

## Just what the patient ordered

Better GP services



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# Foreword

BY RICHARD LAMBERT | DIRECTOR-GENERAL | CBI



The effectiveness and long-term sustainability of the National Health Service (NHS) is of vital concern to the CBI, as the economic prosperity of the country relies heavily on a healthy workforce. Business acts as a user, a funder and a provider of NHS services and the GP's surgery is, for most people, the first point of contact with the NHS. As well as helping people manage acute or long-term, life-changing illnesses, GPs are crucial to meeting some of the UK's tougher public health challenges through encouraging lifestyle changes. The experience people have in the waiting room, the surgery or the nurse's clinic shapes their journey through the wider NHS. The choices made by GPs about treatment pathways and hospital care resonate throughout the system.

GP services have benefitted from significant investment in recent years and changes in system design to re-shape services more around the needs of individuals and patients. The aim, as always, is to deliver high-quality services. But the system in which they operate is creaking under the pressures of increased patient demands, the challenges of demographic and epidemiological changes and the ever-present need to deliver value for money for the taxpayer. There are numerous headlines about lack of access to GPs'

books and problems getting appointments which attest to the pressures that exist. Therefore, it is right that we consider how this system can be refined and improved so that it provides the varied services patients and communities want and need.

This report recommends that for GP service improvements to be made, patients must be in the driving seat. Well-informed patients, with greater freedom to choose the service most suitable for themselves, will mean accessible and effective service providers will flourish and poorer providers will have to improve. This is reliant on a fluid funding system, with money closely following the preferences of patients. Alternative providers should be encouraged into the system to offer greater choice and new and innovative approaches to healthcare.

GPs are well placed to be the pioneers of service redesign and the creation of a new patient-led, primary care model. But at present, the incentives necessary to engage them in this role do not exist, or work imperfectly. Only by seizing the opportunity to make changes to the system will patients benefit.

*Richard Lambert*

# Executive summary

An effective, responsive and properly funded National Health Service (NHS) is of vital importance to business as a user, funder and provider of healthcare services. It funds the NHS through taxation and relies on it to ensure a healthy workforce. And business increasingly plays a role in providing the high-quality healthcare, support services and infrastructure that the modern NHS needs. For this reason, the CBI believes it is essential NHS reform is not stalled. Primary care is of critical importance to patients and must be at the heart of this reform.

As medical professionals, GPs are often the closest NHS staff to patients and understand what their health concerns and needs are. They have the insight and experience to re-design services around patient needs. But this level of transformational change is not happening fast or broadly enough. The quality of GP services is variable across the country, meaning patients can no longer be certain of a minimum level of service quality irrespective of where they live. GPs and primary care trusts (PCTs) must improve service provision to address two vital challenges which lead to patient dissatisfaction:

- **Poor access to GP services, particularly in deprived areas and inner cities** – significantly, one in three patients still find it difficult to access GP services<sup>1</sup>; efforts to ensure appointments within 48 hours have, perversely, often reduced choice for patients
- **The quality of services GPs offer is variable** – different types of diagnostic, health and social care services need to be integrated if they are to deliver the best outcomes for patients. But too often these services are not managed effectively around what works best for the patient.

Improvement comes when patients can challenge poor services, and PCTs use creative commissioning strategies to

challenge alternative providers to come up with new solutions to stubborn service delivery problems. Patients who are better able to choose GP services will create clearer signals than exist at present about what improvements are needed, and what solutions are available from healthcare providers.

The CBI wants to see a GP sector in which increased patient involvement and innovation embed continuous improvement, so that a range of high-quality, tailored care services are the norm up and down the country. This requires the primary care market to operate more effectively. Recommendations to reform primary care must be interpreted at a local level: no PCT area is exactly like another and a one-size-fits-all approach will not effectively address the diversity of population and health risks we have in England.

The CBI recommends the Department of Health takes action to improve GP access and service delivery by ensuring:

- **Patients are able to change GP if they are not happy with the service they receive.** Patients must be able to register with more than one GP, and wherever they like. Allowing more flexibility in the registration process by opening up patient lists will help drive improvements
- **More information on GP services is available to patients.** Changing GP, and demanding better, more accessible services, depends on people having clear information about what services are available to them, where, and when. Patient feedback should be encouraged and acted on and patients should be more aware of the costs of services
- **Alternatives to existing GP services sector are encouraged.** Patient choice, if it is to mean anything, must be tangible and easily managed. Informed patients, faced with a choice of providers, will choose the one they think offers

the best service to meet their needs. In turn, this increases competition between GPs, who must raise their game to attract a greater number of patients and think differently about how they deliver services. Entrepreneurial GPs should be incentivised to innovate and alternative independent providers must also be encouraged to offer services. GPs offering poor services will become more visible to commissioners in PCTs who can then act to remedy the situation.

To ensure these aims are achieved, the Department of Health should prioritise the following reform objectives:

- **GPs should be incentivised to deliver the services that best meet the needs of local populations.** Practice-based commissioning (PbC) is a crucial tool to enable GPs to align services with patient needs. Improving patient access may require GPs to offer more specialist services within their practice, such as diabetes or dermatology services. The idea of ‘polyclinics’, proposed in the latest review of NHS services in London, is one extension of this process of service re-engineering.<sup>2</sup> PbC is currently used sporadically. It must be embraced more widely
- **GP funding should follow the patient more fluidly.** The most popular GPs, based on numbers of patients treated and the quality and range of services they offer, should be funded to reward successful service innovation
- **PCTs should improve their role as effective market stewards.** They should increase the opportunity for innovative solutions to arise, as they have the community wide oversight to see trends that shape what primary care must deliver. PCTs should create the conditions in which providers from all sectors can see the scope for improving services and for doing so more efficiently. GPs should be responsible for prioritising patient care and communicating patient needs to the PCT
- **Regulation of the wider primary care market should balance clinical rigour with freedom to innovate.** Regulation must work in the interests of patient equity and access; the shape of primary care provision in any locality must not be distorted by the needs of any other stakeholder group. To do this, all healthcare providers should be regulated equally and fairly.

# 1 The need for patient-responsive GP services

GPs are, for most people, the first point of contact with the NHS and they have benefitted from significant investment in recent years. But a commonly heard complaint is that GP practices are not open at weekends, early in the morning or in the evening – when it is more convenient for many patients to visit. This highlights a fundamental weakness in the system: GP services are not responding to clear signals for change from patients. And crucially, patients do not feel able to challenge them. This creates frustration within the system and mitigates efforts to engage with patients on other issues like smoking cessation or improving fitness. These failures build inefficiencies into the system at a time when, under the upcoming comprehensive spending review, the funding regime for health becomes tighter.

Such systemic weaknesses should challenge policy makers and providers to restructure GP services to better meet people's needs without undermining the principle of equitable access which lies at the heart of the NHS.

GPs are at the heart of a modern NHS and play an extremely important role in delivering healthcare in a fair way based on medical need:<sup>3</sup>

- Around 42,000 GPs work in 10,500 surgeries in the UK. There are more GPs than all the consultants in all specialties combined
- Over 250 million consultations take place annually in general practice, with 15% of the population seeing a GP in any two-week period
- GPs refer 14% of the population to hospital for specialist care, meaning that 86% of all health needs are managed within primary care
- Each GP looks after 2,000 patients on average, and will conduct about 7,000 consultations a year
- The average patient will visit his or her GP about four times a year, with 78% of people consulting their GP at least once a year.

Most GPs are independent contractors to the NHS and this has been the case since the NHS was established in 1948. This model of delivery has served the public well for many years, but problems of access and variable service quality means now is the right time to change this model – making it fit for the 21st century. Change requires challenge; but there is currently no effective way to do this. The CBI believes there are two main reasons for patients to challenge current provision:

- Access to GP services is poor
- The quality of GP service provision is variable.

## Access to GP services is poor

People now enjoy greater control and more choice in their lives and are accustomed to high-quality services in many commercial markets. As a result, services offered by the public sector too must become increasingly personalised to meet the public's needs. The government has recognised this as a considerable challenge to the future of public services:

*“An ageing population puts greater demands on public services, and in an age when we commute further... and live ever more diverse lives, people expect fast, flexible, responsive public services that are built around their needs – not those of the people delivering them”.*<sup>4</sup>

People interact with the NHS in different ways according to their particular health needs, and therefore differential access is required. There are three broad categories of user accessing GP services:

- ‘Convenience’ users want to see a doctor when and where they can. These people are highly mobile, include students and commuters, and are likely to want access to walk-in centres, early morning, evening and weekend services

- ‘Mainstream’ users make up the majority of users and benefit from a range of services offered by their GP, including proactive and preventative care focused on overall wellbeing. Often these users want to plan their lives in advance around caring for children and work commitments
- ‘High-impact’ users need integrated and well-managed care of long-term conditions to improve their quality of life and to reduce avoidable hospital visits.

Modern GP services must be able to respond effectively to all these patient groups. Improving access to GP services is therefore crucial to build an NHS that fits around people’s lives. Accessibility of GP services is variable throughout England and also varies according to the type of patient user. For instance, limited GP access is a particular problem in inner city areas. In rural areas, small populations make GP choice more difficult.<sup>5</sup> And primary care is still struggling in some areas to meet the levels of responsiveness required, particularly in relation to the working population.<sup>6</sup> The inconvenience of restricted opening hours is likely to put people off visiting a GP for less urgent, less specific health concerns, such as losing weight and stopping smoking. This also has a knock-on cost to the economy. Employers lose up to £1bn every year through people taking 28 million hours off work to visit their GP.<sup>7</sup>

Just registering with a GP can be difficult for some people, and this problem affects all types of NHS user. The consumer group Which? found that one in four GP surgeries across the UK had turned away a new patient.<sup>8</sup> London has particular problems: four out of five surgeries in some areas are closed to new patients.<sup>9</sup> If someone cannot get on the register of a local surgery, the local PCT must allocate a surgery. But while this ensures registration, it does not guarantee the best quality service and removes the patient’s ability to choose their preferred practice.

Even when registered, access can still be difficult. GPs are under pressure to meet the national targets set out in the NHS Plan, which aims for everyone to be able to access a primary care health professional in 24 hours and a GP in 48 hours. But some practices are not offering appointments in advance of 48 hours, thereby technically meeting the target while not actually achieving the underlying goal. This is particularly difficult for patients who need to plan a GP visit around childcare and work.

Access to a specific GP in a practice can sometimes mean waiting much longer (up to three weeks) for an appointment.<sup>10</sup> This situation has been exacerbated by the new GP contracts, which mean patients register with a practice rather than a specific doctor. This is especially a problem for high-impact users, who are more likely to value the continuity of care provided by their regular GP.

Many people are frustrated by what they perceive to be the inability of GPs to work more flexible patterns, such as shift work and weekends. GPs received a 22% wage increase between 2003/4 and 2004/5, pushing average net salary to £103,564 a year in England.<sup>11</sup> It is therefore reasonable to expect productivity improvements.<sup>12</sup> This does not necessarily require increasing capacity and capabilities, but it does mean using existing capacity more effectively, working more flexibly and across traditional boundaries. This should be possible with more than 42,000 GPs – an increase of more than 4,500 compared with 1997 – and the modernisation of more than 2,800 GP premises.<sup>13</sup> Increased GP productivity is also vital for the future of the NHS. Cost pressures will increase after 2008 when the rate of taxpayer-funded spending increases will slow. The NHS faces a possible £7bn deficit by 2010.<sup>14</sup> Without greater productivity, deficits will rise, job insecurity will increase and services could be reduced.

### **The quality of GP service provision is variable**

In addition to access, another key factor in patient satisfaction is a GP’s ability to provide effective ‘care pathways’ that allow patients to be treated closer to home and which focus on long-term illness prevention. This is better for patients and is often more cost-effective than inappropriately referring patients for treatment in hospitals and out-patient clinics. Redesigning service pathways, from initial appointment, diagnosis, referral to specialist and treatment, can ensure patients are treated by the most appropriate healthcare professional in the most appropriate location. This cannot be carried out by GPs alone and needs the local oversight of the Primary Care Trust. The quality of GP service provision is variable and has been poor in some inner city areas for decades.<sup>15</sup> However, PCTs have only limited ways of identifying and addressing poor service levels and their oversight of GP service redesign is limited.<sup>16</sup>

**CASE STUDY**

**Joined-up services – Birmingham East North (BEN) PCT and the OwnHealth scheme**

- The service is based on understanding the needs of a specific local population
- Patients are encouraged to take responsibility for setting their own health improvement goals with the help of a qualified care manager
- By targeting patients with high-risk healthcare needs, the service helps patients to manage their conditions more effectively so they are less likely to need hospital care
- The service saves the NHS £2,000 per patient.

OwnHealth began operations in April 2006 and offers a personalised programme of healthcare support over the telephone from a care manager – a fully trained, experienced nurse employed by NHS Direct. The programme is open to those with cardio-vascular disease, heart failure and/or diabetes. In Birmingham, 27% of people have a limiting long-standing illness. The programme devised an eligibility criteria to select suitable patients, and this is validated with GPs.

The initiative is a partnership between the PCT, Pfizer Health Solutions and NHS Direct. Care managers are assisted by Pfizer’s disease management software, which helps them devise personalised health plans in line with national and local clinical guidelines. The software provides decision support and captures data on progress; Pfizer also provides training and information support, project management and design consultancy. NHS Direct offers care delivery and care management co-ordination, technical and calling infrastructure.

The PCT provides the GP network, clinical governance, clinical leadership, and patient identification and stratification. The programme also crucially depends on the partnership with the patient. It aims to help people look after themselves so they have control and responsibility for setting their own health goals.

Success is measured in outcomes. For instance, 700 patients have so far managed to reduce their blood pressure through the system. The scheme has been successful in reducing the number of GP admissions and referrals. The cost of a patient under the scheme is £500 but if they go to hospital it increases to £2,500.

The project has now been integrated into a Local Area Agreement (LAA) as part of a project to increase male life expectancy. The value of the contract has just increased to £1.5bn – with 850,000 patients in the PCT OwnHealth programme and a further 750,000 through the LAA.

The majority of emergency hospital admissions are made for one of 19 illnesses – including conditions such as asthma, diabetes and congestive heart failure, which are believed to be manageable to the point where some emergency admissions can be avoided. There are more than 15million ‘high impact’ users, accounting for around half of all GP visits and 75% of patient time in hospital beds. These patients cost the NHS a total of £2.3bn a year – a figure set to increase over the next 20 years as the population ages and more people are diagnosed with chronic conditions.<sup>17</sup> Many of these emergency admissions could be avoided through better designed, more effective care pathways. There is an opportunity for PCTs to prioritise supporting and improving these patients’ quality of life, as demonstrated by best practice examples such as the OwnHealth scheme.

## 2 Informed patients must challenge poor provision

Improving the quality and accessibility of GP services relies on reforms which let patients make choices about how and when they receive healthcare. This means patients being informed about their options and able to challenge poor provision. The CBI believes that informed patients choosing their healthcare from a range of providers will drive improvements. A range of providers could compete to offer services that are more attractive to patients. Although patient choice and provider competition have been advocated by the government over the last ten years to improve service delivery, the implementation of these policies has often been sporadic and inconsistent. The CBI therefore recommends the Department of Health to take action to ensure:

- People should be able to change GP if they are not happy with the service they receive
- More information on GP services should be made available to patients
- Alternatives to existing GP services should be encouraged.

### **People should be able to change GP if they are not happy with the service they receive**

To improve GP access and services, patients need to be able to challenge poor existing services. More freedom to choose a GP means patients' health needs and preferences will have a greater impact on shaping service design and accessibility. A choice of GP already exists in theory but is largely restricted to where the patient lives through the existence of practice boundaries. Once registered, people generally do not change GPs – even if they are unhappy with the service received. As a result there is little incentive for GPs to offer more patient-responsive services.

Changing this culture will take time, but the first step is to increase choice by allowing patients to register with more

than one GP. Current restrictions arising from practice boundaries should be removed. These historic geographic boundaries once related to the ability of GPs to travel short distances to undertake home visits and out-of-hours service, but home visits are rarer now; and the use of boundaries to create de facto local monopolies in primary care is no longer acceptable.

More freedom for patients to choose one GP practice over another will encourage practices to open at more convenient times. Those offering a range of services in a convenient location will flourish. Extending opening hours to evenings and weekends is what people want.<sup>18</sup> More flexible opening times mean people could see a GP more quickly, leading to faster treatment and helping prevent more serious problems later on. This could also reduce pressure on surgeries in particularly busy times – such as Monday mornings – meaning GPs could spend more time with patients and facilities could be used more effectively. Flexible hours could reduce pressure on A&E services – and also benefit businesses and the economy – by reducing the 28 million working hours lost each year due to GP appointments during the working day. This does not mean GPs must be made to work longer hours. Rather, they should be incentivised to work more flexible hours and rewarded for offering more accessible and well designed patient care pathways.

This is not a one-size-fits-all recommendation. Different patient populations require different services. For instance, increased flexibility of patient registration will be particularly useful for commuters and students who want to register with a GP near to their work or college. Patients who value a high degree of continuity of care – particularly older patients and those with long-term conditions – are less likely to want to change GP, but they would nevertheless benefit from the service improvements that result from GPs

trying to attract more mobile patients. Flexible services will also help inner city residents who are more likely to have a GP shortage, because the commuter population will encourage GPs to move into the area to absorb the extra demand. Removal of geographic demarcation would allow patients to maintain a relationship with their GP even if they move house.

Risk is part of any process of change, but the risks associated with the removal of geographic lists can be managed effectively. For instance, the current capitation formula – which already provides additional remuneration to populations with higher needs – could be used to provide additional financial incentives to encourage GPs to attract more demanding patients. The Department of Health could also explore the option of additional funding for each chronic condition, so multiple conditions could attract multiple payments.

### **More information on GP services should be made available to patients**

If people know what services are available, they are able to make the right choices. With more accessible information regarding GP performance, people could make an informed choice based on factors including quality of care, range of services offered, reputation, continuity of care, number of GPs, facilities, location and opening hours. The Department of Health is raising people's awareness of their options when choosing secondary care providers – for example, through the launch of the 'choose and book' website, a national electronic booking system which gives patients a choice of place, date and time for their first outpatient appointment. But more innovative ways must be explored to develop people's awareness of the primary care services they receive. The government should consider running a national awareness campaign to highlight patients' rights and responsibilities in the NHS. This could also include technological innovations, like the touch screens available in job centres, to guide patients through the system. Touch screens could be available in GP surgeries, pharmacies, libraries, supermarkets and benefit offices. Another example is the Boots initiative 'Ask your Boots Pharmacy Team' which includes a series of 'bodcasts' – health information files downloadable through iTunes. Feedback forms should be available in surgeries and

patients should be encouraged to fill in such forms after every visit to their GP. The information can be collated by PCTs, who are already responsible for ensuring GPs respond to feedback. If service levels remain unsatisfactory, PCTs should take more proactive steps to challenge it, for example by encouraging alternative providers to offer solutions.

But increasing patients' rights to challenge poor service should be balanced with increasing their awareness of service costs. The NHS is 'free' at the point of need – but it is not cost free, as it is funded from general taxation. One way to raise awareness would be to provide a list in every GP practice which details the cost of treatment for the top ten most common illnesses. The list would act as a reminder that patients are paying for their service through taxation, and therefore can demand a service that is responsive to their needs. This is likely to increase patient understanding of the services they receive and could lead to increased user satisfaction. Hypothetical personalised invoices should also be sent to patients who do not turn up for their appointments, detailing the cost to the NHS of their failure to attend.

### **Alternatives to existing GP services should be encouraged**

The success of a system that encourages well-informed patients to choose their preferred GP service – and challenge poor service – depends on how well such services can be tailored to meet specific patient needs. The ability of patients to choose is increased by the existence of alternatives to existing GPs. Although patients can currently switch between GPs, the market for general practice is not very competitive. GPs are independent contractors to the NHS but operate on a monopoly basis within demarcated geographical boundaries. This fails to challenge poor performers to improve their service: despite best intentions, monopoly providers do not always put the customer first because their survival does not depend on it. Uncompetitive markets will all too often result in a lack of choice – consumers can either 'like it or lump it'. This is no longer acceptable in health care.

To improve services further, competition between existing GPs should be augmented by competition between existing GPs and alternative providers, in line with the rest of the

government's NHS reform plans in secondary care. There is already an independent sector presence in the primary care market, including the 42,000 GPs who operate on a monopoly basis, 10,000 pharmacists, and 25,000 independent social care providers. Independent providers are commissioned by PCTs to provide elective care and long-term services for people with acquired brain injuries, mental illness, learning disability and nursing care needs in old age. In addition, there is a growing social entrepreneurial sector. To improve access and build capacity in under-doctored areas, new providers from the social enterprise, voluntary or private sectors are already being encouraged by the Department of Health to offer services alongside existing GP services. For instance, the department launched the *Fairness in primary care* initiative in March 2007. It has been working with nine PCTs to put GP services in under-doctored areas out to tender. Other healthcare systems which encourage alternative providers – such as in France, Germany, Switzerland and the Netherlands – show the highest patient satisfaction levels in Europe and are more productive than the NHS.<sup>19</sup>

The public agrees with the use of the independent sector to drive improvements in the NHS. An ICM poll found that 83% of the public agreed with the statement: *“It shouldn't matter whether hospitals or surgeries are run by the government, not-for-profit organisations or the private sector, provided that everyone including the least well-off has access to care”*.<sup>20</sup>

PCTs should also be responsible for encouraging alternatives to existing GP services. This will challenge providers to become more innovative and discover better ways of serving patients – as demonstrated in other public service sectors, such as prisons.<sup>21</sup> Service innovation could be in the form of technological advances or services that are more accessible and designed to fit around people's lives. Increased efficiency and innovation leads to enhanced productivity and places downward pressure on costs, therefore increasing value for money. PCTs should build on the successes of GP services in train stations and walk-in centres in commuter-rich areas such as the Atos Origin walk-in centre in Tower Hamlets, London.

Before 2002, most GPs operated to national terms and conditions under old General Medical Services (GMS) contracts, which PCTs could not influence. Now, four types of contract are available and since April 2004 PCT commissioners have been able to commission services from independent sector organisations under the alternative provider medical services (APMS) contract. APMS providers do not have to provide 'essential services' that are considered core GP services. It was anticipated that the easing of restrictions on market entry would alleviate difficulties in under-doctored areas, improve the quality of failing practices and give patients greater choice of primary care provider.

#### CASE STUDY

#### Patient convenience – Tower Hamlets Primary Care Trust walk-in centre and Atos Origin

- Patient focus is paramount – 97% of patients are happy with the service
- A team of experienced nurses and an on-site GP ensure patients receive the appropriate level of care
- Complements existing GP services and other primary care facilities in the area.

In April 2006 an NHS walk-in centre opened in London's Canary Wharf

offering commuters and local residents fast and convenient access to primary healthcare services. A wide range of minor illnesses and injuries can be treated without the need for an appointment.

Since the centre opened surveys show that 97% of patients have found the care 'good' or 'excellent'. A GP is present at

its walk-in centre at all times, rather than just the hours specified in the contract, to ensure maximum patient care. The PCT has a seat on the project board, which is part of the formal governance arrangements for the centre. This allows the PCT to effectively integrate the walk-in centre with other parts of the local health economy.

Despite this flexibility, few PCTs have taken advantage of these contracts. Only 3% of independent healthcare providers have an APMS contract. A King's Fund survey found 28 PCTs had awarded 34 APMS contracts between them, most being used to fill long-term practice variances. The majority of these contracts were awarded to local entrepreneurial GPs rather than new types of provider.<sup>22</sup>

Good, creative examples of commissioning do exist, for example, a PCT in Poole has opened an NHS Healthcare Centre in the Boots store in the city centre. It is a satellite surgery in which five GPs from the local practice work one day a week. The service offers convenient access to patients who would prefer to see their GP on the high street rather than a separate visit to the GP practice. The centre offers blood testing, a diabetes service, podiatry and other services.

More effective and innovative use of contracts should lead to better integration of GP services with complementary health services, such as pharmacy. Many health complaints which cause people to visit a GP, such as hay fever, dry skin and coughs and colds, could equally be addressed by pharmacists. Pharmacies can be more accessible and convenient than GP surgeries – they are where people live, shop and work, and there is no need to book an appointment.

The new pharmacy contract has enabled pharmacists to widen their healthcare role in collaboration with GPs who, in theory, can then focus on those patients who are 'upstream' in the clinical needs hierarchy. But PCTs are not using their commissioning powers fully and pharmacy is, therefore, underused.

The government must articulate a clearer vision on the developing shape of the primary healthcare market and how alternative providers can improve services. Reforms in secondary care have introduced market principles, but some GPs would evidently rather retain their existing provider status than rise to the challenge. The tools available to the NHS to implement real change must now be more fully deployed.

### 3 The existing tools for improvement must be effectively deployed now

PCTs and GPs already have many of the tools available to improve services, but they are not using them to optimal effect. Consequently, access to GPs and quality of care is variable across the country. In order to address this, the CBI recommends the Department of Health should take steps to ensure the following:

- GPs should engage more proactively in practice-based commissioning
- Funding should follow the patient more fluidly
- PCTs should improve their role as effective market stewards
- Better PCT commissioning capability should be prioritised
- Regulation should balance clinical rigour with freedom to innovate.

#### **GPs should engage more proactively in practice-based commissioning**

The aim of practice-based commissioning (PbC) is to align budget responsibility with commissioning. PbC has the potential to enable GPs to redesign services around patient needs. But despite government targets to have all GPs actively involved by 2006, PbC is taking off only in some areas of the country under the supervision of the most entrepreneurial GPs. GPs need the capability and willingness to engage, but PCTs have a crucial role to incentivise them to take action.

A King's Fund and NHS Alliance poll of 250 GPs and practice managers showed respondents thought PbC had not improved the quality of patient care at all (53%) or very much (18%).<sup>23</sup> The quality of support from PCTs was also criticised, with 33% of GPs saying this was 'poor' and 37% that it was 'not very good'. While 70% of the GPs surveyed had not received their mutually agreed budget last financial year, 37% of those that did receive a budget said they did not fully understand how it was set.

The CBI believes PbC must be more actively pursued because:

- GP targets are driving improvements in efficiency but, because demand is increasing, they have reinforced the hospital as the place to receive care. PbC is essential to manage this demand for services.<sup>24</sup> Because GPs are often the gatekeepers to secondary care, PbC should incentivise them to reduce clinically avoidable demands for NHS secondary care by designing more effective patient pathways
- By bringing service provision and commissioning together, the boundary between primary and specialist care could become more permeable, as GPs choose between the direct provision of services and the commissioning of others to design the most appropriate and coherent patient pathway
- PbC and payment by results (PBR) are essential for providing the appropriate incentives for GPs to optimise the amount of healthcare that can be provided from the NHS budget. Without the significant advances in efficiency that both measures could bring, the NHS will be faced with the choice of either increasing the level of spending or providing less care for a given sum.

PbC should encourage GPs to offer more specialist services in their practice, such as diabetes or dermatology services. GPs could use these new services to offer people quicker, more convenient access to specialist care. GPs are not currently expected to be specialists, but GP contracts issued and renewed by PCTs could encourage further training. For instance, GPs with accredited specialist skills could handle more minor operations, with specially trained GPs and senior consultants working together in local health clinics. Dr David Colin-Thome, national clinical director for primary care at the Department of Health, emphasises this point:

**CASE STUDY**

**GP service innovation despite budgetary constraints – Epsom Downs Integrated Care Services**

- Bottom-up initiative based on the needs of a local population
- Consideration to fully integrate into the local healthcare economy
- Disseminating best practice and encouraging other practices to apply the same successful model
- Service has saved more than £5m for the local PCT.

The Epsom Downs Integrated Care Services (EDICS) was the first multi-practice GP group delivering a specified range of outpatient care for its 121,000 population. The group offered to cover a volume of outpatient referrals

previously costing the PCT (and thus their PbC budgets) £8m a year, for £6.8m. The group is achieving this by relocating specialist services (with the specialist working with GPs) into primary care centres and working with GPs to manage patients' needs at a lower cost than in district general hospitals.

The group of GPs also set up the first primary care independent diagnostic and day surgery service in 1994 (now known as independent sector treatment centres) in a new theatre at the Old Cottage Hospital in Epsom. This has

become a government model for integrated care out of hospital.

EDICS is a bottom-up development to meet the needs of a given population, supported by investment from GPs who wanted to extend their range of services for patients and do so within their given share of patient resources. The service has achieved cost efficiencies year on year since 1998 and has saved the PCT in excess of £5m at today's healthcare prices. EDICS now covers 220,000 patients and is contracting for outpatient services to other GP practices within the same PCT locality.

*“The evolution of GP services is about adding and improving, not cutting and rationing services. It is designed to take the pressure off hospitals and recognises that 21st century hospitals should be centres of excellence, but only for care that has to be delivered there – emergency and core specialist services. It allows us to give patients what they want – personal care closer to home”.*

GPs should be encouraged to offer more comprehensive packages of care, for example by bringing day care centres into GP practices and partnering with secondary, community and social care providers to offer more comprehensive, joined-up services for patients. NHS patients would benefit from a one-stop service which could refer them to consultants working in the same practice. Operations like cataracts, hernias and varicose veins could be undertaken on the same site, reducing waiting times and saving money. Of course this depends heavily on surgery space and facilities. The CBI recently published a report which recommends ways for the government to develop new types of public private partnerships, such as the Local Improvement Finance Trusts, which could be used to meet this demand.<sup>25</sup>

The successful implementation of PbC requires GPs to improve their commissioning and financial management

capabilities. Innovative and successful examples of GP commissioning, like the Epsom Downs Integrated Care Services, should be encouraged. This needs better diffusion of best practice information and could be something the Department of Health considers including as a performance target for PCTs.

**Funding should follow the patient more fluidly**

More patient choice over GP services means more funding of GP practices must closely follow the choices made by patients. This will enable the best GP service providers to flourish and require the poorer providers to either improve or exit the market. Reform of GP contracts in 2004 aimed to link GP income to the number and quality of services they provide. This included the introduction of the minimum practice income guarantee (MPIG). This is a payment to ensure that no practice would face a reduced income after the new contracts were taken on, provided a minimum level of service quality was achieved. The Department of Health, in its review of GP contract arrangements, should consider whether this payment is still appropriate. Abolishing this payment and linking more practice income to quality targets could allow more funding to follow patient choices and therefore improve patient care by rewarding the more efficient and responsive practices.

The new contracts also introduced financial incentives to reward practices for delivering higher quality patient care through the evidence-based quality and outcomes framework (QOF). In most places, the current target system works very well. GPs are earning more because they are doing more, in particular doing more to care for people with long-term conditions such as coronary heart disease. However, there is room for this incentive system to be better utilised by making targets more challenging. Dr Colin-Thome has argued that QOF requirements should be made 'a bit tougher' in order to get more value from the GP contract.<sup>26</sup> The QOF mechanism focuses on outputs, but should focus more on health outcomes. It is prescriptive and is limited in its capacity to encourage innovation to meet targets in a more efficient way.

More opportunities to encourage GPs to expand their practices could be provided through the payment by results system currently being rolled out by the Department of Health. This system aims to reward the most effective hospitals and alternative providers by linking their payments to levels of activity in terms of treating patients. Each activity is awarded a payment or 'tariff'. The CBI believes that tariff prices should be set locally within a national framework and serious consideration should be given to unbundling the tariff into more specific phases, such as:

- Diagnostic – usually one to two days in hospital
- Stabilisation – also usually one to two days
- Discharge – the bulk of hospital stays.

For example, stroke patients can be stable after two days but in hospital for 20. Splitting the tariff into component parts could enable GPs to offer alternative stabilisation care options and operate step-down centres – especially for the over-65s, who make up the greatest patient population in hospitals. GPs could be allowed to withhold part of the tariff when referring people to hospital for treatment to influence length of stay. For instance, in the United States it is rare for a patient to stay in hospital for longer than three days as the health system is geared towards keeping people out of hospital when appropriate. Hospitalisation is often the most costly phase and it is often better for the patient to be returned to a more personalised care setting.

## PCTs should improve their role as effective market stewards

The PCT is crucial to making system reform work more effectively. In order for the PCT to oversee reform, its own role should be examined and classified. A PCT's role should change from provider of services to commissioner, with responsibility for securing outcomes from a 'mixed economy' of public, private and voluntary sector providers of GP services. It is therefore urgent that PCTs build up the skills and experience for managing this. From 2008, PCT commissioners will no longer be responsible for directly allocating contracts to providers for services to which patients have the right to choose – as this will be the role of patients. Instead, PCT commissioners should be accountable for the use of resources, achieving financial balance, ensuring quality of care, understanding local population needs, securing an appropriate supply side to match those needs, and overseeing service re-design and reconfiguration.<sup>27</sup> PCTs should act as stewards and designers of the wider health system, passing resources to specific bodies – namely GPs – who undertake design, purchase and delivery.

Essential to developing the primary care market is opening it up to alternative providers. However, alternative providers currently face barriers to entry into the local healthcare economy so it should now be the responsibility of PCTs to reduce these barriers, which include:

- **Political and cultural** – including ideological concerns about the use of the independent sector; the government's commitment to increasing the extent of alternative providers
- **Contractual and commissioning** – a lack of capability in long-term strategic planning; developing alternative suppliers and delivery models; variability in commissioning skills and experience
- **Economic** – poor information relating to pricing and performance obscuring the true costs associated with service provision; the lack of a level playing field, particularly with regard to the transfer of NHS pension liabilities to private providers; costs associated with market entry; economies of scale affecting the ability of smaller organisations to compete

- **Labour supply** – recruitment and retention of qualified and skilled staff; ensuring, wherever possible, that there is free movement of staff between NHS and non-NHS organisations.

Competition should reward the providers who are better at attracting patients, but it should also mean poorer providers are required to improve or exit the market. PCTs should be responsible for removing barriers to exit for inefficient suppliers, such as:

- **Insufficient commissioning capability** – an inability to quickly replace one supplier with another
- **Lack of reliable and transparent information** – which could lead to ineffective services being retained.

PCTs should focus on creating and sustaining a well-regulated, competitive primary care market and commit to developing a competitive neutrality policy. This is a commitment to fair markets and a level playing field between public, private and voluntary sector providers of goods and services.<sup>28</sup> When certain providers compete with an unfair advantage, public spending will be redirected away from the most efficient providers. This undermines the credibility of the process and leads to poor patient care.

An effective market creates a framework to challenge traditional GP service delivery and encourage innovation in order to meet people's changing healthcare needs. Supplier dialogue is essential and independent sector providers should also be encouraged to build links with public sector commissioners and share best practice. This will help PCT officials better understand what can be achieved through smarter commissioning. Periodic market testing of all GP service providers should be encouraged to renew or terminate contracts on the basis of whether or not other providers could offer a better service. PCTs should also ensure the assessment criteria they apply to potential GP service providers are transparent and fair.

### **Better PCT commissioning capability should be prioritised**

Effective commissioning is the key to improving health outcomes and creating a more patient-responsive system.

It is also fundamental to the drive to shift care out of hospitals and closer to people's homes. In order for PCTs to act as custodians of the local primary care market, they should concentrate resources on their commissioning role, which includes needs analysis, procurement and contract management. Commissioning strategies coupled with efficiency targets allow PCTs to fund redesigned care pathways in spite of deficits. Achieving some of these planning and demand management functions will mean a huge change for PCTs in both the volume and accuracy of the data they receive and their ability to analyse it.

Commissioning strategies should aim to complement and relieve pressure on other health providers and make efficiency gains. Liverpool PCT, for example, appointed two independent sector companies to provide dermatology services across part of its locality. This was initiated by a PbC consortium representing 19 general practices in south and central Liverpool. The new services will run as a six-month pilot. If successful they are expected to receive around 1,400 referrals a year from GPs in the consortium. The long-term aim is for GPs to gain more experience of treating dermatology patients, reducing the need for referrals. The service will be paid £90 for each new patient, which is below the national tariff.

Real cultural change is required to invigorate primary care. PCT and GP commissioning of primary care must be focused on understanding and delivering what patients need, rather than relying on traditional service delivery channels. Commissioners should not be ideologically concerned about whether the provider is from the public, private or voluntary sector: the main aim should be to ensure seamless, quality patient care and value for money.

The Department of Health has a number of initiatives and pilots in place to help PCTs achieve this and to capitalise on private sector expertise, including the framework for procuring external support for commissioners (FESC). This involves the department conducting a national procurement exercise to generate a shortlist of recommended companies who could provide commissioning functions. But PCTs remain ultimately accountable for patient care outcomes. They must use the framework effectively to ensure it becomes a long-term solution to the commissioning capability shortfall, rather than a short-term stop-gap.

Managers need to develop improved quantitative and commercial skills such as contracting, negotiating, risk management and project management. NHS organisations should therefore do more to recruit high-calibre managers from outside the health service. There are examples of good PCT commissioning, such as the East and North Hertfordshire PCT dental care commissioning project, and these should be championed and learned from.

One option to encourage the dissemination of best practice could be for strategic health authorities to create and host 'commissioning and commercial expertise hubs' made up of individuals with a high level of relevant skills and experience. PCTs could draw on this expertise when they need additional help with their role as market stewards and PbC facilitators. This addresses the problem of PCTs having insufficient size and wealth to attract experts. The CBI is currently exploring a similar option with the Communities and Local Government department to help improve local authorities commissioning capability.<sup>29</sup>

The requirement to operate within budgetary limits on an annual basis can act as a disincentive for PCTs to invest in initiatives that may not yield benefits within that time. Although budget allocation is increasing to three years, better financial management in PCTs is needed to improve the effectiveness of commissioners and to support GPs. This means PCT finance directors must evolve from being day-to-day financial custodians to become strategic decision-makers.

### Regulation should balance clinical rigour with freedom to innovate

The effectiveness of a competitive primary care market depends on how well it is regulated. This must be carried out by an independent body which is not inappropriately influenced by healthcare providers; it is currently the responsibility of the Healthcare Commission, and this will continue under Ofcare.

The right balance of regulation and oversight is required. The answer lies in fewer but better common regulatory standards. A simple set of shared data should be developed and applied to providers across the public and independent sectors. A level playing field in regulation will reduce the need for the government to apply strict national management and clinical targets, as the market will be able to operate more effectively. The right incentives should encourage the desired behaviour – for instance, targets to ensure patients are only referred to hospital when it is clinically appropriate. When patient choice is universal and people really can choose their GP provider, the market should start to self-regulate more effectively as poor providers must either improve or exit the market.

#### CASE STUDY

#### Bottom-up innovation – East and North Hertfordshire PCT dental care commissioning project

- Careful assessment of current health-care provision landscape
- Strategic commissioning taking the whole of the local healthcare economy into account, enabling NHS capacity to be used more efficiently
- Cost savings of more than £1m
- Neighbouring PCTs working collaboratively together.

In 2005, four PCTs in East and North Hertfordshire assessed all oral and maxillofacial surgery (OMFS) referrals in order to identify a long-term commissioning solution. Within two weeks of

this exercise, it was clear half of OMFS referrals involved routine dentistry that could be undertaken by specialist dentists in the community dental surgery, rather than by the trust in secondary care facilities. The PCT's jointly established a clinical assessment service and processed referrals prior to offering choice, and utilising available surgery facilities at a community hospital in a neighbouring PCT.

Patient feedback has been positive on both the facilities and the quality of services provided. To ensure rigour and

consistency, a common referral template was established and adopted across all four PCTs. Implementation of this new patient pathway has resulted in huge cost savings. Performance up to December 2006 showed cost savings of £495,330. In addition, 1,045 patients contacted to facilitate a choice of provider and arrange treatment, effectively removed themselves from the waiting list as either symptoms had subsided or they changed their mind. The financial impact of this 'patient validation of the waiting list' was estimated at £581,608.

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## Annexe 1: NHS reform

The 2006 white paper *Our Health, our care, our say* sets out the government's vision of a NHS designed around the patient. This means more local services, an increased focus on illness prevention, more patient choice, an expanded role for professionals, extended surgery hours, reduced inequalities, better links between health and social care and a shift in care closer to people's homes. These aims have been reiterated in the 2007 guidance, *Commissioning framework for health and well-being*, which is designed to enable NHS commissioners to create more personalised care services, develop a strategic reorientation around health and wellbeing and tackle health inequalities.

Reforms are moving the NHS away from its traditional model of service provision towards a new model in which the provider community is increasingly diverse, with patient choice driving competition between providers. The government is attempting to achieve reform goals by strengthening the demand and supply sides of the healthcare economy.

Demand-side reforms create more knowledgeable, assertive and influential service users. This includes creating more forums to enable patients to express their opinions and ensuring PCT commissioners are more responsive to the needs and preferences of patients and their local communities.

Supply-side reforms aim to create more flexible, responsive and innovative service provision. This includes creating a health market that is open to a range of different providers. The aim of these two types of reform working simultaneously is to create a well-functioning market that achieves optimal allocative efficiency – getting the most patient care out of limited resources. This requires balance in the system as it is crucial that demand is effectively managed if the NHS continues to be taxpayer-funded.

Supply and demand-side reforms are mutually reinforcing. Demand-side reforms include the following:

- **Patient choice.** Greater patient choice over when, where and how they receive healthcare is a central policy objective. For example, 'choose and book' enables patients to select a secondary care provider
- **Patient information.** PCTs are responsible for providing accessible information on all primary care services in their locality. For instance, NHS Choices is a new internet-based service launched in June 2007 that has been developed to help patients make choices about health – including lifestyle decisions like smoking, and exercise, and practical aspects of finding and using NHS services
- **Payment by results.** A new type of funding the NHS which fixes tariffs to healthcare services.

These demand-side reforms need to be balanced by an increasingly responsive supply side, for which the government has implemented the following policy levers:

- **Practice-based commissioning,** putting GPs in control of redesigning patient pathways by providing the service themselves or by commissioning a service from another provider, either in the public or independent sector. The aim is to align budgetary responsibility with commissioning
- **Renegotiating the GP pay and pension package.** GPs received a 22% wage increase in 2004/5. An average GP is now earning more than £100,000 a year. That means that, retiring today, they have a pension pot to buy an annuity which would cost £1.25m to buy in the private sector<sup>30</sup>
- **New contract flexibilities for primary care trusts.** PCTs have local healthcare perspective so can spot more eas-

ily where there are gaps in service provision, where services could be improved and to regulate GP services they have commissioned. They also have the opportunity to drive the formation of healthcare markets that do not exist at the moment. The introduction of new GP contracts was intended by the Department of Health to devolve greater power to PCTs to shape local services, allowing PCTs to directly commission services from GPs. The new pharmacy contract allows PCTs to commission advanced services (for example, medicine use reviews) and enhanced services (for example, smoking cessation clinics)

- **New performance management system**, the quality and outcomes framework (QOF). This is an assessment process for GPs intended to measure, encourage and support clinical care to improve patient experience
- **Other government initiatives**, such as the fairness in primary care agenda. This is a nationally procured programme to tackle the problem of under-doctored areas, especially in socially deprived inner-city centres. The government is also working on improving access by streamlining the registration process and encouraging PCTs to offer more flexible opening hours among their GP surgeries.

## Annexe 2: More about the PSSB

### **CBI Public Services Strategy Board – transforming public services**

Formed in 2002, the Public Services Strategy Board (PSSB) leads the CBI's campaigning work on public service reform. As a funder, user and provider of public services, business is keen to influence the ongoing debate of public service reform and shape policy development in this area. Our campaign seeks to increase awareness and understanding of the contribution business is making to one of the most pressing public policy issues facing the UK today.

The PSSB is made up of CBI member companies which are involved in the design and delivery of a wide range of public services and support functions.

The CBI Public Services Strategy Board promotes quality and value in public services through competition and choice.

For more information about its work visit:  
[www.cbi.org.uk/publicservices](http://www.cbi.org.uk/publicservices)



