The King's Fund>

Ideas that change
health care

Authors
Candace Imison
Chris Naylor
Nick Goodwin
David Buck
Natasha Curry
Rachael Addicott
Paul Zollinger-Read

Transforming our health care system

Ten priorities for commissioners

Introduction

The draft Health and Social Care Bill proposed the introduction of GP commissioning consortia who, by 2013, would hold the majority of the NHS budget, more than £60 billion of public money. Their task, or the task of any wider clinical commissioning group that emerges from the current listening exercise, is to deliver a sustainable health care system in the face of the most challenging financial and organisational environment since the introduction of the purchaser/provider split within the NHS in 1991. The task is especially daunting in the context of a population in which the burden of disease is growing and medical advances offer increasing opportunities to treat disease, but at a cost. The result, if nothing else changes in the NHS, will be significant unmet need and threats to the quality of care.

The ageing population and increased prevalence of chronic diseases require a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated. This paper is designed to support commissioners to transform the health care system. We have identified ten priorities for action. A striking feature of all the priorities is the degree to which they call for change within primary care and the way in which primary care relates to the rest of the system. Commissioners will need to play an active role in improving the quality of local primary care. They need to set out what 'good care' looks like and use peer influences to lift performance. This underlines the importance of the proposed NHS Commissioning Board working collaboratively with GPs and commissioners to influence and develop the provision of local primary care services. Critically, they need to help drive:

- more systematic and proactive management of chronic disease – not only will this improve health outcomes, and reduce inappropriate use of hospitals, but it will also have a significant positive impact on health inequalities

- the empowerment of patients – patients are arguably the greatest untapped resource within the NHS (Corrigan 2009). The active engagement of patients is a common thread to all of our ten priorities

- a population-based approach to commissioning – key challenge for commissioners is to direct resources to the patients with greatest need and redress the 'inverse care law' by which those who need the most care often receive the least. This means shifting their focus from the patients that present most frequently in their practice to the wider population that they serve:

- more integrated models of care – this will take a variety of forms from 'virtual' integration through shared protocols to integrated teams and in some cases shared budgets and organisational integration. The aim is to improve the quality of care for patients and reduce waste (Ham *et al* 2011).

We describe below the ten priorities. In our discussion at the end of this document, we review their collective impact and look at some of the key organisational factors that will help commissioners not only 'to do the right thing' but just as important, 'to make the right things happen'.

1. Active support for self-management

What is it?

Self-management support can be viewed in two ways: as a portfolio of techniques and tools to help patients choose healthy behaviours; and a fundamental transformation of the patient–caregiver relationship into a collaborative partnership (De Sliva 2011, p vii).

Why is it important?

- Around 15 million people in England have one or more long-term conditions. The number of people with multiple long-term conditions is predicted to rise by a third over the next ten years (Department of Health 2011a).

- People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days. Treatment and care of those with long-term conditions accounts for 70 per cent of the primary and acute care budget in England (Department of Health 2011a).

- At the heart of the chronic disease management model (Wagner *et al* 1996) is the informed, empowered patient with access to continuous self-management support.

- Around 70–80 per cent of people with long-term conditions can be supported to manage their own condition (Department of Health 2005).

What is the impact?

- Self-management has potential to improve health outcomes in some cases, with patients reporting increases in physical functioning (Challis *et al* 2010).

- Self-management can improve patient experience, with patients reporting benefits in terms of greater confidence and reduced anxiety (Challis *et al* 2010).

- Self-management programmes have been shown to reduce unplanned hospital admissions for chronic obstructive pulmonary disease (COPD) and asthma (Purdy 2010) and to improve adherence to treatment and medication (Challis 2010), but evidence that this translates into cost savings is more equivocal. A cost analysis performed in the United States did indicate that expenditure in other parts of the system can be reduced (Stearns *et al* 2000).

How to do it

There are a number of well-established self-management programmes. Any of the following could be offered as a stand-alone intervention or as part of a package of care:

- patient and carer education programmes
- medicines management advice and support
- advice and support about diet and exercise
- use of telecare and telehealth to aid self-monitoring
- psychological interventions (eg, coaching)
- telephone-based health coaching
- pain management
- patient access to their own records
- systematic training for GPs in consultation skills that help engage patients.

Many of these interventions are provided by professionals from within the health care team, but some can be delivered by other patients or the voluntary and community sector (Campbell *et al* 2004). Commissioners can draw on a range of existing examples, such as the DESMOND programme introduced widely across the NHS for people with diabetes.

Useful resources

The self-management website is a new resource for all those involved in the self-management community: tutors, assessors and trainers of tutors, delivery organisations and health professionals: www.selfmanagement.co.uk/

The Health Foundation has launched a self-management support resource centre that includes research reports and practical tools and approaches: www.health.org.uk/areas-of-work/topics/sms-resource-centre/

Birmingham University has a useful webpage that introduces the DAPHNE and DESMOND diabetes education programmes: http://medweb.bham.ac.uk/easdec/prevention/diabeteseducation.htm

2. Primary prevention

What is it?

Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks or by targeting high-risk groups.

Why is it important?

- Effective primary prevention helps patients to avoid health problems before they occur. While prevention in childhood provides the greatest benefits, it is valuable at any point in life.

- It is estimated that 80 per cent of cases of heart disease, stroke and type 2 diabetes, and 40 per cent of cases of cancer could be avoided if common lifestyle risk factors were eliminated (WHO 2005).

- Primary prevention is an excellent use of resources when compared with many treatment and curative interventions. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year (QALY) and almost 80 per cent cost less than £30,000 per QALY, the cut-off used by the National Institute for Health and Clinical Excellence (NICE) for cost-effectiveness (van Gils *et al* 2010).

- The financial sustainability of the NHS in the future will depend on more systematic primary prevention in order to reduce the overall burden of disease in the population.

What is the impact?

More systematic primary prevention in general practice has the potential to improve health outcomes and save costs in many areas of primary care (Health England 2009), for example:

- five minutes of advice in general practice to middle-aged smokers to quit smoking can increase quit rates and save £30 per person for a cost of £11 per person

- brief interventions in general practice to reduce problem drinking can reduce alcohol consumption by 40 per cent over 12 months with overall cost savings outweighing intervention costs

- brief intervention in general practice to improve exercise uptake can increase the chances of adults undertaking moderate activity by over 20 per cent and vigorous activity by 6 per cent with cost savings of £3,300 per person.

How to do it

Guidance on how to achieve good results from primary prevention through primary care and through working with other local agencies is available to commissioners from NICE, public health departments, Health England and the National Support Teams for tobacco, alcohol, infant mortality and inequalities.

Evidence-based interventions range from:

- brief advice to individuals to quit smoking during an opportunistic consultation (even simply raising the issue)

to:

- systematic, planned community interventions in schools to reduce childhood obesity.

NHS Knowsley has had a major impact on smoking rates in disadvantaged communities through cross-partnership action including targeting illicit tobacco sales, reducing smoking in pregnancy, and providing drop-in clinics in disadvantaged areas. These approaches often require new ways of engaging with communities to ensure they reach those in greatest need.

Useful resources

NICE's public health guidance including on primary prevention: www.nice.org.uk/guidance/phg/indevelopment/ publichealthguidancetopics.jsp

Health England has developed several useful reports on the impact and cost-effectiveness of primary prevention and modelling tools to help local areas prioritise: www.healthengland.org/index.htm

Relevant National Support Teams, including those focussing on tobacco, alcohol, infant mortality and inequalities, have information on their systematic approach to primary prevention, modelling and case studies: www.dh.gov.uk/ en/Publichealth/NationalSupportTeams/index.htm

3. Secondary prevention

What is it?

Systematically detecting the early stages of disease and intervening before full symptoms develop – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure.

Why is it important?

- Secondary prevention is based on a range of interventions that are often highly cost-effective and that, if implemented at scale, would rapidly have an impact on life expectancy.

- There is substantial variation between practices in terms of the systematic implementation of approaches towards secondary prevention – for example, use of disease registers. Only a minority of patients receive all recommended interventions.

- There are many patients who would benefit from secondary prevention but are not currently benefiting. Evidence suggests that this is an area where the 'inverse care law' applies and those in greatest need are least likely to benefit. This suggests significant opportunities exist to improve care.

- Identifying those at risk and intervening appropriately is one of the most effective ways in which GPs can reduce the widening gaps in life expectancy and health outcomes (Marmot Review 2010).

What is the impact?

- Successful secondary prevention would have a major impact on health outcomes, in terms of improvement in life expectancy and reduction in complications.

- Cost savings are likely to accrue over the medium term, as patients are prevented from going on to suffer a wide range of adverse events as their life expectancy lengthens.

How to do it

Secondary prevention largely involves more systematic application of standard, low-technology interventions. The key actions for commissioners are:

- ensuring appropriate coverage of key preventive interventions and processes

  – managing disease registers systematically through modelling expected versus actual prevalence and incidence

  – ensuring systematic control of hypertension, cholesterol and diabetes among the consortium's population

- understanding the key drivers of local health inequalities and identifying where and how to intervene to have the biggest and quickest impact

- working systematically with local authorities and other partners to ensure primary care prevention forms part of a broader strategy on public health

- working with community and voluntary sector groups to offer interventions to patients who do not engage well with mainstream health services.

Several free resources exist to support this, such as the London Health Observatory's 'Health Inequalities Intervention Tool', which can be used to help commissioners understand where to focus their efforts to have the greatest effect in their local area. Modelling tools can be used to measure expected and actual numbers of people on disease registers, and thereby identify practices where improvement is needed.

Useful resources

The Department of Health's health inequalities intervention tool available at the London Health Observatory was developed on the basis of the criteria of the most cost-effective interventions that would have the quickest impact, most of which are secondary prevention interventions in primary care: www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx

The Health Inequalities National Support Teams' 'how to' guides for secondary prevention in primary care and related resources: www.dh.gov.uk/en/Publichealth/NationalSupportTeams/HealthInequalities/index.htm

4. Managing ambulatory care sensitive conditions

What is it?

Ambulatory care sensitive (ACS) conditions are chronic conditions that include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension. Actively managing patients with ACS conditions – through vaccination; better self-management, disease-management or case-management; or lifestyle interventions – prevents acute exacerbations and reduces the need for emergency hospital admission.

Why is it important?

- Despite admission being largely preventable, a significant proportion of all acute hospital activity is related to ACS conditions. In the East of England region they accounted for 12.2 per cent of all acute hospital admissions in 2006/7 (ERPHO 2009).

- There is significant variation in how effectively ACS conditions are managed – for example, the NHS Atlas of Variation in Healthcare shows a five-fold variation in emergency admission rates for asthma across PCTs in England (after standardising for population characteristics).

- These admissions are costly. The total cost to the NHS in 2005/6 was estimated at £1.3 billion for a core set of 19 ACS conditions.

What is the impact?

- Maintaining wellness and independence in the community prevents deterioration in conditions and therefore results in better health outcomes.

- Emergency admissions to hospital are distressing, so better management that keeps people well and out of hospital should lead to a better patient experience.

- Reducing variations in ACS admissions by spreading existing good practice could produce cost savings of £170 to £250 million across England (NHS Institute 2011). This variation-based calculation may significantly underestimate potential savings from managing ACS more effectively as admission rates in all areas are significantly above what should be achievable.

How to do it

Early identification of ACS patients is crucial if their management is to be successful. GPs are well placed to do this through the use of risk stratification tools and clinical decision support software within GP practices. Some progress can be made through relatively simple measures such as expanding vaccination, where available, to prevent the onset of a condition. For other ACS conditions (chronic and acute aggravated conditions), commissioners will need to encourage active disease management. This can include a number of elements, such as:

- treatment decisions based on explicit proven guidelines

- case management to support people with complex long-term conditions

- disease management and support for self-management for those with less complex long-term conditions

- telephone health coaching, and other behavioural change programmes, to encourage patient lifestyle change

- easy access to urgent care for those with acute aggravated conditions.

Useful resources

The NHS Institute estimate the potential to reduce emergency admissions for ambulatory care sensitive conditions at national and local levels and by condition: www.productivity.nhs.uk/Indicator/608/For/National/And/25th/Percentile

Birmingham Ownhealth is a service that uses specialist care managers to support people with ACS conditions via telephone coaching: birminghamownhealth.co.uk/

The King's Fund has developed a risk stratification tool that uses inpatient data to identify patients at risk of re-hospitalisation within a year.

5. Improving the management of patients with both mental and physical health needs

What is it?

Developing a more integrated response to people with both mental and physical health problems, in particular supporting people with common mental health problems (such as, depression or anxiety) alongside a physical long-term condition.

Why is it important?

- Around 30 per cent of people attending general practice have a mental health component to their illness (Jenkins *et al* 2002).

- There is a strong association between mental and physical ill health. For example, depression has been associated with a four-fold increase in the risk of heart disease, even when other factors are controlled for (Osborn *et al* 2007).

- Co-morbid mental health problems have a significant impact on the costs related to the management of long-term conditions. For example, the total cost to the health service of each person with diabetes and co-morbid depression is 4.5 times greater than the cost for a person with diabetes alone (Egede *et al* 2002).

- Unidentified mental health problems are linked to patients with 'medically unexplained symptoms', who can place heavy demands on health services without their problem being resolved (Reid*et al* 2001).

What is the impact?

- Improving the way we respond to co-morbid physical and mental health problems would have a high impact in terms of patient experience and clinical outcomes, since both of these are known to be poor relative to those for people with a single condition.

- There could also be a significant impact on costs, with evidence suggesting that addressing underlying mental health or psychological needs can reduce costs related to physical long-term conditions (Naylor and Bell 2010). For example, provision of psychological support for angina patients in Liverpool achieved a reduction in hospital costs of £1,337 per patient per year (Moore *et al* 2007).

How to do it

Some of the changes required – such as, expanding screening and monitoring – would be relatively simple for commissioners to implement. However, others would be more complex as they involve redesigning the interface between multiple providers. Specific actions might include:

- expanding screening for mental health needs among people with long-term conditions

- encouraging more systematic coding and recording of mental health needs

- implementing collaborative care models as recommended by NICE for people with depression and a long-term condition (NICE 2009). The model emphasises case management, systematic follow-up and close collaboration between primary and secondary care

- working with 'Improving Access to Psychological Therapy' (IAPT) services. The government's new mental health strategy gives these a key role in providing mental health support for people with a long-term condition, and many are already taking this on; for example, in Salford, IAPT services have developed a new care pathway for people with diabetes and co-morbid depression or anxiety commissioning new liaison psychiatry services in acute hospitals, care homes and elsewhere.

Useful resources

The Joint Commissioning Panel for Mental Health, launched in March 2011, is developing a range of resources for GP commissioners to support effective commissioning of mental health services: www.jcpmh.info

A joint publication from The King's Fund and the Centre for Mental Health describes the opportunities to make savings and improve quality of care within mental health:

http://www.kingsfund.org.uk/mentalhealth

A recent LSE publication evaluates the economic case for investment in 15 interventions to prevent mental illness and promote mental health:

www2.lse.ac.uk/LSEHealthAndSocialCare/PSSRU/pdf/MHPP%20The%20Economic%20Case.pdf

6. Care co-ordination through integrated health and social care teams

What is it?

Creating patient-centred care that is more co-ordinated across care settings and over time, particularly for patients with long-term chronic and medically complex conditions who may find it difficult to 'navigate' fragmented health care systems.

Why is it important?

- Co-ordination of care to people with complex chronic illness is a global challenge. Driven by broad shifts in demographics and disease status, long-term conditions absorb by far the largest, and growing, share of health care budgets (see 'Active support for self-management').

- Co-ordination of care for patients with complex needs and long-term illness is currently poor (The King's Fund 2011), and those with long-term conditions have a lower quality of life (Department of Health 2011).

What is the impact?

- Robust evidence on health outcomes is limited, but improved care co-ordination can have a significant effect on the quality of life of the frail elderly and people with multiple long-term conditions (Hofmarcher *et al* 2007).

- Highly integrated primary care systems that emphasise continuity and co-ordination of care are associated with better patient experience (Starfield 1998; Bodenheimer 2008).

- Impact on costs and cost-effectiveness is less easy to predict and is likely to be low in the short-term given the upfront investments required to develop infrastructure and change clinical practices. However, health systems that employ models of chronic care management – in which care co-ordination is a central component – tend to be associated with lower costs, as well as better outcomes and higher patient satisfaction (Singh and Ham 2005).

How to do it

There is no one model of care co-ordination, but evidence suggests that GP commissioners that employ a multi-component approach will achieve better results than those that rely on a single or limited set of strategies (Singh and Ham 2005; Powell Davies *et al* 2008; Kodner 2009). Some of the key components (The King's Fund 2011) are:

- a move to multi-professional teams, including generalists working alongside specialists

- a focus on case management and support to home-based care

- joint care planning and co-ordinated assessments of care needs

- personalised health care plans and programmes

- general practitioners acting as navigators, rather than the gatekeepers, retaining responsibility for patient care and experiences throughout the patient journey

- clinical records that are shared across the multi-professional team .

Torbay Care Trust provides a good example of the kind of change required. Torbay established five integrated health and social care teams that are organised in localities aligned with general practices. The teams target their efforts at the very highest-risk individuals who require intensive support from community matrons and integrated teams.

Northamptonshire Integrated Care Partnership is also developing new models of long-term condition management in primary care, under the leadership of Nene Commissioning. Their approach has focused on helping patients remain independent for longer and creating personalised care plans for high-risk individuals that aim to reduce admissions to hospital.

Useful resources

NHS Institute for Innovation and Improvement 'Joined Up Care' resources – a new suite of products and tools to help create seamless care between services: www.institute.nhs.uk/qipp/joined_up_care/joined_up_care_homepage.html

The Department of Health's (2008) compendium of information on long-term conditions summarises the need for more effective care co-ordination and included some examples from local communities: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082069

A 2005 review of the evidence on the impact of care co-ordination for people with long-term conditions by Debbie Singh and Chris Ham: www.download.bham.ac.uk/hsmc/pdf/transforming_chronic_care.pdf

7. Improving primary care management of end-of-life care

What is it?

Within primary care, improving the systematic identification of patients who are at the end of life, and then providing the appropriate support; in particular, improving the co-ordination of care, continuity, quality of communication, and the provision of bereavement care.

Why is it important?

- Two-thirds of people would prefer to die at home, but in practice only about one-third of individuals actually do (Higginson 2003)

- The annual number of deaths in England and Wales is expected to rise by 17 per cent from 2012 to 2030. Further, the average age at death is set to increase markedly, with the percentage of deaths among those aged 85 or over expected to rise from 32 per cent in 2003 to 44 per cent in 2030. To respond to this, both inpatient and community care facilities must increase substantially (Gomes and Higginson 2008).

- The costs of caring for people at the end of their lives is estimated to run into billions of pounds (National Audit Office 2008). Care for the 27 per cent who die from cancer is around £1.8 billion in the last year of their life, or £14,236 per patient (Hatziandreu *et al* 2008).

- Wide variations exist in the quality of end-of-life care across England. Spending by primary care trusts (PCTs) on palliative care has varied from £154 to over £1,600 per patient (National Audit Office 2008).

What is the impact?

- Research by The King's Fund has identified many examples of how improvements in end-of-life care can have a high impact on patient experience as well as the experience of family members and carers (Addicott and Ross 2010).

- Some evidence suggests greater co-ordination of care can improve quality without incurring any additional costs (Addicott and Dewar 2008). There may be some scope to make cost savings, particularly through a reduction of unnecessary admissions into the acute setting, although research on this is limited.

How to do it

End-of-life care is provided in a variety of organisational settings by a range of health and social care professionals. To meet patients' needs a whole-systems approach is needed that co-ordinates care across professional and organisational boundaries (Addicott and Ross 2010). GPs will be in a central position to do this.

Commissioners should be driving a whole-systems approach that focuses on the availability of a range of services across the care pathway, such as:

- facilitation of discharge from the acute setting

- rapid response services during periods out of hospital

- centralised co-ordination of care provision in the community

- guaranteeing 24/7 care.

It will also be important to ensure that end-of-life care features in any care pathway to ensure that that we shift the focus beyond terminal cancer.

The Gold Standards Framework (GSF) is a tool for identifying, documenting and sharing patients' end-of-life care needs and preferences and subsequently planning their care (National Gold Standards Framework Centre 2011). For the dying patient, the Liverpool Care Pathway sets out best practice in caring for patients in the last hours/days of life.

Useful resources

The Gold Standards Framework (GSF) is a systematic, evidence-based approach to help clinicians to a) identify patients in the final years of life, b) assess the needs, symptoms and preferences of those patients, and c) plan care on that basis, enabling patients to live and die where they choose: www.goldstandardsframework.nhs.uk/

The National End of Life Care Programme provides policy guidance, and education and training to health and social care services across all sectors in England to improve end of life care for adults: www.endoflifecareforadults.nhs.uk/

The Liverpool Care Pathway for the dying patient is an integrated care pathway that is used at the bedside to drive up sustained quality of the dying in the last hours and days of life:www.mcpcil.org.uk/liverpool-care-pathway/index.htm

8. Effective medicines management

What is it?

Medicines management supports better and more cost-effective prescribing in primary care, as well as helping patients to manage medications better. Good medicines management can help to reduce the likelihood of medication errors and hence patient harm.

Why is it important?

- There is a considerable body of evidence from the point of view of patient safety, service efficiency and cost that medicines management needs to be improved. .

- Prescribing costs are rising at a relentless rate – about 7 per cent per year in real terms – and account for 12 per cent of the overall NHS budget. In 2010, the annual drugs bill in primary care alone was around £8.6 billion (NHS Business Services Authority, Prescription Pricing Division 2010).

- Medication errors occur in up to 11 per cent of prescriptions, mainly due to errors in dosage (Sanders and Esmail 2003).

- Around 7 per cent of all hospital admissions have been attributed to, or associated with, adverse drug reactions – with up to two-thirds of these being preventable (Pirmohamed *et al* 2004). Adverse reactions are particularly common among vulnerable groups, such as, frail older patients in nursing homes (Gurwitz *et al* 2005).

- Between one-third and one-half of all medication prescribed for long-term conditions are not taken as recommended (Nunes *et al* 2009).

What is the impact?

- The evidence cited above suggests that improved medicines management could be expected to have a high impact in terms of patient experience and health outcomes. There is good evidence that guidance and peer review can support improvements in the quality and safety of prescribing (Duerden *et al* 2011), although achieving major improvements in patient compliance may be more difficult (Haynes *et al* 2008).

- The impact on costs could also be substantial, given the levels of drug wastage, opportunities to improve the cost-effectiveness of prescribing certain drugs, and the high numbers of preventable drug-related emergency hospital admissions. For example, standardising prescribing practices for certain treatments (such as low-cost statins) could save the NHS more than £200 million a year (NAO 2007).

How to do it

There are a number of techniques available that GPs will be in a prime position to implement:

- medication reviews, usually in general practice, that seek to ensure prescribing standards are being met – for example, through practice-based audits linked to peer review of prescribing practices and outcomes

- use of IT and decision-support tools to support best practice in prescribing by professionals, and to help reduce medication errors

- pharmacist and nurse-led interventions that provide educational information and outreach services to reduce prescribing and monitoring errors among high-risk patients (Avery 2010)

- use of pharmacy technicians to support practices to improve their prescribing practice by conducting systematic audits, evaluating patients and recommending changes to medication

- improved systems to support safe transfer of information on patient medication at admission and discharge

- providing clinicians with benchmarked information on prescribing performance.

Useful resources

The National Prescribing Centre website contains a number of guides to support effective medicine management: http://www.medman.nhs.uk/guidance_mm.php#

NeLM is the largest medicines information portal for health care professionals in the NHS: National electronic Library for Medicines (NeLM)

9. Managing elective activity – referral quality

What is it?

Managing elective (planned) hospital activity by systematically reviewing and auditing referrals with a view to benchmarking against other pra

Why is it important?

- GPs make more than 9 million referrals to hospitals for elective care each year that then trigger an annual spend of more than £15 billion in the NHS (McKinsey 2009).

- Referral rates to a particular specialty within a single area vary by as much as 10-fold between GPs (Creed *et al* 1990; Ashworth *et al* 2002). There is strong evidence that a wide variety of factors account for this variation, clinical and non-clinical (Foot *et al* 2010). The available research suggests that not all referrals are necessary in clinical terms, and a substantial proportion of activity is discretionary and avoidable.

- There are also patients who need a referral but fail to receive one. For example, lack of or late referral is thought to be a key driver of poor survival rates for cancer (Department of Health 2011b).

- There is strong evidence to suggest that the quality of referral letters could be improved in some cases (Foot *et al* 2010). The absence of key information can prevent reliable decisions with regard to risk assessment, triage or resource allocation, as well making it difficult to decide on the most appropriate destination for the referral (Speed and Crisp 2005).

- GPs, patients and specialists do not always share a common understanding of why a referral is being made – for example, whether it is primarily for diagnosis, investigation, treatment or reassurance (Grace and Armstrong 1986, Broomfield *et al* 2001, Molloy and O'Hare 2003).

What is the impact?

- Given the link between poor outcomes and late referral, particularly for cancer, improving referral quality should have an impact on health outcomes in some cases.

- Improving the quality and appropriateness of referral would have an impact on patient experience by avoiding unnecessary visits and improving the timeliness of treatment.

- There is some scope to reduce costs by avoiding unnecessary referrals. However, this needs to be balanced against the likelihood that improved review and audit processes would also identify under-referral in some clinical areas.

- Referral audit can help to identify training needs and thereby improve the quality and cost-effectiveness of clinical care.

How to do it

The implementation of active referral review should be straightforward for GPs as it requires little investment and can be incorporated within wider audit programmes that should become day-to-day business for practices in the future. Referral review could involve:

- use of comparative information about GP and practice referral rates by specialty and routine audits at practice level

- discussion of a sample of referrals to examine their content and appropriateness

- generalists and specialists agreeing redesigned elective care pathways including consultant-to-consultant referral protocols.

Approaches based on review and audit are recommended over the establishment of referral management centres, which can add a significant overhead cost to each referral, fail to address individual practice deficits, and introduce new clinical risks (Imison and Naylor 2010).

Useful resources

The King's Fund report on referral management, *Referral management: Lessons for success* (Imison and Naylor 2010), describes the strengths and weaknesses of the different approaches to referral management and provides some practical suggestions of ways to support the referral process.

There is also a case study on The King's Fund website that provides a detailed description of how one practice has introduced referral management and the impact that it has had. Both resources can be accessed via: www.kingsfund.org.uk/referral

10. Managing emergency activity – urgent care

What is it?

Developing a more integrated approach to urgent care for patients who have an injury or illness that requires immediate attention but is not serious enough to warrant a visit to an accident and emergency department (A&E) through better co-ordination of the range of services available and sharing of clinical information across different agencies.

Why is it important?

- Urgent care services are currently often highly fragmented and generate confusion among patients about how and where to access care (Lattimer *et al* 2010).

- Poor sharing of information as patients move between different providers of care in an emergency is a cause of many significant failures of care (Gandhi 2005).

- The quality of out-of-hours care is highly variable, particularly in terms of continuity of care, leading to variable patient experiences (NAO 2006).

- The growth of new forms of urgent care has failed to reduce A&E attendances (Cooke *et al* 2004). Emergency attendances in England rose by 46 per cent between 2003/4 and 2009/10, (Department of Health 2011c).

- Walk-in centres do not appear to have led to shorter waits in general practice or lower admission rates at other health care providers (Salisbury 2003).

- Emergency admissions have also grown rapidly. The number of emergency admissions in England rose by 11.8 per cent between 2004/5 to 2008/9 – resulting in around 1.35 million extra admissions (Blunt *et al* 2010).

What is the impact?

- Addressing poor practice, improving care continuity, and reducing variation could have a major effect on health outcomes.

- Making the urgent care system easier to navigate would improve patient experiences substantially.

- Integrated urgent care services that manage demand more effectively could be expected to be significantly more cost effective.

How to do it

Although the impact could be highly positive, redesigning the urgent care system is likely to be very challenging.

Specific actions for commissioning bodies could include:

- GPs playing an active role in commissioning primary care out-of-hours services as part of a whole-system urgent care response including community support and ambulance diversion opportunities

- developing a clinical dashboard for GPs to inform strategic changes in urgent care services

- establishing better and more integrated triage systems

- providing effective signposting and access to urgent care services for patients

- building systems to improve co-ordination of care between different providers

- investigating patient flows around the urgent care system to support the development of a locally revised 'whole system' model of care (Boyle and Pratt 2004).

NHS Bolton developed a clinical dashboard for general practice, giving GPs a clearer picture of urgent care activity, so they could ensure patients accessed the appropriate services. The PCT piloted its dashboard in 2009/10 in 56 practices; that year A&E admissions in the area fell 3 per cent amid a regional increase of 9 per cent and unscheduled hospital admissions fell 4 per cent, with one practice showing reductions of 16 per cent.

Useful resources

Details of the performance indicators used in NHS Bolton's GP urgent care dashboard are available online : www.excellence.eastmidlands.nhs.uk/welcome/improving-care/emergency-urgent-care/transforming-urgent-care/gp-urgent-care-dashboard/

'Tackling demand together: a toolkit for improving urgent and emergency care pathways by understanding increases in 999 demand' offers practical analysis, worksheets and tools to help all commissioners and providers improve urgent and emergency care services through better understanding of the factors affecting significant rises in 999 demand: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106925

Discussion and conclusion

The 10 high-impact interventions provide an action plan for any new commissioning bodies and GP practices to transform the health of their local population. The table below maps each of the interventions showing their relative impact versus ease of implementation. This is a subjective assessment by the authors of this paper but one that draws on the evidence underpinning the interventions, as described in the previous sections. The assessments also drew on feedback gathered during a commissioning masterclass we held in April with GP leaders and a range of senior NHS professionals involved in commissioning.

It is clear that the potential gains in terms of health outcomes, patient experience and cost savings are considerable. Yet implementation will not be straightforward. In the main, as can be seen from the examples, this is not because we lack the evidence and information about what to do, but because of the scale of the change management task, particularly as investing in community-based care, will deliver savings only if accompanied by strategic disinvestment from hospitals. Commissioners will need to make a robust case for such disinvestment where it is clinically justified, and will need to develop strong communication and political skills in order to defuse potential resistance to much-needed, evidence-based change.

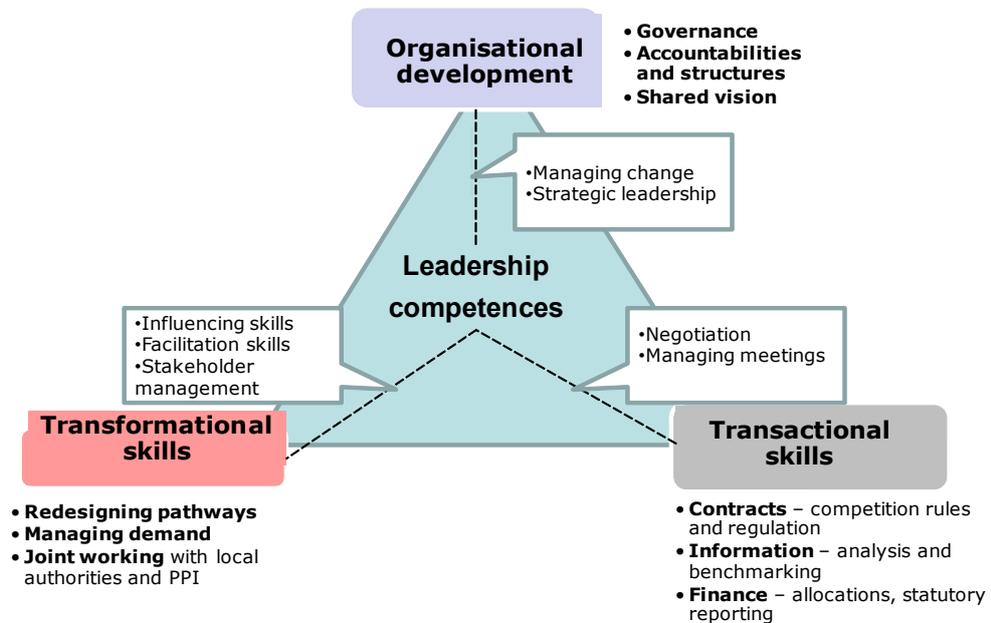|	Health outcome	Patient experience	Savings	Ease
Self-management	M	H	M	M
Primary prevention	H	M	M	M
Secondary prevention	H	M	M	M
Managing ACS conditions	H	M	M	M
Integrating mental and physical health care	H	H	M	M
Care co-ordination and integration	M	H	L	L
End-of-life care	n/a	H	M	M
Medicines management	H	H	H	H
Managing elective activity	M	M	M	H
Managing emergency activity	H	H	H	L

Low impact / low ease (high difficulty)
Medium impact / medium ease
High impact / high ease (low difficulty)

It is not just a question of 'doing the right thing' but 'making the right things happen'. Much of what we describe has been known for some time, yet it is not applied in practice. Why? Because while it is relatively straightforward to impart knowledge about what to change, it is much harder to create the culture and enthusiasm required to deliver change, particularly when working across organisational boundaries. The potential strength of GPs' engagement in commissioning is that their clinical foundation is a step towards creating the necessary culture, but if they are given hard budgets they will need to invest heavily in developing strong commissioning organisations and good working relationships across the health system if they are to exploit this advantage. There are three important areas that require developing - organisational development, transactional skills and transformational skills (see Figure 1 below).

Organisational development - 'the healthy organisation'
Much has been written about the factors that lead to healthy organisations. It is clear that organisations that focus on these factors are more likely to deliver on their objectives. For example, organisations with a clear vision and values, owned by the members, are more likely to succeed (Senge 2004; Zairi 1998). There is also evidence that when budgets are handed to medical groups their success is strongly linked to strong medical leadership and governance (Ham 2010; Thorlby *et al* 2011). Establishing strong clinical and organisational governance not only underpins high-quality performance but also ensures the accountability that is essential for GP commissioners as the guardians of £60 billion of taxpayers' money.

Organisational development
- **Governance**
- **Accountabilities and structures**
- **Shared vision**

•Managing change
•Strategic leadership

Leadership competences

•Influencing skills
•Facilitation skills
•Stakeholder management

•Negotiation
•Managing meetings

Transformational skills
- **Redesigning pathways**
- **Managing demand**
- **Joint working** with local authorities and PPI

Transactional skills
- **Contracts** – competition rules and regulation
- **Information** – analysis and benchmarking
- **Finance** – allocations, statutory reporting

Support for commissioning - transactional skills
Commissioners will require high-quality commissioning support services to undertake the 'transactional' elements of commissioning and inform their commissioning decisions. The evidence shows that the achievement of commissioning goals and objectives is strongly linked to the quality of these support services (Thorlby *et al* 2011). Strong Information management and technology capabilities will be particularly important to help commissioners understand variation in outcomes, resource utilisation and benchmark performance. While there are many sources of information on secondary care, commissioners will have to work with community, mental health and not-for-profit providers to generate equivalent information.

Driving service transformation
Finally, commissioners will need the skills to deliver service transformation. They will need to understand what works and be able to collaborate with partners across the health and social care system to deliver change. As Stephen Shortell pointed out in his seminal work on integrated delivery systems: 'The Community Healthcare Management System is a complex set of interorganisational relationships that requires extensive collaboration and coordination as well as subordination of individual organisational interests to achieve a larger common good' (Shortell *et al* 2000, p 275).

References

Addicott R, Ross S (2010). *Implementing the End of Life Care Strategy. Lessons for good practice*. London: The King's Fund.

Addicott R, Dewar S (2008). I*mproving Choice at End of Life. A descriptive analysis of the impact and costs of the Marie Curie Delivering Choice Programme in Lincolnshire*. London: The King's Fund.

Appleby J, Crawford R, Emmerson C (2009). *How Cold will it be: Prospects for NHS funding 2011-2017*. London: The King's Fund.

Ashworth M, Clement S, Sandhu J, Farley N, Ramsay R, Davies T (2002). 'Psychiatric referral rates and the influence of on-site mental health workers in general practice'. *British Journal of General Practice*, vol 52, no 474, pp 39–41.

Avery T (2010). 'Avoidable prescribing errors: communication and monitoring, *Prescriber*, vol 21, issue 6, pp 44–6.

NHS Institute for Innovation and Improvement (2011). *'NHS Better Care, Better Value Indicators (incorporating Opportunity Locator)'*. NHS Institute website. Available at: www.productivity.nhs.uk/Indicator/608/For/National/And/25th/Percentile .

Blunt I, Bardsley M, Dixon J (2010). *Trends in Emergency Admissions in England 2004-2009: is greater efficiency breeding inefficiency?* London: The Nuffield Trust. Available from: http://www.nuffieldtrust.org.uk/publications/detail.aspx?id=145&PRid=714

Bodenheimer T (2008). 'Co-ordinating care - a perilous journey through the health care system'. *New England Journal of Medicine*, vol 358, pp 1064--70.

Boyle S, Pratt J (2004). 'Agent-based modelling: urgent care as a complex system'. In: Kernick D (ed) Complexity and Health Care Organisation. Oxford: Radcliffe Publishing

Broomfield N, Fleming P, Foot D (2001). 'An investigation of the correspondence between psychological problems diagnosed by GPs and those subsequently targeted for treatment by clinical psychologists'. *Health Bulletin (Edinburgh)*, vol 59, no 3, pp 178–87.

Campbell HS, Phaneuf MR, Deane K (2004). 'Cancer peer support programs - do they work?' *Patient Education & Counselling*, vol 55, pp 3-15.

Challis D, Hughes J, Berzins K, Reilly S, Abell J, Stewart K (2010). Self-care and case management in long-term conditions: the effective management of critical interfaces. London: HMSO. Available at: www.sdo.nihr.ac.uk/files/project/SDO_FR_08-1715-201_V01.pdf (accessed on 18 April 2011).

Cooke M, Fisher J, Dale J, McLeod E, Szczepura A, Walley P, Wilson S (2004). *Reducing Attendances and Waits in Emergency Departments: A systematic review of present innovations*. Report to the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development (NCCSDO) [online]. Available at: www.sdo.nihr.ac.uk/files/project/29-final-report.pdf (accessed on 26 April 2011).

Corrigan P (2009). 'DIY doctors: patients can boost NHS's value'. *Health Service Journal* 30 April, pp12-13.

Creed F, Gowrisunkur J, Russell E, Kincey J (1990). 'General practitioner referral rates to district psychiatry and psychology services'. *British Journal of General Practitioners*, vol 40, no 340, pp 450–54.

De Sliva D (2011). *Helping People Help Themselves*. London: The Health Foundation.

Department of Health (2005). *Supporting People with Long-term Conditions: An NHS and social care model to support local innovation and integration*. London: Department of Health.

Department of Health (2008). *End of Life Care Strategy – Promoting High Quality Care for All Adults at the End of Life*. London: The Stationery Office.

Department of Health (2011a). *'Ten things you need to know about long term conditions'*. Department of Health website. Available at: www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm

Department of Health (2011b). *Improving Outcomes: A strategy for cancer*. London: Department of Health.

Department of Health (2011c). 'A&E Attendances'. Department of Health [online]. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AccidentandEmergency/DH_077485

Dr Foster (2010). 'The GP practice index'. Dr Foster website. Available at: www.drfosterintelligence.co.uk/downloads/latestnews/DFI-GP_PracticeIndex-2010.pdf

Duerden M, Millson D, Avery T (2011). *The Quality of GP Prescribing*. London: The King's Fund [online].

Egede LE, Zheng D, Simpson K (2002). 'Comorbid depression is associated with increased health care use and expenditures in individuals with diabetes'. *Diabetes Care*, vol 25, no 3, pp 464–70.

ERPHO (2009) Commissioning brief No. 1: *Ambulatory care sensitive conditions (ACSC) in the East of England* . Available at: www.erpho.org.uk/viewResource.aspx?id=19016

Foot C, Naylor C, Imison C (2010). *The Quality of GP Diagnosis and Referral.* London: The King's Fund

Gandhi TK (2005). 'Fumbled handoffs: one dropped ball after another.' *Annals of Internal Medicine*, Pp 352-8.

Grace JF, Armstrong D (1986). 'Reasons for referral to hospital: extent of agreement between the perceptions of patients, GPs and consultants'. *Family Practitioner*, vol 3, pp 143–47.

Gurwitz J, Field T, Judge J (2005). 'The incidence of adverse drug events in two large academic long-term care facilities. *American Journal of Medicine*, vol 188, no 3, pp 251–8.

Ham C (2010). *GP Budget Holding: Lessons from across the Pond*. Birmingham: Health Services Management Centre, University of Birmingham.

Ham C, Dixon J, Chantler C (2011). 'Clinically integrated systems: the future of NHS reform in England? *'British Medical Journal,* vol 342:d905.

Hatziandreu E, Archontakis F & Daly A (2008). Technical report. *The potential cost savings of greater use of home- and hospice-based end of life care in England. London*: National Audit Office.

Haynes RB, Ackloo E, Sahota N, McDonald HP, Yao X (2008). 'Interventions for enhancing medication adherence'. *Cochrane Database of Systematic Reviews*, issue 2, article CD000011.

Health England (2009). *Report no 5: Intervention Reports*. Available at: http://help.matrixknowledge.com/page/Full-Report-Listing.aspx

Higginson IJ (2003). *Priorities and Preferences for End Of Life Care in England, Scotland and Wales*. London: National Council for Hospice and Specialist Palliative Care.

Hofmarcher, Oxley H, Rusticelli E (2007). *Improved Health System Performance through Better Care Coordination. Health Working Paper No. 30*. Paris: Organisation for Economic Co-operation and Development (OECD).

Imison C, Naylor C (2010). *Referral Management. Lessons for success.* London: The King's Fund.

Jenkins R, McCulloch A, Friedli L, Parker C (2002). *Developing a National Mental Health Policy*. Maudesley monograph 43. Hove: The Psychology Press.

The King's Fund (2011). *Improving the quality of care in general practice. Report of an independent inquiry commissioned by The King's Fund.* London: The King's Fund.

Kodner D (2009). 'All together now: A conceptual exploration of integrated care. *Healthcare Quarterly*, vol 13(Sp), pp 6–15. Available at: www.longwoods.com/content/21091

Lattimer V, Burgess A, Knapp F, Dalton S, Brailsford S, Moore M, Baverstock J, Heaney D (2010). *The impact of changing workforce patterns in emergency and urgent out-of-hours care on patient experience, staff practice and health system performance.* Final report for the National Institute for Health Research Service Delivery and Organisation Programme[online]. Available at: www.sdo.nihr.ac.uk/files/project/SDO_FR_08-1519-97_V01.pdf.

Marmot Review (2010). *Fair Society, Healthy Lives: Strategic review of health inequalities in England, post 2010*. London: The Marmot Review. Available at; www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

McKinsey & Co (2009). *Achieving World Class Productivity in the NHS 2009/10-2013/14: Detailing the size of the opportunity* [online]. London: Department of Health. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_116521.pdf

Molloy E, O'Hare JA (2003). 'Unravelling referrals to medical outpatients'. *Irish Medical Journal,* vol 96, no 5, pp 145–6.

Moore R, Groves D, Bridson J, Grayson A, Wong H, Leach A, Lewin R, Chester M (2007). 'A brief cognitive-behavioral intervention reduces hospital admissions in refractory angina patients'. *Journal of Pain and Symptom Management*, vol 33, no 3, pp 310–16.

National Audit Office (2006). *The Provision of Out-of-Hours Care in England.* London: NAO. Available at: www.nao.org.uk/publications/0506/the_provision_of_out-of-hours.aspx

National Audit Office (2007). *Prescribing Costs in Primary Care.* London: National Audit Office. Available at: www.nao.org.uk/publications/0607/costs_in_primary_care.aspx (accessed on 28 October 2010).

National Audit Office (2008) *End of Life Care.* London: National Audit Office.

National Institute for Health and Clinical Excellence (2009). *Depression in Adults with a Chronic Physical Health Problem: Treatment and management.* National Clinical Guideline Number 91. London: NICE. Available at: www.nccmh.org.uk/downloads/DCHP/CG91NICEGuideline.pdf

Naylor C, Bell A (2010). *Mental Health and the Productivity Challenge.* Improving quality and value for money. London: The King's Fund.

Naylor C, Goodwin G (2010). *Building World Class Commissioning*. What role can external organisations play? London: The King's Fund.

National Gold Standards Framework Centre (2011). Gold standards website. Available at www.goldstandardsframework.nhs.uk/.

NHS Business Services Authority, Prescription Pricing Division (2010). 'Prescription Volume and Prescription Cost'. NHS Business Services Authority website. Available at: http://www.nhsbsa.nhs.uk/PrescriptionServices/951.aspx

Nunes V, Neilson J, O'Flynn N, Calvert N, Kuntze S, Smithson H, Benson J, Blair J, Bowser A, Clyne W, Crome P, Haddad P, Hemingway S, Horne R, Johnson S, Kelly S, Packham B, Patel M, Steel J (2009). *Clinical Guidelines and Evidence Review for Medicines Adherence: Involving patients in decisions about prescribed medicines and supporting adherence.* London: National Collaborating Centre for Primary Care and Royal College of General Practitioners.

Osborn D, Levy G, Nazareth I (2007). 'Relative risk of cardiovascular and cancer mortality in people with severe mental illness from the United Kingdom's General Practice Research Database'. *Archives of General Psychiatry*, vol 64, pp 242-9.

Pirmohamed M, James S, Meakin S, Green C, Scott A, Walley T, Farrar K, Park B, Breckenridge A (2004). 'Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients'. *British Medical Journal*, vol 329, pp 15–19. Powell Davies G, Williams AM, Larsen K, Perkins D, Roland M, Harris MF (2008). 'Coordinating primary health care: an analysis of the outcomes of a systematic review'. *Medical Journal of Australia*, vol 188 (8 suppl), pp S65-S68. Available at: www.mja.com.au/public/issues/188_08_210408/pow11099_fm.html

Purdy S (2010). *Avoiding Hospital Admissions. What does the research evidence say?* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/avoiding_hospital.html (accessed on 17 February 2011)

Reid S, Wessely S, Crayford T, Hotopf M (2001). 'Medically unexplained symptoms in frequent attenders of secondary health care: retrospective cohort study'. *British Medical Journal*, vol 322, pp 767-72.

Purdy S, Griffin T, Salisbury C, Sharp D (2009). 'Ambulatory care sensitive conditions: terminology and disease coding need to be more specific to aid policy makers and clinicians'. *Public Health*, vol 123 , pp 169-73.

Salisbury C (2003). 'Do NHS walk-in centres in England provide a model of integrated care?' *International Journal of Integrated Care*, 21 August. Available at: www.ijic.org/index.php/ijic/article/view/URN:NBN:NL:UI:10-1-100326/167

Sanders J, Esmail A (2003). 'The frequency and nature of medical error in primary care: understanding the diversity across studies'. *Family Practice*, vol 20, no 3, pp 231-6.

Senge P (2004). 'Building vision: New roles for new leaders'. *Executive Excellence*, vol 21, no 7, p 16.

Singh D, Ham C (2005). *Transforming Chronic Care: Evidence about improving care for people with long-term conditions.* Birmingham: University of Birmingham, Health Services Management Centre.

Speed CA, Crisp AJ (2005). 'Referrals to hospital-based rheumatology and orthopaedic services: seeking direction'. *Rheumatology*, vol 44, no 4, pp 469-71.

Starfield B (1998). *Primary Care: Balancing health needs, services and technology.* Oxford: Oxford University Press.

Stearns SC, Bernard SL, Fasick SB, Schwartz R, Konrad TR, Ory MG, DeFriese GH (2000). The economic implications of self-care: the effect of lifestyle, functional adaptations, and medical self-care among a national sample of Medicare beneficiaries. *American Journal of Public Health,* vol 90 , no 10, pp 1608–12.

Thorlby R, Rosen R, Smith J (2011). *GP Commissioning: insights from the medical groups in the United States.* London: The Nuffield Trust.

Van Gils, Tariq L, Verschuuren M, vwn der Berg M (2010). *Cost-effectiveness research on preventive interventions: a survey of the publications in 2008. European Journal of Public Health,* electronic advance version. Doi: 10.1093/eurpub/ckq069

Wagner W, Austin B, Von Korff M (1996). 'Organizing care for patients with chronic illness'., *The Millbank Quarterly,* vol 74, no 4 pp 511–4.

World Health Organization (2005). *Preventing chronic diseases: A vital investment.* Geneva: World Health Organization Available at: www.who.int/chp/chronic_disease_report/full_report.pdf

Zairi M (1998). 'Building human resources capacity in health care: a global analysis of best practice Part III'. *Health Manpower Management*, vol 24, issue 5, pp 166–9.