

In order to explore more deeply and respond to the challenges and opportunities for commercial partners arising from the planned NHS reforms, Red Door Communications hosted a workshop with Dr Nick Summerton attended by colleagues working in marketing and communications capacities in various clinical areas.

This report reflects the key discussion points that came out of that workshop. For more information please contact Julia Harries on 020 8392 8040.

Equity and Excellence: Liberating the NHS

By Simon Warne

When it comes to the latest NHS reforms everyone working in healthcare has to think about the outcomes for the patient not the processes. In order to put the patient at the centre of the health service there is going to be a period of organisational upheaval. While healthcare professionals and service providers go into a period of 'temporary paralysis,' the pharmaceutical industry has an opportunity to re-engage with a profession in a state of flux.

GPs find themselves in the middle of an organisational upheaval as the Government aims to make £20 billion of 'efficiency savings' by 2014. Strategic health authorities and primary care trusts will go, while GP commissioning consortia will come in – with responsibility for 80% of the NHS budget. 'Choice' and 'competition' are the new buzz words as the health service focuses on encouraging localism within a national framework of priorities, standards and regulation.

For the average GP the sweeping changes bring opportunity as at the moment there's a lot of frustration in primary care with the current provision. Patients are denied treatments, because they may not be classified as a priority; there are delays in receiving results of hospital tests; patients can be diverted through hospital systems before they see the specialist; some patients wait for hours in hospitals before they can have an appointment; others are dissuaded from having the treatment they want; and, in some cases, hospitals are dirty and a source of further infection or illness. The latest reorganisation can help us move away from these frustrations.

The relationship between hospital consultants and GPs is not what it once was, and 'old fashioned' phone conversations between clinicians about patients' needs have been lost in bureaucracy and paperwork. As a result GPs no longer turn to their local consultants for telephone advice - they may never actually meet - and have no real relationship with them.


At the same time patients expect a lot more from their health service; they want appropriate treatment on demand. Patients are living longer with the accompanying illnesses that old age can bring.

GPs and patients are now more equal partners during consultations compared to twenty years ago, and there's a third party in every consultation – the computer screen – which plays an ever-increasing role. The internet and computer-based resources are important tools in discussions with patients and can often help GPs explain the patient's particular circumstances.

At the end of the day patients are the experts on their symptom and presentation while the GP is the expert in interpreting and seeking solutions to the patients' problems.

"No decision about me, without me"

The Government is determined that its revamped health service will be patient-centred and focus on outcomes that matter to patients. At the same time it wishes to empower and liberate clinicians to innovate.



Currently the NHS is obsessed with process and is driven by waiting times and targets. Shifting the emphasis to outcomes will focus more on the 'd' words – disease, diagnosis, dissatisfaction, disability and death.

Interestingly, even though this is a Conservative/ Lib Dem initiative the proposed changes mean that Lord Darzi's guiding principles for the health service outcomes – clinical effectiveness, safety and patient experience – remain intact.

It's a pincer movement by Government with national organisations working closely with newly formed GP consortia at a local level to provide the best service possible for the patient.

GP Commissioning

At a local level effective GP commissioning is key: GPs will be commissioning elective hospital care, rehabilitative care, urgent/emergency care, most community health services, mental health/learning disability services and maternity services.

GP consortia will not be commissioning primary health care, national/regional specialist services and prison health care.

Every GP practice will be a member of a consortium. As of 5th March there are 177 pathfinder consortia which are piloting the system and working out how it might work on the ground. No matter how many GP consortia are finally established – there are expected to be between 100 and 200 with each responsible for between 100,000 and 500,000 patients – they will need to be large enough to negotiate effectively with potential providers, liaise with local authorities, take responsibility for issues such as child protection and look after unregistered patients. It's much more complicated than a group of GP colleagues simply getting together to work out which services they might want to buy.

Under the reforms it will also be the GP consortia's duty to promote equalities and work in partnership with local authorities, inform, engage and involve the public, be transparent and fair in making their commissioning choices, and, take responsibility for their prescribing costs.

At the same time they won't have carte blanche to do exactly what they want. A GP Commissioning Board will sit centrally to provide national leadership, promote involvement and choice, develop and regulate consortia, exercise some direct commissioning, and, provide central resources for GPs across the country.

Whether the GP Commissioning Board is merely a reincarnation of the Strategic Health Authority remains to be seen, but it will be very powerful and will be responsible for steering GP consortia in the right direction.

Because of the volume of patients presenting to doctors and the co-morbidities attached to the growing older age group, the NHS is going to have to stop providing some services. This is largely for financial reasons. If the new GP consortia are going to help the Government save the NHS its target billions, then they are going to restrict what they can offer patients. Some pathfinder consortia are already using referral management systems, and others are taking a particularly robust approach to prescribing costs.

GPs want to see additional services and investigations that tell them something new or help them diagnose and treat their patients. For example, over recent years there has been major growth in the appointment of specialist nurses in complex areas such as rheumatology, neurology and chronic obstructive pulmonary disease. Unfortunately, many of these are unable to make diagnostic and management decisions and end up simply telling the GP what they already know about a patient! The appointment of such expensive individuals should be particularly carefully scrutinised in the restructured health service.

There is real waste in the NHS at present, and GPs will need to be ruthless to help reduce this and refrain from purchasing unnecessary services. However, not all GP consortia have a great deal of choice. In some areas there is one Hospital Trust which will continue to dictate what services it offers. GPs will have no option but to use these services if they are going to keep health provision local for their patients.

To make the new system work properly GPs will need to exercise intelligent commissioning, suppliers must offer new and innovative patient-centred services, and hospital consultants must act only as specialists and not try to do the GP's job too.

Even though GP consortia appear to be holding the purse strings, in secondary care Foundation Trusts will still be very powerful. They're huge and might try to tell their local consortia what services they will and will not provide.

Local empowerment

Directors of Public Health will move from Primary Care Trusts to the local authority, and a local

consumer champion HealthWatch will help to safeguard patient choice.

A statutory Health and Wellbeing Board will be set up by the local authority. The local authority will also lead on joint strategic needs assessments and seek to promote 'joined up commissioning' at a local level.

While these changes are important, analysis by independent bodies such as the King's Fund suggests that local authorities will not hold substantial power – the real influence will be with the GP Commissioning Board and GP consortia.

Extending choice

At the moment patients experience very managed choice, and most of it is centred on the type of hospital to which they are referred rather than the treatment they receive once they get there.

GP consortia will be encouraged to consider services from 'any willing provider' and must in turn present that information to the patient so that they can make a shared decision on their treatment. In order for patients to make an informed choice they will also need more information about their treatment options.

The regulatory body, Monitor, will be responsible for developing a level playing field and facilitating competition. This powerful body can alter prices and will introduce a national tariff for NHS services. Monitor's role is not totally clear, especially in relation to price adjustments, but is expected to become more so over the coming weeks and months. **This is a key area to watch.**

If patients do not feel they are getting a fair choice they can vote with their feet. Under the new system patients can move practice to a different GP consortia if they feel the options they will be offered are better.

Timetable for change

2011/2012: Shadow Consortia

2012/2013: Consortia & Board established

2013/2014: Fully operational

Concerns

From a GP's point of view there's a real sense of we've been here before with fund-holding and practice based commissioning. There's a generation of GPs who feel they've seen constant change and are, therefore,

not bothered (or particularly engaged) with another system and another set of political claims. Some GPs are burying their heads in the sand, concentrating on the day job and ignoring the changes, while other GPs, often younger, are embracing the proposals with gusto...but limited experience.

The main challenge is the cultural shift in accepting services from 'any willing provider'. Even though the Royal College of GPs and British Medical Association are determined to keep everything within the NHS if they can, the concept that the NHS has to deliver everything is becoming increasingly outmoded: quality, patient outcomes and patient choice have to come first.

Also, for many GPs there is so little choice at a local level – who are GPs going to commission from if not from the local Hospital Trust? In many cases GPs do not know what else is out there.

In order to appreciate what's on offer GPs, specialists, local authorities and industry need to talk to each other more and work towards the common goal of developing services that are locally responsive but nationally consistent.

The reformed NHS inevitably throws up conflicts which need to be tackled. GP direct service provision and service quality – enhanced services provided by GP practices – will also need to be scrutinised so that they are truly of value to the patient and not restricting choice.

The next conflict comes with GP practice income and what happens if a practice achieves its targets but is let down by another practice within the consortia, particularly when it comes to prescribing budgets and referrals. This is of particular concern to dispensing practices which might be partnered with non-dispensing practices in their consortia.

What can the Pharmaceutical industry do?

In changing times the pharmaceutical industry needs to engage with GPs and work out what services it can offer to support them with their new commissioning role.

GPs will need a new set of skills including needs/risk assessment, contract writing/negotiating, data analysis, monitoring, planning/sequencing. They also need to improve their knowledge of other service models/approaches and innovations, and develop relationship building skills.

Pharmaceutical companies also have an opportunity to help GPs by providing support for choice – this might be in the form of written information, DVDs and podcasts, decision tools for shared decision making, interactive websites and information scripts.

The important thing to remember is that GPs don't know what they don't know! For example, in mental health many GPs are keen to readjust the current service, but probably 8 out of 10 have no idea how to go about this – they are not sure of the evidence or the models of service available. They will need considerable help developing any new mental health treatment pathway.

Pharmaceutical companies can also help broker partnerships between GP consortia and patient organisations to secure holistic commissioning along chronic disease care pathways and deliver better outcomes in accordance with quality standards.

Pharmaceuticals are still going to be central to patient care, and drugs will continue to be prescribed. However, GPs are going to need to know the broader impacts of the drug on patient experience and cost-effectiveness in terms of, for example, effects on hospital referrals and the impact on other services. It is important that consortia look at the whole patient pathway (and outcomes) and not simply the cost of an individual component (such as a drug). Sustainability is also an area that has, unfortunately, often been given insufficient consideration by PCTs; for example, a new pharmaceutical approach for chest or heart disease might be a much more sustainable option than non-drug approaches such as a telephone advisory service.

Among the 'new friends' pharmaceutical companies need to make are the innovative commissioning groups or 'pathfinders'. These are populated by the enthusiastic GPs who want to make the new system of GP consortia work.

Then there is the GP Commissioning Board which has already been identified as very powerful. Its members will need to be as up-to-date as possible and have all the necessary information about pharmaceutical industry developments to hand. National Clinical Directors and QIPP leads are another key group, together with regional commissioning networks.

Unsurprisingly, provision of data (safety, economic and clinical) will continue to be important, and 'managed entry' of drugs will be crucial for future new products in the reformed health service. However, the requirement to move beyond the basic price of the drug towards considering the cost-effectiveness and sustainability of the treatment within the whole patient pathway (and impacts on patient outcomes) needs to become the new focus for drug manufacturers.

From a GP point of view a particularly important development would be the opportunity to re-build relationships with clinical specialists. In addition to enhancing good clinical care advice from specific specialists about individual conditions (face-to-face or indirectly by phone, video or email) can make the difference between effective and less effective pathway commissioning.

The pharmaceutical industry is very good at building relationships and encouraging regular meetings between primary and secondary care. For the healthcare professional the results of exchanges with pharmaceutical companies need to be tangible. It's not just about the product, it's about what else you bring with it and how that is going to improve patient care and cost-effective/sustainable commissioning.

What matters is what the patient gets.

Dr Nick Summerton is a GP in Yorkshire. He also has a background in academic clinical epidemiology and public health medicine. Over the last 15 years, he has developed an expertise in primary care diagnostics, gaining a doctorate (DM) from the University of Oxford in 2002. Currently, he is particularly interested in the commissioning of 'direct access' testing services including the development of 'appropriateness ratings'.



Dr Summerton serves on the NICE Diagnostics Committee, the National Imaging Board, the DH Cancer Early Diagnosis Group. He has also recently been appointed as an RCGP 'Clinical Commissioning Champion'. His fourth book 'Primary Care Diagnostics' has just been published.