Healthcare Commissioning

— time for a more business-like approach?

How borrowing ideas from the commercial world could help address the NHS deficit and nurture innovation.
ABOUT THIS ARTICLE

“Healthcare Commissioning – time for a more business-like approach?” was authored by Guy Gross, a healthcare entrepreneur, innovation consultant, former Innovation Delivery Lead for the NHS in London and member of the IET Healthcare executive panel. Published by the Institution of Engineering and Technology, this opinion piece was produced with input from other members of the IET Healthcare panel, but does not represent overall IET policy.

ABOUT IET HEALTHCARE

IET Healthcare has been established to promote innovation and creativity amongst future leaders in healthcare, social care and wellbeing. Its mission statement is “because we believe that technology can drive better health, we exist to harness all sector vices to build a healthier future for all”. By bringing together stakeholders from groups including clinicians, patients, technologists and entrepreneurs it ultimately aims to bring about more effective and efficient solutions to the health and care needs of international populations.
INTRODUCTION

It is difficult to simplify the complexities and history as to why and how the NHS has got to where it is today, with its lack of standardised products and services, inconsistent investment in training, anti-risk culture, variable staff incentives and in terms of the deficit, a total overspend in 2016-2017 of £3.7bn, according to the Nuffield Trust.

A key driver, however, would be how healthcare services are commissioned and paid for. Commissioning has become a key area of focus for IET Healthcare, which has a duty to promote the introduction of new innovations and technology that can help the NHS become more efficient and make best use of the resources and funds at its disposal. It is also the theme for the second event in IET Healthcare’s Think BIG Future Health & Life Science event series, taking place in Manchester on 28th June 2018.

The development of technology has the potential to improve productivity within the NHS and deliver improved patient outcomes, which coincides with the IET’s objectives, but in order to move forward, the methods by which services are planned, agreed and monitored require closer scrutiny. Though the total healthcare system may benefit from lower costs from an innovation, who pays is not necessarily who benefits - this acting as a structural barrier to innovation.

This article aims to challenge conventional healthcare sector thinking on how the NHS deficit might be tackled and more innovation achieved by considering business-like approaches that focus on standardisation rather than rationalisation.

Let’s begin by looking at how commissioning is currently structured.

CLINICAL COMMISSIONING GROUPS

- England has 207 separate organisations called Clinical Commissioning Groups (CCGs), controlling total annual budgets of around £75bn (approximately £1,400 per head of the population).

- Each CCG reviews 60-plus separate clinical care pathways on a rotating basis (comparable to consumer “products or services” in the commercial world). These review processes will usually be done independently of all other 206 CCGs, and will build on unique historic pathways and infrastructure that have evolved over decades, giving a unique landscape to each local area.

- CCGs often have to limit their interaction with local specialist clinicians during the design of services because as a “free” market it is deemed to be anti-competitive to have those same clinicians designing services while also bidding to deliver them.

- To meet the guidelines of the National Institute for Health and Care Excellence (NICE), as well as the articulated local needs identified by the CCG Board, each of these pathways will have been developed by a unique mix of clinicians, managers, commissioners, contract teams, professional patients and other stakeholders across the local health ecosystem.
THE PROBLEMS WITH CCGS

With every CCG organisation believing it needs custom-built local solutions in order to meet the needs of their “unique” local demographics, we are seeing less rather than more commonality in approaches to commissioning and delivery of care across the country.

The “not-made-here” culture, whereby local teams feel that off-the-shelf pathways are inferior to anything they can custom-build locally, has perpetuated the widening range in outcomes and has made rolling out innovation and sharing learnings a difficult task.

The introduction of the Quality Outcomes Framework (QOF) in 2004 was meant to address some of these issues and drive primary care (GPs) to ensure best practice was delivered at scale. This has improved outcomes by ensuring that more of the right things are done to more of the right patients. However, the by-product has been an ever-increasing paternalistic approach to care with doctors “owning” patients’.

This effect has been further enhanced by misaligned incentives - GPs will refer patients to community and hospital services but they have little incentive as to whether those patients attend or complete the treatments they have been sent for.

This split between primary care and the rest of the system results in an important additional issue: cost savings in one part of the system may result in additional costs elsewhere, acting as a disincentive to innovation.

Without a whole system view, there is significant shifting of costs from one profit and loss account to another with no control or accountability. This is changing as the NHS moves towards accountable care structures like those in Fig. 1, where a whole system approach to care provision will force competing entities to work together and make savings through partnerships and prevention of disease. This remains one of the biggest if not the biggest challenge to the NHS in enabling net cost savings over the next few years.

It may appear logical that the Department of Health, NHS England or some other organisation should just impose pathways across the system, but the grass-roots have developed “antibodies” to top-down approaches.

The Primary Care Trust (PCT) and Strategic Health Authority (SHA) structures that existed prior to CCGs, and Primary Care Groups before them, bore the political brunt of this problem and were ultimately closed down as a result, with power handed directly to those same grass-root organisations that have emerged as CCGs.

Fig. 1: An example of a typical accountable care structure. Image courtesy of Healthy London Partnership 2016.
THE BALANCE OF POWER

It is also important to consider that GP practices are structured as independent businesses in their own right and are not directly employed by the NHS. In other words, the NHS already spends £7.6bn on private health care providers – the GPs who are providing their services to the NHS. They have a contract to deliver some core services and a budget per head of the population under their care, but each practice runs as an independent partnership or company – a private healthcare provider within the NHS.

Partner GPs who own a practice will employ other mainly junior GPs, practice nurses and support staff, and will develop their own independent internal infrastructure within which they operate to make business decisions. Those GP partners are making money when their staff are seeing patients; this means that diverting those staff away from their jobs for training not only costs money but loses revenue.

The mechanics of how primary care decides on which services to provide is also politically charged; the right thing to do may not make financial sense to everyone, not least the GPs. This becomes an issue where the CCG may have identified a need to address, for example, community diabetes service provision in a region at primary care level, but the GP practices have no requirement to agree or co-operate to provide the service, but may choose to if the business case makes sense for them.

In addition, the fact that staff from one practice cannot work in a neighbouring practice because of the insurance and contractual obligations of employment and it starts to become clear why “resource” optimisation is a very difficult problem to address in the community setting.
THE BUSINESS CASE

So how might the system benefit from more business-like methods? Firstly, let’s consider how successful companies meet the expectations of their customers – the key to commercial success for most is their ability to develop and scale a simple core offering as a product that can be consistently delivered and supported, often with some principles, rules and brand guidelines for localised adaptation.

The benefits of such an approach include consistency with the customer experience, staff training/culture and marketing/brand values, common incentives, reduced costs due to scale economies, and importantly an ability to drive change through the whole system effectively and efficiently.

Leading companies will also set up ways to leverage the goodwill, talents and ideas of their employees by encouraging them to try new things and to develop new products and services, rewarding them if they work and then embedding them in the wider system. They also align their corporate culture to accept failures as part of the natural cycle of innovation, progress and learning.
The stress on CCG commissioners and providers at present is unsustainable. This is compounded by a belief that new channels to access clinical support will take pressure off other parts of the system; conversely each new channel becomes immediately saturated with little impact on demand elsewhere in the system.

There are three possible levers that, if implemented by commissioners, could change the workings of the whole system, allowing this more business-like approach that could benefit patient outcomes.

1. EDUCATION AND MARKETING: CREATING A CURRICULUM WITHIN CONTINUED MEDICAL EDUCATION (CME).

PROBLEM
After leaving university there is no formal curriculum for maintaining GP, practice nurse or any speciality knowledge across even the main disease areas for generalists. Through CME, clinicians can choose to focus their learning on areas of interest or perceived weakness, which is not linked to actual performance, meaning their knowledge could be significantly out of date in core areas. Revalidation processes, while more formal, do not cover knowledge of local clinical pathways, which is critical in giving patients the right management plan.

Furthermore, despite around 20 disease pathways being recommissioned each year by CCGs, there are no standardised communications channels to reach out and train all staff in all practices. Each commissioned service has to develop a different GP outreach programme within its budget, which in most cases results in uptake limited to just 20-30% of GPs, and even less in other practice staff.

SOLUTION
Introduce a training infrastructure through which a mandatory part of the CME curriculum covering all main conditions would be delivered in primary care. Each disease module would deliver core components (not influenced by geography or demographics) around the NICE guidance, along with locally adapted components such as how the newly commissioned service works and the associated incentives and metrics, along with why they are important. There would be local statistics to demonstrate relative performance of practices compared to their peer group.
2. PRODUCT CONSISTENCY: ESTABLISHING A STANDARD FRAMEWORK FOR COMMISSIONING

PROBLEMS

Value in the NHS is a measure of the cost required to achieve a patient outcome. For the purposes of commissioning, NICE uses the Quality Adjusted Life Year (QALY) as a metric that makes interventions comparable and shows which of those interventions is most cost-effective.

- **Product consistency**
  - **Establishing a standard framework for commissioning**

**a. No common commissioning approach**

CCGs rarely baseline performance against each NICE recommendation; this means they don’t really understand how much could be saved by delivering any one piece of guidance over another.

The default of most managers is to use the guidance as a tick-box process to make sure all bases are covered in pathway design rather than focussing efforts on investing in those areas of service improvement that will have highest impact on patient outcomes, quality of life and potentially savings.

**b. Little or no advice on implementation**

Commissioners are free to interpret and implement the guidance their way, which can differ significantly form one person to the next and from clinician to clinician. The CCG processes, personalities, priorities, population and budgetary constraints drive decision making that means no two CCGs commission the same process. With 207 CCGs that means 207 different pathways commissioned by 207 different teams and a lot of variation.

On some key issues of pathway design there are opposing schools of thought that make standardisation of advice on implementation challenging but not impossible.

**c. Inconsistency with evidence**

The evidence used to produce the NICE guidance is massively variable in reliability. When considering the evidence behind many of the Long-Term Condition pathways, it has been estimated than it applies to less than 20% of the whole disease population. This is because most people don’t fit the narrow recruitment criteria for the studies, such as having only a single condition, being on a specific regimen, being of a mindset to opt in to a study, or having had the correctly diagnosed acute episode (recorded under the right code) to be eligible.

**d. Innovation isn’t easy**

One of the biggest challenges for the NHS as a whole is how to embed innovation in an archaic system. It currently takes 17 years for an innovation to come to widespread use in the NHS at a time when the introduction of new innovations is crucial to the future of the NHS and the improvement of healthcare outcomes.

Some of those innovations will be radical, expensive, require new models of care and different staff, but all will impact current ways of working; implementing these into pathways involves taking money out of the “business as usual” service delivery that is proven to work (however inefficiently) in order to try something less proven.

Aside from the obvious reputation risk that would come from getting it wrong, those commissioning services are normally generalists who need to take advice from hospital specialist physicians, surgeons and/or service delivery leads. Many of these specialists have their preferred methods of practicing and will, without exception, have been involved with trying something new as part of their personal development or watching the development of peers.
It results in each specialist having their own preferred new models, innovations, pet projects and vested interests, which inevitably end up being pushed onto the commissioner. This causes a benefit in getting to something deliverable quickly, but at the cost of increasing pathway variation, and it takes away the desired neutrality of the provider’s view when contributing to the commissioner.

It is essential to understand how commissioners commission in order to structure a framework that could solve these problems. For a given disease pathway commissioners look at three business cases side-by-side, and they do this by asking what would happen if they did: a) nothing, b) the same as the last commissioning contract, c) something different. It is this framework which is used to assess whether there are savings to be made by doing something different and whether the benefits outweigh the risks.

There is no standard means of creating these business cases with each case articulated very differently both across diseases within the same CCG or even the same pathway between neighbouring CCGs. One key issue of the process is that proposals for “do something different” pathways are usually created from scratch by a project manager and clinical lead GP (usually there at least two or three of each at a CCG) with support from a number of key stakeholders including commissioners, providers and knowledge specialists, patients and contract managers.

**SOLUTION**

We need a systematic approach to commissioning with tools that:

a. Identify areas of highest realisable value

b. Can support decisions to commit appropriate levels of investment

c. Help commissioning teams make some sense of the hundreds of innovations in the market for consideration in their new pathways

If CCGs had to perform a baselining exercise before commissioning they could quantify performance comparably to any other area. Right Care has developed a map so that areas can find the most comparable places around the country in terms of demographic and disease. This exposes where areas of highest need are, where services need to be bolstered, and could be used to justify increases in investment where significant in-year savings could be realised through a specified course of action including introducing innovations.

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**3. KPIS AND INCENTIVES: ALIGNING WITH OUTCOMES, NOT ACTIVITIES**

**PROBLEM**

Bridging the conflicting drivers between commissioning/providing and health/social care using the right incentives is critical to sustainability. It is pivotal to put patients in control of their health because while doctors are incentivised based on activity (i.e. to do things to patients), those patients become passengers in their care with little incentive to change or take responsibility for their wellbeing. Equally, while CCGs want to spend less, providers are geared up to try and get CCGs to spend more.

**SOLUTION**

This is already changing:

a) NHSE is giving CCGs a powerful new lever to support rapid GP behaviour change through co-commissioning. This allows for the creation of localised outcome-based key performance indicators (i.e local incentives that target local areas of underperformance). Where this has been applied by early adopters in London, CCGs and their providers are seeing significant improvements in patient outcomes and experience, fewer missed attendances at hospital clinics, and reduced A&E attendances from patients with long-term conditions.

b) CCG incentives have been adapted slightly so that they can consider business cases which deliver returns over two years rather than just those delivering in-year savings. This is particularly important for innovations where in-year savings are often extremely difficult to achieve even if everything goes as planned. This has meant that innovation infrastructure within the NHS, such as Academic Health Science Networks (AHSNs), Digital Health London (DH.L), and particularly the National Innovation Accelerator (NIA) are able to get some traction with innovations that previously would have taken too long to demonstrate results.

c) Healthcare under NHSE and social care run by local authorities have been separated since 1993 with their own budgets and incentives. This has led to a lack of continuity of care for patients and added complexity and cost to patient management and planning. Accountable care structures will see these budgets coming together over the next few years, which when accompanied by the right incentives will drive an agenda of prevention, wellbeing and improved community management of citizens whether they are in need of care or not.
CONCLUSION

The current siloed approach to commissioning has led to high degrees of variation in infrastructure, service quality, investment, clinical expertise, and most importantly outcomes for each clinical care pathway – directly impacting patient outcomes. Devolving decision-making powers down to Clinical Commissioning Groups (CCGs) has meant that there is now a wider variation in practice than has been seen since the formation of the NHS.

To minimise disruption the goal of implementing the above ‘enablers’ is to keep delivering with local commissioning and control of services, but include best-in-class practices while reducing unnecessary variations in clinical outcomes. The National Health Service could become significantly more organised and functional if it focused on these three areas of Education, Product Consistency and Incentive Alignment, and learned lessons from successful businesses as laid out in ‘The Business Case’.

The ability of the NHS to have a commissioning structure that eliminates barriers preventing the adoption of innovations and new technology is essential, which is why the IET – with Innovation as its President’s Theme for the year – has thrown its support behind the issue.

Brave decisions and changes need to be made – cutting across interest groups – for the benefit of patients, taxpayers, commissioners and the NHS as a whole, as these would help deliver world-class healthcare at an efficient cost.
AN OPPORTUNITY FOR THE IET

The IET has a large base of members who are pushing the boundaries with a number of technologies. At the same time there are huge needs in healthcare, the identification of which requires an engineer to talk to a healthcare professional and vice versa.

The IET can play a significant role by facilitating these mutual introductions and ‘let the sparks fly’, starting with the inaugural ‘Think BIG Future Health & Life Science’ event in Glasgow.

Have you enjoyed reading this article? Commissioning will be the theme of the next Think BIG event in Manchester on 28th June 2018. For more information on the series visit www.theiet.org/healthcare.

REFERENCES

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