Debate & Analysis

GP commissioning:

will it save money and raise standards of care?

The controversial Health and Social Care Act, passed a few weeks ago, will trigger the most radical re-organisation of the NHS that we have ever experienced. With the abolition of primary care trusts and strategic health authorities, and the creation of new bodies and governance arrangements, the responsibility for a budget of between £60–80 billion will pass to GP-led clinical commissioning groups, (CCGs) who will have the unenviable task of tackling variations in standards of care and reducing health inequalities while attempting to save as much as £20 billion over the next 5 years. We asked a number of experts and health service leaders to look into their crystal balls and say whether they think that these challenging aspirations can be achieved.

> *"Meeting the scale of these challenges will require all parts of the NHS to take bold measures to secure long-term, sustainable change."*

THE CHALLENGE FACING THE NHS AND PRIMARY CARE

Sir David Nicholson

The NHS needs to transform the way services are provided to patients and local people — both to meet the increasing healthcare needs and expectations of those it serves and to ensure it continues to drive real improvement in health outcomes in more constrained financial circumstances.

Meeting the scale of these challenges will require all parts of the NHS to take bold measures to secure long-term, sustainable change. Giving frontline clinicians greater freedom and a strong leadership role is an essential element in meeting those challenges. CCGs can use their knowledge of patients' needs and of local services, as well as their standing in local communities, to change clinical practice in ways that improve the quality of care and make more effective use of resources. CCGs will be able to build on their excellent relationships with the public as well as their emerging partnerships with local authorities to lead a collective case for change, focused around the improvement of patient outcomes.

Having a GP-led system of clinical commissioning will build on the strengths of general practice: its holistic view of patients' medical, psychological, and social needs; its role in promoting continuity of care; and its pivotal role in coordinating patient care, particularly for people with long-term conditions, and in helping patients to access wider or more specialised NHS services. Evidence shows the importance of a robust system of primary care for health economies. High quality health systems and healthy populations require strong and effective primary care services.[1]

Clinical commissioning will also enable health professionals to come together to develop more integrated services that give patients more control over their health and care. Innovation will be critical to the way we achieve sustained improvements across the system and unlock quality and productivity gains. Clinical commissioners will need to work with providers to accelerate the pace of new developments — through the greater use of technologies and by a more systematic, rapid approach to spreading innovation.

Clinical commissioning will also provide new opportunities for GP practices to work collaboratively to transform the way that they provide general practice services, so that they support wider improvements in quality and productivity. This will require a greater focus on prevention and on shared decision-making to give more control to patients. There will need to be a stronger focus on providing more integrated, community-based care, including care in people's own homes supported by initiatives such as tele-health and tele-care.

While there is no single model for how these challenges should be addressed, local clinical leadership and innovation will be a vital ingredient. GPs — working with other healthcare professionals, local communities, the new HealthWatch bodies, local government, through the health and wellbeing boards, and the NHS Commissioning Board — have an unprecedented opportunity to lead transformational change that improves the health and wellbeing of local communities and ensures more productive use of NHS resources.

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WHAT DOES PAST EXPERIENCE SUGGEST WILL HAPPEN?

Martin Roland

Can we learn anything about the new reforms from the past? The best evidence comes from GP fundholding in the 1990s

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where GPs had financial incentives to reduce certain types of hospital referral and prescribing costs. Some responded by developing services in the community designed to reduce outpatient referral, such as community-based physiotherapy. Overall, however, fundholding had only a small impact on clinical practice, reducing waiting times in some places and probably limiting the rise in prescribing costs.[1] A few enthusiasts worked hard to improve services for their patients, but there was little change in the majority of practices. Fundholding also didn't encourage GPs to take a strategic view of their populations' needs, that was one reason for the introduction of total purchasing as a variant of the scheme relatively late on.[2] In addition to the benefits being patchy, patients in more affluent areas benefited more, and this was one of the reasons why fundholding was abolished by the Labour Government in 1997. A scheme introduced in 2005 to re-engage clinicians in commissioning (practice-based commissioning) was generally thought to be weak and ineffective.

It remains unclear how CCGs will exercise their commissioning functions, and considerable scepticism has been expressed about their ability to do so. Furthermore, it is not clear what control they will have over their GP members. They will largely rely on 'soft governance'[3] for much of their influence, and it remains uncertain what options they will have in dealing, for example, with GPs who provide high quality care and are popular with patients but chronically overspend their budget. This area of self-regulation by the profession is completely uncharted territory.

One size won't fit all for the range of functions that CCGs need to deliver. For some functions, CCGs need to be large, and small CCGs will want to group together. However, quality improvement works best when a single practice or small group of practices works together on a problem. This may be informed by data from a larger group, but GPs won't engage if the outcome seems to them to be remote and irrelevant to their own practice.

Experience of fundholding and practice-based commissioning provides very indirect evidence for what will happen under the new commissioning arrangements. Lessons from the rest of the world suggest that clinicians working together can produce substantial improvements in care, but these are very unlikely to be seen quickly and probably require close working between primary care doctors and specialists — not a prominent feature of the current arrangements.

If one thing is clear from the multiple NHS reforms (redisorganisation[4]) of past decades is that nothing will change quickly. The problems will become apparent before the benefits, and the reforms will need 7–10 years to really show whether there are longer-term improvements in care.

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THE PRIORITIES FOR THE CLINICAL COMMISSIONING GROUPS

John Hussey

The crux of the challenge to CCGs is to commission increasing quality of care closer to the patient while also delivering the quality, innovation, productivity, and prevention programme (QIPP) savings. Quality measures have to be maintained and they must also reduce health inequalities.

It is likely that 'more of the same' will yield the same results rather than success. 'The same' has, for the last decade or more, been an over reliance on the hospital-based specialist care often related to an overuse of A&E departments. Within any large city in the UK one may find as much as a tenfold variation in referral rates to the same specialty between GP practices. A similar variation exists in admissions for ambulatory care sensitive (ACS) conditions and other unplanned admissions. At the same time average lengths of stay for the same type of admissions varies widely between trusts.

All of these variations not only cost the NHS enormous amounts of money but also have deleterious effects on the 'patient journey' and can undermine their confidence in the system. Some variations are due to organisation specific issues — education, training, and resources (including workforce), and of course their local demographics. However, a consistent theme is poor integration of services and lack of clarity for the public to know how to access care at the right place and time.

Priorities for new CCGs therefore emerge. First, if they are not to replicate past mistakes or omissions then they need to understand the picture of the past and the reasons for past priorities. Therefore, maintaining organisational memory within their appointments is vital. Similarly those appointments need to be of high quality.

They will need a clear understanding of how their economy is performing, benchmarked against other

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demographically similar areas. Solid informatics services are essential. The contract with their commissioning support service should be clear about what information they need and who then should be able to obtain this from a wide variety of providers. New ways of accessing quality measures, especially patient experience feedback, need to be developed. Where variation does exist they should be honest in discerning why it is there and seek solutions.

They will need to review the performance of their membership practices, the community services providers, and acute providers. How integrated are they with one another? Is social care truly integrated to enable services to be delivered safely in the community, enable timely discharges, and avoid unnecessary admissions? Funding arrangements with local authorities and community providers will need to be reviewed, fully understood, and changed if necessary.

They will need to engage with their public as to what services are needed and valued and how they can best be provided so that they can be accessed efficiently and appropriately. To achieve this they will need to have strong relationships with HealthWatch, their health and wellbeing boards, and also maintain strong ties to their public health colleagues. Are the right people being reached to tackle the inequalities issue? What evidence can be used from elsewhere? How do we do it at the right scale?

Importantly they will need to review if as much effort and resource has been exerted historically in getting the 'out of hospital' services (including their own member practices) right in terms of quality and capacity. Without this building block an over reliance on secondary care services is inevitable. To achieve it they will need to have strong relationships with all stakeholders in order to negotiate and commission for change. They are in effect creating very new organisations and will need to demonstrate good governance arrangements with structure that promote sound and transparent decision making. It is a difficult challenge but I feel one that clinicians need to take ownership of.

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HOW MIGHT ALL THIS AFFECT PATIENTS?

Antony Chuter

The majority of the general public probably won't notice any difference for the time being. Most patients don't need IVF or specialist drugs but when they do, when they need something out of the ordinary, the new structures will become apparent. Those with a long-term condition may also notice changes where their care is concerned, as CCGs look for savings by scrutinising drug costs, cutting education programmes like the Expert Patients Programme, and reorganising outpatient contracts and sexual health services.

In many ways we have had a postcode lottery for years — the high profile cases in the media are well known and include treatments for breast cancer and Alzheimer's disease. Although CCGs will be trying hard to reduce inequalities, the new structures may increase variations in care that can only be delivered to those able and willing to be involved. Inequalities will be greater for the most excluded in society. The new structures threaten to make things more unequal and breathe life once again into the inverse care law. CCGs, for example, will be funded on the basis of their registered populations: what about people who are not registered, such as the homeless? Rough sleepers are far more likely not to be registered, yet have a much reduced life expectancy compared to the general population. These are the groups most in need of good quality health care, free at the point of use.

One thorny issue that the change of structure has not yet grasped is the future of district general hospitals. Many are in the wrong place, with unsustainable services, and are set to become more unsustainable as the European Working Time Directive comes fully into force. They are almost all foundation trusts or on their way to becoming one; they are required to keep their books balanced, or else! I don't think we will see many going bust, but we may well see lots of mergers, which will mean moving services to locations that have the critical population mass to make their services profitable. The population won't like seeing their A&E or maternity units moving away — they will feel very scared.

Ultimately most patients will need to travel further to receive care. We may even see the 'good school' effect on the housing market turning to health care. If you live close to a decent hospital with lots of

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services it will cost you more to buy or rent. The inverse care law strikes again!

I wonder at what point health care will become like dentistry, free to those on means-tested benefits but chargeable in bands to everyone else. How far we are from co-payment is up for debate. Not too close, I hope, but this is a real possibility for the future.

I think GPs have the upper hand in the system for the time being but managing the limited resources available to provide care is going to add complexity and stress to their jobs, as they try to give patients what they need while balancing the books for the CCG.

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BEING MORE PRODUCTIVE: CUTTING COSTS AND IMPROVING QUALITY

John Appleby

It hardly needs restatement, but across the UK's NHS money is tight. Over the 4 years to 2014/2015 Scotland, Wales, and Northern Ireland will see a real cut in NHS spending. In England the NHS could end up with just about enough extra cash to cover increases in pay and prices (with perhaps a little bit left over). But as the funding growth slows or even reverses, the pressure to spend more on health care seems to rise inexorably. The key pressures are not so much to do with changes in demography, but more a desire to improve quality.[1]

For the English NHS the task — the so-called Nicholson Challenge — is to generate productivity improvements to the value of around £20 billion by 2014/2015 (around £5 billion a year). Expressing the goal in monetary terms has its uses. The eye-watering size of the numbers certainly grabs attention and emphasises the importance of the policy. But the numbers can not only obscure, practically, what needs to be done, but can over-emphasise one aspect of what it means to be more productive — namely, cutting costs.

"... the goal is not to simply save money; it's to reallocate what the NHS has to get more and higher quality outputs."

Just over 1 year into the (for the moment at least) 4-year productivity programme and the tactics adopted by the Department of Health in England appear to be producing results. Three-quarters of the way through 2011/2012 the Department reported that just over two-thirds of its total productivity plans of around £5.8 billion had been achieved[2] through a combination of real pay cuts for NHS staff, real cuts in the prices hospitals are paid, sweeping management cost cuts (largely as a result of cuts to the number of primary care trusts and regional bodies), and cuts in budgets administered by the Department of Health.

Savings categorised by the Department as 'prescribing' and, broadly, 'primary care' have contributed around 10% (£396 million) so far — only 41% of the target for these areas for the first full year of the productivity programme.[2]

But the goal is not to simply save money; it's to reallocate what the NHS has to get more and higher quality outputs. As the NHS moves forward with its productivity programme the pressure to clearly demonstrate that savings are being used to generate more benefits for patients will increase.

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