GP Commissioning

The role of research in helping general practice commission efficient healthcare

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The CLAHRC's partners include Leicester City, Leicestershire County and Rutland, and Northamptonshire PCTs.

Key messages

- The new commissioning consortia must improve NHS efficiency quickly, but face enormous challenges.
- To improve efficiency, the best available research evidence about treatments and services must be identified, understood and applied.
- The NHS has invested in research, and consortia should develop effective ways of drawing on the findings.
- Partnership with research organisations would help consortia not only find and apply evidence, but also become more capable of designing new ways of delivering services and evaluating the outcomes.
- It is imperative that a process for sharing the findings of local research projects conducted by consortia is established to avoid unnecessary duplication of projects and enable rapid learning about what approaches to delivering services do, and what do not, work.

Why this matters to us

I (RB) am a GP and director of one of the NIHR's research organisations (a Collaboration for Leadership

in Applied Health Research and Care, or CLAHRC for short). As a researcher, I am familiar with the problem of delay in the implementation of research findings; there is no simple solution, but bringing researchers and practitioners together seems a sensible starting point. If researchers can better understand the needs of practitioners, there is a chance that research evidence will better meet the needs of practitioners and their patients. The reforms now underway place a great deal of responsibility on GPs – if we can make a success of commissioning, we will have helped secure the future of the NHS. If we fail, the future for the NHS and our discipline is difficult to predict. Now more than ever, it is essential to apply research evidence in commissioning decisions, and to bring researchers and practitioners together to design and deliver efficient services. Although anxious about the consequences of failure of commissioning consortia, I am also positive about the potential of GPs to make a success of consortia. I hope some GPs, now involved in establishing consortia, having read this article, will think about how they will ensure the consortia do make use of relevant research evidence on which aspects of care are most efficient, and how their consortia can generate evidence themselves and share it with others.

ABSTRACT

The new commissioning consortia face a major challenge in improving the efficiency of the NHS. They are new organisations, and at the same time as establishing themselves they need to overcome significant obstacles to reforming services. Research evidence about the value of care can help consortia achieve efficiencies, but there are often delays between the provision of evidence and its routine use in policy and practice. The National Institute for Health Research (NIHR) has invested substantial funding in providing evidence for the NHS, and in this article we discuss how consortia can make sure

they obtain and apply relevant evidence as quickly as possible, and also generate evidence on practical questions such as the impact of redesigned services. Partnership with NIHR research organizations, particularly the Collaborations for Leadership in Applied Research and Care (CLAHRCs), offer one approach to helping consortia commission efficient health care.

Keywords: healthcare organisations, primary health care, research

Introduction

In this article, we argue that the effective application of research evidence will be key to the success of the new commissioning consortia. The major investment made in recent years by the National Institute of Health Research (NIHR) in research programmes and organisations is delivering fresh evidence on ways to provide efficient care, and those consortia that make best use of this evidence will be the ones that survive and grow in the next decade. Failure to use evidence effectively will be followed by poor outcomes, higher costs of care than necessary, and the eventual termination of the consortia concerned. In the following paragraphs, we summarise the challenges facing the new consortia, the new research programmes of the NIHR, in particular the Collaborations for Leadership in Applied Health Research and Care (CLAHRCs), discuss the use of research in informing commissioning decisions, and use examples to show how research applied to primary care problems could improve consortium efficiency.

The context for consortia

Consortia are being born into a difficult world. The funds available to them will be limited, but the demands placed upon them are considerable and growing. The population is increasing, but more importantly, there are more of the very young and of the old. Both these groups have high demands on healthcare. In the older age group, in particular, the numbers of people with one or more chronic conditions is steadily rising. Consequently, the need for services for the continuing management of these patients will grow, as will the need for acute services when complications and severe events occur. Consortia will therefore be seeking low-

cost alternatives to high-cost means of caring for people with long-term conditions, but the context in which they find themselves will make this very difficult.

Efficiency may be achieved through stopping services that produce little or no benefit, improving care or redesigning specialist services to lower treatment costs, or shifting services to less costly settings such as community or primary care. The hospitals with whom the consortia must negotiate are powerful and have voracious appetites for money, and the new consortia will find it very difficult to disturb the traditional dominance of hospitals in the NHS. The National Audit Office estimates that the productivity of hospitals, rather than improving, has been falling at around 1.4% per year.¹ Consortia will face skilful resistance to attempts to withdraw funds from unproductive activities, and redesigning services will often be a slow process.

Consortia will be required to choose lower cost ways of delivering the same or better outcomes. When these choices are made on the basis of trustworthy evidence, better value for patients is more likely. Consortia can draw on various sources of support for commissioning, including the NHS Primary Care Commissioning (NHS PCC) service² and the work streams set up for the Quality, Innovation, Productivity and Prevention (QIPP) programme.³ These are likely to help consortia; the addition of collaboration with researchers could add even more. Research-mindedness in decision making can assist not only in using existing evidence, but also in ensuring that, when evidence is limited, processes are put in place to ensure the collection of sufficient information to enable decisions about the value of existing or new services to be made.

Drawing on research into the translation of evidence into practice in health and social care, Nutley and colleagues have identified three models of research use.⁴ In the research-based practitioner model,

it is up to the individual practitioner to remain abreast of the evidence, with substantial reliance being placed on professional education and training. In the embedded model, research use is embedded in the policies, standards and guidelines that direct care, with the process being supervised at a local level by managers. In the organisational excellence model, organisations take on responsibility for using evidence effectively, adapt research findings, provide leadership in creating a research minded culture, and often work with external organisations in creating and using research evidence. Although education and training are necessary, reliance on these features of the research practitioner model will not deliver the efficiencies that consortia must achieve. Supplementation of education with systems and pathways of care that embed research evidence will help. But for most impact, consortia need to take charge of the application of evidence as in the organisational excellence model, a step that will involve them in developing individuals and systems to achieve the routine use of best evidence in clinical and policy decisions. Such consortia will also generate evidence themselves on which pathways or service designs are more cost effective.

Collaborations with researchers

The NIHR has established well-funded programmes of research in fields that include health technology assessment, service delivery and organisation, and public health. It has also created substantial research groups or institutes, including biomedical research centres, biomedical research units, clinical research networks, and the collaborations for leadership in applied health research and care (CLAHRC). All these agencies are potential collaborators for consortia, but the CLAHRCs, with their focus on partnership with the NHS and the translation of evidence into practice, are particularly relevant. There are nine CLAHRCs

(Box 1), fairly widely distributed throughout England, with one in London. Each CLAHRC has been investigating means of meeting the needs of the NHS for evidence, and ways of developing effective partnerships between practitioners and researchers. Funded for five years in the first instance, the CLAHRCs have different approaches to translating evidence into practice and are undertaking applied research into long-term conditions, but together they form a network that is collectively working out how to achieve better health outcomes through partnership between research and practice.^{5,6} Examples of work with commissioning groups and PCTs underway in NIHR CLAHRC for LNR include evaluation of a means of preventing progression of chronic kidney disease to enable commissioners to decide on service design in partnership with Nene Commissioning,⁷ and studies of emergency hospital admissions to help primary care trusts develop approaches to containing admission rates.⁸ Other ways in which CLAHRCs could assist consortia include rapid reviews of published evidence to provide timely summaries of research on relevant questions, support in planning and undertaking evaluation of new or existing services in order to provide evidence to inform commissioning decisions, and training in how to find, appraise, adapt and apply research evidence.

Examples

The work of GPs in Cumbria illustrates activities consortia might do to develop primary healthcare in ways that produce efficiencies, where development of clinical leadership laid the foundations for improved care pathways, reduced referrals, and led to the adoption of better data collection systems.⁹ In the NIHR CLAHRC for LNR, we have been working with local PCTs in investigating rates of acute hospital admission (Box 2). After preliminary analyses to understand some of the factors influencing admission rates, we

Box 1 The nine NIHR CLAHRCs

CLAHRC	Website
Birmingham and the Black Country	http://medweb4.bham.ac.uk/websites/bcra/clahrc/index.htm
Cambridgeshire and Peterborough	www.clahrc-cp.nihr.ac.uk/
Greater Manchester	http://clahrc-gm.nihr.ac.uk/
Leeds, York and Bradford	www.clahrc-lyb.nihr.ac.uk/
Leicestershire, Northamptonshire and Rutland	www.lnr-clahrc.org/
North West London	www.clahrc-northwestlondon.nihr.ac.uk/
Nottinghamshire, Derbyshire and Lincolnshire	www.clahrc-ndl.nihr.ac.uk/
South West Peninsula	http://clahrc-peninsula.nihr.ac.uk/
South Yorkshire	http://clahrc-sy.nihr.ac.uk/

Box 2 A joint PCT-CLAHRC partnership addressing acute hospital admission rates, a project currently almost completed

Priority identified a meeting between PGT Medical Director & CLAHRC researcher.

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Joint PCT-CLAHRC project group established, and local project conducted without additional funding.

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Analyses of routine data managed and interpreted by joint group, providing practically useful evidence of associations between admission rates and practice activities.

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Potential strategies to reduce admission rates identified

- Disease-specific advice
- Feedback of relevant data to practices

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Joint development of methods of evaluating impact of interventions.

have been assisting in the evaluation of schemes to contain admission rates. These are brief, small-scale projects that can provide organisations such as consortia with timely evidence that helps them make decisions. The role of the research partner in such projects is to contribute expertise that ensures a better study, and therefore better quality evidence. All consortia will have questions about the effectiveness of services or interventions such as those in the acute admission work; by forming partnerships with researchers they will be more likely to generate better evidence and therefore make better decisions.

But the potential benefits do not end there. Consortia throughout the country will be addressing similar problems with similar approaches and similar evaluation projects. Duplication of evaluation projects not only wastes money, but also slows the pace at which consortia will be able to develop and test new systems of care that might improve efficiency. Consortia should not only undertake projects with researcher partners, but also take steps to share their findings with others. Some of the stronger projects may be published formally, but many will not. Sharing

reports of evaluation projects in a way that acknowledges the limitations of such local studies is essential in enabling consortia to learn how to improve efficiency. An Internet resource, hosted by a consortium or a research organisation such as a CLAHRC, could facilitate exchange of information about unpublished consortia projects.

Small-scale, local projects have an important role to play. Sometimes, larger projects will be needed. We are beginning to turn attention to the detection of hypertension, having shown that better detection of hypertension is associated with lower coronary heart disease mortality.¹⁰ However, levels of detection are variable. Despite evidence from more than 30 years ago that detection and control of hypertension reduces the incidence of stroke and coronary heart disease,¹¹ the Health Survey for England shows that only around 60% of those with hypertension have been diagnosed (Table 1).^{12–14} Increasing the prescribing of drugs to control hypertension has been identified as one of the three most cost-effective interventions to reduce the gap in life expectancy between deprived and advantaged groups, but progress is slow.¹⁵ In Leicester City,

Table 1 Levels of detection, treatment and control of hypertension in English adults (aged 16 or over), reported in the Health Survey for England (hypertension defined as 140/90)

Year	Prevalence males (%)	Prevalence females (%)	% with hypertension in survey reporting having a diagnosis of hypertension		% controlled, of those treated	
2003	32	30	36	45	41	48
2006	31	28	40	52	52	52
2007	31	29	46	53	56	55
2008	32	29	46	57	57	57
2009	32	27	59	61	58	50

Box 3 A consortia, PCT and CLAHRC programme on hypertension detection, a project currently under development

Priority identified

- Coronary heart disease is a priority for the local NHS
- Agreement at a PCT–CLAHRC meeting

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Joint project team established

- PCTs
- CLAHRC
- Consortia (as they form)

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Initial developmental study planned to:

- Develop a practice-level approach to improving detection
- Pilot the approach, including costs and feasibility
- External research funding

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Roll-out and evaluation

- Interrupted time series or randomised controlled trial design

around 11% of patients are on practice Quality and Outcomes Framework hypertension registers (2008 data); in Northamptonshire, the proportion is around 13%, and in Leicestershire County and Rutland PCT, around 13.5%. However, the proportion of people with hypertension in the population is likely to be around 20%. A consortium that decides to address this issue could achieve improved efficiency through reducing the numbers of strokes and heart attacks.

We are now developing a partnership to address the issue of detection of hypertension (Box 3). In both these examples, the first step involved recognition of the topic as a priority, followed by the creation of project management groups that brought practitioners and researchers together. In the case of hypertension detection, research is used to develop and pilot a feasible approach to improving detection, and also to evaluate the benefits in an experimental way such as in an interrupted time series study or randomised trial. In such an initiative, a real understanding of the nature of general practice is critical; variation between practices is the norm, but as practices have different patient populations and different resources available to them, uniform approaches to getting evidence into practice can have only limited success. Appreciation of the likely workload implications is critical.¹⁶ One advantage of consortia is their ability to really understand general practice and the challenges practices face, and by drawing researchers into collaboration to address key local problems, they have the potential to combine their understanding with appropriate research techniques. CLAHRCs are based in the NHS, and are led by or extensively involve general practitioner researchers, and therefore offer a real source of practical support in applying research to improve health outcomes.

Conclusions

Consortia face a tough task. Some will fail and some will succeed, but the greater the numbers that learn how to find, adapt and apply research evidence, the greater the number that will be successful in improving NHS efficiency. In many ways, the introduction of consortia is a gigantic, uncontrolled experiment in how to use research evidence to benefit healthcare. Health professionals in primary care teams seek to apply research evidence, blended with patient preferences and clinical judgement, in daily clinical practice, and sometimes have argued the case for evidence-based management. Although evidence-based policy is some way off, we now have an opportunity to apply research evidence in managing services. By developing partnerships with researchers who understand the needs of the NHS, consortia will be better able to use research evidence to make better decisions about clinical services. By establishing means of sharing reports of local projects undertaken in partnership with researchers, consortia will be able to generate usable evidence relatively quickly about what does and what does not improve outcomes.

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CONFLICTS OF INTEREST

RB and MYT are both members of NIHR CLAMRC for LNR.

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