

Commissioning Excellence

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Practical tips for closing the health gap

Chris
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Enhanced recovery: savings without cuts

Alan Nye



Of all the issues most likely to derail GP commissioning, defeatism is the biggest.

As James Kingsland points out (p3), many of the things we worry about will fall into place eventually. They are difficult, not impossible.

It would be easy to caricature GPs as unworldly individuals who had never set foot out of their surgeries. But they already run businesses where they deal with suppliers, make buying decisions and manage staff while holding down demanding day jobs as clinicians. They have to sit face to face with the consequences of their commissioning decisions in every surgery they hold.

Doing the right things more often

It is GPs' connection to the real world, not their remoteness from it, that most qualifies them as commissioners.

Our research (p6) suggests that GPs have a realistic view of the challenges ahead. They are well aware of the gaps in their commissioning expertise, are worried about how their jobs will change, about business models and organisational structures, the financial risks and the professional ones. Above all, they are still worrying about what they are about to take on, what it involves, what it will feel like.

But GPs also remain overwhelmingly positive about the prospects for a better NHS. They believe that the combination of higher quality care and improved efficiency is possible.

A minority of cynical NHS managers may feel this optimism will be tested and eventually worn out by a system which endlessly reinvents itself. We need to hope they are wrong and give GP commissioners the chance to prove it.

There is plenty of evidence that the NHS can be improved. The existing system has produced fine examples of innovation, often produced by partnerships of PCTs and clinicians.

GP commissioning can bottle these successes and mass produce them. Doing things at scale doesn't mean increasing the size of the machinery or the distance between the patient and the NHS. It simply means doing the right thing more often.

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Commissioning tools updated

Helen Northall
director NHS PCC

Download the PCCS tool: www.pcc.nhs.uk/primary-care-commissioning-support-application. See also: www.pcc.nhs.uk/commissioning-tools

The latest release of the Primary Care Commissioning Support application (PCCS) is now available to download from the NHS PCC website.

PCCS presents data at PCT and practice level, enabling commissioners to compare and analyse performance data and identify areas that may require attention. The Excel based tool also allows further practice data to be input to allow more detailed comparisons

The PCCS application complements the Quality and Product Calculator (QPC), which brings together secondary care PbR data (NHS Comparators), national quality data (FIMS year-end returns) and primary care benchmarking data.

A new version of QPC (v2.1) with the latest data and several improvements to the user interface is imminent.

Helen Northall, director of NHS PCC, said: "Where QPC has been used to most effect it is where PCTs and clinicians have worked together to analyse the results. We are committed to refreshing the data and bringing out further versions to give consortia and practices more of the local picture."

QPC is available free of charge to commissioning organisations. For more information or to arrange a demonstration and training session contact lisa.bourgaize@pcc.nhs.uk

Cumbria shows the way to engage GPs in redesign of local services

A presentation on the NHS Cumbria scheme is available from www.pcc.nhs.uk/nhs-cumbria-improving-referrals-and-care-pathways

A programme introduced by NHS Cumbria to improve the evidence base for referrals and planning of care pathways shows what can be achieved by PCTs working closely with the GP community.

The scheme had a number of goals, including:

- Systematic and consistent use of evidence in referrals
- Better care pathway design based on good practice and more effective information sharing
- Better use of community services and GPs with special interests (GPwSI)
- Supporting GPs preparing for revalidation

The main aim was to analyse referral patterns and examine how changes of behaviour on the part of the PCT and GPs could produce efficiencies and better outcomes for patients.

A local project manager and clinical champion were appointed to steer the project which successfully engaged 83 of Cumbria's 91 GP practices.

Non-PCT clinical interface managers were embedded with practices to provide in-house support; evaluate new care pathways, good practice, and community service alternatives;

and manage communications between practices and the PCT.

Clinical education sessions in protected learning time involved primary and secondary care clinicians across elective, unscheduled and out of hours care.

Improving the data available to GPs – particularly their own data -- is a key element of the scheme. Practices are provided with real-time data on all elective referrals.

Results include the adoption of an evidence based scheme for referrals for low-priority procedures, a plan for reinvesting savings, better use of primary care resources and early evidence that best-practice pathways are working, including a 40% reduction in endoscopy for patients under the age of 55 with dyspepsia.

Commissioning has benefited from better informed pathway development, thanks to increased clinical input and improved data. Better data and collaboration between clinicians and commissioners have identified gaps in services and new opportunities. A more rigorous approach to validating data about activity and costs has also enabled cost savings from contract negotiations.

Not a big problem, but a series of small ones

by James Kingsland

There is no shortage of obstacles to GP commissioning if we go looking for them. Issues about form and organisational structure, statutory functions, governance, regulation, the role of the centre, financial viability, peer review, professional risk, the new GP contract and the sheer scale of the task ahead could slow us down or stop us in our tracks.

In the past GPs have complained that reforms have not delivered, that the culture was wrong, that we did not have the tools for the job. We are about to be handed the tools – fully accountable budgets – and with them the power to shape the reform programme and create the conditions for cultural change.

The worst outcome would be if GP consortia invent themselves in the image of PCTs with a focus on process, procedure and management systems.

If managing the system is more difficult than delivering care then there is something wrong. Of course we face management challenges, but the alternative is to leave it to someone else to run the system – and we've tried that.

The big machine costs too much to run and doesn't ever seem to do what it was built to do. The answer is to turn the traditional notion of scale on its head.

Things done at large scale should be cheaper and more effective. In practice, starting at scale has often been the problem. Solutions designed with a big population in mind fail to address the particular problems experienced at practice or locality level.

The bottom-up approach sees clinicians, other professionals and patients sitting down to redesign services and map out appropriate care pathways. The chances of success at this micro-commissioning level are much higher – and the risks of failure are much lower. When we know what works we can scale it up to an appropriate level, which might be a small group of practices, a consortium, groups of consortia, a region or even the country as a whole.

This is not reinventing the wheel but recognising that solutions to local problems must be developed locally and grown organically.

The other critical pieces are the networks to link the microsystems and allow them to share experiences, adapt good practice from other areas to local need and enable the free flow of information.

The main role of the clinical leaders, healthcare professionals and GP commissioning networks is to build the evidence base. NHS Networks is helping to marshal and shape the case studies and tools that are already being used locally to good effect. It is also developing an online information portal to make it easier for commissioners to find the resources they need.

The evidence of what works can help show what practical steps GPs can be taking now to prepare for GP commissioning before the dust has settled on the white paper. We should draw inspiration as well as information from the best examples of practice-based commissioning and the actions of individual practitioners (not just GPs) in refusing to let obstacles in the existing system stop them from doing the best for their patients.

For me, this is the key lesson and my top survival tip for the future.

Worrying about the unknowable is unproductive and ultimately pointless. Concentrating on being the best GP the patient could possibly get, making small service changes, listening to what others are doing and staying alert to the possibilities for reducing waste and improving care – this is and always has been the core business of general practice. If we focus on this, we can deal with the management issues as they arise.

No one said that GP commissioning was going to be easy, but if we focus on the obstacles, the best interests of the patient will be an ever-receding horizon.



James Kingsland
national clinical
commissioning lead
Department of Health



Chris Burton

Top Tips

To achieve optimal outcomes at a population level commissioning with need to ensure interventions are:

- **Evidence based**
– concentrate on interventions where research findings and professional consensus are strongest
- **Outcomes orientated**
– with measurements locally relevant and locally owned
- **Systematically applied**
– not depending on exceptional circumstances and exceptional champions
- **Scaled up appropriately**
– “industrial scale” processes require different thinking to small “bench experiments”
- **Appropriately resourced**
– refocus on core budgets and services rather than short bursts of project funding
- **Persistent**
– continue for the long haul, capitalising on, but not depending on fads, fashion and policy priorities

Further information –
HINST@dh.gsi.gov.uk

Practical tips for closing the health gap by Chris Burton

The Health Inequalities National Support Team (HINST) has visited and supported the 70 areas in England with the highest deprivation and poorest health over the last four years. The HINST has capitalised on this unique experience to identify common barriers to progress, but also to recognise and share a wide array of good practice in commissioning and delivering services, which impact at a population health level – minimising inequalities in health, mortality and life expectancy.

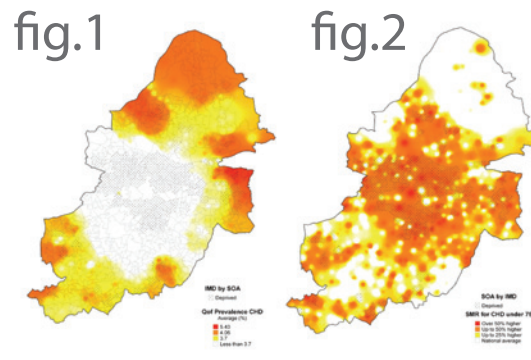


figure 1: **2005 map of Birmingham showing CHD prevalence (by super output area) according to QOF registers**

figure 2: **2005 map of Birmingham showing CHD standardised mortality rates under 75 (by super output area)**

KEY – Darker colour indicates higher prevalence or higher mortality

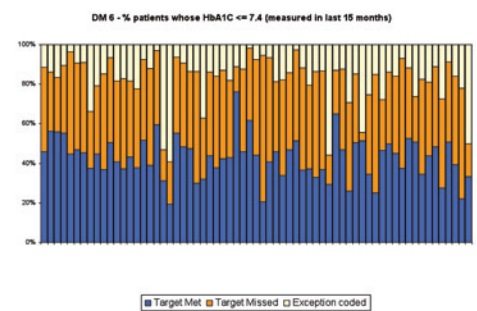
Most deprived areas of Birmingham are in the centre

The missing link has been knowledge of how to make interventions, which improve the health of individuals, accessible and effective for those most vulnerable in society. There have been many attempts to reach out to those missing out on the potential to benefit from interventions, but these have often been patchy and ad hoc. They have not achieved the system and scale to make a lasting change at population level.

Commissioners need understanding, capacity and organisation to commission services which reach out to and draw in people previously excluded by reason of geography, cultural mismatch, lack of community

knowledge and expectations and personal understanding, aspirations and self confidence.

QOF outcomes for each practice within one PCT



This PCT was renowned for its excellent diabetes service. Less than 40% of the diabetic patients (diagnosed and on the registers) had their blood sugar controlled. Health inequalities are evidenced by the high number of exceptions and the variability of outcomes across GP practices. It will always be the most vulnerable who are left behind. Unless commissioning can work to reduce that variability then the most vulnerable in the population will die prematurely.

Extra and ongoing inputs will be necessary to help individuals make the most of investigations, treatments and advice, as well as support to self manage their problems. This requires planning and resource if it is not to be tokenistic, and if it is to enable equitable outcomes for those with the most complex needs. Targets often incentivise 70% achievement. Who will be in the failed 30%?

While initiatives to prevent health inequalities may require increased resources, they will ultimately deliver QIPP benefits – by reducing emergency admissions, for example.

Chris is associate delivery manager with the Health Inequalities National Support Team (HINST), Department of Health

Useful materials HINST resources – guides to commissioning and implementing interventions that will reduce the all-age-all-cause mortality of the local population. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_115113

COPD service shows what community pharmacy could deliver

The government is clear that the GP in GP commissioning is for general practice not general practitioner. It's a distinction that matters to other primary care clinicians and allied professionals because if GP commissioning does not include the range of professions, it will fail to deliver its full potential.

This is the view of Stephen Foster, a community pharmacist and founder member of the Healthcare Professionals' Commissioning Network. The aim of the network is to promote the role of its members both by disseminating information about what's possible and by developing models for collaborative working. "We already know that there are exciting possibilities for service change. The challenge will be to innovate in a concerted and co-ordinated way," Foster says.

Foster specialises in COPD and allergy, conditions which could be treated more cost-effectively and with better health outcomes in primary care, he argues.

Of the estimated 2m-3m cases of COPD in England, only around 900,000 are recorded on practice registers. "Many are undiagnosed or misdiagnosed as asthmatic and by the time the symptoms are obvious it's already too late. If we could diagnose the mild cases, some may never go on to become moderate or severe."

Foster offers a screening service for smokers over 35 with 20-a-day habits of 20 years or more. The early results are promising. Of 47 people screened to date, 16 have COPD and of these 10 were previously undiagnosed.

Foster argues that COPD screening services are a natural fit for community pharmacy, which is already acknowledged as the key provider of smoking cessation services.

He believes there is a clear invest-to-save case for COPD screening, but acknowledges that commissioners don't always see it that way. "I have heard the argument that there is no point in improving screening when we can't afford to treat the cases we uncover. But if we leave it until these cases turn into admissions at £2000 a time then we can't afford not to treat them."

Allergy is another area where Foster believes better primary care services could lead to significant savings. "One in three people have an allergy of some kind. Two-thirds of these cases could be treated in primary care, at more convenient time and place for the patient and at lower cost to the NHS. Instead these people are taking a range of symptoms to chest specialists, ENT consultants and dermatologists when an allergist could cure the whole lot."

Foster says that local GPs were enthusiastic supporters of his proposals for an allergy service provided by his business, but he warns that colleagues in some areas have faced resistance from PCTs and hospital consultants. "This is why we are excited about GP commissioning. It could untie our hands," he says.

"Commissioning has to reflect the reality of provision, which is that general practice does not see all the people who need treating. To cover the whole population and particularly those most likely to be affected by health inequalities we need to commission services across the range of primary care settings."

Foster argues both for a cultural change in community pharmacy and a change of mindset on the part of commissioners. "This probably won't be driven by the traditional pharmacy next door to the GP surgery, nor is it true that just because you make a good business case someone will go ahead and commission the service, but we are beginning to see a groundswell of support," he says.

Foster cites the Pharmacy Clinical Leadership Network, which now has 118 members and at least four or five in each SHA region. "We're aiming to get the network to 150 local champions. At that point, it will be difficult to ignore."

For details of the networks mentioned in this article see www.networks.nhs.uk.



Stephen Foster
pharmacy superintendent
Pierremont Pharmacy

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Social enterprise: focus on health

The essential event for anyone considering setting up a social enterprise in the health and social care sectors. Free to NHS delegates.

10 November, London.
For details see
www.pcc.nhs.uk/events

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Optimism, pragmatism and anxiety: the mood of GPs

“Quality means doing it right when nobody is looking”

Henry Ford

GPs overwhelmingly believe that GP commissioning presents an opportunity for the NHS. 85% of respondents to a survey by PCC agreed that GP commissioning will benefit the NHS, 70% believe GPs are the best people to commission NHS services and 65% thought that it would benefit patients.

Not surprisingly, PCT staff are less enthusiastic. But despite the threat to their own jobs, nearly half (47.8%) of PCT respondents believe that GP commissioning will be good for the NHS.

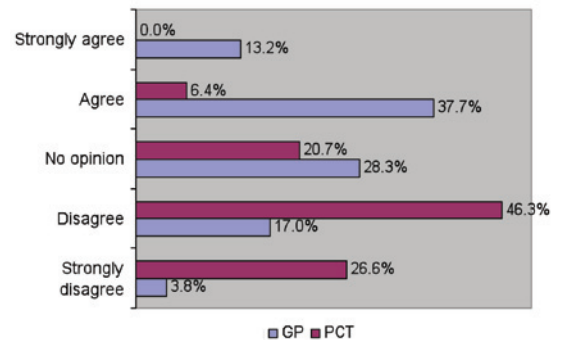
GPs exhibited predictable anxieties about the economic situation and the financial and management challenge posed to practices.

There are also concerns about lack of commissioning experience (77%) and business skills (66%).

The survey of more than 450 GPs, other clinicians, PBC managers and PCT commissioners, produced some striking contrasts. GPs believe that clinical commissioning could achieve the central objective of the QIPP programme and deliver higher quality care at lower cost to the NHS. PCTs take the opposite view.

One of the most striking differences is over the job prospects of PCT commissioners. While 58% of PCT managers thought that “good PCT managers” would find jobs in GP consortia, GPs themselves are much more positive. 89% believe that key roles in GP consortia will be filled by existing PCT staff.

GP commissioning = higher quality care at lower cost



(The table below shows some differences in the importance of critical success factors depending on who answers the question. The significance of the rankings should not be exaggerated as every one of the factors listed scored highly and was considered important by 85% or more of respondents.)

The desire to influence the future shape and direction of GP commissioning policy comes through loud and clear, as do the importance of good information and the need for emerging consortia to acquire commissioning skills.

Among critical HR issues are the potential loss of good PCT staff before GP consortia are in a position to employ them, the wholesale transfer of not so good PCT staff, and uncertainties around employment costs if TUPE or similar schemes apply.

Top eight critical success factors for GP commissioning	Ranked by GP response	Ranked by all responses
Strength of GP voice in policy decisions	1	8
Timely, reliable information on which to base decisions	2	1
The attitudes of GPs	3	2
Rapid skilling up of commissioners	4	5
How the transition period is managed	5	4
Getting the right business model for consortia	6	7
Organisational form of consortia	7	6
GPs' ability to involve other clinicians	8	3

Enhanced recovery: fewer cuts, bigger savings



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Alan Nye

Enhanced recovery is an innovative approach to care before and after surgery, which can dramatically improve both recovery times for patients and efficient use of hospital resources.

Enhanced recovery can reduce lengths of stay after major surgery from 7 to 10 days to 2 to 3 days or less. That equates to a 30-40% increase in surgical capacity.

Patients benefit from better outcomes and experience of treatment, while commissioners can make cost savings from fewer complications, reduced length of stay and lower conversion rates. Enhanced recovery has already been shown to benefit patients facing colorectal, urological, gynaecological and orthopaedic surgery.

According to Dr Alan Nye, clinical adviser, elective care, Department of Health: "Enhanced recovery is based on the principle that better informed, better prepared and better supported patients will get better more quickly."

The most striking feature of enhanced recovery is rejection of the traditional nil by mouth pre-operative regime. Starving patients before operations has been shown to slow the recovery of bowel function, one of the key determinants of length of stay. The enhanced recovery nutritional regime treats patient like athletes, preparing them for the event by carbohydrate-loading their diet – boosting the system rather than encouraging it to shut down.

The other dramatic shift in emphasis is from the idea of the patient as sick and needy to one who is as fit and fully informed as possible.

Dr Nye is responsible for the development of a suite of decision-making tools for use with patients in primary care settings. The first, on knee arthritis, has just completed testing. Tools will follow for hip arthritis, carpal tunnel syndrome, cataract, hysterectomy and localised prostate cancer, among others.

The work is based on an international review that showed that decision aids could reduce conversion rates for surgery by 20%. "If you help patients understand the alternatives, one in five will decide not to go for surgery and will opt for a more conservative treatment with no detriment to clinical outcomes," Dr Nye says.

He acknowledges that until now enhanced recovery has been championed by secondary care clinicians, but argues that this needs to change. "Enhanced recovery starts and ends in primary care, with diagnostics such as screening haemoglobin and blood pressure, and then with follow-up care to keep people from returning to hospital unnecessarily."

Commissioners could play a key role in commissioning enhanced recovery as a standard pathway using available incentives such as CQUIN.

Dr Nye acknowledges that obstacles to enhanced recovery remain. "It goes against the traditional thinking and will be counterintuitive not just for some professionals but for patients themselves who may expect a long, slow recovery from surgery. It also requires a team approach involving nurses, doctors, anaesthetists, dieticians and physiotherapists right along the care pathway."

Commissioning gains

- More efficient use of NHS resources – shorter stays, fewer complications (reduced ITU), lower conversion rates
- Improved patient experience and empowerment through decision aids
- Better motivated medical teams through best practice, innovation and patient outcomes

Social enterprise for commissioning support?

There are currently over 20,000 social enterprises in the health and social care sector. This trend is likely to increase significantly following the government's "big society" agenda which aims to get rid of centralised bureaucracy and give professionals much more freedom, opening up public services to new providers like charities, social enterprises and private companies.

Social enterprise has proved popular as an organisational form for provider organisations, but following suggestions by the Department of Health that the "right to request" may be extended to PCT non-clinical staff, may also be suitable for organisations delivering services to support GP commissioning consortia.

In a Q&A for PCC, Gayle Curry, partner and leader of the healthcare group of solicitor Morgan Cole, answers key questions about different organisational forms, and examines the benefits and risks of taking the social enterprise route.

<http://www.pcc-cic.org.uk/articles/briefings/socialenterprise.pdf>

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More of the same

Commissioning Excellence is two years old this issue. The quarterly publication was originally conceived as a digest of commissioning news and views for chief executives but has a growing readership among commissioners at all levels, finance managers, PBC managers, the Department of Health, GPs and anyone interested in the development of commissioning, the spread of good practice and the future of the NHS.

In response to the growing appetite for timely information, expert opinion and shrewd analysis, Commissioning Excellence will now appear six times a year. The next issue will appear in early December.

Commissioning Excellence is supported by NHS PCC, PCC CIC and NHS Networks.

To find out more contact wendie.groves@pcc.nhs.uk or visit

www.pcc.nhs.uk
www.pcc-cic.org.uk
www.networks.nhs.uk

GP prescriptions now on video

With several big events devoted to the issues raised by GP commissioning planned this autumn, PCC has produced an event on a disc.

In a series of short video interviews, clinicians and managers at the forefront of clinical commissioning consider what lessons we can learn from the past. The video highlights how GPs, other clinicians and commissioners have worked together to change how services are delivered and improve the experience of patients.

Participants emphasise the importance of constructive relationships with PCTs and acute trusts, strong partnerships with patients and local authorities, the role of community services, and the key management issues faced by emerging consortia.

The disc will be available to visitors to the PCC stand at the NAPC conference in Birmingham on 20 October and at the NHS Alliance event in Bournemouth on 18 November. Copies can also be ordered free of charge by emailing debbie.dove@pcc.nhs.uk.

Excerpts from the video are available on the NHS Networks Channel on Youtube. See www.youtube.com

Good practice and wicked issues come together

PCC and NHS Alliance are bringing together some of the best examples of clinical commissioning and partnership working in a pre-conference session at the Alliance's annual conference and exhibition on 17 November.

Invited representatives from leading health economies will come together to share their experiences and debate the "wicked issues" facing GP commissioning. The session will examine how we capture the best aspects of the current system and build on them in the new world.

Workstreams will include:

- Getting the footprint right – ensuring that GP commissioners, acute trusts and local authorities line up and fit together
- Managing the transition – financial, organisational and staffing issues facing emerging commissioning organisations
- Health improvement – care pathways, service redesign and public health
- Owning the agenda – demand management, performance management and accountability

For further information contact anna-marie.nelson@pcc.nhs.uk

Practical support at all levels

PCC has a history of practical support for commissioners and providers in primary care. Our advice informs national policy and local practice.

PCTs continue to benefit from a subscription service that gives them access to events, network meetings, the expertise of our regional advisers, the helpdesk, regular news and comprehensive online resources.

PCC also provides project support around dental contract management, optical contract management, performance management and other areas.

We work with PBC and emerging GP commissioning consortia on strategic planning and operational issues. PCC supports national and regional clinical networks through its sponsorship of NHS Networks, which provides free web space, information management and facilitation services to NHS organisations.

PCC is also developing a suite of products for provider organisations around training, workforce planning and organisational development.

For further information see www.pcc-cic.org.uk.