give people with long term conditions and disabilities greater choice and control over the healthcare and support they receive.

**Polypharmacy:** Definitions of polypharmacy vary. For the purpose of this inquiry, we have defined polypharmacy as the use of multiple medications.

**Prime contracting:** A model where the commissioner enters into a contract with one provider (the prime contractor or lead provider), who then sub-contracts specific roles and responsibilities to other providers. The prime contractor remains responsible to the commissioners for the delivery of the entire service.

**Social impact bond:** Social impact bonds are a form of outcomes-based contracts. A payer (usually Government, at a national, regional or local level) agrees to pay for measurable improved outcomes of social projects. This prospective income is used to attract the necessary funds from commercial, public or social investors to offset the costs of the activity that will achieve those better results. This approach is possible where better outcomes lead to tangible public financial savings (Mulgan et al 2011).
In-depth
The


References


The views expressed in this report are those of the independent panel and do not necessarily represent the views of the Royal College of General Practitioners.