TRIBAL

Industrial transformation in the NHS

Preserving a publically funded health service in an economic downturn

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TRIBAL NEWCHURCH

Introduction

At the end of 2008, NHS commissioners were planning on an average growth in funding from 2011 of 2.7% a year. In just 6 months those expectations have been shattered. Whilst the wider economy may just be showing some signs of a slowdown in its precipitous descent, the NHS, along with the rest of the public sector, is now on notice of a major downturn of its own.

Perhaps the best that can be hoped for is that the NHS funding will continue to grow in the coming years, if even at a marginal rate. The reality, however, is that after nearly two decades of growth, funding may actually fall. Either way, given the inevitable tendency for demand to rise, reductions in NHS services will only be avoided if there are real and dramatic improvements in productivity.

Citizen expectations of public services are changing and during a recession their patience may perhaps wear thinner. Unless the NHS responds to this challenge, the very notion of the NHS may come into question.

The purpose of this paper is to look at how NHS commissioners, Primary Care Trusts and their partners, can and should respond. Given the tremendous expansion in resources over the last 10 years, few would argue that major improvements in performance can not be achieved. This paper argues that commissioners have the tools to drive those improvements; the question is, do they have the capacity and indeed the courage to become the fulcrum of a process of industrial-scale transformation that would regenerate the NHS for the 21st century?

This paper is therefore the latest in a series that stretches back more than 20 years. Over the last two decades Newchurch papers have provided independent commentary on the major issues facing the NHS. Now, with Newchurch becoming part of Tribal, that tradition is continuing in the context of the UK's largest provider of professional services to the NHS.

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Improving efficiency through World Class Commissioning

The NHS is facing its greatest challenge since its creation in 1948. The likely prolonged recession, with the inevitable consequences for public spending, will result in a significant contraction in NHS funding growth from 2010 onwards. Unless the NHS can improve its performance to an unprecedented extent, then significant service cuts are inevitable. The resulting reduction in the universal nature of free NHS services and the impact on its 'compact' with the public would then raise the prospect of a loss of confidence and alternative funding mechanisms that would strike at the heart of the NHS.

This paper argues that this outcome is not inevitable. Unlike other industries the NHS has 18 months notice of the impending downturn and has therefore time to plan and respond. Furthermore the opportunities and tools for making major improvements in productivity are already to hand. Using known and proven technologies and methodologies, the NHS could achieve the necessary savings whilst delivering a step-change in service and clinical quality.

Given the history of the NHS and public services in general, many will of course be sceptical. A transformation of a publically funded health service of this magnitude is unprecedented – but then so was the foundation of the NHS. Arguably the reforms of the last 10 years provide much of the required framework; the challenge is whether ministers – of either party – have the courage to implement the logic of those reforms. At the heart of those reforms and any hope of an industrial scale transformation of the NHS, is commissioning.

Commissioning is the key, the fulcrum around which transformation can be driven. Decoupling service provision from resource allocation decisions has been the most important reform of the last twenty years. So, the primary purpose of this paper is to look at what NHS commissioners, PCTs and their partners could do now, in the current year, to begin the transformation process.

The coming crunch

Following the 2009 Budget statement, nobody can now doubt that the recession and associated financial crisis will result in significant reductions in public spending from April 2010 onwards. Whilst the extent of any contraction is still unknown, at a minimum NHS funding growth will be severely reduced and a real cut in funding cannot be ruled out.

Since 1991 the NHS has averaged real expenditure growth of an astonishing 5.6% a year. Even before 1997 the average real growth was running at some 3.4%. So, the impact of a reduction in funding growth will be enormous both financially and culturally to a system that has been force fed with cash over recent years.[1]

Any reduction in funding growth will result in a spending deficit. For the NHS the deficit is the difference between the available cash and the projected resources required, based on past funding growth, to meet the inexorable rise in demand and consistent above inflation increases in NHS costs. Even if the rate of funding growth was reduced to just 1%, which

1. Parliamentary written answers, Jan 2009, http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090112/text/90112w0036.htm

is higher than the general growth rate for public spending of 0.7% announced by the Government, we estimate that by 2013-14 the NHS deficit would be about £15 billion per year. If there were a real reduction in funding of 1% per year, then the deficit would be nearer £21 billion, and if the Institute for Fiscal Studies' projection of a 2.3% reduction in real funding comes to pass, the deficit without other action in the NHS would be £25bn.

Even before the recent budget, the search for 'administrative savings' within the NHS had begun and will doubtless be pursued with greater vigour by any incoming administration. But even if half the managers in the DH, SHAs and PCTs were cut, this would only contribute some £1.5 billion a year.

The challenge and the opportunity

Therefore, there is no choice but to deal with the deficit through tackling the spending on patient services, with the scale of the challenge being much greater than can possibly be achieved by the traditional NHS cost improvement programme. In any event the 'simplistic' cuts of previous difficult times, such as ward closures, will no longer be acceptable. In this new world of transparency the almost immediate impact on waiting lists and waiting times would prove unacceptable to the public. Nothing short of a transformation in the NHS' productivity is required, maintaining core service standards but with significantly lower unit costs.

The potential for such a transformation is undeniable. Whilst activity, capacity and access have all increased over the last ten years, they have done so almost in direct proportion to spending and of course, to the number of staff employed. Undoubtedly whilst service quality and the patient experience has in many areas improved, this massive investment has had little or no impact on system efficiency.

On almost every measure the productivity of the NHS system is either flat or improving only marginally. Despite the near doubling in revenue over the last decade, coupled with more than £30 billion invested in capital assets, there has been only a very modest improvement in NHS unit costs and in some areas unit costs have even got worse. Data from the Office for National Statistics (ONS) published in 2008 showed a fall of 2% a year from 2001 to 2005 in NHS productivity across the UK. An earlier report from the ONS showed NHS productivity fell by between 0.6% and 1.3% a year from 1995 to 2004. The most recent figures from the ONS suggests that productivity improvement peaked at 1.6% in 2005/2006 and has since fallen back to under 1% a year. The recently published paper from the Centre for Health Economics at the University of York is consistent with these conclusions.[2]

This productivity failure is not unique to the health industry in the UK; all the leading industrial nations are facing a similar challenge. The failure to improve system performance does highlight, however, the extent to which healthcare has avoided the transformational processes that have radically changed most other industries over the last few decades, including those in the public sector such as education, local authorities and transport. There are many cultural and ideological arguments that have been

mustered to explain why healthcare is or should be different; but in the face of the cash realities of the current recession such arguments are largely academic.

Lessons from elsewhere

Over the last 30 or 40 years most major industries have gone through a process of radical transformation. From insurance to steel making, the process of industrial transformation has demonstrated similar characteristics:

- There's usually a catalytic event which triggers rapid and widespread change – from Wapping to the 'Big Bang'
- The process of transformation invariably exploits existing technologies – so that major industrial change is almost without exception about the rapid adoption of working methods and technologies that have been around for a number of years
- The adoption of those technologies and working methods inevitably shifts fundamentally the skill mix within the industry, with overall unit labour costs falling alongside a technology driven redistribution of skills and knowledge
- Significant and rapid shifts in business models with the simultaneous destruction of old organisations and construction of new ones
- Both powering and as result of all of these changes, a renegotiation of the contract with the consumer, with a mutual repositioning of their expectations and the delivery model for products and services.

Since 1948 there simply hasn't been a sufficiently strong event to bring about a similar and fundamental change in UK healthcare – until now. The forecast reduction in spending is of such a magnitude, particularly when coupled with shifting consumer attitudes towards the public sector, that this could be the event that makes the difference; with commissioning providing the mechanism for transmitting that effect across the NHS.

PCTs have taken up the challenge of World Class Commissioning with varying degrees of success, gradually shifting from the role of healthcare planner, working in exclusive partnership with NHS providers, towards the goal of system manager, contracting with a range of plural suppliers. In this journey towards 'world class performance' the focus so far has been on vision, strategies, capacity building and processes. So far, so good. But now it needs to move on, for commissioning to become operationalised – with PCTs driving system transformation with productivity and efficiency as a primary goal. The challenge and the opportunity, is to use the commissioning as the process and the PCTs as the agents of the transformational process.

A four layered programme for transformation

PCTs are therefore the front line. They will be the first to see and appreciate the scale of the resource reductions the system will be facing. Their task in the current year is to put in place the actions required to prepare for the pressures of 2011 and beyond.

There are four key actions or programmes that NHS commissioners should consider implementing, with a common, single objective but with different timescales. In line with our observations of how other industries have been transformed, there is by design little new or novel about

2. NHS Input and Productivity Growth 2003/4-2007/8 Andrew Street and Padraic Ward, The Centre for Health Economics, The University of York, April 2009

these programmes. What is different is the determination to apply what we know already works in a systematic and focused fashion, with each programme mapping directly to World Class Commissioning competencies.

The four programmes are:
1 Improving system performance
2 Challenging business models
3 Repositioning the consumer contract
4 Building capacity and capability.

The first programme focuses on delivering rapid cash-releasing improvements in performance, based on the current structure of supply. The second initiates the process of structural reform of the local health economy, a process which will take longer but should deliver a step-change improvement in productivity. The third programme recognises that any radical improvement in productivity will only be possible with, at least, the acquiescence of the public and in many cases with their active support for different patterns of service delivery. The fourth and final programme underpins the other three; assembling and embedding with the commissioner the necessary skills to trigger and manage the transformation of the local health economy.

Improving system performance

The key actions required to bring about a rapid improvement in the short-term performance of the NHS are already known; the technologies already exist, the working methodologies are already understood. Either within the NHS or internationally, someone is already applying the approaches that the NHS needs to adopt universally. Indeed, in many local health economies, there are good examples of high performance. But, despite the evidence, the drivers of high performance are neither universally pursued nor the tools generally applied. To bring about a rapid improvement in performance, best practice must be spread to become the norm, not just in some areas by some commissions, but amongst all NHS commissioners.

The starting-point is to understand current performance. This will require a productivity assessment, to determine the potential for performance improvement across the local health economy. The data for making such a comparative assessment across health systems is now readily available, even if the capacity to make sense of that data is rarer. However, it is now possible for all PCTs to determine the metrics which show how their local health economy performs by focusing on each major transition point as patients flow through the system. From comparing demand, expressed both in terms of patients needs and commissioning spending patterns, through the performance of the care services at first contact, to the delivery of complex and continuing care and finally to the restoration and maintenance of the patient as far as possible in a full and active lifestyle. In this way it is possible to see how patients flow through the system, using services and so constituting a ‘cost chain’.

As a result it is possible for each PCT to assess the performance of its local healthcare system, in comparative and absolute terms and to identify how the maximum impact on performance can be achieved. The information is available, the analytical technology is already known and well understood, yet few PCTs undertake

such an analysis on a systematic basis. PCTs working in partnership with practice based commissioners can then identify where the performance is out-of-line, along the cost chain. Working together, commissioners can then prioritise those areas where action can have the greatest effect, recognising that the relative rate of return from keeping patients out of the care system invariably exceeds any gain from improving the technical efficiency of the clinical care itself, delivered to the patient as they pass along the cost chain.

This is particularly the case in the immediate future where some 35% of spend is at fixed price, i.e. tariffs. In the longer term, significant tariff reductions might lead to cash benefits for commissioners but in the short term, productivity improvements within acute providers, primarily result in increased cash surpluses for those organisations. Therefore, the immediate focus for improving performance has to be on managing the overall flow of patients through the system and, where possible, to make use of lower cost suppliers outside the tariff regime.

On the basis of this productivity assessment, the local commissioners can design their action programme. When developing these types of approach most NHS organisations revel in making things as complex as possible, however the art in making a rapid and significant impact is to focus on a small number of key areas. These four key areas will probably be identified as:

- Managing demand
- Care at first contact
- Complex and continuing care
- Health maintenance.

In each of these areas there are already great examples of good practice both nationally and internationally.

Managing demand

The starting-point, where there is maximum impact, is to limit the flow of patients into the cost chain. Inevitably, demand for health care services will continue to rise and it is the responsibility of all commissioners to ensure that all citizens continue to have access to appropriate, free services, when they need them. But there are substantial savings to be made by meeting this challenge, whilst at the same time ensuring that NHS resources are allocated effectively to maximise health gain for the community as a whole and that the services delivered are the most cost-effective.

This is possible because the NHS commissioner, as market manager, has leverage over both key aspects of demand; the allocation of how resources are spent and the behaviour of the population. In many respects these issues are closely related, with the misallocation of resources encouraging supplier induced behavioural changes in the population leading to increased demand – an expensive and damaging ‘vicious’ circle.

NHS commissioners are dealing with surprisingly differentiated populations and although the Joint Strategic Needs Assessment process has bought significant rigour to the alignment of resources with needs, there remain inexplicable variations in investment patterns between PCTs. The process therefore needs to be further refined and strengthened, using methodologies such as the John Hopkins Adjusted

Clinical Groups (ACG) tool, which stratifies healthcare populations and places costs against projected needs. The evidence suggests that using these approaches, savings of 1-2% of the total budget[3] are possible.

In many cases, these allocative inefficiencies are tied to historic supply patterns and the implicit assumption of support to existing providers. Commissioners need to identify where this is the case and working with those providers, have a time-limited – typically three years – and explicit process of disinvestment; where appropriate, entering in exit contracts to provide transitional support for providers, as part of the process of challenging business models described below. Given the financial context commissioners have a responsibility to take the bold step of planning the purchase of healthcare against future need rather than to maintain historic patterns of provision. Short-term investment is justifiable to avoid continuing longer-term costs and to remove unacceptable local subsidies.

Self-care is the most efficient form of care, but the supply-orientated NHS has been reluctant to invest in self-care and wellbeing programmes, other than those related to specific issues, such as smoking, sex and alcohol. Yet the benefits from such programmes can be very significant, particularly when focused on particularly vulnerable or high cost groups, using predictive modelling techniques. Evidence from North America suggests that every £1 invested in wellbeing programmes, such as health and wellness coaching, could yield £3 in cost savings.[4] Whilst UK experience of using similar techniques showed a return of 2.4 to 1. Another recent study of the impact of combining health coaching with predictive modelling and active outreach, suggests a total saving of 8-9% in medical expenditure.[5] Even if this level of savings could not be replicated across the whole NHS population, the potential is clearly worth commissioners pursuing with a much greater degree of enthusiasm.

Care at first contact

In healthcare, as in most service industries, meeting demand and dealing with it early and effectively, is a critical determinant of the effectiveness of a total system. As the system stands today, the key supplier in first contact care, at least in terms of direct costs, is the GP practice. However, there are a wide range of other players, providing together multiple and often uncoordinated points of first contact, from NHS Direct, the pharmacist, the Minor Injuries Units to A&E. The key metric for the system as a whole is the extent to which first contact services deliver completed episodes of care and at what cost.

The evidence from GP practices is that their success in doing this is very varied. In the case of GPs and their practices, the key metrics that commissioners need to measure are:

- Treatment completion rates, allowing for differences in their local populations, as reflected in differential referral rates to specialist providers
- Practice population behaviour, as measured for example through inappropriate A&E attendances
- Treatment costs, as measured for example through differential medication costs.

Our studies suggest that performance across GPs and GP practices varies significantly, with many PCTs remarkably tolerant of these variations. It is typical for GP referral rates to vary by as much as 200%, even taking into account differences in population. Indeed, where PCTs have focused on GP practice performance it is not unusual to discover that a relatively small number of practices are responsible for generating a disproportionate part of the total load on the local health system. Helping these practices improve their performance, within the supportive incentives of Practice Based Commissioning, can yield very substantial benefits.

Making GP practices more efficient as deliverers of first contact care is very attractive, but the benefits are limited by the high and increasing costs of GP treatment. For most local healthcare systems there are significant savings to be gained through the rationalisation of first contact services, where the current proliferation of services is both confusing and demand-inducing. In particular, shifting first contact care to more cost effective providers which service users often find more convenient and of at least equal quality, may well represent the most attractive development route.

Complex and continuing care

First contact care will not always be sufficient or appropriate, and a proportion of patients will always need complex and/or continuing care, delivered in a range of environments, including the acute hospital, the clinic and the home. The key to maximising performance is well recognised – encouraging patients to receive their treatments and interventions in the most cost effective, clinically safe and appropriate environment. Hence, the commissioners' strategy here is to only pay for optimal performance whilst at the same time encouraging the transition of current providers to more appropriate models of care.

In terms of optimising current performance, the evidence from the UK and internationally suggests that the greatest benefits come from commissioners focusing on just four areas:

- Admission management, focusing both on inappropriate planned and unplanned admissions
- Care planning, focusing on inappropriate resource utilisation, including care location, lengths of stay and follow-up rates
- Medicines management, tackling the pharmaceutical budget across the health system as a whole
- Invoice validation, both to ensure the accuracy of the underlying data but also to ensure that the commissioner is only paying for what is delivered.

Improvements in the quality and timeliness of the data increasingly allow NHS commissioners to manage the gateway into complex and continuing care. Monitoring and challenging inappropriate planned and unplanned admissions offers significant opportunity for delivering both cash savings and quality improvements for patients. Whilst the recurrent increase in referrals and admissions being observed within most local health systems may have underlying systemic causes, there is considerable evidence of wide and persistent variations in admission thresholds. Tackling these variations through active management

3. Esther J. Nash, MD Connection Health Management Performance, Blue Cross. (8) Siegel M. Health Dialogue UK, HSJ 25.9.2008

4. Health Coaching Benchmarks: Operations and Performance Data for Optimal Program ROI and Participant Health Status

5. Health Dialog Service Corp, study in course of publication.

on the part of the commissioner, for example using tools such as MCAP™[6], can deliver substantial cash benefits. For example, it is estimated that tackling the unexplained variation in emergency admissions, some 20% of all admissions, could deliver savings of some 1.5% of the total NHS budget.

Weak care planning compounds and adds cost to poor admission management. The default position for most health systems is to over-provide services within settings which are unnecessarily resource intensive. For example, by international comparison, the NHS continues to provide an unnecessary and disproportionate amount of care within traditional acute hospital beds. There are examples in North America, where there are similar overall bed levels to the NHS, but 40-50% of the beds are of a transitional nature, at half the acute cost.

Similarly, there is UK experience of shifting care from the traditional hospital setting to the home, with benefits to all. Home chemotherapy for example can be delivered at a third of the standard NHS outpatient tariff and with tremendously increased patient satisfaction. Tariff splitting provides commissioners with a whole range of opportunities to incentivise existing and new service providers to introduce alternative and cheaper service offerings.

For commissioners, the key to tackling weak care planning is through utilisation reviews and audits. This needs to be embedded within contract management processes to minimise drift from agreed and appropriate care plans, delivering better quality for patients and lower costs for commissioners.

Drug budgets continue to increase faster than funding and inflation. Whilst considerable progress has been made in both primary and secondary care there is considerable evidence that a failure of medicines management across the system as a whole is leading to unnecessary costs and risks for patients. The silo approach to medicines management employed in most health economies can be transformed through a cross-functional approach. The introduction of whole systems integrated formularies across primary and secondary care, can help contain cost in both acute and primary care drug budgets and can deliver very significant additional savings.

The fundamental key to the effective commissioning and subsequent management of complex and continuing care is invoice validation. This apparently administrative function is key to transforming system performance. Effective validation contributes significantly to the creation of reliable and credible data with which to manage the system as a whole. At the same time there is evidence that any investment in invoice validation delivers a substantial and rapid return through ensuring that the commissioners only pay for what is delivered. Evidence from an increasing range of PCTs suggests typical savings of 0.5% of acute hospital spend in the first year.

Health maintenance

There is considerable evidence recognised by many commissioners that however efficient the current system is at tackling clinical need on presentation, it isn't very

good at sustaining patients following successful interventions. As a result a small but very important cadre of patients become very expensive serial users of services, often experiencing a continuing decline in the quality of their lifestyle with detrimental effects for their carers and the wider community.

Despite the evidence, few commissioners have put in place a systematic approach to rehabilitation and health maintenance. Where this has been done the results are impressive. For example, the total costs of managing diabetes are estimated for the NHS to be some £5bn a year[7]: Evidence from North America suggests that proactive health maintenance programmes could deliver savings of 15-20% a year, with some savings being delivered within 12 months of the introduction of the programme.

There is similar evidence for savings from other areas of chronic illness, such as chronic obstructive pulmonary disease (COPD). In the case of the chronic heart failure (CHF) programme providing support for chronic heart failure patients including telephone coaching and educational support, have been reduced inpatient hospitalisation rates by nearly 50% and attendances[8] for emergency treatment by an even greater amount.

Challenging business models

Improving the current productivity of the system, although significant, will simply not be enough. The predominant business models, which reflect provider interests rather than those of the patient or the taxpayer, place substantial barriers to the extent that major improvements can be achieved. Radical improvements in performance will require new and innovative business models.

It is not the job of the commissioner to design or determine those business models but it is their task to catalyse the development of new approaches, to support innovation, to encourage new entrants and to facilitate the exit of existing suppliers who cannot or will not change. Many of the current supplier organisations will be successful in developing new business models but some will not and ultimately these organisations, thought not necessarily their services, must be allowed to fail.

In acting as the catalysts for this process, NHS commissioners can draw on the developing policies for system reform and competition. The framework for system reform, provided by the Transactions Manual[9], sets out in a systematic fashion the processes for bringing about structural changes amongst NHS-owned service providers and Foundation Trusts, even if it is less than explicit about dealing with provider failure.

The companion piece to the Transactions Manual is provided by the Principles and Rules for Cooperation and Competition[10/11] under which commissioners are required to progressively introduce a much greater degree of competition and supplier plurality. Under the oversight of the Cooperation and Competition Panel[12], commissioners can, where appropriate, use the pressure of competition to encourage existing suppliers to improve services and a reduction in entry barriers to persuade new providers to deliver new service models.

6. http://www.oakgroupuk.co.uk/mcapSystem.html

7. Williams R. Yorkshire Public Health Observatory March 2006: Diabetes Key facts

8. Utilization Reduction, Cost Savings and return on Investment for the Pacificare Chronic Heart Failure Program, Vaccaro, Cherry, Harper, O'Connell, Disease Management, September 2001

9. The Transactions Manual, Department of Health, February 2009

10. The Principles and Rules for Cooperation and Competition, Annexe D, The Operating Framework for 2008/9, The Department of Health, December 2007

11. Framework for Managing Choice, Cooperation and Competition, The Department of Health, May 2008

12. Launch of the Cooperation and Competition Panel, The Department of Health, January 2009

Taken together, the Transactions Manual, with increased competition and an increasingly difficult financial environment, will bring about a significant shift in the structure of the NHS suppliers. This will inevitably result in a redistribution of both their assets and their workforce. The task for the commissioners is to give this process impetus and as far possible, to ensure that the interests of both patients and taxpayers are protected along the way.

This will require active management and proactive interventions on the part of the commissioners, over an extended timescale, based on the acquisition of a range of unfamiliar skills and techniques. The five key components of this process are:

- Market analysis, to understand where supply and demand are mismatched, in the light of future needs and changing economic reality and which lead to service failures, poor quality and higher costs
- Market strategy, for although commissioners cannot design or determine the structure of their local market they do have considerable influence as to its key components, provided they have a clear view or strategy as to where they want to end up, in terms for example of degrees of choice, level of competitive intensity and distribution and acceptance of risk
- Communications, which are clear and consistent with current and potential suppliers is crucial, so that they understand the direction of travel and can make investment decisions accordingly – transparency of market strategy and planned interventions is both vital and equitable
- Targeted interventions, are likely to have a much greater impact rather than a scatter gun approach. The most attractive interventions are those where there will be a resulting 'ripple' across the whole local health economy, cutting across different service areas and making use of different forms of intervention, such as information, market entry support, Any-Willling-Provider lists and exit contracts
- Market supervision, is the continuing responsibility of the commissioners, to ensure not only that it is open and fair, but that the interests of service users and taxpayers are protected.

For some PCTs this approach will build on the current work of the Health Market Analysis studies undertaken in a number of SHAs. Though some of these analyses have been data rich and action-light and have avoided moving into high-impact areas where the 'ripple' effect might be too challenging.

The process will be given support at a national level by the Department of Health's encouragement towards the marketisation of key areas, where there is a demonstrable imbalance of supply and demand. Initial focal points of interest will include areas such as end-of-life care and a range of community services, where the impact of developing new business models will be significant across the entire health economy.

Repositioning the consumer's contract with the NHS

Sustainable improvements in productivity and service efficiency will only be possible if there is a change in the relationship between the individual citizen and the NHS. The historic compact between the public and

the NHS with its almost mythical origins in the Second World War needs to be bought up-to-date. Many citizens, not least those under 50, appear to be adapting different attitudes from previous generations to both the NHS and to their own health. Sometimes, however, it seems that some in the NHS appear to be more interested in preserving the past than in reform.

NHS commissioners, as local leaders, have to play a key role in reshaping that relationship, with three objectives; gaining some acceptance of changing patterns of service, raising the level of self-care, and reducing level of inappropriate service usage.

Leading the charge for change in the NHS has never been popular with the public and perhaps that partially explains a perception that PCTs and their predecessors only ever consult the public when they want to shut something down to save money. Tackling that perception requires PCTs to move away from intermittent consultation to consistent civic engagement, with a transparency over the need to get value-for-money, but founded on the PCT's role as the patients' advocate for quality and clinical safety.

Changing the public's attitude towards their own health and their interaction with the health services is a long term project but cannot be viewed as too difficult. Even in cash strapped times commissioners will need to protect if not expand their budgets for health promotion and wellness programmes. To make that money go further PCTs will need to be smarter in:

- Targeting the key groups, either on the basis of risk or current usage – this technology is already available but used only by a very small number of PCTs
- Making greater use of intervention tools, using the already proven methodologies, such as health counselling, commissioned directly by the PCT
- Adopting supportive technologies, from information flows, to home support and carer training, commissioned directly by the PCT.

All of this requires the commissioner to take on a higher profile within its local community and in relation to key partners, such as local authorities. For the PCT board this will mean seeking greater exposure; a challenge for many.

Building capacity

To underpin the role of the commissioners their capability and capacity needs to be substantially enhanced. Sadly, the fundamental shift in the role and function of the PCTs has not been matched by a comparable investment in capacity building. Given the immediacy of the task now facing NHS commissioners they need to consider a comprehensive organisational development programme of capability building, including;

- Recruitment of key skills, although the availability of skilled individuals remains very tight, the opportunity of recruiting some skills, such as analytics, procurement and contract management from outside the health care industry may be growing
- Training and development, focusing on the acquisition of the basic commissioning skills by all staff, the shifting role of the board and the reassertion of the importance of management development – ultimately commissioners need to grow their own talent

- Acquisition of tools and methodologies, casting aside the habits of a lifetime, commissioners should look at buying ready made solutions to replicable elements of the commissioning process, such as contract and relationship management and investment analysis
- Insourcing technologies and skills, through renting specific services, such as analytics or invoice validation, and the associated staff, with the option of transferring the process to NHS commissioning staff over time
- Outsourcing, particularly routine processes and procedures where a larger-scale provider can deliver robustness and value-for-money.

Given the scale of the task, the number of PCTs and the variation in size, the only way in which commissioners will be able to respond is by taking a much more imaginative approach to the nature of their organisations and the flexibility of its boundaries.

The recently announced Commercial Support Units will have a contribution to make to this process, particularly in the areas of procurement and commercial advice, when they come on stream in early 2010. Similarly in a number of areas commissioners are forming joint service arrangements, or hubs, to provide a range of commissioning services. And in parallel there will be a growing range of private sector suppliers operating under a revitalised FESC framework.

Will it be enough?

The comprehensive approach laid out in this paper meets the crucial criteria that all of it can be done now. There is no requirement for new technologies or methods, only the wholesale and general adoption of what we know already works. The crucial question is, of course, whether such a programme, led by NHS commissioners, could deliver sufficient savings and soon enough to meet the challenge of a real cut in NHS spending.

Achieving that objective is crucially dependent on the impact that commissioners could have in the short-term on the operational efficiency of the local health system as it is currently organised; changing the supply-side structure may be much more important in the longer term but is unlikely to have a significant impact within the next two to three years. Based on our practical experience of working with NHS commissioners and on the national and international evidence, we think that real, cash-savings, of greater than 10% a year are achievable for most PCTs, before any impact that might come from tariff reductions. In Table 1 we have set out the major interventions, the evidence and the resulting savings for a typical PCT.

In other words, most PCTs could still meet the current needs of their populations whilst spending 10% less. By comparison to the potential challenge facing the NHS, such savings may barely be enough to avoid reductions in services, but their rapid achievement would give time for the structural reforms of the supply-side to begin to deliver longer-term and sustained further savings.

As part of that process we expect to see a dramatic reduction in NHS tariffs, which will reinforce the process of

supply-side reform and contribute further to PCT savings, so long as service and demand expansion are controlled. The impact of the forthcoming recession in NHS spending on service providers will be examined in our next paper.

In the meantime the challenge to NHS commissioners is to determine how well they are prepared for the chilly times ahead. Commissioning in the NHS over the next few years will not be for the faint hearted. Although NHS commissioning is relatively new, even novel, it represents the best chance we have of catalysing the transformation of the NHS that is needed if its basic principles are to be preserved.

Table 1. Improving Performance – Anytown PCT

Intervention	Typical Tool or Approach	Evidence	Estimated Full year Savings Year	Cash Savings
Resource Allocation	John Hopkins Adjusted Clinical Group	Esther J. Nash, MD Connection Health Management Performance, Blue Cross. (8) Siegel M. Health Dialogue UK, HSJ 25.9.2008	1-2%	
Wellbeing programmes		Health Coaching Benchmarks: Operations and Performance Data for Optimal Program ROI and Participant Health Status Health Dialog Service Corp, study in course of publication.	3-4%	
Care planning	MCAP™	www.oakgroupuk.co.uk/mcapSystem.html	1-2%	
Medicines management		Tribal case studies	0.5-1%	
Invoice validation		Tribal case studies	0.25-.5%	
Health maintenance programmes		Williams R. Yorkshire Public Health Observatory March 2006: Diabetes Key facts Utilization Reduction, Cost Savings and return on Investment for the Pacificare Chronic Heart Failure Program, Vaccaro, Cherry, Harper, O'Connell, Disease Management, September 2001	2-3%	
TOTAL			**7.75-12.5%**	

About Tribal

In today's complex world, effective and efficient public services depend on the collaborative effort of people working across the public, private and voluntary sectors.

Tribal's distinctive offering combines professional, commercial and public service expertise. We work in partnership with our clients to help shape policy and improve the quality and value for money of public services.

We work with 2,500 public sector organisations in health, education, central and local government, housing and regeneration. Whether we are raising standards in schools and colleges, regenerating communities or improving hospitals, our focus is on delivering outcomes that enrich lives.

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