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Editorial

Could GP commissioning enable collaboration throughout the NHS?

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LJPC acknowledges, as does the current RCGP president, the evidence that national health systems produce better health outcomes at less cost than highly privatised systems.[1] *LJPC* also accepts the analysis of Pollock and Price that general practice commissioning consortia must provide comprehensive healthcare for all residents in geographically bound areas if a national health system is to work.[2]

Vital ingredients of a comprehensive health system is local collaboration and participation.[3] Over the past 20 years the NHS approach to change, termed the *new public management*,[4] has emphasised *markets and targets*. It is based on the idea that competition is the best way to get people to perform well. This ideology works against collaboration and against comprehensive care. It does what markets are good at – trading commodities. It over-emphasises specialist treatment of discrete diseases rather than coordinated care for multiple morbidities and wellbeing that is increasingly a priority. It inhibits team-working across organisational and disciplinary boundaries. With the best intentions, clinicians and managers make costly errors every day through inability to see beyond their own domain.[5] Care pathways, guidelines, research, and education all make the mistake of over-emphasising transactional tasks, and under-emphasising things that are complex, inter-connected and developmental. The inevitable consequence is higher cost at lower quality. These are dangerous times, what happens next might improve things, or make them very much worse.

So can GP commissioning reverse this trend, and redesign health systems to nurture collaboration, keeping competition in its place? Will we reinvent relationship-building mechanisms like extended primary care teams, generalist/specialist interaction, and inter-professional learning? Can we develop techniques that help practitioners and managers to evaluate their collaborative effort? Will we pilot innovations that empower patients and families to collaborate in their own care? If so, then the GP commissioning experiment will have been worth while.

GPs and other generalist primary care practitioners are well placed to see system failure, every day patients bring their stories of things going wrong in every part of health and social care. Generalists are also well placed to see the multiple factors that affect health. Every ten minutes another 'universe of meaning' walks into a GP consulting room. Experienced practitioners know that the 'presenting complaint' is often not the most important thing and is often intertwined with many other issues. One of the jobs of a generalist is to disentangle these multiple components, many of which are better suited to low-tech, coordinated local solutions than to expensive specialist referral or medical testing.

But exposure to the melange of problems inside everyday situations does not mean that every practitioner has eyes to see them, nor skill and opportunity to translate insights into system-wide change. Undergraduate and postgraduate training both fail to adequately train practitioners to think and act beyond the one-to-one encounter, and beyond the medical. Furthermore, divisive structures have prevented exploration of the world beyond the practice front door. Theory and practice of whole system learning and change is unknown and unused. Indeed, as the King's Fund inquiry shows, general practice does not act as part of a wider system of care even for the co-ordination of the core general practice work of end-of-life care.[6]

Just how big is the appetite of GPs to lead commissioning? GP teams are already overwhelmed with the job of dealing with all aspects of health and illness for the diversity of their patients. Many will not want to hold budgets, hold hospitals to account and fiercely gate-keep to contain costs. They will have to change their consultation styles to better explain systems of care to patients. They will need to code and understand data better than before. They will need to

collaborate with other practices and with patient groups, using hours in the day that do not exist. If it is to work there has to be fire in the belly. GPs and other primary care practitioners and managers have to see this as a fight to safeguard traditional NHS values of comprehensive, integrated care. They must hunger to learn the skills to achieve this.

There is a science of whole system integration to be learned.[7] It requires that local people understand their problems, and collaborate to solve them. It sets linear (vertical) links so loved by market theorists inside broader (horizontal) processes of trust-building between human beings.[8] Research into UK healthcare organisations (including in primary care) shows that the high performing ones have clinicians and managers who know how to build trusted relationships, and multidisciplinary leadership teams that build productive relationships across organisational boundaries and over time.[9] Unfortunately, the world expects instant results – trust takes time to build and is more difficult to link to outcomes. It can also be carelessly destroyed, as happens in America when insurance companies reallocate all patients on an insurance scheme to different primary care practitioners.

The RCGP Centre for Commissioning has made a good start on a curriculum for commissioning (www.rcgp.org.uk/commissioning). Commissioning is much more than buying services, it requires broad participation in annual cycles of collective reflection and coordinated action across organisations for a raft of quality improvements. But how to facilitate such complex collaborative improvements is much less well evidenced. Health Services Research into European Policy and Practice (HSREPP) has identified need for research into these knowledge gaps, including: 'the influence of funding on cooperation between primary care providers... the relationship between primary and secondary care... community oriented primary care... professional-manager relations... the role of primary care in increasing equity in access and health outcomes.'[10]

We need to become skilled at techniques that help organisations, communities and networks to collaborate – systems mapping, coordinated data capture, large group interventions, learning networks. These allow large numbers of people to meaningfully engage in system-wide improvements, spreading the load in a way that has high impact on culture and low impact on personal time.

We have to build the enabling structures and leadership teams to redesign services, evaluate whole systems of care, and empower patients. This edition of *LJPC* gives examples of work being done on these challenges. It contains: three different stages of redesigning a service; three ways to help evaluate complex care pathways; four visionary models of patient empowerment.

Three stages of redesigning services to meet health need

Papers by Dachsel, Coetzee and Bernstein show three stages of commissioning a new service. First you identify what is wrong with the present situation, then you pilot better ways to do things, then you improve relationships between different services to 'redesign' them.

- Dachsel and Lee (page X) offered health screening to passers-by outside a supermarket in south east London. Of the 1024 people screened, 43% had previously undetected abnormal blood pressure, blood sugar or spirometry that warranted follow up. In this way they identified unmet need.
- Having identified a need for alcohol services in Wandsworth, Coetzee (page X) undertook a 12-month pilot to identify the most effective model to deliver treatment. He compared outcomes from brief interventions by a range of practices funded by a Local Enhanced Service (Model A) with a 'Fresh Start' facility shared between practices and staffed by a Specialist Nurse Prescriber (Model B). Model B greatly outperformed the first model. In this way he established the best model for his situation.
- In Ealing, Bernstein (page X) had already gone through the first two stages and established a community based 'interface clinic' for musculoskeletal conditions. He describes how it is now acting as a focus for whole system redesign, bringing together primary and acute care practitioners.

Three ways to help evaluate complex care pathways

- Baker and Tang (page X) emphasise that commissioners must generate their own evidence and not merely rely on the wisdom of others. When designing new ways of delivering services they should draw on the best available knowledge. They may benefit from academic partnerships to do this, including Collaborations for Leadership in Applied Research and Care (CLAHRCs). Every context is different, with different needs, existing services and competencies, so models from elsewhere need to be adapted to the specific local context. Interventions often have unexpected impacts, both good and bad, so a process for sharing the findings of local research projects helps to learn how to gain advantage from these.

- Understanding local context means understanding inter-dependant factors and communication lines, both formal and informal. Cordeaux *et al* (page X) describe systems mapping software that helps to do this. Cross-organisational groups can use such software to test different scenarios. This helps to see flaws in original assumptions that can be rectified at an early stage; it highlights places where gaming of the system is likely to take place, allowing safeguards to be put in place; and it can reveal previously invisible factors which support or obstruct success.
- Stoddart *et al* (page X) show that it is possible to monitor complex innovations with routinely gathered data from hospital and community databases. If you set up the searches well they can produce near real-time reports about progress. Even better, they can allow individual practices and clusters of practices to evaluate their own innovations. The authors warn us that London risks losing this ability because Commissioning Support for London plans to 'warehouse' data will not help to evaluate local innovations and are instead centred on invoice validation and risk-stratification.

Models of patient empowerment

Papers by Fisher, Launer, Iliffe, and Mackenzie propose innovative models to help patients, families and communities to help themselves.

- Fisher (page X) describes a way for patients to electronically access their records. This avoids problems of inaccurate information and also anxieties that come from being excluded from knowledge about oneself. He presents evidence that the imaginary dangers of such openness are unfounded. Instead, sharing records is an easy thing to do, improves relationships with the general practice and empowers patients to self-help.
- Launer (page X) argues that the present fragmentation of care for people with mental illness has mainly negative effects. GP commissioning should create mental health services that cross the boundaries of mental and physical care, individual and family care, and mental, social and economic domains. It should help primary care practitioners to have therapeutic conversations in their consultations, and as well as timely specialist interventions.
- Iliffe *et al* (page X) explore new territory of huge significance for primary care – case management. This is normally used for patients who are high users of hospital care, community matrons and others use it to create a personalised care plan for the breadth of their problems. This team of researchers in Brent discovered that it can be used to good effect with other vulnerable groups including the elderly. Practice nurses and GPs can incrementally build care plans, using prompts embedded in GP computer systems.
- Mackenzie (page X) reminds us that the health system does not operate in a vacuum. Strategic commissioning decisions must take account of wider determinants of health and well-being, and operate within the finite limits of the planet's natural resources. The NHS is the largest emitter of greenhouse gases in Europe, what will GP commissioning do about that? *LJPC* will pick up this theme of public health in its next edition.

This edition of *LJPC* also includes the wisdom of a past RCGP president. These times bear comparison with the emergence of general practice as a visionary force 50 years ago, capturing the imagination of the world. John Horder, one of the architects of that emergence, comes to an account of those days in the penultimate instalment of his autobiography, serialised by *LJPC*. He describes the development of general practice postgraduate training in the 1960s, the 1972 Leeuwenhorst Group that agreed the general practitioner role, and his election, in 1979, as president of the Royal College of General Practitioners, from where he promoted inter-professional learning. GP Commissioning could well take inspiration from those pioneering days.

We face a new conceptual challenge – to apply modern understandings about organisational learning and collaborative improvements to the old vision of comprehensive health systems. We have technologies to help us, like the internet, data warehousing, electronic libraries and social networking software: these can be used to empower creative thinking and make connections in shared dialogic spaces beyond time and physical limitations.[11] We must use these tools to foster collaboration and participation.

We live in dangerous times. What happens next could destroy the values of the NHS, as chasing invoices and technical fixes make us sleepwalk into the same mistakes made by American healthcare, that has forgotten that 'primary care is not a commodity but a set of ongoing relationships.'[12] Conversely, imaginative and courageous GP Commissioning, supported by a new-style health authority that is skilled at partnership working, could lead the renaissance of the NHS. This new NHS would develop relationship-based health systems in which cross-boundary relationships are nurtured, and generalists and specialists use each others' skills wisely. It would still use markets and targets, but only for those aspects amenable to discrete actions. But its main focus will be to facilitate co-evolution, through ongoing collaborative improvements, and fuelled by creative interaction across

disciplinary and institutional boundaries. It would redefine 'public service ethos' as participation in collaborative improvements, and translate traditional primary care values of family and community care to the modern world. Now that's got to be worth fighting for.

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